Review

Nepali Migrant Workers and Their Occupational Health Hazards in the Workplace: A Scoping Review

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Abstract: An increasing number of people are relocating to search for work, leading to substantial implications for both local and global health. Approximately 3.6% of the global population (281 million) migrates annually. Nepal has experienced a notable surge in labour migration in recent years, with a substantial proportion of its residents actively seeking work opportunities abroad. Understanding work-related risks is crucial for informing policies, interventions, and practices that can improve the welfare of this hard-to-reach population. This scoping review aims to systematically identify and analyse occupational health hazards encountered by Nepali migrant workers employed overseas. Medline, Scopus, Directory of Open Access Journals (DOAJ), and the NepJOL databases were systematically searched for primary research papers published in English up to July 2024. Relevant data, including workplace hazards and their impact on health outcomes, were extracted and narratively synthesised by highlighting key themes in the existing literature. A total of 24 articles met the inclusion criteria and were included in this review. Of these, twelve studies were conducted in Nepal, five in Gulf countries, four in Malaysia, two in Hong Kong, and one each in India and Korea. Workplace injuries (motor vehicle injuries, machinery injuries, falls from a height, and falls on a heavy object), poor working environment (including long working hours, work without leave, discrepancy in pay scale, limited access to drinking water and toilet/bathroom facilities), workplace abuse, sexual abuse, and torture were identified as key occupational health hazards faced by the Nepali migrant workers abroad. Multi-level intervention strategies, such as safety training standards, improving working conditions, and eliminating exploitative labour practices, are critical to improving occupational health and safety standards for Nepali migrant workers abroad. This includes creating a supportive working environment where employees can easily and timely access health services as needed.

Keywords: migrant workers; occupation; health hazards; Nepal; scoping review

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1. Introduction

Migration is a global phenomenon, and its impact is increasingly recognised in global public health agendas. The sustainable development goals (SDGs) indicator 8.8.1 calls for each country to report rates of fatal occupational injuries disaggregated by migrant status, identify migration as a catalyst for development, and emphasise the need to 'leave no one behind' to achieve universal health care [1,2]. Addressing the health needs of migrant workers is timely and contributes to achieving the UN's SDGs, which promote decent work and economic growth by "protecting labour rights and promoting safe and secure

working environments for all workers, including migrant workers" [3]. The United Nations estimates the number of migrants has nearly doubled globally, from 173 million in 2000 to 281 million in 2020, with the top three destination countries being the USA (51 million), Germany (13 million) and Saudi Arabia (13 million), respectively. Over 30.5% (about 86 million) of migrants only live in the Asian continent [4]. The protection of migrant workers and refugees was also highlighted at the 72nd World Health Assembly, where it was set as a global health priority and a global action plan to promote their health from 2019 to 2023 [5]. Despite the dearth of research on migrant occupational hazards, the international media frequently highlights South Asian construction workers. This attention is due to their role in building the football stadiums for Qatar's 2022 World Cup [6,7].

Nepal is a low-income country experiencing a demographic transition, characterised by an ageing population and an increase in chronic diseases. A recent national survey reported that nearly half (47%) of households had at least one family member migrate internationally, and around one-third (31%) of males migrated due to work [8]. Nepali migrants have contributed more than a quarter (27%) of the country's gross domestic product (GDP) through remittances, and the migration outflow has been dominated by low-skilled workers [9,10]. Men continue to dominate labour migration from Nepal, with female migrant workers accounting for less than 10% of the total labour force. In 2021, the number of male migrants was 64,903, significantly outnumbering the 7018 female migrants, which reflects how men participate in labour migration [11]. Today, Malaysia and Gulf countries (Qatar, Saudi Arabia, the United Arab Emirates (UAE), and Kuwait), including the East Asian countries (Japan and Korea), continue to be the main destinations for Nepali labour migrants, (informal) movements to India aside. The increase in Nepali migrants to these countries can be attributed to the countries' flexible policies and their self-declaration of safety and work opportunities [11,12]. While the economy has improved dramatically, increased migration has resulted in a plethora of health issues affecting both the countries of origin and destination.

The risks of serious health issues are significant for Nepali workers, particularly in Malaysia and Gulf countries, as they are often employed in higher risk occupation groups such as 'difficult, dirty, and dangerous (3Ds)' [13,14]. These occupations are primarily in agriculture, construction, transport, and heavy industry. They also work longer hours and are poorly paid compared to native workers [15,16]. According to a recent global study among migrant workers, around half (47%) of migrant workers had experienced at least one occupational morbidity, and approximately a quarter (22%) had sustained at least one severe injury due to falls from heights, fractures and dislocations, ocular injuries, and cuts [17]. Likewise, previous research also revealed that migrant workers are over-represented in physically demanding high-risk jobs like manufacturing, mining, construction, and farming, and they experience a higher proportion of occupational injuries, including discrimination and exploitation, compared to native-born workers [5,14,18,19].

Over a million Nepali migrants currently work semi-skilled (factory workers, carpenters, and electricians) and unskilled jobs such as labourers [14]. These workers are often exposed to risk factors such as low wages, poor housing, an unhealthy diet, and difficulty accessing health services, which negatively affect their health and wellbeing [16,20]. Many Nepali migrants die abroad every year, including a number of unexplained deaths, and more return home with debilitating injuries as well as mental and physical illnesses. Often, they also carry the silent risk of transmitting sexual or other infectious diseases back home [16,21,22]. Migrant workers often encounter various occupational health hazards in their workplace. However, no comprehensive evidence synthesis has been conducted to better understand the occupational health hazards that Nepali migrant workers experience abroad. This scoping review aimed to systematically map and analyse the published literature reporting occupational health hazards experienced by Nepali migrant workers employed overseas.

2. Materials and Methods

A scoping review of the literature on occupational hazards in the workplace among Nepali migrant workers was carried out based on the five-step scoping review framework of Arksey and O'Malley (2005) [23]. The framework included the following stages: (a) identifying the review question; (b) identifying relevant studies; (c) selecting relevant studies; (d) charting the data; and (e) collating, summarising, and reporting the results [23]. A scoping review was chosen because it provides in-depth and comprehensive coverage of the available literature and allows for answering broader research questions [24]. The findings are reported according to the recommendations of the preferred reporting items for systematic and meta-analysis extension for scoping reviews (PRISMA-ScR) [25]. This review, therefore, concentrated on the depth of pertinent studies. The following is a detailed explanation of how this review applied the framework:

Stage 1: Identifying the Review Question

The scoping review question for this study was: What are the most common occupational health hazards encountered by Nepali migrant workers abroad? The research question incorporated the population, concept, and context (PCC) framework [26], which includes three key elements: population (Nepali migrant workers employed overseas), concept (occupational health hazards in the workplace), and context (Nepal).

