

Exploring the Health of Sri Lankan Female Foreign Domestic Worker Returnees from
the Middle East

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Thesis submitted in partial fulfillment of the requirements for the degree of Master of
Science in the Duke Global Health Institute in the Graduate School of Duke University

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ABSTRACT

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Abstract

Over the past few decades, Sri Lanka has experienced a feminization of migrant labor whereby increasing numbers of women have gone abroad to seek employment as foreign domestic workers. Despite the dominance of this profession among the female migrant labor force, little is known about their occupational health and, thus, little care has been devoted to meeting the health needs of this population. This study aimed to contribute to the current gap in knowledge and bring greater attention to the issue primarily through qualitative inquiry. More specifically, the objectives pursued were to obtain information regarding the health problems that Sri Lankan female foreign domestic workers face, understand how foreign domestic work may have caused those problems, and identify what these women consider to be the more common and more concerning health problems and their causes.

Twenty-five Sri Lankan female foreign domestic workers from Galle District, who were formerly employed in the Middle East, participated in focus group discussions, comprised of six to seven women in each session. During each focus group discussion, the women also engaged in free listing and pile sorting tasks, so as to obtain quantifiable data regarding common and concerning health conditions among female foreign domestic workers. Subsequently, eight participants were invited for in-depth interviews, so as to gain more personal information regarding their individual health.

Through qualitative and quantitative analysis, the study found that not all former female foreign domestic workers suffered from health problems. Of those that

did, problems with their physical and mental health were most prevalent. While some experienced only a single concern, others had multiple issues. A number of health conditions perceived to be more common among foreign domestic workers were not thought to be of great concern and vice versa. Furthermore, in reporting what they perceived to be causes of their ill health, the women revealed certain health beliefs. In terms of overall employment, the majority of participants had negative experiences, suffering from overwork and poor treatment as employees. Not all women, however, had the same unpleasant experiences.

Taken together, these findings prompt the need for the Sri Lankan government and the Sri Lanka Bureau of Foreign Employment to do more in terms of prevention and improving the working conditions of Sri Lankan women working as foreign domestic workers. Moreover, the findings can inform the reformation of pre-departure training, legal frameworks, and post-migration assistance to meet the needs of foreign domestic workers, particularly in terms of protecting their rights and health. Future studies may be qualitative so as to further explore foreign domestic workers' health beliefs or cross-cultural and utilizing mixed-methods. Finally, the results of this study will be used to develop a health questionnaire to be administered to this population in a future quantitative study, so as to obtain more generalizable data in regard to prevalence of certain health problems.

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List of Abbreviations

FDW	Foreign Domestic Worker
SLBFE	Sri Lanka Bureau of Foreign Employment
FGD	Focus Group Discussion
IDI	In-depth Interview
MOH	Ministry of Health
PHM	Public Health Midwife

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1. Introduction

1.1 Global Labor Migration Trends

The era of globalization has witnessed a global exchange of not only consumer goods, cultures and ideas, but also of human resources and services. Specifically, the migration of workers from low-income to high-income nations has risen in the past few decades. The International Organization for Migration (n.d.) estimates that there are at present approximately 105 million migrant workers worldwide, who earned a combined total of 440 billion US Dollars (USD) in 2011. Given the sheer number of those who work abroad, it is no wonder that the global economy has come to depend on transnational labor migration.

The most influential factor pushing the migration of workers from low-income countries is lack of economic opportunity in their home countries, which has many implications for one's quality of life and that of their family (International Labour Organization, n.d.). On the other hand, the International Labour Organization adds that the demand for labor, particularly of the cheap and unskilled kind, in high-income countries serves to pull a foreign migrant workforce. The phenomenon of international labor migration has had profound implications for the economy of many countries worldwide, particularly those in the Middle East region (Gamburd, 2009).

The influx of migrant workers to the Middle East was largely catalyzed by the oil boom of the 1970s, which increased the demand for labor for further development

(Gamburd, 2009; Ukwatta, 2010). According to Gamburd (2009), this flow of labor changed the demographic makeup of several countries. For instance, these migrants constitute the majority of the population of the United Arab Emirates (UAE), Qatar, Saudi Arabia, Kuwait, Oman and Bahrain, that is, the nations that form the Gulf Cooperation Council (GCC). Among these, Gamburd reported that a remarkable 75-81% of the population of the UAE is made up of migrant workers. While migrant workers comprise 70% of the workforce in the aforementioned GCC countries, the situation in the UAE is more dramatic. There, 90% of the workforce is dominated by these workers. The nature of the dual economy in these countries is such that the migrant labor force is allotted lower-paying jobs in the private sector. Perceived as a threat, in some ways, to the citizens of the GCC nations, governments have exacted a number of regulations to ensure that migrant workers work under a short-term contract period, with limited rights as temporary workers. Despite this marginalization, Gamburd added, foreign labor continues to flow into these countries.

1.2 Feminization of Labor Migration

It is approximated that half of migrant workers today are women (International Labour Organization, n.d.; Caritas Sri Lanka- SEDEC, 2012; Jureidini & Moukarbel, 2004). The feminization of global labor migration is evident in the overwhelming number of women who leave their countries to perform domestic work elsewhere (Ehrenreich & Hochschild, 2002). At present, there are at least 53 million domestic

workers worldwide, with 80% of these workers being female (International Labour Office, 2013). As greater numbers of women in more affluent nations of the Middle East and elsewhere have entered the labor market, the result has led to a “care drain”, where the women of low-income countries migrate to high-income countries to take over the responsibilities of care taking and household duties (Ukwatta, 2010; Ehrenreich & Hochschild, 2002). Likewise, Ehrenreich and Hochschild wrote (2002), the export of domestic female labor is encouraged by the governments of low-income countries so as to provide a much needed influx of money. Thus, they added, remittances not only aid to improve the lives of many women and their families, but also the economies of their native countries.

Domestic work constitutes any work performed in or for a household or multiple households, including the tasks of maids and nannies. Thus, a *female foreign domestic worker* (FDW) is a woman who provides a range of domestic services as employment, outside of her native country. A domestic worker may be called a housemaid, domestic helper, domestic aide, household service worker, domestic cleaner, or domestic servant, in some cases (Malhotra et al., 2013; Ahonen et al., 2010; Medina-Ramon et al., 2006; Gamburd, 2009). However, from hereafter, the term *foreign domestic worker* is used to encompass all of the aforementioned. “Foreign”, here, is used instead of the term “migrant”, as the later may imply internal migration, while the former refers to the flow of labor from outside of a country. A female FDW may either be a “live-in” worker, residing in the household of her employer, or a “freelancer”, living on her own and

working for multiple employers, according to Jureidini and Moukarbel (2004). They also added that the former, as a resident of the household, is subject to the control of her employers and, thus, may experience more restrictions and harsher living conditions. Although the profession is not necessarily restricted by gender, women do make up the majority of FDWs.

Among labor-receiving countries, most female FDWs seek employment in the Middle East and Southeast Asia. Among the number of push and pull factors that particularly drive female FDWs to seek work outside of their native countries, inadequate and irregular income in the native countries, along with job opportunity and financial security in the host countries, are the most influential (Caritas Sri Lanka-SEDEC, 2012). While seeking foreign employment provides financial benefits, there are a great number of risks involved that are of increasing concern.

1.3 Conditions of Foreign Domestic Work

Recent media coverage has highlighted the human rights abuses and exploitation that female FDWs can suffer at the hands of their employers and household members. Through their website and various reports, the Human Rights Watch (2007; 2008; 2011) has highlighted that some women are met with not only physical but also psychological, sexual, and verbal abuse. The reported inhumane treatment may extend to food deprivation and inadequate living conditions; lack of privacy; lack of access to medical care; confiscation of personal identity documents; restriction on communication with

outsiders; and limitation on ability to travel to one's home country. As minorities in their countries of employment, these women apparently may also face racial discrimination, gender segregation and inequality, as well as restrictions on religious practice. As reported, further exacerbating these are employment-terms abuses, including: lack or delay of wages; exploitation of labor contract; long working hours and relatively few, if any, days of respite.

For all of the above reasons and more, FDWs are considered an extremely vulnerable group to whom little protection is offered. On the part of their native countries, the export of FDWs as cheap labor has been marketed through pro-migration laws (Jureidini & Moukarbel, 2004; Malhotra et al., 2013). As mentioned earlier, the political structures of labor-receiving countries, such as certain ones in the Middle East, particularly affect FDWs. Overall, in the Middle East, female FDWs are paid less than most other migrant workers and those coming from Asian regions, especially, are perceived to be a better source of cheap labor and more compliant than their non-GCC Arab counterparts (Gamburd, 2009; Jureidini & Moukarbel, 2004). Even within the category of Asian female FDWs there remains further discrimination, as women from the Philippines have a higher salary and are favored over others for being more educated and for their ability to speak English well (Jureidini & Moukarbel, 2004).

In certain host countries, female FDWs are regarded as "aliens" and, thus, have fewer rights as workers than the natives, making it difficult for them to form unions (Malhotra et al., 2013; Gamburd, 2009). While some efforts have been made

internationally to protect FDWs, thus far they have had questionable impact on the majority of these women (Jureidini & Moukarbel, 2004; Malhotra et al., 2013). The *United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, for instance, has not been signed by any of the top labor-receiving countries, although major labor-sending countries, like Sri Lanka and the Philippines, have done so (Jureidini & Moukarbel, 2004; Malhotra et al., 2013). Passed in 2011, the Domestic Workers Convention (No. 189) and the accompanying Recommendation (No. 201) became the first international labor standard for domestic workers (International Labour Office, 2013). The International Labour Office reports that, although only three countries have ratified the Convention, including Uruguay, the Philippines, and Mauritius, apparently 20 or so countries are taking measures to begin the process of ratification. This type of legislation brings some hope for the future of FDWs. Still, certain host countries, such as Lebanon, perceive that it is not the government's place to intervene in moral matters pertaining to the working and living conditions of migrant workers (Jureidini & Moukarbel, 2009). Instead, as Jureidini and Moukarbel found, they deem this to be the natural workings of the market.

1.4 The Health of Female Foreign Domestic Workers

The demands of the domestic workplace, especially in a foreign country, may take a serious toll on the health of FDWs. Given the aforementioned examples, it is understandable how female FDWs could develop health problems within the context of

their workplace abroad. Most studies on these women, however, have been focused on highlighting the abuses and discrimination faced by these women and the political and legal structures surrounding the profession (Malhotra et al., 2013). Some also discuss the motivations of female FDWs to work abroad and the remittances that they send back to their home countries. However, thus far, studies conducted to examine the health problems of female FDWs have been limited in number and scope. As female FDWs are mostly categorized as “live-in” workers, they are largely confined to the household of their employer, often with limited communication and interaction with the outside world (Malhotra et al., 2013). This, Malhotra et al. reported, explains the apparent challenge in collecting data on the health status of this population.

Nevertheless, a recent systematic review by Malhotra et al. (2013) of the scientific and gray literature, published between 1990-2013 on health issues of FDWs, did find 32 relevant research papers and reports. The majority of these papers and reports focused on female FDWs formerly employed in the Middle East (43.8%) and Southeast Asia (40.6%), and included FDWs of varied nationalities (62.5%). Quantitative studies dominated the group (65.6%), while only 28.1% utilized qualitative methods. In terms of common adverse work conditions and health problems, studies from varied regions reported excessively long work hours (13-19 hours); lack of rest days or hours; not receiving wages on time; lack of privacy; deplorable living conditions; food deprivation; limited mobility and communication; and lack of instruction on safety measures. The physical health problems reported include back pain; respiratory problems; skin

irritations; joint pain; musculoskeletal strain; injuries; headaches; and dental issues.

Various forms of abuse, ranging from the verbal to the physical and sexual were common. Malhotra et al. added that there were also reports of lack of access to medical care and confiscation of passports and food deprivation.

Fewer studies (mostly from Kuwait) focused on the investigation of mental health problems (Malhotra et al., 2013). Of those that did, neurotic, psychotic, and mood disorders were reported, as well as stress-related disorders. Among related symptoms, delusions, depression and auditory hallucinations were common. Various sources of stress, such as social isolation and worry about family, were found to be common risk factors for some of the aforementioned diagnoses of mental disorders. Only a handful of studies, all from the Middle East, gave attention to the presence of infectious diseases among female FDWs. Intestinal parasitic infections were somewhat prevalent (1.7-21.2%) and less so among women from the Indian subcontinent (32%). Among sexually transmitted diseases, Malhotra et al. reported that Hepatitis B, syphilis and HIV were found in studies.

Some research focused on exploring the health attitudes, knowledge and practices of these women, particularly in terms of sexual and reproductive health (Malhotra et al., 2013). The majority of these studies focused on women from the Philippines, with Hong Kong being the most common host country. In terms of seeking medical care, one study of female FDWs from the Philippines found that symptoms of coughing, fever and hypertension were the most common reasons for these women to

visit a physician, while using painkillers seemed to be the most utilized form of treatment. Although certain health conditions may have been pre-existing in the cases of some women, Malhotra et al. reported that the majority of emerging health problems were either caused or further exacerbated by the nature of domestic service.

1.5 The Case of Sri Lankan Female Foreign Domestic Workers

Despite having one of the highest literacy rates (91.1%) and levels of access to health care in South Asia, women still experience gender inequality in many forms in Sri Lanka (Human Rights Watch, 2007; Central Bank of Sri Lanka, 2013). Within the economic sphere, this manifests itself in terms of women's participation in the labor force and their earning power (Human Rights Watch, 2007). The Central Bank of Sri Lanka (2013) reported that, although women accounted for 51.5% of the total population of the country in 2012, the female labor force participation rate (LFPR) in the same year was 29.9%. The latter is a 3.5% decrease from just five years earlier. Men continue to dominate the labor force in both the rural and urban sectors. In the year 2012, the unemployment rate among the female labor force was 6.2%—more than double that of the male unemployment rate in the same year. Not only do men dominate most trades, but they earn significantly more than women do. According to the Human Rights Watch (2007), it is estimated that in 2003, women's earned income was half that of men. The Sri Lankan Wages Board even established different wage rates for male and female workers,

despite their work of equal value, in the tobacco and cinnamon trades. In the face of gender inequality, added the Human Rights Watch, the majority of job opportunities available to women are low-skilled, low-paying, and characterized by poor working conditions. Of these, foreign domestic work serves as the dominating profession for Sri Lankan women.

Within the global flow of labor migration, Sri Lanka serves as one of the foremost labor-sending countries, particularly to the Middle East. According to Gamburd (2010), the nature of labor migration out of Sri Lanka has evolved over the past several decades, after the independence of the country in 1948. However, since the middle of the 1970s, the number of migrant workers working abroad has been on the rise. The Sri Lanka Bureau of Foreign Employment (SLBFE) (2011) reported that this number increased by 61,012 people within just a five year period, from 2008 to 2011. There were 262,960 departures for foreign employment in the year 2011 alone, with an average of 718 migrants leaving to work abroad as foreign employees every day. In 2010, 1,932,245 Sri Lankans were working abroad as migrant workers. Thus, foreign employment accounted for 23.83% of the total labor force of the country and 25.07% of total employment. Five countries, including Saudi Arabia, Qatar, Kuwait, the U.A.E., and Jordan, dominated Sri Lanka's foreign labor market, receiving 85% of migrant workers in 2011. Saudi Arabia alone received 26.10% of Sri Lankan migrant workers. Overall, the SLBFE reported that more than 93% of Sri Lankan migrant workers were employed in the Middle East in 2011.

As with global trends, the feminization of migrant labor in the case of Sri Lanka is also evidenced by the fact that from the late 1980s until the later 2000s, women constituted the majority of those going to work abroad (Gamburd, 2010). In recent years, the number of departures for foreign employment has more consistently increased for women than for men (Sri Lanka Bureau of Foreign Employment, 2011). In 2011, 127,090 women, or 48.3% of departures for the year, left Sri Lanka to work abroad (Sri Lanka Bureau of Foreign Employment, n.d.). Of these, 107,816 sought employment as “housemaids”, representing 84.8% of the Sri Lankan female workforce abroad (Sri Lanka Bureau of Foreign Employment, 2011). Although slightly fewer women went to work abroad as migrant workers in 2011, the fact that the majority of these were FDWs is worth noting. This supports the argument made that job opportunities for Sri Lankan women are limited and heavily concentrated in the profession of foreign domestic work, particularly in the Middle East.

To the issue of why such an overwhelming number of Sri Lankan women seek foreign employment in domestic services, the cause is largely attributed to the economic need of not only their families but also Sri Lanka’s economy. As previously mentioned, job opportunities for women in Sri Lanka are limited to a few occupations. Even when able to find employment, the work is often compensated by a low salary. Domestic work, however, is one example of a profession which provides potential for women to earn more and support their families. The local market for domestic workers is increasing in Sri Lanka as well, although their work in the domestic market is only

compensated by a monthly salary of about 3000 to 6000 Sri Lankan Rupees (LKR) (Palaniappan, 2010). In the Middle East, these FDWs can earn two to ten times more, with an approximate average of 13,000-18,000 LKR per month (Human Rights Watch, 2007). Whether or not remittances actually improve household well-being for Sri Lankan female FDWs remains to be analyzed. However, one study focused on temporary international contract migration (not specific to FDWs) found that high upfront costs of securing a contract and migration-related expenses, along with lack of social connections in finding foreign employment, may be potentially problematic (Sharma, 2011). Moreover, whether the financial benefits of foreign employment outweigh the social costs incurred by female FDWs' families and children also remains questionable.

At the national level, in 2011, total private remittances amounted to 569,103 million LKR, with 333,201 million LKR, or 58.5%, stemming from migrant workers employed in the Middle East (Sri Lanka Bureau of Foreign Employment, 2011). Remittances are considered to be a greater source of finances than tea exports, which serves as the country's second most important commodity export after apparel, as reported by the Human Rights Watch (2007). Moreover, remittances are part of Sri Lanka's economic strategy for poverty reduction and allow the country to finance its trade deficit. Finally, the Human Rights Watch also added that remittances amount to significantly more than Sri Lanka receives in foreign aid and foreign direct investment. It is no wonder, then, that Sri Lanka actively promotes the export of cheap domestic labor

(Jureidini & Moukarbel, 2004). This establishes a mutually beneficial scenario where Middle Eastern countries benefit by cheaply employing Sri Lankan women, whereas Sri Lanka is then provided with a much needed influx of money. It is this economic relationship, however, which complicates and subverts any efforts made by Sri Lanka, as a debtor and a low-income country, to protect the rights of its migrant workers abroad (Gamburd, 2009). Even when taking workers' rights into consideration, little attention is paid to the protection of their health.

Of the 32 studies covered by Malhotra et al. (2013), 14 included Sri Lankan female FDWs in the sample and only two studies exclusively focused on this population of FDWs. Fifty percent of the aforementioned 14 studies examined the adverse work conditions and abuses suffered by women. The rest covered a range of health topics and conditions. It is difficult to attribute any single health problem to Sri Lankan FDWs, as these studies included FDWs from different countries of origin in their sample. However, in general, researchers found that women complained of the following physical health problems: fatigue, back aches, joint aches, chest pains and breathing problems. Among mental disorders, diagnoses included acute situational disturbance, schizophrenia, conversion hysteria, severe stress, manic episode, depressive episode, and acute and transient psychotic disorder. Risk factors for mental disorders included: limited or no contact with family; worry about employer's treatment; sexual abuse; harassment; receiving lower wages than expected; history of medical illness or psychiatric illness; history of previous hospitalization; young age; and religious

affiliation. Among infectious diseases, only intestinal parasitic infections were found. The most common infections reported were hookworm, *Trichuris trichiura*, and *A. lumbricoides*. Finally, in terms of health knowledge and attitudes, Sri Lankan female FDWs were only included in a study focused on HIV/AIDS. Malhotra et al. reported that this study found an overall lack of knowledge of HIV/AIDS and its transmission.

At present, the SLBFE does conduct a pre-departure medical screening for prospective FDWs to ensure that only healthy women go to work abroad as FDWs (Sri Lanka Bureau of Foreign Employment, n.d.). This medical examination is done to determine whether women are both physically and mental fit for foreign employment. Specifically, women should not have any “physical weaknesses”, including “poor eye sight and hearing” (Sri Lanka Bureau of Foreign Employment, n.d.). Prospective FDWs over the age of 45 should take a physical fitness test and provide a medical report conducted by a MBBS physician. Physical anomalies, such as “burnt injuries” and “ugly patches on skin” are reported by the SLBFE as potentially causing immediate rejection by employers (Sri Lanka Bureau of Foreign Employment, n.d.). The Human Rights Watch (2007) reported that often the pre-departure medical screening is done without the women’s informed consent or without allowing them to view the test results. It was also reported that tests were done for: pregnancy, HIV infection, elevated cholesterol levels, TB, eyes, speech, and hearing. If a prospective FDW is found to be pregnant or tests positive for HIV, then she is not allowed to go work abroad. Besides not being informed about the tests that would be done, no women received pre- or post-test

counseling. Finally, the Human Rights Watch reported that there have even been cases of female FDWs being coerced into receiving injectible contraceptives or these being administered without their informed consent.

