Impact of migrant workers on the Malaysian health scene

Balachandran S and Azmi AR *International Health Unit, Disease Control Division, Ministry of Health, Malaysia. (Correspondence: Dr Balachandran S)*

Abstract

The influx of migrant workers has created an impact on the Malaysian health scene. Communicable diseases among migrant workers and their use of government health services are identified as some of the problems related to migrant workers. The potential for the spread of communicable disease from migrant workers to the local population is of concern to the Malaysian health authorities. The Ministry of Health has put in place a mechanism to ensure that only those who are free from communicable disease are allowed to work in Malaysia.

Key words: migrant workers, communicable diseases

Introduction

The movement of workers from one country to another seeking better working opportunities is not something new and the migration of workers in recent times was far greater than anything that occurred during ancient times. It was reported that about 120 million people now live in foreign lands (WHO, 1996a).

Migrant workers can be broadly divided into 5 major groups (Stalker, 1994):

i) **Settlers** - people who enter a country to live there permanently. In 1992 the United States, Canada and Australia received more than a million new settler immigrants.

ii) **Contract workers** - unskilled or semi skilled workers who are brought in to work for a limited period. In 1990 the Middle East had about 6 million of these workers. There are about 3/4 million legally registered workers in Malaysia.

iii) **Professionals** - people with higher level of education and training, including expatriates at management levels.

iv) **Illegal immigrants** - people who have either entered the country illegally or who have overstayed their visas. The United States is thought to have at least 3 million illegal immigrants. Malaysia too has a large number of illegal immigrants.

v) **Asylum seekers and refugees** - people who have left their home country to escape danger. Malaysia until a few years ago had a large number of Vietnamese refugees.

The above categorisation is very broad but migration of workers is not purely for the purpose of employment. Also involved are more complex social, political and psychological reasons but the main driving force for the migration of workers is the economic factor as poor or non existent job opportunities in their own country is the motivating factor (Encyclopaedia of Occupational Safety and Health, 1983; Stalker, 2000).

International migration continues to play an important role in the global spread of infectious diseases. This was seen 500 years ago when the Spanish in the course of their travel to the Americas introduced smallpox while the African slaves were thought to be responsible for the spread of Yellow Fever from Africa to the Americas. The International Health Regulations of the World Health Organization was introduced to counter the threat posed by diseases associated with international travel. The potential for the spread now has been enhanced by better and faster modes of transportation available. In addition, these workers come from regions where communicable diseases are still a major public health problem. Emerging and re-emerging infectious diseases further compound this. Infectious diseases are the number one cause of death globally (WHO, 1996a). The presence of drug resistant TB in India (WHO, 2000b), drug resistant malaria in Cambodia and Thailand (WHO, 2000a), and plague in Myanmar, Vietnam and Indonesia (Benenson, 1995) are of concern to us as there are many travel and trade links between Malaysia and these countries.

The objective of this paper is to highlight the health impact created as a result of the influx of the large number of migrant workers into Malaysia.

Migrant workers in Malaysia

The vibrant economy of Malaysia over the last 8 - 10 years has resulted in an increased demand for migrant workers

in almost all sectors including construction, plantation, manufacturing, service and domestic help (maids). The source countries of migrant workers in Malaysia include Indonesia, Bangladesh, Philippines, Thailand, Pakistan, Sri Lanka and Cambodia. Recently the Government has allowed employment of workers from Nepal and Myanmar. As of October 2000 there were 737,104 legal workers registered with the Immigration Department. About 60% of the legal migrant workers in Malaysia are from Indonesia while about 25% are from Bangladesh (unpublished data, Ministry of Home Affairs Malaysia, 1999). The exact number of illegal workers is not known but has been estimated to be about 500,000.

Most of the legal migrant workers are employed in the manufacturing (33%), followed by the agricultural (25%), construction (10.8%), domestic help (22%) and service (7.4%) sectors (unpublished data, Ministry of Home Affairs Malaysia, 1999).

The current policy for the recruitment of migrant workers includes a full medical examination in the country of origin of the workers. This is to ensure that the workers are medically fit and are free from communicable diseases. Some source countries like the Philippines have included psychological testing as part of the full medical examination. The Philippines also has regulations in place whereby if a worker certified fit by a particular doctor is later found unfit in the country of employment within a three month period, the doctor concerned would then have to bear all costs of repatriation of the worker back to the home country (Department of Health, Manila, 1990).

This medical examination is important as these workers usually come from the lower socio-economic groups and are prone to infectious diseases. Annually about 17 million people die due to infectious diseases and the impact of international migration on the global spread of infectious diseases is likely to increase (WHO, 1996a). This is especially so when the majority of migrants come from areas where many infeetious diseases are rampant.

