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Migrant Workers: Sustainable Not Disposable– A Challenge for Safety and Society

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Introduction

The employment of migrant workers is widespread in Europe, North America, Asia and Australasia. If they are employed on a temporary basis to replace permanent positions, this can create a two-tiered society with a "disposable' workforce that is admitted only for its labour and that may be less valued by employers than permanent workers.

The UK has experienced a large influx of migrant workers to prepare for the 2012 Olympics, and this has highlighted the importance of companies' recruitment processes and adequate training, particularly in health and safety issues (Paul 2006, McHugh 2007).

The poor housing, long working hours, low pay, and food insecurity experienced by many migrants has important implications for public health and safe performance at work. Evidence from Europe also indicates that migrant workers face greater psychosocial risks, such as stress or burn out (Weishaar 2008).

Migrant workers may not speak the language of the country fluently and, therefore, have difficulty in understanding instructions, asserting their rights at work, and seeking help. As a result, they are less likely to report accidents. They may be unable to communicate effectively with other employees, and their understanding of risk may be impaired.

There have also been reports of exploitation, for example in the meat and poultry processing industry in the UK, where employees reported physical and verbal abuse and lack of health and safety protection (Tasker 2010).

Furthermore, migrant workers tend to be employed in industries and occupations where there is already a higher risk of injury, such as construction, and their status as new workers compounds this (McKay, Craw and Chopra 2006). Being a temporary worker also gives them a higher risk of occupational injury than permanent workers (Virtanen et al 2005). High-profile accidents, such as the death of 23 migrant cockle pickers in Morecambe Bay, UK in 2004, have further highlighted their vulnerability.

These issues provide a key challenge to the OSH professional. This paper will look at the issues facing migrant workers, particularly in the UK, and discuss ways in which their health and safety might be improved, particularly by changing the way in which health and safety messages are communicated in the workplace. This will be illustrated by practical examples from IOSH-sponsored research with migrant construction workers, carried out by Cameron et al. (2011), which used pictograms and photographs to demonstrate hazards, consequences, and controls.

The Extent and Definition of Migration

The UN Convention on the Rights of Migrants defines a migrant worker as a "person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national." Within this definition, it is understood that the migrant worker decided to migrate of their own volition, which differentiates them from refugees or others who are forced to leave their countries. In addition, there are those who migrate illegally to seek a better life.

However, in practice, it is quite difficult to distinguish between migrant workers who decide to leave their countries for political or economic reasons, and those who are just looking for a better life than they could achieve in their own country.

In 2010, the total number of international migrants in the world was estimated at 214 million, an increase of 58 million since 1990. International migrants represented 3.1 per cent of the total world population in 2010 (UN 2011). Not all migrants are international ones, however; many move within their own country. For example, in China, people travel from villages to work in factories in the eastern and southern provinces. Most migrants do not travel very far. For example, most African migrants migrate to other countries in Africa. In Asia, migration within the continent accounts for nearly 20% of all migration worldwide (Clark 2009).

The largest number of international migrants live in Europe (70 million), followed by Asia (61 million) and North America (50 million). There are approximately 19 million international migrants living in Africa, seven million in Latin America and the Caribbean, and six million in Oceania (UN 2011).

In 2010, the number of refugees was estimated at 16.3 million. Asia hosted by far the largest number of refugees (10.9 million), followed by Africa (2.6 million), Europe (1.6 million), Northern America (0.7 million), Latin America and the Caribbean (0.5 million) and Oceania (0.1 million) (UN 2011).

Almost half of migrants are female. In 2010, female migrants outnumbered male migrants in Europe, followed by Oceania, Northern America and Latin America and the Caribbean.Men continued to outnumber women in Africa and Asia (UN 2011).

Historically in Europe, there have been different waves of migrants. In the period following the end of the Second World War, migrants tended to be single males looking for unskilled employment. In some countries, such as the UK and Sweden, they were allowed to settle permanently; in others, such as Germany, they were granted temporary status. The second wave of migration was characterised by families joining migrants who had settled permanently in their new countries. In the 1980s, the trend started towards skilled migrants who were recruited to fill skill shortages in Western European countries. In addition, there are seasonal workers who work in sectors such as agriculture, catering, and so forth, and are recruited by agencies. For instance, the UK has witnessed a large influx of migrant workers to prepare for the 2012 Olympics.