Pre-departure training courses provided include discussion of “first aid”, “personal health and cleanliness” and “occupational safety”, according to the SLBFE (Sri Lanka Bureau of Foreign Employment, n.d.). Further, the Human Rights Watch (2007) reported that prospective FDWs with no previous working experience in the Middle East must complete a 12-day training course. Unless a FDW has six months worth of experience in the Middle East, a certificate of completion of the training is compulsory. The 12-day training provided for prospective FDWs headed to the Middle East is only required for first time employees. The eight modules provided include training on basic Arabic, utilization of household appliances, the culture of the host country, protection against HIV infection, and “how to mentally adapt to socially sensitive topics” (Human Rights Watch, 2007). Only a few hours are allotted to briefing about FDWs’ rights, with cases of misinformation and inadequate guidance. Finally, according to the Human Rights Watch, female FDWs are only provided with the contact number of the embassy and told to run away to the Sri Lankan embassy, presumably in the face of trouble.

It seems that the SLBFE goes to great lengths to ensure that women who are sent abroad are healthy and presumably ready to work. However, it is unclear whether the training is adequate enough to prevent women from acquiring health problems abroad, during employment. Moreover, whether or not any health concerns that the women may

have prior to leaving for foreign employment are addressed during the training sessions is unclear. In consideration of previous studies, including those in Malhotra et al. (2013), it appears that even with the actions taken by the SLBFE, Sri Lankan women still face many health problems while employed as FDWs abroad.

1.6 Study Objectives and Rationale

In view of the existing literature on the health issues of female FDWs, there is a recognizable need to address the adverse health conditions that these women may suffer as the result of their often harsh working conditions. Prior to addressing this need, however, it is necessary to obtain a more comprehensive understanding of the experiences of these women that may contribute to their current health problems. The primary aim of this qualitative study was to contribute to currently scarce knowledge about the particular health problems that Sri Lankan female FDWs, who have previously been employed in the Middle East, face. Second, the study aimed to attain an understanding of how the nature of their occupation may have led to the presence of any ill health, if at all. Finally, this study also sought to identify what female FDWs find to be the more concerning and more common health problems in their profession and their causes. The following are the specific research questions that guided this research:

- How do Sri Lankan female FDWs formerly employed in the Middle East perceive their employment experiences?
- What are the health problems, if any, that Sri Lankan female FDWs

encounter as a result of their foreign employment?

- Which health conditions do Sri Lankan female FDWs consider to be more concerning and more common among women in their profession?
- What do Sri Lankan female FDWs believe are the causes of health problems common among women in their profession, as related to the nature of foreign domestic work?

To achieve these objectives and questions of inquiry, qualitative data was collected primarily through focus group discussions (FGDs) and subsequent in-depth interviews (IDIs). FGDs were supplemented with two group activities: free listing and pile sorting, so as to diversify the method of data collection and obtain quantifiable data.

Through the formative research process, findings of this research will serve to inform the development of a health questionnaire to be administered to female FDWs of the same community in a future quantitative study. This instrument will provide a more thorough investigation of the particular health concerns female FDWs face, as a result of their previous employment abroad. Results from the current study complemented with generalizable data obtained through the questionnaire can be utilized toward the development of a future intervention study, either focused on a particular subgroup of female FDWs in Galle District or a specific prevailing health issue among these women. Additionally, results from both the present study and the proposed quantitative research aforementioned, may serve to inform and influence local and national policy decisions toward improving the work conditions and health of Sri Lankan female FDWs

abroad. Dissemination of findings from these studies to the local, national and international communities can potentially raise awareness of the health issues that not only Sri Lankan, but other female FDWs as well, encounter through their profession.

1.7 Research Team

This research study was initiated as a “twinning project”, through a partnership between the Duke Global Health Institute (of Duke University) and the Faculty of Medicine of the University of Ruhuna, in Galle, Sri Lanka. As such, the principal investigator of this study was partnered with a Master’s degree student and faculty member of the University of Ruhuna, Dr. Janithra De Silva. Through the collaborative research process, the two worked together through various stages of the research process, from development to implementation. Funding for the research was provided by the Duke Global Health Institute. As part of the “twinning project”, Dr. De Silva expanded upon the objectives of the present study through her own independent project, which focused on female FDWs living in Galle District who terminated their contract early and returned from the Middle East due to ill health. The research team was expanded to include Mr. Hemajith Tharindra, also a faculty member of the University of Ruhuna, who graciously accompanied the principal investigator and Dr. De Silva to FGD and IDI sessions and assisted with data collection and translation of research materials. Dr. Monika Wijeratne, a visiting scholar at the Duke Global Health Institute, later joined the team to also assist with translation of research materials.

Several faculty members from the Duke Global Health Institute, the University of Ruhuna and the Duke-NUS Graduate Medical School, including Dr. Truls Ostbye, Dr. Justine Strand de Oliveira, Dr. Vijitha De Silva and Dr. Rahul Malhotra, served as advisors for this study throughout the entire research process.

2. Research Design and Methods

2.1 Study Site

This study was conducted in the city of Galle, Sri Lanka for a period of ten weeks during the summer of 2013. Located on the southwestern coast of Sri Lanka, the city serves as the capital of Galle District and the administrative capital of the Southern Province. According to the most recent data provided by the Department of Census and Statistics (2011) in Sri Lanka, the district is populated by approximately 1,081,387 people, of which 7% reside in an urban area and 84% reside in a rural region of the district (the remaining 18,407 people live on estates).

The SLBFE estimated that there were 12,438 departures for foreign employment from Galle District out of a total of 262,960 for the twenty-six districts in the country reported on in 2011 (Sri Lanka Bureau of Foreign Employment, 2011). This is a significant increase from five years prior, when there were 10,083 departures in the same district. Out of all those who left Galle District to work abroad in 2011, 6,255 were women and 5,183 of these were “housemaids”. Thus, Galle District had the highest departures in the entire Southern Province and the number of those working abroad as housemaids was greater than the average of 4,146 departures among all of the districts combined, with 4% of Sri Lankan FDWs coming from Galle District. Given that women in this profession outnumbered those in all other fields, from professional to unskilled workers, there is a great need to give due attention to this large, understudied

population in Galle District.

2.2 Study Sample

Originally, the aim was to recruit 24 participants; however, there were two extra FDWs who were recruited. One woman with vision problems was dismissed from a FGD session and was still provided with monetary compensation. Therefore, a total of 25 participants were finally recruited for this study. In Sri Lanka, cultural norms dictate that the profession of foreign domestic work is restricted to women, therefore all participants were female. All female FDWs residing in Galle District who returned from their employment in the Middle East under normal terms of their contract qualified for inclusion in this study. Thus, this study excluded those women who specifically terminated their contract and returned early for any reason. Participants were not required to have knowledge of the English language, however, as FGDs and IDIs were carried out in Sinhala, subjects needed to be Sinhala-speaking. Apart from a minimal age requirement of 18 years, participants were not excluded by marital status or length of marriage, religious affiliation, level of education, years/length of employment as a FDW, country of employment as a FDW, current employment status or occupation, and whether or not they have children. Finally, female FDWs were recruited from four Ministry of Health (MOH) divisions, covering all the different population areas in Galle District: the Galle Municipality MOH division (urban), Akmeemana MOH division (semi-urban), Gonapinuwala MOH division (rural), and Elpitiya MOH division (estate).

Given the nature of this study and its objectives, obtaining a heterogeneous sample allowed for maximum variation in the sample and, subsequently, was crucial for finding any common, shared experiences across various groups of FDWs living in the area (Patton, 2002). However, we still wanted the participants to be similar in the following ways: gender, normal terms of contract and former employment in the Middle East. It should be noted, however, that one extra participant who was recruited had only previously been employed in Singapore. However, as there was another participant whose most recent employment happened to be in Singapore, the two were still allowed to participate in the study. Other than the inclusion criteria, we considered all FDWs of Galle District to be of equal interest to the study and did not want to focus on a particular subgroup.

2.3 Participant Recruitment

Prior to the recruitment of the study participants, contact was established with the Medical Officer of Health in charge of each MOH division. The aforementioned four MOH divisions were selected purposively, out of the two MOH divisions in Galle District, through maximum variation (heterogeneity) sampling. Thereafter, upon establishing contact with each MOH division, the study and its purpose were explained to the Medical Officer of Health in charge of each division. If interested in becoming involved with the research, the Medical Officers of Health were asked to purposively select two Public Health Midwives (PHMs) from their division to aid in the recruitment

of the study participants. These women, subsequently, were directed to each select three female FDWs (thus, a total of 6 from each division) whom they knew of, who met the inclusion criteria. This was done either through FDWs visits to clinics or home visits. Once all participants were selected, a suitable date for each data collection session was determined by consulting with the FDWs. PHMs then informed each participant of the official date, time, and location of each session. Once a convenient date and time was set for each FGD and subsequent IDIs, participants were contacted the day before each session took place so that they would be reminded of their participation in the study the following day.

2.4 Data Collection

Prior to the collection of data, the instruments for both the FGDs and IDIs were pilot-tested with two female FDWs. This was done not only as practice for the two facilitators, but also to determine whether FDWs could grasp the meaning of each question. This pilot-testing phase was also helpful in determining which particular question was the source of confusion, if any, or was repetitive. Subsequent to the pilot-testing phase, no significant changes needed to be made to the instruments.

Upon arriving at the session, the participants were introduced to the researchers and, again, briefly explained the purpose of the study and how the session would proceed. Each was handed an informed consent form and asked to read through it and provide their signature, if they chose to participate. Any questions or clarifications

needed by the FDWs were immediately addressed. After this, participants were all assigned a unique number, which was used when writing notes during the session and identifying participants later in the transcription of data.

Prior to beginning each session, a short demographic survey (see Appendix A) was verbally administered to each female FDW individually. This was done for several reasons; namely, to collect basic information about the women (including age, marital status, number of children, education level, current employment status, and employment experience as a FDW), which could also aid in select which women would be invited for an IDI. More importantly, perhaps, this survey aided in verifying that all of the women recruited indeed met the inclusion criteria and were eligible to participate in the study. For this reason, the decision was made to administer the survey at the beginning, rather than at the end of each session. Other than the two participants whose most recent employment was in Singapore, all other women were deemed eligible for participation. All of the aforementioned procedure was conducted in Sinhala. Given the ethnoreligious tensions underlying the Sri Lankan civil war (1983-2009), women were not asked for their religion or ethnicity, which was deemed a sensitive topic (Georgetown University, 2013). Further, other than being asked for their current employment, women were not asked for their income. Our interest lied more in learning about what work the women are engaged in after being employed abroad, rather than how much they are earning.

2.4.1 Focus Group Discussions

Four focus group discussions were held, always on a weekend when both researchers and participants were available, with three sessions of six women and one session of seven women. Each was held at a location determined to be easily accessible by the study participants and that could facilitate uninterrupted FGDs and IDIs.

The FGD interview guide (see Appendix B) was comprised of a series of open-ended questions in a semi-structured format. Although the format appears to be very structured, probing questions were adjusted as necessary. Questions in the interview guide were organized or sequenced into sections that would trace the path of the women's experiences as FDWs, that is: introduction (with questions about their motivations for becoming a FDW and their perceptions of the profession); employment experience (questions about their employment experience and the experiences of others, as well as the potential effects on health); health information (utilizing the methods of free listing and pile sorting); discussion of aforementioned activities; and, conclusion (with questions pertaining to women's opinions on the future of the profession, as well as actions that could be taken to improve the health and working conditions of FDWs). To gather the most comprehensive information possible, yes or no questions were generally avoided, although a few were inserted to add variety in the structured format. Both main questions and probing questions fell within the following categories: experiences and behaviors; and, opinions and values (Patton, 2002). Background

questions were dealt with through the administration of the demographic survey separately, so as not to disrupt the flow of the FGDs.

Although all FGD sessions were audio-recorded, comprehensive short-hand notes of responses were taken by Dr. De Silva during each session, so as to allow for preliminary data analysis. Particularly interesting responses were communicated to the principal investigator on occasion, so that observations and corresponding nonverbal cues could be noted. Overall, each FGD lasted between one to two hours.

2.4.2 Free Listing and Pile Sorting Tasks

To venture from and complement the standard FGD format, free listing and pile sorting activities were included in the study. The inclusion of free listing and pile sorting in this study served several purposes. The first of which was to elicit female FDWs understanding of how the nature of domestic work can affect health. Secondly, as the researchers felt that open discussion of certain health topics (e.g., sexual health) may cause some women discomfort, these activities served as a more appropriate alternative way of gaining information about the health problems that some women face. Finally, pile sorting allowed for the women to establish a connection with each other, and together the activities made the women, particularly those who were more timid, to feel more engaged in the FGD. The participants were informed that they could draw upon their own experiences or those of other women they have interacted with or heard of.

During the free listing activity, the participants were each handed a blank sheet

of paper and asked to work individually on creating a list of as many health conditions that they could think of that are caused by some aspect of their work. Then, they were asked to write down the specific reasons for why these health problems occur (i.e., the causes of each). Overall, the researchers tried not to influence the women's responses in any way; however, for those that needed clarification, the directions were explained again. Following this, the women participated in the pile sorting activity. Before the first FGD, 26 health conditions thought to be common among FDWs were selected by the research team, based on the results of the systematic review conducted by Malhotra et al, along with more general conditions such as fever and common cold. Some more technical terms were broken down into symptoms (such as pain, fatigue and sleep disturbances, in the case of musculoskeletal pain), so that women could more easily grasp the meaning. Different wording was used for relatively similar conditions to determine whether particular terms were more well-understood or perceived differently than others (e.g., STDs in terms of reproductive health versus communicable disease; injuries versus accidents). However, at times, it was still necessary to explain to the women what was meant by the use of certain terminology (e.g., depression). For the first part of the pile sorting activity, the women were divided into pairs (except for one group of three) and handed a stack of small sheets of paper on which the 26 health conditions were written in both English and Sinhala. They were asked to sort the conditions according to what they deemed to be the *more common*, *less common* or *not common* among female FDWs, by placing the sheets of paper in three different piles. Each of the piles

was collected from each group and results recorded thereafter. For the second portion, the women were handed a new set of sheets of paper with the same health conditions written on them. This time, however, the participants were to sort the conditions according to whether they are *more concerning*, *less concerning* or *not concerning* to FDWs. These new piles were also collected from the women and recorded. Following the completion of both activities, the FGD continued with asking the women about the following: how they sorted the conditions; why they did so; if there were any disagreements within the groups; how their individual lists compared with the piles they formed; and, if there are any health conditions that were missing from the pile sorting activity.

In studies such as this one, free listing should precede pile sorting. The reason for this is so that the content of the cards (in this case, the health conditions that participants sorted) in the pile sorting task does not influence the participants' generation of a list of items in the free listing task. For instance, if the pile sorting activity took place first, the women may have simply memorized some of the conditions that were given on cards and included these in their own list of health problems during the free listing phase. If this had happened, we may not have been able to tap into certain health beliefs and explanatory models of illness that naturally came as a result of the free listing task. Both the free listing and pile sorting activities took place during the middle of the FGD. With the understanding that the inclusion of these activities would add to the overall length of the FGDs, this time also served as a break for the participants, where refreshments

were provided by the researchers and served to the women.

2.4.3 In-depth Interviews

Taken together with the results of the demographic survey, women's responses during the FGDs were utilized in purposively selecting two women from each FGD to participate in an IDI. Through purposive sampling, we sought to interview both women who seemed to have positive experiences working abroad and those who seemed to have negative experiences (i.e., exploitation of some sort or health problems). Eight in-depth interviews were conducted, with two interviews following each FGD. IDIs were held in the same location as the FGD sessions, although the women second in line for the interview waited in a separate location. The IDI interview guide (see Appendix C) was organized in much the same fashion as the interview guide for the FGDs. An assortment of questions were asked and divided into the following sections: employment experience; health information; and, conclusion. Questions in the IDIs were oriented toward gathering in-depth information regarding a number of topics, including: the women's motivations for working as FDWs; their expectations, working conditions and job satisfaction; their interaction with others during employment; their health behaviors, threats to their health and current health status; and, finally, their recommendations to other FDWs for health maintenance. There was some variety in the questions asked, since the IDIs were conducted with women who already participated in FGDs. For instance, while women were asked during FGDs to reflect on how the health and

working conditions of FDWs could be improved, during the IDIs they were asked for their advice to other FDWs in regard to health maintenance, as aforementioned.

In place of the free listing and pile sorting activities of the FGDs, participants were asked more directly about their health problems, if any, in regard to their: physical health; mental health and/or emotional health; sexual health; and, health behaviors. Subsequently, they were asked whether the aforementioned were present during, after or before their employment abroad. IDIs allowed for a more private and intimate session between the investigators and the participants, eliciting more sensitive information which was not revealed during the FGDs. Each IDI lasted approximately thirty to forty-five minutes. As with the FGDs, IDIs were also audio-recorded and short-hand notes were taken by Dr. De Silva. If participants in the IDIs had some particularly interesting responses to the questions, these were conveyed to the principal investigator and noted.

2.5 Participant Compensation

Given the length to which they were expected to stay in the FGDs and IDIs, all female FDWs received modest monetary compensation of 1000 LKR, or approximately 8 USD, for any travel expenses that participation in the study may have incurred. Women who participated in both a FGD and an IDI received an additional 1000 LKR (thus, approximately 2000 LKR, or 16 USD total). Additionally, given the length of the data collection procedure, the researchers thought it appropriate to provide the women with some refreshments during the free listing and pile sorting activities of the FGDs. The

two women who had participated in the pilot-testing phase were also provided monetary compensation of 1000 LKR.

2.6 Ethical Considerations

Ethical approval for this study was granted from both the Institutional Review Board of Duke University and the Ethics Review Committee of the Faculty of Medicine at the University of Ruhuna. All participants were provided with informed consent forms (see Appendix D and Appendix E), assuring their voluntary participation and the protection of their privacy by not including their names in any form of verbal or written report about the study. Instead, participants were each assigned a number, which was used on all research materials. All forms of data (i.e., hand written notes, response to free listing and pile sorting tasks, transcriptions and audio files) were kept by the primary investigator and the co-researcher, Dr. De Silva and protected accordingly.

2.7 Data Analysis

The process of data analysis was preceded by validation of data collected. During the FGDs and IDIs, detailed notes were taken by Dr. De Silva to allow for preliminary data analysis and extraction of emerging themes. These notes were read through several times by the principal investigator, who would ask Dr. De Silva if any clarification was needed. Subsequently, three medical interns at the University of Ruhuna were hired to read through the notes and verify that nothing was missing by comparison with the audio recordings. These, as well, were checked by both Dr. De

Silva and the principal investigator to ensure that everything was well understood. Full transcripts were obtained with the aid of Dr. Wijeratne, who would listen to the audio recordings in Sinhala and translate everything to English. These verbal translations were then transcribed by the principal investigator and, finally, compared with the original notes taken by Dr. De Silva. Other research material, such as the women's responses to the free listing activity, was translated and verified by Dr. De Silva and Mr. Tharindra at the end of each data collection session.

The FGD and IDI guides were organized into various themes themselves. These were of interest to the principal investigator, however, we did not want exclude other themes that may have emerged from the women's responses. Therefore, during the first phase of data analysis, the notes were read through by both the principal investigator and Dr. De Silva. Dr. De Silva then shared her list of potential themes and comments, which were compared to that of the principal investigator's in the next step of the process. Full transcriptions of the FGDs and IDIs were read through and emerging themes were noted. Each new theme was coded with a number. Once a final list of emerging themes was obtained, relevant quotes were selected to fit in with each theme. These were also coded with a number scheme, according to whether they were selected from a FGD or IDI. Finally, results of the free listing and pile sorting tasks were analyzed quantitatively for frequency distribution. The entire data analysis procedure was not aided by utilization of any computer-assisted qualitative data analysis software (CAQDAS), other than Microsoft Word ©.

2.8 Quality and Credibility of Methodology

To strengthen the credibility of our qualitative inquiry from the outset, the principal investigator and her co-researcher, Dr. De Silva, coupled their individual skill sets: the principal investigator was previously involved in qualitative research, while Dr. De Silva had worked with the population of foreign domestic workers both in a clinical and research setting. Mr. Tharindra, who was also there to assist with translation of data collected, had his own experience with conducting qualitative research in a cross-cultural setting. Dr. Wijeratne, who also dedicated her time to aiding with translation of materials, was familiar with the population as well and had previously been involved in qualitative research. While both Dr. De Silva and Dr. Wijeratne had previously worked with the foreign domestic worker population, the participants in this study were unknown to them personally.

To further enhance the quality of the study, triangulation of qualitative data sources was sought by deriving information from the same pool of participants through different means. These different means include FGDs, IDIs and free listing and pile sorting activities, the latter two which lend themselves to quantitative analysis and, thus, further triangulation of methods. This triangulation led to the comparison of participants' responses to questions in a group versus individual setting. In terms of external validity, qualitative research does not lend itself to generalizability to the same extent as the quantitative method can. However, should recurring responses, or themes,

emerge from the participants' responses, this means that theoretical saturation has been attained. This can lend itself to proximal similarity, rather than generalizability, whereby the results can be applied more confidently to a setting and population similar to the one in this study (Patton, 2002). Finally, multiple translations (by both Dr. De Silva, Dr. Wijeratne, and the three medical interns) assured that nothing was left out of the final transcripts obtained and that the original meaning in Sinhala was conveyed as accurately as possible.

