



ARTIGOS

HEALTH CONCERNS AMONG SRI LANKAN FEMALE FOREIGN DOMESTIC WORKER RETURNEES FROM THE MIDDLE EAST

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ABSTRACT

Female foreign domestic workers (FDWs) are an important and growing occupational group, especially in the Middle East. Although Sri Lankan female FDWs comprise a significant percentage of those employed in this region, little is known about the health issues this population experiences during their employment. Prompted by this dearth in the extant literature, this study aimed to explore self-reported health problems and perceived causes, as well as health behaviors, beliefs, coping, and concerns of Sri Lankan female FDWs through the narratives of returnees formerly employed in the Middle East. Implementing a multi-faceted qualitative approach, focus group discussions and in-depth interviews were utilized to investigate FDWs' health problems, behaviors, and coping mechanisms. Participants' health beliefs and concerns were explored through free listing and pile sorting. Data was analyzed using thematic analysis and descriptive statistics. Headaches, backache, irregular meals and symptoms of depression were the most frequently self-reported health issues, most commonly attributed to overwork. Cleanliness was the most commonly adopted health maintaining behavior. The presence of cultural health beliefs in terms of illness causation was revealed, and FDWs' spoke of the perceived health benefits of social interaction and religious practice as coping strategies. Findings of this study have several implications for policy and future research. FDWs' concerns and recommendations prompt the need for greater accountability, legal enforcement of policies, and strengthened training and health monitoring. Policy, prevention and intervention measures may be more effective if they consider FDWs' self-reported health problems, health belief models, health maintaining behaviors, concerns and coping strategies.

Keyword:

Health; female workers; migration; Middle East.



INTRODUCTION

The global economy has become increasingly dependent on transnational migration, particularly for domestic labor. Foreign domestic workers (FDWs)—who provide various domestic services outside of their native countries—are recognized as an important occupational group in that regard. Of the 11.5 million foreign domestic workers worldwide, most (73.4%) are female and are employed in South-East Asian, Northern, Southern and Western European, as well as Middle Eastern countries¹. 27.4% of all FDWs work in the Middle East—an area which boasts the highest share (60.8%) of female FDWs among all migrant workers¹.

Beyond directly financially supporting their families, FDWs provide a steady influx of foreign earnings to lower-income, labor-sending countries². FDWs also contribute to development within their native countries by providing “social remittances” in the form of knowledge, skills, ideas, advocacy and political activism³. Furthermore, female FDWs enable women in labor-receiving countries to seek employment themselves^{2,4}, by taking over household duties. As resident aliens in these countries, however, they are afforded fewer rights

than native workers and little legal protection^{5,6}.

The International Labour Organization considers female FDWs to be vulnerable, and recognizes their susceptibility to a number of occupational health risks⁷. Language and other cultural barriers, employment in a private setting, social exclusion and restriction on movement, various forms of discrimination, lack of access to medical care and benefits, involvement in arduous and perilous work, overwork and lack of respite, and various forms of abuse and exploitation all pose threats to their health and safety⁸. Thus far, much research has been focused on their adverse work and living conditions, infringement of rights and maltreatment, as well as on the political and legal frameworks of foreign domestic service⁹⁻¹¹.

While these efforts provide a better understanding of the plight of FDWs, much needed research that examines the occupational health problems FDWs experience is lacking at present. A review by Malhotra et al. (2013)⁵ found only 32 relevant studies published between 1990-2013. Among these, nearly half reported adverse work conditions and related health problems⁵. Inadequate work conditions

included long work hours, little to no rest, irregular wages or denial of payment, restricted mobility and social interaction, deprivation of meals and limited access to medical care⁵. Female FDWs reported back and joint pain, injuries, headaches, musculoskeletal, respiratory, skin and dental issues, as well as verbal and physical abuse⁵. Second most common were studies on mental health issues and risks leading to their manifestation⁵. The latter included various neurotic, psychotic and mood disorders, stress-related disorders, delusions and hallucinations, and symptoms of depression⁵. Social isolation and worrying about one's family were found to be major risk factors for mental health issues⁵. A few studies focused on infectious diseases and health knowledge, attitudes and practices, namely in regard to sexual and reproductive health⁵. Only a single study reported on medical care seeking practices and treatment⁵. A noteworthy finding overall is that many of the health problems prevalent among female FDWs were caused or exacerbated by their work⁵.

Despite its relatively small size, Sri Lanka is one of the most influential labor-sending countries for foreign domestic employment, particularly to the Middle East. Lack of employment opportunities, low income, and

gender inequality in the economic sphere compel Sri Lankan women to enter foreign domestic service. Sri Lankan women have a low labor force participation (35.9%), and an unemployment rate (7%) more than double that of men¹². Sri Lankan women also earn significantly less than men, and among the low-skilled and low-wage occupations available to them, foreign domestic service dominates⁹. As FDWs, women can potentially earn two to ten times more than they can in Sri Lanka⁹. In 2016, 34% of migrants who left Sri Lanka to work abroad were women, and 78.8% of these women sought employment as "housemaids"¹³. That same year, "housemaids" accounted for 26.8% of migration for foreign employment and 96.9% of these women went to the Middle East¹³. Considering the substantial number of Sri Lankan women who work as FDWs, little effort has been made to better understand and prevent their health problems. Particularly, given the high concentration of Sri Lankan female FDWs in the Middle East, it is important to examine their health situation more closely.