Refugees and asylum seekers are another category and, in Europe, these have increased in the 1990s. Then there are the illegal migrants who, in Europe, are estimated at up to 8 million, but the true figure is unknown. The UK Home Office estimates there are around 500,000 illegal immigrants in the UK. The majority of these workers are in the southeast of England, in the hotels and catering, construction, agriculture, and textiles industries.

In the USA, there has been a long tradition of immigration from Europe to look for a better life. Today, migration to the USA is mainly from China, India, the Philippines, and Mexico (Howard 2010).

One fact is certain however; migration is likely to continue to increase because of the increasingly mobile global workforce. Regardless of whether a migrant arrives legally or illegally, they are still entitled to a safe and healthy working environment, and this is reinforced by ILO Article 12, which requests that countries "guarantee equality of treatment, with regard to working conditions, for all migrant workers who perform the same activity, whatever might be the particular conditions of their employment," and by the UN International Covenant on Economic, Social and Cultural Rights, Article 7, which details that everyone is entitled to fair wages, equal pay for equal work, safe and healthy working conditions, reasonable working hours, and periodic holidays with pay. What people are entitled to and what happens in practice is however very different.

The Link between Poor Health and Poor Pay and Living Conditions

Research has stressed the low pay experienced by many migrant workers, particularly non-white immigrants (Whysall and Ellwood 2006). One report (TUC 2003) cites the case of immigrant nurses, who get lower pay and lower grade jobs than promised on arrival in the UK, and another (Craig et al. 2007) reports a number of individual case studies of migrant workers working for gangmasters for low wages. May et al. (2007) found that 90% of those they interviewed for their survey "Keeping London working" were immigrants employed in contract cleaning, hospitality, and catering, and were earning below the minimum wage.

Working very hard for low pay and having a low status in society is bad for health. Two models are used in the literature to explain the relationship between these factors. The first model, the "demand-control-support" model (DCS) assumes that the external environment

determines the emotional reactions and behaviour of an individual. It does not take psychological traits into consideration. It proposes that poor long-term psychosocial working conditions and high psychosocial demands, coupled with low control, reduces the individual's self-efficacy and creates strain, which has a negative impact on health. The types of jobs with these common features are low-status service work (Karasek and Theorell, as cited in Rydstedt et al. 2007). The "effort-reward-imbalance" model (ERI), on the other hand, focuses on the social and economical rewards from work, and links self-esteem and the psychosocial working conditions. It takes into account that social rewards are not evenly distributed in the labour market, and that the jobs that are most demanding physically are often the lowest paid. Krause et al. (2010) have discussed this "effort-reward imbalance" model, and highlighted that workers who receive low rewards for high efforts can suffer from psychological distress affecting physical and mental health. Their study of Las Vegas female hotel cleaners found that ERI at work was strongly associated with poor general health. The cleaners (84% of whom were immigrants) had consistently lower mean scores on all health measures than the general U.S. population. However, mental health illness, in particular, can be derived not just from work but also from the acculturation process, as Weishaar (2008) reported in her study of Polish immigrants in Scotland.

Another issue is food insecurity. This concept includes not only having insufficient amounts to eat but also only having access to non-nutritious food, which can lead to obesity. Borre (2010), in her study of Latino migrant workers in Carolina, found food insecurity to be rooted in the cultural lifestyle of farmwork, poverty, and dependency. Faihoome (2011) highlighted the experience of Haitian migrant sugar workers, who were brought to Eastern Cuba through company and private contractors to provide cheap migrant labour. The threat of hunger caused by their low pay meant they were working night and day to survive. This food insecurity was also reported by Hill et al. (2011) in their study of migrant farmworkers in Georgia, where nearly two thirds were found to have insufficient food to eat. This has important implications for public health.

Research on neighbourhood experiences of new migrants (Robinson and Reeve 2006) illustrated how they are disadvantaged. Good housing is important for health and wellbeing. Unfortunately, migrants tend to live in poor quality accommodations, which are in a bad state of repair and often suffer damp and cold conditions. Many new migrants also live in hostels and hotels providing bed and breakfast. New migrants tend to live close to others from similar backgrounds in less popular inner city areas. Other migrants can have their accommodation organised by their employer, which can result in even worse conditions. For example, Ziebarth (2006) report on the housing for seasonal workers in the Minnesota processed vegetable industry, where migrants are housed in substandard conditions while assisting with the green pea and sweet corn harvest. Migrants' accommodation can also expose them to risk of injury or death. Holland (2008) reported the high incidence of fatal fires at substandard houses occupied by migrant workers in Great Britain.