3. Results

3.1 Demographic Profiles

As the exclusion criteria for participation in the study was lax, the sample of participants varied in a number of ways (as described in Tables 1 and 2). Table 1 shows the sociodemographic characteristics of the women. In terms of age, the youngest and the oldest participants were 23 and 66 years old, respectively. The average age of the women was 45.1 years (SD 12.2). Of the 25 participants, the majority of the women were in their 50s, accounting for 36% of the total sample. Of the rest, 16% of the women were in their 20s; 20% were in their 30s; 16% were in their 40s; and 12% were in their 60s. Since the participants were asked to provide their year of birth, rather than age, their age was calculated based on the age they would be turning in the year 2013. It should also be noted that these ages did not indicate the age of the women at the time of their employment abroad, since the sample was made up of women formerly working in the Middle East at some point in their lives. To determine whether the sample was actually comprised of women originally from Galle District, we found that five participants (20%) were from another district, including the districts of Colombo, Polonnaruwa, Kalutara, and Ratnapura. All but one of these women have resided in Galle for the past 20 years or more.

The collection of other sociodemographic information revealed that 36% of participants—the majority—received an education up to the middle school level (or

junior secondary level, in Sri Lanka). The lowest grade level completed among women was grade 5 of primary school, comprising 20%. The highest education level attained by one participant was the general certificate of education advanced level (G.C.E. A/L), which serves as the university entrance exam in Sri Lanka (Classbase, 2012). Six other women reached the general certificate of education ordinary level (G.C.E. O/L) of post-secondary education, allowing them to enter grades 12-13 (Classbase, 2012). 80% of participants received their education in Galle. Among the 25 participants, only one woman was single. Finally, the majority of women (i.e., 88%) had children, ranging from one to five. Most of the participants (48%) had one to two children, with overall average of 2.5 children for the entire group (SD 1.1).

Table 1. Sociodemographic Characteristics of Participants

Characteristic	Number	Percentage	Mean (SD)
Age (years)			45.1(12.2)
20-29	4	16	
23	1	4	
26	3	12	
30-39	5	20	
34	1	4	
35	1	4	
36	1	4	
37	1	4	
39	1	4	

40-49	4	16
42	1	4
44	1	4
47	1	4
49	1	4
50-59	9	36
50	3	12
51	1	4
53	1	4
54	1	4
55	2	8
58	1	4
60-69	3	12
60	1	4
61	1	4
66	1	4
Galle District native		
Yes	20	80
No	5	20
Colombo	2	8
Polonnaruwa	1	4
Kalutara	1	4
Ratnapura	1	4
Education level		
Primary	5	20
Grade 5	5	20
Middle (Junior	9	36

Secondary)	1	4	
Grade 6	3	12	
Grade 7	5	20	
Grade 8	4	16	
Secondary (Senior			
Secondary)	4	16	
Grade 10	7	28	
Post-secondary	6	24	
G.C.E. O/L*	1	4	
G.C.E. A/L**			
Educated in Galle District	20	80	
Yes	5	20	
No			
Marital status	24	96	
Married	1	4	
Single			2.5 (1.1)
Children	22	88	
Yes	12	48	
1-2	4	16	
1	8	32	
2	9	36	
3-4	7	28	
3	2	8	
4	1	4	
4+	1	4	
5	3	12	
No			

*G.C.E. O/L: General Certificate of Education Ordinary Level

**G.C.E. A/L: General Certificate of Education Advanced Level

Table 2, below, displays the socioeconomic information that was collected from the participants in the study. The majority, or 36%, of the women were previously employed in only a single country, while an equal number of women (i.e., eight in each category) were employed in two to three countries. Overall, the average for the group was two countries (SD 0.8) of previous employment. The pool of countries that the women worked abroad in includes Kuwait, Saudi Arabia, United Arab Emirates, Jordan, Lebanon, Qatar, Bahrain and Singapore. Of these, Kuwait was the most frequent country of employment, with 56% of women having previously worked there; while Saudi Arabia closely followed as the second most frequent, comprising 52%. Qatar, Bahrain, and Singapore were equally the least frequent countries of employment, with only two participants (i.e. 8%) being employed there previously. In regard to their most recent country of employment, Kuwait and Saudi Arabia were both the most frequent, with 24%. This time, Lebanon, Qatar, Jordan, and Singapore were the least frequent countries of employment, with 8% of women having gone to work there. In terms of the duration of their most recent employment, the participants overall worked an average of 3.4 years (SD 2.6) abroad. More specifically, 80% of women were employed for less than five years, with the majority of women (i.e., 64%) being employed for a duration of two years. 16% of participants were employed for five to ten years in the last country, while

only one woman was employed for a longer period of time, a total of 13 years. Women were not asked whether this time was interrupted with visits to family in Sri Lanka or other travel.

Regarding their recent situation, the majority of women, 80%, informed us that they were currently unemployed, while five participants were. Currently employed women reported that they were engaged in the following occupations: cinnamon peeling, plucking tea, chicken farming and home gardening, and sewing clothes. Two of the five women earned their living by peeling cinnamon. One of these two participants identified herself as a laborer, while another who plucked tea also considered herself a laborer. The two remaining women identified themselves as being self-employed, with one engaged in chicken farming and home gardening and the other sewing clothes.

Table 2. Socioeconomic Characteristics of Participants

Characteristic	Number	Percentage	Mean (SD)
Number of countries employed in			2 (0.8)
1	9	36	
2	8	32	
3	8	32	
Countries employed in			
Kuwait	14	56	
Saudi Arabia	13	52	
United Arab Emirates	8	32	

Jordan	5	20	
Lebanon	3	12	
Qatar	2	8	
Bahrain	2	8	
Singapore	2	8	
Country of most recent employment			
Kuwait	6	24	
Saudi Arabia	6	24	
United Arab Emirates	5	20	
Lebanon	2	8	
Qatar	2	8	
Jordan	2	8	
Singapore	2	8	
Duration of recent employment (years)			3.4 (2.6)
<5	20	80	
2	16	64	
3	3	12	
4	1	4	
5-10	4	16	
6	2	8	
7	2	8	
>10	1	4	
13	1	4	
Employment status			
Unemployed	20	80	

Employed	5	20
Current occupation		
Cinnamon peeling	2	40
Plucking tea	1	20
Chicken farming and home gardening	1	20
Sewing clothes	1	20

3.2 Emerging Themes

3.2.1 Individual versus Family Motivations and Social Conditions Leading to Foreign Domestic Employment

For the majority of participants, becoming a FDW was not something that they were expecting to do. This sentiment was unanimously expressed among women in three of the four FGDs, although a few women in one of the FGDs mentioned that they were expecting to go abroad. The circumstances of their lives, however, lead all of these women, eventually, to seek work as a FDW. These circumstances motivated some women to seek employment abroad for personal reasons, while many others spoke of their families, especially children.

Among the latter reasons mentioned for leading them to seek employment abroad, women were largely motivated by the financial circumstances (i.e., being poor

or having economic troubles) and well-being of their families. For many women, both within and across FGDs and IDIs, working abroad as a FDW was believed to be a means through which they could improve their living quarters and provide for their children or siblings' education and take care of their parents. Improvement of living quarters often meant building up a house, buying land, or constructing a specific part of one's house (e.g., kitchen or wall around the house). Besides allowing one to provide for their children's education, foreign employment was believed to provide money to allow women to properly raise their children. For many others, this employment could serve to supplement their family's income or allow them to serve as the breadwinner for the family. In the latter circumstance, some married women revealed that their husbands did not maintain a stable job, had an insufficient salary, or were entirely unemployed. One participant mentioned how she wanted to assist her husband in buying a tuk-tuk (or three-wheeler). Another even openly disclosed during a FGD that her husband was a substance abuser as her reason for becoming a FDW. Overall, women expressed their motivations in the following ways:

"I wanted to raise up my children in a good way. So it needs money."

"I had a lot of financial difficulties. My husband was an alcoholic and drug abuser. We had no place to stay, we lived in a rented house."

"I had many members in my family. I'm the tenth child, so I couldn't learn well. I wanted to help my brothers and sisters learn. So I went for foreign employment."

"When my father died and mother became ill we had financial problems. So I wanted to go for foreign employment because I wanted to construct a new house and I also wanted to help my younger sister in her studies and I want to buy

some jewelries and I want to make good future for me and rest of my family. So I got to know good agency who supply foreign employment with help of my brother. So they help me, so I got this foreign employment.”

“I wanted to buy a three wheeler for my husband. I wanted to send my child to a good school. He was going to a small school, I want to send him to a big school. And I want to make him comfortable for his studies.”

“My husband was doing some business but still the money was not sufficient. Because I didn’t have enough money, I had to go.”

Among more personal reasons, one participant mentioned the attraction of beauty and material goods (i.e., jewelry) that can come from working abroad. Financial independence and freedom were also given as reasons for some women to choose to become FDWs. Some participants also went to work abroad as a FDW so as to lead a better life for themselves and their families.

“Yes, I feel like to go when I see the woman who has gone for foreign employment coming beautifully. With wearing jewelries and valuable clothes. And also, I thought that for my requirements, I should not bother my parents but I myself need to earn, so I also need to go for foreign employment.”

“I need my freedom. Some people go because they need their freedom.”

When reflecting on the type of women that end up seeking employment as a FDW, some participants responded with motivations similar to those mentioned above, including: economic problems; husband’s insufficient income or lack of contribution to the family’s livelihood; husband’s substance abuse; and responsibility for children. Yet, others made mention of insufficient education being an influential factor as well as lack of economic opportunity in Sri Lanka. Even if they enter the labor market in Sri Lanka, it seems that women who are not very well educated—according to one participant’s

perspective— are limited in terms of job opportunity by becoming either become garment workers or FDWs. The participants' sentiments were expressed in the following ways:

“When the breadwinner's income is not sufficient to meet the demand of the house, we had to go.”

“Some are not very educated. Some don't have garment employment, so those ladies tend to go for foreign employment.”

“If husband is drunken and doesn't give money to house expenses, women happen to go for foreign employment.”

“When the man of the family doesn't have a good income, mother has to take the responsibility to teach her children. So she goes for foreign employment.”

“We had to go to foreign employment because we don't have enough money. If we try to go for any other work in foreign country, like hospital work, to work as a hospital labor or something, we need to pay big amount of money to agency. Since we did not have enough money to get such a job, we had to go as foreign workers.”

“In my opinion it is because women cannot earn good salary by working here in Sri Lanka. When we go abroad, our requirements are looked after by the employers and we can send our earned money and salary to our home, so that family members can live peacefully.”

Some women in two of the FGDs spoke of foreign employment serving as a means by which women could gain their freedom. Although the type of freedom referred to (whether economic or social) was not mentioned, it should be noted that participants also discussed the entertainment value of going to work abroad and even exhibiting some “unacceptable behaviors”. From one woman's perspective, the Middle East offers a better standard of living, or “facilities”. Attaining beauty is yet again

mentioned by another, as a newly evolved motivation for some to work abroad, rather than economic problems. Being beautiful and young was one participant's description of the type of woman that goes to work abroad.

"Some ladies are going because they need some entertainment. Some going because of economic problems."

"Some women go for foreign employment for their freedom. Some have unacceptable behaviors and unhealthy relationship with people. Do what they want, they go for foreign employment."

"It is because some Middle East domestic workers are treated by their employers very well. So they don't want to stay back in Sri Lanka. Even though they come back to Sri Lanka, they try to go back because they have all the facilities at their workplace."

"Earlier women used to go because of economic problem, but now they want to go because they want to maintain their beauty."

3.2.2 Pre-departure Concerns, Advice from Others, and Employment Training

The majority of the women within and across FGDs and IDIs expressed that they had positive expectations of their work abroad. That is, they anticipated having a good experience. Despite this, some concerns were noted, which were largely based on what they had heard from other FDWs and their unfamiliarity with the profession and its demands. Among these, participants mentioned that they were fearful because of potential language problems, as well as having cruel employers with misbehaving children. Some spoke of their worries about being unfamiliar with their employers and their work expectations. Others were worried that they would not be able to properly

use household appliances and were concerned about their safety while working abroad. Besides unfamiliarity with work expectations, one participant even mentioned that she was primarily worried about not having a place to live. However, it is important to note that not all women were concerned with the aforementioned matters. One participant heard of the harsh working conditions that she may be met with from other FDWs, however, she was not worried about them.

“I was scared because the people to whom I am going to work for are not familiar to me. I was scared because I was worried about their language.”

“I have heard a lot of things about this foreign employment. I have heard that they have several storied houses. I have heard that these people are cruel and I have also heard that their children are mischievous and so I was scared before going.”

“I also had my worry about the instruments that they are using in the kitchen. I worried about whether I could work with those instruments.”

“We went with a lot of problems in our mind. We’re scared to go because we didn’t know anything about our working environment.”

“I had contacts with a few who had gone for foreign domestic work earlier. They say that sometimes we will be having to work for long hours and will not be fed properly but I didn’t consider about those things seriously.”

Some participants received advice from other FDWs (sometimes family members) they knew of or from their employment agency. The former was helpful in comforting the women and familiarizing them with their work expectations. In the case of the latter, however, women’s interaction with employment agencies was mixed. Some participants did not find them to be supportive and were advised to only contact the agency in specific cases of need (e.g, threat of harm). Some others spoke of the comfort

that the employment agencies brought them and their advice toward working abroad safely.

“I had advice from those who have gone to foreign countries previously. They said there is nothing to be scared about. You will have to clean clothes and look after children and cook. So I was not scared to go. I took their word.”

“One of my aunt to for foreign employment previously, so she has told me if I could learn their knowledge, I’ll be finding very easy to work there. She also wanted me to learn to work with electric instruments.”

“I was told by my friend, the things that she come out with, how it affected her employment.”

“I was very scared before going there but agency people comfort me. They say not to worry.”

“Before I go there my children had a lot of concerns about my security and all, but I managed to get advice from agencies and many other people and I managed to have my stay safely there.”

“Some peoples say that a lot of nasty things happen in foreign employment, so we got scared and we wanted to get advice from the agency. I was given a card from the agency and I was advised to call back to the agency if I faced any such problem.”

“The agency has instructed that we are going there for work, so don’t complain to us. You have to do the work that you are allocated, because you are going there for work. We were only asked to call them if we were beaten or if people tried to abuse us sexually and if the children are naughty.”

Prior to working abroad, the majority of participants consulted with their family members (including husbands, parents, siblings and children) in making the decision to work abroad as foreign domestic workers. Some women did not, however, either due to their age and independence, or the lack of support from their family members. It should be noted that not all women, however, knew any FDWs personally and so they could

not receive any advice from them.

“I have taken permission from my parents, siblings, and husband.”

“In the case of ours we discuss the problem with family members and we go with their consent, only I went for foreign employment. But there are women who do not discuss the problem with their family members but go for foreign employment for their own decision.”

“I am forty-five years old, my son is also old enough now, so I didn’t worry about what others say.”

“No, I didn’t have chance to speak with people who went for foreign work because my father doesn’t allow me to go away from home. I got the opportunity to go to foreign country only when my mother also became ill.”

“No, I didn’t know anyone personally but I have seen people who have gone for foreign employment previously.”

“I didn’t know anyone to have work in foreign country before I went.”

Some participants directly spoke of or alluded to their pre-departure training.

For one participant, the training she received prepared her for everything that she might be expected to do as a FDW. However, another participant mentioned the difference in present-day training versus the training that she received. The inadequacy of her previous training made her frightened of working abroad. As previously mentioned, women were worried about whether they would be able to properly utilize the household appliances at their employer’s home. Besides that, there was also frequent mention of expected and encountered language difficulty and the understanding that it is necessary, as a FDW, to learn the language of the host country. One participant commented on these two points (i.e., inability to use household appliances and struggles

with language) by saying that the two week training provided by the foreign employment bureau was not enough.

“I was trained before going there as a housemaid. I was trained for everything that I might happen to do, but I had to do only child rearing.”

“I was very very scared about people. When we are going for foreign employment, we were not trained like this, unlike today. So we have a lot of concerns about the foreign place we are going.”

“I had language problems. I could not understand what they were speaking about. So the very first day when they asked me to bring some fruits and a knife, I brought rice and a knife. Still I can remember.”

“I didn’t think that I’ll have too much work to do there. I had to learn their language when I go there.”

“Because we cannot understand the language so we face problems there. And we happen to use electric instrument that we have not used to use while staying in our country. So we were given on two weeks training by foreign employment bureau which is not enough.”

3.2.3 Living Environment and Heterogeneous and Gendered Work Responsibilities

In terms of their working and living conditions, the majority of participants had expressed that prior to working abroad they had certain expectations of their workload, salary, and living arrangement. Anticipated work responsibilities include domestic work in general, cooking, washing clothes, cleaning, and taking care of children. One participant mentioned her thoughts about the work not being difficult, as domestic work is already done by women in Sri Lanka. Some did not expect to have much to do, while others did. For instance, a few participants expressed that they expected (or hoped) to

work for a small family or only have one child to take care of. However, not all FDWs had prior thoughts regarding what was to be expected of them to do for their job. In terms of their living conditions and their employers, participants expected to have facilities (e.g., a single room); that they would be treated well and that their employers would be good people; that they would have a good salary; and, that they would be able to work abroad without any problems, allowing them to return home safely.

“I thought that those works are already done by houses even in Sri Lanka. So I thought that those tasks will not be difficult for me.”

“I had my expectation to have a good house, good people and to work there without any problem. After the completion of my work, I wanted to come back to Sri Lanka safely.”

“I expected to do cooking and cleaning of the house, washing clothes and looking after children. Actually those are the work I received.”

“I expected facilities and good salary.”

“I thought that I would get a single room and other facilities.”

“I expected that I would be treated well.”

“I expected that these people would be good.”

“I had not thoughts about my work there. I didn't know what work I had to do there. But after I went there I understand there are only sir, madame, and two children.”

With regard to their actual work duties, FDWs were involved in a slew of duties including: cooking, cleaning the house, washing clothes, taking care of children or elders, grocery shopping, taking children to school, washing carpets, etc. For many participants, although they expressed a positive expectation of not having much work to do, they

later found themselves overloaded with tasks. On the other hand, others found their expectations reversed, in that they had a lighter workload than they anticipated. Some participants reported being assigned all of the tasks that they had expected to be asked to perform. Overload of work meant either being asked to complete more kinds of tasks (e.g., washing carpets, cleaning fish bowls, etc.) or being assigned the same tasks but for a greater number of people (e.g., multiple children instead of one, or 20 household members instead of a few). Meanwhile, a lighter workload implied the opposite, having less tasks to complete (e.g., only having to perform household work and not take care of children, or only being asked to take care of children) or being asked to clean after fewer household members (e.g., only taking care of elders). The majority of women were asked to take care of children. Taking care of children implied watching over them, cleaning their clothes, taking them to and from school, etc. One participant mentioned how Sri Lankan women are perceived as being more loving and more careful than FDWs from other countries, so employers put the children in their care. Cooking sometimes entailed the preparation of exotic foods, which the women were not familiar with or uncomfortable preparing. In terms of sharing the burden of domestic work, some FDWs were the only ones employed in the household. One such participant was hired to look after a household of 20 people in total. Others were employed in households with more than one FDW, who, in some cases, were in charge of other duties. Still others, while assigned to perform certain tasks, were merely asked to assist their employers with other work (e.g., assisting the female head of the household with cooking).

“There was a difference for me with regard to my expectations. I didn’t expect that much of work but I had a lot of work to do. I had to work throughout the day.”

“I could work according to my expectations.”

“The work which I had to do there is cooking. And I had no children to look after there. Sometimes I cooked Sri Lankan meals for them.”

“I had expectations to look after one child but I had to look after four children.”

“I had to look after three children. I didn’t do any household work.”

“I had taken children home and cooked and cleaned the house. I have done the work of twenty.”

“In my case I was hoping to work in a small family but I had two families at one house. One man has married two women and they had several children and I had to look after even their grandchildren. I had twenty people in that house to look after. When I cleaned the downstairs and go to upstairs to clean, when I come back to the downstairs it’s again messy like it was.”

“They like us to look after their children. Because unlike Philippine, Bangladesh and Indian housemaids, Sri Lankan housemaids love the children, they carefully look after the children. So they want us to look after their children.”

“Mostly I did this looking after this elderly, but I had to attend some other works also. But there were some other people to look after other works in that house.”

“Madame is cooking, I had to help her for cooking.”