Stage 2: Identifying the Relevant Studies

The search strategy was developed in accordance with the review question and the delineation of key concepts. Medline, Scopus, the Directory of Open Access Journals (DOAJ), and the NepJOL databases were searched to identify the potential studies. Each database was searched using keywords from both controlled and free vocabulary sets, combined with Boolean operators ('or' and 'and'). The search strategy was formulated using the PCC framework [26]. This review was focused on population ("migrant" or "emigrant" or "migrant workers" or "migrant labours" or "expatriate workers" or "returnee migrants"), the concept ("workplace hazards" or "occupational health hazards" or workplace health risk" or "work-related illness" or "occupational injuries" or "occupational diseases" or "work-related accidents" or "workplace abuse" or "harassment" or "workplace torture" or "mental health issues"), and the context (Nepal" or "Nepali" or "Nepalese"). The search aimed to identify all relevant studies, regardless of the types of workplace hazards encountered by Nepali migrant workers while working abroad. In addition to searching major health and social science databases, the included studies' reference lists were searched manually for additional relevant studies. The searches were limited to reports written in English, but no limitations were imposed on the year of publication. The search covered the literature published up to June 2024.

Stage 3: Selecting the Relevant Studies

First, the selected studies were screened based on their titles and abstracts, and irrelevant studies were excluded. Finally, the relevant studies were screened using their full texts before deciding on full data extraction. Figure 1 depicts the PRISMA ScR flowchart, illustrating the various stages of the study selection process. The final inclusion of studies was based on the following criteria:

Inclusion and exclusion criteria for the studies:

Inclusion criteria:

- Nepali migrant workers working abroad;
- Workplace hazards, injuries, and risks faced by Nepali migrant workers in working abroad;
- Peer-reviewed publications, either quantitative, qualitative, or mixed-methods research;
- Literature published up to July 2024;
- Only publications in the English language.

Exclusion criteria:

- Studies conducted with non-migrant workers or internal migrant workers and their workplace hazards;
- Studies not in the English language;

- Systematic reviews, scoping reviews, book chapters, editorials, or commentaries.

Stage 4: Charting the data

A data extraction Excel spreadsheet was developed, and the data were charted based on the data extraction sheet. Two authors (AS and PW) extracted data independently to ensure the publications were selected correctly. Two reviewers independently screened the titles and abstracts. All authors reviewed the data extraction process to ensure it addressed the review research questions and inclusion criteria. Any disagreements were resolved through discussion between all authors. The extracted information sheet contained identifiers (e.g., first author's surname, year of publication, and type of study), study year, study country, study design, method, study participant characteristics, sample size, the prevalence of burdens, and key workplace hazards faced by migrant workers during overseas work. Finally, all authors read the extracted data and discussed the results.

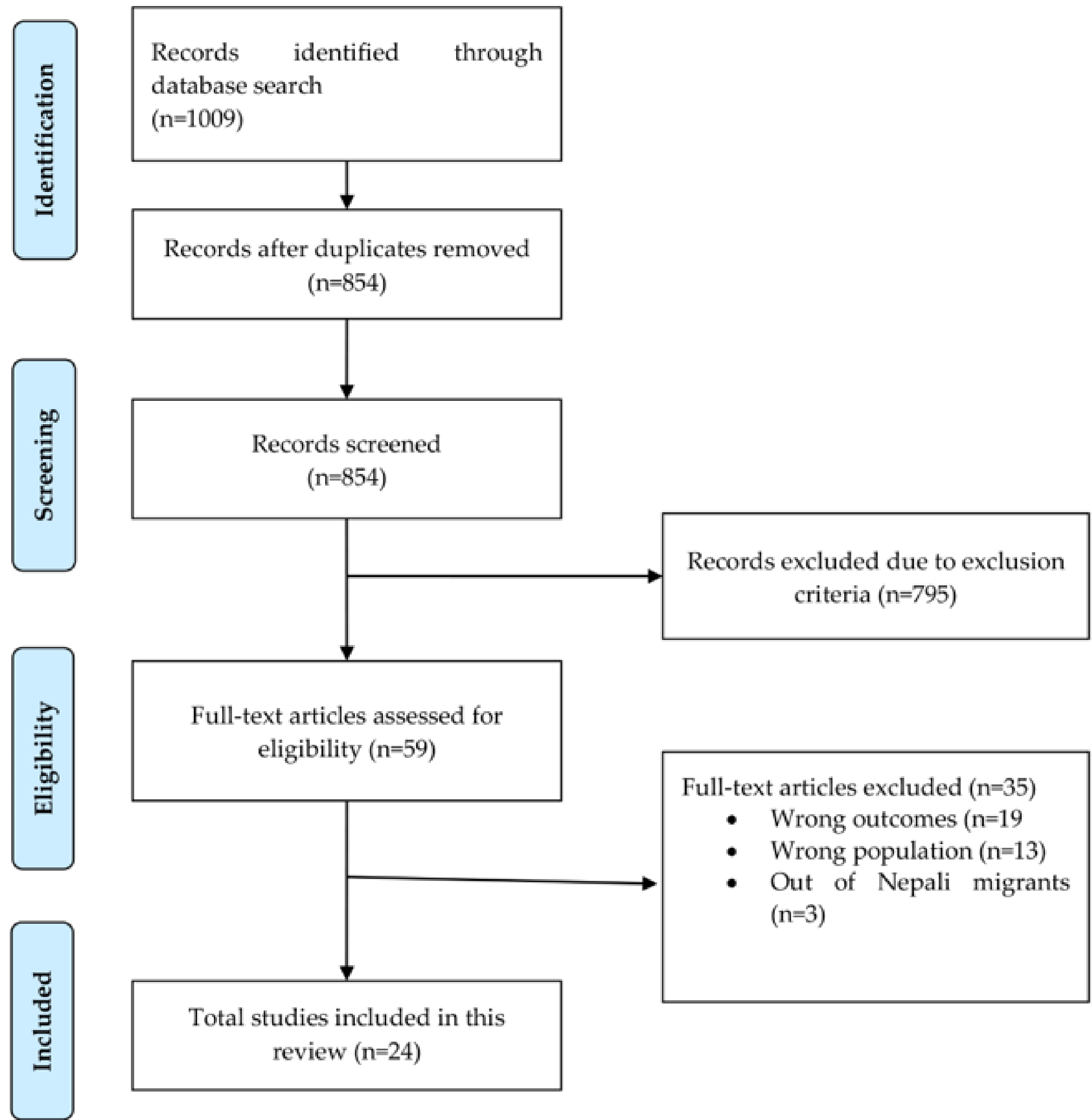

Figure 1. PRISMA-ScR flowchart of this study's search and selection process.