Most migrants live in poor inner city areas, where they are more likely to experience social exclusion and deprivation. These areas tend to have poorer facilities and high crime rates. Interestingly, Wheeler et al (2010) in their study of immigrants as crime victims, found that immigrant residents of U.S. central-city areas had a statistically lower prevalence of victimisation when compared with U.S.-born residents of central city areas. However, local residents may resent the intrusion of new migrants, and they can be subjected to harassment and violence,

which decreases the likelihood of their being able to integrate socially. The ethnic composition of their neighbourhood also has an effect on how well they integrate into wider society.

Health and safety is plagued in the UK by media myths, and there is evidence worldwide that migration is subject to similar misinformation. Distortion of the role migrants play in societies, and the way policy issues are communicated by governments, affect how migrants are perceived in society. Informing and educating the public about the reality is a challenge (IOM 2011).

Migrants are, therefore, a vulnerable group; this can lead to their exploitation. For example, in the UK, this has been reported by Tasker (2010), who highlighted the physical and verbal abuse and lack of health and safety protection of employees in the meat and poultry processing industries, and by Laurence (2004), who featured the work of Portuguese migrants in the production of bagged salads for supermarkets in Eastern England. Wasley (2011) reflected on similar conditions endured by migrant workers from Africa on tomato farms in Basilicata, Italy.

Craig et al (2007), in their research on contemporary slavery in the UK, highlight the case of a group of Polish workers who arrived to work in the UK, unable to speak English but having been recruited to work near a large town in the south of England. On arrival, they were met by a gangmaster, who transported them to a house in another area of the country where they had to sleep, crowded on bare mattresses. They were taken to and from a factory in a minivan for their shift but were unsure who they were working for, as their jobs were provided through an agency. Their pay was low; they received just over half the minimum wage per hour with deductions for housing made at nearly twice the legal maximum. They had no information on who to contact for help.

This case study is not unusual. Lelkaitis (2007) describes how he posed as an unskilled worker in Lithuania and was recruited for work in the Hull UK. He had to pay money to the agency that provided him with a job but, when he arrived in Hull, there was no job initially; he was told to wait in a room with no bedding for six days. He then had 20 minutes notice to pack his things and be transported to a farm in North Yorkshire, where he slept in a room with 12 men and women. He worked a 12-hour night shift at a chemical packing plant. After three weeks, he was paid for 20 hours at less than the minimum wage, having completed more than 120 hours work. Deductions were made for his accommodation at more than the legal maximum. He claims he was required to operate machinery without receiving training.

These two case studies highlight how vulnerable, migrant workers can become bound to their employer by debt and circumstances. Interestingly, Porthe et al (2010) found that immigrant employers were regarded as more exploitative than nationals.

So to summarise, the poor pay and the nature of their work make it difficult for migrants to integrate socially. This, coupled with their unfamiliarity of the culture of the country, makes them vulnerable.

Language Barriers

Language barriers can play a major role in preventing access to facilities and services that might help migrants integrate into the wider community. Shields and Price (2002) explored what determined ethnic minority immigrants' fluency of English in the UK, and the role their language skills played in occupational success. They found that there were clear links between level of

education and fluency in English. The younger migrants, at the time of immigration, are more likely to become fluent in English. Having one or more dependent children is also associated with fluency but surprisingly, not marriage to a UK-born national. It is thought this might be because they tend to act as a translator rather than a teacher of English. Those migrants sending money home on a regular basis were less likely to become fluent. This could be because they are less interested in assimilation into the local culture. Regarding occupational success, higher fluency in English was associated with higher pay. There is also evidence from European studies that language skills affect how migrants are viewed in the workplace (European Risk Observatory 2007). Porthe et al (2010) highlighted the fact that migrant workers' ability to benefit from their rights is also influenced by their fear of losing their employment.

