Health Issues among Nepalese migrant workers in the Middle East

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Abstract

Background: There is little specific published research which examines the health issues among Nepalese migrant workers in the Middle Eastern countries. In particular, it examines the nature and quality of health care situation, work-related health risks, working condition and living condition in host countries.
Aim: This study reviewed the literature about work-related health risks, access to health care, working and living condition of Nepalese migrant workers in the Middle East.
Method: The published literature was searched through electronic databases such as CINAHL and Medline using a number of key words and their combinations, and the searching of published books and reports from number of UN agencies. Bibliographies of published articles retrieved from electronic database searches were searched in turn, and relevant articles retrieved for further review.
Results: This review of the literature suggested that being a migrant worker involves number of specific risks, including anxiety, depression, tuberculosis and eye injury. In addition to this, work-related accidents and injury, headache, suicide attempts, cardiac arrests, mental illness and high death rates are further evidence of health risks among Asian migrant workers working in the Middle East. Furthermore, these workforces generally have poor working and living conditions.
Conclusion: Migrant workers mainly from Nepal and other Asian countries, working in the Middle East face various work-related risks including accidents at work; stress and mental health issues and lifestyle related factors such as illegal drinking. Thus, future research needs to focus attention on minority ethnic groups in the Middle Eastern countries.

Key words: immigrants, emigrants, migration, health risks, Nepal, Middle East, construction, agriculture, mining

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Background

An estimated three percent of the global population moves outside their country of birth, often for economic reasons[1]. International mobility has more than doubled over the past four decades, increasing from about 82 million in 1970 to 200 million in 2005[2]. Migrants move to both developed and developing countries. Nevertheless, a majority (60%) settles in developed countries. The largest single majority of migrant has settled in Europe, followed by Asia and North America; in 2000, Europe received 56.1 million migrants, Asia 49.9 million, North America 40.8 million, Africa 16.3 million, Middle East around 16.00 million[3], Latin America 5.9 million and Australia 5.8 million migrants[2].

Looking at individual host countries, it is clear to see that the majority appear to settle in the USA (United States of America) (20%) followed by the Russian Federation (7.6%), Germany (4.2%), Ukraine (4%) and India (3.6%)[2]. Approximately one-third of all migrants live in only seven developed countries. Although the vast majority of migrants have moved legally, some migrate illegally. For example, approximately 200,000 unskilled migrants entered Japan illegally during the 1980s and 1990s[4]. It is interesting that there are nearly as many female migrants (48.6%) as males[5]. The proportion of female emigrants is higher than men from Latin America, North America, Oceania, Europe and the former Soviet Union[2]. Considering the countries from where migrants originate from, in 2000 some 35 million people migrated from China, followed by India (20 million) and the Philippines (7 million)[2]. It is estimated that nearly half (100 million) of the 200 million people living outside their country of birth, are economically active and engaged in the workforce. The foreign-born workforce in western European countries appear to be lower (e.g. 15% in Ireland, 25% in Switzerland and 40% Luxembourg)[6] than the foreign-born workforce in some Middle Eastern countries (e.g. 90% in UAE and Qatar and 60% in Bahrain and Saudi Arabia) [7]. The paper reviews academic literature around migrant labour in the Middle East, focusing in particular on the health status and risks of Nepalese migrant workers.

Materials and methods

Electronic databases, for example, Medline, Global Health, CINAHL and Google Scholar were accessed to search for electronic journals and reports using keywords such as immigrants, migration, health risks, Nepal, Middle East, construction, agriculture and mining. Likewise, relevant reports and papers published on websites pages from the World Health Organization (WHO), the Human Development Report (HDR), the International Labour Organisation (ILO), the United Nations Population Fund (UNFPA), and the United Nations Development Programme (UNDP) were also accessed for relevant reports and papers. Published and unpublished organisational reports and other relevant articles have also been included in this review paper. The review covers the period 1984-2010.

