

VITAL SIGNS

THE DEATHS OF MIGRANTS IN THE GULF

REPORT 1 / MARCH 2022



vitalsignsproject.org





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

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A Nepali mother at Tribhuvan International Airport, Kathmandu, Nepal in June, 2020 after the body of her daughter, who had been working in the Gulf, was returned to the country.
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EXECUTIVE SUMMARY

The economies of the six oil-rich Gulf states of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates (UAE) are highly dependent on low-paid migrant workers from Asian states such as India, Nepal, Pakistan, Bangladesh, Sri Lanka, and the Philippines. These workers sustain a wide range of sectors, from domestic service, to hospitality, to construction. Despite widespread criticism of their systematic abuse and exploitation in the international media- notably in relation to Qatar's preparations to host the 2022 World Cup- the Gulf states have largely avoided structural labour reforms, and origin states have been unable to ensure proper protection for their nationals abroad. The perceived benefits of outward migration for origin states, combined with vested interests in the south Asian and southeast Asian recruitment industry, and the Gulf states' effective use of their economic and political leverage, in large part explains why origin states have never collectively demanded better protection for their workers. Whereas rights groups, trade unions, academics and the media have extensively documented the serious abuses to which these workers are routinely subjected, and identified the laws and policies and practices responsible, there is a

critical gap in this body of research: nobody knows how many of these workers are dying, or the causes of their deaths.

This project sets out to answer these questions and to propose and advocate for policies that will better protect the health and lives of low-paid migrant workers in the Gulf and ensure compensation for the families of those who have died needlessly. The purpose of this initial report, which will be supplemented by more detailed reporting on key thematic issues in 2022 and 2023, is to present a general overview of what we currently know about this issue.

Cumulative risks to health of low-paid migrant workers

There are approximately 30 million migrants in the Arab Gulf states, accounting for 52% of the region's total population of 58 million.¹ A significant proportion of these migrants - between 70 and 80% - work in low-paid sectors of the Gulf states' economies.

1. This statistic is based on the estimates provided in the [United Nations Department of Economic and Social Affairs International Migrant Stock 2019](#).

Low-paid migrant workers in the Gulf are subject to a combination of risks to their physical and mental health. These risks originate from the workplace, their living conditions (encompassing their accommodation and their broader neighbourhoods), and the environment. They vary in seriousness, and they are to varying extents under-researched and under-reported. Some of the risks are more measurable than others, but they are cumulative, and the likelihood is that, when they combine (as they often do), they can do so to deadly effect.

Heat and humidity is one of the risks that can be most easily measured, and where protection is most obviously lacking. Researchers in Kuwait found in 2020 that non-Kuwaiti males were vulnerable to hot temperatures “with a doubling to tripling risk of mortality.”² Research published in 2019 found a correlation between heat and deaths of Nepalese migrant workers in Qatar.³ New York University professor Natasha Iskander, conducted extensive field research on construction sites in Qatar and noted the impact of heat on workers.

Heat wrecked their bodies; they found themselves vomiting, suffering from headaches and muscle cramps, experiencing sudden shortness of breath, or feeling exhaustion so intense that it felt like crushing physical pain, rendering them unable to eat, wash, or undress at the end of the day. Rashes spread across their bodies, and shivers racked them. These were all symptoms of heat stress injury, frequently indicators of organ damage.⁴

None of the Gulf states have laws that adequately mitigate the risk posed to outdoor workers by its extremely harsh climate. Each country operates a rudimentary summer working hours ban that imposes a blanket ban on work at certain hours of the day during the summer months. There is a striking lack of evidence to support this method of protection as well as a lack of consistency in the hours of the day and the times of the year when these various bans are in force, which underscores the non-scientific character of these protections.

Bom Bahadur KC from Nepal died in Qatar in May 2021, at the age of 30. At the time of his death he was working in the construction industry. He told his family that the work was physically demanding. On May 10, 2021, Bom went to sleep

at around 10pm, but in the morning his colleagues found him dead in his bed. The death certificate, which the family showed to the Vital Signs Partnership, shows that the certified cause of Bom’s death was “acute heart failure due to natural causes.” His death occurred at a time of the year when there were no restrictions on working hours despite the day-time temperatures reaching 40 degrees centigrade on the day he died.⁵

Medical researchers believe that migrant workers in the Gulf may also be suffering from a form of chronic kidney disease, CKDnt, which appears to disproportionately affect men performing strenuous work in hot climates.⁶ There is a dearth of data and of research on the prevalence of the disease within migrant worker populations in the Gulf, but a study conducted in a tertiary care centre in Nepal in January-July 2019 found increased incidence of chronic kidney disease among Nepali migrant workers returning from Gulf States and Malaysia.⁷

Heat and humidity are not the only environmental risks facing workers who are employed outdoors in the Gulf. Dust storms are a frequent occurrence in all of the Gulf states throughout the year. A 2019 paper explored the association between exposure to poor air quality and acute mortality in Kuwait during a 17-year period from 2000 through 2016.⁸ The report concluded that the risk of dying among non-Kuwaiti males was 5% higher during dust storm days as compared to non-dust days.

These risks are compounded by abusive working conditions, which often include excessive working hours. Occupational health specialists have partly attributed the disproportionately high rate of male deaths from occupational diseases - 80% of the global total deaths involve men - to their involvement in occupations with a heavy physical workload.⁹ Workers in sectors like construction also face risks to their physical health as a result of the dangers inherent in such work and lax occupational health and safety (OHS) practices. Researchers from the Civil and Architectural Engineering Department at Sultan Qaboos University in Muscat, for example, have referred to a general “lack of knowledge and information about OHS in the construction industry” and provided detailed evidence of how “the implementations of such regulations varies dramatically” across the sector.¹⁰ Julhas Uddin was a 37 year old farmer from the district of Tangail in Bangladesh, who died in October 2017 when a supervisor instructed him

2. Barak Alahmad, Ahmed F. Shackarchi et al., “Extreme temperatures and mortality in Kuwait: Who is vulnerable?”, *Science of the Total Environment*, vol. 732, (25 August 2020).
3. Bandana Pradan, Tord Kjellstrom, Dan Atar, Puspa Sharma, Birendra Kayastha, Ghita Bhandari, Pushkar K. Pradhan, “Heat Stress Impacts on Cardiac Mortality in Nepali Migrant Workers in Qatar”, *Cardiology*, 2019,
4. Natasha Iskander, “Does Skill Make Us Human?: *Migrant Workers in 21st-Century Qatar and Beyond*”, Princeton University Press, (November 2021).
5. Historical daytime temperature data available at [timeanddate.com](https://www.timeanddate.com) and May 2021 temperatures for Doha available at <https://www.timeanddate.com/weather/qatar/doha/historic?month=5&year=2021>
6. CKDnt stands for Chronic Kidney Disease of unknown etiology.
7. N. Dhakal, N. Bhurtyal, P. Singh, D. Shah Singh, “Chronic Kidney Disease in Migrant Workers in Nepal”, *Kidney International Reports* (2020), p. 58.
8. Barak Alahmad et al., “Acute effects of air pollution on mortality: A 17-year analysis in Kuwait”, *Environment International*, (March 2019).
9. See Paivi Hamalainen, Juka Takala, Kaija Leena Saarela, “Global Estimates of Fatal Work-Related Diseases,” *American Journal of Industrial Medicine* 50, 2007, p. 29.
10. Amjaad Al Ghafri et al., “Evaluating the Occupational Health and Safety Practices in Small and Medium Construction Companies in Oman”, *International Journal of Structural and Civil Engineering Research*, (November 2020).

to enter a sewerage line without an oxygen cylinder. His family told the Vital Signs Partnership that there was no investigation into the circumstances of his death and his death certificate states that the cause of his death was “heart and breathing stopped.” Adeel Riaz was only 22 years old when he died in November 2018 in Saudi Arabia. His mother told the Vital Signs Partnership that his working conditions were “abysmal” and that he and his colleagues often worked without any supervision. “Everyone on the site was junior - they placed a ladder on the wrong spot - it had exposed electric wires. All of them got electrocuted. Two people were severely injured and the other two died.” Adeel’s death certificate states that the cause of death was “electrical short circuit” and added that the death was “natural”.

The aforementioned risks disproportionately affect male workers, but the gendered aspects of migration mean that women are also acutely at risk from their working conditions. It has long been established that domestic work makes women vulnerable to physical, psychological and sexual abuse, and these abuses have been extensively documented in the Gulf. A Human Rights Watch report that documented abuses of domestic workers in Oman and the United Arab Emirates found that 21 out of 87 domestic workers they interviewed experienced “psychological or health problems upon their return because of their exploitative working conditions in the Gulf.”¹¹ In 2010, Migrant-Rights.org reported how in one 2 month period, there was a migrant worker suicide or attempted suicide roughly every 2 days in Kuwait, and that many of these were domestic workers.¹² (The report noted that this was a particularly high rate of attempted suicides, but presented it as indicative of a general problem.) In 2012 a therapist at Hamad Hospital’s Psychiatric Unit in Doha told a local newspaper that 12 to 15 domestic workers visited the unit daily for treatment to cope with anxiety, including suicide ideations and attempts.¹³

Many migrant workers are exposed to long term chronic psychosocial stress that, the scientific evidence suggests, is likely to have a detrimental impact on their mental and physical health: they live away from their families for lengthy periods of time (and in the case of domestic workers often have no social support structures at all); they are subject to long and often abusive working conditions; they are housed in cramped unsanitary conditions; and often endure a range

of serious abuses. There is a clear lack of research and data on this topic - as psychiatric experts in the Gulf have noted, the mental health of migrant workers in the Gulf “is under-documented, under researched and underreported”¹⁴ - but there is emerging evidence of the possible extent and gravity of the problem. A 2018 study of 403 migrant workers from Nepal who had spent more than 6 months in either the Gulf states or Malaysia found that nearly a quarter reported mental health issues and concluded that “the strong association between self-reported poor health and perceived work environment is an important issue that policy makers in Nepal and destination countries should address.”¹⁵

Many of the factors that cause negative mental health outcomes also impact workers’ physical health. A survey in Kerala found a significantly higher rate of hypertension among subjects who had been migrant workers in the Gulf versus those who had not.¹⁶ The extent to which psychosocial stressors contributed to these particular findings is unknown, but there is no doubt that stress is a contributory factor to hypertension, which physicians refer to as the ‘silent killer’. The wife of a Keralite worker, Izaque John Varkey, who died in the Gulf five months after being made redundant, and whose employer did not pay his end of service benefits until seven weeks after his death, told us that she believed that the stress and isolation from his family had contributed to his death. “His friends were aware of his situation but he never told us the state he was in”, she said. The cause of his death was officially recorded as “acute heart failure due to natural causes.”

The Covid-19 pandemic exacerbated many of the health risks facing migrant workers. Kuwaiti researcher Sharif Alshalfan wrote that the “dire housing situation has been exacerbated by the onset of COVID-19” with social distancing and handwashing directives undermined by pre-existing overcrowding and that the imposition of a curfew “effectively created a petri dish for the spread of the disease” and “imprisoned [migrant workers] in an enclave of emotional and physical distress.”¹⁷ In Saudi Arabia, hundreds if not thousands of Ethiopian migrants were held in squalid detention conditions during 2020 while they awaited removal from the country. Human Rights Watch spoke to migrants who estimated that 300 to 500 women and girls were held in one room in severely overcrowded conditions.¹⁸ Migrant-Rights.org reported that the pandemic had “wreaked havoc on the mental health of migrant workers in the GCC states.”¹⁹

11. Human Rights Watch, “‘Working Like a Robot’: Abuse of Tanzanian Domestic Workers in Oman and the United Arab Emirates”, (14 November 2017).

12. Migrant-Rights.org, “Almost every two days a migrant worker commits suicide in Kuwait”, (5 October 2010).

13. Quoted in <https://www.amnesty.org/en/documents/mde22/004/2014/en/>. Full article accessible at <https://www.thefreelibrary.com/Housemaids+learn+coping+skills+with+occupational+therapy-a0314454936>

14. Muhammad Ajmal Zahid and Mohammad Alsuwaidan, “The mental health needs of immigrant workers in Gulf countries”, International Psychiatry, volume 11, (2014).

15. Pratik Adhikary, Zoë A. Sheppard, Steven Keen, and Edwin van Teijlingen, “Health and well-being of Nepalese migrant workers abroad”, International Journal of Migration, Health and Social Care, (January 2018)

16. N Shamim Begam, Kannan Srinivasan, and G K Mini, “Is Migration Affecting Prevalence, Awareness, Treatment and Control of Hypertension of Men in Kerala, India?”, Journal of Immigrant and Minority Health, (2016).

17. Sharifa Alshalfan, “COVID-19 in Kuwait: how poor urban planning and divisive policies helped the virus spread”, London School of Economics Public Policy Blog, (September 16, 2020).

18. Nadia Hardman, ‘Immigration Detention in Saudi Arabia During Covid-19’, Human Rights Watch

19. Migrant-Rights.org, “Covid Relief Report 2021”, (3 November 2021)

The pandemic also exposed systematic problems with migrant workers' access to healthcare, which is often dependent on their employers providing them with health cards that they need to access affordable, subsidised care. A 2020 Konrad Adenauer Stiftung report on migrant workers' access to health concluded that despite some positive steps during the pandemic, when Saudi Arabia and the UAE, for example, allowed migrant workers to receive free medical treatment regardless of their immigration status, the pandemic-driven rise in unemployed and uninsured migrant populations is one of the reasons why, in their view, "it is likely, more migrants will inevitably face health insecurity due to lack of access to employment and full health insurance coverage, particularly for those irregular migrants."²⁰ Medical professionals in the Gulf noted the importance of insurance and the tendency of migrant workers to go without medical care for extended periods of time, leading to rapid declines in their health. "Medical care in Bahrain is definitely costly, so they don't get medicines. Not everyone has insurance", said Dr Babu Ramachandran, of the American Mission Hospital in Bahrain.²¹

A 2019 policy brief by the Qatar Foundation and Georgetown University Qatar noted that the absence of health cards "imposes an immense burden" on migrant workers and said that, "strict measures of accountability must be in place to ensure that employers issue Qatar IDs and health cards to their employees in a consistent and timely manner."²²



Data

The data that is available on the deaths of migrant workers in the Gulf is incomplete, in places contradictory, and it precludes effective analysis of the extent and gravity of the problem. These problems are compounded by a general lack of transparency. However, despite the shortcomings of the data, it appears that as many as 10,000 migrant workers from south and southeast Asia die in the Gulf every year (this figure will obviously be higher when migrant workers of other nationalities are included) and that more than 1 out of every 2 deaths is effectively unexplained, which is to say that deaths are certified without any reference to an underlying cause of death, instead using terms such as "natural causes" or "cardiac arrest".

In Pakistan, for example, the only data available on this issue relates to the raw numbers of claims made for compensation to the State Life Emigrants Insurance Fund with

no disaggregation at all. In India, where a relative wealth of data is available, there is a serious discrepancy relating to the number of nationals who have died in Saudi Arabia, the Gulf country that employs more migrant workers than any other. Whereas India's Minister of State in the Ministry of External Affairs said that 12,595 Indians had died in the Kingdom between 2015 and October 2019, the Indian Embassy in Saudi Arabia, responding to a right to information request from the Center for International Migration Studies in Kerala said that 7,444 Indians had died in almost exactly the same period - a difference of 5,151 people. Despite the number of migrant workers it employs, Saudi Arabia publishes no meaningful mortality data so India's data cannot be cross-checked against anything published by Saudi Arabia.

A more systematic discrepancy is evident in the distribution of causes of death. According to the Indian authorities in Kuwait, 42% of deaths were classified as heart attacks. The Indian authorities in Bahrain, meanwhile, reported that only 4% of Indian deaths there were from heart attacks, while 47% were attributed to "cardiac arrest". These discrepancies are critically important and point to serious problems, either in the investigation, the certification, or the categorisation of these deaths, or a combination of all three problems. Whereas a heart attack is something that physicians can diagnose as an underlying cause of death and can appear on a properly formulated death certificate, 'cardiac arrest' provides no information on the underlying cause of death and should not appear on a death certificate. (A heart attack is when a blockage stops blood flow to the heart. A cardiac arrest simply means that the heart stopped beating, it does not explain what caused it to stop). Whereas the high rate of cardiac arrests in Bahrain - 47% - is an indication of a systematic failure to identify an underlying cause of death, the disproportionately high rate of heart attacks in Kuwait - 42% - points either to the same conclusion, with heart attack appearing to represent a 'best guess' as opposed to a medically identified cause of death. A second possibility is that it indicates that Indian authorities are reclassifying deaths certified by the Bahraini medical authorities as having occurred from "cardiac arrest" as having been caused by heart attacks. A third explanation - the least plausible - is that the rate of heart attacks among Indians in Kuwait is significantly higher than the global rate, which would be of urgent interest and concern to cardiologists everywhere.²³

Further evidence of systematic problems in the reporting in the causes of deaths is available in the data published by the Qatari authorities. From 2010 to 2015, a significant number of non-Qatari deaths were coded in categories indicating that the

20. Konrad-Adenauer-Stiftung, "Migration and The COVID-19 Pandemic in the Gulf", (October 2020).

21. Migrant-Rights.org interview with Dr Babu Ramachandran, American Mission Hospital in Bahrain, (date).

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

23. There is no precise data on the percentage of global deaths attributable to heart attacks. The WHO has said (see [factsheet](#)) that 27% of global deaths are caused by heart attacks and strokes, but provides no further breakdown. More detailed information comes in peer-reviewed literature, but these do not report mortality statistics in crude percentages, and what is most clear is how the mortality rate for cardiac-related diseases varies in different countries and across different socio-economic groups. See Fang Wang et al., "Global Burden of Ischemic Heart Disease and Attributable Risk Factors, 1990–2017: A Secondary Analysis Based on the Global Burden of Disease Study 2017", *Clinical Epidemiology*, September 2021.

cause of death was unknown. However, from 2016 onwards these numbers dropped dramatically, while at the same time numbers of deaths classified as “circulatory diseases” increase correspondingly. To illustrate this, in 2015, 376 non-Qataris of all ages were reported in official Qatari statistics to have died from unknown causes, dropping to 82 in 2016. In contrast, the equivalent figures for circulatory diseases increased from 221 in 2015 to 464 in 2016. Unless there was a major change in the way the Qatari authorities investigated migrant deaths (and there is no evidence of this), it appears likely that the increased number of migrant workers categorised as dying of “circulatory diseases” since 2016 is obscuring the fact that in many cases their cause of death was unknown.

Despite its limitations, the data is enlightening in many respects and points to many issues worthy of further investigation. The data made available by the Kuwaiti authorities, for example, provides a breakdown of how Kuwaitis and non-Kuwaitis die from external causes and shows that whereas non-Kuwaitis account for 69% of the country’s population, they account for 89% of the country’s suicides. It should also be noted that the age and sex structure of migrants is different to the whole Kuwaiti population, so this is not a like for like comparison. Data made available by the UAE authorities shows that the age profile of non-Emirati men who died was significantly different to the profile for non-Emirati women. In 2018 and 2019, for example, 47% of men who died were between the ages of 20 and 49, whereas only 24% of women who died were in this age bracket. This data is not broken down by nationality or occupation, and more importantly there is no information on the numbers of non-Emirati men and women in these age distributions across the population. To calculate and compare rates of death from different causes, it is imperative not only to know the precise causes of all deaths (in statistical terms, the numerator) but also to know how many individuals were present among any given population - this number is known as the denominator. A serious and common failure in the data published by origin and destination states is the lack of any denominator data. Even when denominators are presented, a time component (e.g., week, month, etc.) is needed to measure a death rate per a time unit. Death rates usually exhibit a seasonal trend which could coincide with external environmental stressors such as summer heat. Aggregate annual estimates cannot uncover these death patterns.

To properly inform public health experts, countries should make detailed and disaggregated easily available, breaking it down by age, nationality, sex, occupation, date of death, cause of death

and ensuring that a denominator is provided to facilitate the calculation of mortality rates per number of population. Causes of death should be certified into categories and sub-categories outlined in the International Classification of Diseases (ICD), which is the basis for comparable statistics on causes of mortality and morbidity between places and over time.

Investigations and compensation

The aforementioned problems with data are to some extent linked to failures to properly investigate deaths. Traditional autopsies are the subject of some sensitivity in the Gulf region. As noted by Saudi Arabian physicians, the reason that traditional autopsies have not been routinely performed “is partly religious in origin” and there is a general failure or hesitancy to conduct invasive autopsies except in the most obviously suspicious circumstances.²⁴ Medical researchers in Kuwait have noted that pathologists in the country are under pressure “to avoid evisceration as much as possible.”²⁵ In Qatar, the authorities have claimed that, “in accordance with the law, the family of the deceased must first approve an autopsy before it is carried out.” However, the focus on invasive autopsies as the primary method of identifying cause of death ignores significant advances in the techniques and technologies that are available to pathologists.

In 2014, medical researchers in Bahrain proposed the introduction of virtual autopsies in the country.²⁶ These types of autopsies use computed tomography (CT) and magnetic resonance imaging (MRI) scans and thereby should enable pathologists to investigate deaths more thoroughly in a way that does not contravene religious prohibitions. In October 2021, the government of Abu Dhabi announced that it would introduce non-invasive post-mortem imaging to conduct autopsies in what appears to be the first introduction of the technology in the region.²⁷

None of the families of deceased workers whose cases are featured in this report were offered autopsies and none of their death certificates suggest that there was any meaningful investigation into the causes of their death. Proper investigations into causes of death are the only way to ensure that the families of migrant workers who die in the Gulf understand how their loved ones die. Carlos de Guzman Ely Jr. from the Philippines died in Saudi Arabia in 2021 at the age of 45. Despite the fact that he had been diagnosed with a heart condition and high cholesterol before he left the Philippines

24. Salah Al-Waheeb et al., “Forensic autopsy practice in the Middle East: comparisons with the West”, *Journal of Forensic and Legal Medicine*, (February 2015).

Mohammed Omar Sohaibani, “Autopsy and Medicine in Saudi Arabia”, *Annals of Saudi Medicine*, (1 May 1993).

25. Salah Al-Waheeb et al., “Forensic autopsy practice in the Middle East: comparisons with the West”, *Journal of Forensic and Legal Medicine*, (February 2015).

26. Eamon Tierney et al., “Is It Time for a Virtual Autopsy Service in Bahrain?”, *Bahrain Medical Bulletin*, (December 2014). See information on post-mortems at the website of the British Embassy in Bahrain.

27. Abu Dhabi Government Media Office, “Department of Health Abu Dhabi Introduces Virtual Autopsy for Mortuary Investigations”, (24 October 2021).

and was taking medication for his heart condition, his death notification, issued by Saudi Arabia's Ministry of Health, recorded the cause of death as "unknown". Carlos' son said that his death had left the family "devastated and confused." In addition to the emotional impact of not knowing how their loved ones have died, investigations are imperative to ensure that families receive compensation, in cases where deaths are the result of a lack of protection or other forms of negligence. Currently, it is workers themselves who have to either take out insurance or pay into mandatory insurance schemes run, for example by Bangladesh's Wage Earners Welfare Board or the Philippine Overseas Worker Welfare Administration, to compensate the families of the workers who die. Thus, the burden of providing families with some measure of redress, does not fall on the Gulf states or the origin states, but on the low-paid workers themselves.

- Ensure that migrant workers have access to mental as well as physical healthcare and that mental health policies, where they exist, are updated to include reference to the specific requirements and vulnerabilities of low-paid migrant workers.
- Pass legislation to ensure that employers are required to provide outdoor workers with breaks of an appropriate duration, in cooled, shaded areas, when there is an occupational risk of heat stress; mandatory break times should take into account the environmental heat stress risks along with the exertional nature of the work being performed.
- Conduct widespread screening and treatment programs for hypertension.
- Conduct a study into the prevalence of CKDu or early-stage kidney disease among low-paid migrant worker populations.



Key Recommendations

The governments of **Gulf Cooperation Council States** should

- Establish specialised teams of inspectors and medical examiners to ensure that all deaths of migrant workers are investigated and certified in accordance with international best practice.
- Commission independent investigations into the causes of migrant workers' deaths and ensure that any investigation examines the possible role played by heat and humidity, overwork, air pollution, psychosocial stress, and workers' ability to access health care.
- Improve the quality of available data on mortality statistics for migrants. The data should be fully disaggregated by age, sex, occupation, nationality, date of death, and underlying cause of death to allow comparison across multiple categories.
- To take account of circumstances and contexts where invasive autopsies are not possible, introduce non-invasive and verbal autopsy procedures after consultation with experts.
- Make primary and emergency healthcare for low-paid migrant workers free of charge at the point of care, irrespective of workers' immigration status or their possession of a health card, and ensure that fully resourced clinics and emergency rooms are in close proximity to areas with large populations of low-paid migrant workers. Ensure that a follow-up system is in place to ensure that labour inspectors follow up with employers of workers who do not possess health cards and impose meaningful sanctions on those who have not provided their employees with up-to-date health cards.

The governments of **origin states** should:

- Make available all historical data on deaths of overseas workers, disaggregated by destination, occupation, age, gender, date of death and cause of death. This data should be available online and presented in a way that facilitates effective analysis by public health experts. It should be accompanied by accurate, detailed data on the numbers of nationals in each Gulf destination state.
- Ensure that all government ministries that collect and publish data on deaths of nationals overseas report to international standards (the WHO's International Classification of Diseases). In cases where death certificates provide no underlying cause of death (for example when they are certified without further context or explanation to "natural causes", "cardiac arrest", "acute heart failure", or "acute respiratory failure") they should be attributed in government records to the ICD code that refers to "ill-defined or unknown cause of mortality".
- Call on the Gulf states to: enhance investigation procedures for migrant worker deaths; commission independent investigations into the causes of migrant worker deaths; enhance legal protection from heat stress.
- Strengthen the capacity of embassies in the Arab Gulf states to ensure that remains are returned in a timely fashion and to provide support to the families of the deceased, including in relation to cases where families are entitled to compensation.
- Ensure that the issue of the investigation of migrant worker deaths, protection from risks to migrant worker health, and migrant workers' access to healthcare are on the agenda of regional processes such as the Abu Dhabi Dialogue and the Colombo Process.