While some previous studies have included Sri Lankan FDW participants, only two of the 32 studies reviewed by Malhotra et al. (2013) were exclusively focused on this

group—neither of which examined their health problems⁵. However, they did report various forms of abuse, restrictions on meals, mobility and social interaction, and exploitation of their labor rights in terms of work hours, wages and legal documentation⁵. The studies that included Sri Lankan FDWs employed in the Middle East concentrated on the prevalence of mental disorders and risk factors among female FDWs hospitalized for psychiatric treatment⁵. Most (49.2%) of hospitalized FDWs (53.3% of whom were Sri Lankan) were diagnosed with acute stress reaction and adjustment disorder¹⁴. Age, ethnicity, religion, education level, and history of previous illness were identified as risk factors for psychiatric disorders¹⁵. Language barriers and insufficient social support were suggested as explanations of the high rates of mental health issues among Sri Lankan FDWs in particular¹⁵. Psychosocial stressors related to payment, work conditions, and contact with family were most frequently reported¹⁶. Among these stressors, harassment was most influential for acquiring stress-related disorders and receiving less pay than expected was most strongly related to the development of other psychiatric disorders¹⁶.

Research on the health beliefs and health maintaining behaviors of Sri Lankan female FDWs has been particularly scant. One study on female migrant workers (only some of whom were FDWs and of Sri Lankan nationality) employed in Hong Kong found that although 84.1% of the women believed that those in their profession should be concerned about HIV/AIDS, the majority did not believe they were at risk (63.3%) and felt that they lacked enough knowledge to protect themselves (62.2%)¹⁷. In fact, 61.4% of women reportedly were not aware of the availability of AIDS-related information¹⁷. Although there is no research exploring the coping mechanisms of Sri Lankan female FDWs specifically, findings of studies on FDWs of different nationalities suggest the importance of religious belief, practice and social interaction. Among Filipino migrant workers (mostly female FDWs) in Hong Kong, religion was found to be important for coping through prayer and social networks in the religious community¹⁸. Migrant workers mentioned the perceived positive psychological benefits of engagement in religious activities as well¹⁸. In another study on stress and coping among Filipino female FDWs, praying and reading the Bible (55.2%) were most frequently reported, and in terms of social support, women would most often talk with friends (27%) to

overcome hardships¹⁹. Among Ethiopian female FDWs formerly employed in the Middle East, social networks and interaction with other Ethiopians by exchanging information and advice, as well as practicing religion together, allowed FDWs to cope with cultural isolation and brought them comfort²⁰. Finally, among Filipino, Indonesian and Burmese female FDWs employed in Singapore, prayer was the most commonly relied on coping strategy and faith overall was believed by FDWs to aid in prevention of suicidal ideation and suicide attempts²¹.

Although female labor migration has been continuously encouraged in Sri Lanka²² and given the societal and economic contributions of female FDWs, more concerted effort, devoted to the protection of the health of female FDWs informed by an in-depth understanding of their occupational health problems is lacking. At present, there is a dearth in the extant literature in terms of research focused on Sri Lankan FDWs, particularly those employed in the Middle East. Moreover, of those studies that have included this population, the majority have leaned toward a quantitative approach. Evidence from these studies points to the adverse health of this occupational group, and previous

research on female FDWs as a whole suggests the influence of the nature of and circumstances surrounding foreign domestic labor on such health outcomes. Given this, the primary aim of the present study was to conduct formative research that qualitatively explores the potential effects of the foreign domestic employment experience on the health of Sri Lankan female FDW returnees from the Middle East.

Led by an interdisciplinary team of researchers from population health, health services research, occupational and women's health, the study implemented focus group discussions, in-depth interviews, free listing and pile sorting to investigate Sri Lankan female FDWs' self-reported health problems, perceived causes, as well as health beliefs, health maintaining behaviors, and coping mechanisms. The researchers also sought to gain insight into FDWs' perceptions about foreign domestic service, common and concerning health problems among their population and their potential causes. By exploring the narratives of Sri Lankan female FDWs, the study allowed them to share their experiences and voice their opinions and concerns. Finally, the present study proposes recommendations for policy changes and further research based on findings.

Materials and Methods

STUDY	SITE,	PARTICIPANTS	AND
RECRUITMENT			

This study implemented a qualitative approach combining focus group discussions (FGDs), free listing, pile sorting, and in-depth interviews (IDIs) with a total of 25 Sri Lankan female FDW returnees previously employed in the Middle East. Due to the often secluded and constrained environment in which female FDWs work, recruiting returnees residing in Sri Lanka, rather than FDWs currently employed in the Middle East, was deemed to be the most viable method of fostering an environment where participants could openly share their experiences. Conducted in Galle District, Sri Lanka—a region populated by approximately 1,063,300 people, who are concentrated (approximately 86%) in rural areas¹², the study was carried out over a period of three months. According to the most recent statistics, Galle District has the highest departures of women seeking foreign employment as “housemaids” in the southern province of Sri Lanka (3,144 departures)¹³. Nearly 78% of women who leave Galle District to work abroad seek

employment as FDWs, and almost 5% of Sri Lankan FDWs come from this area¹³. For this reason, Galle District was selected as the appropriate study site due to its economic influence in Sri Lanka as a whole, particularly in the southern region.

Within Galle District, four Medical Officer of Health areas were purposively selected, representing each of the urban, semi-urban, rural, and estate regions. The Medical Officer of Health from each area designated two public health midwives, each of whom recruited three female FDWs through home or clinic visits. As respected members of the community, public health midwives were identified as the most apt individuals to recruit participants for this study. Eligible participants included Sinhala speaking women over 18 years of age, who were previously employed as FDWs in the Middle East and returned to Sri Lanka under normal terms of their contract. In this way, the researchers aimed to obtain a heterogeneous sample, allowing for maximum variation, to find common, shared experiences²³ among a group of women diverse in terms of age, education level, and history of foreign domestic employment.

STUDY INSTRUMENTS AND DATA COLLECTION

Interview guides for the FGDs and IDIs were first developed in English, then subsequently translated to Sinhala and pilot-tested with two former female FDWs for cultural validity. Materials for the pile sorting activity were also translated in the same vein. Data collection alternated between FGDs and IDIs, with two IDIs following each FGD. Each session was conducted in Sinhala, with a lead facilitator and two moderators, and was audio-recorded and supplemented with detailed notes. The study was approved by the Ethics Review Committee at the University of Ruhuna and the Institutional Review Board of Duke University.