Reasons for migration

Prospects of better opportunities and earning a guaranteed income to support one's family are key reasons for migration, especially for emigration from the developing countries[8]. The Middle East is one of the major migrant receiving regions of the world. Millions of Asian migrants immigrated to the Middle East due to the oil boom in the early 1970s. By the 1980s, the majority of temporary workers (over 80%) in the Middle East had come from Asia (20% from India) compared with just 13% from elsewhere in the world[9,10]. Similarly, in 2004, almost 7 out of ten of the workforce in the Gulf States: Saudi Arabia, Kuwait, Bahrain, Qatar, the United Arab Emirates (UAE) were foreigners – taking Qatar and UAE by themselves, 90% of their workforce are foreigners[5]. The participation of women in the workforce in Gulf countries is far less than that of men. In 2004, between 10-25% of foreign women

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were part of the expatriate workforce, whereas only 2-10% of women nationals were part of the workforce in these countries[5]. Host countries often perceive migrants as exploitable, cheap and flexible labour and employ them in 3-D jobs - Dirty, Dangerous and Degrading'[6]. Underpaid and without workplace safety and health protections, migrants are easily hired and fired; put another way, there are vulnerable[6].

Migrants' Health status and risk

Migrants are also vulnerable in terms of their health status. Migration has created health care challenges in both countries of origin and destination. Migrants can face serious health problems due to discrimination, language and cultural barriers, their legal position, and their low socio-economic status[11]. Their previous medical history, nature and quality of health care and the social and health characteristics of re-settlement can also determine the health status of migrants[12]. Migrants' health status is also a function of the policies and practices that surround migration[12]. One New Zealand study has revealed that the increased anxiety and depression among immigrants can be due to feelings of discrimination, lack of close friends, unemployment and spending most of their time with their own ethnic group[13]. A recent study concerning the health and lifestyle of Nepalese migrants in the United Kingdom (UK) has found that migrants with low levels of education and poor immigration status (e.g. refugee/asylum seeker) are more likely to lack good dental hygiene and regular exercise[14]. A study about Nepalese migrants in India has suggested that migrants (male labour migrants and female sex workers) who have returned from India are highly vulnerable to HIV and AIDS[15].

Research in India has highlighted that an increasing prevalence of skin diseases among migrant construction workers, who work in a hot and humid climate and in over crowded and unhygienic working conditions[16]. Asian migrant construction workers working also face a higher risk of occupational accidents compared with the general population[17]. Several studies in the USA have revealed that migrant farm workers confront high risks of tuberculosis, eye injury and pain[18,19]. Migrant workers working in mining industries also face adverse health conditions. Indian gypsum mine workers face a high risk lung function impairment, pulmonary restrictive impairment, musculoskeletal symptoms, hypertension and diabetes[20]. And a study of men from Botswana working in South African's mining industry has highlighted revealed that the majority of workers have had tuberculosis and a disabling occupational injuries[21].

Migrant workers in the Middle East

Similar to other countries receiving large number of immigrants, migrants in the Middle-East also face difficulties in adjusting to their new society including adopting safe and healthy lifestyles. A study of Middle Eastern immigrants from Asia has found that migrants from poorer groups are at a higher risk of mental illness due to their living and working conditions[22]. Moreover, female migrant workers are at a high risk of physical, sexual and verbal abuse[22,23]. A review on occupational injuries in Bahrain has revealed that immigrants work with high risks of having accidents than national workers and that this risk is high still for immigrant construction workers[17]. Research carried out among Filipino home-care workers in Israel has concluded that workers are at a high risk of workplace injuries, verbal abuse and hunger[24]. A further study with Israeli Arabs has shown that HIV prevalence is lower in Arab Israelis than it is in non-Arab Israelis and Arabs residing in neighbouring countries[25]. Similarly, the proportion of the prevalence of pulmonary tuberculosis among migrant workers in Kuwait is higher than the general population[26].