A migrant worker carries a bag of coal, Jeddah, Saudi Arabia, 2014. © REUTERS/Faisal Al Nasser/Alamy

1. ABOUT THIS REPORT

1.1. Methodology

This report presents an initial overview of a complex and multifaceted problem and is the first of a series of reports that the Vital Signs Partnership will release in 2022 and 2023. This report:

- presents, compares and analyses the data that is available on the deaths of low-paid migrant workers from five significant countries of origin - Pakistan, Bangladesh, Nepal, India, and the Philippines - and in the six countries that constitute the Gulf Cooperation Council (GCC) - Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates;
- details and describes the most significant risks to the physical and mental health of low-paid migrant workers in the GCC and outlines how the Gulf states mitigate these risks; and
- presents a series of individual case studies that illustrate many of the risks that low-paid migrant workers face in the Gulf and the impact of the deaths of migrant workers on their families.

In relation to data, we have obtained information from right to information requests submitted in India and data made available by Indian embassies in Bahrain and Kuwait, data

published by the State Life Emigrants Insurance Fund in Pakistan, information made public by Nepal's Ministry of Labour, Employment and Social Security based on data provided by Nepal's Foreign Employment Board. The data we have published here on the deaths of Bangladeshi workers abroad was obtained from informal government sources. In the Philippines, we sent Freedom of Information (FOI) or Right to Information (RTI) requests on mortality statistics to a range of Philippine government agencies, including the Department of Foreign Affairs, the Overseas Worker Welfare Administration and the Department of Labour and Employment. The Center for Migrant Advocacy organized a meeting with Philippine government stakeholders in November 2021 to discuss the Vital Signs project and discussed with them the lack of publicly-available data on such deaths. In the GCC states, we examined "Vital Statistics" birth and death datasets published by the statistical and/or health authorities in each country. The only country that does not make any data available on this issue is Saudi Arabia.

In relation to the identification of the risks facing low-paid migrant workers in the GCC, this is based on a summary of the most relevant sources of secondary information, most notably reports from international and non-governmental organisations, peer-reviewed articles, newspaper articles. We also conducted interviews with human rights researchers,

physicians and individuals with direct experience of the physical and mental health care provision for migrant workers in the GCC.

Partner organisations conducted multiple interviews with the families of migrant workers who died in the GCC in the last five years and one case study was selected for each country of origin. These interviews were not designed to provide representative examples of the various ways in which migrant workers die in the GCC and they are not intended to be presented as evidence of prevalence of any of the systematic risks or abuses identified in section 4, rather they serve to highlight some of those risks and abuses, and to demonstrate the financial and emotional impact of deaths of migrant workers on their families.

The report reflects the fact that migration is a gendered process and the health risks facing male and female migrant workers are not the same. Considerable attention is therefore paid to the particular risks that face low-paid female migrant workers in particular domestic workers. The case studies in this report predominantly involve the deaths of male workers. On the one hand, this reflects the gender split of the low-paid migrant worker population in the Gulf, where men outnumber women by an approximate factor of four to one, but it is also a reflection of the cases that we identified and documented. Several cases of female workers were documented, but we considered them unsuitable for inclusion as case studies. In subsequent reports, where specific thematic issues will be addressed in far greater detail, we expect to pay considerable attention to gendered risks to physical and mental health and to document cases that illustrate these.

With regard to the secondary sources of information on migrant workers abuses in the Gulf, it is important to note that the general absence of critical NGOs in the GCC means that with some notable exceptions, and despite the impressive body of research produced by Migrant-Rights.org (a member of the Vital Signs Partnership) much of the criticism over the treatment of migrant labour has come from international human rights research and advocacy organisations and they have often focused their efforts on the most visible abuses on the most high-profile projects and in countries they can more easily access. As such, there is a disproportionately small body of research on migrant worker abuses in Saudi Arabia (where access is particularly difficult), and to a lesser extent Bahrain, and Oman. Qatar's successful bid to host the 2022 World Cup, announced by FIFA in December 2010, has placed it under intense scrutiny on labour abuses generally and on the issue of migrant worker deaths in particular. Human Rights Watch

and Amnesty International have both issued detailed pieces of research on migrant worker deaths and in August 2021, Amnesty International stated that "Qatar's long-standing failures to prevent, investigate and remedy the deaths of migrant workers constitute violations of the right to life and the right to healthy working and environmental conditions." This assessment of Qatar's record on this issue has been facilitated by the large body of research conducted in the country, and the information in this report to some extent also reflects this higher level of focus. However, it is important to note that Qatar is not an outlier in the Gulf context, either in terms of offering significantly better protection to workers or in terms of living and working conditions being any worse than elsewhere in the Gulf. Due to the relative homogeneity of the laws, policies and practices that shape migrant workers' living and working conditions, it would be more accurate to say that the situation in Qatar is representative of conditions across the region.

With regard to terminology, we use the term low-paid migrant workers, to denote workers whose salaries are below the limit that would entitle them to secure family visas for their dependents.²⁸ Natasha Iskander has noted how migrant workers in sectors such as construction are highly skilled, even though their employers and supervisors 'routinely and indiscriminately dismissed their workers as unskilled, disparaging them as "poor quality," "unproductive," or simply and most derisively, "bodies."' ²⁹ Similarly, we avoid the use of the terms 'expatriate' or 'professional' to denote workers who earn enough to secure family visas for their dependents.

1.2. The Vital Signs Partnership

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

28. See for example Migrant-Rights.org, "[Oman reduces minimum salary required to bring families](#)", (6 October 2017).

29. Natasha Iskander, "[Does Skill Make Us Human?: Migrant Workers in 21st-Century Qatar and Beyond](#)", Princeton University Press, (November 2021).



A family member waits with offerings for the final ritual of their relative whose body has been returned from the Gulf to Tribhuvan International airport, Kathmandu, June 2020, © Rojan Shrestha/NurPhoto/Getty Images

2. WHAT WE KNOW ABOUT THE NUMBERS AND CAUSES OF DEATH OF MIGRANTS IN THE GULF

There are approximately 30 million migrants in the Arab Gulf states, accounting for 52% of the region's total population of 58 million.³⁰ A significant proportion of these migrants - between 70 and 80% - work in low-paid sectors of the Gulf states' economies such as construction, hospitality and other service sectors, and domestic work.

Information about the deaths of migrants in the six countries of the Gulf Cooperation Council (GCC) is fragmented and incomplete. This makes analysis of the causes and circumstances of migrant workers' death more challenging. Not knowing how migrant workers have died means there is no pressure on governments to implement public health policies to better protect migrant workers and minimise preventable deaths, and prevents families from seeking compensation that may be available to them. This chapter sets out what is publicly known about the deaths of nationals of Bangladesh, India, Nepal, Pakistan, and the Philippines in the GCC states.

This reflects information sourced through Right to Information (RTI) requests, publicly available information, and requests to government authorities. In view of the poor quality of the data, it is not possible to make direct comparisons or perform meaningful analysis, so for each country we only offer observations on the data that is available.

The optimal situation in relation to mortality statistics occurs when states systematically investigate deaths, using all medical and non-medical means at their disposal to determine the causes of all deaths, and certify those deaths in line with best practice on death certification. They should then record these deaths on a central database, with each death being coded into the categories and sub-categories outlined in the WHO's International Classification of Deaths (ICD), which is the basis for comparable statistics on causes of mortality and morbidity between places and over time.

30. This statistic is based on the estimates provided in the [United Nations Department of Economic and Social Affairs International Migrant Stock 2019](#).

2.1. Origin states

All of the origin state governments provide some data on the numbers of nationals who die, and most provide some form of breakdown by country of death. Some provide further detail on cause and date of death and other important characteristics such as sex, age and occupation. In no cases, however, are disaggregated statistics available on the population of nationals in the destination country, which would allow a meaningful analysis of data around deaths. The lack of denominator data (the precise number of workers from each origin country that are in each GCC country at a given date or over a fixed period of time) is a critical factor precluding definitive assessment of the extent to which the incidence rates of different causes of death among migrant worker populations compare to rates among other populations

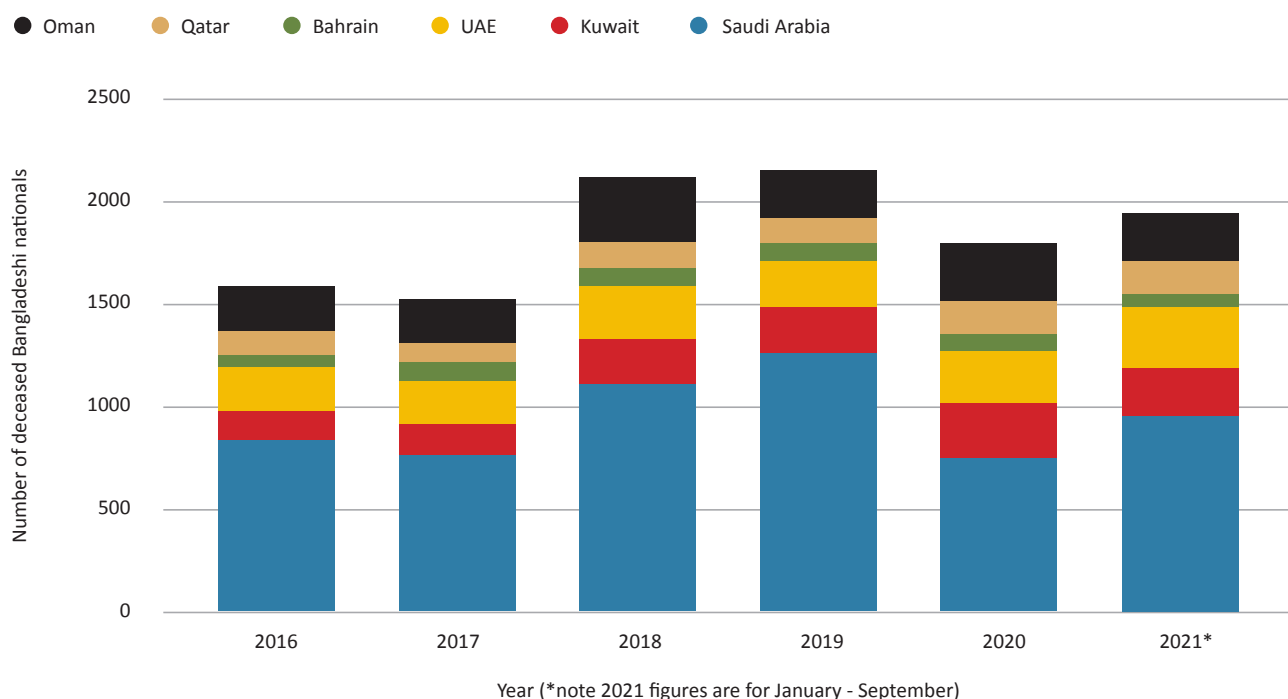
2.1.1. Bangladesh

Transparency and quality of data

There is very limited data publicly available on the deaths of Bangladeshi migrant workers in the Gulf. Vital Signs in-country partner, RMMRU, was able to obtain country specific data from the Shahjalal International Airport, Dhaka, where more than 90% of deceased Bangladeshis, including the vast majority of bodies of migrant workers from the Gulf states, are received. However, no data is available on the causes of deaths nor on the characteristics of the returning deceased migrants. There are also some contradictions between the data from Shahjalal International Airport and figures provided by the government for the total number of deceased Bangladeshi returning each year through all of the country's three international airports.

Returns of deceased migrant workers from the GCC countries, Dhaka airport, 2016-2021

Source: Shahjalal International Airport, Dhaka



Observations

The number of deaths in the Gulf have been gradually rising since 2016, with a significant dip in 2020, perhaps as a result of the Covid-19 pandemic. While this led to the deaths of large numbers of Bangladeshi migrant workers, it also meant the repatriation of about 400,000 Bangladeshi migrant workers, and a drop in new deployments of workers from 700,000 to 215,000.³¹

51% of all deaths occurred in Saudi Arabia, where about 2.28 million Bangladeshis were resident in 2021 (see Table 1). This is a slightly higher share of deaths than Saudi Arabia's share of the Bangladeshi population across the region. Kuwait's share of deaths is considerably higher than the population of Bangladeshis it hosts.

31. Mohammad Rakibul Hasan and Naimul Karim, 'Bangladesh's pandemic-hit migrants seek local work as loans mount', Thomson Foundation, (30 March 2021)

Data	Saudi Arabia	Kuwait	UAE	Bahrain	Qatar	Oman
Deaths registered at Dhaka airport 2016-2021	5743	1233	1452	478	784	1486
	51.35%	11.04%	13.00%	4.28%	7.02%	13.31%
Approximate population 2020-21	2,280,000	350,000	750,000	200,000	400,000	680,000
	48.93%	7.51%	16.09%	4.29%	8.58%	14.59%

Official sources for population figures include Bangladeshi embassies and foreign ministry, Oman National Centre for Statistics and Information.³²

However, because it is not clear if the mortality numbers are accurate and because the population figures are imprecise and are not broken down by other characteristics, it is impossible to know if these anomalies in the data reflect anomalies in reality, let alone to attempt to explain what the underlying reasons for them could be.

2.1.2. India

Transparency and quality of data

Through RTI requests, and analysis of fragmented data sets shared by Indian embassies in the Gulf, it is possible to make some assessment of the circumstances of the deaths of Indian nationals. The Indian government shares total figures about the deaths of nationals in response to RTIs as well as more specific data about causes of death, and the populations of Indian nationals, when requested. As noted below, however, these figures can be contradictory, raising concerns about the accuracy of information shared by the authorities.

In addition to data provided by the federal government, Indian embassies in Bahrain, Kuwait and Oman, have also at various points shared data sets on their website detailing the deaths of nationals. In the case of Kuwait and Bahrain, the detail provided- which includes age, sex, and cause of death but not occupation - allows for some analysis of the circumstances of deaths. It is, however, not possible to tell how complete these data sets are for the time periods they cover. In the case of Kuwait, the total number of entries in the embassy's data is substantially lower than the total figures provided by the Indian federal government for the corresponding years.

In relation to the data published by Indian embassies in the Gulf, the data is not classified with any consistency or with reference to the codes in the WHO's International Classification of Deaths. It is therefore not possible to

meaningfully compare Indian deaths in Bahrain and Kuwait, with the result that patterns or anomalies in mortality rates, which may reflect badly mitigated risks or emergent new ones, cannot be detected with reference to the data.

Observations

In the Indian government's responses to requests for information, there is a substantial discrepancy relating to the number of nationals who have died in Saudi Arabia. In November 2019, responding to a question asked in the Lok Sabha (India's parliament), the Minister of State in the Ministry of External Affairs said that 12,595 Indians had died in the Kingdom between 2015 and October 2019. However, responding to a RTI request made by the Centre for Indian Migration Studies (Kerala) in December 2020, the Indian Embassy in Saudi Arabia said that between 2015 and 2019, 7,444 Indians had died. This represents a dramatic difference of 5,151 people (69%) for an almost identical time period. A further response to a question in the Lok Sabha in February 2022 appears to confirm that the higher figure is more likely to be accurate.

The February 2022 response shows that deaths increased notably in 2020 and 2021, the years of the Covid-19 pandemic. For the three years prior to the outbreak of the pandemic the total number of deaths was 17,667, an average of 5,892 deaths per year. In 2020 and 2021, 16,732 Indian nationals died in the Gulf states - an average of 8366 deaths per year. This represents a difference of nearly 5,000 deaths over this two year period. Until 31 January 2022, 3,670 Indian nationals were recorded as dying of Covid-19 across the Gulf. The fact that the number of excess deaths is greater than the number of recorded Covid-19 deaths may reflect reporting failures in the Gulf states, or deaths indirectly resulting from the pandemic.³³

32. Md Owasim Uddin Bhuyan, 'Over 40,000 Bangladeshis may be legalised in Bahrain', New Age, (12 May 2020) Jamil Mahmud and Rashidul Hasan, 'Bangladeshi Workers: Around 2 lakh may have to leave Kuwait', The Daily Star, (15 July 2020) Samihah Zaman, 'Bangladeshi Embassy moves to new location in Abu Dhabi', Gulf News, (15 January 2021) 'Dhaka seeks Qatar's urgent step to help Bangladeshis return, join work', Dhaka Tribune, (1 December 2020)

33. According to the [World Health Organization](#), "excess mortality is defined as the difference in the total number of deaths in a crisis compared to those expected under normal conditions. COVID-19 excess mortality accounts for both the total number of deaths directly attributed to the virus as well as the indirect impact, such as disruption to essential health services or travel disruptions."

Source	Lok Sabha question, November 2019	RTI response, December 2020	Lok Sabha question, February 2022
Time period of deaths	January 2015 - October 2019	January 2015 - December 2019	January 2017 - December 2021
Bahrain	1,060	1,090	1,337
Kuwait	3,021	3,144	4,437
Oman	2,490	2,573	3,049
Qatar	1,332	1,736	1,622
Saudi Arabia	12,595	7,444	13,649
UAE	8,044	8,345	10,315

Country	Covid deaths up to January 2022	Covid deaths by %	Indian population 2020	Indian population by %
Bahrain	203	6%	323,292	4%
Kuwait	668	18%	1,029,861	12%
Oman	555	15%	779,351	9%
Qatar	113	3%	756,062	8%
Saudi Arabia	1,237	34%	2,594,947	29%
UAE	894	24%	3,420,000	38%
Total	3,670	100%	8,903,513	100%

Source: RTI response, 2020 and Lok Sabha response, 2022

Data from the Indian embassies in Bahrain and Kuwait, which we have arranged into broad categories based on the terms used, provides insights into the main causes of death

for Indian nationals in these countries, but the most notable aspect of the two datasets is the inconsistency in the way they classify deaths.

Main cause identified in Indian embassy data	Bahrain, mid-2014 to mid-2018	Kuwait, 2014 to 2017
Accident	11.6%	16.3%
Brain stem death	2.0%	–
Cardiac arrest	46.6%	–
Cardiogenic shock	2.8%	–
Heart attack	4.2%	42.1%
Murder	–	0.4%
Natural causes	–	20.3%
Respiratory failure / arrest	2.6%	–
Sickness	–	10.1%
Septic shock / sepsis / septicaemia	6.9%	–
Suicide	8.6%	6.9%
Under investigation	–	3.0%
<i>Other cause mentioned or unclear</i>	14.7%	0.8%
Total	100%	100%

In Kuwait, 42% of deaths were classified as heart attacks. In Bahrain, meanwhile, only 4% of deaths were classified as heart attacks, while 47% were attributed to cardiac arrest.³⁴ No deaths were attributed to cardiac arrest in Kuwait. Similarly 20% of deaths are attributed to “natural causes” in Kuwait and a further 10% to “sickness”, whereas no deaths are attributed to “natural causes” or “sickness” in Bahrain. These discrepancies are critically important and point to serious problems, either in the investigation, the certification, or the categorisation of these deaths, or a combination of all three problems.

A heart attack is when a blockage stops blood flow to the heart. A cardiac arrest simply means that the heart stopped beating, it does not explain what caused it to stop.³⁵ Whereas a heart attack is something that physicians can diagnose as an underlying cause of death and can appear on a properly formulated death certificate, ‘cardiac arrest’ provides no information on the underlying cause of death and should not appear on a death certificate. The term “natural causes” likewise provides no information on the cause of a person’s death.³⁶ Thus, whereas the high rate of cardiac arrests in Bahrain - 47% - is an indication of a systematic failure to identify an underlying cause of death, the disproportionately high rate of heart attacks in Kuwait - 42% - points either to the same conclusion, with heart attack appearing to represent a ‘best guess’ as opposed to a medically identified cause of death, or it could be an indication that Indian authorities are reclassifying deaths certified by the Bahraini medical authorities as having occurred from “cardiac arrest” as having been caused by heart attacks. The third option is that the rate of heart attacks among Indians in Kuwait is significantly higher than the global rate, which would be of urgent interest and concern to cardiologists everywhere.³⁷

2.1.3. Nepal

Transparency and quality of data

Nepal’s Foreign Employment Board and Department of Foreign Employment through FEIMS is the government entity under the Ministry of Labor, Employment and Social and Security are the institutions responsible for collecting and maintaining data on the deaths of Nepali nationals abroad. The most useful data available on the deaths of migrant workers from Nepal was published in the Ministry of Labour, Employment and Social Security’s 2020 Labour Migration report, based on data provided by the Foreign Employment Board.³⁸ This provided a breakdown, by cause of death, of all recorded deaths of Nepali nationals

in the six Gulf states, and Malaysia, between 2008/09 and 2018/19. It collates causes of death into seven broad categories: cardiac arrest; heart attack; natural cause; traffic accident; suicide; workplace; and other causes. These categories are not aligned with international guidance on classification and contain potential for overlap (for example, worksite is a location not a cause of death). Additionally, the available data does not break these causes of death down by age, gender, occupation or date of death, limiting its usefulness. Accurate information about the number of Nepali workers in Gulf states is not available (the MOLESS report includes only information about the number of migrants departing for each destination country, as opposed to the number of residents), meaning there is no denominator data. MOLESS also provides total numbers for deaths, each year in Malaysia and the Gulf, for men (who constitute about 98% of deaths) and women (2%). These are not broken down by country of destination nor by cause of death. The Welfare Activities report of the Foreign Employment Board also provides basic information about the number of families provided financial relief after the deaths of their relatives.³⁹

Observations

47% of all deaths recorded (1,598) are registered as either cardiac arrest or natural cause. Numbers for these causes of death are particularly high in Qatar and Saudi Arabia, the Gulf countries that host the highest numbers of Nepali nationals. Notably, there are very high numbers of “natural cause” in Saudi Arabia, and correspondingly high numbers of “cardiac arrest” in Qatar, suggesting that deaths where no underlying cause of death has been identified (making the death unexplained) are certified with different terminology in different Gulf states. The fact that more Nepalese deaths in the Gulf are attributed to “natural causes” than to any other cause of death is particularly troubling.

Traffic accidents are the cause of 20% of all deaths (672). The majority of these deaths (465) occurred in Saudi Arabia and represented 29% of all deaths of Nepali nationals in Saudi Arabia over the time period. Unlike suicide, workplace accidents, and other causes, where numbers for Qatar and Saudi Arabia are broadly comparable, there is a big difference between the scale of traffic accident deaths in Saudi Arabia and Qatar.

Suicide accounts for 9% of all deaths (299 people in total) across the Gulf. In UAE the share of deaths from suicide is notably high, accounting for 15% of all Nepali deaths in the country.

34. The data here is slightly more complex than as presented above, in the sense that not all of these were specifically classified as “cardiac arrest” or “heart attack” but the term used is more or less the same, for example we placed “cardiopulmonary arrest” into “cardiac arrest” and we placed “heart problem” into “heart attack”.

35. For a full description of the difference see [Harvard Medical School explainer](#), 26 April 2018.

36. See for example, UK Office of National Statistics, [Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales](#), page 8

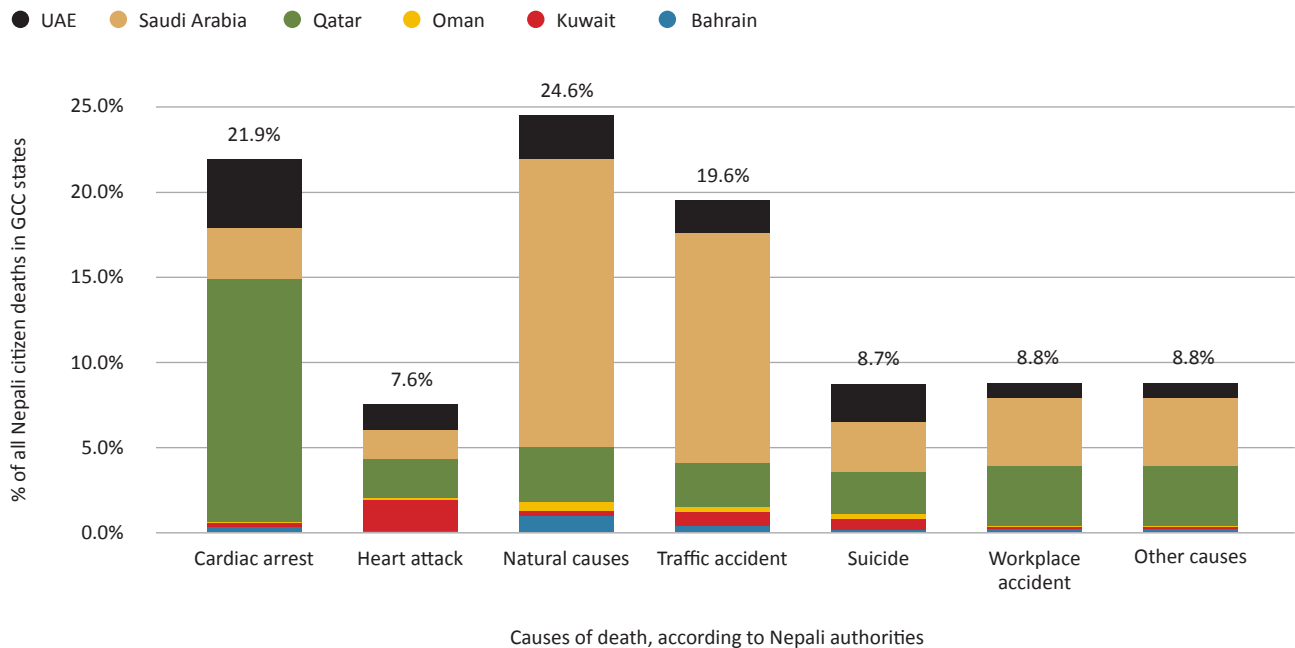
37. There is no precise data on the percentage of global deaths attributable to heart attacks. The WHO has said (see factsheet) that 27% of global deaths are caused by heart attacks and strokes, but provides no further breakdown. More detailed information comes in peer-reviewed literature, but these do not report mortality statistics in crude percentages, and what is most clear is how the mortality rate for cardiac-related diseases varies in different countries and across different socio-economic groups. See Fang Wang et al., “Global Burden of Ischemic Heart Disease and Attributable Risk Factors, 1990–2017: A Secondary Analysis Based on the Global Burden of Disease Study 2017”, *Clinical Epidemiology*, September 2021.