Stage 5: Collating, summarising and reporting results

A narrative synthesis approach was used to report the results. The main findings of workplace hazards among migrant workers were assessed, and the conditions con-

sidered were summarised when identifying the patterns and investigating similarities and differences between studies. This review did not assess the methodological quality of the included studies because that was not the aim [23]. Though no ethical approval was required due to the nature of the evidence synthesis, issues of transparency, accuracy, misrepresentation, and misinterpretation were carefully considered to minimise the ethical impact on the studies included in this review [27].

3. Results

3.1. Identification and Selection of the Articles

The initial comprehensive search of databases yielded 1009 records. After removing duplicates, 854 records were screened through an initial title and abstract review. Following the title and abstract screening, the full texts of 54 articles were assessed, of which 24 articles were included in this scoping review. Figure 1 depicts the PRISMA-ScR flow chart, which summarises the data screening processes.

3.2. Characteristics of Included Studies

The methodology used in these 24 studies varied largely, with half of the studies (n = 12) using quantitative research methodology [16,20,28–37]. Ten studies used qualitative methods [38–47], and the remaining two used mixed methods [13,48]. The studies looked at a wide range of settings and sectors. Nine studies were conducted in the community setting; six were conducted at the international airport in Nepal, five were health facility-based, and one each at construction industry [39], non-governmental organisation [20], self-help group [44], and multiple workstations [48], respectively. The majority of the studies were conducted in Nepal (n = 11), followed by Qatar (n = 4) [28,29,31,33], Malaysia (n = 3) [34,38,48], Hong Kong (n = 2) [32,39] and one each in Bahrain [30], India [43], Korea [44], and a multiple country—Malaysia and Nepal [46], respectively (Table 1). Workplaces included in these studies were highly fragmented, such as construction, factories, agriculture, domestic work, security guards, and housemaids, all of which remain unregulated and often have hazardous working conditions as well as poor safety and security [40,44,46]. This diversity emphasises the complexities and hazards encountered in various contexts. The study sample size ranged from seven participants [39] to 4997 [33]. Thirteen of the studies were exclusively conducted on male migrants, while eight studies included both male and female migrants, and three studies [20,45,47] included only female returnee migrant workers. Migrant workers' ages ranged from 19 to 60 years, and the majority were in semi-skilled to unskilled positions, i.e., construction, manufacturing, security guards, agriculture, domestic, and house maids. The included studies were published between 2004 and 2024, whereas five studies were published in 2023 [13,37,38,45,48], followed by four studies in 2019 [29,41–43] (Table 1).

Table 1. Key characteristics of the studies included in this review.

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Adhikari et al., 2017 [35]	To assess the extent of workplace accidents among Nepali migrant workers in Malaysia, Qatar, and Saudi Arabia	Nepal; 2011	Kathmandu, Tribhuvan International Airport	Quantitative survey	403	Age (range): 45.9% were aged between 20 to 29 years Sex: all male Literacy: 24.6% were illiterate Marital status: 91.3% married Migrant's working sector: 30.8% were in unskilled jobs.
Adhikary et al., 2018 [36]	To assess the health and mental wellbeing of Nepali construction and factory workers employed in Malaysia, Qatar, and Saudi Arabia	Nepal; 2011	Kathmandu, Tribhuvan International Airport	Quantitative survey	403	Age (range): 45.9% were aged between 20 to 29 years Sex: all male Literacy: 24.6% were illiterate Marital status: 91.3% married Migrant's working sector: 30.8% were in unskilled jobs.
Adhikary et al., 2019 [42]	To explore the personal experiences of male Nepali migrants with unintentional injuries at their place of work.	Nepal; 2011	International Airport and nearby hotels /guesthouses	Qualitative study	20	Age (range): mean age 31.3 years (ranged from 20 to 49 years) Sex: all male Literacy: 50% had no education Marital status: 75% were married Migrant's working sector: NR.
Ahmed et al., 2022 [39]	To identify the key stressors faced by ethnic minority construction workers (EM-CWs) and propose practical solutions to manage these stressors in the industry.	Hong Kong; NR	Construction industry	Qualitative study	13	Age (range): ranges between 20–59 years old Sex: all male Literacy: NR Marital status: NR Migrant's working sector: 6 skilled and 7 semi-skilled workers.

Table 1. *Cont.*

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Al-Sayyad and Hamadeh, 2014 [30]	To measure the burden of climate-related conditions (CRC) on health services in the main labourers' clinic in the Kingdom of Bahrain	Bahrain; 2008	Health facility	Quantitative survey	3715	Age (range): NR Sex: NR Literacy: NR Marital status: NR Migrant's working sector: NC.
Al-Thani et al., 2015 [31]	To analyse and describe the epidemiology of these injuries based on the worker's nationality residing in Qatar.	Qatar; 2010–2013	Trauma centre	Retrospective routine data analysis	563	Age (range): mean age was 32 years (10.3) Sex: NC Literacy: NC Marital status: NC Migrant's working sector: NC.
Atteraya et al., 2021 [44]	To delineate the main suicide risk factors for this group of migrants.	Korea; NR	Self-help groups of migrant communities	Qualitative study	20	Age (range): ranges between 22 to 41 years Sex: 85% male and 15% female Literacy: NR Marital status: NR Migrant's working sector: semi-skilled in manufacturing sectors.
Consunji et al., 2022 [28]	To describe the work-related injuries and deaths in Qatar.	Qatar; 2020	Health facility	Retrospective routine data analysis	44,687	Age (range): NR Sex: NR, Literacy: NR Marital status: NR Migrant's working sector: semi-skilled in the construction sector.
Devkota et al., 2021 [40]	To explore the mental health and wellbeing experiences of Nepali male returnee migrants.	Nepal; 2020	Community	Qualitative study	19 interviews (FGDs—4 and IDIs—15)	Age (range): ranges between 19 to 55 years old Sex: all male Literacy: 72% had secondary level Marital status: NR Migrant's working sector: 48% were labourers—security guards, office boys/cleaners.