However, lack of fluency in the language of the country can have wider implications. Anthony (2007) pointed out the potential dangers faced by migrant workers, particularly in the construction sector. Tool-box talks and site briefings are verbal, so it can be easy to miss important instructions and warnings. Winterbottom (2007) pointed out the difference in safety standards between the UK and other European countries. Training and skills assessment, supervision, and communication of health and safety measures were made more difficult because English was not the migrants' mother tongue. The high use of contractors on construction sites also increased communication problems. Some employers, however, had made arrangements for migrants who could not speak English. These included the providing interpreters, arranging for each gang on the site to have a designated English speaker, mixing up gangs of migrants and UK workers, and translating signs and instructional materials. While this is good practice, it does not encourage migrant workers to learn English (Dainty et al 2010).

Work-Related Injuries and Ill Health

Inability to communicate is also a problem if a migrant has an accident. McKay et al (2006) reported that HSE inspectors often have problems investigating accidents involving migrant workers because the injured person is not able to give an account of what happened. Also, some migrants are worried about reporting accidents in case they lose their jobs or, if their papers are not in order, draw attention to themselves.

In fact, the language barrier was identified by McKay et al (2006) as the major factor affecting risk to migrants. There are other factors that influence their risk of injury, including the fact that they may not have been in the country very long and are not familiar with the health and safety system, which may be very different from their home country. As they work for subcontractors, there is a long supply chain; this may result in confusion about who is in charge. Migrants are often young and lack experience in their area of work. They are keen to earn a high a wage as possible, as quickly as possible and, therefore, may be more prepared to cut corners. In spite of their often poor working conditions, some migrants are happy to endure the situation to earn money on a temporary basis (Rogaly 2007). However, by working long hours and perhaps having more than one job, they increase their risk of injury in the workplace.

Contradictory evidence suggests that migrant workers actually do not face higher risks than other workers doing the same jobs (Jones 2008). However, they tend to work in areas such as construction, cleaning, catering and agriculture, which carry higher risks. But international studies do indicate that they are more vulnerable. Although the statistics are not completely reliable, the European Risk Observatory indicates that there seems to be a higher accident rate for migrant workers in France, Austria, Slovenia, Italy, Spain, Germany and Ireland. In the U.S.,

Mexican workers were reported to be 80% more likely to have a fatal accident at work (Pritchard 2004). However, in Finland and Sweden, studies showed that migrants were at no greater risk.

Perhaps it is the fact that they are temporary workers that makes them more vulnerable (Virtanen et al 2005). Migrant workers are traditionally recruited through temporary employment agencies. They may increase their risk of injury and ill health because they tend to work long and anti-social hours, which may cause greater fatigue. The nature of their work may be repetitive, e.g., packing or fruit picking, and this can lead to musculoskeletal problems. The fact that migrants are temporary workers may also mean they have less training and development opportunities, which impacts their health and safety (Arrowsmith 2006).

However, sometimes migrants' employment can be associated with a lower accident rate. This can be the case, for example, where migrant supervisors return year after year to supervise tasks in an agricultural setting. This provides some stability, and ensures that the migrant workers are aware of health and safety messages. Also, where there is a stable migrant workforce, this can help embed a culture of health and safety (McKay et al 2006). When employers use fewer temporary agency workers, it provides further support for the argument that it is migrants' status as temporary workers that puts them at a disadvantage.

There have also been reports from the UK that migrants tend to have most accidents in the first three months of their employment (McKay et al 2006). This is a trend that is also apparent in apprenticeships, Miller et al. (2005) indicating the importance of induction training and supervision of new workers.

The sector in which they work will determine the risks they face. For example, Wang et al. (2010) reported the influence of high workloads on neck and shoulder pain experienced by migrant sewing machine operators in Los Angeles.

Ahonen et al. (2010) looked at migrant women working in household service in Spain. Injuries included musculoskeletal problems as a result of heavy lifting of furniture and people with limited mobility, along with reaching to clean windows, and respiratory and skin reactions as a result of using cleaning products containing bleach and ammonia. There were also psychosocial hazards because of the demands made by employers, and the lack of control migrants had over their jobs and isolation and the isolation they felt. These hazards are very similar to those experienced in the hotel, restaurant, and catering sectors, where there is also the addition of slip, trip and fall risks on wet floors (European Agency 2007).

Rees et al. (2010) reported on the migrant labour system in South African gold mining, which has led to a higher incidence of silicosis, tuberculosis and HIV infection. These migrant workers come from neighbouring countries and return to their homes regularly. Unfortunately, they carry diseases, such as TB and HIV, back to their own communities.