38. ‘[Nepal Labour Migration Report 2020](#)’, Government of Nepal, Ministry of Labour Employment and Social Security, Pg 82-84

39. ‘[Welfare Activities Report](#)’, Foreign Employment Board

Causes of death, Nepali citizens in the Gulf states, 2008/9 - 2018/19

Source: Nepali Ministry of Labour, Employment and Social Security



2.1.4. Pakistan

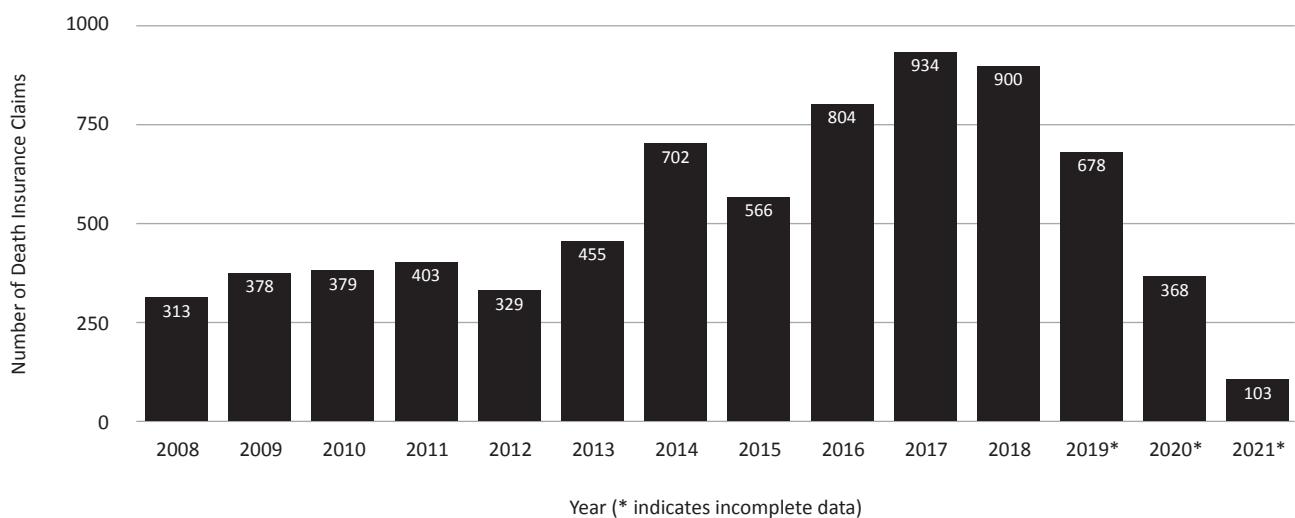
Transparency and quality of data

There is a lack of transparency in the reporting of deaths of overseas Pakistani workers in the Gulf. The only data available relates to death claims made to the State Life Emigrants Insurance

Fund.⁴⁰ Insurance is compulsory for migrant Pakistanis and 96% of Pakistani migrant workers are employed in the Gulf region, and thus this figure gives us a very approximate overview of the number of deaths in the Gulf each year. However, not every death is likely to be reflected in a claim made by the deceased's family, and it should also be noted that death claims of pilgrims and tourists are included in the data.

Insurance claims filed for death of Pakistani citizens overseas, 2008 - 2021

Source: State Life Emigrants Insurance Fund



40. For example see 'Analysis Of Manpower Export', Bureau Of Emigration And Overseas Employment (Hq) Islamabad (2018)

Observations

The only meaningful conclusion that can be drawn from the available data is that death insurance claims have been rising significantly, with the ten years between 2008 and 2017 seeing a near threefold increase. This may reflect an increase in the overall migrant population. Pakistan experienced a surge in outward migration during this period, with an average of 560,890 workers migrating every year from 2008 to 2015, most to the Gulf.⁴¹

2.1.5. The Philippines

Transparency and quality of data

Data is available for deaths of Philippine nationals in the Gulf states between 2014 and 2019. This data, released by the Philippine Statistics Authority in response to an RTI request submitted by the Center for Migrant Advocacy, is disaggregated for each country of death by occupation, age bracket and cause of death. Figures are disaggregated throughout by sex. This provides a relatively detailed and consistent data set that allows for some meaningful analysis. Causes of death, in particular, are precisely categorised against internationally recognised ICD codes. However, there are limitations to the figures: in particular, it is not possible to see how the factors of age, occupation and cause of death relate to each other. This precludes analysis of whether younger or older people are more at risk of certain causes of death, for example. Available information about occupation is also very poor, with around

three quarters of deceased individuals given classifications that do not provide any meaningful sense of their jobs.

In relation to the provision of denominator data, there are credible estimates, published by the Department of Foreign Affairs on its website, for the number of Philippine nationals present in each Gulf country in 2014.⁴² However these population totals are not disaggregated by age, sex or occupation, making them only of limited use when comparing the number and types of death in 2014.

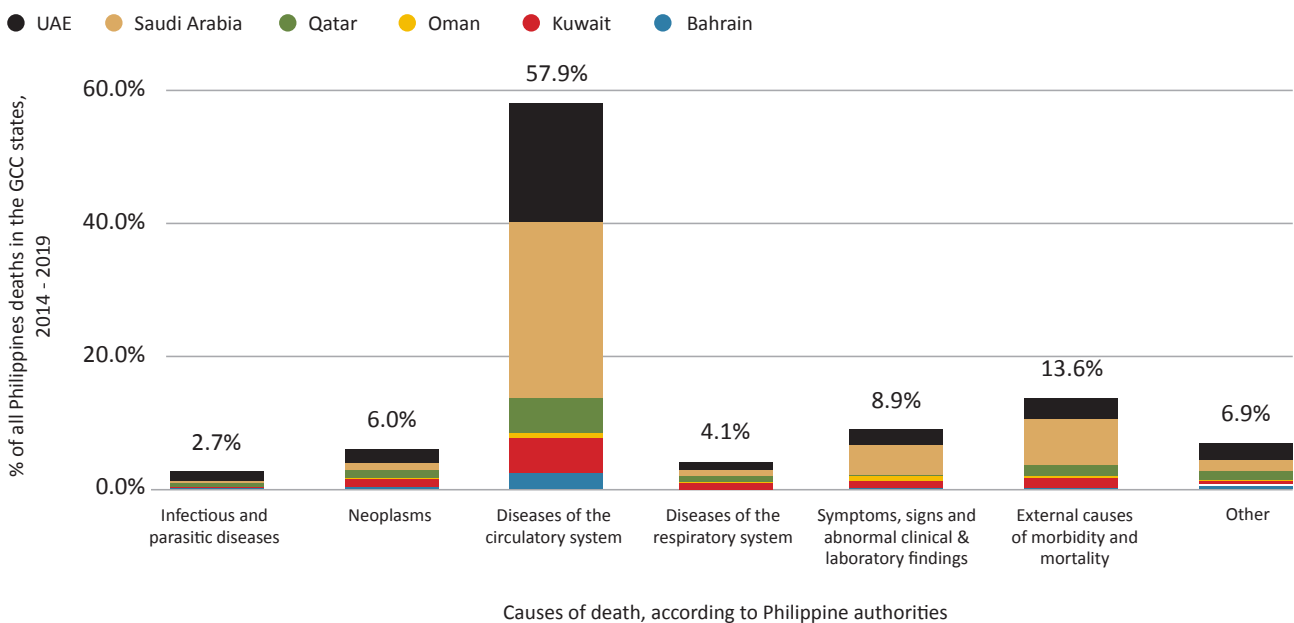
Observations

The bulk of the 4,621 nationals who died between 2014 and 2019 (71%) did so in Saudi Arabia and UAE, home to the largest populations of Philippine nationals. In 2014, the last year for which reliable population totals are available, 52% of all deaths occurred in Saudi Arabia, where just under a million Philippine nationals were resident. Saudi Arabia’s share of the population of Philippine nationals across the region was only 45% during this year, a difference which may potentially be of significance.

According to data provided by the PSA, the majority (58%) of Philippine nationals died of circulatory diseases between 2014 and 2019. Within this family of causes, the large majority of deaths - 1,912 of 2,674 - were categorised simply as “other heart diseases”. These make up 41% of all deaths of Philippine nationals during this period.

Causes of deaths of Philippines nationals in the Gulf, 2014-19

Source: Philippine Statistics Authority



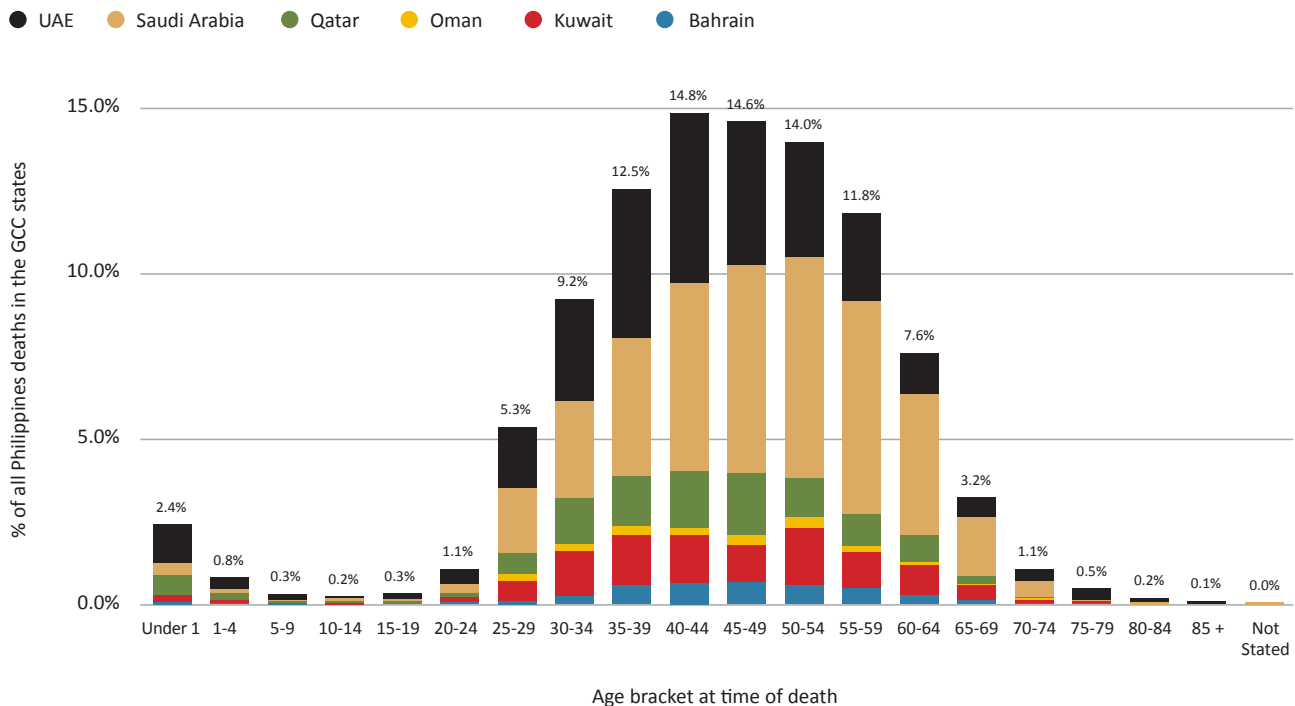
41. ‘From Pakistan to the Gulf Region: An Analysis of Links Between Labour Markets, Skills and the Migration Cycle’, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and International Labour Organization, (2016)
 42. ‘Statistics on Filipinos Overseas’, Department of Foreign Affairs, Republic of the Philippines

Women were more likely to die from neoplasms (cancer) than men (12% of deceased women died of this cause, compared to 3% of men), while men were more likely to die from circulatory diseases (62% of deceased men died of this cause, as opposed to 51% of women).

57% of all deaths were of people aged between 20 and 49. It is not possible to identify the causes of their deaths or their occupations. 111 Philippine nationals under 1 died between 2014 and 2019, with 53 of these occurring in the UAE.

Deaths of Philippines nationals in the GCC states, by age, 2014-19

Source: Philippine Statistics Authority



2.2. Destination states

With the exception of Saudi Arabia, all GCC states publish some data on deaths that disaggregates between nationals and non-nationals. Some provide cause of death and age-stratified data. However no governments disaggregate by country of origin.

2.2.1. Bahrain

Transparency and quality of data

Bahrain’s Ministry of Health publishes annual Vital Statistics reports, which provide data on the number of non-Bahraini nationals who died each year, disaggregated by gender and cause of death, by gender and age range, and by gender and location of death.⁴³ It is not possible to assess how age and cause of death relate to each other for non-Bahrainis (these

comparisons are provided but only for the whole population), nor is any information provided about the occupations of those dying. No information is provided about the country of origin of those dying.

Observations

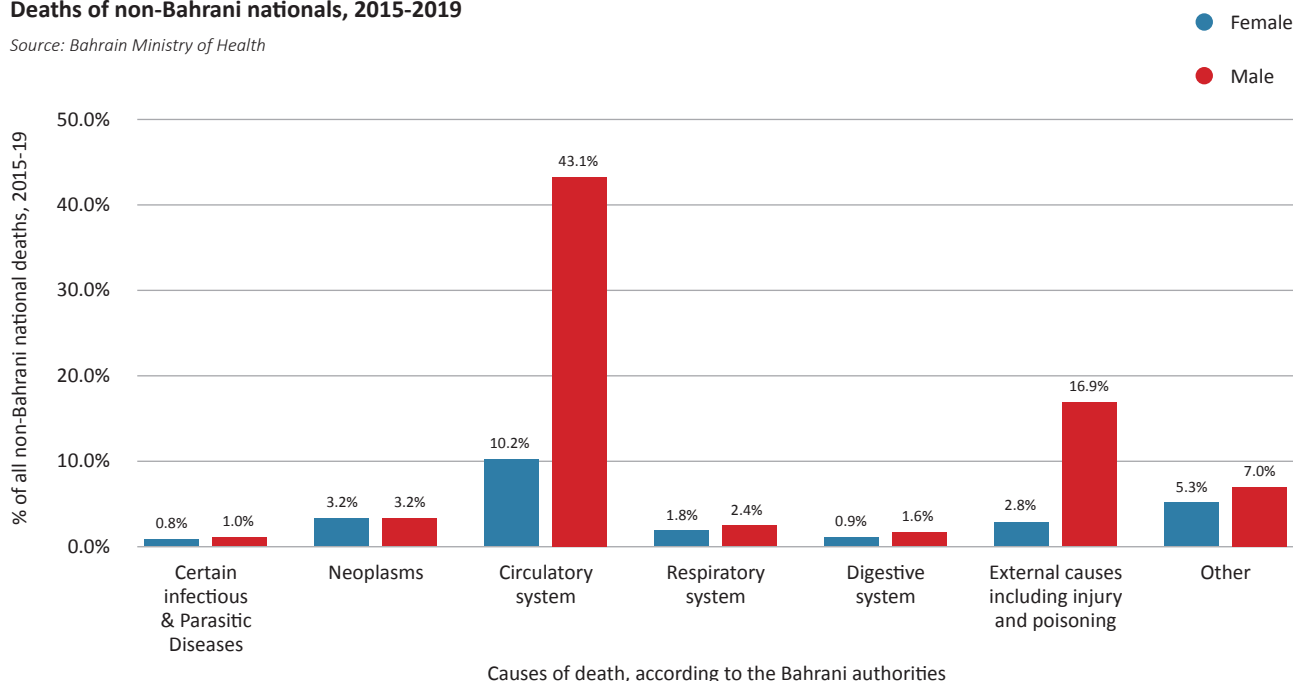
Between 2015 and 2019 inclusive, 3191 non-Bahraini nationals died in Bahrain, an average of 638 per year. 53% of all deaths were classified as diseases of the circulatory system. External causes were given as the cause in 20% of deaths.

In 2019, 42% of men and 30% of women who died were between the ages of 20 and 45. The lack of a denominator in this data is an obvious and serious shortcoming and precludes any definitive analysis of the rates of death per the population, which could then be compared against other datasets to identify patterns or anomalies.

43. Ministry of Health Statistics, Kingdom of Bahrain Ministry of Health

Deaths of non-Bahrani nationals, 2015-2019

Source: Bahrain Ministry of Health



2.2.2. Kuwait

Transparency and quality of data

Kuwait’s Central Statistical Bureau publishes detailed annual death statistics. These provide data on the number of non-Kuwaiti nationals who died each year, disaggregated by gender and cause of death, by gender, age range, and cause of death, and by gender, month of death, and cause of death.⁴⁴ However there is no information provided about the occupations of those dying, nor is information provided about the country of origin of those dying. Kuwait publishes annual population statistics disaggregated by age and gender.

Observations

Between 2011 and 2020, 32,748 non-Kuwaiti nationals died in Kuwait, an annual average of 3,275. 2020 saw a very significant rise in the number of deaths recorded in Kuwait, with the

increase particularly steep for non-Kuwaitis. This is likely to be related to Covid-19.⁴⁵ 569 Covid-19 deaths were recorded for non-Kuwaitis in 2020, but the total number of non-Kuwaiti deaths from all causes rose by 2183 against 2019 figures, an increase of 63% despite a reduction in the numbers of deaths from external causes, likely due to the stoppage of work and reduced traffic volume.

Between 2018 and 2020, the main causes of death were diseases of the circulatory system, which were responsible for 5680 of the 10,830 deaths of non-Kuwaiti nationals, or 52% of all deaths.

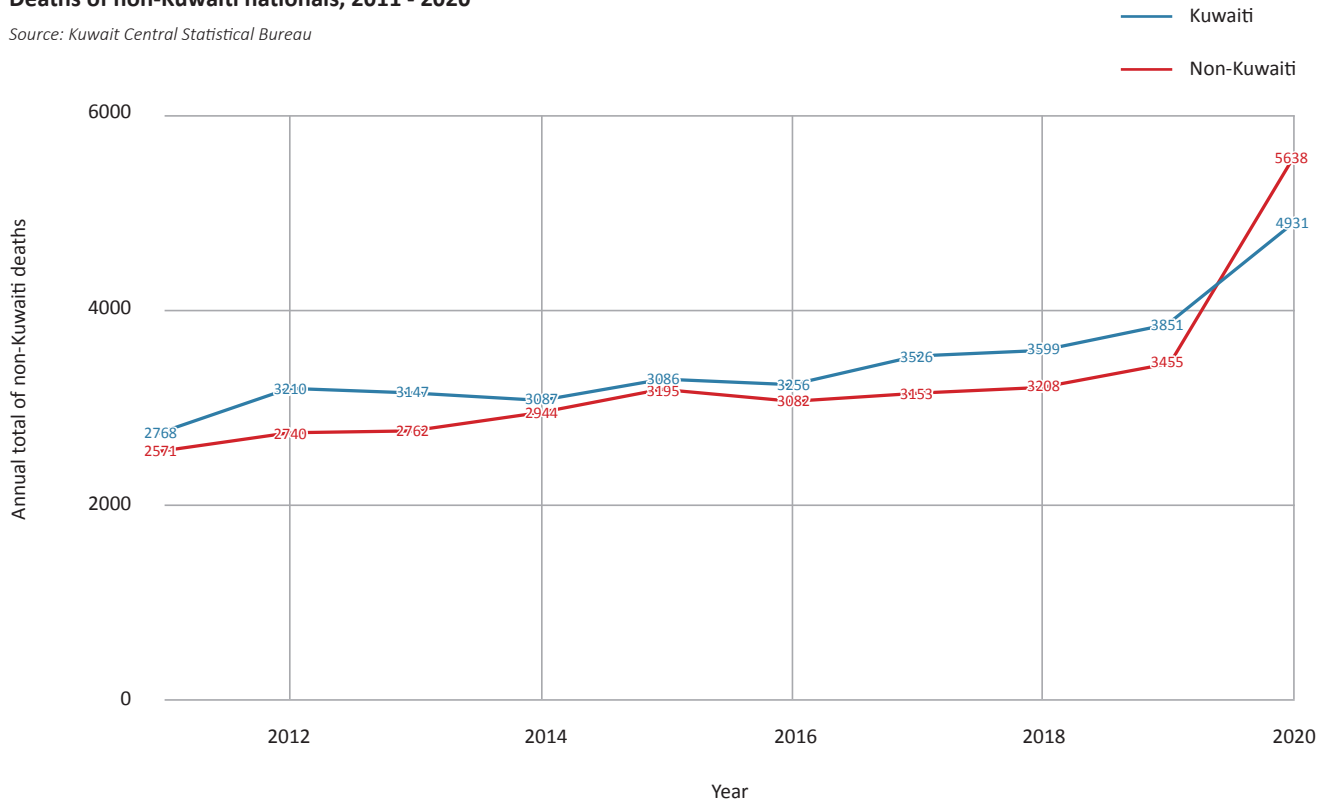
Kuwaiti data also provides a breakdown of how Kuwaitis and non-Kuwaitis die from external causes. The tenfold difference in deaths from suicide is notable. According to population estimates in 2020, Kuwaitis made up 31% of the country’s population, while they only accounted for 11% of the country’s deaths from suicide, although the different age and gender breakdown of the national vs non-national population must also be taken into account.

44. [Statistical Bulletin](#), Kuwait Central Statistical Bureau

45. According to the [World Health Organization](#), “excess mortality is defined as the difference in the total number of deaths in a crisis compared to those expected under normal conditions. COVID-19 excess mortality accounts for both the total number of deaths directly attributed to the virus as well as the indirect impact, such as disruption to essential health services or travel disruptions.”

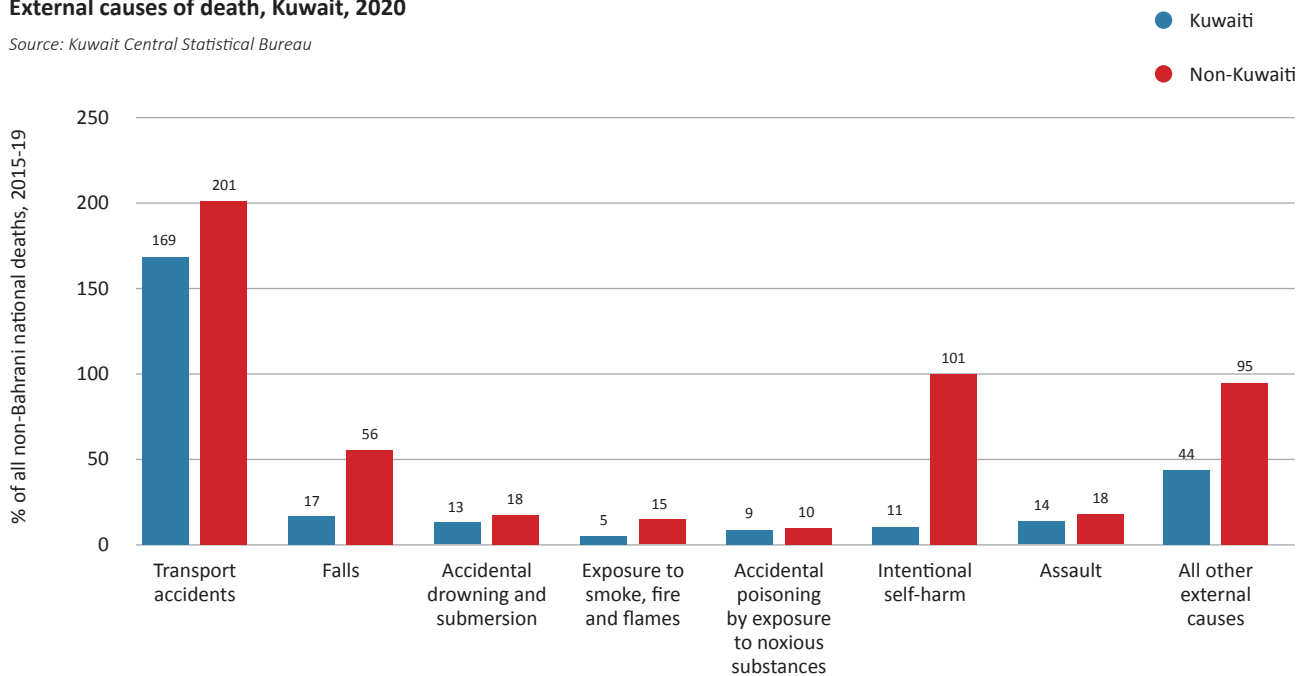
Deaths of non-Kuwaiti nationals, 2011 - 2020

Source: Kuwait Central Statistical Bureau



External causes of death, Kuwait, 2020

Source: Kuwait Central Statistical Bureau



Causes of death, according to the Kuwaiti authorities

2.2.3. Oman

Transparency and quality of data

Oman’s National Centre for Statistics and Information publishes annual death statistics.⁴⁶ These are disaggregated by gender, by Omani / non-Omani and by governorate. There is no information about cause of death, age, or occupation of those who died. Data is provided about the months in which deaths occurred but this is not disaggregated. The government publishes annual population statistics for the

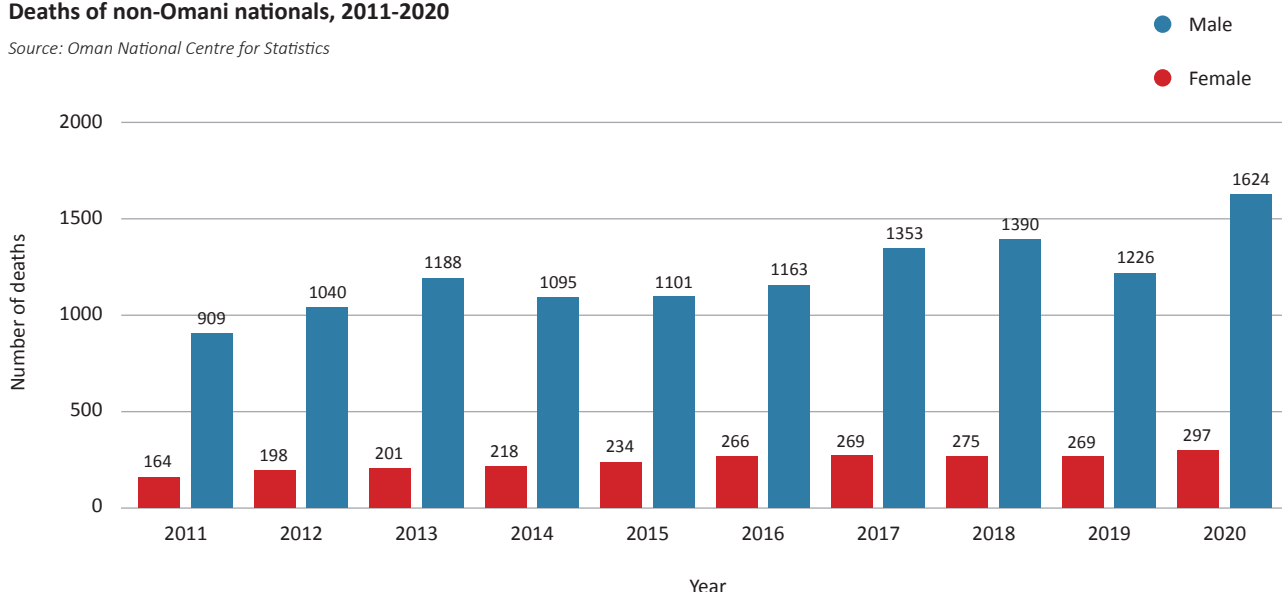
non-Omani population which makes some basic assessment of crude death rates possible.