Four FGDs were conducted with six to seven participants in each session. After obtaining written informed consent, demographic information was collected verbally and noted. The FGD guide consisted of a series of open-ended and sample probing questions that delved into participants' reasons for becoming FDWs, perceptions of the occupation, their employment experience, and perceptions of what it means to be healthy and the effects of their work on their health. Participants were also asked about their opinions on the future of

foreign domestic employment and how the health and work conditions of FDWs could be improved.

Free listing and pile sorting activities were incorporated into the focus group sessions. For the free listing activity, participants were given a blank sheet of paper and asked to list as many health problems they could think of that are caused by foreign domestic work, including the perceived causes of each problem. For the pile sorting activity, health conditions found to be common among female FDWs, based on the extant literature, were listed on individual pieces of paper. Participants were paired up and asked to sort these according to how common and, subsequently, how concerning they were perceived to be. The resulting piles from each stage of sorting were collected and recorded.

Based on their demographic characteristics and responses during the FGDs, eight FDWs were selected for individual IDIs. Through purposive sampling, we sought to interview both women with seemingly positive experiences working abroad and those with negative experiences (i.e., exploitation of some sort or health problems acquired). The IDI guide included an assortment of questions largely focused on the

participants' work conditions, job satisfaction, interaction with other FDWs, as well as recommendations and health advice to other FDWs. Greater emphasis was placed on participants' individual health, health maintaining behaviors, and the perceived influence of interaction with others on their health.

DATA ANALYSIS APPROACH

After data collection, detailed notes from FGDs and IDIs were compared with the audio recordings. Subsequently, full English transcripts were obtained and compared with these notes. Data collected from the free listing activity and the pre-session demographic survey were translated to English and reviewed at the end of each session. Firstly, data was reviewed for preliminary analysis and validation. An initial list of codes was then generated and subsequently sorted into potential themes by the first and second authors. Through a multistage review of the data, codes and themes were reviewed several times until a final list was agreed upon, and salient quotes were selected for each theme. Utilizing a hybrid approach to thematic analysis, identification of themes was both data-driven and theoretical. The quantifiable results of the free listing and

pile sorting activities were analyzed for frequency distribution. Complementary to the FGDs and IDIs, the qualitative aspects of these methods allowed the researchers to gain insight into what FDWs from this population tend to believe are prevalent occupational health issues among women of their profession, the most attributable causes, and health problems they are concerned about. Previous studies have touted the benefits of using free listing and pile sorting to qualitatively explore participants' perceptions on a particular research topic^{24,25}.

Results

PARTICIPANT CHARACTERISTICS

The majority of participants (see Table 1) in this study were previously employed as FDWs in only one country (36%) and worked for a period of less than five years (80%). Overall, Kuwait (56%) and Saudi Arabia (52%) were the most frequent countries of employment. With a mean age of 45.1 years (SD = 12.2), the majority of participants had children (88%) and were married (96%). The largest portion (36%) of the FDWs had attained education up to the middle school level and 80% were unemployed at the time of data collection.

Characteristic	Number	Percentage	Mean (SD)
Age (years)			45.1 (12.2)
20 – 49	13	52	
< 50	12	48	
Education level			
Primary	5	20	
Middle (Junior Secondary)	9	20	
Secondary (Senior Secondary)	4	16	
Post-secondary	7	28	
Marital status			
Married	24	96	
Single	1	4	
Children			2.5 (1.1)
Yes	22	88	
No	3	12	
Number of countries of previous employment			2 (0.8)
1	9	36	
2	8	32	
3	8	32	

EMERGENT THEMES

Eleven themes emerged in analysis of participants' responses during FGDs and IDIs. Those related to FDWs' health (including problems, causes and management) as well as their views on work conditions and living environments are highlighted in this paper. These themes were salient with regard to the impact of employment on FDWs' health, concerns about health problems or risks of illness, and FDWs' thoughts on improvements. The researchers also focused on the potential of these perspectives to inform future research and policy reformation.

Overall, Sri Lankan female FDWs in this study performed a variety of duties, including cooking, cleaning, washing, taking care of employers' family members, and grocery shopping. Many participants had positive expectations in terms of workload, but later felt overworked. Although not all had negative experiences, there were many accounts of inadequate living conditions and maltreatment. Many FDWs found themselves unable to eat or sleep properly, or get any rest. Some women also experienced restrictions in their communication with family, interaction with others, religious practice and mobility. Maltreatment took

the form of verbal and physical abuse, being confined to the home, scolded for not understanding the local language, threatened to be sent away and having their salary confiscated, as well as being asked to convert or having to hide their religious identity. Some women were monitored by cameras in the home, had their phone conversations recorded, their food restricted, or their passports and personal documents seized.

SELF-REPORTED HEALTH CONDITIONS ATTRIBUTED TO FOREIGN DOMESTIC EMPLOYMENT

Many participants felt that working as a FDW had adversely affected their health, reporting single to multiple health problems during FGDs and IDIs. Some women recovered upon their return home, while for others the conditions persisted. Among those who had health issues, some felt strongly about the effect of their employment. Reflecting on her experience, one participant reported:

“Sometimes if I have some health problems that I think are due to my foreign employment, I think about why I went for foreign employment. That is a harm that I have done to myself.”

The majority of health problems participants experienced were related to both physical and emotional health. Among these, back pain, headaches, and symptoms of depression (i.e., feeling sorrow or sadness, regret, loneliness, crying, or being in a bad mood) were most commonly mentioned during FGDs and IDIs. For one FDW, arduous physical labor caused her backache:

“It was very difficult for me to wash their carpets. When their carpets were soaked in water, they were very heavy, but I didn’t receive any assistance from them. So, ultimately, I got a backache.”