One FDW was able to lead a relaxed life in Singapore (unlike her experiences in the Middle East), due to the few work responsibilities that she had. For those that had less positive experiences, they either left their job and sought employment elsewhere, or went to the embassy (albeit being bribed with money to return). Some women found that they were not earning the salary that they were expecting (e.g., either have a lower

salary or being paid irregularly). However, other participants were satisfied with their salary. One such participant did not even need to spend her salary on certain expenses (such as airplane tickets for visits home), as these were taken care of by the employer, and there were even instances of paid holidays. For those forced to live under inadequate conditions, they found that they were not provided with basic facilities and sanitary goods. Others were given everything they needed, some even private facilities, so they felt comfortable. Women with experiences of overwork also mentioned not being able to eat or sleep properly, skipping meals and having to stay up too late or wake up rather early. While some were not able to get any rest, others were able to get enough sleep and take naps.

“I had no big workload. Actually, I could spend a relaxed life there. It is different from my previous employment at Middle East countries. Here in Singapore I could lead a good life.”

“After one year I had to choose another place to work, because I had so many work to do there. I myself had to do all cooking, ironing and cleaning and everything. So, I got fed up and want to find a new place.”

“The last place I was not treated well, I was not paid well. So I went to the embassy, embassy people gave 500 rupees to come back.”

“The last place I worked, I stayed there for three years. But they didn’t give the salary in time. They give the salary usually once in three months time. Even though my mother get ill, I couldn’t send money because they didn’t give me money.”

“I also had supplies. I did not want to spend my salary to purchase those things.”

“I was not given soap and daily utility things. These things I had to purchase from my salary.”

“Even though we happened to work, we got all the facilities. We could sleep as we want and we could get our meals in time and we could do whatever we want. We had all the facilities even though we had to work hard.”

“Even though I had to work there. I spend a very good life there. I had very good facilities there. I had air conditioned room. I had been given a mobile phone so I could get calls to Sri Lanka whenever it was necessary. And I had good food and I could rest as I wish. So I was about to forget Sri Lanka. I had a good life there.”

“I had my own room, own bathroom, so I was comfortable there.”

“That lady came early in the morning to me and she wants me to wash all the vehicles in the house and she wants me to clean all the walls and all the house, which is not possible for me to do. They don’t allow me to have a good sleep.”

“Even though I work hard throughout the day, I need to get up early morning to the other work in the home.”

“I told that I have to look after one child, but when I go there I had to do lot of work. I have to look after more than one child. And I had to cook, I had to wash clothes and I had to clean the house. And also they wanted me to be very clean, so I had to have daily bathing and those things. When I go to bed, it’s almost 4 AM in the morning. So there’s no time for me to sleep.”

“We could not take our breakfast at the due time, sometimes we had to skip our breakfast and sometimes we had to work till late hours and sometimes we could not have a good sleep because of work.”

“I of course have a nap after lunch. Two to four hours of sleep.”

“I went to Singapore to look after one child. There was one other Philippine domestic worker for work there and there were three children in that house to look after. When I get there the Philippine worker went on vacation to her home country so I happened to look after all three children. The problem I had was once she left I had to look after all three children. I had to take them to school, I had to go for groceries and I had to do everything. I had hardly any time to sleep. So I was overloaded with work, but I was paid very well. I was paid with the other person’s salary as well because she didn’t come back. They gave me clothes and even jewelries and the salary. I had lot of work there. I went to bed very late in the night and I had to get up very early in the morning, at about 4 AM in the morning. But still I worked happily because I was paid two salaries. I was paid

very well. When I do not come to Sri Lanka in two years time. They gave that amount they spent for us for travel also they pay us. So we are paid for that holiday also.”

3.2.4 Impact of Foreign Domestic Employment on Family Dynamics

Throughout the FGDs and IDIs, the participants would comment on the way in which their family or their familial relationships were affected by their employment abroad. In some cases this occurred during the time of employment or upon their return home in Sri Lanka. During their time working abroad, some participants learned of an ill family member, such as their mother, husband, and son. Some women expressed their inability to return home to visit their sick mothers or send money home, due to restriction by employers. In the case of one participant, her mother passed away during the time that she was employed abroad, without being able to return to Sri Lanka to visit her. Another FDW, however, was able to be provided with money to send to her injured son in Sri Lanka. Still other women spoke of the changes that they had found in their family dynamics upon their return home. While there was mention during one FGD discussion of other women finding their husbands married to another, one participant actually experienced this. Another relocated to her parent’s home after being left by her husband, while another found her children married, unbeknownst to her. Not all women, however, experienced such dramatic changes to their family life.

“Even if we tell that our mother is dead and we want to go back to Sri Lanka they question us, are you going back to wake her up? I had my own experience

and my mother was very very ill, so I wanted to go back. When I asked to go back, the owner told me that if you want to go you need to pay back all the money that we have paid to the agency. Only then are you allowed to go. Even if she was asked, when you go back to Sri Lanka, will your mother regain health because you went back? But all of the houses are not like that. For example, the house in which my sister worked, she was treated very well. And she was allowed to even visit my place. She came every week to visit me, and she prepared Sri Lankan foods and we tasted Sri Lankan foods there and we had a nice time together. The caretaker used to drop her and take her.”

“The last place I worked, it is a good place, but they didn’t allow me to go to Sri Lanka when my mother became ill. So I couldn’t see my mother. She died before I came.”

“Some women disturb their family life when they go for foreign employment. Most of the times they found when they come back to Sri Lanka their husband has entered into second marriage. Because they don’t have anything to involve in the country they tend to go back again.”

“My husband left me and now I am staying with my parents and children.”

“No, we have not divorced but we live separately. He is living with another woman.”

“I had no any mental problems but only concern was when I am coming back, all my three children have got married without my knowledge.”

“My foreign employment didn’t affect my family life. I’m living peacefully with my husband. My children are schooling, now they are getting ready for their exams.”

Not only were family dynamics influenced in the aforementioned ways, but some female FDWs also discussed how their employers restricted their communication with their family members. This was not the case for all women, as some were able to keep in contact through letters and phone calls (although phone calls may have been brief). One participant who was unable to communicate with her family members took

the liberty to buy a phone for herself. Communication or thinking of their family helped some women to cope with the difficult life that they encountered while working as FDWs. For one woman, frequent communication was viewed by her employers as a means to prevent her from regretting her choice to work as a FDW and becoming more “thoughtful”, or perhaps worried about her decision and leaving her children behind. Not all women were adversely affected by thoughts of their family. For some, this was a protective factor or even a motivation to keep up with their work. Finally, there was also mention of mutual worry, in that family members in Sri Lanka would worry about the women if they shared their concerns with them over the phone.

“The main problem is that we don’t have anyone to discuss our problems. Even if we give a call to Sri Lanka, we cannot take it for a long time. It is limited only for 5 minutes. Within those 5 minutes we cannot express all of our thoughts. So we feel helpless.”

“They don’t allow us to have frequent communication with our home. Because once we contact our home, people living in our house, husband or other family members, we feel sorry about our children and we used to regret and we used to more thoughtful. They don’t want us to be like that so they don’t allow us to have frequent communication with our family members. They allow only once a month for us to have a chat with them.”

“They restricted my phone calls so I had to buy phone for my own. So after buying that I was able to communicate with my family members. When I have any problems I went inside to bathroom and discuss my problem with my family members.”

“Most of the times I used to cry. There was my cousin brother there and I used to give him a call and I tell him everything and I cry.”

“When I have bad thoughts, when I had sorrowful mind. I thought about my husband and my children. And that’s how I expel my worries.”

“I didn’t feel guilty about leaving my child. Some people they cry thinking about their childrens. We try to made up their minds, saying that we came here because we don’t have enough income but to work as far as you can.”

“I didn’t share my worries with family members because they also become worried when I speak those things with them over the phone.”

3.2.5 Relationships with and Treatment by Employers: Positive versus Negative Experiences

Regarding their relationships with their employers, throughout the FGDs and IDIs participants had mixed experiences. On the more positive end, some FDWs worked in households where they were treated very well by the members of the household. In these cases women were cared for as family members and established a close relationship to the head of the household or the children they cared for. One participant mentioned joining the family on travel abroad to other countries, and another joined family outings. Some participants were treated fairly as employees, provided all of the amenities, given freedom to interact with others and go outside, allowed to take a rest (and even prevented from overworking), and free to practice their religion. One participant mentioned that her employer would cover the cost of her expenses, even purchasing her airplane ticket to come work there. Another was treated as one of the members of the family, such that she could ask for favors of her employers. For another, this was extended to sharing her feelings with her employer and receiving advice. Some employers would not only share household and purchased goods, but would also share their food with the FDWs or would provide them with food they are more familiar with

or enjoy more. Likewise, they would ask to be cooked Sri Lankan meals, which they enjoyed. For several women, not having enough food to eat or not finding the time to eat was not an issue. One participant mentioned that her employer contacted her after she returned to Sri Lanka, asking for her to return and offered her to bring her daughter along. Another was even sent money by her employers to support her. Finally, in terms of living in a safe environment, one FDW spoke of not being scared about her privacy and protection.

“If I have some depressive feelings, I used to speak with madame. She share my thoughts and even I can share my thoughts with children. So I can explain my sorrows. Children loves me.”

“The lady of the house was very good person and she was very close to me. She helped me with all my problems.”

“If they were to travel in foreign countries, they used to took me also. So I had a good life there. I had been even to Australia with them.”

“The place I went to was very good, and the Madame was very kind and I was paid a good salary. And I was treated very well. Whatever I needed was brought to me through Madame’s cost. I didn’t have to spend a cent of my salary for those requirements. They even sent me the ticket to go there.”

“The place I went to was a very good place and I could meet all my expectations there. I stayed there as if it was my own place, my own house. They treated me very well and I could meet all of my objectives. I was taken as a member of that family and the family did whatever I requested them to do for me.”

“Yes, she was very flexible. She allowed me to go out to buy the things that I want. So I could help them.”

“No, that depends on the place you are staying. You must not be scared to say that you are Buddhist. They allow us to keep pictures of Lord Buddha. I used to keep a photo of Lord Buddha with me and I was allowed to observe sil on poya day.”

“I had a very good working place at Lebanon. At that place the Madame used to cook. When she cooks first give my portion in a tray to me and then only they take their meals. And if Madame buys some clothes for her she brought the same clothes for me also. They treated me as their own family member.”

“Some employers very helpful and they are very friendly and they love us. Sometimes they even share with us plates and cups. But some are different.”

“They don’t eat chili food, but they bring chili foods for us. When they bring shampoo, soap from groceries, they give me my part before they took theirs.”

“If we cannot eat their food they bring us the food that we like to eat and we can prepare those meals and we can eat ourselves.”

“I also had good life there. I could take my meals regularly in time. And I could sleep whenever I want, so I did everything in good way.”

“The place I worked was very well. Everything was went in order. I was expected only to give the least of groceries that is required. So everything was brought. So I had to cook and do other household things. I had good life there. There were no small children, so I didn’t have to look after children. Even now they give me phone calls and they request me to come back. But I’m saying that I need to stay here till my daughter get married. After that I can go back. Now they say to come there with my daughter.”

“She had even send me money after I came here. After I gave birth to this child she had send me 50,000 rupees.”

“My working environment was good. There was nothing to be scared about my privacy and the protection and those things. I’m overall satisfied about my working place.”

However, some women found themselves in less fortunate circumstances. In some cases, even if some aspects of their relationship with the employers were satisfying, problems would emerge. In the case of one woman, she would accompany the family on vacations, had little work to do, and would be allowed to leave the house

on her own. On occasion, though, she would be subject to some verbal abuse by her employer when she was in a drunken state. Other FDWs also suffered from verbal and physical abuse by their employers, were not allowed to interact or communicate with others, were limited to staying in the home, and not allowed to practice their religion. One participant was scolded for not understanding the language the employer was using. In the case of religion, some had to pretend not to be Buddhist or would be asked to follow Islamic practices. One participant spoke of not being allowed to go outside to take the trash without being supervised, and another was accompanied by her employer at all times. For one FDW, restrictions placed on mobility and interactions were done by the employers out of concern for her. There was mention of keeping of cameras in one household, as well as recording telephone calls in another. Besides not finding the time to eat due to work overload, some participants mentioned certain food restrictions being placed on them, such as employers counting food to monitor when the FDW ate them. One participant spoke of being threatened to be sent to the agency and not provided with a salary if not able to work. Confiscation of passport and personal documents was only the case for one FDW.

“They verbally abuse us. They scold with various names. Like ‘smelly’.”

“I was scolded and verbally abused but I was not abused physically.”

“I was not allowed to have interaction with anyone in the neighbor surrounding. I think in a way it is because they concern about me, because I was not married and they want me not to have unnecessary involvements so the madame treated me in good way.”

“They don’t take us to any picnic or any places that they used to go for entertainment. They left us at home.”

“We are not allowed to go out. We are allowed to go only to empty the dust bin. Even though we go out to empty the bin, they look at us from the house.”

“They don’t want us to worship Lord Buddha. They are not happy with that.”

“I was asked to join their religion, in that case they said I’ll be paid better salary. So I pretended them that I’m doing their religious activities but I didn’t. I refused to get into their religion, even though how much I was paid.”

“If we get telephone call, it is get recorded.”

“I hadn’t enough food. I had to ask for food from my other friends from Sri Lanka. That’s how I survived. I bring those food home and take it to the bathroom and have my meals inside the bathroom. If they go somewhere they keep me inside the house and locked and go. If they bring something home, fruits like, they count those things and they don’t allow me to eat those things. When they go somewhere, they close all rooms in the house, except the kitchen. Even in the kitchen they count the number of goods, to know whether I have eaten or not. I feel like to come back but they had my passport in their custody, so I couldn’t come back.”

“If we cannot work they threaten us to send us back to the agency. So, in that case, they don’t pay our salary. They pay some amount to the agency.”

3.2.6 Engagement in Leisurely Activities and Social Interaction as Coping Strategies

Although many participants were overworked, some were still able to find time to rest and engage in certain activities. For one participant, she was even allowed to use the family car to go outside (albeit having to be accompanied by the child in her care). Those who were allowed to communicate with others would contact their families through phone calls or letters and would interact with other FDWs in the neighborhood.

Interaction with other FDWs was particularly considered as a happy and comforting occasion. As previously mentioned, some participants were welcomed by employers to go traveling or on family outings together. Engagement in religious activities was permitted for some, who would either practice their religion daily in the room or visit a temple during their holidays. Religious practice, as one participant experienced, helped to improve mental health. Besides writing letters, listening to music was also mentioned by one participant as an activity they were engaged in.

“They helped me a lot. They took me for picnics. They took me to even makhama. Everything is good other than the heavy work.”

“Yes, I had a very good opportunity. They gave me their vehicle and driver, but they gave me their child to take with me.”

“Friday is the most happiest day. They go to the relations place so we have a lot of interactions.”

“I use mobile phone. I had a mobitel phone so I used to speak with others using that phone. I speak to one of my friend or home. That’s how I relieve my worries.”

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

“I had four holidays per month. During those holidays I used to go to temple. During the days that I go on holidays they bring down someone else to look after their children. So these holidays help me to improve my mental health.”

“I had opportunity to have social interaction with other workers once a week. At that time I had a good interaction with them.”

“When I’m in bad mood I write letters to my house.”

As is demonstrated by some of the sentiments expressed by participants in

previous sections, for many FDWs interaction with others was strictly controlled or prohibited. Even women who considered their working environment and employment experience to have been positive overall also made mention of restriction on their communication and interaction with others in the neighborhood, including other FDWs. According to one woman's narrative, even though she worked in a household with another FDW, the two were not allowed to engage in conversation or spend time with one another. Even when the employers (or *hamputha* in Sinhala) were away, the two women would keep to this order. Other participants spoke of finding a means through which they could still communicate with FDWs in their neighborhood, unbeknownst to their respective employers. This is not to say that all women were not allowed to spend time with others, as several participants above spoke of the times that they would meet together with the other FDWs.

"I had no chance to have any interaction with them. I worked there for more than 1 ½ years, during that period I had no interaction with them."

"The neighbor community foreign employment workers they used to share their experience with us. We used to speak with each other when we meet, but our *hamputha* they don't want us to have that sort of discussions and interactions and we are questioned about what we were discussing. So we tell that we discuss about our parents, our husbands and our children."

"They don't want us to have very much interactive. Because they are scared that we will share other things in the house. If they know that we have interaction with the other domestic workers, they don't even allow us to go out from the house."

"We could not have good social interaction with other Sri Lankan maids. They don't want us to speak with each other. In my case, I used to help the other domestic worker living in neighborhood. I gave her food and everything,

without knowledge of their employers.”

“We have made a messaging system through the wall between houses. If the other Sri Lankan domestic worker is working in the other house, we communicate through the hole in that wall. We used to exchange food or other things through that hole.”

For many women, social interaction with other FDWs was believed to have a positive effect on their health and overall employment experience. For some, this form of social interaction was a regular event and for others a rare one. An exchange of words with other FDWs was mentioned as being helpful for them in terms of their mental health and emotional well-being. These would most often discuss their families and the problems they were experiencing at work. They would also give each other health advice and support, as well as additional training (with cooking, for example). Several expressed experiencing difficulties with the language, but receiving help from fellow FDWs. Besides having conversations with one another, FDWs also exchanged various goods, including food, whenever one was in lack of something. In some cases, the participants were the providers, supporting other FDWs who were in less fortuitous circumstances. In other cases, the women in our study were the beneficiaries, receiving assistance from others. In a few instances, participants’ employers would provide advice and comfort to other FDWs who were experiencing difficulty at their workplace. Sometimes they would even directly address the issue with the employers of those women.

“I feel comfortable when I have the company of other domestic workers, the neighbors. But we have 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 leave I feel sorry.”

“I had very good relationship with all neighborhood domestic workers and they loved me.”

“The place where I was working, they had their brothers and sisters who had Sri Lankan domestic workers. So when they come to their place, the Sri Lankan domestic worker came with them. So they had the opportunity to speak in their language and discuss with them. I usually meet them on Friday. It is a big relaxation for me. I feel like I had a visit to Sri Lanka when I had a chat with them.”

“When I give some solution to my friend’s problem, I feel better.”

“None of us domestic workers, who had interaction with each other didn’t get ill. We could come back to Sri Lanka in good health. We have never taken any medicine or any medical treatment. We were in good health.”

“We were shared our thoughts and I have helped many domestic workers in the neighborhood. I have bring them food, I have given them medicine and I have helped them in many things.”

“If someone new come to for foreign work we teach them how to cook, how to prepare salads and even how to take medicine because they don’t know.”

“I had lot of difficulties initially because I didn’t know the language. So my friend, domestic worker living nearby helped me, she came to our place and she explained about my problems to my house owners. So it was a great help for me.”

“When I have problem I discuss it with the others. When they have problem they discuss their problem with others. That’s how we interact with each other to solve our problems.”

“One of my neighbor worker had a burn injury but the employers in the house didn’t take it seriously. So I had to discuss the problem with my madame and she wanted me to help her and she scolded the house owners and ultimately she was taken to the hospital.”

3.2.7 Self-reported Health Conditions Influenced by Foreign Domestic Employment Experience

When reflecting on how the occupation of foreign domestic work impacts women's health, in some instances, the participants expressed during the FGDs that all women return to Sri Lanka in poor health, mostly due to the demands of work. Whether a woman returns in better or worse health depends on their place of employment, one participant mentioned. There were cases of participants reporting that some FDWs return in better health or with no changes in their health status. Personally speaking, some did not find a difference in their health prior to and after their employment nor did others experience any concerning health problems, thus returning in good health. Still others mentioned that their health may have been affected for the worse during employment, but that they recovered once they returned to Sri Lanka. A few others expressed that they still suffer from certain health problems. One woman even mentioned that although FDWs come back with a health problem their appearance improves due their diet and living environment abroad. Becoming beautiful was expressed earlier as a more personal motivation for some women to seek employment as a FDW.

"Everybody who goes for foreign employment, in a healthy situation, happen to come back in ill health."

"My health was not good when I was working there, but it became good again when I came back. I had wheezing when I worked there, but once I got back I never had wheezing."

“In my opinion it depends on the place and person. Some people come back in good health, some come back in bad health.”

“I worked hard there and I became ill there. I came with illnesses.”

“I had no physical health problems. I had no headaches, I had no psychological problems. I had never swallowed even a paracetamol at my stay there.”

“Sometimes if I have some health problems, when I think it is due to my foreign employment I think why I went for the foreign employment. This is a harm that I have done for myself.”

“I had no health problem when I go there. For some period of time, I didn’t have any health problems, but while I’m working there, after some time I develop bodyaches and pain and other problems.”

“They come in good health. They become fair and beautiful because they have good food there and good environment there. So they come back in good health.”

Overall, participants of both FGDs and IDIs most commonly self-reported problems with physical and mental health. The number of health problems experienced by women ranged from a single problem to multiple concerns. The most frequently mentioned include back pain, headaches, and symptoms of depression (including feeling sorrow or sadness, regret, loneliness, crying, or having a bad mood in general). The majority of participants were not able to get a sufficient amount of sleep or food to eat. In terms of the later, participants reported not only a lack of food but also skipping meals or not eating at the “proper time”. Many participants also expressed that they would often think of their families or their children back in Sri Lanka, which negatively affected their mental health. There were some rare reports of various types of injuries (burns from cooking or cleaning, electrocution, falling), skin irritations, cough, cold,

fever, wheezing and asthma, gastritis, various other body pains besides backache (e.g., hand pain or knee joint pain), and allergies. Unlike those who did not have enough to eat, some participants experienced a change in diet which resulted in weight gain (i.e., becoming fat or even obese, by their report). In other rare cases, FDWs even attempted suicide. Threats to sexual health and health problems that fall within this category (i.e., irregular menstruation) were rare overall. Overall, a few women reported attempts of sexual assault, with one participant actually having this threat realized. Forms of verbal abuse, including scolding and name calling, were more common. One participant mentioned that she was verbally abused initially but that her employer eventually stopped. Another had an overall positive experience but would occasionally be verbally abused when her employer was drunk. Several women also spoke about experiencing difficulty with adjusting to the change in climate and living in an air-conditioned environment.