Table 1. *Cont.*

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Frost, 2004 [32]	To explore the Nepali migrant's work-related issues working in Hong Kong.	Hong Kong; 2001	Community	Quantitative survey	267	Age (range): 17% were younger than 25 years old Sex: 88.4% male and 11.6% female Literacy: NR Marital status: NR Migrant's working sector: 74% of Nepali migrants worked in the construction sector.
Grossman-Thomps, 2023 [45]	To explore the violence experience of Nepali women migrant workers abroad.	Nepal; 2016	Community and virtually (telephone or online)	Qualitative study	30	Age (range): NR Sex: All female Literacy: NR Marital status: NR Migrant's working sector: NR.
Jones et al., 2024 [46]	To explore the migrant worker's work and accommodation in Malaysia.	Malaysia and Nepal; NR	Community	Qualitative study	104	Age (range): NR Sex: both male and female migrants including other stakeholders. Literacy: NR Marital status: NR Migrant's working sector: males worked in service, construction. and agriculture whereas all females worked as factory workers.
Joshi et al., 2011 [16]	To explore the health problems and accidents experienced by a sample of Nepali migrants in three Gulf countries.	Nepal; 2009	InternationalAirport and nearby hotel/guest house	Quantitative survey	408	Age (range): mean age 32 (6.5) years Sex: 92.4% male and 7.6% female Literacy: 76.2% had primary-level education Marital status: 80.6% married Migrant's working sector: majority were semi-skilled—54.9% construction work, and 18.1% household/manual servant.

Table 1. *Cont.*

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Latifi et al. (2015) [33]	To analyse the traffic-related pedestrian injuries (TRPI) amongst expatriates to RDC.	Qatar; 2009–2011	Health facility	Retrospective routine data analysis	4997	Age (range): NR Sex: NR Literacy: NR Marital status: NR Migrant's working sector: NR.
Min et al. (2016) [34]	To describe the epidemiology of work-related ocular injuries and their visual outcome in a tertiary hospital in southern Malaysia.	Malaysia; 2011–13	Health facility	Retrospective routine data analysis	935	Age (range): ranges 20 to 60 years old Sex: 98.2% were male Literacy: NR Marital status: NR Migrant's working sector: NR.
Paudyal et al., 2023 [13]	To understand the health and wellbeing issues of Nepali migrant workers in Gulf Cooperation Council (GCC) countries.	Nepal; 2019	Community	Mixed-methods study	N = 80 (Survey—60 and KIIs 20)	Age (range): median age 34 years, ranges 23–51 years Sex: male 96.7% (n = 58), female 3.3% (n = 2) Literacy: 8.3% (n = 5) had no formal education Marital status: 91.7% (n = 55) currently married Migrant's working sector: semi-skilled—28.3% manufacturing /factory workers.
Pradhan et al., 2019 [29]	To analyse the mortality status due to occupational heat stress working in high ambient temperature and its association with cardiovascular problems (CVP) of Nepali migrant workers in Qatar.	Qatar; 2009–2017	Community	Retrospective routine data analysis	1354	Age: NR Sex: NR Literacy: NR Marital status: NR Migrant's working sector: NR.

Table 1. *Cont.*

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Regmi et al., 2019 [43]	To explore issues of accommodation and working environments in the context of health vulnerabilities amongst Nepali migrants in India.	India; 2017	Community	Qualitative study	78	Age (range): ranges 19–50 years Sex: 51.3% (n = 40) male and 48.7% (n = 38) female Literacy: 21.8% were literate Marital status: 91.5% were married Migrant's working sector: 31.5% security/watchman, 45% domestic workers/cleaners.
Regmi et al., 2019 [41]	To identify triggers of mental ill-health among Nepali migrant workers.	Nepal; 2017	Tribhuvan International Airport	Qualitative study	FGDs—4, IDIs—7 and KIIs—8	Age (range): ranges between 21 to 53 years Sex: male and female Literacy: NR Marital status: NR Migrant's working sector: semi-skilled worked in the security and domestic workers.
Sharma et al., 2023 [37]	To identify and determine the predictors of psychological wellbeing among Nepali migrant workers in Gulf countries and Malaysia.	Nepal; 2019	Tribhuvan International Airport	Quantitative survey	502	Age (range): mean age—32.97 (7.6) years Sex: male 93% and female 7% Literacy: primary level (35.7%) Marital status: unmarried 18.3% Migrant's working sector: office workers (7.8%), construction (25.9%), housemaid/housekeeping (8.4%), and security (7%).
Simkhada et al., 2018 [20]	To explore the health problems of female Nepali migrants working in the Middle East and Malaysia.	Nepal; 2009–14	Non-Governmental Organization (NGO)	Retrospective routine data analysis	1010	Age (range): median age of 31 Sex: all female returnee migrants Literacy: 37.4% were illiterate Marital status: 24% were unmarried, 20.7% divorced/separated, and 7% were widowed Migrant's working sector: unskilled in domestic work.

Table 1. *Cont.*

Author, Year	Aim of the Study	Study Country, Year	Study Setting	Type of Study	Sample Size	Participants' Characteristics
Sunam, 2023 [38]	To explore the lived experiences of migrant workers in Malaysia.	Malaysia; 2017–19	Social network in Malaysia-based Nepali diaspora	Qualitative study	31	Age (range): ranged between the ages 20 to 35 years Sex: 26 male and 5 female Literacy: NR Marital status: 80% married Migrant's working sector: security guards and restaurant workers.
Wahab et al., 2023 [48]	To assess the barriers and causes underpinning actual and potential drivers of forced labour involving Nepali workers in Malaysia.	Malaysia; 2021	Multiple workstations	Mixed-methods study	N = 117 (Survey—76 and in-depth interviews—41)	Age (range): NR Sex: NR Literacy: NR Marital status: NR Migrant's working sector: unskilled and low-wage labourers.
Wu et al., 2024 [47]	To explore precarity in short-term women's migration using the case study of Nepal.	Nepal; 2022	Community	Qualitative study	46 (6 FGD & 12 KIIs)	Age (range): NR Sex: female returnee migrants Literacy: NR, Marital status: NR, Migrant's working sector: domestic work.

FGD: focus group discussion; KII: key informant interview; NR: not reported.

3.3. Studies Exploring Occupational Hazards in the Workplace

This review identified four interactive core themes: (a) poor working environment, (b) injury risks and safety, (c) discriminatory behaviours, and (d) psychosocial hazards.