Insufficient sleep or food deprivation, along with irregular meals, were reported by a majority of participants. For some, eating irregularly or insufficiently was attributed to overwork or employers’ restrictions. One woman described the measures she took to find food:

“I didn’t have enough food. I had to ask for food from my other friends from Sri Lanka. That’s how I survived. I brought that food home and took it to the bathroom and had my meals inside the bathroom. If they went somewhere, they kept me inside the house, locked, and would go. If they brought something home, like fruit,

they counted it and didn’t allow me to eat those things. When they went somewhere, they closed all the rooms in the house, except the kitchen. Even in the kitchen they counted the number of goods, to know whether I ate them or not. I felt like coming back, but they had my passport in their custody, so I couldn’t come back.”

FDWs also reported various workplace injuries, skin irritations, cough, cold, fever, wheezing and asthma, gastritis, allergies, generalized body aches, and weight gain. Suicide attempts and threats to sexual and reproductive health, including a few cases of attempted sexual assault, were less commonly reported.

Participants attributed their physical and emotional health problems to their work conditions and living environment, with overwork (including strenuous labor) emerging as the primary cause of many issues. One FDW explained how overwork caused her negative health outcomes:

“I worsened my health status after going there, because I had to work hard, and I had to climb up many stairs daily. Even doctors told me I got ill because I worked hard. And I had to lift heavy weights, so I had this knee

problem and I became obese at work because we didn't have rice to eat and we were eating their foods, which were not suitable for us."

For another, overwork affected her lifestyle and, in turn, had an impact on her mental health:

"I overworked there, and my sleep was lessened, so my mental health was not good at work. So, I had worries about that."

Headaches and depressive symptoms were believed to result from worrying, thinking of one's family, being scolded, or feeling underappreciated by one's employer. Backache, leg or knee joint pain were ascribed to overwork, lifting heavy objects, or walking and standing for too long.

While the majority of FDWs reported having insufficient or irregular meals, some complained of weight gain caused by overeating, change in diet, oily food, and a lack of staple foods. Gastritis was attributed to spicy food and lack of food or skipping meals, while eating fish or other types of meat and oily food was believed to cause illness in general. Cooking or handling appliances caused burns, electric shocks and accidents for some. Use of cleaning

products resulted in wheezing, skin irritations and allergies in particular. Several FDWs had difficulty adjusting to climate change and living in an air-conditioned environment, which were considered causes of asthma:

"We are not used to staying in air-conditioned rooms, so it badly affects our health. I had a lot of wheezing there. Also, I had to clean bathrooms with detergents. Those detergents, liquids, and powders--I was allergic to those things, so I had allergy problems."

HEALTH BELIEFS, BEHAVIORS, AND EXCHANGE OF ADVICE FOR HEALTH MAINTENANCE

During FGDs, the participants reflected on what it means to be healthy and ways in which they maintained their health. Their responses were not exclusively focused on health in the sense of physical and mental well-being. For some, being healthy means being able to rest, engage in a pastime activity, and live freely. Many stated that being able to do one's work, being clean, and not being ill mean that one is in good health:

“Good health is absence of diseases and being able to work properly at the place that you are going to work.”

FDWs viewed health as important for their work efficiency, economic well-being, happiness and self-empowerment, as well as providing for their families, and not troubling others with health problems:

“I protected my health because I wanted to work hard, I wanted to lead a good life, and I wanted to earn money. If I am healthy I can earn money.”

Poor health was expressed as potentially leading to financial problems, becoming more “sorrowful” and helpless, and causing one’s family to suffer.

Cleanliness was the most prevalent health maintaining behavior adopted by FDWs, whether self-initiated or advised by their employers. Participants also mentioned using skin creams, drinking milk or tea, practicing religion or engaging in leisure activities, resting, and eating properly. One FDW described her approach to health maintenance through nutrition:

“I developed healthy behaviors. I used to eat vegetables and fruits, so that

improved my health. And I was very clean, so that I could improve my health.”

In order to maintain a healthy diet, some women cooked separately for themselves, obtained food from other FDWs or took healthy food that was restricted or unavailable to them:

“I used to steal their fruit and eat it, because we’re not allowed to eat fruit. I stole nutritious foods and had those things as my meal. I stayed clean. I washed my body and I applied available creams to maintain my health.”

Participants said they did not need to exercise given their physical activity at work. Some FDWs mentioned receiving health advice from their employers or peers, including which foods to consume and which to avoid.

Participants also gave their recommendations for how other FDWs could maintain their health. Women particularly advised others to stay clean, eat properly, rest, get enough sleep, practice their religion, and drink milk or tea in the morning. One FDW spoke of making time for oneself to achieve this:

“We need to consider our own health. If they ask us to get up at 5:30 AM, we need to get up at 5:00 AM to clean ourselves and do something to help ourselves.”

Some added that FDWs should work together to make up for any lack of food, dress warmly, protect their skin, get medical treatment, and avoid sugar intake, cold drinks and overeating.

ACCESS TO MEDICAL CARE, TREATMENT OF HEALTH PROBLEMS, AND REPERCUSSIONS OF FALLING ILL

When it came to meeting their health needs, several FDWs said that they were prevented from resting when they were ill. They also reported being too busy with their duties to treat illness, having to purchase their own medicine, being given improper medication by their employer for a perceived serious condition, not being allowed to seek care, or being helped by the employer only when in severe pain:

“They didn’t give me anything. I had to buy paracetamol tablets on my own. They didn’t allow me to take their medicine because they said they had spend money on those things.”

When they became ill, some women were scolded, taken away by the embassy, sent back to the agency and denied pay, sent back to Sri Lanka, or had their visas rescinded:

“Even though we became ill they wanted us to work. They wouldn’t allow us to rest. If we couldn’t work they threatened to send us back to the agency. So, in that case, they don’t pay our salary. They pay some amount to the agency.”

A few FDWs with more positive experiences reported that their employers did allow them to rest, assisted with their duties, facilitated medical treatment, gave them health advice, or provided them with money:

“If we get illnesses they take us to the doctor. They have medicine at home, so you can be treated at home also.”