“I have worsened my health status after going there. Because I had to work hard there and I had to climb up many stairs daily. Even doctors told me I have got ill because I worked hard. And I had to lift heavy weights so I had this knee problem and I became obese at my work there because we didn’t have rice to eat and we were eating their foods which were not suitable for us.”

“Yes, I had lot of problems. Headache, and I was very thoughtful. I was very worrying. I used to cry when I have sorrowful mind.”

“It affected badly for my health because I developed gastritis because I could not have my meals in time.”

“Because of work I don’t have time to eat. And the food’s also not that available. They don’t give adequate amount of food.”

“I had overwork there and my sleeping time was less so my mental health was not good at my work there. So I had worries about that.”

“I got burned with hot water. They need us to work fast. When we hasten our work, we get injured.”

“In my case, when I go there, I was very lean. But when I’m coming back I was obese and I had a big tummy because I ate big amount of fat, their food. It badly affect my health. I become weakened. So I cannot run and move around because I’m obese now.”

“When they don’t have enough food in Sri Lanka, their home, they try to eat everything they get in these countries.”

“Baba was very cruel. Sometimes he would verbally abuse us and even I have been physically assaulted once by some instrument.

“Yes, one day I swallowed big amount of paracetamol tablets to self harm. I swallowed 20 tablets.”

“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. So those detergents, liquids and powders, I was allergic to those things so I had allergy problems.”

3.2.8 Health Beliefs, Health Maintaining Behaviors, and Exchange of Advice

During the FGDs, participants discussed their understanding of health, what it means to be healthy or unhealthy and why their health is important to them. The majority of women explained that they considered a healthy woman as one that can do her work, that is clean, or one that does not have a disease or illness. Others shared that they think good health means being able to have a rest, engage in some pastime activity or form of entertainment, be in a healthy mental state, and live freely. Some participants

stated they their health is important to them as individuals but, more frequently, one needs to be healthy in order to work efficiently, provide for their families and children and not trouble others with their health problems. Bad health was mentioned as interfering with the aforementioned. More specifically, problems with health could lead to financial problems and having a poor mental state (i.e., thinking a lot). One participant mentioned that it is important to be in good health in order to work diligently, while for another it is important for her happiness. Not being able to work due to poor health meant not being cared and becoming helpless. It was mentioned that, particularly for a woman, if she is not healthy her family would suffer as a result. Being healthy was also expressed as empowering, allowing one to do anything according to their will.

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

“If I was taken out for camping, I think we can have a good time there, can have food outside, so I think it is good health.”

“For us to live without troubling others, we need to be healthy.”

“If the person is unable to do his or her own work. If he or she’s not staying in clean, she’s in bad health.”

“It does not allow you to work efficiently and it causes you to have economic problems.”

“If we don’t have good health we will be more thoughtful, we will be more sorrowful.”

“They will not become able to do their work. Noone will care about these people, so they will become helpless.”

“I like to be happy every day. I like to smile and laugh every day, so good health is important to me.”

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

“It will mainly affect the women of the family, because children complain about need of food and everything to their mother. If mother is not healthy, it will affect her family.”

“If I am healthy, I can do whatever I want. My only wish is to be healthy. I wish not to get even a cold or fever.”

Throughout the FGDs and IDS participants described the ways in which they strived to maintain their health and provided causes that led them to experiencing health problems. By adhering to certain health behaviors or practices and in explaining the causes of their ill health, women revealed their health beliefs. Among the most prevalent health behaviors was maintaining ones cleanliness, which was, for some women, what they were asked to do by their employers. Besides being clean, some participants applied certain creams to their bodies, such as Vaseline, for skin protection. Some participants described how they would drink milk or tea, particularly in the morning. As previously mentioned, engaging in religious activities or other forms of leisure, was perceived to be beneficial towards maintaining good health. Having a rest and eating properly, particularly maintaining a healthy diet by not eating too much oily food and consuming enough fruits and vegetables, were also mentioned. If necessary, women would cook food for themselves if they could not tolerate to eat the food their employers enjoyed. For those participants who were not provided with ample amounts

of food, they would receive some from other FDWs. One participant mentioned how she had to steal food in order to supplement her diet. Daily exercise was not something that participants engaged in, stating the reason that their workload was enough to keep them active. One participant, however, would have an evening walk with the child she was taking care of.

“I have good health practices. I get up early in the morning and I clean myself and I drink water. And I used to do those things very well.”

“I have good health behaviors. I wash my hands after going to toilet and I clean my hands before prepare food. I think because of that good health habits I’m maintaining my health in this state.”

“When I get up early in the morning I have a glass of milk then I start to work. I don’t have time to have my breakfast. The lunch I have later on. But even while I’m having the lunch I have to attend to the children’s work.”

“I developed healthy behaviors. I used to eat vegetables and fruits. So it improved my health. And I was used to be very clean, so I could improve my health.”

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

“I need no any other general exercise. I was climbing up and down all the staircase throughout the day so that exercise is enough for me.”

“I didn’t do anything specifically for my good health. In the evening I go out with child to have a walk. Apart from that I have not done any special things.”

Likewise, in their explanations for why they came to have certain health problems, women came to describe their health beliefs. Working conditions and environmental factors were mentioned as affect various physical and mental health

conditions. Headaches, as well as depressive symptoms, were primarily attributed to worrying, thinking of one's family, and either being verbally abused (i.e., scolded) by or not feeling as if one was appreciated by their employers. One participant mentioned that her headaches were not the result of her work responsibilities, but rather thinking about her home in Sri Lanka. However, backaches and certain other physical health problems (such as leg pain or knee joint pain) were believed to be the cause of overwork, carrying heavy goods, walking a lot, and standing for long periods of time. A change in diet, with consumption of more oily food (e.g., butter and cheese), not being able to eat certain foods such as rice, and overconsumption itself, was mentioned as the primary cause of weight gain. On the other hand, overwork and employers' restrictions prevented women from eat regularly and sufficiently. Consumption of certain foods, such as fish or other types of meat and oily food overall, was thought to lead to illness in the general sense, while spicy food and lack of food were mentioned as leading to gastritis. Certain tasks, such as cooking or handling appliances, led to some injuries (e.g., burns and electrocution) and accidents. Some participants mentioned the effects of using cleaning appliances, which would lead to wheezing, skin irritations, and allergies. Finally, climate change (both hot and cold temperature) and exposure to the air conditioner was considered to be the cause of asthma, and one participant even mentioned that hot weather and dust was primarily the cause of many of the health problems faced by FDWs.

"I had a headache. The reason for that, I was thinking about my home, so I got

headache. It is not because of my work.”

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

“I had to take children to school and class. So I had to walk long distance. So I developed knee joint pain.”

“I got electrocuted while trying to clean some electrical instrument with a wet cloth.”

“Main thing is their food. We try to not add fat to our food, but they always want to add fat to their meal and they eat a lot of flesh with fat. They don’t take off the fatty part of the meat before they cook. We should not eat their food. We should not eat food cooked in that way. If we refuse to eat this food, we are scolded.”

“It affected badly for my health because I developed gastritis because I could not have my meals in time.”

“We became ill because we had to eat mostly meat and fish.”

“When they eat too much oily foods, butter and cheese, they become ill. And some become ill because of the cold.”

“A lot of hot weather and dust is the main problem for our health.”

Participants also discussed the recommendations that they would offer to other FDWs seeking employment abroad to maintain their health. The majority of the women advised others adopt the health practices that they maintained abroad. Particularly, women stressed the need to eat properly, stay clean, take a rest and get enough sleep, engage in religious activities, and drink milk or tea in the morning. Others spoke of working together with other FDWs to make up for any inadequacies in food, wearing warm clothes, protecting one’s skin, leaving time for oneself to engage in some activity,

avoid the consumption of sugar and cold drinks, not eating too much, and getting proper medical care. Again, there was mention of not needing exercise due to the workload that FDWs have.

“You need to maintain your health. You need to eat properly. Even though you are not given food, when they go away you should take food and look after your health.”

“We need not to do exercise because we work hard. But we need to be careful about food. We should not eat sugary food.”

“We need to use cream to protect our skin. We use Vaseline to protect our skin.”

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

“We need to control our diet. We should not eat even if there is plenty of food at our desire. And we need to dress properly in the winter to protect our warmth.”

“The climate is different, so you should not take cool drinks. You should take hot drinks.”

“They should get up early in the morning, they need to be clean and they have to drink milk and drink a cup of tea early in the morning. And they should work as they are going to be instructed.”

“I will advise them to consider about their health. If they have any health problems they should get treatment.”

“I recommend them to get up early in the morning, and give about half an hour for their health. To get clean and get ready and start work and also I recommend them to get some rest.”

Not only did the participants give advice to others, but they also spoke of the health advice that they received from their employers. Previously there was mention of employers (or *hamputha* in Sinhala) advising certain participants during bouts of

depression, however, employers would also lend some FDWs their advice for maintaining their health, including which foods to avoid eating. One participant said that she did not consider the advice given to her at first but later found it to be beneficial. One woman would likewise exchange health advice with her employer, helping her to relieve her health symptoms as well.

“They advise me not to eat fatty meals, and eat yogurt and fruits.”

“Earlier I did not follow the instruction I was given, but later on I follow those instructions and I was keep my good health.”

“My interaction with hamputha was affected in good way for my health.”

“The lady (of the house) was very good person and she was very close to me. She helped me with all my problems.”

“I think they should follow the healthy behaviors they adapted in Sri Lanka in their work at foreign country also. Cleaning their body and they can even advice to the employer. I used to help my employers to relieve her health problems. I advise her to drink green tea and when she developed toothache I asked her to wash her mouth with salty water. Then the condition improved and next day she said I was able to have good sleep last night.

3.2.9 Access to Medical Care, Treatment of Health Problems, and Repercussions of Falling Ill

In terms of their health, several participants described how their employers would not allow them to rest even though they may have been ill. One FDW mentioned the extent to which they are busy with work, by not even having the time to take medicine. They may not have been provided medicine to alleviate their illness or allowed to seek medical care. One participant reported that she had to buy her own

medicine (another over-the-counter drug). Another spoke of receiving an over-the-counter pain reliever from her employer, even though her health condition was serious. In terms of seeking medical care, one participant was not allowed to go to government facilities. Another was only paid attention to by her employer when she was in serious pain. Other FDWs, however, had more positive experiences. Some participants found their employers to be accommodating and understanding, allowing them to rest or taking over their duty, providing them with medicine, taking them to be seen by a physician or even giving them health advice. For one participant, even for a minor illness, the employer would provide her with money and ask whether she was seen by a physician.

“Even if we get ill, we have to work. We don’t have time even to take our medicine. We don’t have time to rest.”

“When we become ill, there was no one to look after us.”

“They don’t give me anything. Paracetamol tablet I had to buy my own. They don’t allow me to take their medicine because they say they have spend money on those things.”

“I were not allowed to go to government health institutions because it takes a long time. So I used to visit this private doctor.”

“I scream when I have gastric irritation and pain then only madame paid her attention on me.”

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

“If I became ill, the lady didn’t go for work but to stay at home to look after children.”

“There was a doctor who we used to be seen by. So if I get any minor illnesses, even I go to that doctor to get treatment.”

“I cannot tell exactly about that. If I got ill, they give money to me to get treatment. If I have a little cough they ask me whether I went to a doctor.”

Women in one FGD mentioned that they would receive a regular check up every several months. Only “fit” women are hired as FDWs, according to one participant. For those found to be ill, either by a physician or their employers, there would be a number of repercussions. FDWs could potentially be scolded, taken away by the embassy, sent to the agency or back to Sri Lanka if the illness was severe, or have their visa revoked. If sent to the agency, one participant said, then they would not receive their salary.

“In Singapore, every six months time we are examined by a doctor. He examined us and we were given a card, whether we have any illness or not. It is a rule set by the government. Every six months domestic workers should undergo medical examination.”

“If they complain about health problems, we think she is not well. Before you go for foreign employment you are examined by medical doctor and you will be issued a medical certificate. So you will be sent to foreign employment only if you are healthy.”

“If you we do not have good health, we cannot do our day to day work. We will be scolded by households.”

“To maintain our good health, every six months time we were taken to a doctor, even though we had any illness or not.”

“So they complained to the embassy and they want embassy people to take us away.”

“No they don’t facilitate us to take medical treatment. Even though we get serious illness we were treated with paracetamol. If the condition is very severe they send us back to Sri Lanka.”

“If we have an illness, our visa get canceled.”

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

3.2.10 Satisfaction with Outcomes of Foreign Domestic Employment and Attitudes toward the Occupation

For female FDWs in our study, family is an important influence on the women’s decisions to go abroad, as described in an earlier section. Thus, when discussing their overall satisfaction with foreign domestic work and whether they were able to meet their expectations, some women would speak to whether or not they could provide for their family (especially children). For those women who were largely motivated to improve their family’s quality of life (e.g., provide for the children’s education; improve financial circumstance of the family; assist with educating siblings, etc.), the majority were able to meet their goals, while a few were not. For one FDW, leaving her child behind in Sri Lanka is a necessary choice that she had to make in order to better the child’s life. Without making the choice to become a FDW, one participant commented that she would not have been able to support her family otherwise. Others’ reasons for not being satisfied were primarily related to not having met their expectations, particularly due to an insufficient salary, and to unsuitable working and living conditions. The latter mainly refers to what have previously been mentioned in terms of poor treatment by employers, overwork, and dissatisfaction with the facilities. Some

women. Some participants mentioned that they could only meet some of their expectations

“It’s true that I left my child but because of that only my child is in good position today. She’s practicing for being a nurse. Also, I was able to construct my house. So I was able to do that two things by going Middle East.”

“No, in a way I’m happy because I could support the financial status of my family.”

“I was able to help my family members. Because if I didn’t go for foreign employment my mother will provide us the meal but not other things. I think I helped my family be in a better environment by doing an employment at foreign country.”

“Yes, I’m satisfying because I could help my family. Unless I went for the foreign employment, I won’t be able to financially support my family. My husband’s income is not enough for our family.”

“I went because my husband had no permanent job and I want to help my children. But I couldn’t meet my target, I was not paid well. I only received 12,000 rupees per month.”

“I couldn’t meet all my expectations. I wanted to construct a new house but I couldn’t do it as I expected. I had no kitchen in my house but I could help my children to learn.”

“I couldn’t meet all my target because I couldn’t earn enough money.”

“I want to go to foreign employment but not as a housemaid. It is a difficult job. We cannot earn good salary, even though we had to work hard.”

“I did that job for 10-12 years, so I’m not satisfied with that job.”

Some participants expressed that they would not go abroad to work as a FDW again if they had the opportunity. Others, however, felt that either their continued struggles in Sri Lanka or their positive experiences working abroad as a FDW would

compel them to enter the profession again. For one participant, a FDW's salary cannot be earned in Sri Lanka and yet, for another, the income earned is not enough. Another mentioned that she would like to work abroad, but not as a FDW. While one's husband does not want her to return, another FDW said that she would like to go work abroad with her husband. In regard to other women, some recommended that others work as they did and improve their life in Sri Lanka; however, others felt differently, viewing foreign domestic work as an unsuitable and unsafe profession, not recommending others to work as FDWs. Some participants were neutral towards others' decisions to work abroad. Finally, in terms of the future of foreign domestic work, as a profession, women commented that despite lack of improvement of the present situation, women will continue to work as FDWs. Some added that, in the future, families will suffer when the women go abroad, especially children. Also, according to the current state of things, the future of foreign domestic work will not be a success. In one FGD, the women recommended that men seek employment abroad, rather than women (especially mothers).

"I'd like to go again for foreign employment because I have to complete my house construction and my daughter in law is now working abroad, so I need to get down her back because they only have one child so they need to complete their family. So I'd like to go again for foreign employment in her place."

"I have earned money for my satisfaction, I recommend others also to go there and earn money and make their family happy."

"I like to go to work there because I cannot earn that salary by working here in Sri Lanka."

“I want to go with my husband. Last time my husband was there to look after the child but this time I’m going with him.”

“Because it is not a safe place for a lady to work. If you are going, you need to go to a good agency which takes all the responsibility.”

“I want to go to foreign employment but not as a housemaid. It is a difficult job. We cannot earn good salary, even though we had to work hard.”

“I did that job for 10-12 years, so I’m not satisfied with that job.”

“I would like to go for work in hospital.”

“In my opinion I won’t advise anyone to go for foreign employment as housemaid.”

“Because the condition is not so favorable now, they have powerful rules. It’s very difficult, we can hear various incidents through the media. Saudi is not safer place for us to work anymore.”

“Yes, I feel like to go. But my husband doesn’t want me to go. He’s a laborer, he doesn’t have a good idea about that.”

3.2.11 Greater Social Support of and Accountability toward Foreign Domestic Workers

Previously some women made mention of having interaction with embassies and agencies at various points throughout the duration of their employment as FDWs abroad. These interactions were positive for some, such that they could receive some benefit and some comfort from the agencies in the form of advice. Other women mentioned being treated unfairly or exploited in some ways by agencies in charge of FDWs. One participant recalled being sent to the agency when she made a mistake in her work and subsequently being physically abused there. Besides physical abuse, one

FDW experienced sexual abuse. Another who went there on her own to seek help was sent back to her employers without any assistance provided. Still another had her salary confiscated and given to an agency employee. According to one FDW's experience, employees of the agency even ask FDWs to perform certain personal favors for them. Women have given up complaining to the agencies due to distrust, as was mentioned by one participant.

Women also gave their recommendations for the actions that could be taken to improve the standard of foreign domestic work abroad, as well as specific measures that the Sri Lankan government, embassies and agencies could work toward to improve the working conditions of FDWs going abroad. According to the women, governments should take legal actions against fraudulent agencies and existing laws should be implemented. A salary that is suitable for the amount of work that is done should be provided and safety of the women should be ensured. Additionally, one participant advised that policies regarding rest from labor be developed, and another mentioned that even if FDWs interests are not cared for, at least abuse should desist. In terms of training, FDWs should receive information about the climate and the people in the host country, as well as how to develop (good) food habits. The president should take action to ensure the well-being of FDWs abroad. The government can also give some donations to the families of FDWs. For the embassy, they should consider the problems of FDWs and both embassies in the host and labor-sending countries should work together. Agencies should not deceive the employers and employees by giving false certifications.

Finally, the job given to the FDWs should lie with the agreement made beforehand.

“They only ask our problems only for a three months time. After that they don’t ask us anymore. Even if the dead body is taken to Sri Lanka, they don’t mind.”

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

“But I cannot work at this place, so I went to the agency. But the lady who worked at the agency did harm for me. She called my employer and she wanted my employer to take me back. She did not help me.”

“When I complain that I cannot stay in this place, I was sent to another house. But when I am working at that place also, it was 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 money was given to the agency person but she did not give it to me. Agency people should act more kindly towards us, because we have some complaint and we complain to them because we have no one else to tell our problem to. We expect them to take it as a problem and treat us fairly.”

“Agency people misuse us. They want us to wash even their clothes, when we stay at the agency. And when we complain that we cannot stay in one place, we were again sent to a bad place that someone already turned back from.”

“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 of that, they tend to commit suicide.”

“I think it’s better if we could have good policies with regard to resting hours.”

“I need do not need them to care after us but should not abuse us (agency people).”

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

“Even though the government has policies regarding places we are going to be

employed. The 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 have to do there."

3.3 Free Listing Task

During the free listing activity, a variety of health conditions emerged that participants listed as those that female FDWs may have as a result of their employment. All of the various health conditions that emerged from participants' responses are listed in Table 3. These are organized according to frequency of mention in Table 3, below. For terms that were unique, such as "crying", "stressed", or "angry", no attempts were made to alter the original meaning. "Abdominal pain and discomfort" were listed together and thus presented that way in Table 3, due to uncertainty as to whether the participant meant "abdominal pain" and "abdominal discomfort" or just "discomfort". Health conditions that were listed multiple times in various ways were grouped together under a common term and any variation in the terms was included in Table 3. For instance, "knee joint pains" and "pain over both knees" were grouped together under "knee pain". Likewise, "weight gain" was considered to be the most fitting term to encompass both "obesity" and "got fat". In the case of "irregular meals", "weight gain", and "depression", these health conditions were not those originally listed by the participants but were instead only used to group together like terms. Thus, for example, while "obesity" and "got fat" were each listed once, "weight gain" was chosen as an all-encompassing term and was thus not included in the frequency count. Eleven health

conditions (28.9%) had at least one alternate term that was used. The remaining 27 health conditions did not have any variation and are thus written exactly as the participants listed them. “Irregular meals” had the greatest variation with six different terms used. Some terms, such as “irregular meals”, “lack of rest”, “lack of sleep”, “dropped on the floor”, etc., were questionable as health conditions; however, these were still included for being perceived so by the participants and for being understood as symptoms, if not conditions. In some cases where it was clear that the term did not fit as a health condition or even a symptom, such as “lack of clothes” or more general terms such as “problems”, these were excluded and not reported in Table 3.