3.3.1. Poor Working Environment

Nepali migrant workers were predominantly engaged in manual or low-skilled jobs and confronted precarious employment arrangements that included temporary or informal contracts, low wages, and heightened exposure to physical demands [30,38–40,43]. Over half (54.3%) of workers did not have access to on-site toilets, while only 12% benefited from having a regular and drinkable water supply. These sites lacked basic amenities, with 90.2% of workers having never seen soap, 89.1% having never seen towels in the bathroom, and surprisingly, only about half (47.9%) of respondents being allowed to use the bathroom when necessary [32]. All of these factors contribute to poor living conditions (overcrowded hostels with squalid housing) and frequent street crime and violence [37,46]. Inadequate workplace and regulatory infrastructures lead to overtime work and workplace accidents. Although companies did offer treatment services, there were no paid sick days or sick leave [38,43].

Four studies [16,29,30,36] indicated that workplace risks predominantly stemmed from environmental health issues. Al-Sayyad and Hamadeh reported that 26.7% of the migrants mentioned the burden of environmental health as a concern, whereas 6.7% reported an allergic reaction [30]. Similarly, Adhikari et al. reported that approximately 21.3% of migrants indicated that they were employed under unfavourable or highly unfavourable circumstances [36]. Around one-fifth (18%) of migrants suffered from heat-related illnesses such as heat stroke or fainting [16]. Moreover, a retrospective study by Pradhan et al. found that cardiovascular-related deaths among migrant workers were higher (48.2%) during the summer session compared to the winter (33.6%) [29] (Table 2).

Table 2. Key findings of the studies included in this review.

Author, Year	Reported Workplace Hazards	Key Findings	Limitations of the Study
Adhikari et al., 2017 [35]	Workplace accidents and injuries	• Around half of respondents (46.4%) perceived health risks (hearing problems, vision problems, skin problems, muscular pain, injuries and heart disease) at work; • 21.3% reported a poor/very poor work environment; • Higher risk of having accidents at work in the Middle East (OR 3.6, 95% CI 1.5–8.5) than those working in Malaysia; • 17% had experienced accidents and injuries (e.g., road accidents, cuts, falls, heart attacks) at work.	• Study was conducted in Nepal rather than in host countries; • A convenience sampling frame was used.
Adhikary et al., 2018 [36]	Poor workplace environment/general health issues	• Poor/very poor work environment (21.3%); • Not satisfied with the accommodation abroad; • Higher perceived health risks (46.4%) at work (e.g., hearing problems, vision problems, skin problems, muscular pain, injuries, and heart disease).	NR

Table 2. *Cont.*

Author, Year	Reported Workplace Hazards	Key Findings	Limitations of the Study
Adhikary et al., 2019 [42]	Work-related accidents	• Risk-taking among workers during their work increased workplace accidents and injuries; • Poor working conditions and high workplace accidents; • Exposure to excessive heat at work, leading to sweating, dehydration, and heat stroke; • Communication issues with colleagues and supervisors, leading to a higher risk of experiencing accidents at work; • 45% of respondents reported work-related accidents–injuries and accidents related to falling from the roof or being trapped; • High work pressure, long working hours, mostly without timely food and drinking water resulting in dehydration and heat stroke.	• Purposeful sampling; • Self-reported workplace issues; • Interview was conducted during migrant workers' annual leave visits or returnees in Nepal at the international airport in Nepal but not in the destination countries.
Ahmed et al., 2022 [39]	Poor work environment, long working hours, pay differences	• Discriminatory behaviours (pay difference); • Long working hours; • Heavy workload; • Job insecurity—fear of job termination; • Poor and insufficient facilities at work sites—extreme temperature, lack of drinking water, toilet services, changing room.	• Subjective bias in coding and analysis (manual contextual analysis).
Al-Sayyad and Hamadeh, 2014 [30]	Climate-related conditions/heat-related disease	• Heat-related issues (27%), followed by 6.7% allergic, and 55.6% infectious diseases.	• Non-probability (convenience) sampling.
Al-Thani et al., 2015 [31]	Occupation injuries/falls of heavy objects	• Occupational injury (28%), of which 52.4% fell from height, 21% were related to falls of a heavy object, 17% had motor vehicle crash injuries, 5% faced machinery injuries, and 5% were other categories.	• Differences in definitions of workplace injuries and reporting systems in Gulf countries.
Atteraya et al., 2021 [44]	Workplace risks factors	• Occupational health issues (back pain; isolation, loneliness and suicide); • hazardous work and long working hours.	• Small sample size.
Consunji et al., 2022 [28]	Workplace injuries	• Workplace injuries are mostly construction industry-related (falls from height, falling of heavy objects and road traffic injuries); • ~1 in 5 had severe or mild work-related injuries.	NR
Devkota et al., 2021 [40]	Adverse working condition	• Adverse living and working conditions; • Exploitation and abuse by employers; lack of privacy and congested accommodation; • Long working hours; • Verbal misbehaviours to employees and the threat of job termination.	• Self-reported health and wellbeing (over-reporting and recall bias); • Findings are not generalisable due to the qualitative nature of the study.

Table 2. *Cont.*

Author, Year	Reported Workplace Hazards	Key Findings	Limitations of the Study
Frost, 2004 [32]	Payment discrimination/no access to basic facilities (i.e., drinking water, toilet, bathroom)	• Female workers were paid less, and experienced sexual harassment from the management of their fellow male workers (74%); • No access to bathroom/toilet facilities on-site (54%), 90% of workers had never seen soap and only 48% were allowed to use the bathroom when necessary; • 11% seldom used any safety equipment at work; 47.1% workers were not treated fairly on-site by management; • 19% of workers had personally been verbally or physically demeaned or abused by a coworker or supervisor; • 57.2% faced discrimination based on language ability.	NR
Grossman-Thomps, 2023 [45]	Workplace abuses	• Not providing food, sleeping in the toilet; • Faced verbal and physical abuse and intimidation; • Not paid as per the contract.	• Purposively selected respondents; • Self-reported workplace issues.
Jones et al., 2024 [46]	Poor living environment and long working hours	• Long working hours—seven days a week without a day off; • Unsafe and overcrowding in the accommodation heightened stress levels; • Poor sanitation and lack of windows in these spaces; • Threat of attacks or robberies.	NR
Joshi et al., 2011 [11,16]	Workplace injuries/accidents	• 25% had some type of injury or accident at their workplace; • 20% had musculoskeletal problems; • 40% had different types of cuts; • 21% faced fractures or dislocations; • 18% faced temperature-related illness (such as heat stroke or fainting); • 12% falls from height.	• Convenience sampling, which is prone to selection bias; • Self-reported health problems during their stay abroad (recall bias).
Latifi et al., (2015) [33]	Traffic-related pedestrian injuries	• 25% faced traffic-related pedestrian injuries; • 41% were injured in road driving conventions.	• Analysis used hospital records (retrospective), and not all data were supplied.
Min et al., (2016) [34]	Eye injuries due to fall of objects	• 22% faced work-related eye injuries (hit by a machine, nail, wood, and metal while grinding).	• Retrospective analysis of hospital data and it was not possible to retrieve specific incident activity.