ENGAGEMENT IN LEISURE ACTIVITIES AND SOCIAL INTERACTION AS COPING STRATEGIES

During FGDs and IDIs, participants revealed coping strategies that had a positive impact on their emotional health or working experiences and life abroad. Communicating with other FDWs in the neighborhood,

contacting family, joining employers on outings or travel, and practicing religion were common leisure activities. Others mentioned listening to music or driving around. Some participants said contacting family or friends was a way to relieve their worries or bad mood. Those who were able to engage in religious practice spoke of its health benefits:

“Every day in the evening I was involved in religious activities in my room. This helped me to be more calm, and also I had harmony in my mind, so it helped me to be in good health.”

Although interaction with other FDWs was restricted or prohibited for many, those who were allowed to meet with others cited the benefits to their health and employment experience. FDWs most often talked about their families and problems with employment, with some exchange of health advice, emotional support or tips on improving skills:

“I felt comfortable when I had the company of other domestic workers, the neighbors. But we had this company only occasionally. So, during those times we used to talk about our family and those things. It was a big

relief for me. When they left I felt sorry.”

“None of us domestic workers who interacted with each other got ill. We came back to Sri Lanka in good health. We had never taken any medicine or received any medical treatment. We were in good health.”

Some participants mentioned that they would exchange assorted items, including food, when they were in need. When interaction was not permitted by employers, women spoke of how they found ways to communicate or exchange such goods in secret:

“We did not have good social interaction with other Sri Lankan maids. They didn’t want us to speak with each other. In my case, I used to help the other domestic worker living in the neighborhood. I gave her food and everything, without knowledge of her employers.”

“We had a messaging system through the wall between our houses. If the other Sri Lankan domestic worker was working in the other house, we communicated through the hole in that

wall. We used to exchange food or other things through that hole.”

GREATER SOCIAL SUPPORT OF AND ACCOUNTABILITY TOWARD FOREIGN DOMESTIC WORKERS

Some FDWs reported receiving assistance and advice from agents when dealing with embassies and agencies. Others reported experiencing exploitation, physical and sexual abuse, being sent back to their employers, having their salary confiscated, and lack of concern from agency employees:

“I was only allowed to sleep for one hour. I couldn’t eat properly. When I made a small mistake, I was taken to the agency and I was beaten there.”

One participant explained the effect that such experiences have on FDWs:

“Now the women who go to the Middle East have lost their faith in agencies, so they don’t complain about their problems to agencies anymore. Instead, they tend to commit suicide.”

Offering their recommendations, participants felt that the Sri Lankan government should enforce existing laws, take legal action against fraudulent

agencies, and provide more protection to FDWs or donations to their families:

“We expect more protection from the government. We expect the government to have a policy with regard to our salary. If the government does not consider this problem, there will more issues regarding foreign domestic workers.”

The women expressed that the president of Sri Lanka should take action to ensure FDWs’ well-being. Participants also mentioned that embassies should consider the issues FDWs face and cooperate with each other, while agencies should not mislead FDWs or employers:

“Even though the government has policies regarding places we are going to be employed, people don’t follow those policies. And sometimes we were given the wrong information regarding the number of households and the type of work we had to do there.”

FDWs spoke of the need for better pay, a guarantee of safety, respite from labor, and work conditions consistent with previously agreed to expectations. One participant expressed needed improvements to treatment from agencies:

“When I complained that I couldn’t stay in that place, I was sent to another house. But when I was working at that place, it was also not a good place for me. So, I complained to the agency and this lady took me away from that house, but she did not give me my salary. I worked there for three days and the salary was given to the agency employee, but she did not give it to me. Agency employees should act more kindly toward us, because we have some complaints and we complain to them because we have no one else to tell our problems to. We expect them to consider those as problems and treat us fairly.”

Finally, participants recommended that training for FDWs include information about the climate and people of the host country, along with strategies for improving nutrition.

FREE LISTING ACTIVITY

During the free listing activity, participants created a list of 38 health conditions that they believed could be caused by foreign domestic employment. Most of these health conditions (see Table 2) fit within the category of physical health. The free listing activity yielded a list of 34 causes that FDWs

understood to lead to these types of conditions. Among these, “overwork” was the most frequently listed, followed by “cold season”. “Headache” was not only the most frequently listed health condition (followed by “fever” and “backache”), but it also had the greatest number of causal attributions (followed by “depression”).

Table 2. Most Frequently Listed Health Conditions and Causes in Free Listing Activity

Health Condition	Frequency	Cause	Frequency
Headache	10	Overwork	17
Fever	7	Cold season	6
Backache	7	Hot season	5
Leg pain	6	Oily food	5
Irregular meals	6	Climbing stairs	5
Lack of rest	3	Dust	4
Wheezing episodes	3	Air conditioner	4
Knee pain	3	Irregular meals	4

Note. Conditions and causes are listed in order of descending frequency; Causes listed do not correspond to health conditions listed directly across; For data parsimony, conditions and causes with a frequency of <3 were excluded.

PILE SORTING ACTIVITY

During the pile sorting activity, 12 of the 26 predetermined health conditions were sorted by participants as “more common” and the other 14 as “more concerning” (see Table 3). “Back pain” and “body aches” were most frequently categorized as “more common” health conditions, while “accidents”, “cervical cancer” and “burns” were considered to be those “more concerning”. None of the health conditions

were most frequently categorized as “not concerning”. The most common categorical pairing overall was “more common” and “less concerning”, followed by “not common” and “more concerning”. The former includes conditions such as “fever” and “chronic headaches”.

Table 3. Health Conditions Most Frequently Categorized as ‘More Common’ and ‘More Concerning’ in Pile Sorting Activity

More Common	Frequency	More Concerning	Frequency
Back pain	10	Accidents	9
Bodyaches	10	Cervical Cancer	9
Fever	9	Burns	9
Fatigue	9	HIV/AIDS	8
Chronic headache	7	Assault	8
Intestinal problems	7	Sexual abuse	8
Sleep disturbances	7	Unplanned pregnancy	8
Common cold	7	STDs	8
Injuries	6	Back pain	6
Burns	6	Sleep disturbances	6
Sexual abuse	5	Beatings	6
Irregular menstruation	5	Psychiatric illnesses	6
		Emotional imbalance	5

Note. Conditions are listed in order of descending frequency; For data parsimony, conditions with a frequency of <3 were excluded.