After the grouping together of similar health conditions, the free listing activity yielded a total of 38 health conditions which were mentioned a total of 84 times. Frequency was calculated by adding up the number of times a health condition was listed, including all variation in terms. The majority of health conditions loosely fit within the category of physical health (89.5%), with a few cases of mental or emotional health problems (e.g., “crying” and “depression”). Among health conditions, headache was the most common, being listed 10 times, by 40% of participants. Fever and backache were the second most frequent, each being listed seven times (i.e., by 28% of the participants). There were a total of 21 unique terms (55.3%), in that these were all listed a single time by the participants. They included, but were not limited to: stomachache, diabetes, loss of appetite, cholesterol, cough, bodyache, etc. There were certain terms that were used which had to be interpreted. Given the cause it was attributed to,

“dropped on the floor” was understood to mean “weakness of the body” and was thus grouped as such in Table 3. “Discomfort” and “difficult to cope up” were perceived as physical discomfort and fatigue, respectively, based on the causes given. “Irregular meals” were understood to reflect poor nutrition, while “lack of rest” was considered as contributing to other health conditions, such as fatigue. Thus, each was considered to be a health condition and included in the table.

Table 3. Frequency Distribution of “Health Conditions” in Free Listing Task

Health Condition	Frequency (%) N= 84	Variation in Terms
Headache	10 (40)	
Fever	7 (28)	
Backache	7 (28)	
Leg pain	6 (24)	<i>Chronic leg pain; paining leg</i>
Irregular meals	6 (24)	<i>No time to eat; not provided with meals properly; no proper food; no time to get food properly; no food in proper time; no food regularly</i>
Lack of rest	3 (12)	<i>Had to work continuously; no off days</i>
Wheezing episodes	3 (12)	
Knee pain	3 (12)	<i>Knee joint pains; pain over both knees</i>
Hand pain	2 (8)	<i>Pain over hands</i>
Difficulty in	2 (8)	<i>Could not breathe</i>

breathing		
Asthma episodes	2 (8)	<i>Asthma</i>
Gastritis	2 (8)	
Stomach gas	2 (8)	
Weight gain	2 (8)	<i>Obesity; got fat</i>
Depression	2 (8)	<i>Depression like; depressed severely</i>
Lack of sleep	2 (8)	<i>Did not get time to sleep</i>
Weakness of the body	2 (8)	<i>Dropped on the floor</i>
Problems with vision	1 (4)	
Discomfort	1 (4)	
Abdominal pain and discomfort	1 (4)	
Stressed	1 (4)	
Stomachache	1 (4)	
Hand injury	1 (4)	
Diabetes	1 (4)	
Blood pressure	1 (4)	
Chest pain	1 (4)	
Crying	1 (4)	
Loss of appetite	1 (4)	
Skin getting dry	1 (4)	
Cholesterol	1 (4)	
Angry	1 (4)	
Excessive cold	1 (4)	
Chicken pox	1 (4)	
Cough	1 (4)	

Burn injury	1 (4)	
Common cold	1 (4)	
Bodyache	1 (4)	
Difficult to cope up	1 (4)	

During the second portion of the free listing task, the participants provided what they understood to be the cause(s) of each of the health conditions that they listed in Table 3. These were compiled together and organized in Figure 1. For certain health conditions, such as “lack of sleep”, “diabetes”, “blood pressure”, “chicken pox”, and “common cold”, some of the participants did not provide a cause. Therefore, these health conditions were excluded from Figure 1. The majority of health conditions had multiple causes listed by the women. Each bullet point indicates a separate cause listed, either by a single participant or multiple participants. However, if a particular cause was given more than one time (i.e., by more than one participant) for the same health condition, the cause was only listed once in Figure 1. Table 4, however, provides the frequency distribution of each unique cause. Revision of grammar mistakes was avoided so as to retain the original meaning of translations. In cases where there was only an insignificant difference in meaning, this was indicated. For example, “climbing stairs/staircase” includes both “climbing stairs” and “climbing staircase” as causes of leg pain. However, in the case of “more workload” and “excessive workload”, given the slight difference in meaning both were listed as separate causes of backache. It should be noted that certain causes that were written together appear exactly as intended by the

participant. For example, “overwork, so thought a lot” were grouped together by the participant and reflected that way in Figure 1. However, they were counted as two separate causes in Table 4.

Some of the most frequently listed health conditions (in Table 3), had the most causes listed. “Headache”, the most frequently listed health condition during the free listing task, had the most variation in causes given—a total of eight. “Depression”, although only listed by two participants nevertheless had the second most varied causes, with a total of six. Headaches were attributed to a number of causes, including: “difficult to cope up with air conditioner”; “very difficult to cope up with the climate changes”; “more workload”; “reminding my childrens”; “reminding problems in my home (Sri Lanka)”; “chronic sleeplessness”; “hot season”; and, “winter season”. Depression was attributed to “could not get the salary at the correct time”; “restricted communication with others”; “lack of ability to go somewhere”; “lack of sleep”; and, “overwork, so thought a lot”. Twelve health conditions (36.4%) had only one cause each, and the average number of varied causes for the 33 health conditions was two.

Headache	<ul style="list-style-type: none"> •difficult to cope up with air conditioner •very difficult to cope up with the climate changes •more workload •reminding my childrens •reminding problems in my home •chronic sleeplessness •winter season
Fever	<ul style="list-style-type: none"> •more workload •climate change •no medicine •excessive workload
Backache	<ul style="list-style-type: none"> •more workload •excessive workload •carrying fruit boxes •climbing staircase •work while standing up •two, three works in same time
Leg pain	<ul style="list-style-type: none"> •climbing stairs/staircase •it was two story house, around 25 or 30 times had to climb up and down •helping children •everday I'm going to supermarket
Irregular meals	<ul style="list-style-type: none"> •overwork •more work
Lack of rest	<ul style="list-style-type: none"> •heavy workload

Wheezing episodes

- in the hot seasons, a lot of dust is there
- air conditioner
- dust
- cold weather

Knee pain

- more time standing up for works
- more works
- frequent walking
- had to climb up several stairs

Hand pain

- polishing the glasses of windows
- everyday I'm going to supermarket

Difficulty in breathing

- polishing the glasses of windows
- when cleaning the bathroom had use a powder

Asthma episodes

- dust
- winter season

Gastritis

- no foods at proper time
- intake of chilies

Stomach gas

- no food(s) at/in proper time
- more oily foods
- not having food in proper time

Weight gain

- oily food

Depression

- could not get the salary at the correct time
- restricted communication with others
- lack of ability to go somewhere
- lack of sleep
- overwork, so thought a lot
- when remembered babies

Weakness of the body

- not eating meat and fish
- lack of food

Problems with vision

- hot weather

Discomfort

- in the hot seasons, a lot of dust is there

Abdominal pain and discomfort

- oily food
- no proper time for meals

Stressed

- had to pluck dates and cut leaves of those trees

Stomachache

- more workload

Hand injury

- cleaning powder

Chest pain

- winter season
- washing car at early morning

Crying

- when I was reminding about my home and my illnesses

Loss of appetite

- more works

Skin getting dry

- high temperature
- low temperature

Cholesterol

- more oily food taken

Angry

- more works

Excessive cold

- cold season

Cough

- air conditioner
- cold weather

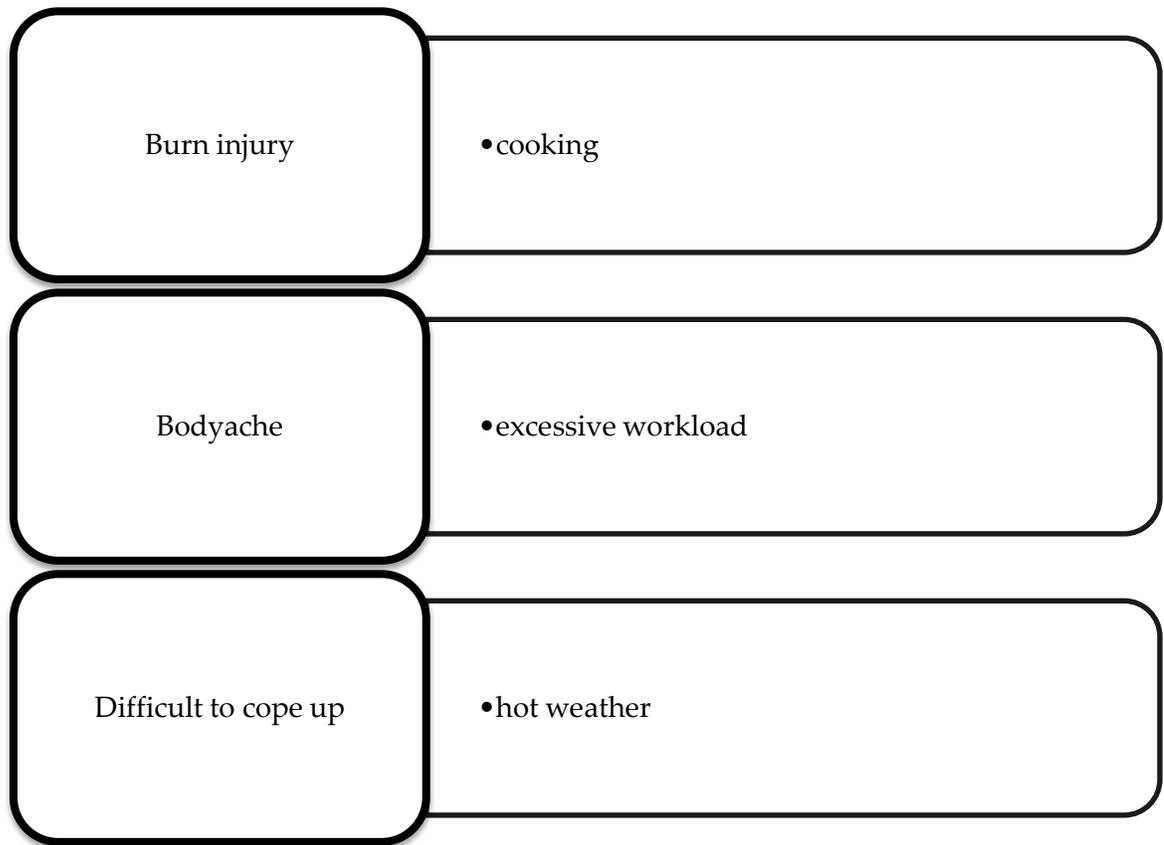


Figure 1. “Health Conditions” and their Causes in Free Listing Task

While Figure 1 presents the various causes that women used to explain health conditions that they listed during the free listing task, Table 4, below, organizes these according to frequency of mention. As with Table 3, no attempt was made to alter the original meaning of unique terms such as “lack of ability to go somewhere” or “washing car at early morning”, for example; however, if there were certain causes that varied only slightly in their meaning, these were grouped together under a common term, with any variation in the terms provided in Table 4. For instance, “winter season” and “cold weather” were grouped together under “cold season”. This was also done so as to be

consistent with the use of “hot season”. “High temperature” and “low temperature” were not grouped together with “hot season” or “cold season” so as to avoid misunderstanding the participants’ intended meaning. Perhaps they may have referred to temperature within an indoor space, as opposed to the external environment. In some cases, as already stated, causes that were previously grouped together by the participants were separated and listed as two separate causes in Table 4. One such example would be “had to pluck dates and cut the leaves of those trees”, which were counted as two separate causes of feeling “stressed”.

Frequency was calculated by adding up the number of times a cause (including both the common term and various other terms used) was used for any of the health conditions listed in Table 3 (including their variation in terms), rather than just the 33 health conditions shown in Figure 1. For example, in the case of “overwork”, the frequency of mention includes the number of times that “overwork”, “more workload”, “more works”, etc. were given as causes for all of the health conditions that fit under the umbrella terms “irregular meals”, “depression”, etc. For this reason, the numbers that appear in the frequency column of Table 4 are greater, in some cases, than the number of times the causes appear for the 33 health conditions in Figure 1.

Overall, the free listing activity resulted in a total of 34 unique causes of health conditions. Among causes provided, overwork was the most frequently mentioned, being listed 17 times (or 20.2%). Likewise, it had the greatest variation in terms used to describe causes of health conditions. Listed a total of six times (or 7.1%), cold season was

the second most frequently attributed cause. The majority of causes, a total of 18, were mentioned only a single time by the participants. They included, but were not limited to: carrying fruit boxes, restricted communication with others, helping children, no medicine, frequent walking, etc. Overwork was reported to be a cause of the following health conditions: irregular meals, headache, depression, fever, backache, stomachache, loss of appetite, knee pain, angry, lack of rest, and bodyache. Overall, a total of 11 health conditions were attributed to overwork. Cold season and hot season followed in second place, with each being listed as causes of five health conditions. All causes that had a frequency of one also were listed as causes of a single health condition. In total, the causes were mentioned 84 times, which corresponds to the number of times that the 38 health conditions shown in Table 3 were mentioned.

Table 4. Frequency Distribution of Causes of “Health Conditions” in Free Listing Task

Cause	Health Conditions	Frequency (%) N= 84	Variation in Terms
Overwork	Irregular meals; headache; depression; fever; backache; stomachache; loss of appetite; knee pain;	17 (20.2)	<i>More workload; more works; heavy workload; two, three works in same time; excessive workload</i>

	angry; lack of rest; bodyache		
Cold season	Wheezing episodes; headache; chest pain; excessive cold; cough	6 (7.1)	<i>Winter season; cold weather</i>
Hot season	Problems with vision; difficult to cope up; discomfort; wheezing episodes; headache	5 (6)	<i>Hot weather</i>
Oily food	Weight gain; abdominal pain and discomfort; stomach gas; cholesterol	5 (6)	<i>More oily foods; more oily food taken</i>
Climbing stairs	Leg pain; backache; knee pain	5 (6)	<i>It was two story house, around 25 or 30 times had to climb up and down; climbing staircase; Had to climb up several stairs</i>
Dust	Discomfort; wheezing episodes; asthma episodes	4 (4.8)	<i>In the hot seasons, a lot of dust is there</i>

Air conditioner	Wheezing episodes; headache; cough	4 (4.8)	<i>Difficult to cope up with air conditioner</i>
Irregular meals	Abdominal pain and discomfort; gastritis; stomach gas; weakness of the body	4 (4.8)	<i>No food(s) at/in proper time; not having food in proper time; lack of food; no proper time for meals</i>
Polishing the glasses of windows	Hand pain; difficulty in breathing	2 (2.4)	
Lack of sleep	Headache; depression	2 (2.4)	<i>Chronic sleeplessness</i>
Climate change	Headache; fever	2 (2.4)	<i>Very different to cope up with the climate changes</i>
Reminding my childrens	Headache; depression	2 (2.4)	<i>Remembered her babies</i>
Reminding about my home	Headache; crying	2 (2.4)	<i>Reminding problems in my home</i>
Work while standing up	Backache; knee pain	2 (2.4)	<i>More time standing up for works</i>
Every day I'm going to supermarket	Hand pain; leg pain	2 (2.4)	
Cleaning powder	Hand injury; difficulty in breathing	2 (2.4)	<i>When cleaning the bathroom had use a powder</i>

Thought a lot	Depression	1 (1.2)
Could not get the salary at the correct time	Depression	1 (1.2)
Restricted communication with others	Depression	1 (1.2)
Lack of ability to go somewhere	Depression	1 (1.2)
Had to pluck dates	Stressed	1 (1.2)
Cut leaves of those trees	Stressed	1 (1.2)
Carrying fruit boxes	Backache	1 (1.2)
Helping children	Leg pain	1 (1.2)
Washing car at early morning	Chest pain	1 (1.2)
High temperature	Skin getting dry	1 (1.2)
Low temperature	Skin getting dry	1 (1.2)
No medicine	Fever	1 (1.2)
Frequent walking	Knee pain	1 (1.2)
When cleaning the bathroom	Difficulty in breathing	1 (1.2)

Cooking	Burn injury	1 (1.2)
Not eating meat and fish	Weakness of the body	1 (1.2)
Intake of chilies	Gastritis	1 (1.2)
Reminding about my illnesses	Crying	1 (1.2)

3.4 Pile Sorting Task

During the pile sorting activity, participants sorted 26 health conditions in two stages, according to categories of commonality and concern. The results of the activity are displayed in Table 5, below, with the frequency of assignment into each category and percentage given. Frequency was used to determine which category each health condition was most often sorted into and was subsequently bolded to indicate this. For instance, irregular menstruation was most frequently placed in the “more common” pile in the first round and the “less concerning” pile in the second round. Thus, this condition was considered as a more common health condition, yet a less concerning one among the participants. In some instances a health condition was not sorted in all of the piles (i.e., it was not sorted by anyone into a particular category). Irregular menstruation, burning, chronic headache, and assault, for example, were not placed into the “not concerning” pile by any of the 12 groups (as the 25 participants were divided into 11 groups of two and one group of three). In other cases, a certain health condition was not

sorted most frequently into any particular pile. Unplanned pregnancy was equally placed into all three categories of commonality (i.e., four groups considered it to be: “more common”, “less common”, and “not common”) and accidents was equally placed into the “more common” and “not common” categories. On the other hand, “abuse” was equally sorted as “more concerning” and “less concerning”.

In the first round, there was most agreement between the 12 groups on the sorting of “back pain” and “bodyaches” as “more common” health conditions. 10 groups, or 83.3% of the groups, categorized these health conditions as such. Meanwhile, in the second round, “cervical cancer”, “accidents” and “burning” were the most agreed upon as being “more concerning”. There were no health conditions which were most frequently sorted into the “not concerning” pile. The majority of health conditions were sorted into the “more common” (in the first round) and “more concerning” (in the second round) categories, with 12 and 14, respectively. However, only a handful of health conditions were sorted as both “more common” and “more concerning”, including: sexual abuse, back pain, and burning. However, quite a few were sorted into both “more common” and “less concerning” categories, including: irregular menstruation, fever, common cold, injuries, fatigue, bodyaches, chronic headaches, and intestinal problems. Likewise, many fell within the two categories of “not common” and “more concerning”. These were interpreted as being those health conditions that may be more common among female FDWs; however, if they occur they would not be taken very seriously.

Table 5. Frequency Distribution of Common and Concerning Health Conditions in Pile Sorting Task

Health Conditions	More Common	Less Common	Not Common	More Concerning	Less Concerning	Not Concerning
Frequency (%) N=12						
Irregular menstruation	5 (41.7)	3 (25)	4 (33.3)	5 (41.7)	7 (58.3)	0 (0)
Cervical cancer	2 (16.7)	6 (50)	4 (33.3)	9 (75)	2 (16.7)	1 (8.3)
Unplanned pregnancy	4 (33.3)	4 (33.3)	4 (33.3)	8 (66.7)	2 (16.7)	2 (16.7)
STDs (RH)*	3 (25)	4 (33.3)	5 (41.7)	8 (66.7)	2 (16.7)	2 (16.7)
Fever	9 (75)	1 (8.3)	2 (16.7)	5 (41.7)	6 (50)	1 (8.3)
STDs (CD)**	3 (25)	4 (33.3)	5 (41.7)	8 (66.7)	3 (25)	1 (8.3)
Common cold	7 (58.3)	2 (16.7)	3 (25)	4 (33.3)	7 (58.3)	1 (8.3)
Sexual abuse	5 (41.7)	4 (33.3)	3 (25)	8 (66.7)	2 (16.7)	2 (16.7)
Injuries	6 (50)	3 (25)	3 (25)	4 (33.3)	7 (58.3)	1 (8.3)
Accidents	5 (41.7)	2 (16.7)	5 (41.7)	9 (75)	2 (16.7)	1 (8.3)
Infectious parasitic disorders	1 (8.3)	5 (41.7)	6 (50)	3 (25)	8 (66.7)	1 (8.3)
Back pain	10 (83.3)	1 (8.3)	1 (8.3)	6 (50)	5 (41.7)	1 (8.3)
Stress	1 (8.3)	5 (41.7)	6 (50)	2 (16.7)	6 (50)	4 (33.3)

Fatigue	9 (75)	2 (16.7)	1 (8.3)	4 (33.3)	6 (50)	2 (16.7)
Emotional imbalance	2 (16.7)	4 (33.3)	6 (50)	5 (41.7)	4 (33.3)	3 (25)
Bodyaches	10 (83.3)	1 (8.3)	1 (8.3)	4 (33.3)	7 (58.3)	1 (8.3)
Sleep disturbances	7 (58.3)	1 (8.3)	4 (33.3)	6 (50)	4 (33.3)	2 (16.7)
Depression	2 (16.7)	2 (16.7)	6 (50)	3 (25)	6 (50)	3 (25)
Beatings	4 (33.3)	3 (25)	5 (41.7)	6 (50)	5 (41.7)	1 (8.3)
Abuse	1 (8.3)	5 (41.7)	6 (50)	5 (41.7)	5 (41.7)	2 (16.7)
HIV/AIDS	2 (16.7)	6 (50)	4 (33.3)	8 (66.7)	3 (25)	1 (8.3)
Burning	6 (50)	3 (25)	3 (25)	9 (75)	3 (25)	0 (0)
Chronic headache	7 (58.3)	1 (8.3)	4 (33.3)	5 (41.7)	7 (58.3)	0 (0)
Assault	4 (33.3)	3 (25)	5 (41.7)	8 (66.7)	4 (33.3)	0 (0)
Psychiatric illnesses	3 (25)	3 (25)	6 (50)	6 (50)	4 (33.3)	2 (16.7)
Intestinal problems	7 (58.3)	2 (16.7)	3 (25)	3 (25)	7 (58.3)	2 (16.7)
Total	12	2	10	14	11	0

*RH: described in terms of reproductive and sexual health

**CD: described in terms of communicable disease

Table 6, below, provides a supplementary visual of the categorization of health conditions according to commonality and concern. As can be seen, the most prevalent categorization of health conditions was as “more common” and “less concerning”, followed by “not common” and “more concerning”. None of the health conditions were sorted into the following combination of categories: “more common” and “not concerning”; “less common” and “not concerning”; “not common” and “not

concerning”; and, “less common” and “less concerning”. There were two health conditions which were most frequently sorted only into the category of “more concerning”, while another health condition was most frequently sorted into only the “not common” category.