Observations

14,480 non-Omani nationals died between 2011 and 2020, an annual average of 1448. 2020, the year in which Covid-19 affected Oman, saw a meaningful rise in the deaths of non-Omani men, as illustrated by the graph below on the right. The crude death rate for this population rose in 2020, as compared to 2019 and 2018.

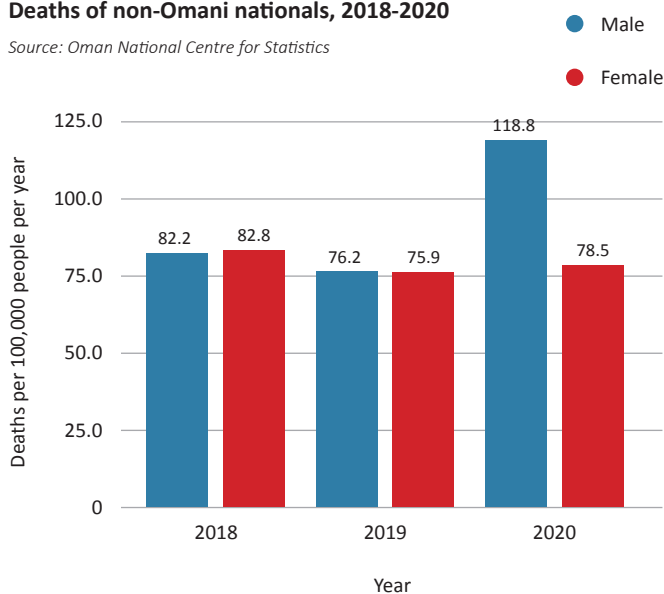
Deaths of non-Omani nationals, 2011-2020

Source: Oman National Centre for Statistics



Deaths of non-Omani nationals, 2018-2020

Source: Oman National Centre for Statistics



46. [Publications](#), Oman National Centre for Statistics and Information

2.2.3. Qatar

Transparency and quality of data

Qatar’s Planning and Statistics Authority publishes detailed annual statistics on deaths.⁴⁷ These are disaggregated by Qatari / non-Qatari nationality, gender, and by cause of death, age of death, occupation, and month the death occurred. However, it is not presented in a form that allows analysis across categories, so, for example, it’s not possible to see the age breakdown of the deaths in the construction sector, or the times of year when they died. Some basic information is

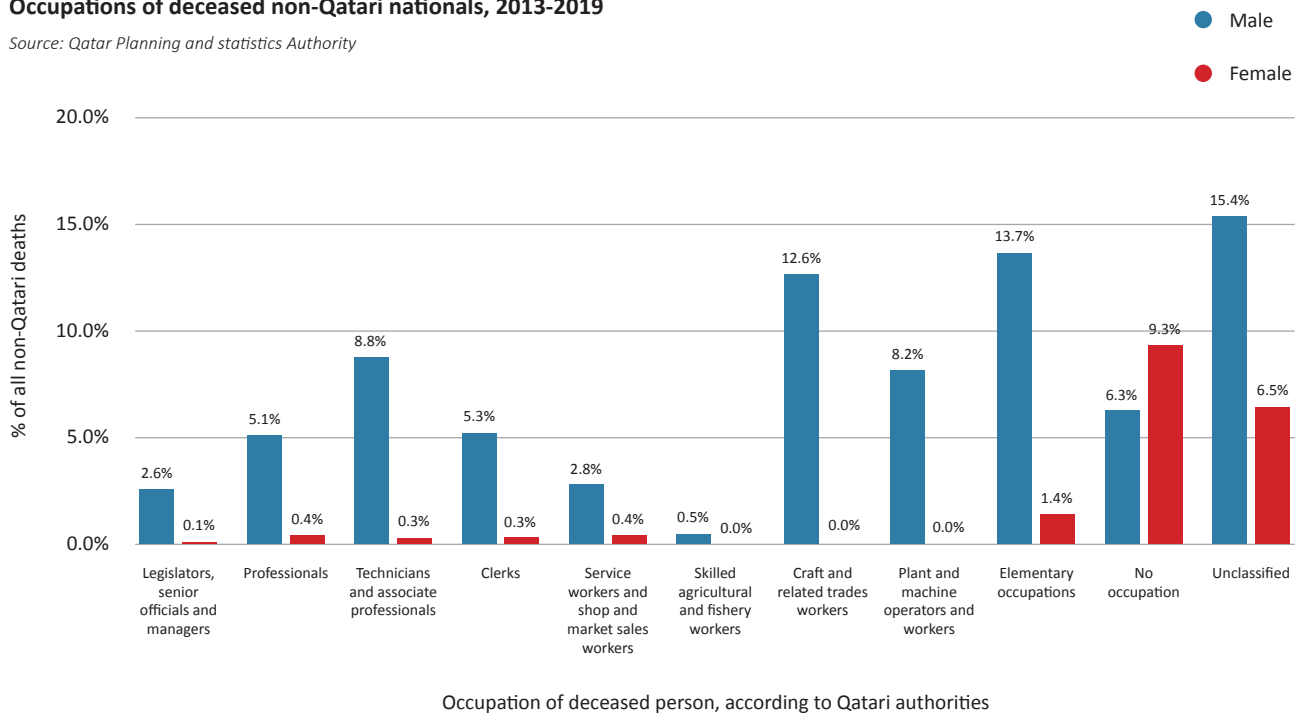
provided about the regions of the world that the deceased came from. The population data published by Qatar does not disaggregate by nationality, making it impossible to compare data on non-Qatari deaths to a meaningful denominator.

Observations

Between 2010 and 2019, 15,021 non-Qataris died, an annual average of 1502. 79% of these deaths were male and 21% female. 8497 of these deaths (57%) were categorised as coming from “Asian countries”, with 87% of Asian deaths being male.

Occupations of deceased non-Qatari nationals, 2013-2019

Source: Qatar Planning and statistics Authority



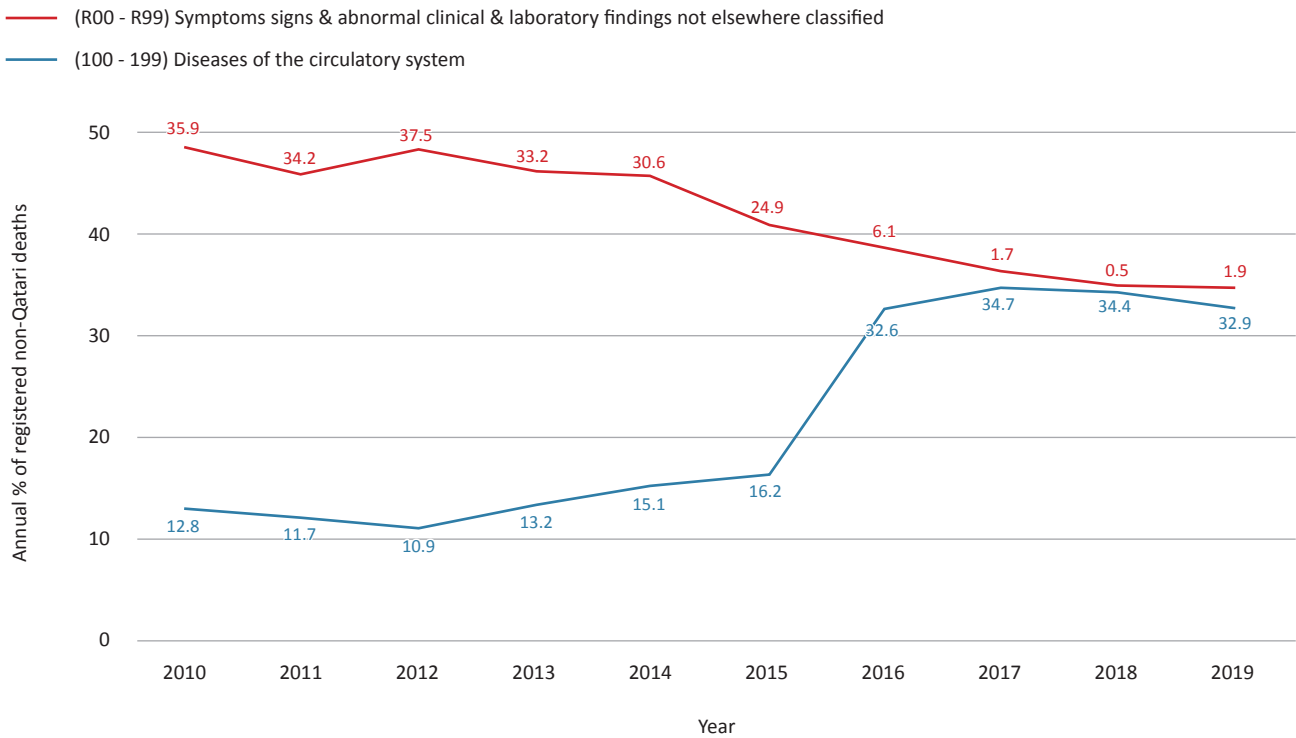
Circulatory disease accounted for 20% of non-Qatari deaths from 2010 to 2019. However during this period, it appears that classification changes may have occurred. In the mid-2010s the number of deaths that were previously classified as “Sudden death cause unknown”, which falls under the broad category of “Symptoms signs & abnormal clinical & laboratory

findings not elsewhere classified”, reduced significantly and by the end of the decade made up less than 2% of all deaths, having constituted 36% of all deaths in 2010. In parallel, the share of deaths classified as circulatory disease rose from 12.8% to 32.9%. Over the 10 year period, the two categories together accounted for about 42% of all non-Qatari deaths.

47. [Births and Deaths](#), Qatar Planning and Statistics Authority

Circulatory disease vs “symptoms signs & abnormal findings” - non-Qatari deaths, 210-19

Source: Qatar Planning and Statistics Authority

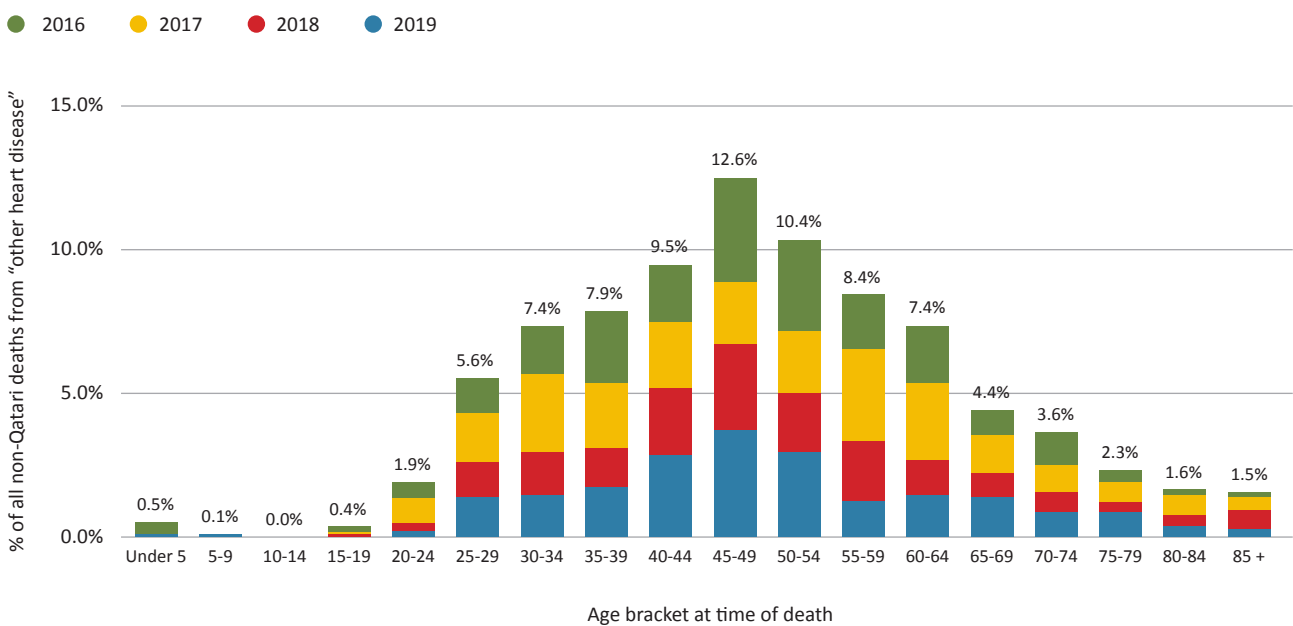


About half of all circulatory disease deaths were classified as “other heart disease”. More than half of the 891 men who

died of “other heart disease” between 2016 and 2019 were aged between 20 and 49.

“Other heart disease”, male non-Qatari deaths by age - 2016 to 2019

Source: Qatar Planning and Statistics Authority



2.2.5. Saudi Arabia

Data published by Saudi Arabia’s General Authority for Statistics states that 80,247 people died in 2018. This figure is disaggregated by age band but not by nationality or any other characteristics.⁴⁸ We have not been able to find any other reliable data relating to deaths of migrant workers or non-nationals in Saudi Arabia.

2.2.6. UAE

Transparency and quality of data

The UAE’s Federal Competitiveness and Statistics Centre publishes annual death statistics.⁴⁹ Between 2011 and 2017 these included total figures for the number of deceased non-Emirati nationals, disaggregated by gender and by which of the seven Emirates the individual died in. In 2018, the figures were disaggregated by age, and in 2019 further information was provided regarding cause of death. Individual emirates also publish similar information. It is not possible to assess

how age and cause of death relate to each other, nor is any information provided about the occupations of those dying. No information is provided about the country of origin of those dying.

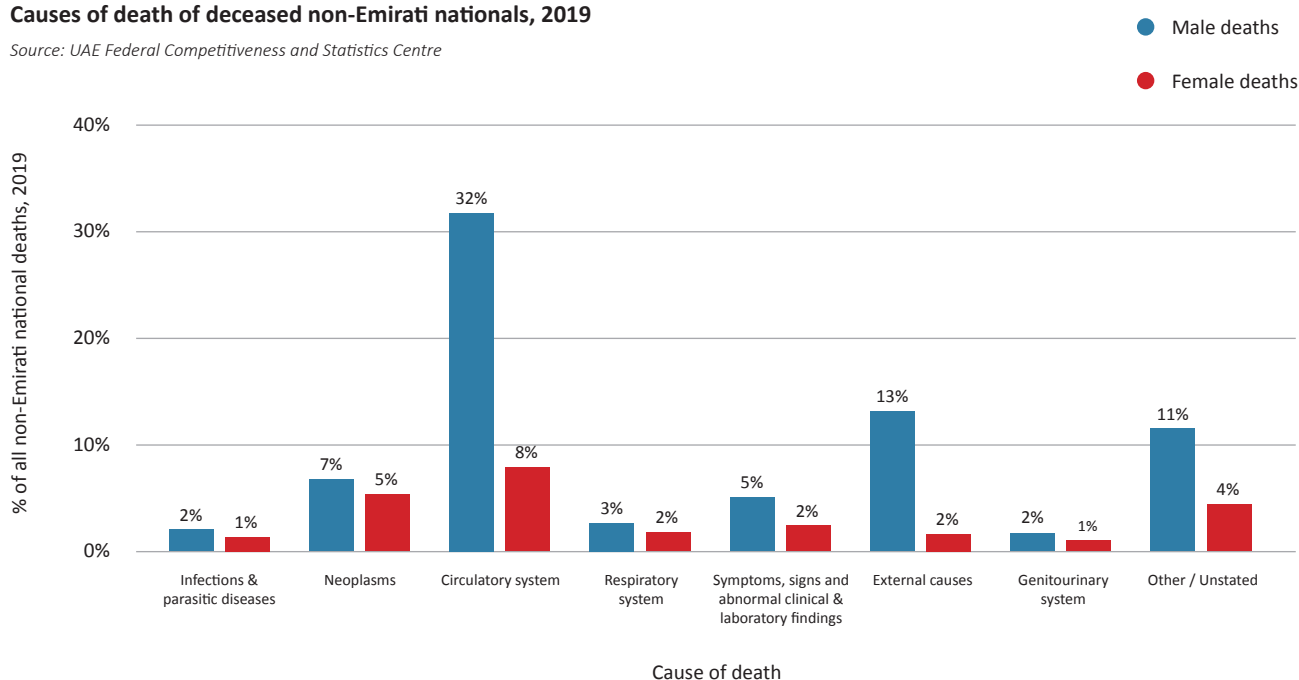
Observations

In the ten years between 2010 and 2019, 58,663 non-nationals died in the UAE, an average of 5866 per year. 25% of these deaths were women and 75% were men. Non-nationals make up 80-90% of the UAE’s population of 9.3 million.⁵⁰

In 2019, the main causes of death were diseases of the circulatory system, which were responsible for 2606 of the 6588 deaths of non-Emirati nationals, or 40% of all deaths. (In comparison, 32% of UAE nationals’ deaths were attributed to diseases of the circulatory system). 67% of circulatory system deaths (1734) were classified under the general “other diseases of the circulatory system” category. 12% (309) were classified as “Acute Myocardial Infarction” which is the medical term for a heart attack. The second highest group of causes of death were external causes.

Causes of death of deceased non-Emirati nationals, 2019

Source: UAE Federal Competitiveness and Statistics Centre



In 2018 and 2019, 42% of non-Emiratis who died were between the ages of 20 and 49. There is not sufficient information

available to accurately assess how this compares to the age distribution of non-Emirati men and women in the population.

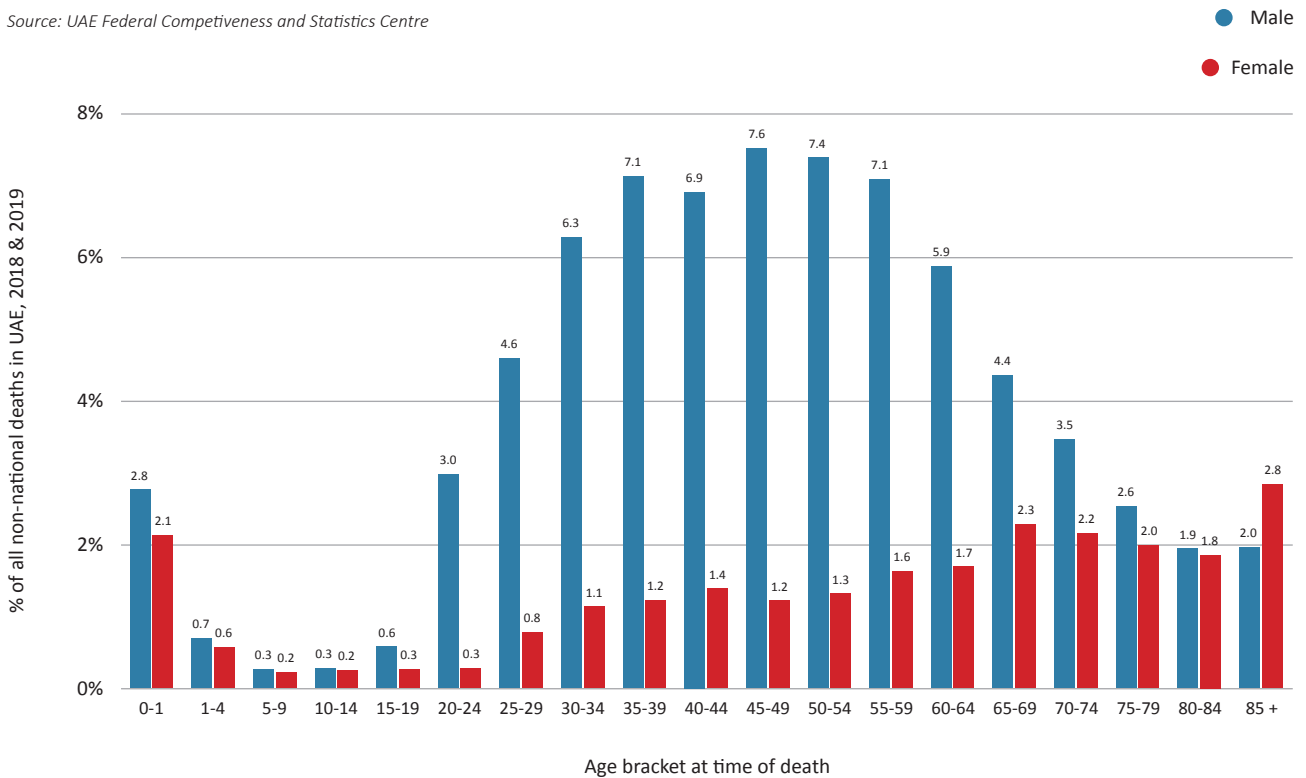
48. [Statistical Database](#), Saudi Arabia General Authority for Statistics

49. [Births and Deaths](#), UAE Federal Competitiveness and Statistics Centre

50. See [Population and demographic mix](#), on U.AE, the UAE government portal. There is no single figure available for the proportion of migrant workers in the UAE but the two largest emirates publish some data in this respect. In 2020, according to the [Dubai Statistics Centre](#), non-nationals accounted for 92% of Dubai’s population of 3.4 million, while in 2016, according to the [Abu Dhabi Statistic Centre](#), 81% of Abu Dhabi’s population of 2.9 million were non-Emiratis.

Deaths of non-nationals by age, UAE, 2018 and 2019

Source: UAE Federal Competiveness and Statistics Centre



2.3. Summary of availability of data on migrant deaths in the GCC states

In summary, there is insufficient data available on migrant worker deaths and the data that is available is scattered, and is not comprehensive nor intersectional enough to enable meaningful analyses. However despite the shortcomings of the data, it appears that as many as 10,000 migrant workers from south and southeast Asia die in the Gulf every year (this figure will obviously be higher when migrant workers of other nationalities are included) and that more than 1 out of every 2 deaths is effectively unexplained, which is to say that deaths are certified without any reference to an underlying cause of death, instead using terms such as “natural causes” or “cardiac arrest”. With regard to origin states, in the cases of Bangladesh and Pakistan, the only data that is available is raw numbers from non-government entities. It is not possible to say with any certainty how many Bangladeshi and Pakistani workers from each country are dying in the various Gulf countries, or how they are dying. In the case of India, there is a lot of data available but it is of poor quality- there are serious discrepancies in the data held and produced by different branches of government and there are striking inconsistencies in the manner in which causes of death are reported by foreign embassies. Nepal is

relatively transparent and regularly publishes the data that it holds, outlining the numbers of Nepalese nationals that have died in the Gulf states, but the high rate of deaths attributed to “natural causes” is a serious shortcoming, and the data produced by origin governments should not include only those workers whose families received financial compensation from the government. Data from the Philippines is not readily available but the data that the authorities hold is broken down by country and deaths are grouped into codes that correspond to international standards on categories of different types of death.