During the discussion that followed, participants considered “more common” health conditions as those that they were either afflicted with, witnessed in others, or heard of from others or through media.

“More concerning” health conditions were perceived as life threatening, causing serious problems, having a negative effect on health, being unexpected, and possibly preventing FDWs’ return to Sri Lanka. For health conditions not included in the

activity, participants added that they consider “rape”, “skin diseases” and “hair loss” as “more concerning”, and “hand pain”, “skin diseases”, “dry skin”, and “hair loss” as “more common”. “Less common” health conditions were those which participants lacked knowledge of or personal experience. Certain health conditions were “less concerning” for FDWs because they did not find evidence of them, they are considered normal, common, may disappear with time, are not a cause for worry or are unimportant and ignored. Participants added that they would include “communicable diseases” as “less common” and “leg pain” and “communicable diseases” as “less concerning” health conditions, beyond those provided in the activity.

Discussion

At present, a comprehensive understanding of the health problems that Sri Lankan female FDWs working in the Middle East face is lacking. As with the FDW population as a whole, studies on this group have been focused on the work conditions, living environments and maltreatment experienced by FDWs, with limited research on occupational health issues. Given this, the primary objective of the present study was to explore the potential effects of the

nature of foreign domestic work on health through the lens of this population, as well as gain a better understanding of their health beliefs, health maintaining behaviors, coping mechanisms, and concerns.

Among those Sri Lankan female FDWs who suffered from health problems, the most commonly reported during FGDs and IDIs were related both to their physical and emotional health. Specifically, backache, headaches, irregular meals, and symptoms of depression emerged as the most prevalent. For some women, these problems continued even after termination of employment. Consistent with findings of previous studies that included Sri Lankan female FDWs⁵, there were multiple accounts of FDWs being unable to get enough sleep and rest, particularly eat regularly or properly, which either caused or further exacerbated existing health problems. Unlike backache, headache was not a significant finding of other studies⁵. Although the majority of health-related studies that have included Sri Lankan female FDWs have been focused on psychiatric disorders, a few¹⁴⁻¹⁶ have reported on the prevalence of stress and depressive episodes among this population. Through FGDs and IDIs, participants in the present study reported that being overworked

(including strenuously working) was the perceived primary cause of multiple health problems, including backache. Headaches and depressive symptoms were perceived to be primarily impacted by FDWs' relationships with their employers and family, as well as worrying.

In this study, free listing was utilized as a method of gaining insight into the health problems Sri Lankan female FDWs perceive to affect the female FDW population by some aspect of their work, as well as their causes. As the most prevalent health problems self-reported during FGDs and IDIs, backache, headaches, and irregular or insufficient meals were also some of the most frequently listed during free listing, while insufficient sleep and symptoms of depression were rarely listed. There is some inconsistency between what women themselves experienced and their perception of symptoms of depression as an occupational health problem. This may mean that emotional health problems are generally not perceived as being caused or affected by foreign domestic work. It may also imply that such emotional health problems are not considered to be health problems in the way that those related to physical health are. Cultural beliefs may influence such perceptions among Sri

Lankan female FDWs, causing emotional or mental health problems to be stigmatized and thus, underreported. Studies on mental health and illness in Sri Lanka have identified stigma and negative attitudes associated with having mental health problems^{26,27}. One of these studies found that the majority (61.8%) of participants evaded disclosing their mental health problems, and for a third of participants, others' reaction was their reason for hiding these problems²⁶. In the other study on health professionals and non-health professionals who provide community-based mental health services, participants expressed how individuals with mental health issues are excluded by community members who possess negative attitudes towards them²⁷. Such negative reactions include fear, ill treatment in the form of physical and verbal attacks, and neglect²⁷. Overall, the study pointed to ignorance among communities about the true causes of mental health problems and the tendency to blame individuals afflicted with these problems²⁷. In this context, it is understandable why emotional health problems would be underreported or disregarded as true health problems, attributable to one's occupation. Beyond recognition of the significance of emotional and mental health problems, efforts to

mitigate stigma attached to them are needed.

Given that overwork was both one of the most commonly perceived causes of self-reported health problems as well as the most frequently listed, overall, FDWs in this study did seem to find that domestic work does have an impact on their health. Climate was found to be both a frequently listed cause (i.e., “hot season” and “cold season”) as well as a finding of FGDs and IDIs. Fever and leg pain, albeit being frequently listed, were rarely self-reported by FDWs as health problems they experienced. It is possible that participants were more likely to self-report certain persistent or more frequently experienced health problems (e.g., backache) during FGDs and IDIs, than conditions such as fever, which may be more episodic. However, they may still consider them to be possible common health problems that FDWs experience due to the nature of their occupation and were thus frequently listed during free listing. A noteworthy finding of the free listing activity is that all of the most frequently listed health conditions were related to physical health. This may hint at the underreporting of mental or emotional health problems for reasons previously outlined, or the perception that

these types of problems cannot be attributed to physical labor directly. Finally, certain conditions, such as irregular meals, were listed as both conditions and causes, revealing their potentially significant impact on the health of female FDWs.