Emerging infectious disease like Ebola, Lassa fever, Yellow Fever, Rift Valley fever and others, which have potential for international spread, are also of concern.

The health impact in Malaysia

The unpact on the Malaysian health scene include the following: (i) problems of communicable diseases, (ii) utilisation of health services, (iii) development of services, and (iv) image of the country.

Communicable diseases amongst migrant workers

One important impact on the health services in the country is the increasing burden of communicable diseases like tuberculosis, leprosy, malaria, HIV and Kalaazar (a disease previously not reported in Malaysia).

Tuberculosis

WHO declared tuberculosis (TB) to be a global emergency in 1993. In 1996 there were 3.1 million deaths due to TB and at least 30 million will die within the next 10 years if the current trends prevail (WHO, 1996a). In Malaysia about 12,000 new cases are reported annually of which about 10% involve migrant workers. In 1999 there were 1,435 cases involving migrant workers out of the 14,908 cases reported for the whole country. Of this 679 were Indonesian, 593 Filipinos and 82 Bangladeshis (Ministry of Health Malaysia, 1999a). The number of TB cases has not decreased for the past several years in countries like Australia, Singapore, Malaysia and Hong Kong due to increased detection of TB among immigrants (WHO, 1999).

Leprosy

Leprosy is an important public health problem in South East Asia accounting for more than 70% of all cases registered world-wide (WHO, 1996a). In 1995 it was estimated that Indonesia had 60,000 cases, Bangladesh and Myanmar 30,000 cases while India had 680,000 cases (WHO, 1999). More than 30% of the cases reported annually in Malaysia involve migrant workers. In 1996 a total of 273 cases were reported in Malaysia. Most of the cases involved workers from Indonesian and Philippines. This declined to 224 new cases in 1999 (Ministry of Health Malaysia, 1999a). Of late, there have been cases involving workers from Bangladesh.

Malaria

Malaria is endemic in 91 countries and each year there are 300 - 500 million clinical cases with 1.5 million to 2.7 million deaths (WHO, 1996c). There were 97,208 malaria cases in Bangladesh in 1995 and the rise of drug resistant cases in the region especially in the Mekong Delta is of concern (WHO, 2000a).

The total number of malaria cases reported in Malaysia involving migrant workers increased over the years from about 6,113 in 1993 to 7,450 in 1996. This is about 15% of the total number of cases reported annually for the whole country. Since then there has been a sharp decline and in 1999 there were 1,816 malaria cases involving foreigners. The majority of the cases were reported in the state of Sabah (Ministry of Health Malaysia, 1999b). This is not surprising as Sabah has a large migrant population from neighbouring countries.

Kalaazar (Visceral Leishmaniasis)

To date, 6 cases of Kalaazar have been reported amongst

Bangladeshi workers. Kalaazar is commonly found in countries like Bangladesh, India and Pakistan (Benenson, 1995). According to WHO, Bangladesh has about 900 - 1,000 cases annually (WHO, 1995). As this disease was not previously seen in Malaysia it posed a problem to both our general practitioners and pathologists (Hamidah *et al.*, 1995).

Sexually transmitted diseases

In 1995, sexually transmitted diseases in South East Asia in the 15-49 age groups was 128 per 1000 population and this was the second highest in the world (WHO, 1996b).

Migrant workers have been known to have high rates of sexually transmitted diseases. This is not surprising as these workers are young adults and sexually active. There were reports in the local media of mobile sex services being provided to the large migrant population during the construction of the Kuala Lumpur International Airport at Sepang. Ooi (2001) explained the historical association between migrant workers and prostitution, which was a source of revenue for the British Colonial authorities in Malaya. To prevent the spread of these diseases, the contagious disease ordinance was gazetted in 1870 requiring registration of brothels and prostitutes. As of December 2000 there were 950 HIV confirmed cases and 75 AIDS cases detected amongst foreigners (unpublished data, Ministry of Health Malaysia).

Nutritional diseases

Foreign workers especially the unskilled and semi-skilled workers come from the lower socio-economic group and may have nutritional problems. This problem is more evident amongst the illegal workers who are on the move to avoid being caught by the authorities. These workers may also have different food habits and have difficulty adapting to the local diet. Another important aspect is the workers' goal of earning as much as possible and spending the minimum on food. The causes of sudden deaths amongst foreign workers reported in Singapore and other South East Asian countries resembled deaths from acute cardiac beriberi (Anon, 1990).

Cases of beriberi (both wet and dry) have been reported amongst illegal foreign workers in Selangor. Similar cases have been reported amongst illegal foreign workers from detention camps in Perak (Jeyakumar, 1995).

Utilisation of Health Services

Another important problem is the utilisation of the government health facilities in the country. The large number of foreign workers has been causing congestion in hospitals and health centres in the country. The situation is most critical in Sabah where separate counters have been introduced, one for citizens and the other for non-citizens.