The greatest indictment of the body of data on worker deaths that is produced by these origin states is that it is impossible to compare any of the datasets against each other. Despite the fact that each state possesses the data of each workers’ age, occupation, gender, date of death, and cause of death (as noted on the death certificates produced by the Gulf states), this data is either withheld entirely, reproduced in part, or apparently reclassified, such as when deaths are attributed to heart attacks or heart disease (this is essentially meaningless in any discussion on cause of death). This makes it impossible for public health experts to quickly spot patterns or anomalies that warrant investigation and a public health response. To illustrate this, consider the Qatari data from 2016 referenced previously. As the following section explains, the increase in the

number of migrant workers categorised as dying of “circulatory diseases” since 2016 is most likely obscuring the fact that in many cases their cause of death is unknown. However if the categorization is correct, it would indicate that non-Qatari men are dying from cardiovascular diseases at a significantly higher rate than Qatari men (43% to 28%), and would warrant serious investigation from public health experts.

Destination states vary significantly in the information they publish, from Kuwait and Qatar at one end of the spectrum - which provide quite detailed datasets that allow for some analysis of trends and patterns- to Saudi Arabia at the other, which publishes almost no information about deaths that take place within the country. Bahrain and UAE provide basic cause of death information, while Oman publishes largely headline figures for non-Omani deaths. All four of the Gulf states that provide information about cause of death do so against codes that correspond to international standards on categories of different types of death. One of the major limitations to data produced by the Gulf states is that no country provides a breakdown of deceased people’s nationalities, grouping all non-nationals together. This makes it impossible to assess whether rates of death are comparable

to those in migrants’ countries of origin and to the deaths of Gulf nationals of the same age and sex. Additionally, only Kuwait publishes comparable age and gender-stratified datasets for both population and deaths of non-nationals, providing both the numerator and denominator to make meaningful statistical analysis possible.

However, the most serious problem with the data produced by the Gulf states is that the data is unreliable in relation to its specification of the causes of migrant worker deaths. Indeed, in criticising origin state failures in relation to data on deaths, it should be stressed that it is the responsibility of the authorities in the Gulf to provide origin states with specific and detailed information on how their nationals are dying. Based on the material inconsistencies between the data on causes of migrant worker deaths made available by origin states and that made available by the Gulf states, and the apparently very high rate of deaths for which no underlying cause is provided, it is clear that this is not happening. The most simple explanation for this data problem, and one for which there is some evidence, is that there are serious and systematic issues with the manner in which the Gulf states investigate migrant worker deaths.



Workers erect scaffolding on a construction site in Manama, Bahrain, 2010 © Dominic Dudley / Alamy Stock Photo

3. CONCERNS ABOUT INVESTIGATIONS INTO MIGRANT DEATHS

As noted above, origin states do not, in general, report on this issue with sufficient detail or transparency. However, it should be noted that they are not responsible for investigating and certifying the deaths of their nationals abroad. That responsibility primarily lies with the Arab Gulf states and an examination of the manner in which they investigate the deaths of low-paid migrant workers reveals serious shortcomings.

There are currently no internationally recognized guidelines detailing how states should investigate the cause of someone's death, but there are internationally accepted standards on death certification and these are inextricably linked to investigations. A WHO working group is developing a set of standards on investigations, and a number of countries have established processes from which a set of best practice standards can be drawn. Consultant pathologist Dr David Bailey, Chair of the UK Royal College of Pathologists Death Investigations Committee and member of the WHO working group, explained this best practice to the Vital Signs Partnership.

“When somebody dies, regardless of the cause, the certifying doctor should gather as much information as possible about the deceased’s medical history and the circumstances surrounding the death (usually from family, friends, colleagues, other witnesses) and complete a full external examination of the body. If the cause of death is not clear after all of that, the death should be further investigated by referral to the coroner or equivalent legal entity depending on the country, which would usually result in a postmortem, either traditional [i.e. a surgical, invasive examination] or based on a CT scan, or both. Once a coroner’s investigation is complete, whether or not it includes a post-mortem, if the death is deemed natural, it can be certified by a doctor, and the death registered with the local registrar of births, deaths and marriages. If the death is not natural, i.e. an accident, industrial disease, due to negligence etc, an inquest is held, the outcome of which is for the coroner to decide what category of death has occurred and then allows registration of the death as before.”⁵¹

51. See Amnesty International, [“In the Prime of Their Lives: Qatar’s Failure to Investigate, Remedy and Prevent Migrant Worker Deaths”](#), (August 2021), p. 33.

There are detailed and consistent guidelines on death certification issued by a range of national bodies. In the USA, for example, the Center for Disease Control and Prevention offers clear guidance to doctors: “The mechanism of death (for example, cardiac or respiratory arrest) should not be reported as the immediate cause of death as it is a statement not specifically related to the disease process, and it merely attests to the fact of death.”⁵² In India, the Physicians’ Manual on Medical Certification of Cause of Death offers identical guidance: “The mode of dying (e.g. heart failure, respiratory failure) should not be stated at all [as an immediate cause of death] since it is no more than a symptom of the fact that death occurred and provides no useful information.”⁵³ The UK’s Office of National Statistics Death Certification Advisory Group says this: “Terms that do not identify a disease or pathological process clearly are not acceptable as the only cause of death. This includes terminal events, or modes of dying such as cardiac or respiratory arrest, syncope or shock.”⁵⁴

There are a variety of methods that can be used to determine the cause of any individual’s death and it is nearly always possible to do so. Traditional autopsies are the subject of some sensitivity in the Gulf region. As noted by Saudi Arabian physicians, the reason that traditional autopsies have not been routinely performed “is partly religious in origin”, since Islam prohibits organ removal or disfigurement of the dead, but dissection is permitted provided it is legally required, for example in cases where the death is suspicious.⁵⁵ The effect of this is potentially to reduce the thoroughness of medical investigations into cases where deaths are not considered to be suspicious. In Kuwait, limited or complete autopsies are performed at the discretion of the Forensic pathologist, but medical researchers have noted that “the culture in Kuwait...is heavily influenced by the social boundaries and puts a lot of pressure on the forensic pathologist to try to avoid evisceration as much as possible.”⁵⁶

Verbal autopsies and non-invasive autopsies using examination methods including CT scanning, MRI and needle biopsies are not as effective as traditional autopsies, but when it is not possible to perform an invasive examination, they provide a very useful alternative and can often identify or narrow down the cause of death.⁵⁷

In 2014, medical researchers in Bahrain proposed the introduction of virtual autopsies in the country, but to date it

appears that traditional, invasive autopsies are the only post-mortem technique available, and these only occur if the cause of death is suspicious.⁵⁸ In October 2021, the government of Abu Dhabi announced that it would introduce non-invasive post-mortem imaging to conduct autopsies in what appears to be the first introduction of the technology in the region.⁵⁹

In Qatar, the issue of the lack of investigation into migrant worker deaths has been the subject of far greater scrutiny than in the other Gulf states, due to its hosting of the 2022 FIFA World Cup. In a briefing paper circulated to journalists in March 2021, Qatar’s World Cup organisers stated that the state of Qatar “has robust investigation procedures in place” and that “a post-mortem examination can be requested by immediate family members or by the authorities when medical examinations are unable to determine the cause of death.”⁶⁰ It also stated that, “in accordance with the law, the family of the deceased must first approve an autopsy before it is carried out” and that “in most cases related to guest workers, families refuse an autopsy due to their desire to have the body repatriated as quickly as possible for the completion of religious burial rites.” It said that, “in some circumstances, families refuse to eat or drink until the remains of a loved one have been properly buried or cremated”, adding that “this creates difficulties in respect to investigating the cause of death.” In communication with Amnesty International, the Qatari authorities said that autopsies are conducted when requested by immediate family members except when the death is suspected to involve criminal activity, in which case a forensic doctor from the Ministry of Interior can perform the post-mortem following a request from the police.⁶¹

However, an examination of Law No 2 of 2012 suggests that it in fact provides for a broader range of circumstances in which autopsies are permitted. Article 2 states: “If the cause of death cannot be determined by means of clinical, laboratory, radiological (X-ray) or medical examination” an autopsy can be conducted with the approval of the medical director of the hospital authorised by the Minister as well as the consent of the deceased’s relatives. However, article 4 outlines circumstances in which autopsies can be conducted without the consent of the deceased’s relatives, including “for the purpose of protecting public health”. Therefore, the law in itself does not preclude invasive autopsies in some circumstances.

52. ‘Physicians’ Handbook on Medical Certification of Death’, Centers for Disease Control and Prevention (2003)

53. ‘Physicians’ Manual on Medical Certification of Cause of Death’ (fifth edition), Office of the Registrar General India.

54. ‘Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales’, Office for National Statistics.

55. Salah Al-Waheeb et al., ‘Forensic autopsy practice in the Middle East: comparisons with the West’, *Journal of Forensic and Legal Medicine*, (February 2015).

Mohammed Omar Sohaibani, ‘Autopsy and Medicine in Saudi Arabia’, *Annals of Saudi Medicine*, (1 May 1993).

56. Salah Al-Waheeb et al., ‘Forensic autopsy practice in the Middle East: comparisons with the West’, *Journal of Forensic and Legal Medicine*, (February 2015).

57. See comments from public health experts in Amnesty International, ‘[In the Prime of Their Lives: Qatar’s Failure to Investigate, Remedy and Prevent Migrant Worker Deaths](#)’, (August 2021), 34.

58. Eamon Tierney et al., ‘Is It Time for a Virtual Autopsy Service in Bahrain?’, *Bahrain Medical Bulletin*, (December 2014). See information on post-mortems at the website of the British Embassy in Bahrain.

59. Abu Dhabi Government Media Office, ‘Department of Health Abu Dhabi Introduces Virtual Autopsy for Mortuary Investigations’, (24 October 2021).

60. See Amnesty International, ‘[In the Prime of Their Lives: Qatar’s Failure to Investigate, Remedy and Prevent Migrant Worker Deaths](#)’, (August 2021), p. 37.

61. See Amnesty International, ‘[In the Prime of Their Lives: Qatar’s Failure to Investigate, Remedy and Prevent Migrant Worker Deaths](#)’, (August 2021), p. 37.

Critically, consent appears not to be required to use a wide range of other non-invasive post-mortem investigation methods that should, in all but a small percentage of cases, be able to identify the cause of death. According to Amnesty International, “the evidence ... strongly suggests that Qatar rarely conducts any post-mortem investigations into migrant worker deaths where the cause of death is not obvious, and does not systematically reach out to families to request their consent to conduct an investigation. ...Consequently, a significant number of deaths are certified without any underlying causes of death.”

In 2021, a report by the International Labour Organization on the collection and analysis of data on occupational injuries in Qatar found that, “there is a need to review the approach taken to investigating deaths of seemingly healthy young workers from “natural causes”, to be able to determine whether they are in fact work-related, and ensure more accurate identification of the cause. This is important for [Occupational Safety and Health] data collection purposes, but more importantly to ensure workers’ families receive due compensation.”⁶²

The death of Carlos de Guzman Ely Jr. from the Philippines

Carlos de Guzman Ely Jr. from the Philippines died in the Kingdom of Saudi Arabia (KSA) on February 13, 2021 at the age of 45. His roommate tried to wake him up to go to work but found him lifeless. Because of a lack of employment opportunities in the Philippines, Carlos had gone to Saudi Arabia to work as a pushback (the procedure during which an aircraft is pushed backwards away from its parking position) operator at Jeddah Airport. His son told the Vital Signs Partnership that Carlos was diagnosed with a heart condition and high cholesterol before he left the Philippines in 2018. Nonetheless, he worked 10 to 12 hour shifts, taking overtime whenever he could. His son said that his father was frequently stressed, partly due to lack of sleep because of changing shift patterns. The work required Carlos to work long hours outside, in intense heat, and his son said that Carlos often had to go inside the airport staff lobby to cool down and drink water. Despite his medical history and the fact he was taking medication for his heart condition, his death notification, issued by Saudi Arabia’s Ministry of Health, recorded the cause of death as “unknown”. His family told the Vital Signs Partnership that to their knowledge there was no investigation into Carlos’s death - a friend of the family who had worked as a nurse in Saudi Arabia told them it was common practice for examining doctors to only check bodies for signs of injury. According to Carlos’s son, the family were shocked by this at first but decided to not to press for an autopsy upon researching the issue and concluding that the remains of non-Saudi Arabians were not a priority. In addition, a representative of the Undersecretary for Migrant Worker Affairs told them that, if they wanted to proceed with an autopsy, it could take 6 months and delay the return of their father’s remains. The company only provided Carlos’s family with 80,000 pesos (approx. US\$1,603) in End of Service Benefits. The family told the Vital Signs Partnership that Carlos’s death had left them “devastated and confused.”

3.1. Compensation

The lack of investigations into migrant worker deaths means that there is rarely any effort to determine if a fatality was related to

occupational accidents or diseases and therefore the families of workers who have died cannot claim any compensation from employers or from the Gulf states.⁶³ Instead, the burden to compensate workers’ families is shifted to the origin states or onto workers’ themselves via insurance schemes.

62. *One is too many: The collection and analysis of data on occupational injuries in Qatar*, International Labour Organization, 2020, page 24

63. In **Bahrain**, article 94 of the labour law (No. 36 of 2012) states that “If the worker dies as a result of an occupational injury, compensation shall be distributed over his heirs in accordance with the Sharia inheritance rules.” Article 110 of **Qatar’s** Labour Law provides deceased workers’ families with the right to compensation in the event of their family member dying “by reason of work” or being wholly or partially disabled by an occupational injury. Qatar’s civil code also provides for compensation for people who have suffered loss or injury as a result of unlawful acts. In **Saudi Arabia** family members of dead workers are entitled to claim compensation from the country’s General Organization for Social Insurance, although the extent to which foreign workers are enrolled in the program is not clear. In the **United Arab Emirates**, article 149 of the labour law entitles family members to an indemnity equal to the basic pay of the employee for a period of 24 months, provided that the amount of indemnity shall not be less than eighteen thousand Dirhams and not more than thirty five thousand Dirhams. In **Oman**, [Decree No. 40 of 1977](#) Issuing the Compensation for Work Injuries and Professional Diseases Law (Arabic text only) requires employers to pay in case of death or permanent disability, minimum 1300 OMR and max 2400 OMR.

The families of Bangladeshi nationals who die overseas are eligible for compensation from its Wage Earners Welfare Board, which is a single trust fund pooled from the mandatory membership contributions of migrant workers, who pay 3,500 Bangladeshi taka (\$41) in fees to become a member, and other sources such as investment and interest income on these funds.⁶⁴ Families receive 35,000 Bangladeshi taka (approximately \$408) in burial costs when they collect their family member's body at the airport and they then receive a 300,000 Bangladeshi taka (\$3475) payment in compensation, but these payments are only for the families of workers who were documented abroad at the time of their death.

In India, there has been a mandatory insurance scheme for foreign workers - the Pravasi Bharatiya Bima Yojana - since 2003. Workers pay either 275 or 375 Indian rupees (\$3.50 or \$5) in premiums and families receive a payout of 1 million Indian rupees (\$13,225) in cases of "accidental death or permanent disability leading to loss of employment while in employment abroad." In order to be eligible, workers' families must obtain certification of accidental death or permanent disability from the Indian authorities in the country where the accident occurred.⁶⁵

In Nepal, the Foreign Employment Board (FEB) is mandated with the responsibility to provide compensation in cases of deaths by Nepal's Foreign Employment Act, the governing legislation on foreign labour migration of Nepali migrant workers. The compensation that the FEB provides is drawn from a range of sources including contributions from migrant workers, who pay either 1500 Nepalese Rupees (\$12.50) or 2500 Nepalese Rupees (\$20) depending on the length of their work contract abroad.⁶⁶

In the case of the Philippines, there are various compensation schemes available to families of deceased overseas foreign workers. These schemes are either government initiatives or are a part of contractual insurance schemes. The families of workers who paid the Overseas Worker Welfare Administration membership fee of US\$25 are eligible for 200,000 pesos (\$4,000) in case of a death by accident and 100,000 pesos (\$2,000) in case of a death by what they call "natural causes". Under the Republic Act 10022, recruitment agencies are obliged to provide death insurance for workers they send abroad, which pays families \$15,000 in case of an accident and \$10,000 in case of "natural causes".

64. The Wage Earners Welfare Board replaced the Wage Earners Welfare Fund in 2017 and membership has been mandatory since October 2021. See "[Registration made mandatory for expatriate Bangladeshis](#)", The Financial Express, (12 October 2021). See also "[Review of the Wage Earners' Welfare Fund \(WEWF\) in Bangladesh](#)" International Labour Organisation, (2014).

65. See description of the scheme at the website of India's [Ministry for External Affairs](#)

66. Workers who leave on a 2-year contract pay NPR 1500 and workers who leave on a contract of 3 years or longer pay, NPR 2500 'Nepal Labour Migration Report 2020', Government of Nepal, Ministry of Labour Employment and Social Security, p. 79. According to LAPSOJ, a member of the Vital Signs Partnership, the other sources of money for the compensation fund include interest accrued from the security deposit of recruitment agents, and a portion of the licensing fees and renewal fees paid by recruitment agencies.



Migrant workers taking a break on a building site, Kuwait, 2003. © Stephanie McGehee / Alamy

4. RISKS TO WORKERS' HEALTH IN THE GULF

Low-paid migrant workers in the Gulf are subject to a range of risks to their health that place their lives in jeopardy. For the purpose of this report, we have split these risks into three broad categories:

- Working and living conditions
- Psychosocial stress
- Lack of access to healthcare

These three categories of health risk are complementary and mutually reinforcing: low-paid migrant workers in isolated and unsanitary labour camps are often working extremely long hours in dangerous conditions to service debt from recruitment fees. They often do not receive training on occupational health and safety and cannot access healthcare.

4.1. Working and Living Conditions

The most obviously identifiable risks to migrant workers' health come from their working and living conditions. Low-paid migrant workers in the Gulf are the only social groups in the region that are regularly exposed to the region's harsh climate in labour-intensive sectors of the region's economies where abuses such as overwork are common. A significant proportion of them live in accommodation that would meet the UN housing agency's definition of slums.⁶⁷ In this regard, their living and working conditions are significantly different from those of the region's national populations and wealthier migrant workers.⁶⁸

67. Slum Households are defined as one in which the inhabitants suffer from one or more of the following: 1) Lack of access to improved water source, 2) Lack of access to improved sanitation facilities, 3) Lack of sufficient living area, 4) Lack of housing durability and 5) Lack of security of tenure. See UN Habitat, "[Monitoring and Reporting the SDGs: Adequate Housing and Slum Upgrading](#)", (2018), p. 8.

68. In addition to low-paid migrant workers, the region's bidoon population (stateless groups), among some other groups, also endure discrimination in relation to housing. See, for example, [Minority Rights Group](#) description of the Bidoon in Kuwait.

4.1.1. Overwork

A study published in May 2021 by the World Health Organization and the International Labour Organization found that long working hours increase deaths from heart disease and stroke. In what the two organisations said was the first global analysis of the loss of life and health associated with working long hours, they estimated that, in 2016, 398,000 people died from stroke and 347,000 from heart disease as a result of having worked at least 55 hours a week. The organisations argue that excessive working hours represent “the risk factor with the largest occupational disease burden”.⁶⁹

In 2018, a landmark paper, based on a detailed study of data from Taiwan, concluded that overwork contributes to illness, disability and death from cerebrovascular diseases, such as strokes, and cardiovascular diseases, such as heart attacks, and that as working hours increase so does the risk of these outcomes.⁷⁰ Occupational health specialists have partly attributed the disproportionately high rate of male deaths from occupational diseases - 80 percent of the global total deaths involve men - to their involvement in occupations with a heavy physical workload.⁷¹

Excessive working hours remain a serious and widespread problem in the Gulf, putting workers at risk. Labour laws place an upper limit (typically 8 hours per day 6 days per week) on the hours that can be worked, but with the exception of Oman, all of the Gulf states specify vaguely worded exceptions that allow employers to make them work 12 hours per day, or 15 hours per day in the case of Saudi Arabia.⁷² Data on overwork from the region’s most high-profile construction projects is illustrative in this regard. A 2020 audit report commissioned by Qatar’s World Cup organisers found that 20% of employers made their employees work in excess of legal maximums outlined in Qatar’s labour law.⁷³ The situation was much worse for security guards than construction workers.⁷⁴ At one company, two workers each worked shifts of 25 consecutive hours and the report quoted a security guard saying that “he often spends 16 hours a day on work related matters.” and “tends to only sleep 4-5 hours”.⁷⁵ In the UAE, a 2014 Human

Rights Watch investigation into the construction of Saadiyat Island found construction workers who were working six and a half days a week, and were on site for 76.5 hours a week.⁷⁶

The situation for the region’s domestic workers, who are typically excluded from the regions’ labour laws and rely on recently introduced and as yet ineffective domestic worker laws to regulate their working hours, is even more serious. In a report on domestic worker abuses in the United Arab Emirates, Human Rights Watch reported that “almost all” of the 99 domestic workers they interviewed were required to work for between 15 and 21 hours a day and “only a few” said they were regularly allowed rest periods during the day or a day free of work each week or fortnight.⁷⁷ A domestic worker hired to work for an elderly couple told Human Rights Watch that she had to serve about 20 people and was required to work from 6 a.m. to 3 a.m. without rest periods or a day off. She said, “The work wasn’t what I expected it to be. It was totally different. I would wake up to start cooking, then cleaning, washing clothes, and then cooking again. No rest, there was just no rest.”⁷⁸ Long hours are exacerbated by a lack of rest days. In Kuwait, according to a 2018 survey conducted by the Kuwait Society for Human Rights (KSHR), 28% of employers admitted they never allowed their domestic workers to have a weekly day off (in violation of Kuwaiti law), while 42% said they gave workers the mandated weekly day off “from time to time”.⁷⁹ Domestic worker experts consulted by the Vital Signs Partnership said that overwork is the norm and is widespread in all of the Gulf states.⁸⁰ Male domestic workers also face the issue of overwork: an Indian driver in Saudi Arabia told Human Rights Watch researchers that the family employing him expected him to work continuously from 7 a.m. until after midnight.⁸¹

4.1.2. Heat stress

Heat can be deadly. A comprehensive 2019 report by the International Labour Organization defines, explains and outlines the dangers associated with heat stress.

69. ‘Long working hours increasing deaths from heart disease and stroke: WHO, ILO’, World Health Organisation (17 May 2021)

70. Lin Ro-Ting, Chien Lung-Chang, and Kawachi Ichiro, “Nonlinear associations between working hours and overwork-related cerebrovascular and cardiovascular diseases (CCVD)”, *Scientific Reports*, (2018). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6018699/> The report noted that “Number of working hours was found to be a significant nonlinear predictor of each severity outcome of overwork-related cerebrovascular and cardiovascular diseases.”

71. See Paivi Hamalainen, Juka Takala, Kaija Leena Saarela, “Global Estimates of Fatal Work-Related Diseases,” *American Journal of Industrial Medicine* 50, 2007, p. 29.

72. For a detailed breakdown and comparison of the Gulf states’ labour laws see the ILO FAIRWAY Fact Sheet available at <https://www.migrant-rights.org/wp-content/uploads/2019/10/FAIRWAY-Factsheet-GCC.pdf>

73. Impactt, Annual External Compliance Report of the Supreme Committee for Delivery & Legacy’s Workers’ Welfare Standards Building a legacy: laying the foundation, <https://impacttlimited.com/wp-content/uploads/2020/07/IMPA09-2020-Qatar-Annual-Report-v12-Digital.pdf> p. 7.

74. Law No. 14 of 2004 on promulgation of the Labour Law, article 76. Article 76 exempts guards and cleaners from the maximums imposed in article 73.

75. See Impactt, Annual External Compliance Report of the Supreme Committee for Delivery & Legacy’s Workers’ Welfare Standards Building a legacy: laying the foundation, <https://impacttlimited.com/wp-content/uploads/2020/07/IMPA09-2020-Qatar-Annual-Report-v12-Digital.pdf> p. 16

76. ‘Migrant Workers’ Rights on Saadiyat Island in the United Arab Emirates’, Human Rights Watch (10 February 2015)

77. Human Rights Watch, “I Already Bought You: Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates”, (22 October 2014).

78. Human Rights Watch, “I Already Bought You: Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates”, (22 October 2014).

79. Kuwait Society for Human Rights, “The Rights of Domestic Workers between Legislative System and Enforcement”, (2018): 30-37.

80. Telephone interview with Rothna Begum, Human Rights Watch, (6 December 2021).

81. ‘Saudi Arabia: Personal Drivers Face Abuse’, Human Rights Watch (2019)

“Heat stress” refers to heat received in excess of that which the body can tolerate without suffering physiological impairment. Maintaining a core body temperature of around 37°C is essential for continued normal body function. Above a certain threshold of heat stress, the body’s internal regulation mechanisms are no longer capable of maintaining body temperature at a level required for normal functioning. As a result, there is an increased risk of discomfort, of limitations in physical functions and capabilities, and ultimately also of injuries and heat-related illnesses. The latter illnesses range from mild forms, such as heat rash, heat cramps and heat exhaustion, to potentially fatal heatstroke.⁸²

According to the ILO, heat stress is more prevalent in countries with decent work deficits, and agricultural and construction workers are the worst affected.⁸³ Low-paid migrant workers in the Gulf who work outdoors are subjected to dangerously high levels of heat and humidity, and, as the previous section noted, many are overworked in physically demanding sectors such as construction.