Table 6. Categorization of Health Conditions by Commonality and Concern in Pile Sorting Task

		More Common	Less Common	Not Common
More Concerning	Unplanned pregnancy; Accidents	Sexual abuse; Back pain; Sleep disturbances; Burning;	Cervical cancer; HIV/AIDS	Abuse
				STDs (RH); STDs (CD); Emotional imbalance; Beatings; Assault; Psychiatric illnesses
Less Concerning		Irregular menstruation; Fever; Common cold; Injuries; Fatigue; Bodyaches; Chronic headaches; Intestinal		Infectious parasitic disorders; Stress; Depression

	problems		
Not Concerning			

After the completion of both the free listing and pile sorting activities, the FGDs were resumed and participants were asked to reflect on their work together during the pile sorting task. When asked about which health conditions they thought to be more common, participants mentioned: chronic headaches, back pain, burning, sexual abuse, beatings, injuries, unwanted pregnancies, stress, depression, less sleep and sleep disturbances, fever and other communicable diseases, common cold, abdominal pain (perhaps referring to intestinal problems), worm infestation (perhaps referring to infectious parasitic disorders). When asked to reflect on why they chose these, women reported in two ways: with causes of the diseases they mentioned or how they became aware of those conditions. Causes provided by the participants included: climate change, stress, overwork or heavy workload, no rest, air conditioner, being worried about their children or thinking about their family in Sri Lanka, and mental problems. Among other reasons given, women spoke of having faced those health conditions themselves or having seen them very frequently; hearing of their friends (other FDWs) having those health problems or seeing other FDWs with those health conditions in the embassy; and, being aware of those health problems through the television or news. Also, one group mentioned that health conditions that are more common are “small diseases, but everybody get those”. The following quote by one of the participants speaks to those

who did not acquire some of the more common health conditions themselves:

“I have not experienced any dangerous or any scary situation like burning, sexual abuse, but we have heard that some are getting exposed to those things. We have heard that some people are burned and those things, but I have no such experience.”

Other health conditions that the participants mentioned as being more common were not those that were provided during the pile sorting tasks: hand pain, skin diseases, dry skin, and hair loss.

In regard to less common health conditions, participants included: STDs, beatings, burning, unwanted pregnancies, HIV/AIDS, backaches, (mild) headaches, accidents, and abuse. Communicable diseases were also mentioned as being less common health conditions among groups in one FGD, despite not having been included among the cards handed out during the pile sorting activity. Participants in one group spoke of their lack of knowledge (regarding these health conditions) due to not having contact with the rest of the world. Another group mentioned that if any of these health conditions were present the FDWs would be sent back to Sri Lanka, so they have not seen these health problems frequently. Still others said that they either did not experience these health conditions themselves or that they had not seen or heard of others who were afflicted by them. Participants were also asked whether there was any disagreement within their groups as to how to categorize a particular health condition by commonality. Only one group had this experience, with the problem of irregular menstruation.

Discussion then moved on to more and less concerning health conditions.

Among those more concerning, participants reported unwanted pregnancies, STDs, beatings, burning, sexual abuse, assault, injuries, chronic headaches, accidents, HIV/AIDS, fever, and cervical cancer. Rape, skin diseases, and loss of hair were also mentioned, but not included on the cards provided. Several reasons were given for why the participants chose the aforementioned: because they are life threatening; rare to see, but can be life threatening; they are not needed for society; they create huge problems; they are not expected and if acquired the women cannot come back to Sri Lanka; because they have bad effects on health. Some groups provided separate reasons for specific health conditions. For skin diseases, women spoke of wanting to have healthy skin. Hair loss was thought to disrupt beauty. Burning, beatings, accidents were also believed to lead to deformities and thus change in one's beauty. Finally, unwanted pregnancies were thought to endanger life. Participants particularly commented on unwanted pregnancies in the following ways:

"If we have these unwanted pregnancies we cannot go back to our country the usual way, you will be rejected by your family members and you will have a lot of social problems."

"We came here to earn some money. We had our targets, to build houses, to look after our children. The only thing we need is to go back safely to our home, without any problems. We need to face to our children and our family members. So, it is a big concern for myself. But there are women who do not have this concern. They involve in various socially unacceptable relationships at their work, but in my case, I don't want to have such relationships but I want to come back home safely."

Among less concerning health conditions, participants mentioned the following:

irregular menstruation, fever, common cold, bodyaches, chronic headaches, back pain, lack of sleep (presumably, sleep disturbances), cough. Leg pain and communicable diseases were also mentioned, albeit not being included in the cards. Participants perceived these health conditions as being less concerning because: there is no evidence of them; they are more or less natural or normal conditions, as well as common and simple, so no need to worry about them; one could get them frequently, but they are not important; they do not have any significance; and they will disappear with time or persist for some time and then wear off. Additionally, some groups mentioned that they are not thought of and FDWs just have to keep working, as well as employers disregarding these problems. One group warned that if these conditions worsen then FDWs will need to be concerned about them. Specifically in regard to fever and the common cold, one group said that one can just take some tablets. For leg pain as well, one can apply some ointment and then work again. Across all of the FGDs, none of the groups disagreed on sorting the health conditions according to concern. Likewise, participants did not find any disagreement between the health conditions they listed during the free listing activity and those that they sorted during the pile sorting activity. If they had to add any health conditions that were not included during the pile sorting activity (i.e., not included on the cards provided to them), participants mentioned measles, chicken pox, conjunctivitis, skin cracks, loss of hair, knee joint pain, dry skin, and pinworm infestations.

4. Discussion

Although the profession of foreign domestic service has been on the rise for the past several decades, research has lagged behind in terms of studying the foreign domestic worker population. Of studies conducted, most have been focused on exposing the abuses suffered by FDWs not only in the workplace but also at various stages of the migration process. Still others have led investigations into the nature of domestic work and the demands placed on FDWs, particularly in the Middle East and parts of Asia. Previous studies have typically focused on a specific nationality or multiple nationalities of FDWs (i.e., FDWs from a particular labor-sending country) within a specific host country. Only four studies included in Malhotra et al.'s (2013) systematic review did not fit the above description.

As Malhotra et al. (2013) identified, overall, studies examining the health effects of the domestic service occupation on female migrant workers have been limited in number and in scope. The Human Rights Watch (2007) report, Jureidini and Moukarbel's (2004) study and a report by Palaniappan (2010), all centered on abuses against and adverse work conditions of Sri Lankan female FDWs in certain Middle Eastern countries, while Caritas Sri Lanka-SEDEC (2012) developed an analysis of the complete migration experience among these women. Beyond these efforts, inadequate attention has been given to the population of FDWs from Sri Lanka, who constitute a significant portion of women working abroad in the profession. Therefore, it was a goal

of this study to take a different approach in contributing to the dearth of research in this area and bring attention to the needs of Sri Lankan female FDWs.

Following the recommendation by Malhotra et al. (2013) that efforts be made to conduct studies on the health concerns of female FDWs, the primary objective of this study was to identify the prevalent health problems female FDWs from Galle District in Sri Lanka self-report and how they perceive the nature of domestic service to affect their health, if at all. Moreover, the researchers wanted to learn which health conditions these FDWs consider to be common among women in their line of work and which they find of concern to them. Thus, rather than simply conducting a survey to determine the health problems of this population, according to certain pre-determined health conditions, this study sought to allow these women to construct their individual narratives and inform the researchers of their health problems and health concerns, from their perspective. The methodology used in this study combined FGDs and IDIs with free listing and pile sorting techniques in order to gather quantifiable data and allow for comparison of the two methods of data collection.

Data collected provided an array of rich information regarding not only the FDWs' health problems resulting from their employment, but also their overall experiences working and living abroad. Various themes emerged, covering a range of topics from women's motivations for becoming FDWs, to their relationships and interaction with their employers and other FDWs. Some of the themes were more prevalent within the FGDs or IDIs, given the questions that were asked during each

session. For instance, social interaction with other FDWs was more explicitly asked about during IDIs, however, discussion of such interaction also emerged during FGDs. Also, discussion of the role of governments, agencies and embassies in providing more support for FDWs was more present during FGDs, given the interview guide. By the final FGD and IDI sessions, no new themes or topics of discussion had emerged which prompted the researchers to conclude the study, having reached theoretical saturation. Overall, while some findings matched those of other studies, some new and surprising details regarding FDWs' health and work experiences abroad were revealed.

Surprisingly, not all of the FDWs' experiences were dismal, as previous research studies and the media may lead us to believe. It is important to acknowledge this fact, surely. However, it is perhaps even more important to profess that certain women did experience a number of injustices while working abroad, that not only resulted in having an unsatisfactory work experience, but also a number of concerning health problems. Results from FGDs and IDIs revealed that issues with one's physical and mental health were the most prevalent among the participants. Compared with the results of the free listing activity, certain health conditions commonly spoken of during FGDs and IDIs were also those most frequently listed by study participants. It is important to note, however, that in completing the free listing activity, women were told that they should list health problems that FDWs, in general, typically have.

Undoubtedly, however, some participants were referring to their own experiences. One such example of this is one participant's listed cause for backache — climbing the stairs —

which she spoke of during her interview.

Overall, headache, backache, and irregular meals were the most prevalent among the women's own experiences as well as some of the most frequently listed health conditions during the free listing task. Lack of rest, although frequently discussed during FGDs and IDIs, was only listed by a few participants. Lack of sleep and depression were also surprisingly among the least frequently listed health conditions, but were frequently discussed. Fever, however, was the second most frequently listed but rarely a condition that had afflicted the participants' own health. In regard to the causes assigned to health conditions, overwork was the most frequently mentioned during the free listing activity, as well as a significant contributor to poor health among FDWs in the study. Cold season and hot season, the next two most commonly attributed causes, were less frequently mentioned among FDWs; however, one participant did state that dust and hot weather were the most problematic for health.

The particular health conditions and their causes that were mentioned by women during FGDs and IDIs did overlap with those in the free listing activity. One such example to illustrate this would be the use of a cleaning powder being given as the cause of hand injury. During the pile sorting activity, headaches were again found to be perceived as more common among FDWs. However, they were not of great concern. Interestingly enough, although assault was mentioned by several women as something they experienced while working abroad, during the pile sorting activity this health condition was sorted as not common. Although cases of sexual abuse were less

frequently spoken of during FGDs and IDIs, they were contrastingly sorted as more common. Both of the aforementioned, however, were categorized as more concerning health conditions. Although we cannot be sure of why the results of the FGDs and IDIs did not match those of the pile sorting activity, one reason for the over reporting of assault during the former, compared to the activity, may be that some women were thinking of the experiences of others and perhaps cases of assault were rarely heard of. In the case of sexual abuse, women may have underrepresented their own experiences due to being uncomfortable with disclosing such information to others. However, perhaps they were aware of frequent cases of sexual abuse among other FDWs and, thus, categorized the health condition as more common during pile sorting.

Compared to the studies in Malhotra et al. (2013) that included Sri Lankan female FDWs in their sample, there are some similarities in our findings. One of the most common findings among studies was food deprivation or inadequate quantities of food provided to the FDWs, which corresponds to the results of our study. In terms of health, as previously discussed, only a few studies actually focused on investigating health problems. The few that did found various physical health complaints including: fatigue, backache, breathing problems, chest pain, etc. These did appear in our study as well, either through FGDs and IDIs or through the free listing activity. Headaches, while frequently mentioned by our participants, were not a significant finding of other studies. One study found a high prevalence of parasitic infections, which did not arise from our research. During pile sorting, participants themselves categorized infectious parasitic

disorders as not common and less concerning. Although our study did not test female FDWs knowledge of and attitudes toward HIV/AIDS, one study included in the systematic review did so. Finally, in regard to mental health issues, several of the studies were more technical in their approach, focusing on female FDWs who had been admitted to a psychiatric hospital at some point in time. One of these studies found stress and depressive episode to be prevalent and another reported that female FDWs experienced certain negative feelings (e.g., loneliness), which does correspond to some women's self-reported health problems within our study. However, all of the others reported more clinical disorders, including: neuroses, psychoses, manic episode, etc., which our study did not investigate.

Overall, it is important to take from the study that many of the physical health problems that women either reported having or provided during free listing are those that are fairly easily preventable. Although some of these (e.g., headaches), are not of great concern to FDWs, given their commonality they are important to prevent. Moreover, ensuring that FDWs are able to have regular and proper meals, an adequate amount of sleep, and some time to rest, may go far in preventing not only physical health problems but mental health problems as well. Regardless of prevalence and report of perceived commonality, appropriate measures should be taken to prevent health conditions of considerable concern to FDWs (e.g., STDs, sexual abuse, etc.).

There were a number of health conditions that only emerged during the free listing activity (and not the FGDs and IDIs): stomach gas, problems with vision,

discomfort, abdominal pain and discomfort, stressed, stomachache, diabetes, blood pressure, chest pain, loss of appetite, skin getting dry, cholesterol, excessive cold, chicken pox, and difficult to cope up. It is interesting to note that lack of sleep and irregular meals were cross-listed as both health conditions themselves and causes of certain other conditions. The attribution of some health conditions to causes revealed what can be considered as the women's individual health beliefs. For instance, weather (i.e., seasons) and temperature were both considered to have an influence on bouts of wheezing episodes or headaches. Both of these were reported to occur because of both cold seasons and hot seasons. In some cases, attributed causes matched biomedical models of disease, such as the attribution of gastritis to eating chilies (or spicy food), and not eating meat and fish (i.e., lack of protein) as leading to weakness of the body.

The aforementioned health beliefs did not always coincide with biomedical models. Therein lies the very need for studying such individualized health knowledge and making a more informed decision as to how the health needs of FDWs can be met and how certain problems can be evaded. Although it was beyond the scope of this study to examine cultural consensus between health beliefs, it nevertheless revealed that there are differences between what health professionals and researchers may have to say about certain health conditions and their causes and what FDWs themselves believe to be true. It is important, therefore, to identify and acknowledge both models and incorporate them accordingly in prevention of health problems.

Given that all of the participants in this study were live-in FDWs, the blurred

boundary between workplace and living space made their work experiences abroad all the worse or better. This was heavily dependent on the treatment that FDWs received by employers, both as their employees and—essentially—guests in their homes. It was pleasantly surprising to hear stories of FDWs being treated as if they were family and given certain degrees of freedom. More importantly, some were treated justly as hard-working employees. Still, it was disturbing to hear stories of maltreatment and abuse of their rights as not only laborers but as human beings.

The findings of this study echo those of the Human Rights Watch (2007), Jureidini and Moukarbel (2004), Palaniappan (2010), and Caritas Sri Lanka- SEDEC (2012). In regard to injustices in the workplace, participants within our study also experienced various forms of abuse and poor treatment as employees. In terms of the latter, many women were overloaded with work, not provided with enough rest, and some were not able to receive their salary on time or even a sufficient salary, corresponding to the amount of work put in. Other issues that also emerged both within our study and those of others include restrictions placed on mobility, communication, access to medical care, and religious practice. Beyond working experiences, some female FDWs also faced inadequate living conditions. Although confiscation of personal documents (including passports) is a common phenomenon, only participant within our study had such an experience. Other than the few instances of female FDW interaction with agencies or embassies in our study, the Human Rights Watch (2007) report and Caritas Sri Lanka-SEDEC's (2012) report, in particular, were more comprehensive in

their investigation of exploitative practices of various agents throughout the migration process, as well as the failure of legislation and protective measures. Unlike these reports, our study did not delve into the details of the female FDWs' experiences prior to arriving in the Middle East and later returning to Sri Lanka.

During FGDs, in particular, most of the women were cheerful and positive, even when speaking of harsh realities. Judging solely their nonverbal cues and not being able to comprehend Sinhala, one might guess that the topic of discussion was a light-hearted one. Of course, the IDIs probed into some more personal matters, such that some women's expressions were more telling of the negative experiences they had. The behavior that was witnessed speaks to one of the surprising findings of the study: the benefit of social interaction with other FDWs. The inclusion of questions asking women about their interactions served to add yet another understudied component to our research. Very few studies have examined the interaction that women have with others while working abroad and none could be found specific to Sri Lankan female FDWs. Only one of the studies included in Malthora et al.'s (2013) systematic review focused on coping strategies. Conducted in Hong Kong, the study examined coping strategies among Filipina FDWs in terms of religion, with some mention of the benefit of social interaction through a church group setting. Another study done on FDWs in Singapore found that in face of limited resources for treatment of health problems, women had to rely on other forms of coping (Wong, 2010). Prayer was the most common, with some participants believing that faith helped to prevent suicidal ideation and suicide attempt.

Two other forms of coping were common: distracting oneself with work and crying, particularly to ignore mental suffering and relieve feelings of sadness and anger. Less common among coping mechanisms was: singing, calling a helpline, painting, joining a church group, keeping a journal, etc. There was no explicit reference to interaction between FDWs and the potential for such interaction to serve as a way of coping with problems or frustrations within Wong's study.

It turned out that, within our study, beyond other forms of leisure activities, participants' interaction with other FDWs worked well as a coping strategy, particularly for FDWs who had restricted communication with their families or suffered in the workplace due to poor treatment from their employers. Since the majority of participants were mothers, social interaction could serve to ease the sorrow and regret that comes as a result of leaving their children behind. Given that mental health problems were quite common among participants, the potential impact that social interaction as a coping strategy may have on preventing or mitigating the severity of these problems is worth highlighting. Additionally, beyond health benefits, social interaction with others may not only enrich FDWs' experiences working and living abroad, but it may even better equip them to perform their work duties and more effectively communicate with their employers. A simple course of action taken to allow FDWs to interact with each other on a regular basis, without restrictions, may go very far in enhancing FDWs' working experiences and their overall job satisfaction.

Although some participants were not pleased with their overall experiences and

had certain problems while working abroad, they were still willing to consider returning to work as FDWs. Not all would make the sacrifice again, but those who mentioned that they might or surely would spoke of the lack of economic opportunity in Sri Lanka propelling them to do so. Thus, it is not that the participants seemed apathetic or unconcerned with the current state of things, but rather that they feel that not much of anything will change in their lives that will allow them to seek out other opportunities. Although certainly a vulnerable group, FDWs are by no means weak. As their narratives reveal, these women are aware of their goals and are very driven, particularly to help their families. Despite the gendered nature of their work responsibilities, women are becoming more empowered as the breadwinners of their families. As such, it is crucial to give attention to the concerns that they raise and the knowledge and understanding that they possess in terms of their own needs, particular in regard to their health.

4.1 Strengths and Limitations

The primary strength of this study lies in its comprehensive qualitative nature and its focus on an understudied population: Sri Lankan female FDWs. Previous studies, as shown in Malhotra et al. (2013), may have been focused on FDWs from multiple countries of origin in a single host country. However, the present study was unique in its approach, in that it exclusively focused on Sri Lankan FDWs who have previously worked in a number of countries in the Middle East. Moreover, as aforementioned in a previous section, this study attempted to obtain a heterogeneous sample of former

female FDWs from Galle District in Sri Lanka. This maximum variation in the sample allowed for the achievement of theoretical saturation to lend itself to proximal similarity, rather than generalizability of results. Thus, we can say that these women may not represent all of the female FDWs from Sri Lanka, but may be representative of this community. This can more easily allow for further quantitative research to be conducted with the same target population.