For the year 1996 some hospitals in Sabah had up to 37% of the deliveries, 51% of the in-patient and 38% of the out-patients involving foreigners. For the year 2000 the scene had not changed and deliveries in major hospitals continue with high percentages involving migrants. In hospital Kinbatangan it was as high as 45.76% and in Hospital Queen Elizabeth this was 30.85% (Jeyakumar, 1995). There were instances where the utilisation of the services was seen even at the Intensive Care Unit of some centres where there was competition for the limited number of life support systems.

The estimate cost of treatment of foreigners in Sabah was about RM12.7 million out of a total annual budget of RM100 million for the State. According to the Finance Division of the Ministry of Health Malaysia, foreigners owe the Government RM 24.8 million in unsettled bills as of December 1999 (unpublished data, Ministry of Health Malaysia).

Development of Services to Cater for the Migrant Workers

The presence of foreign workers in Malaysia has other impacts on the health services. Government hospitals and health centres had to develop different formats for reporting. The Finance Division of the Ministry of Health, Malaysia had to review its fees schedule. Laboratories had to look into testing for disease previously unknown in Malaysia like Kalaazar. The Ministry had to appoint clinics and hospitals in the country of origin of workers for pre-employment medical examination. Random checks at the entry points were started not only to pick up cases but also to check on the quality of examination conducted in their home countries. A privatisation exercise was undertaken for the monitoring and supervision of the medical examination of the foreign workers, utilising computerised central databases and electronic transmission of medical reports. With this in place all the medical reports of foreign workers are collected via a central computerised database and this information is made available to the Ministry of Health. From the screening of migrant workers it was found that about 3.6% in 1998, 2% in 1999 and 1.6% in 2000 were found unfit in Peninsular Malaysia. In Sabah 11.3% in 1998, 4.9% in 1999 and 3.75% in 2000 were found unfit (Table 1).

Research priorities also changed and issues involving the migrant workers had to be studied. In the private sector, health insurance schemes were developed to cater for these workers and laboratories started providing special services

Table 1. Diseases or conditions of foreign workers certified unfit in Peninsular Malaysia and Sabah, 1998 - 2000.

Medical Condition	Peninsular Malaysia			Sabah*		
	2000	1999	1998	2000	1999	1998
HIV	77	69	173	22	11	5
STI	659	1,360	2,978	860	1,102	649
Leprosy	1	3	7	1	5	9
Malaria	0	0	1	6	7	3
TB	1,044	853	1,467	153	350	442
Hepatitis B	2,444	3,907	12,030	2533	3,923	4,712
Cancer	4	7	12	3	7	10
Epilepsy	3	4	13	1	0	0
Psychiatry	6	9	15	0	0	4
Urine contains cannabis	150	170	152	3	36	4
Urine contains opiates	102	293	255	23	3	1
Pregnant	572	601	751	39	74	538
Other causes*	1,832	1,310	270	0	NA	NA
Total unfit (% of total examined)	6,894 (1.6%)	8,586 (2%)	18,124 (3.6%)	3644 (3.7%)	5,344 (4.86%)	6291 (11.28%)
Total examined	421,059	435,279	510,009	97,928	109,943	55,728

*In Sabah there were migrant workers who had more that one cause of unfitness;
**Other causes (uncontrolled hypertension, Diabetes mellitus, etc)
Source : International Health Unit, Ministry of Health, FOMEMA data base.

for them. Even health education materials were prepared in the language of these workers so that they could understand the messages.

Impact on the image of the country

The occurrence of communicable diseases in Malaysia has been highlighted from time to time in the media. The reports of Kalaazar, involving Bangladeshi workers and the deaths due to measles amongst unimmunised immigrant Filipino children in Sabah in 1997 were highlighted in the media.

These reports created concern amongst the international community especially amongst the tourists, businessmen and investors as these reports paint a negative picture of the health system in Malaysia. Even our exports especially food exports may be jeopardized especially when there are outbreaks of food and waterborne diseases like cholera. The spread of infectious disease and it's economic impact can clearly be seen, as in Peru in 1991 where, as a result of the outbreak of cholera, there was 60% drop in tourism. Cancelled export orders for seafood and fresh fruit resulted in a loss of $ 700 million (APEC, 2000; WHO, 1996a).

Conclusion

Migrant workers, while helping to reduce the labour shortage, have the potential to contribute to the spread of diseases. The preventive and control measures will only succeed if all the relevant parties play their roles i.e. the employers employ only those workers who have been recruited legally and have been medically examined and certified fit; the workers are given appropriate accommodation and waste disposal facilities and access to health care. The doctors on their part must ensure that a thorough examination is done and notify cases of infectious diseases without delay to local health authorities.

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