In 2020, researchers in Kuwait published a report on how heat affected the mortality rates of Kuwaitis and non-Kuwaitis.⁸⁴ The researchers “observed a health disparity where less-advantaged non-Kuwaitis have systematically adverse health impacts from heat exposure” and a “striking difference” between Kuwaitis and non-Kuwaitis in relation to exposure to hot temperatures and overall mortality rates. They noted that low-paid migrant workers are the non-Kuwaitis most exposed to the country’s harsh climate, concluding that “Non-Kuwaiti males and in working age were vulnerable to hot temperatures with *doubling to tripling risk of mortality*” (emphasis added). The study called for a re-evaluation of the effectiveness of summer working bans, and noted that the clear disparity of health outcomes raised what it termed a “serious environmental justice problem”:

“We have observed a health disparity where less-advantaged non-Kuwaitis have systematically adverse health impacts from heat exposure. Because of climate change, the intensity of heatwaves is likely to escalate over the next decades (Pachauri et al., 2014), whereas at the same time, there is a growing near-constant demand for workers to build new buildings and complexes in an energy-intensive city like Kuwait. The health disparity between Kuwaitis and non-Kuwaitis is set to widen as temperatures continue to rise.”

In response to an initial draft of this report, one expert on the risks to migrant workers from heat and humidity expanded on the issue of environmental justice.

“Disadvantaged communities do not get the same level of protection from environmental exposures, nor do they get a seat at the decision-making table. Low-paid migrant workers in the Gulf are differentially exposed to outdoor heat, and they are more vulnerable to poor health. When they are excluded from the policy conversation and are offered very limited protection, it becomes a clear environmental injustice issue. Climate change is only going to exacerbate this.”⁸⁵

Natasha Iskander, who conducted ethnographic research on construction sites in the Gulf and who “chose construction sites and affiliated labor camps that had good reputations in terms of their labor Practices” described the impact of heat on the workers she spoke to in striking terms.

“Workers described the heat as a kind of torment. In interviews with me, workers ranked extreme temperatures as the most difficult and harmful pressure they faced by far. “I had never imagined a climate like this,” said one worker from Nepal. “Until you feel it, you cannot believe it.” “The heat is like a wall,” said another from Kenya. “It melts the air, and you feel you are drowning. You cannot breathe,” added his compatriot. “It is like the sky is pressing down on your body,” described another worker. They reported that heat wrecked their bodies; they found themselves vomiting, suffering from headaches and muscle cramps, experiencing sudden shortness of breath, or feeling exhaustion so intense that it felt like crushing physical pain, rendering them unable to eat, wash, or undress at the end of the day. Rashes spread across their bodies, and shivers racked them. These were all symptoms of heat stress injury, frequently indicators of organ damage.”⁸⁶

None of the Gulf states have laws that adequately mitigate the risk posed to outdoor workers by its extremely harsh climate. Each country operates a rudimentary summer working hours ban that imposes a blanket ban on work at certain hours of the day during the summer months. There is a striking lack of consistency in the hours of the day and the times of the year when these various bans are in force, which underscores the rather arbitrary and non-scientific character of these protections.

82. International Labour Organization, “Working on a Warmer Planet: The impact of heat stress on labour productivity and decent work”, (2019), p. 17.

83. International Labour Organization, “Working on a Warmer Planet: The impact of heat stress on labour productivity and decent work”, (2019), p. 17.

84. Barak Alahmad, Ahmed F. Shackarchi et al., “Extreme temperatures and mortality in Kuwait: Who is vulnerable?”, *Science of the Total Environment*, vol. 732, (25 August 2020).

85. Comment from external expert (anonymous), 13 January 2022.

86. Natasha Iskander, “Does Skill Make Us Human?: *Migrant Workers in 21st-Century Qatar and Beyond*”, Princeton University Press, (November 2021).

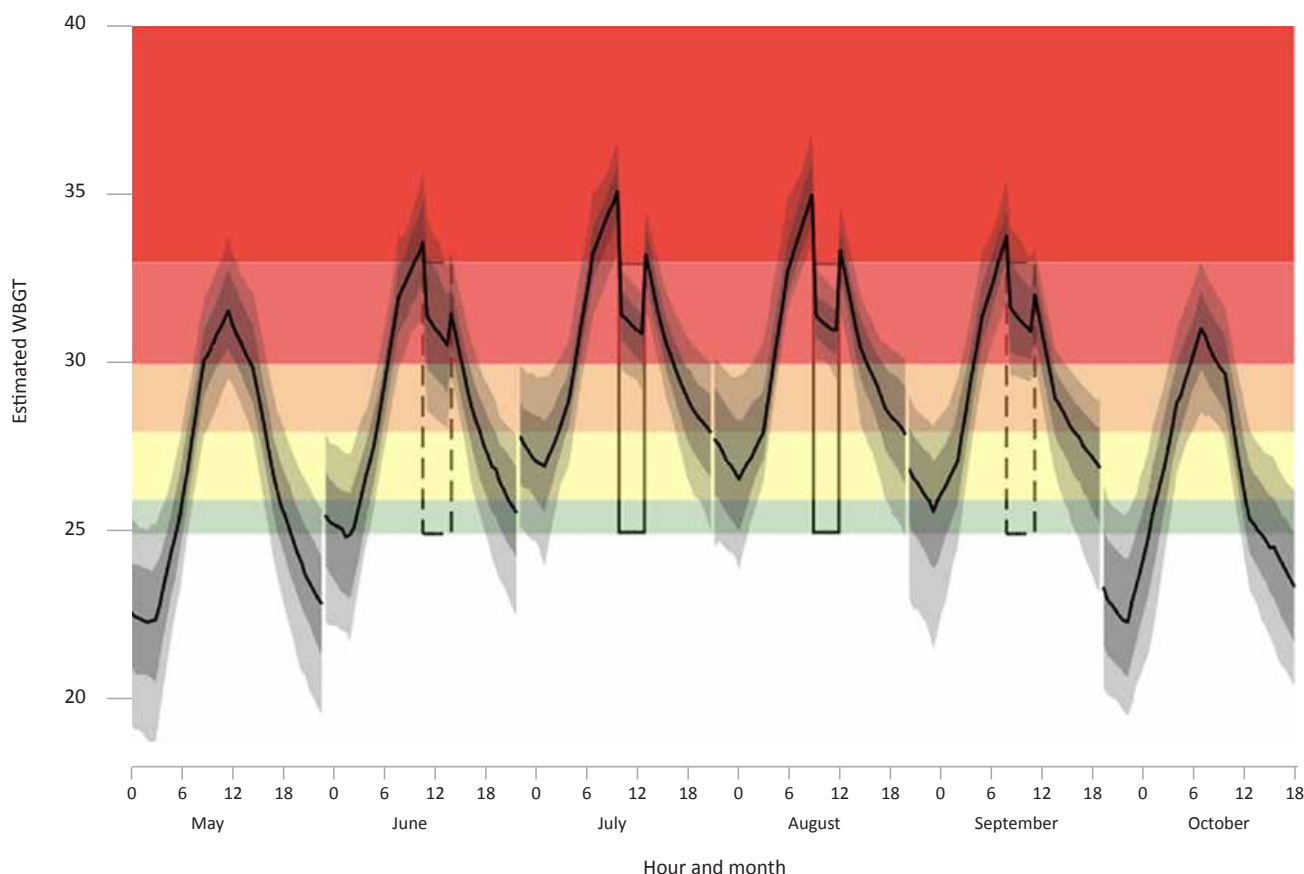
Summer hours working bans across the Gulf⁸⁷

Country	Dates ban in force	Hours of ban	Mandatory work stoppages per year
Bahrain	July 1 to August 31	12pm - 4pm	248 hours
Kuwait	June 1 to August 31	11am - 4pm	460 hours
Oman	June 1 to August 31	12.30pm - 3.30pm	368 hours
Qatar	June 1 to September 15	10am - 3.30pm	588.5 hours
Saudi Arabia	June 15 to September 15	12pm - 3pm	279 hours
UAE	June 15 to September 15	12.30pm - 3pm	232.5 hours

To take the example of Abu Dhabi, a coastal city on the southern coast of the Arabian Gulf, the graph below shows the length of time that outdoor workers would be exposed to different levels of environmental heat, which is measured by something

called the Wet Bulb Globe Temperature (WBGT).⁸⁸ The wet bulb temperature is a composite measure that incorporates air temperature, humidity, wind speed and sunlight exposure to assess the environmental heat risk.

Abu Dhabi



87. For a summary of each of the Gulf states' labour laws see Building Responsibly and ILO Labour Law Factsheets, available online at <https://www.building-responsibly.org/internal-resources>. Migrant-rights.org have also published a comparison of the Gulf states' summer working hours bans, available online at <https://www.migrant-rights.org/2021/06/summer-midday-work-ban-fails-to-adequately-protect-workers>

88. WBGT is a highly authoritative index that is used by: regulatory bodies, including International Standards Organization and the American College of Government Industrial Hygienists; armed forces, including US, UK and Australia; and sporting bodies including the International Olympic Committee. It also takes into account wind and solar radiation.

Each of the colours in the graph above (produced by data scientist Erik Hanson using data provided by the UK Met Office) represents a threshold above which different types of work, corresponding to different levels of physical activity, should only be undertaken with scheduled rest periods every hour.⁸⁹ It is clear from the graph that heat and humidity levels frequently pose a clear and in many cases an extreme risk to workers' health, at times when there are no restrictions on the performance of outdoor work. An analysis of meteorological data conducted in 2019 by a specialist, shared with the Vital Signs Partnership, confirmed the shortcomings of summer working bans in the Gulf to address the risk from heat.⁹⁰ It found, to take the example of Abu Dhabi, that someone working outdoors and doing only moderate physical activity, would on average have been exposed to unsafe levels of heat and humidity for 84% of daytime hours between May and October.⁹¹

As a result of its hosting of the 2022 World Cup, Qatar has faced more scrutiny over this issue than the other Gulf states and in May 2021 it passed a new law on heat stress protection, but even this falls well short of the protection required. The Ministerial Decision extended the summer working hours ban and introduced additional measures that require employers to mitigate the risk to workers by completing, and regularly updating, heat stress risk assessments; performing annual health check-ups to diagnose and manage chronic diseases that may contribute to the risk of heat stress; and providing workers with appropriate personal protective equipment for the hot weather. Qatar, for the first time, adopted the WBGT heat stress index to assess the level of occupational heat stress. However, employers are only compelled to stop work if the WBGT rises above 32.1°C, which is the upper limit above which no work can be performed safely. The new law gives workers "the right to stop working and submit a complaint ... when they have good reason to believe that heat stress is a threat to their safety or health". While this language is drawn from international conventions, this creates a significant risk in the Gulf context as it could allow employers to rely on "self-pacing", which places responsibility on workers to stop work.

Professor David Wegman, who is an expert on health and safety in the construction industry described the new legislation as "an improvement that falls far short of what is necessary for the protection of labourers who are subject to heat stress exposures of all types". He added that ensuring work is safely performed without risk of heat-related illness "is critically dependent on a balance of work and rest periods" and that limits on work "should be determined objectively according to WBGT measurements combined with an objective assessment of work effort".

The shortcomings of this law give particular cause for concern in the light of peer-reviewed research that has drawn a causal link between the lack of protection from Qatar's climate and mortality rates. A seminal peer-reviewed paper published in the scientific journal *Cardiology* in June 2019 examined mortality statistics for Nepalese migrant workers in Qatar and found "a strong correlation between monthly WBGT max and the death rate due to cardiovascular causes."⁹² It concluded that "a large proportion" of deaths attributed broadly to cardiovascular diseases were due to "serious heat stroke."⁹³

*"As many as 200 of the 571 cardiovascular deaths [of Nepalese migrant workers] during 2009–2017 could have been prevented if effective heat protection measures had been implemented as a part of local occupational health and safety programs. ... Based on the ongoing trends of monthly heat conditions in Qatar, we also conclude that climate change is already contributing to these occupational health risks, and it will further increase the risks in the future."*⁹⁴

One of the report's primary authors, cardiology Professor Dan Atar from the University of Oslo said the following:

"In our work, we found a correlation between heat and deaths of migrant workers in Qatar. There is no reason to doubt this link, as it shows that the death toll follows the peaks in the annual heat waves. Indeed, the curves not only follow each other up during the hot months, but likewise down during cooler periods. Since relatively young male workers selected

89. The median WBGT estimates in each hour and month is displayed as a black line in the figures, and the dark and light grey areas indicate the 50% and 80% range of the WBGT estimates for that hour and month. These rest periods, which should be in a cool, shaded area, enable the body to thermoregulate and keep internal body temperature at a level that is safe. A WBGT of 28°C, for example, is the highest WBGT at which moderate physical activity, such as raking leaves, should be permitted without breaks. More strenuous activity requires scheduled breaks when the WBGT exceeds 26°C. The length of the break required every hour is therefore a factor of the environmental heat and the level of physical activity being performed.

90. Data supplied by the UK Meteorological Office covering the time period January 1, 2008 to August 31, 2018. The Met Office supplied air temperature and dew drop temperature data for the following cities: Abu Dhabi and Dubai (United Arab Emirates), Manama (Bahrain), Doha (Qatar), Mecca and Riyadh (Saudi Arabia) and Muscat (Oman). Data for Mecca and Riyadh was incomplete and precluded a detailed analysis. The data analysis was performed by Erik Hansson. Erik is a qualified physician and a doctoral candidate at Gothenburg University, working on a thesis that addresses the environmental determinants of Chronic Kidney Disease (CKD) in the department of Occupational and Environmental Medicine.

91. It found that in Abu Dhabi, from 2008- 18, outdoor workers were exposed to heat stress exposure levels that exceeded the recommended reference value for moderate physical activity for 84% of the summer daytime when outdoor work is permitted. In other words, for 84% of this critical 6 month period, there were no regulations in place to prevent or restrict the type of work that could cause heat stress or other heat-related injuries. In Kuwait City, the figure was 48%, in Dubai it was 86% and in Doha it was 79%.

92. Bandana Pradan, Tord Kjellstrom, Dan Atar, Puspa Sharma, Birendra Kayastha, Ghita Bhandari, Pushkar K. Pradhan, "Heat Stress Impacts on Cardiac Mortality in Nepali Migrant Workers in Qatar", *Cardiology*, 2019, p. 46.

93. Bandana Pradan, Tord Kjellstrom, Dan Atar, Puspa Sharma, Birendra Kayastha, Ghita Bhandari, Pushkar K. Pradhan, "Heat Stress Impacts on Cardiac Mortality in Nepali Migrant Workers in Qatar", *Cardiology*, 2019, p. 37.

94. Bandana Pradan, Tord Kjellstrom, Dan Atar, Puspa Sharma, Birendra Kayastha, Ghita Bhandari, Pushkar K. Pradhan, "Heat Stress Impacts on Cardiac Mortality in Nepali Migrant Workers in Qatar", *Cardiology*, 2019, p. 47.

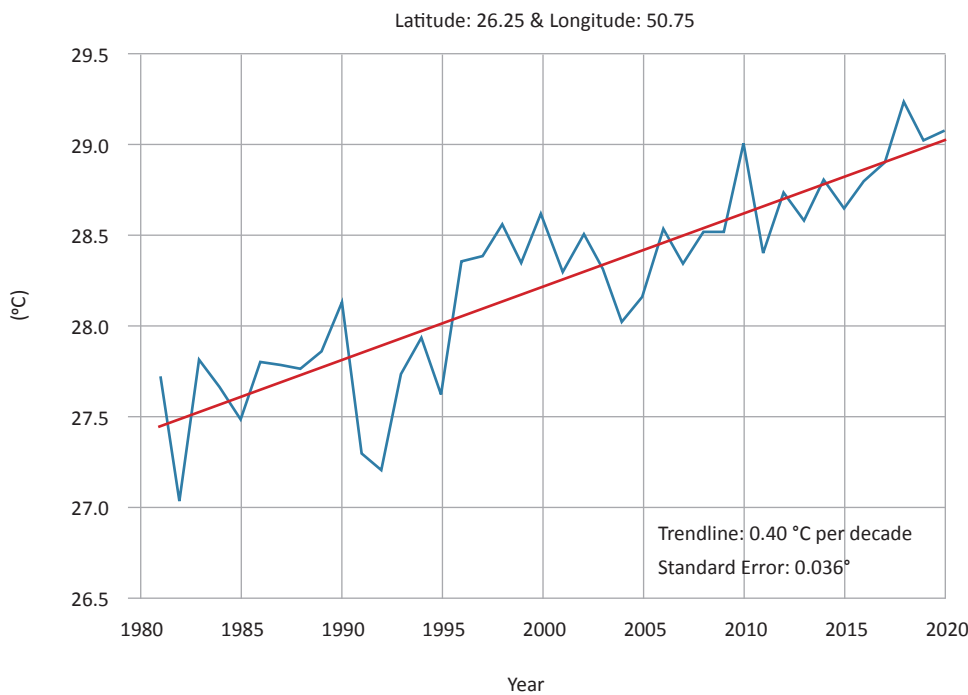
for their ability to sustain physical work usually don't suffer from deadly cardiovascular disease, my conclusion as a cardiologist is that these deaths are caused by heatstrokes. The concern is that the bodies of the workers cannot take the heat stress they are being exposed to."⁹⁵

As the Kuwait study notes, the risk to outdoor workers from heat and humidity in the Gulf is increasing. Climate CHIP is a non-profit website that provides a range of information and resources about heat stress and other health impacts of climate change, and it includes a wealth of data on WBGT levels in the Gulf. To take one example, the graph below shows

the increase in the mean WBGT for the month of July in Manama, Bahrain. The graph shows a clear upwards trajectory that is consistent with an increase in mean and maximum WBGT levels in cities across the region. Not only are the Gulf states' laws inadequate to meet the current risks to outdoor workers, but those risks are gradually increasing, making the implementation of scientifically-grounded protection mechanisms more urgent. One scientific projection from 2016 noted that extremes of wet-bulb temperature in the region around the Arabian Gulf are likely to exceed the critical threshold for human survivability in the absence of significant reductions in greenhouse gas emissions.⁹⁶

Mean WBGT levels in Manama, Bahrain from 1980 to 2020

Source: ClimateChip.org



The death of Bom Bahadur KC from Nepal

Bom Bahadur KC died in Qatar in 2021, at the age of 30. Growing up in the rural Pyuthan Gaumukhi municipality of Nepal, Bom was the youngest of three siblings. His father died when he was only six years old and he did not complete school, first leaving Nepal for work in India at the age of 16. His brother told the Vital Signs Partnership that he first went to Qatar in 2015 at the age of 24 and worked as a labourer in its agricultural sector, having paid 60,000 Nepali rupees (US\$500) to a local recruitment agent and receiving a monthly salary of 900 Qatari riyals (US\$247). He stayed in this job for four years, before returning to Nepal in 2019. After losing work in India as a result of the

95. Email from Professor Dan Atar, University of Oslo, 26 March 2021.

96. Jeremy Pal and Elfatih Eltahir, "Future temperature in southwest Asia projected to exceed a threshold for human adaptability", Nature, 2016.

Covid-19 pandemic, he decided to move to Qatar for work again, this time paying a much higher recruitment fee of 140,000 Nepali rupees (\$1,157) to work in a subcontracting company in Qatar's construction industry, where he earned a monthly salary of 2000 Qatari riyals (\$550). His work involved repairing buildings, maintaining plasters, walls and ceilings of the buildings and his brother said that it was physically demanding. On May 10, 2021, Bom returned to his accommodation, which he shared with five other workers, in the evening after the day's work. The men ate together and went to sleep at around 10pm, but in the morning his colleagues could not wake him up. They called their supervisor, who called a doctor who confirmed that Bom Bahadur KC was dead. Bom's uncle and brother-in-law were working for the same company and they called and informed his family of his death. The death certificate, which the family showed to the Vital Signs Partnership, shows that the certified cause of Bom's death was "acute heart failure due to natural causes." His death occurred at a time of the year when there were no restrictions on working hours. On the day he died the maximum day-time temperature was 40 degrees centigrade and overnight, the minimum temperature was 30 degrees centigrade.⁹⁷ The family said that they were not aware of Bom having any medical conditions and he had never complained of feeling sick in the period before his death. They told the Vital Signs Partnership that they were not offered an autopsy to determine the cause of his death. Bom left behind three children. The family received compensation from a private insurance scheme they had set up and from Nepal's Foreign Employment Board, but none from his employer or any institution in Qatar.

4.1.3. Air pollution

According to the World Health Organisation, air pollution is now one of the greatest environmental risks to health.⁹⁸ Air pollution is the presence of one or more contaminants in the atmosphere, such as dust, fumes, gas, mist, odour, smoke or vapour, in quantities and duration that can be injurious to human health. This pollution kills an estimated seven million people worldwide every year, with 4.2 million of those deaths resulting from exposure to ambient (outdoor pollution).⁹⁹ Breathing in pollutants leads to inflammation, oxidative stress, immunosuppression, and mutagenicity in cells throughout our body, impacting the lungs, heart, brain among other organs and ultimately leading to disease. There is a close, quantitative relationship between exposure to high concentrations of fine particulates (PM10 and PM2.5) and increased mortality or morbidity, both daily and over time.¹⁰⁰

Two peer-reviewed scientific studies in Kuwait suggest that air pollution contributes to an increase in mortality rates among low-paid migrant workers in the Gulf. A 2019 paper explored

the association between exposure to poor air quality and acute mortality in Kuwait during a 17-year period from 2000 through 2016.¹⁰¹ The report concluded that "exposure to poor air quality conditions was associated with an increased risk of total non-accidental mortality... with non-Kuwaiti males and adults being more vulnerable."¹⁰² The report noted that "men, especially non-Kuwaiti men, tend to spend more time outdoors for work and other activities." Specifically, investigators estimated that the risk of dying among non-Kuwaiti males was 5% higher during dust storm days as compared to non-dust days. Between 2017 and 2019, public health researchers in Kuwait used custom-designed particle samplers, developed at the Harvard T. H. Chan School of Public Health, to collect samples under severe dust storm episodes in Kuwait, collecting samples of fine (PM2.5) and large (PM10) particles every day in Kuwait City and at another location near industrial and petrochemical facilities.¹⁰³ The report found that annual concentration of particulate air pollution in Kuwait City and the industrial location were five to six times higher than WHO standards. The analysis shows that "anthropogenic and dust pollution sources dominate both locations in a similar pattern, as compared to local traffic and industrial emissions."¹⁰⁴

97. Historical daytime temperature data available at [timeanddate.com](https://www.timeanddate.com) and May 2021 temperatures for Doha available at <https://www.timeanddate.com/weather/qatar/doha/historic?month=5&year=2021>

98. See World Health Organisation, "Fact Sheet: Ambient (Outdoor) Air Pollution", (22 September 2021). Numerous other WHO online resources on air pollution and its impact on health are available, for example at <https://www.who.int/teams/environment-climate-change-and-health/air-quality-and-health/health-impacts> and https://www.who.int/health-topics/air-pollution#tab=tab_1

99. See World Health Organisation, "Fact Sheet: Ambient (Outdoor) Air Pollution", (22 September 2021). Numerous other WHO online resources on air pollution and its impact on health are available, for example at <https://www.who.int/teams/environment-climate-change-and-health/air-quality-and-health/health-impacts> and https://www.who.int/health-topics/air-pollution#tab=tab_1

100. Ibid.

101. Barrak Alahmad et al., "Acute effects of air pollution on mortality: A 17-year analysis in Kuwait", Environment International, (March 2019).

102. Barrak Alahmad et al., "Acute effects of air pollution on mortality: A 17-year analysis in Kuwait", Environment International, (March 2019).

103. Barrak Alahmad et al., "A Two-Year Assessment of Particulate Air Pollution and Sources in Kuwait", Environmental Pollution, (March 2021).

104. Barrak Alahmad et al., "A Two-Year Assessment of Particulate Air Pollution and Sources in Kuwait", Environmental Pollution, (March 2021).

With the exception of these studies from Kuwait, there is a dearth of research on the impact of pollution on migrant workers' health, especially when exacerbated by extreme

heat and humidity. Given the high levels of anthropogenic air pollution from the heavy petroleum industry in the region and the frequency and intensity of dust storms, this is a significant research gap.