Another significant strength of this study lies in the principal investigator and co-researcher's individual skill sets. Dr. De Silva has previous experience in working with Sri Lankan female FDWs and, as such, she is familiar with the issues that they may be facing and their experiences working abroad. Moreover, as a physician, she was able to gain the trust of the group, thus allowing for a more comfortable and natural discussion and interaction to take place between the participants themselves and her. However, given Dr. De Silva's previous experience in working with the FDW population, to avoid any potential bias, the principal investigator was the one to develop the study, its objectives and methods. Furthermore, the principal investigator herself has been previously involved with qualitative research, even in an international setting. Finally, through triangulation of data sources and methods, theoretical saturation could be achieved and various kinds of information obtained from the participants in regard to their health and their work experiences abroad.

Despite these merits, this study is certainly not without its limitations. The primary limitation lies in the principal investigator's unfamiliarity with the native

language of the participants: Sinhala. This meant relying on a number of co-researchers throughout the process of project development, data collection and even data analysis to verify that any bias was avoided and the original intent or meaning of the participants' responses was retained and appropriately reflected. Moreover, the principal investigator was limited in her ability to analyze certain verbal and nonverbal cues in further detail. This language barrier further prevented her from analyzing results of the free listing and pile sorting tasks to come to understand the local constructs of certain terms and the health conditions they refer to. For instance, the medical term for "depression" is not one that participants were familiar with. Therefore, it would have been interesting to further explore this and find out exactly how this health condition is understood and referred to by these women.

Despite the intention of focusing exclusively on Sri Lankan female FDWs who were previously employed in the Middle East, the study could not entirely achieve this. In order to avoid recall bias, participants were asked to reflect on their most recent employment experience. For two participants, this meant responding to questions according to their job in Singapore, as that was the last country they were employed in. Rather than sending these women home, however, we recognized this flaw in our methodology and allowed the women to stay, hoping to be able to determine if there was any difference in the experiences of women working in Singapore versus the Middle East. This was understood to not be generalizable but would nevertheless be interesting to explore. Also, in terms of recall bias, it is possible that some of the women

referred to all of their previous employment experiences as a whole, rather than their most recent. Additionally, the principal investigators failed to ask how long ago women's most recent employment ended, which could have indicated for which women recall bias may have been a contributing factor.

Finally, given the ethnoreligious tensions underlying the Sri Lankan civil war (1983-2009), women were not asked for their religion or ethnicity, which were deemed to be sensitive topics (Georgetown University, 2013). However, the researchers came to discover that religion was an important aspect of the lives of the participants. Thus, it would have been of interest to have included this demographic variable in the short survey administered to the women.

4.2 Recommendations, Implications, and Direction for Future Studies

As illuminated by participants in this study, although foreign domestic work has been continually absorbing a higher percentage of female labor, work standards have not kept up with the demands of FDWs. Taking into consideration the statements made by the women, several recommendations can be drawn for improvements within the profession of foreign domestic work, to ensure that FDWs are treated fairly as employees and an essential labor force driving Sri Lanka's economy. The following are five basic actions that could be taken:

- The training provided by the SLBFE needs to include extended language

and culture lessons, as well as incorporate health beliefs in lessons on maintaining health while working abroad. Manuals with all of this content need to be given to all departing FDWs.

- There needs to be more strict regulation of embassy and employment agency employees to ensure greater accountability toward FDWs and fair treatment, as well as greater coordination between the two bodies.
- A standard of working conditions, time off, salary, and medical coverage for employment contracts needs to be developed. Further, there needs to be legal enforcement of contract stipulations and punishment for employers who breach a contract.
- The SLBFE should partner with local NGOs within Sri Lanka and host countries, so that NGOs can assist with various stages of migration. NGOs can help to facilitate communication between FDWs and their families while abroad or coordinate activities to encourage social interaction between FDWs. They may also help to provide additional work or language training, health workshops, or counseling services for women both in Sri Lanka and the host countries. Finally, they can assist agencies or embassies in certain instances of case overload.
- Finally, it is recommended that pre-and post-migration health surveys be administered to FDWs, including some of the health beliefs that arose from this study. In addition, medical examinations should be conducted

at the pre-and post-departure stages, with regular checkups during employment.

Health surveys can not only serve as a monitoring technique but can also provide more generalizeable and quantifiable data on the occupational health of FDWs. Further qualitative inquiry with utilization of cultural consensus analysis can be carried out to explore agreement among health beliefs of FDWs. Along with that, although it was beyond the scope of this study to do so, it is important to test assumptions made about the similarity in working conditions and health outcomes of all female FDWs through cross-cultural studies of both the qualitative and quantitative kind. The results of this study will actually serve to guide the development of a quantitative instrument to be used in the same setting of Galle District, to obtain more generalizeable data on the health of Sri Lankan female FDWs, through a larger sample of this population. Finally, it may be interesting to conduct a similarly designed qualitative study focusing on Sri Lankan male FDWs (or perhaps those of another nationality). Although rare, there are some men who migrate abroad to do domestic work. Results could be compared between men and women to see if there is any difference in their working conditions, their treatment, and their health outcomes.

5. Conclusion

Through qualitative inquiry in the form of FGDs, IDIs, and collection of quantifiable data from free listing and pile sorting activities, the researchers came to not only obtain a list of prevalent health problems among female FDWs from Galle District, Sri Lanka, but also an understanding of how the nature of foreign domestic work can potentially cause these problems. Moreover, the participants of the study gave insight into their health beliefs and informed the researchers of the health conditions that they find to be most common and most concerning among FDWs. A quantitative study would not have been able to easily achieve the aforementioned. It is certainly important to obtain generalizable data to determine how many former female FDWs suffer from certain health problems due to their occupation. However, it is equally important to recognize that these women have their own perspectives on their health conditions, their severity, their prevalence, and their causes. By tapping into these health beliefs, the researchers could not only engage with the women of this community on a more personal level, but also empower them. There are several policy implications that results of this study have, namely, to put forth greater effort toward ensuring fairer labor standards and treatment of FDWs. If anything, hopefully this study will serve to bring awareness of the health problems that Sri Lankan female FDWs develop as a result of their employment and encourage continued research on the topic.

Appendix A: Brief Survey of Demographic Information

1. In what year were you born? _____
2. Are you originally from Galle? If not, where were you born and how long have you lived in Galle? _____
3. Which country (countries) have you worked in? _____
4. Which country have you worked in most recently? _____
5. How long were you employed in that country? _____
6. Did you return to Sri Lanka upon normal terms of your most recent contract?

7. Are you currently employed? _____
8. If yes, what is your current occupation? _____
9. What is the highest grade of formal education that you have completed?

10. Did you obtain your education in Galle or elsewhere? _____
11. (If college educated): What was your area of study? _____
12. Are you married? _____
13. Do you have any children? _____
14. If yes, how many? _____

Appendix B: Focus Group Discussion Guide

A: Introduction

Welcome everyone. Thank you for agreeing to participate in this focus group discussion. As we mentioned, the purpose of our study is to gain a better understanding of the health of Sri Lankan female FDWs who have been employed in the Middle East. This focus group discussion will be audio recorded. This is just to ensure that we obtain an accurate account of your responses. We would like to hear from all of you throughout this discussion. Please be respectful of the other group members and allow for others to respond to the questions. Please remember that you may withdraw from the interview at any time. Please be as candid in your responses as you can.

Now I will go ahead and start this session with some general questions about your participation in this study and your employment as a FDW.

1. What motivated your participation in this study?
2. Did you ever think that you would become a FDW?
3. What led you to become a FDW?

B. Employment Experience

I would now like to learn a bit more about your employment experience. Please speak as openly as you would like. We appreciate your honest responses.

1. What are some reasons for women to become FDWs?
 - a. Do you think women make this decision independently or with the aid of others' input (e.g., husbands, parents, older children or any other family members or friends)?
 - b. Do you think that some women are more likely to become FDWs than others? If so, what are such circumstances?
2. What were some of your reasons for becoming a FDW, in light of what was just discussed?
3. What do you think women's expectations of the nature of domestic work are?
 - a. Are these expectations largely positive or negative?

4. What were some of your expectations of your work experience abroad?
 - a. How was your employment different or similar to your expectations?
5. What is your definition of good and poor health?
 - a. How do you define a healthy or an unhealthy woman?
 - b. In what ways can poor health affect your life?
 - c. How important is your health to you and why?
6. According to your definition of good and poor health, do you think female FDWs who return from the Middle East (after their contract has ended) have better or worse health than when they left Sri Lanka?
7. Do you think that your health is better or worse now than before you were employed abroad?
 - a. What are the ways in which domestic work may affect the women's health?
8. How was your life as a FDW the same or different than your normal life in Sri Lanka?
 - a. What were some of the risks posed by the nature of your work?
 - b. Were there any restrictions place on you (e.g., no religious practice, no mobility, no access to health care, etc.)? If so, what were they?
9. What are some of the ways in which female FDWs can better their health while working abroad?
 - a. Are there any actions that these women can take to maintain good health? If so, what are they?
 - b. How can female FDWs work together to improve their working experience and promote better health or positive health outcomes?
 - c. How can female FDWs work together to cope with their negative experiences working and living abroad?

C. Health Information through Free-List and Pile-Sorting Activities

D. Discussion of Activities

Next, I would like to discuss what you worked on during each of the activities.

1. What are some of the more common health conditions that you found within your groups?

a. Why did you choose these?

2. What are some of the less common health conditions that you found within your groups?

a. Why did you choose these?

3. Were there any conditions that your group had disagreements on or ones that did not seem common at all among female FDWs?

4. What are some of the more concerning health conditions that you found within your groups?

a. Why did you choose these?

5. What are some of the less concerning health conditions that you found within your groups?

a. Why did you choose these?

6. Again, were there any conditions that your group had disagreements on or ones that did not seem concerning at all among female FDWs?

7. How do your group choices compare with your individual choices?

a. Are there any health conditions that you thought of individually but were not included in the ones given to your group?

b. Which, if any, health conditions would you add to the list of those provided to you in the group activity?

E. Conclusion

Finally ,we would like to take a few moments to allow you to reflect on your responses during this discussion.

1. How can working conditions be improved in a way that is better for the health of female FDWs?
 - a. What are the actions that female FDWs can take themselves and what are the actions that employers, employment agencies, your government or the host country's government can take?
2. Do you think if such actions were taken that more women would consider working as female FDWs? Why or why not?
3. Where do you see the future of foreign domestic work heading?

Thank you very much for taking the time to participate in this discussion. We sincerely appreciate it.

Appendix C: In-Depth Interview Guide

Thank you for agreeing to participate in this interview. As we mentioned, the purpose of our study is to gain a better understanding of the health of Sri Lankan female FDWs who have been employed in the Middle East. Like the focus group discussion, this interview will also be audio recorded. Again, this is just to ensure that we obtain an accurate account of your responses. You are welcome to answer as many questions as you would like. Please remember that you may withdraw from the interview at any time. Please be as candid in your responses as you can.

A. Employment Experience

The first interview questions that I would like to ask will focus on your perceptions of your employment experience. Please speak as openly as you would like. We appreciate your honest responses.

1. Prior to your employment, what did you know of the working conditions for female FDWs?
 - a. Growing up, did you know of anyone who worked as a female FDW?
 - b. What was your perception of their experience?
 - c. How did this influence your decision to become a FDW?
 - d. Was there anything that you were concerned about prior to going to work abroad?
2. What was your overall employment experience like?
 - a. What were the working conditions like?
 - b. What did you think of the work environment, your employers and the community?
3. What were you satisfied and dissatisfied with your job and your life abroad?
 - a. How did you cope with what you were dissatisfied with?
4. What interaction/communication did you have with other female FDWs during employment?
 - a. How did this interaction affect your employment experience?

b. How did this interaction contribute to coping with your dissatisfaction with your working experience and life abroad?

B. Health Information

I would now like to ask some questions about your current health status. I understand that some of these topics may be of a sensitive nature. Please speak as openly as you would like. Again, we appreciate your honesty.

1. Based on your definition of good and poor health, do you feel that you are in good health?

2. Can you describe some of your recent health concerns that may have been influenced by your employment?

3. Overall, do you feel that your health is better, the same, or worse than before your employment?

4. For the following question, please provide as much information as you can. What are some of the ways in which you think your employment has affected your:

* (in parentheses- only used as prompts)

- i. Physical health (e.g., disability, poor nutrition, skin irritations, headaches/migraines, insomnia, body pains, weight loss, etc.)
- ii. Mental health and/or Emotional health (e.g., depression, anxiety/stress, emotional disbalance, etc.)
- iii. Sexual health (e.g., irregular menstruation, STDs, etc.)
- iv. Health behaviors (e.g., physical inactivity, poor nutrition, not seeking regular medical care, prevention, etc.)
 - a. Which of the above were present during your employment?
 - b. Which of the above were present after your employment?
 - c. Were any of the above present before your employment? If yes, which ones?

5. What threats to your health did you experience during your employment (e.g., sexual, physical, verbal harassments)?

6. What do you think most adversely affected your health? Why?
 - a. Do feel your health was mostly influenced by your employer's actions, work activities, environment (cultural, social), or your own actions?
7. What measures, if any, did you take to ensure that you remain in good health?
 - a. Were there any actions that you specifically took, or any daily regimes that you had to do so? If so, what were they?
8. How did your interaction with others affect your health (e.g., community members, other FDWs, healthcare workers, employers, etc.)?
 - a. Did your health benefit in any way from this interaction? If so, how?
9. Finally, how has your employment experience affected your current life (e.g., personal, social, family, religious, etc.)?

C. Conclusion- Reflection

Finally, we would like to take a few moments to allow you to reflect on your overall experience as a foreign domestic worker.

1. Would you ever consider working as a FDW again? Why or why not?
2. Would you recommend this occupation to other women? Why or why not?
3. What would you recommend that other female FDWs do to maintain their health while working abroad?
4. What would you recommend that other female FDWs do to improve their health upon their return to Sri Lanka?

Thank you very much for taking the time to participate in this interview. We sincerely appreciate it.

Appendix D: Informed Consent for Participation in Focus Group Discussion

Dear Participant,

Thank you for your interest in this research study.

Research Purpose

You are being invited to participate in this study which explores the health of Sri Lankan women who have previously worked as foreign domestic workers in the Middle East. Given your previous work experience as a foreign domestic worker, your participation in this study will not only help the research team members to better understand the health problems that female foreign domestic workers from Sri Lanka are facing, but will inform society at large to bring attention to this issue.

Description of Study

You and 23 other female foreign domestic workers from Galle district have been selected to participate in one focus group discussion each, with a total of 6 women present within each group. During this focus group discussion you will be asked some questions regarding your employment experience and how it has affected your health. These questions will be asked and answered in the presence of five other women who have also worked as foreign domestic workers. The purpose of this discussion is to see how you and women such as yourself think about your current health and your experience working abroad. You will work individually and together with other women in the group on two interactive exercises. One is free-listing and the other is pile-sorting. During these activities you will be asked to individually name particular health conditions which you feel are influenced by employment as a foreign domestic worker and to describe what can be the cause of these health conditions. Working in groups you will then be asked to rate which particular health conditions you feel are the most common and most concerning among women such as yourselves. The focus group discussion will be conducted by a female Sri Lankan physician currently studying at the University of Ruhuna, alongside a female graduate student from the United States in a private and convenient location.

Confidentiality

While there are no physical risks associated with your participation in this study, some

questions may be sensitive in nature. Thus, while we invite your open and honest responses, you may refuse to answer any questions and may withdraw from the study at any time without suffering any penalty or consequences. We would like to remind you that you need not share any information that you may feel uncomfortable with the other women knowing and discussing. We anticipate that the focus group discussion which you are being invited to participate in will take approximately one hour and thirty minutes of your time. Your responses to the questions asked during the focus group discussion will be audio recorded, will be kept safe and private and will only be shared between the two facilitators.

You will be assigned a participant number so that your responses cannot be directly tied to any identifiable information. Your responses to the focus group questions will be entirely anonymous and will be securely stored and only accessible to the two facilitators. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared. If you would like to receive access to any publications or presentations resulting from this study, you may notify us at the completion of this study and leave us with your contact information. All data obtained from this study will be stored and secured in a password-protected personal computer only available to the two facilitators.

Participation in the Study

Other than engagement with other female foreign domestic workers who share similar experiences to yours and being given the opportunity to voice your opinion, we do not anticipate any direct benefits from your participation in this study. However, your participation will greatly aid the research team and society at large in better understanding the circumstances that shape female foreign domestic workers' health. We anticipate that the results of this study will help to inform other studies and can influence policy in the long term to improve the conditions under which future female domestic workers work abroad. You will receive a modest compensation of approximately 1000 LKR after the focus group discussion has been completed. This serves to help cover your travel expenses to and from location where the focus group discussion will be taking place. This money can only be offered to you once you have participated in the focus group discussion. At the end of the focus group discussion you will be given the option of completing a brief survey to comment on your experience in the focus group discussion and to provide suggestions for improvement. This survey is entirely optional. Choosing not to complete it does not in any way affect your participation in this study or your compensation.

Once all of the focus group discussions have been completed, 8 women will each be invited to participate in a one-on-one in-depth interview with the female two co-facilitators. If you are asked to participate in this interview you will be provided with

another informed consent form to read and sign, describing your participation in the interview. If you choose to participate in an interview you will be provided with another monetary compensation of approximately 1000 LKR to cover the additional expense of traveling to and from the interview location. You will receive this compensation after the completion of the interview. This money can only be offered to you once you have participated in the interview.

If you have any questions or concerns regarding this study or your rights as a participant in this research, or if you feel you have been placed at risk, you are welcome to contact Dr.Vijitha De Silva by e-mail at pvijithadesilva123@yahoo.com , or by phone at 077760970.

STATEMENT OF UNDERSTANDING/AGREEMENT TO PARTICIPATE

By signing the statement below you are agreeing to participate in this research study. I acknowledge that I am over **18** years of age and that I have read through this form in its entirety. I understand the purpose of the study, the procedure and any risks and benefits that may come from my participation. I understand that my participation in this study is entirely voluntary and that I may withdraw from the study at any point in time. I acknowledge that all of my questions regarding the study have been answered thoroughly by the research team members; however, if I have any further questions I may ask them at any point in time during the study.

Full Name (Print)

Signature

Date

Appendix E: Informed Consent for Participation in In-Depth Interview

Dear Participant,

Thank you for your interest in this research study.

Research Purpose

You are being invited to participate in this study which explores the health of Sri Lankan women who have previously worked as foreign domestic workers in the Middle East. Given your previous work experience as a foreign domestic worker, your participation in this study will not only help the research team members to better understand the health problems that female foreign domestic workers from Sri Lanka are facing, but will inform society at large to bring attention to this issue.

Description of Study

You and 7 other female foreign domestic workers from Galle district who have also participated in a focus group discussion have been selected to participate in a one-on-one in-depth interview with the two female co-facilitators. No other individuals will be present during the interview.

During this interview you will be asked some questions regarding your employment experience and how it has affected your health. The interview will be conducted by a female Sri Lankan physician currently studying at the University of Ruhuna, alongside a female graduate student from the United States in a private and convenient location.

Confidentiality

While there are no physical risks associated with your participation in this study, some questions may be sensitive in nature. Thus, while we invite your open and honest responses, you may refuse to answer any questions and may withdraw from the study at any time without suffering any penalty or consequence. We anticipate that the interview which you are being invited to participate in will take approximately one hour of your time. Your responses to the questions asked during the interview will be audio recorded, will be kept safe and private and will only be shared between the two facilitators.

You will be assigned a participant number so that your responses cannot be directly tied

to any identifiable information. Your responses to the interview questions will be entirely anonymous and will be securely stored and only accessible to the two facilitators. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared. If you would like to receive access to any publications or presentations resulting from this study, you may notify us at the completion of this study and leave us with your contact information. All data obtained from this study will be stored and secured in a password-protected personal computer only available to the two facilitators.

Participation in the Study

Other than being given the opportunity to voice your opinion and share your personal experiences, we do not anticipate any direct benefits from your participation in this study. However, your participation will greatly aid the research team and society at large in better understanding the circumstances that shape female foreign domestic workers' health. We anticipate that the results of this study will help to inform other studies and can influence policy in the long term to improve the conditions under which future female domestic workers work abroad. You will receive a modest compensation of approximately 1000 LKR after the interview has been completed. This serves to help cover your travel expenses. This money can only be offered to you once you have participated in the interview. At the end of the interview you will be given the option of completing a brief survey to comment on your experience in the interview and to provide suggestions for improvement. This survey is entirely optional. Choosing not to complete it does not in any way affect your participation in this study or your compensation.

If you have any questions or concerns regarding this study or your rights as a participant in this research, or if you feel you have been placed at risk, you are welcome to contact Dr. Vijitha De Silva by e-mail at pvijithadesilva123@yahoo.com, or by phone at 077760970.

STATEMENT OF UNDERSTANDING/AGREEMENT TO PARTICIPATE

By signing the statement below you are agreeing to participate in this research study. I acknowledge that I am over 18 years of age and that I have read through this form in its entirety. I understand the purpose of the study, the procedure and any risks and benefits that may come from my participation. I understand that my participation in this study is entirely voluntary and that I may withdraw from the study at any point in time. I acknowledge that all of my questions regarding the study have been answered thoroughly by the research team members; however, if I have any further questions I may ask them at any point in time during the study.

Full Name (Print)

Signature

Date

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