The pile sorting method allowed for female FDWs in the study to evaluate how common the health problems found among FDWs in previous studies are from their perspective, as well as how great of a concern the problems are to them. Overall, participants considered only four health conditions to be both “more common” and “more concerning”, including: back pain, sleep disturbances, burns, and sexual abuse. In regard to the most commonly self-reported health problems during FGDs and IDIs, only symptoms of depression and irregular or insufficient meals were not categorized as “more common” during pile sorting. Underreporting, for potential reasons aforementioned, may explain why symptoms of depression were not perceived to be “more common” among FDWs. Of the self-reported health problems, only backache and insufficient sleep (which can be the result of “sleep disturbances”) were sorted as “more concerning” health conditions. Given the reasons mentioned by participants as to why certain health conditions were

categorized as such, the other most commonly self-reported health problems such as headaches, symptoms of depression and irregular or insufficient meals may not be considered as life threatening or serious. From the authors' perspective, it is also possible that these conditions are not viewed as those that strongly impede work productivity, unlike backache and insufficient sleep. It is important to note that although emotional or mental health problems were not regarded as "more common" by female FDWs in this study, psychiatric illnesses and emotional imbalance were considered to be "more concerning". Previous research in terms of stigma, negative attitudes, exclusion and maltreatment experienced by those with mental health problems in Sri Lanka^{26,27} may explain this finding. Overall, results of the pile sorting activity revealed that FDWs in this study seem more concerned about accidents, abuse and sexual and reproductive health-related problems, most of which were rarely self-reported during FGDs and IDIs, and all of which are more challenging to prevent and treat, than those sorted as "more common".

Given their frequency of mention across FGDs, IDIs, free listing and pile sorting, provision of regular meals, proper nutrition,

ample amount of sleep and respite may be critical in the prevention of physical health problems among FDWs. Furthermore, participants' personal experiences provided during FGDs and IDIs, as well as results of free listing, amplify the need to address overwork as a potentially significant contributor to poor health among FDWs. While not seemingly perceived by FDWs to be a direct cause of their work duties, FDWs' experiences of emotional health problems, such as symptoms of depression, is not to be taken lightly. From their responses, it appears that their interpersonal relationships with their families and employers play a potential key role in the mitigation of such health issues.

Certain health maintaining behaviors, health beliefs and coping strategies adopted by FDWs emerged from the study. The Sri Lankan female FDWs in this study expressed the importance of being in good health for their quality of life and that of their families. Their nuanced definitions of health stretched beyond absence of illness and incorporated economic potential, independence, and the like. Maintenance of cleanliness was emphasized by FDWs as being important for maintaining good health, which may reflect the emphasis placed on personal health and cleanliness

during the pre-departure training FDWs complete, provided by the Sri Lanka Bureau of Foreign Employment (SLBFE)²⁸. Participants in this study did not report why or how cleanliness is important to health. It is interesting to note, however, that although cleanliness was stressed during FGDs and IDIs, being unclean was never listed as a cause for any health problems during free listing. While cleanliness is recognized an important practice to adopt for health purposes, the emphasis placed on this adopted behavior may hint at a potential lack of knowledge or deeper understanding of disease etiology among FDWs, suggesting a need to strengthen the training provided by the SLBFE.

In that regard, it is important to note that the health beliefs of FDWs in this study did not always align with biomedical models, although in some cases they did (such as the attribution of gastritis to “eating chilies”). Certain health beliefs, such as becoming ill through exposure to air-conditioning or by consuming certain types of meat or drinking cold beverages, point toward the presence of cultural explanatory models of illness among Sri Lankan female FDWs, which have not been explored in other studies on this population. A study on Filipino FDWs discussed folk beliefs within Filipino culture,

including the influence of heat and cold on health-related behaviors, particularly in terms of treatment and perception of illness causation^{29,30}. The authors also brought up the concept of a health locus of control, which addresses an individual’s perception of the extent to which they are in control of an event^{29,31}. A person with an internal locus of control believes that she has more control and is more likely to be aware of what she is experiencing and take preventative measures to avoid becoming ill^{29,31}. In revealing their health beliefs, female FDWs in the present study demonstrated that they are well informed of the health problems they experience and have some ideas about their causes. Although it was beyond the scope of this study to determine the extent to which participants felt in control of their health, by acknowledging their health beliefs and providing additional health education, they may get closer to developing an internal health locus of control and potentially having better health outcomes. With little available information on the health profiles of Sri Lankan female FDWs actively working in the Middle East and given the potential challenges of collecting such data from this vulnerable population, FDW returnees serve as the best informants for better understanding the occupational health

problems of these women. As such, incorporating their health beliefs might better meet the needs of Sri Lankan female FDWs by developing prevention and intervention methods which align cultural and biomedical models of disease causation.

In discussing the coping strategies they adopted while working abroad, FDWs in this study demonstrated their perceived benefit to their health. FGDs and IDIs revealed that social interaction between FDWs may serve as one such strategy. Women spoke of the emotional health and nutritional benefits, in particular, of interaction through conversation and exchange of health advice, food, and even guidance on performing domestic work. Such information reveals that simply allowing for more frequent interaction between FDWs may not only make them healthier and happier, but can perhaps even enhance their skill set—an argument that may appeal to employers. For those leaving family behind, more frequent communication with family members could ease their sorrow and regret for leaving Sri Lanka to become FDWs, as was mentioned during FGDs and IDIs. Given the reported prevalence of emotional health problems among participants, social interaction may potentially be used as a tool for prevention or mitigation of such issues. Beyond social

interaction, engagement in leisure activities also emerged as an influential coping strategy. In particular, religious practice was mentioned as having emotional health benefits among participants. Restriction of religious practice is not an uncommon phenomenon for live-in FDWs, and was even experienced by some participants in this study. Therefore, in combination with increasing access to medical care, encouragement of social interaction and permitting religious practice and leisure may potentially be beneficial for prevention and treatment of health problems afflicting this population. Moreover, as participants' responses suggest, these coping strategies may have a positive influence on job satisfaction as well. Research on female FDWs from different countries¹⁸⁻²⁰ echo the benefit of religion and social support, in particular, and strengthen this argument.