Chronic Kidney Disease

According to data produced by the International Labour Organization, the vast majority of deaths from work-related accidents and diseases around the world occur not from industrial accidents, but from a wide-range of occupational diseases, which is to say diseases or illnesses contracted as a result of an exposure to risk factors arising from work.¹⁰⁵ One such disease is CKDu or Chronic Kidney Disease of Non-Traditional Causes is a type of chronic kidney disease that has been documented as affecting marginalised agricultural communities in specific areas of the world where a large number of people develop a deadly form of kidney disease.¹⁰⁶ According to La Isla Foundation, an organisation that has conducted research on the issue across the globe, with a particular focus on its prevalence among sugarcane cutters in Central America, the disease has killed more than 20,000 people in a single decade in Central America alone. A 2020 article by the Guardian newspapers described the phenomenon among sugarcane cutters:

*"The men start their work fit and strong, but after repeated harvests chopping cane under the tropical sun, they begin to suffer from nausea, back pain and exhaustion, get such severe muscle weakness that they can no longer earn a living, then end up dying of kidney failure, despite many being only in their 20s and 30s."*¹⁰⁷

There is a dearth of data and of research on the prevalence of the disease within migrant worker populations in the Gulf, but a study conducted in a tertiary care centre in Nepal in January-July 2019 found increased incidence of chronic kidney disease among Nepali migrant workers returning from Gulf States and Malaysia. The report said it was not possible to identify the cause of the illness, but noted that "long working hours and access to timely medical care may be contributing factors".¹⁰⁸ Dr Dinesh Neupane from the John Hopkins Bloomberg School of Public Health also identified the scarcity of data as a serious problem, but referred to the aforementioned research as being indicative of an emerging problem and said that any issue affecting Nepalese migrant workers was likely to extend to other nationalities.¹⁰⁹

Professor Vivekanand Jha, the Executive Director at The George Institute for Global Health, India, and Chair of Global Kidney Health at Imperial College London, told the Vital Signs Partnership that there is strong evidence that prolonged exposure to heat has adverse impact on kidney health, and that undocumented heat-related illnesses including kidney diseases may be part of the cause of excess deaths among migrant workers in the Gulf States. He drew attention to the lack of data and research on the issue, but added that the problem of high levels of chronic kidney disease in migrant workers was noted in health circles in south Asia. In November 2021, an investigation by The Times newspaper in the United Kingdom interviewed more than a dozen doctors and public health experts - most of them in Nepal - whose collective conclusion was that "significant numbers of healthy young men were leaving home to work in the Gulf and returning with kidney diseases so severe that they required either transplants or dialysis."¹¹⁰

105. According to the ILO's data, only 14% of global workplace deaths relate to accidents, with 86% of workplace deaths attributable to occupational diseases. According to the ILO "An occupational disease is a disease contracted as a result of an exposure to risk factors arising from work. Recognition of the occupational origin of a disease, at the individual level, requires the establishment of a causal relationship between the disease and the exposure of the worker to certain hazardous agents at the workplace. This relationship is normally established on the basis of clinical and pathological data, occupational history (anamnesis) and job analysis, identification and evaluation of occupational hazards as well as exposure verification. When a disease is clinically diagnosed and a causal link is established, the disease is then recognized as occupational." International Labour Organisation, "The Prevention of Occupational Diseases", 2013, https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_208226.pdf
106. It is alternatively known as CKDu, where the 'u' refers either to unexplained causes or unknown etiology. See "What is CKDu" at the website of the International Society of Nephrology.
107. Kate Hodal and Ed Kashi, "The mystery epidemic striking Nicaragua's sugar cane workers - a photo essay", The Guardian, (27 November 2020).
108. N. Dhakal, N. Bhurtyal, P. Singh, D. Shah Singh, "Chronic Kidney Disease in Migrant Workers in Nepal", Kidney International Reports (2020), p. 58.
109. Telephone interview with Dr Dinesh Neupane, John Hopkins Bloomberg School of Public Health, (12 January 2022).
110. Louise Callaghan, "Dying for the World Cup", The Times, (13 November 2021).

4.1.4. Physical and psychological abuse

Low-paid migrant workers in the Gulf are frequently subjected to physical and psychological abuse that can seriously affect their physical and mental health. The problem is particularly serious among female domestic workers, whose confinement in family homes also cuts them off from support networks and leaves them vulnerable to sexual abuse. The most serious abuses can result in serious injury or death, such as when a Sri Lankan woman had 24 nails and needles inserted into her body by her employers in Saudi Arabia, or when a 29-year old Filipina was found dead inside her employer's freezer in Kuwait, with apparent signs of torture.¹¹¹

Saudi Arabian researcher and academic, Professor Madawi Al-Rasheed has noted how domestic workers are situated within distinct racial hierarchies in the Gulf and occupy a particular role within society and their host families that leaves them vulnerable to abuse.

“For aspiring housewives, it was a matter of prestige and social standing to manage several maids in the house, ranked according to their nationality with English-speaking Asians becoming more prestigious to have than Africans. Others preferred Muslim maids from Indonesia and Bangladesh to ensure religious and social compatibility. Yet single Muslim maids were not spared some of the traumas of their non-Muslim counterparts. A Muslim maid is still a suspicious person who travels alone and lives with a family of strangers.”¹¹²

Rothna Begum, who has conducted extensive research on the abuse of domestic workers in the Gulf states described to the Vital Signs Partnership how social factors and racial stereotyping combine to toxic and violent effect on this overwhelmingly female subset of the migrant worker population, and how a combination of physical and psychological abuse leaves some women dead, and in other extreme cases leaves women unable to work.

“The domestic workers are dehumanised and so when there is stress or marital strife in the home, it is often taken out on the domestic workers. Women report arguments that lead to boiling water being thrown at them, or being burned with irons, or having bottles or pots and pans thrown at them.”¹¹³

Begum said that these abuses were at the extreme end of the

scale but noted that over many years researching the topic, domestic workers repeatedly recounted to her this pattern and type of abuse. A Human Rights Watch report that documented abuses in Oman and the United Arab Emirates found that 21 out of 87 domestic workers they interviewed experienced “psychological or health problems upon their return because of their exploitative working conditions in the Gulf.”¹¹⁴

Migrant-Rights.org has documented numerous cases of serious physical and psychological abuse against domestic workers across the Gulf. A 32-year old Filipina whom police in Kuwait had to rescue from an employer who had previous conviction for assaulting and blinding another domestic worker described “torture and abuse from day one.” She told Migrant-Rights.org, “From the first day, every day, she beat me and the other Filipina. The first day itself I said I want to go back. She also hit me on my private parts and called me ‘f**ker Filipina.’”

In March 2021, the organisation published voice messages from the daughter of a 50-year old Indian domestic worker who had lost contact with her family after seeking shelter from abuses that she had endured from the start of her employment in Qatar. “Five days ago my mother decided to go to the [Indian] embassy to file a complaint. The house owner caught her and beat her up and took her back. That’s all we know. We haven’t spoken to her since. Until today we don’t know if she is there (alive) or not.” Jayanthi was eventually able to leave Qatar and return to India, but Rothna Begum told the Vital Signs Partnership that many are not so lucky. “We don’t know how many because employers are only held accountable when there are signs of serious physical injury. In many cases, there are claims that the women committed suicide, but no investigation into these claims.

Suicide rates among this population of workers appears to be disproportionately high. In 2010, Migrant-Rights.org reported that there was a domestic worker suicides roughly every 2 days in Kuwait.¹¹⁵ In 2012 a therapist at Hamad Hospital’s Psychiatric Unit in Doha told a local newspaper that 12 to 15 domestic workers visited the unit daily for treatment to cope with anxiety, including suicide attempts.¹¹⁶ The data so far available to the Vital Signs Partnership is insufficiently detailed to draw any conclusions on the rate of suicides among domestic workers in relation to rates in their origin states and rates of suicides among low-paid migrant workers in other sectors, but Rothna Begum of Human Rights Watch

111. BBC News, “Nails removed from ‘tortured’ Sri Lankan maid”, (27 August 2010). BBC News, “Joanna Demafelis: Employers of Filipina maid found dead in freezer arrested”, (24 February 2018).

112. Madawi Al-Rasheed, “Maid in Saudi Arabia”, AL-Monitor, (17 July 2013).

113. Telephone interview with Rothna Begum, Human Rights Watch, (6 December 2021).

114. Human Rights Watch, “Working Like a Robot’: Abuse of Tanzanian Domestic Workers in Oman and the United Arab Emirates”, (14 November 2017).

115. Migrant-Rights.org, “Almost every two days a migrant worker commits suicide in Kuwait”, (5 October 2010).

116. Quoted in <https://www.amnesty.org/en/documents/mde22/004/2014/en/>. Full article accessible at <https://www.thefreelibrary.com/Housemaids+learn+coping+skills+with+occupational+therapy-a0314454936>

considered the numbers to be obviously problematic and offered some explanation as to why domestic workers commit suicide. “Often their only act of defiance left is to take their own lives”, she said.¹¹⁷

4.1.5. Living conditions

Much of the accommodation in which low-paid migrant workers in the Gulf are housed meets the UN definition of slum housing. UN Habitat defines slum households as ones in which the inhabitants suffer from one or more of the following: lack of access to improved water source; lack of access to improved sanitation facilities; lack of sufficient living area; lack of housing durability and lack of security of tenure.¹¹⁸

Migrant workers employed on high-profile construction projects, such as Abu Dhabi’s Saadiyat Island or Qatar’s World Cup, typically enjoy a significantly better standard of housing than the vast majority of low-paid migrant workers, but even workers on these projects can endure housing that is harmful to their well-being. In 2014, Human Rights Watch obtained video footage that recorded living conditions of a group of 27 workers working as painters on the construction of a New York University campus in Abu Dhabi. The workers were living crammed into two rooms, 15 in one room and 12 in another. The video shows insects crawling around the kitchen; exposed electrical wires wrapped around a shower head; a room containing six bunk beds with makeshift beds on the floor underneath three of the bunk beds (in the room that slept 15 men); and a hole punched in the fire escape door, which was locked. Foodstuffs such as rice bags were stored in the bedroom, along with work tools. The 27 men shared two small toilets and also washed their work clothes in the bathroom, they said. Several of the men complained of sickness and dizziness from inhaling paint, but said that they wore masks at work.¹¹⁹

According to Sharifa Alshalfan, an architect and researcher at the London School of Economics, “housing and urban planning policies in Kuwait have long neglected male, low-income migrant workers” with these workers forced to live in what Kuwait’s Third Master Plan Review calls “non-Kuwaiti collective dwelling”, located in various areas across Kuwait City such as Khaitan, Jleeb Alshuyoukh and Farwaniya.¹²⁰

According to Alshalfan, in the 99% non-Kuwaiti district Jleeb Alshuyoukh the population divided by the number of housing units produces an average of 16 people per unit, and she cited local newspapers reports of beds being rented to multiple sleepers per day, amid unhygienic environments and sewage-filled streets.¹²¹

In Qatar, media reports of migrant worker abuses prompted the authorities to announce the construction of a series of new compounds to house its low-paid migrant workers in 2015. Newspaper reports on Doha’s Salwa industrial area, where a significant proportion of the city’s low-paid migrant workers are housed, described what they called “desperate conditions” that included “a vast, squalid corridor of tiny bedrooms” each of which housed eight people and “where clothes were hanged to the walls and valued possessions were stuffed under tiny bunk beds.”¹²² A female hospitality worker who spoke to Amnesty International in 2020 described sharing a room with 12 people.¹²³

Worker accommodation in Saudi Arabia has been less well documented than other Gulf states owing in part to the relatively greater difficulty for media and human rights organisations in accessing the country. As a result, conditions in labour camps have only come to the fore at times of crisis, such as when thousands of workers were stranded in their accommodation for months on end in 2016.¹²⁴ However during the Covid-19 pandemic, government authorities were forced to acknowledge the serious overcrowding in migrant worker accommodation.¹²⁵ In April 2020 the government established a new committee to oversee worker accommodation, which Migrant-Rights.org called a “long-overdue response to overcrowding”.¹²⁶

Female domestic workers typically live in their employers’ homes but they also frequently endure inadequate living accommodations. Almost a third of the domestic workers they interviewed in a Human Rights Watch report on abuses in the UAE described sleeping conditions that were inadequate.¹²⁷ A 44-year-old Nepali worker, told the rights group that she slept on the floor, without a mattress, in the room of her employers’ 8-year-old son. A 33-year old woman from the Philippines said she slept on cardboard in a storage room. A 2014 Amnesty International report on domestic workers in Qatar quoted one worker whose room housed her employers’ clothes and which

117. Telephone interview with Rothna Begum, Human Rights Watch, (6 December 2021).

118. See UN Habitat, “Monitoring and Reporting the SDGs: Adequate Housing and Slum Upgrading”, (2018), p. 8.

119. Human Rights Watch, “Migrant Workers’ Rights on Saadiyat Island in the United Arab Emirates: 2015 Progress Report”, (February 2015.)

120. Sharifa Alshalfan, “COVID-19 in Kuwait: how poor urban planning and divisive policies helped the virus spread”, London School of Economics Public Policy Blog, (September 16, 2020).

121. The Alqabas newspaper article that Alshalfan linked to in her blog is no longer active.

122. “Qatar builds seven ‘cities’ to house 258,000 World Cup migrant labourers”, The Guardian, (May 6, 2015).

123. Amnesty International, “Reality Check 2021: A Year to the 2022 World Cup”, (November 2021).

124. Rori Donaghy, “Saudi Arabian dreams turn to nightmares for penniless Pakistanis”, Middle East Eye (17 August 2016)

125. ‘Madinah emir intervenes to end overcrowding at labor camps’, Saudi Gazette (18 May 2020)

126. Annas Shaker, ‘Decades of migration mismanagement has Saudi scampering to contain the spread’, Migrant-Rights.org, (22 April 2020)

127. Human Rights Watch, “I Already Bought You: Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates”, (22 October 2014).

had no lock.

“I did not have my own room. I slept in a cabinet room inside the kitchen. The room had madam’s clothes in it. I had my own bed but there was no lock on the door. I was scared of the driver because my room is not locked. Madam would come into the room sometimes, even Sir did too. Sometimes he would come in at midnight or 01:00 at night and would enter my room.”¹²⁸

4.1.6. Workplace accidents

Low-paid migrant workers are generally over-represented in the most dangerous sectors of the global economy and this is very clearly the case in the Gulf, where they occupy virtually all of the positions in labour intensive sectors such as construction, which have historically been badly regulated. A 2009 paper by medical researchers in the United Arab Emirates stated that “the rapid development of projects employing large numbers of expatriates has often outstripped the ability of education, health and labour ministries to train and deploy adequate numbers of industrial hygienists and safety inspectors to protect workers’ health and safety.”¹²⁹

Researchers from the Civil and Architectural Engineering Department at Sultan Qaboos University in Muscat published a detailed study of occupational health and safety practices (OHS) in Oman in 2020, and referred to a general “lack of knowledge and information about OHS in the construction industry” in the country and noted that “although occupational health and safety regulations are well established in Oman, the degree of implementations of such regulations varies dramatically concerning the rank of the construction company.”¹³⁰ The research, based on an evaluation of health and safety practices

in ten small and medium construction companies (those that employ the majority of low-paid migrant workers deployed on construction sites) from the governorates of Muscat and Al Batinah, is revealing in terms of the general failure to adhere to very fundamental safety standards. For example, while one construction company provided “good electrical wiring and routing”, none of the companies provided a waste management system, resulting in human waste being left to accumulate on site, and there was a general lack of provision of essential personal protection equipment (PPE) - only one of the ten companies provided their employers with safety helmets, and only one company provided eye protection.¹³¹

A 2020 study of occupational health and safety in Jeddah, Saudi Arabia, which interviewed 300 migrant workers on two major construction sites, found that workers reported the most common accidents to be falling from a height, electric shock, falling equipment causing head injuries, and material handling incidents.¹³² According to the Saudi Arabian Health and Safety Association, there were 67,000 work injuries in 2016, with the top three causes of injuries being falls from height, collisions and suffocation inside underground septic tanks.¹³³ A 2018 study found that migrant workers had a 14 times higher chance than Saudi Arabian nationals of suffering an occupational injury.¹³⁴

A 2021 International Labour Organization study of occupational injuries in Qatar found that in 2020, there were 506 severe occupational injuries, with an average of 42.2 severe injuries per month. Severe occupational injuries were most commonly caused by falls, followed by road traffic injuries, falling objects and machinery. There were 50 fatalities recorded: “most fatalities resulted from falls and road traffic injuries, and most occurred in the worksite.”¹³⁵

128. ‘Qatar: ‘My sleep is my break’: Exploitation of migrant domestic workers in Qatar’, Amnesty International, (23 April 2014)

129. Peter Barss, et al. “Occupational injury in the United Arab Emirates: epidemiology and prevention”, Occupational Medicine, (2009).

130. Amjaad Al Ghafri et al, “Evaluating the Occupational Health and Safety Practices in Small and Medium Construction Companies in Oman”, International Journal of Structural and Civil Engineering Research, (November 2020).

131. Amjaad Al Ghafri et al, “Evaluating the Occupational Health and Safety Practices in Small and Medium Construction Companies in Oman”, International Journal of Structural and Civil Engineering Research, (November 2020).

132. Emad Abukhashabah, Ahmed Summan, Mansour Balkhyour, “Occupational accidents and injuries in construction industry in Jeddah city”, Saudi J Biol Sci. 2020 Aug; 27(8): 1993–1998.

133. Arab News, *Work injuries cost over SR370 million in Saudi Arabia*, 17 May 2017

134. Abbas M; Kashif M; Balkhyour M; Ahmad I; Asam Z; Saeed R. *Trends in occupational injuries and diseases among Saudi and non-Saudi insured workers*. East Mediterr Health J. 2018;24(10):1010–1017.

135. *One is too many: The collection and analysis of data on occupational injuries in Qatar*, International Labour Organization, 2020, page 13-14

The death of Julhas Uddin from Bangladesh

Julhas Uddin was a 37 year old farmer from the district of Tangail, who moved to the Gulf for work in 2017 due to his inability to financially support his wife, two children and elderly parents through agriculture. He paid a local recruitment agent 450,000 Bangladeshi Taka (approximately US\$5,250) to secure him a job as a sewerage line cleaner in Saudi Arabia, which he began in June 2017. His family told the Vital Signs Partnership that he completed a mandatory medical check-up and was declared fit and healthy prior to departure. On October 23, 2017, Julhas was instructed by the company supervisor to enter a sewerage line without an oxygen cylinder. He experienced breathing problems and made it back to the entrance to the sewerage line, but he lost consciousness, fell and drowned in the sewage. Despite the fact that Julhas was not provided with essential safety equipment, his family told the Vital Signs Partnership that there was no investigation into the circumstances of his death and his death certificate states that the cause of his death was "heart and breathing stopped." Julhas's family was informed of his death by his colleagues by telephone.

Julhas's brother told the Vital Signs Partnership that, based on information from Julhas's colleagues, his employers had not provided him or the other employees with the Iqama card that serves as a work and residence permit and without which foreign workers can be detained and deported. He said that the company only provided details of Julhas's registration on the Iqama system after his death and Julhas's colleagues told his family that they were all under pressure to perform unsafe tasks at work on account of their precarious status within the country. They said that their employer often made men go without oxygen cylinders in an effort to cut costs, and that Julhas had refused a previous order to go into the sewerage line without an oxygen cylinder, but that he complied with the order on the day he died because he felt under pressure. Julhas's family received compensation from the Bangladesh's Wage Earners and Welfare Board (this is statutory compensation for all Bangladeshi workers who die abroad), but an official document provided to the family by the Bangladeshi authorities stated that since the cause of death had been documented as "accidental", the family would not receive any compensation from Saudi Arabia. Julhas's elder brother, Habibur, told the Vital Signs partnership that Julhas's death has resulted in incalculable loss for this family, in particular for his two daughters, aged 13 and 7. The family, he said, is now completely reliant on the charity of others to survive.

The death of Abdeel Riaz from Pakistan

Adeel Riaz was only 22 years old when he died in November 2018 in Saudi Arabia. He had three older brothers and two sisters. His family are farmers in a rural region of Pakistan. Adeel was part of a team that painted mosques. His mother said: "There was no engineer at the site to better guide them, per the normal routine. The workers would be dropped off at a location and would have to undertake all tasks without any supervision. One day, they took a water break. Everyone on the site was junior- they placed a ladder on the wrong spot - it had exposed electric wires. All of them got electrocuted. Two people were severely injured and the other two died." Adeel's death certificate states that the cause of death was "electrical short circuit" and added that the death was "natural". The family found out about the accident when somebody posted pictures on social media, but they did not get confirmation of his death until one week later. His mother said that his working conditions were "abysmal" and that they lacked training and safety equipment, but she said that due to the debt they had incurred to send Adeel to Saudi Arabia they had no funds left to seek compensation from his employer in Saudi Arabia. "I have to nothing to say, I am only heartbroken, the helplessness is the worst part, there is no recourse. There is no system of fair impartial hearing. There is no legal remedy that we can avail. We do not know what to do, I do not know what is a greater curse; poverty or our illiteracy. After his death we have spent additional funds to get a fair hearing. We have spent upwards of 100,000 Pakistani rupees (564 USD) to pursue a case in OPF." His mother told the Vital Signs Partnership that his death had left the family in significant amounts of debt to banks and to the local recruitment agent who arranged for Adeel's employment in Saudi Arabia. "From the very beginning, it was all very difficult, we have spent everything on Adeel only so he could earn a better living and make us financially stronger. We sold off most of our valuables. We have sold off land. We gave a lot of money to the agents and got Adeel's dead body in return."

4.2. Psychosocial stress

The body's biological equilibrium, crucial for the maintenance of life, is known as 'homeostasis' and the term 'stress' refers to the effect of anything that seriously threatens homeostasis.¹³⁶ All mammals possess reasonably effective homeostatic mechanisms for dealing with short-term stressors, but humans are particularly vulnerable to the adverse effects of chronic stressors "possibly because their high capacity for symbolic thought may elicit persistent stress responses to a broad range of adverse living and working conditions."¹³⁷

Psychosocial stress can cause anxiety, depression and, at the extreme end of the scale, suicide, but long-term exposure to stressors can also lead to disease. Detailed research from 2020 concluded that chronic stress is "a pervasive, underappreciated cardiovascular disease (CVD) risk factor" and a study of 24,767 patients from 52 countries found that heightened psychosocial stress over the previous year was associated with a greater than two-fold increase of myocardial infarction (the medical term for a heart attack).¹³⁸ Numerous longitudinal studies have demonstrated that high job strain is associated with increases in blood pressure. A peer-reviewed study examined the impact of three factors - social isolation and marital stress, low economic status, and racial discrimination - on hypertension and concluded that "there is growing empirical support for the hypothesis that exposure to chronic psychosocial stress contributes to the development of hypertension".¹³⁹ This study drew upon evidence from the United States, so it is not possible to simply extrapolate its findings to migrant workers, although it is notable that these three factors can be typical for many low-paid migrant workers in the Gulf.

Many migrant workers are exposed to long term chronic psychosocial stress that, the scientific evidence suggests, is likely to have a detrimental impact on their mental and physical health: they live away from their families for lengthy periods of time (and in the case of domestic workers often have no social support structures at all); they are subject to long and often abusive working conditions; they are housed in cramped unsanitary conditions; and often endure a range of serious

abuses. There is a clear lack of research and data on this topic - as psychiatric experts in the Gulf have noted, the mental health of migrant workers in the Gulf "is underdocumented, under researched and underreported"¹⁴⁰ - but there is some evidence emerging of the possible extent and gravity of the problem. A 2018 study of 403 migrant workers from Nepal who had spent more than 6 months in either the Gulf states or Malaysia, found that nearly a quarter reported mental health issues and concluded that "the strong association between self-reported poor health and perceived work environment is an important issue that policy makers in Nepal and destination countries should address."¹⁴¹ A cross sectional survey of 191 men who had migrated to the Gulf for work and 193 non-migrant men aged between 25 and 64 years in the Indian state of Kerala, which provides a disproportionately high number of migrant workers to the Gulf states, found a significantly higher rate of hypertension among the migrant workers- age adjusted hypertension prevalence was 57.6 % among migrants and 31.7 % among non-migrants.¹⁴²

Dr. Dinesh Neupane, a Nepalese expert on hypertension at the John Hopkins Bloomberg School of Public Health told the Vital Signs Partnership that not enough attention is paid to the dangers of hypertension among the Gulf's migrant worker population, noting that physicians refer to hypertension as the "silent killer" due to the fact that it does not produce symptoms but causes significant numbers of deaths and serious injuries globally.¹⁴³ Neupane said that there are several lifestyle factors that could lead migrant workers to suffer disproportionately from hypertension, including stress and a poor diet (excessive salt and alcohol consumption are key drivers of high blood pressure), but also noted that it is generally treatable with medication and changes to lifestyle. "The screening of blood pressure is simple and would be a low-cost solution that could prevent a significant number of cardiovascular deaths," he said.¹⁴⁴

As part of this study, Migrant-Rights.org consulted numerous physicians in the Gulf about the issue of migrant worker health. "An overarching concern from practitioners we have spoken with is the impact of social isolation and work stress on migrant workers", they concluded.¹⁴⁵ For example, Dr Babu Ramachandran, a physician at the American Mission hospital

136. See, for example, Neil Schneiderman et al., "Stress and Health: Psychological, Behavioral, and Biological Determinants", Annual Review of Clinical Psychology, 2005.

137. See, for example, Neil Schneiderman et al., "Stress and Health: Psychological, Behavioral, and Biological Determinants", Annual Review of Clinical Psychology, 2005.

138. Michael T. Osborne, Lisa M. Shin, Nehal N. Mehta, Roger K. Pitman, Zahi A. Fayad, and Ahmed Tawakol, "Disentangling the Links Between Psychosocial Stress and Cardiovascular Disease", Circulation: Cardiovascular Imaging, (2020). Annika Rosengren et al. "Association of psychosocial risk factors with risk of acute myocardial infarction in 11119 cases and 13648 controls from 52 countries (the INTERHEART study): case-control study", Lancet (2004).

139. Tanya Spruiell, "Chronic Psychosocial Stress and Hypertension", Current Hypertension Reports, (2010). The article noted that "additional prospective studies are needed before a causal relationship is established, particularly in the case of discrimination."

140. Muhammad Ajmal Zahid and Mohammad Alsuwaidan, "The mental health needs of immigrant workers in Gulf countries", International Psychiatry, volume 11, (2014).

141. Pratik Adhikary, Zoë A. Sheppard, Steven Keen, and Edwin van Teijlingen, "Health and well-being of Nepalese migrant workers abroad", International Journal of Migration, Health and Social Care, (January 2018)

142. N Shamim Begam, Kannan Srinivasan, and G K Mini, "Is Migration Affecting Prevalence, Awareness, Treatment and Control of Hypertension of Men in Kerala, India?", Journal of Immigrant and Minority Health, (2016).