Table 2. *Cont.*

Author, Year	Reported Workplace Hazards	Key Findings	Limitations of the Study
Paudyal et al. 2023 [13]	Work abuse, injuries, sexual violence	• 35% reported verbal abuse at the workplace; • 7% had workplace injuries/road traffic accidents; • Sexual violence consequences, suffered multiple fractures to escape from a sexual abuser, and faced unwanted pregnancies.	• Participants were purposively selected, so they cannot be generalised to all migrant workers.
Pradhan et al., 2019 [29]	Environmental health and workplace accidents	• Deaths from cardiovascular problems (CVP) were greater in the summer session (49.2%) than in the winter session (33.6%) and the CVP mortality rate and mean maximum temperature were found to be statistically significant ($p < 0.005$); • 12% workplace accidents; • 10% road traffic accidents; • 9% suicide cases; and • 2% murder.	• Issues with the classification of death—mode and/or cause of death.
Regmi et al., 2019 [43]	Workplace injuries/accidents	• Unfair treatment at work (low salary, high workload, long working hours, not timely paid, no holiday); • Accidents, injuries and deaths reported at the workplace; • Discrimination at work, including at the health centres; • No compensation to people who got injured or died due to an accident at work.	• Small sample in a qualitative study; • Lacks generalisability.
Regmi et al., 2019 [41]	Maltreatment/ discrimination, workplace abuse	• Unfair treatment at work—discriminatory behaviours from their supervisors, employers, and senior staff that worsen their mental wellbeing; • Low salary, not getting a salary; • high workload; • Poor accommodations—limited facilities, small rooms, poor hygiene); • Physically abused.	• Unable to establish an association and cause-effect relationship of identified mental health risks with migrants; • Participants were purposively selected; • Self-reported health and wellbeing issues.
Sharma et al., 2023 [37]	Workplace issues	• Long working hours: 13–22 h per day (11%); • Overcrowded accommodation: 34% lived with more than 6 persons (6–25 people); • 5% sleep less than four hours a day.	• Respondents were purposively selected; • Self-reported workplace issues.

Table 2. *Cont.*

Author, Year	Reported Workplace Hazards	Key Findings	Limitations of the Study
Simkhada et al., 2018 [20]	Workplace abuse/injuries, torture/maltreatment	• 37% (95%CI 33.6 to 39.9) reported workplace abuse; • 1.1% (95% CI 0.5 to 1.2) had an accident at a workplace; • 30.9% (95% CI 27.9 to 33.9) reported as workplace torture or maltreatment; • 3.1% (95% CI 2.1 to 4.3) migrant women faced pregnancy at a workplace; • 51.7% (95% CI 32.5 to 70.5) (n = 15/29) faced sexual abuse.	• Study was limited to only accessing registered returnee women migrants in Pourakhi (NGO), which may limit its generalisability; • Data were from subjective reports, often without verification; thus, the reliability and validity of the information collected should be treated with caution.
Sunam, 2023 [38]	Workplace injuries/accidents	• Poor regulatory and workplace infrastructures leading to workplace accidents, exceeding overtime work, not providing rest days, no sick leave pay; • The company did not offer treatment services; • Poor living conditions (overcrowded living conditions, noise, not enough toilet and bathroom; • Faced frequent street crime and violence.	NR
Wahab et al., 2023 [48]	Workplace discriminatory behaviours	• Working under hot temperatures for long hours and lifting heavy fruit bunches; • Long working hours (12 to 16 h a day) without a day off; • Witnessing occupational injury in the workplace and did not get compensation for their injuries; • Staff salaries were deducted for personal protective equipment, hand sanitisers and masks, unclear deduction of wages or overtime pay.	NR
Wu et al., 2024 [47]	Workplace abuse	• Poor salary to Nepali housemaid and also not paid a salary as per the contract (contacted in $200 but paid only $150); • Domestic violence, sought, beatings by employers; • Sexual harassment including mental and physical abuse; • Medical institutions defrauded individuals who are then sent home if they have any health issues.	• Purposively selected respondents; • Self-reported workplace issues.

Note: NC: not clear, NR: not recorded.

Furthermore, undocumented Nepali workers residing outside Nepal emerged as a particularly vulnerable subgroup, experiencing heightened health risks compounded by their precarious legal status [32]. Alarmingly, migrant workers from Nepal exhibited higher rates of illness presenteeism, indicating a propensity to continue working despite health adversities, potentially exacerbating health conditions and perpetuating the cycle of vulnerability [28]. Migrants were dissatisfied with their accommodations abroad and working in a poor or impoverished work environment, which had a significant negative impact on their health and wellbeing [35].

3.3.2. Injuries Risks and Safety

Almost all studies reported common workplace-related injuries and accidents, including cuts, falls, road traffic accidents, faint/heat strokes, and fractures among migrants in Gulf countries and Malaysia. Women face elevated risks, with industrial activities as epicentres of perilous work environments [28,32–34,38,42,43]. Min et al. reported 33 cases of Nepali workers with work-related eye injuries, which were the result of being hit by a machine, nail, wood, or metal while grinding [34]. According to Latifi et al. [33], 40.5% of migrant workers suffered injuries as a result of road driving conventions (Table 2).

The construction sector has emerged as a key concern, with migrant workers experiencing higher rates of fatal and nonfatal injuries than their native counterparts. Al Thani et al. [31] reported that 28% of their study population experienced occupational injury. Among them, 52.4% experienced falls from heights, 20.4% had fallen on a heavy object, 17% had motor vehicle accidents, and 5% had machinery injuries. Moreover, Pradhan et al. affirmed that 12% of Nepali migrants had experienced workplace accidents while at work. Furthermore, a quarter (25%) of migrants faced some injury or accident at their workplace, with 19% having musculoskeletal problems, 40.2% having different types of cuts, and 20.6% having bone fractures or dislocations [32]. The study also reported that 13.9% of Nepali migrant workers had injury incidences [16]. The findings of Consunji et al. [28] highlighted the fact that Nepali migrant workers reported severe (18%) and mild work-related injuries (21%), resulting in low composure of healthiness. Moreover, the study also reported a rise in workplace accidents and injuries caused by risk-taking and pressure from senior staff or supervisors during their work [35,36]. These factors' confluence, however, contributed to unhealthy working conditions, increasing the risk of occupational injuries and compromising overall health outcomes [16] (Table 2).