An investigation into migrant accidents carried out by the HSE in Great Britain (McKay et al. 2006) highlighted types of accidents in which migrants had been involved, which included:

- Cuts or amputations from using saws with no guards;
- Falls from scaffolding, ladders and though fragile roofs;

- Entrapment and amputations from clearing blockages in machinery in food processing plants and on farms; and
- Accidents involving vehicles, such as tractors, fork lift trucks, etc.

Training and Good Practice

A common theme arising from investigation of these accidents was a lack of training; this is where the OSH practitioner can be proactive in promoting good practice. Migrants were most likely to have had induction training in the healthcare and construction sectors. However, women and younger migrants were less likely to have received training.

Those workers who had poor English were likely to be unaware of health and safety procedures. The agriculture and cleaning sectors relied on more experienced workers instructing new workers. There was some evidence that employers were not training migrant workers in a language or a way that they could understand.

A report by the National Engineering Construction Committee, published by Amicus in 2004, highlighted concerns in the UK construction industry regarding the language barrier among UK workers and non-UK workers. Migrant workers were put at risk because they were unable to understand on-site safety instructions. Native workers had resorted to industrial action due to the fire wardens' inability to speak or understand English.

Some evidence of good practices was found, however; for example, using bilingual workers to translate existing information given out at induction, although it was sometimes difficult to know whether health and safety messages had been communicated accurately. Some companies provided "train the trainer" courses to help migrant workers communicate the induction process successfully. Other employers translated signs or made them pictorial to encourage further understanding. Color-coded signs, videos, and interactive training were found to be more useful by migrants. Some employers, however, also provide intensive training. For example, one bus company provided training for migrant workers both in language as well as bus driving for several weeks, and assigned mentors to them during their training. For a more detailed discussion, see Dainty et al. 2010.

IOSH-sponsored research, carried out by Cameron et al. (2011), looked at the impact of pictorial occupational safety and health training on migrant worker behaviour and competence. This study looked at whether pictorial materials, compared to training materials using just text, resulted in improved knowledge and understanding in a sample of migrant workers in the construction sector. Topics covered included exclusion zones, storage of materials, safe use of portable tools, and personal protective equipment (PPE). They measured subsequent knowledge with a multiple-choice pictorial test and by behavioural observations. The results showed that the pictorial materials improved knowledge and understanding but the behavioural measures were more variable. Improved behaviour was observed where managers had posted pictorial materials near work areas. The report concludes that using pictorial toolbox talks, alongside poster campaigns, might improve the overall impact and effectiveness of pictorial aids to communicate health and safety information.

The building of the Olympic Park for the London 2012 Games provided an opportunity to promote best practice and learn lessons. A variety of communication methods were used, including briefings, posters, notice boards, and meetings involving the entire supply chain and

encouraging two-way communication (Lucy et al. 2011). Cheyne et al. (2011) reported on the importance of having a coordinated system of communication and encouraging an appropriate culture for good practice sharing. This involved the ability of workers to communicate problems without fear of blame. Worker involvement was key; it was essential that employees felt that management was concerned for their welfare. The project found that the most effective method of communication was verbal with well-planned campaigns and short, relevant messages. Using rewards to positively reinforce messages about safety was important. A set of "Visual Standards" was developed in consultation with contractors, which identified "what good looks like," and "what bad looks like." This involved taking 74 photographs of key risk areas. These were put into a manual made of waterproof material that could be used by supervisors to explain the standards required. This helped ensure consistency across the site and provided an easier method of communicating with those on the site who were migrant workers. This helped establish the positive health and safety culture, which has resulted in the safest project to build an Olympic Park ever. For full details see http://learninglegacy.london2012.com

Conclusion

This paper has looked at the extent of migrant working, how their living and working conditions can impact negatively on their health. It highlights the temporary nature of their work and how the sectors in which they tend to be employed may affect their health and safety risks. Cultural and language barriers can prevent them understanding health and safety information. Good practice from employers was described, including practical examples from IOSH-sponsored research with migrant construction workers, carried out by Cameron et al. (2011), using pictograms and photographs to demonstrate hazards, consequences and controls, and lessons learned from the 2012 Olympic Games construction project.

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