Prevalence of mental health symptoms and higher levels of anxiety, depression and posttraumatic stress have been found in Iraqi refugees, more so than in the general USA population[27]. The prevalence

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of tuberculosis among Asian migrants (mainly from India, Pakistan and Nepal) working in Qatar's garment industry is high[28]. Similarly, lower urinary tract symptoms, especially storage symptoms, are common in young male immigrants (mostly of Indian origin) in Qatar[29]. In addition, a study of immigrants in food handling occupations has revealed that those immigrants from the Indian sub-continent and the Philippines are more likely to carry hookworms[30]. A recent study about Nepalese migrants in the Middle East has shown that migrants working in agricultural and construction industries are at a higher risk of accident and injury[31]. Likewise, another observational study among Nepalese workers in Qatar has found that Nepalese are importers of Hepatitis E in Qatar[32]. News from the popular press based on the case histories and experiences of female migrants returning from Gulf countries highlight that they can be physically, mentally and sexually exploited by employers and suffer from mental disorders, such as psychoses, severe depression and schizophrenia; most women do not have a limit on their working hours and are often not paid the salary agreed with the recruitment agency prior to their departure[33].

Nepalese migrant workers

There are an estimated 2.2 million Nepalese migrant workers, many of whom work in India, however, a large number work in the Middle Eastern oil industry[34]. There are several serious cases of the situation of Nepalese migrants working in unauthorized countries without any legal or social protection by the host countries, for example, the massacre of twelve Nepalese workers by an Iraqi extremist group in 2004[35]. Moreover, more than five hundred Nepalese migrant workers have died in the Gulf region owing to workplace-related accidents and mental illness (including suicide), poor labour conditions (e.g., a lack of safety standards and formal labour relations). These may have contributed to higher mortality rates for Nepalese migrants in this region[36]. More recently, 24 Nepalese workers died in Qatar in a five week period due to cardiac arrests, respiratory diseases, kidney failure, heart attack, road accidents and committed suicide[37]. Media coverage about migrant workers in Qatar has included the death of 12 Nepalese and 11 Indian cleaners on a capsized ship also in 2009[38].

Work-related accidents, deaths and suicides are common in the Gulf countries. It is estimated that two Asians die per day on the Dubai construction sites and one case of suicide occurs every four days[39]. There were 67 Indian suicides in Dubai and the northern emirates in 2004 where as in UAE 100 Indians died in a twelve month period between 2005 and 2006[39]. Independent research has found that 880 migrant construction workers (India – 460; Pakistan – 375; and Bangladesh – 45) died in UAE in 2004, yet the Dubai Municipality recorded only 34 deaths in the same period[40]. During the same period, the total number of deaths of Nepalese migrants in UAE was 30, but in 2005 just one construction-related death was reported. Again, during 2005, the Embassy of Nepal in UAE reported the deaths (cardiac arrests) of 13 immigrants, seven suicides, seven fatal road accidents and two deaths of unknown causes[39].

Anecdotal evidence has suggested that the reason for the high mortality rates of Nepalese workers is because of excessive intake of home made alcohol and the risky nature of many jobs. The most recent study about Nepalese migrants in the Middle East has found that many Nepalese have been working in risky occupations (e.g. agricultural and construction work) and about one in four migrants face accidents and injuries during their work[31]. Likewise, very few migrants have been provided with safety training and most of them do not have private health insurance[31]. In other words, the rates of accidents, deaths and suicides among migrant workers are high and far too high in the Gulf countries. This background literature give credence to the focus of research related to the health of immigrants in the Middle Eastern countries.

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Being away from family and social control

The nature of migrant work generally increases the chances of immigrants engaging in risky sexual practices, as they are separated from regular sexual partners for long periods. As migrant workers are away from their local community and its social control; they can experience what has been termed 'situational disinhibition'[41]. The exploits of migrant workers[42] can be compared to those of long-distance lorry drivers[43], whilst migrants working in the tourism industry meet both tourists and locals[44] which can lead to sexual contacts.

Conclusion

Although the health risks and vulnerability of migrants have been well documented throughout most of the world, few studies have been conducted among minority ethnic groups in the Middle East countries. The issues of migration as well as policies to address them are complex. Lack of legal protection by the migrants sending countries government or the host countries' government may have adversely affected migrants' health and wellbeing. Future research needs to focus attention on minority ethnic groups in the Middle Eastern countries.

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