3.3.3. Discriminatory Behaviours

Discrimination emerged as a pervasive and detrimental phenomenon afflicting Nepali migrant workers in various destination countries [13,38,40,42]. Due to enduring disparities in pay, bullying, and workplace abuse, migrant labourers from Nepal grapple with heightened levels of perceived discrimination, which significantly impacts their overall health and wellbeing [20,35,42,43,45]. Adhikari et al. found that work pressure and long working hours without adequate food and water intake resulted in heat stroke and dehydration. In addition, there was pay discrimination, with women being paid less than men [41,43] as well as not receiving the actual contracted amounts, such as when the contract was for US$ 200 but the worker was paid US$ 150 [32,42,45,47]. Furthermore, workplace discrimination against female migrants based on language proficiency, verbal or physical abuse, and sexual harassment by coworkers or site supervisors are examples of unfair treatment of these workers [32] (Table 2).

A recent mixed-methods study [13] found that 35% of Nepali migrant workers had faced verbal workplace abuse, with women also experiencing sexual violence that led to unwanted pregnancies. A study by Simkhada et al. [20] conducted among female returnee migrants found that 40.9% of Nepali female migrant workers reported workplace abuse, 1.2% experienced work-related injuries, 11.1% suffered physical harm, 30.8% faced torture or maltreatment at the workplace, and 3.1% had an unwanted pregnancy (Table 2). Notably, industrial and construction workers bore the brunt of discriminatory practices, underscoring the intersectionality of occupational hazards and socio-economic vulnerabilities [32,39].

3.3.4. Psychosocial Hazards

Adverse work environments characterised by limited support from peers, high emotional demands, and scant opportunities for professional growth precipitated a myriad of mental health challenges [29]. Gender disparities were evident, with women experiencing heightened psychiatric morbidity attributed to factors such as work dissatisfaction, pay discrimination, and abuses from coworkers [13,16,20,32,38]. Moreover, the data highlighted the profound impact of occupational stressors on physical and psychological wellbeing,

manifesting in cardiovascular conditions and psychiatric disorders among Nepali migrants [33,34,39,42].

A significant proportion of migrants exhibited resilience, returning to work despite diagnosed health ailments, indicative of the precarious balance between economic necessity and health imperatives [35,43]. Paudyal et al. reported sexual violence consequences where Nepali migrant women suffered multiple fractures to escape from sexual abusers and faced unwanted pregnancies. Nepali migrant workers who perceived a high level of work demand also frequently reported high levels of interpersonal and anxiety-depressive disorders [35]. Additionally, there have been cases of psychiatric disorders (schizophrenia, anxious-depressive disorders, or other psychotic disorders) resulting in limitations, prescriptions, or recommendations regarding work fitness [33,34,39,42]. Pradhan et al. [29] added that 9% of migrants had committed suicide while working abroad due to work-related stress. Insecurity and overcrowding in the accommodations were also reported as heightened psychological hazards. The threat of attacks or robberies in accommodations were also reported issues that directly impacted the workers' health and wellbeing [46]. Sharma et al. reported that more than one-third (34.1%) of workers lived with more than six people, ranging from 6 to 25 people, in one accommodation, and around 5% of workers reported sleeping less than four hours a day [37] (Table 2).

4. Discussion

The findings of this study shed light on the continued high prevalence of the occupational health hazards that Nepali migrant workers face, as well as an understanding of the multifaceted challenges that come with their job. This study contributes to the ongoing debate about the complex relationship between occupational hazards, working conditions, and health outcomes for Nepali migrants.

One notable observation from this review is the disproportionate burden of occupational health hazards borne by Nepali migrant workers compared to the native workers of the host country (e.g., Chinese, Hong Kongese) [39] as well as fellow workers, i.e., Indians, Indonesians, and Pilipino in Kuwait [47]. These workers are disproportionately engaged in manual labour or low-skilled occupations characterised by irregular work schedules, low compensation, longer hours compared to native workers, and a higher risk of psychological and physical injury. Findings aligned with the latest National Migration Report [49] and other literature also repeatedly reported that Nepali migrants encountered occupational safety hazards, poor working conditions, a lack of social protection, language barriers, and forced overtime labour while working abroad [14,50]. The Guardian newspaper also highlighted migrant workers' working difficulties in the article "*Have Qatar's work conditions improved?*" where the newspaper highlighted poor pay and long working hours, which were consistent with our review [51,52].

Workplace health and safety of migrant workers were also reported in European countries, where migrant workers faced several workplace problems such as harassment, racism, exploitation, and low salaries, which had a significant influence on the health and safety of migrant workers [53]. Similar problems were also noted in a previous systematic review and meta-analysis, which found that 47% of migrants had at least one occupational morbidity and 22% had at least one injury or accident, including cuts, fractures, dislocations, and falls from heights [15,54]. This implies that each destination country and organisation should explicitly mandate migrant workers' safety and zero tolerance for harassment and discrimination policies and guarantee their execution.

Findings showed that Nepali migrant workers frequently face serious health risks and poor working environment-related issues in their destination countries. Earlier studies also revealed that Nepali migrants are "disproportionately exposed to extreme heat" when they work outside in jobs like agriculture and construction, which can have detrimental effects on their health and wellbeing [14]. Furthermore, poor working environments have many adverse health effects, such as musculoskeletal injuries, kidney disease, dehydration, and pneumonia. Previous studies also documented similar findings among Nepali

migrants [55–57]. Surprisingly, Nepal has a higher proportion of heat-related health problems (26.7%) than India (15.6%), Bangladesh (19.2%), and Pakistani (19.2%) migrant workers working in Bahrain [30]. The study also found that Nepali migrants have a higher mortality rate from cardiovascular diseases in the summer than in the winter [29]. Addressing the climate-related drivers of migration must also be a priority to provide Nepali communities with viable alternatives to working abroad.