Policy Implications and Direction for Future Research

Female FDWs are vulnerable to maltreatment and infringement of their rights when they migrate to seek employment in other countries. This is attributed to a number of catalysts, including: absence of labor and social protection, uncontrolled recruitment practices and non-standardized labor

contracts, reliance on employers, inadequate pre-departure training, and the informality of employment and irregular status of some FDWs, among others^{32,33}. In the Middle East, the kafala system—a private system of sponsorship—subjects FDWs to the unchecked control of their employers who may restrict their mobility or otherwise exploit them³². Given that most FDWs are live-in workers, the argument has been made that including FDWs in national labor laws is challenging for this very reason, as regulation of foreign domestic labor may violate the employers' privacy or even honor³². At present, countries of the Middle East have yet to ratify the International Labour Organization's (ILO) 2011 Domestic Workers Convention (No. 189), which holds member states accountable for ensuring the occupational safety and health of FDWs³⁴. On a larger scale, FDWs have been receiving increasingly more attention, as is evidenced by ILO's efforts to draft legally binding conventions (such as the aforementioned), which require countries to report on compliance. Also noteworthy is ILO's organization of the Global Action Programme on Migrant Domestic Workers and their Families, which seeks to promote research (including occupational-related

research) and capacity-building within regions and worldwide³⁵.

In the case of Sri Lankan female FDWs, although achievements such as the establishment of the Sri Lankan National Migration Health Policy³⁶ are promising, more concerted effort is needed to directly address the health problems and injustices these women face. At present, the SLBFE conducts a pre-departure medical screening to determine whether prospective FDWs are physically and mentally able to work. Any display of "physical weaknesses", physical anomalies, pregnancy or HIV-positive status is grounds for immediate rejection²⁸. FDWs are provided with pre-departure training courses on first aid, personal health and cleanliness and occupational safety²⁸. While the SLBFE attempts to ensure that women are healthy and ready to start working, continued health monitoring and assistance are not provided. Given that these workers are exposed to occupational health risks, the Sri Lankan National Migration Health Policy³⁶ was established to provide an action plan on meeting the needs of this vulnerable population. As one of the only national policies of its kind³⁷, its establishment is a progressive step forward for the country. Additionally, some research on migrant workers has been done

at the national level in Sri Lanka through the Migrant Health Development project³⁸. It is notable that migrant workers were found to be insufficiently physically and mentally prepared to bear challenges faced abroad³⁸.

Therefore, as a starting point, one area of improvement may be the pre-departure training provided by the SLBFE. As aforementioned, one of the primary reasons why FDWs are vulnerable is related to the inadequacy of training provided to them. As this study illustrates, it would be worthwhile to explore the possibility of reforming the training offered by the SLBFE to focus more on health education, incorporating the health beliefs and concerns of FDWs, as well as topics suggested by participants in this study. Compared to other recommendations, this may be more feasible. Labor-sending and labor-receiving countries often hold each other responsible for FDWs' health issues¹⁵. Therefore, both pre- and post-migration efforts must be strengthened so that these problems are prevented and if manifested, are properly treated. In addition to the pre-departure training, this may be achieved by performing comprehensive health assessments post-migration in addition to existing pre-departure assessments³⁹, along

with regular checkups during employment. These assessments could potentially help to promote health in the long term, rather than be used to screen for those who are more "fit" to work abroad as a means of exclusion⁴⁰. Moreover, they may also be used to develop a health care plan for FDWs going to work abroad, as recommended in the Sri Lanka National Migration Health Policy³⁵, which could be tied to their contract.

A more challenging undertaking would be the legal enforcement of the protection of FDWs' rights as employees and more stringent regulation of embassies and agencies' actions. Ratification of ILO's 2011 Convention, as well as engagement in the Global Action Programme, would be a progressive step forward for Middle Eastern countries in this regard. The ILO has recently recommended several strategies for this region specifically that could benefit both domestic workers and employers, including: increasing transparency during recruitment; strengthening skills training; enacting legal protection; instituting monitoring; and developing a mechanism for settling legal disputes⁴¹. Non-governmental organizations (NGOs) in host countries could potentially become involved as advocates for FDWs and work towards facilitating

interaction between them, as well as provide additional occupational or language and culture training, health workshops and counseling. In that regard, the ILO's comprehensive analysis of NGO services provided to FDWs in Lebanon⁴² can serve as a model for future efforts for resource mobilization in other Middle Eastern countries.

Future studies should further examine Sri Lankan FDWs' perceived health problems and health beliefs to arrive at a cultural-consensus model, with a comparison to those of FDWs from other labor-sending countries. Free listing and pile sorting would be useful methods to employ in that regard. The potential benefits of coping strategies to health also need further investigation. Where possible, in-country studies on FDWs currently employed in the Middle East are strongly encouraged and desirable. These would inform better understanding of the relationship between domestic service and health outcomes of this population and would thus allow for development of more targeted strategies to mitigate their occupational health problems. Conducting a review to determine what is being done to improve Sri Lankan female FDWs' health, including efforts made by NGOs in the Middle East and Sri Lanka,

would be beneficial. Finally, developing a guide for each host-country may inform potential FDWs of their rights as migrant workers and offer strategies to maintain good health while employed abroad.

Limitations

As a limitation of this study, unless otherwise stated, whether some FDWs may have had preexisting conditions or were predisposed to acquiring certain health problems could not be ascertained. Also, although participants were asked to reflect on their most recent former employment experience, recall bias may have been an issue for those FDWs who worked abroad too long ago or those who had gone to work abroad on multiple occasions.

Conclusion

This study contributes further insight into the health problems of Sri Lankan female FDWs—a topic which has thus far prompted limited research. FDWs in this study most commonly self-reported experiencing physical and emotional health problems, which were mostly attributed to overwork. To maintain their health, some adopted certain behaviors according to their health belief models, as well as coping strategies. This study recognizes that FDWs can become

informants for the development of policy changes, as well as intervention and prevention programs. By incorporating FDWs' perceived health problems and their causes, health belief models, health maintaining behaviors, and coping strategies, these programs and any policy measures taken to improve the health of these women may be more effective in meeting their needs.

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