143. Telephone interview with Dr Dinesh Neupane, John Hopkins Bloomberg School of Public Health, (12 January 2022).

144. Telephone interview with Dr Dinesh Neupane, John Hopkins Bloomberg School of Public Health, (12 January 2022).

145. Migrant-Rights.org summary of research for the Vital Signs Partnership, October 2021

in Bahrain, who has worked closely with Bahrain's Indian migrant worker population, told the Vital Signs Partnership that depression was one of the most pressing health issues among migrant worker population, and noted that it impacted on workers in administrative positions as well as those in lower-paid work:

“Suicides are not uncommon. The loneliness leads to it. There are cases of labourers in camps committing suicide. But I find the problem more with those a tier up, supervisors. They don't have healthcare, and they are alone. They don't have community support and they are under pressure to send money from their families back home. Many of them want to go back, but they are stuck”¹⁴⁶

As noted above, the data on migrant worker deaths from suicides available to the Vital Signs Partnership does not enable any firm conclusions to be drawn, particularly since suicide rates are generally measured in terms of deaths per 100,000 population (and in the Gulf this “denominator” figure is rarely reported with any accuracy) but where government data is available on suicides, it suggests that the suicide rate among migrant worker populations runs at roughly 10% of

the total number of deaths.¹⁴⁷

Dr Nasra Shah, a public health specialist who has worked with low-paid migrant workers in Kuwait, referred to psychological health as a serious issue that “no one is addressing meaningfully.” She told the Vital Signs Partnership that, “the ones who suffer the worst are the ‘runaways’ and irregular workers – they are under a lot of psychological stress and they will not access healthcare”.¹⁴⁸ A mental health professional in Qatar, who preferred not to be named, told the Vital Signs Partnership of numerous stressors that migrant workers described to them:

“Male migrants deal with stigma. Most of the calls are coming from men with supervisory posts. They have misunderstandings with their families abroad. When the cases appear severe we refer them for clinical help. A lot of them have panic attacks at work. And I ask them how they cope with it. They go somewhere alone like toilets, where they can find some minutes to calm down a bit. They cannot sleep because of the stress. Some lose their appetite. And for women, there are panic and anxiety attacks.”¹⁴⁹

The death of Izaque John Varkey from India

Izaque John Varkey left Kerala for Qatar in July 2015. He worked as a safety officer there until the impact of the Covid-19 pandemic led to him being made redundant in February 2020. He was found dead in his room on June 1, 2020 and according to his death certificate, the cause of his death was “acute heart failure due to natural causes.” Izaque John left behind a wife and three children, aged 13, 11 and 8. She said that her husband did not tell her that he was made redundant, but she had since spoken to colleagues who had described the stress he was under as he was looking for work and attempting to obtain his end of service benefits from his former employer, on whom he was dependent for his work and residence permit. Documents seen by the Vital Signs Partnership show that his employer, a major construction company in Qatar, did not pay his end of service benefits of 33,712 Qatari riyals (\$9,261) until July 22, 2020, nearly five months after they made him redundant and seven weeks after his death. His wife told the Vital Signs Partnership that her husband didn't have any health problems, and took care to eat healthily. “He was alone and under a lot of stress,” his wife told the Vital Signs Partnership. “His friends were aware of his situation but he never told us the state he was in. He had told them about being unemployed and the tremendous stress he was going through. He was also applying for various jobs and was optimistic about getting one, but he ...was keeping all of this to himself. If these things [payments] had happened on time, and he had come back, this wouldn't have happened. That's what I think” She said that nobody from Qatar contacted her to ask if she would like an autopsy to be performed and said she was unaware this was a possibility. Her husband's death had, she said, left the family in serious financial difficulty. “I am working as a nurse in a private hospital where I don't even make \$100 a month. I don't know how I am going to take care of my children.”

146. Migrant-Rights.org interview with Dr Babu Ramachandran, American Mission Hospital in Bahrain, (date).

147. Suicides among Nepal's migrant worker populations are 9% of total deaths. Suicides among 20-49 year old Indian workers in Bahrain between mid-2014 and mid-2018 and in Kuwait between 2014 and 2017 were 10.9% and 14.1% respectively.

148. Migrant-Rights.org interview with Dr Nasra Shah

149. Mental health professional, Qatar.

4.3. Access to physical and mental healthcare

Health care in the Gulf states is not always free at the point of care, and migrant workers often require either health cards to avail of government subsidies, or health insurance, typically provided by their employers. Migrant workers' access to healthcare can therefore be contingent on their employers providing them with the necessary documentation or insurance. At a more fundamental level, workers have to be able to physically access healthcare, which can be a problem if facilities are not located close to worker accommodation, or in the case of female domestic workers, when they must negotiate with their employers in order to be allowed to leave the home.

A 2019 policy brief on 'Single male labourer's health in Qatar', co-authored by the Qatar Foundation and Georgetown University Qatar, listed this issue as the second of ten key policy recommendations to the Qatari authorities.¹⁵⁰

“Currently, the absence of health cards, or the delay in obtaining health cards, imposes an immense burden on SMLs (single male laborers), and is one of the key areas where intervention is needed. Strict measures of accountability must be in place to ensure that employers issue Qatar IDs and health cards to their employees in a consistent and timely manner.”

A Konrad-Adenauer-Stiftung survey of 119 migrant workers from the Philippines, Egypt and Pakistan in Jeddah and Dubai in April and June 2020 found that 23.1% reported not having medical insurance due either to their irregular status or more recently due to the impact of the Covid19 pandemic.¹⁵¹

Healthcare professionals in the Gulf told the Vital Signs Partnership that access to healthcare was a significant problem across the region.

“Medical care in Bahrain is definitely costly, so they don't get medicines. Not everyone has insurance”, said Dr Babu Ramachandran, of the American Mission Hospital in Bahrain.¹⁵² Dr Ramachandran said that many migrant workers in Bahrain had a tendency to look to community groups for care and support rather than the formal government system. “[Voluntary] organisations can provide some medicine, but

providing continuous medication for chronic conditions is difficult without insurance. When they don't have medicine there is a decline in health, leading to early death.”

Dr Nasra Shah offered a similar perspective on problems with access to health in Kuwait, pointing out that migrant workers often did not seek healthcare in a timely fashion due to structural issues:

“In order to go to the clinic you have to take time off, and that means money. So there might be a delay in health care seeking, which is one of the handicaps. When it gets very serious, some of them prefer to see people whom they trust.”¹⁵³

Workers who are undocumented face particular problems in accessing healthcare. This is most obviously a problem in Saudi Arabia, which, as noted in a FairSquare policy brief, “has a large number of undocumented workers in the country, historically a result of visitors overstaying Hajj visas, the difficulty of policing the porous Yemen border, and distrust among businesses of fickle government immigration policies, which resulted in them keeping pools of under-utilised workers, whom they then allowed to work independently under so-called ‘free visa.’”¹⁵⁴ As Saudi Arabian academic Fahad Alsharif noted in a 2019 paper, this community of undocumented workers is “not only in constant fear and danger but also [carries] serious legal, economic and social precariousness.” Alsharif noted how their lack of access to healthcare posed a risk to their own health but also to Saudi society more broadly during the Covid19 pandemic. Konrad Adenauer Stiftung's report on migrant workers' access to health concluded that despite some positive steps during the pandemic, when Saudi Arabia and the UAE, for example, allowed migrant workers to receive free medical treatment regardless of their immigration status, the pandemic-driven rise in unemployed and uninsured migrant populations is one of the reason why, in their view, “it is likely, more migrants will inevitably face health insecurity due to lack of access to employment and full health insurance coverage, particularly for those irregular migrants.”¹⁵⁵

The barriers to migrant workers accessing mental health services are also high. As noted by the Arab Gulf States Institute in Washington, “In the Gulf Arab states ... the treatment of mental health issues and the appreciation of these challenges have faced substantial social barriers.”¹⁵⁶ Kuwait and Saudi Arabia have introduced mental health laws, and Qatar launched a National Mental Health strategy in

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

151. Konrad-Adenauer-Stiftung, “Migration and The COVID-19 Pandemic in the Gulf”, (October 2020).

152. Migrant-Rights.org interview with Dr Babu Ramachandran, American Mission Hospital in Bahrain, (date).

153. Migrant-Rights.org interview with Dr Nasra Shah

154. FairSquare Policy Brief #1: Migrant Workers in Saudi Arabia, October 2020

155. Konrad-Adenauer-Stiftung, “Migration and The COVID-19 Pandemic in the Gulf”, (October 2020).

156. Mohammad J. Al Yousef, “Mental Health in the Gulf: Reforms and Challenges”, Arab Gulf States Institute in Washington, (29 June 2020).

2013, but there remains a social stigma surrounding the issue of mental health.¹⁵⁷ In Qatar, migrant workers have the right to access psychiatry inpatient and outpatient services, as well as access to psychiatric medications including antidepressants, antipsychotics, and mood stabilisers and these services are available at a hospital which opened in 2018 in Doha's Industrial Area, an area where a significant number of Qatar's low-paid

migrant workers live.¹⁵⁸ Although these services are all either free or subsidised, there is no evidence that migrant workers are, in practice, availing of these services, and as the authors of a report into mental health provision for low-paid migrant workers in Qatar outline, there are practical and financial barriers to accessing any healthcare, which are often compounded by "cultural values and stigma", which pose "significant obstacles"

Debt and wage theft

Across the Gulf, it is routine for unethical recruitment practices, lax regulation of employers, and weak enforcement mechanisms, to conspire to trap workers in dire circumstances for extended periods of time. This can lead to what are sometimes described as humanitarian crises, leaving workers at risk of severe mental strain.¹⁵⁹

In February 2020, Migrant-Rights.org documented the plight of 52 workers from Nepal, India, Bangladesh, and Pakistan, who were stuck in a derelict camp in Bahrain while fighting to recoup between six and 18 months of unpaid wages, as well as their end-of-service benefits.¹⁶⁰ When Migrant-Rights.org spoke to the men they were struggling to survive at the company's last remaining labour camp without food, water, or medicine. They said that they and their families were under "immense stress" as they had to take loans for survival and were falling deeper into debt. "The people here all have similar stories, their families back home are taking loans or getting help from others to survive," a Pakistani worker owed over a year of wages said. "No money for medicine, many people are sick, some people have diabetes, high blood pressure and because of this tension they are suffering, one person died of a heart attack last year... Razamiyah from Bangladesh, he died here last Ramadan," another worker told Migrant-Rights.org

Such crises happen even on the most high profile construction projects. A report by Amnesty International recounted the plight of a Filipino construction worker, Ernesto, one of at least 78 migrant workers employed by a firm working on projects directly linked to Qatar's 2022 FIFA World Cup.¹⁶¹

The problems began when Ernesto's employers did not provide him with a residency permit, and in the following months, he said his salary payments began to be delayed. He initially continued to work, but with no pay cheques and no residence permit, he decided he wanted to return to the Philippines. However, his employer refused his request to leave, and when Ernesto and his colleagues successfully filed a complaint with the Qatari authorities his employers simply didn't pay him the \$5000 dollars they owed him. They then refused to allow him to change employers unless he renounced his claim to unpaid wages. Ernesto told Amnesty International that he was so desperate that he considered accepting this, but he was ultimately unable to take the job because he had almost 2,000 QAR (US\$549) in outstanding fines imposed on him for not having a valid residency permit. He eventually returned home being owed 4 months of wages, and told Amnesty that his dreams had been "shattered".

Cases such as these were common before the outbreak of Covid-19, but the pandemic led to a marked increase in cases of workers abandoned without jobs, money or means of survival. In April 2021, Migrant Forum Asia (MFA) issued a report on the impact of the pandemic on the phenomenon now referred to as 'wage theft'.¹⁶² Dasharathi Barik, an Indian migrant worker who experienced wage theft after being made redundant from his job in Saudi Arabia in early 2020, spoke to MFA about his efforts to reclaim lost wages.

157. See [Summary National Mental Health & Wellbeing Strategic Framework 2019-2022](#) at the website of Qatar's Ministry for Public Health (accessed 8 December 2021). For analysis of Saudi Arabia's 2013 Mental Health law see Jessica Carlisle, "[Mental health law in Saudi Arabia](#)", BJPsych International (February 2018).
158. Javed Latoo et al., "[Development of mental health services for lower-skilled migrant workers in Qatar](#)", Asian Journal of Psychiatry, (August 2021).
159. See "[Crying out for Justice: Wage theft against migrant workers during Covid-19](#)", Migrant Forum Asia, (April 2021) and Bassina Farbenblum and Laurie Berg, "[Migrant Workers Access to Justice for Wage Theft: A global study of promising initiatives](#)", Migrant Justice Institute, (2021).
160. Migrant-Rights.org, "[G.P Zachariades workers still unpaid and stranded in dire conditions in Bahrain](#)", (20 February 2020).
161. Amnesty International, "[Unpaid and abandoned: the abuse of Mercury MENA workers](#)", (26 September 2018).
162. Migrant Forum Asia, "[Crying Out for Justice: Wage Theft Against Migrant Workers during COVID-19](#)", (April 2021).

“We have been trying to file our case for the past 6-7 months but there has been no response from the Indian Embassy. We will not be able to file a case after one year in Saudi court. We request all of you to support us file a case to get the money we worked hard for. We are all poor, we have to send our children to school and find a means to feed our family.”

The impact of wage theft has a particularly damaging impact on migrant workers with debts, and due to the high prevalence of migrant workers paying thousands of dollars in recruitment fees, often in violation of laws banning the practice, significant numbers of low-paid migrant workers enter the labour market in debt. In 2017, research from the International Labour Organisation and the World Bank found, for example, that Pakistani workers pay an average \$4,395 in recruitment fees to secure jobs in Saudi Arabia; that Bangladeshi workers pay an average of \$3,136 in fees, to secure jobs in Kuwait, and that Indian workers pay an average of \$1,149 to secure jobs in Qatar.¹⁶³

for those who require mental health care.

4.4. The Impact of Covid-19 on Migrant Workers

The cramped and unsanitary accommodation in which most low-paid migrant workers are housed in the Gulf states posed a further risk to their health and their lives during the Covid-19 pandemic. The pandemic disproportionately impacted low-paid migrant workers more generally, exposing and exacerbating their vulnerability to poor physical and mental health outcomes. A report by the rights group Equidem detailed the Gulf state’s response to the Covid-19 pandemic and its impact on low-paid migrant workers and found that government responses to the pandemic had left “thousands of migrant workers in jobless destitution and, in some instances, facing death, and the ever-present risk of being infected by a deadly virus.”¹⁶⁴ Migrant-Rights.org offered similar analysis.

“For migrant workers in the GCC, decades of marginalisation and exclusion from welfare policies made their situation more precarious. The impact was predictable, and within weeks dire calls of distress emerged from across the region: lower-income migrant workers, but also middle-income migrants with families, lost jobs and income, and struggled for survival. Discriminatory policies and racist discourses proliferated, with citizens receiving preferential treatment in economic responses, medical treatment, and travel restrictions. Emergency decrees empowered businesses to almost unilaterally change contract terms for migrant workers—leave without pay, reduction of salaries and termination — with safeguards against job loss and excessive salary

reduction reserved for nationals only.”¹⁶⁵

A painter employed by a contractor working on the Dubai Expo 2020 project in the United Arab Emirates told Equidem: “each floor has a kitchen and toilet and around 80 people share a single toilet and kitchen. It gets very crowded. In the morning there are lines to use the bathroom. There is no way we can maintain social distance in such a small area.” An Indian national working on a Saudi Aramco site told Equidem a similar story. “There is no adherence to social distance because 8 people live in a single room. All 8 people use the same toilet, which is not cleaned every day. There is a lot of dirt lying there. There are 250 people who use the same kitchen. It is very unhygienic and dirty due to lack of cleaning. The kitchen gets crowded while cooking.”

In Kuwait, Sharif Alshalfan noted how the “dire housing situation has been exacerbated by the onset of COVID-19” with social distancing and handwashing directives undermined by overcrowding. She noted that an 11-hour curfew imposed in March 2020 “effectively created a petri dish for the spread of the disease” among its migrant worker population.¹⁶⁶ Kuwaiti authorities also used barbed wire to fence off areas considered virus hotbeds, all of which were mostly populated by non-Kuwaitis, with alarming effects on their mental as well as their physical well-being: “District lockdowns did not only isolate the residents from their livelihoods, but imprisoned them in an enclave of emotional and physical distress.”¹⁶⁷ In April 2020, Amnesty International documented how hundreds of migrant workers were rounded up and detained by police in parts of Doha including the Industrial Area, Barwa City, and

163. International Labour Organisation and World Bank, “ILO-WB partnership on measuring recruitment costs: progresses on SDG indicator 10.7.1”, Presentation to the Fifteenth United Nations Coordination Meeting on International Migration, (February 2017).

164. Equidem, “The Cost of Contagion: The human rights impacts of COVID-19 on migrant workers in the Gulf”, (November 2020).

165. Migrant-Rights.org, [COVID Relief Report 2021](#)

166. Sharifa Alshalfan, “COVID-19 in Kuwait: how poor urban planning and divisive policies helped the virus spread”, London School of Economics Public Policy Blog, (September 16, 2020).

167. Sharifa Alshalfan, “COVID-19 in Kuwait: how poor urban planning and divisive policies helped the virus spread”, London School of Economics Public Policy Blog, (September 16, 2020).

Labour City, on March 12 and 13. Amnesty reported that the workers were detained in inhumane conditions alongside scores of other people from various countries.¹⁶⁸ Roshan Sedhai spoke to several workers caught up in the arrests and reported that more than 600 Nepali workers were deported from Qatar before Nepal suspended international flights on March 22, according to workers.¹⁶⁹ In Saudi Arabia, hundreds if not thousands of Ethiopian migrants were held in squalid detention conditions during 2020 while they awaited removal from the country. Human Rights Watch spoke to migrants who estimated that 300 to 500 women and girls were held in one room in severely overcrowded conditions.¹⁷⁰

Migrant-Rights.org reported that the pandemic had “wreaked havoc on the mental health of migrant workers in the GCC states.”¹⁷¹ A Bangladeshi worker told Equidem: “Nobody knows the extent of the mental toll this situation has put on us. There is a very real chance that many workers will resort to suicide. The Government should do something for us. It’s

either that or they’ll have to send our dead bodies home.” In August 2020, Kuwait newspapers reported a 40 per cent increase in suicide cases since the beginning of the pandemic and in November 2021 they reported that there had been an average of 12 migrant suicides per month since the start of 2021.¹⁷²

With regard to vaccinations, while Oman was the only Gulf state that did not provide vaccines free of cost to migrant workers,¹⁷³ many migrants faced discrimination when it came to distribution of vaccinations to non-nationals. Kuwait vaccinated its citizens at a rate six times that of noncitizens: a 27 year old Kuwaiti doctor told the Associated Press that “Kuwait has a citizens-first policy for everything, including when it comes to public health.”¹⁷⁴ Kuwaiti researchers analysing a government Covid-19 registry found that non-Kuwaitis were two times more likely to be admitted to the ICU or to die from Covid-19 than Kuwaitis even after controlling for age, gender, body weight and existing conditions.¹⁷⁵

168. Amnesty International, “[Qatar: Migrant workers illegally expelled during COVID-19 pandemic](#)”, (15 April 2020).

169. Roshan Sedhai, “[Migrant workers deported from Qatar without justification return home](#)”, (10 September 2020).

170. Nadia Hardman, ‘[Immigration Detention in Saudi Arabia During Covid-19](#)’, Human Rights Watch

171. Migrant-Rights.org, “[Covid Relief Report 2021](#)”, (3 November 2021)

172. Yasmin Mulla, “[COVID-19: Two Indian expats commit suicide in Kuwait, such cases increasing since start of pandemic](#)”, Gulf News, (13 August 2020). “[Around 12 suicides per month in Kuwait this year: Report](#)”, Kuwait Times, (15 November 2021).

173. Migrant-Rights.org, “[Oman’s discriminatory vaccine policies](#)”, (1 July 2021).

174. ‘[Kuwait vaccine campaign neglects foreign workers](#)’, The Associated Press, (5 April, 2021)

175. Hala Hamada, Barrak Al-Ahmad et al., “[COVID-19 clinical outcomes and nationality: results from a Nationwide registry in Kuwait](#)”, BMC Public Health 20, 384 (2020).



A migrant construction worker on a break, Qatar, 2011. © International Labour Organization

5. CONCLUSION AND RECOMMENDATIONS

This is a report about the living as much as the dead, and it is as much about labour rights and worker protections as it is about migrant workers' right to health and life. The most fundamental duty of all states is to protect the lives of its nationals and all others under its jurisdiction. Where migrants are concerned, however, it appears that states around the world do not approach this basic obligation with the requisite rigour and seriousness, and tragedy and hardship for millions of the poorest people on the planet is the inevitable consequence of their inaction.

Life for a migrant worker in the Gulf appears to have particularly high harmful potential for the millions of low-paid migrant workers employed there, whether in construction or domestic work, or other sectors of their economies. Despite the Gulf states' practical dependence on their migrant workforces and the bolstering impact migrant worker remittances have on the economies of their homelands, both origin and Gulf states have for too long paid inadequate attention to ensuring they return home in good health, and as a result far too many do not return home at all, or do so in coffins or body bags.

The paucity and poor quality of the data that origin and Gulf states make available on this issue is, in general, unforgivably poor, especially when set against the serious and cumulative risks to which low-paid migrant workers in the Gulf are exposed. And in the case of the Gulf states, there can be no appeal to any lack of financial resources. This report describes a range of complex problems, but there are a series of simple steps that can and should be taken immediately to reduce the number of unnecessary deaths and to provide some measure of relief to the families left behind.

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

Data and investigations

- Establish specialised teams of inspectors and medical examiners to ensure that all deaths of migrant workers

are investigated and certified in accordance with international best practice.

- Ensure that the government ministries that collect and record mortality data have the requisite skills to properly code deaths with reference to the categories and sub-categories in the WHO's International Classification of Deaths.
- Commission independent investigations into the causes of migrant workers' deaths and ensure that any investigation examines the possible role played by heat and humidity, overwork, air pollution, psychosocial stress, and workers' ability to access health care.
- Provide death certification training to all medical staff involved in the certification of deaths, and ensure that all death certificates include proper nosological classification of underlying cause of death.
- Improve the quality of available data on mortality statistics for migrants. The data should be fully disaggregated by age, sex, occupation, nationality, date of death, and underlying cause of death to allow comparison across multiple categories.
- To take account of circumstances and contexts where invasive autopsies are not possible, introduce non-invasive and verbal autopsy procedures after consultation with experts.
- Establish mechanisms to ensure that the families of all deceased migrant workers whose working conditions may have contributed to their death receive appropriate compensation.

Access to health

- Make primary and emergency healthcare for low-paid migrant workers free of charge at the point of care, irrespective of workers' immigration status or their possession of a health card, and that fully resourced clinics and emergency rooms are in close proximity to areas with large populations of low-paid migrant workers. Ensure that a follow-up system is in place to ensure that labour inspectors follow up with employers of workers who do not possess health cards and impose meaningful sanctions on those who have not provided their employees with up-to-date health cards.
- Ensure that migrant workers have access to mental as well as physical healthcare and that mental health policies, where they exist, are updated to include reference to the specific requirements and vulnerabilities of low-paid migrant workers.
- Pass legislation to ensure that anyone who employs a domestic worker is legally obliged to take them to regular medical check ups, which should take place without the employer present and which should be patient-led. An

early-warning system should be in place to flag cases where domestic workers do not attend appointments, involving the police in cases where employers do not respond to reminders to attend.

Protection and prevention

- Pass legislation to ensure that employers are required to provide outdoor workers with breaks of an appropriate duration, in cooled, shaded areas, when there is an occupational risk of heat stress; mandatory break times should take into account the environmental heat stress risks along with the exertional nature of the work being performed.
- Conduct widespread screening and treatment programs for hypertension.
- Conduct a study into the prevalence of CKDu or early-stage kidney disease among low-paid migrant worker populations.
- Ensure that labour laws and occupational safety and health regulations align with international standards, that migrant workers are fully informed of regulations and are adequately trained, and that labour inspectorates are properly resourced and empowered to instigate administrative proceedings and to refer serious violations for criminal prosecutions.
- Ensure that the issue of the investigation of migrant worker deaths, protection from risks to migrant worker health, and migrant workers' access to healthcare is on the agenda of the Abu Dhabi Dialogue.

Recommendations to the governments of origin states

- Make available all historical data on deaths of overseas workers, disaggregated by destination, occupation, age, gender, date of death and cause of death. This data should be available online and presented in a way that facilitates effective analysis by public health experts. It should be accompanied by accurate, detailed data on the numbers of nationals in each Gulf destination state.
- Ensure that all government ministries that collect and publish data on deaths of nationals overseas report to international standards (the WHO's International Classification of Diseases). In cases where death certificates provide no underlying cause of death (for example when they are certified without further context or explanation to "natural causes", "cardiac arrest", "acute heart failure", or "acute respiratory failure") the should be attributed in government records

to the ICD code that refers to “ill-defined or unknown cause of mortality”.

- Request the informed consent from migrant workers prior to their departure from their home countries to conduct medical procedures, including autopsies, in the event of their deaths to allow proper investigation into the cause of death and establish a mechanism to ensure that this information is readily available to healthcare providers in the Gulf states.
- Commission a study into the prevalence of CKDu among nationals returning from the Gulf.
- Call on the Gulf states to: enhance investigation procedures for migrant worker deaths; commission independent investigations into the causes of migrant worker deaths; enhance legal protection from heat stress.
- Strengthen the capacity of embassies in the Arab Gulf states to ensure that remains are returned in a timely fashion and to provide support to the families of the deceased, including in relation to cases where families are entitled to compensation.
- Ensure that the issue of the investigation of migrant worker deaths, protection from risks to migrant worker health, and migrant workers’ access to healthcare are on the agenda of regional processes such as the Abu Dhabi Dialogue and the Colombo Process.

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