The results of this study showed that migrants typically worked in hazardous and exploitative conditions and had heavier workloads. This aligned with previous research, which showed that a large number of Nepali migrants work in "difficult, dirty, and dangerous" (3D) jobs, prevalent in low-skilled industries like construction, manufacturing, and hospitality, where workers face health risks from extreme heat, long workdays, heavy workloads, poor communication, abusive environments, and employers' unwillingness to handle work-related accidents quickly [14,50,54]. A previous study of Bangladeshi migrant workers working in Singapore's construction sector found increased workplace accidents due to poor communication [58]; similar issues have been documented among other Asian migrant workers [59]. Preventive measures, including identifying high-risk areas, improving safety training, bolstering equipment usage, and putting in place national surveillance systems, are crucial to reducing accidents and stopping worker fatalities.

Likewise, Nepali migrant workers frequently faced workplace discrimination, exploitation, abuse, and pay disparities, as well as verbal, emotional, and physical harassment, false accusations, and food deprivation. These behaviours exacerbated feelings of isolation and harmed overall wellbeing, raising the risk of poor mental health outcomes, including suicide [29,44]. A key factor contributing to this abuse is the unequal power dynamics between migrant workers and their employers [14]. A recent study showed that twenty percent of people had experienced workplace violence and harassment at least once in their lifetimes; males were slightly more likely to report such incidents (21.9% vs. 19.8%) than females. Around one-third of women who reported experiencing any form of violence or harassment had a sexual component (32.9%), and the foreign-born women had higher rates of workplace violence and harassment than their native-born counterparts (30.2% vs. 21.5%) [60]. Similar findings were also stated for Indian and Ethiopian women working in Middle Eastern countries [61,62]. This issue was not only raised in Middle Eastern countries but also among Mexican farmworkers in the United States, who face significant challenges such as anxiety, depression, low self-esteem, family dysfunction, ineffective social support, and suicidal ideation [63]. Nepali migrants, particularly women, are in a vulnerable position as they are isolated in foreign countries, have limited job mobility, and face financial difficulties such as affording a return travel to Nepal. This lack of bargaining power and social support leaves them susceptible to exploitation by unscrupulous employers [14].

Similarly, female migrant workers who worked in household settings in general were more likely to be exploited [20]. The employment regulations should be strengthened for the provision of safe work conditions, fair pay, and safe and fair accommodations, including the provision of wellness counselling services to prevent unintentional effects, i.e., suicidal attempts. Female Nepali migrant workers are severely mistreated in the United Arab Emirates. They were forced to work twenty-one hours a day without access to food, healthcare, or communication with their family and have their passports seized by their employers [64,65]. However, this was contrary to a study carried out in Korea. Migrant workers in Korea receive higher wages than in their home countries, and they frequently work in industries that require long hours of hard work, which can lead to injuries or even fatalities [44]. A Government of Nepal (2020) report indicated that the Middle East and Malaysia are the major destinations for Nepali migrant workers [66]. The Nepali government should have "government-to-government" contracts with the countries where the majority of female migrant workers are employed or seek employment to reduce workplace hazards and protect workers' rights. On the other hand, more effective lobbying is needed from international organisations such as the International Labour Organisation

(ILO) and the International Organisation of Migration (IOM) to safeguard the health, well-being, and human rights of migrant workers. Moreover, a large-scale longitudinal study is, in fact, necessary to comprehend complex dynamics and create guidelines for interventions to address the burdens of workplace hazards for migrants. Implementing a comprehensive strategy combining policy advocacy, research, and targeted interventions can promote equitable and healthy working conditions for migrant workers, thereby achieving the United Nations' sustainable development goals by 2030 [2].

4.1. Implications for Policy and Practice

The results of this review have the potential to inform the Government of Nepal and other relevant parties, encouraging them to update and enhance evidence-based migration and integration policies and practices. Establishing a national Centre for Migrant Health would significantly improve policy and practice, as it has been done successfully in countries like Norway, Denmark, and Macedonia [67]. The establishment of such a centre would be significant for migrants because more than three million Nepalis work abroad. It is critical to improve migrants' health and wellbeing and also strengthen diplomatic ties with destination countries. Migration health centres should closely monitor and regularly share the key findings in policy briefs so that the government can promptly take the necessary action to improve the health of Nepali migrants.

4.2. Strengths and Limitations of the Study

The current study had several strengths and limitations. To the best of our knowledge, this is the first scoping review that examines the extent, range, and nature of published studies reporting occupational hazards in the workplaces of Nepali migrant workers. The findings also shed light on the occupational hazards Nepali migrants face in the workplace. It emphasises the importance of developing targeted interventions to improve the health and safety conditions of both male and female migrants working abroad.

A number of limitations in this study need highlighting. Our review included a broad range of published peer-reviewed literature, and we excluded grey literature, including reports, books, theses, and dissertations, potentially missing out on valuable insights. As a result, relying solely on peer-reviewed literature may have limited the range of perspectives considered. There was heterogeneity among the studies regarding sample size, recruitment strategies, and methodological approaches. However, we did not assess the methodological quality of the included studies, as this was beyond the scope of this scoping review. This study's focus on Nepali migrant workers may limit its applicability to broader migrant populations, potentially overlooking insights from other working groups facing similar occupational health issues. Similarly, including only published literature in English may have limited the scope of our findings. Although the study provides valuable insights from mixed-methods (either quantitative, qualitative, or both) research, its methodology and scope may limit its generalisability and applicability to larger migrant populations.

5. Conclusions

This review identified workplace injuries and accidents, poor working conditions, and various forms of abuse, including sexual and torture, as key occupational health hazards for Nepali migrant workers. Research on the occupational health risks faced by migrant workers highlights the need for an international response to address unsafe working conditions and mitigate poor health outcomes. Intervention studies and firm policies are essential for protecting these workers, ensuring equitable healthcare access, and preventing and monitoring occupational hazards. Increased social protection measures and compensation for migrant workers, especially female workers, are necessary to protect their rights and well-being in the workplace. Nepal and the host countries should strengthen policy enforcement, enact necessary legislation, and improve preventive measures to mitigate accidents and injuries. More effective lobbying is needed from international organisations like the ILO, IOM, and workers' rights organisations to safeguard the health,

wellbeing, and human rights of Nepali migrant workers working abroad. The findings of this review emphasise the need for targeted interventions to address workplace hazards, and future targeted research is also needed to understand better Nepali migrant workers' workplace safety and health outcomes in Malaysia and Gulf countries, including new destination countries, i.e., Korea and Israel.

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