

Women on the Move

Migration, care work and health

Policy Brief

Introduction

Ageing in late industrial and middle-income economies, combined with rising demographic dependency ratios and female labour force participation, have led to emerging care deficits in many contexts in developed and developing countries. Around the world, more women are entering the labour force, taking them away from traditional unpaid caring roles in the home. Increasingly, immigrant women are being drawn into receiving country economies to care, often in informal settings, and frequently engaged by private households, without full access to social protection and labour rights.

As the leading normative agency on health, the World Health Organization (WHO) calls attention to this paradox: that migrant women care workers buttress health systems in countries where there are shortfalls in health-care provision, while their own rights to health and well-being can be eroded and their health-care needs unfulfilled. These migrant women care workers act as a cushion for states lacking adequate public provision for long-term care, child care and care for the sick.



World Health
Organization



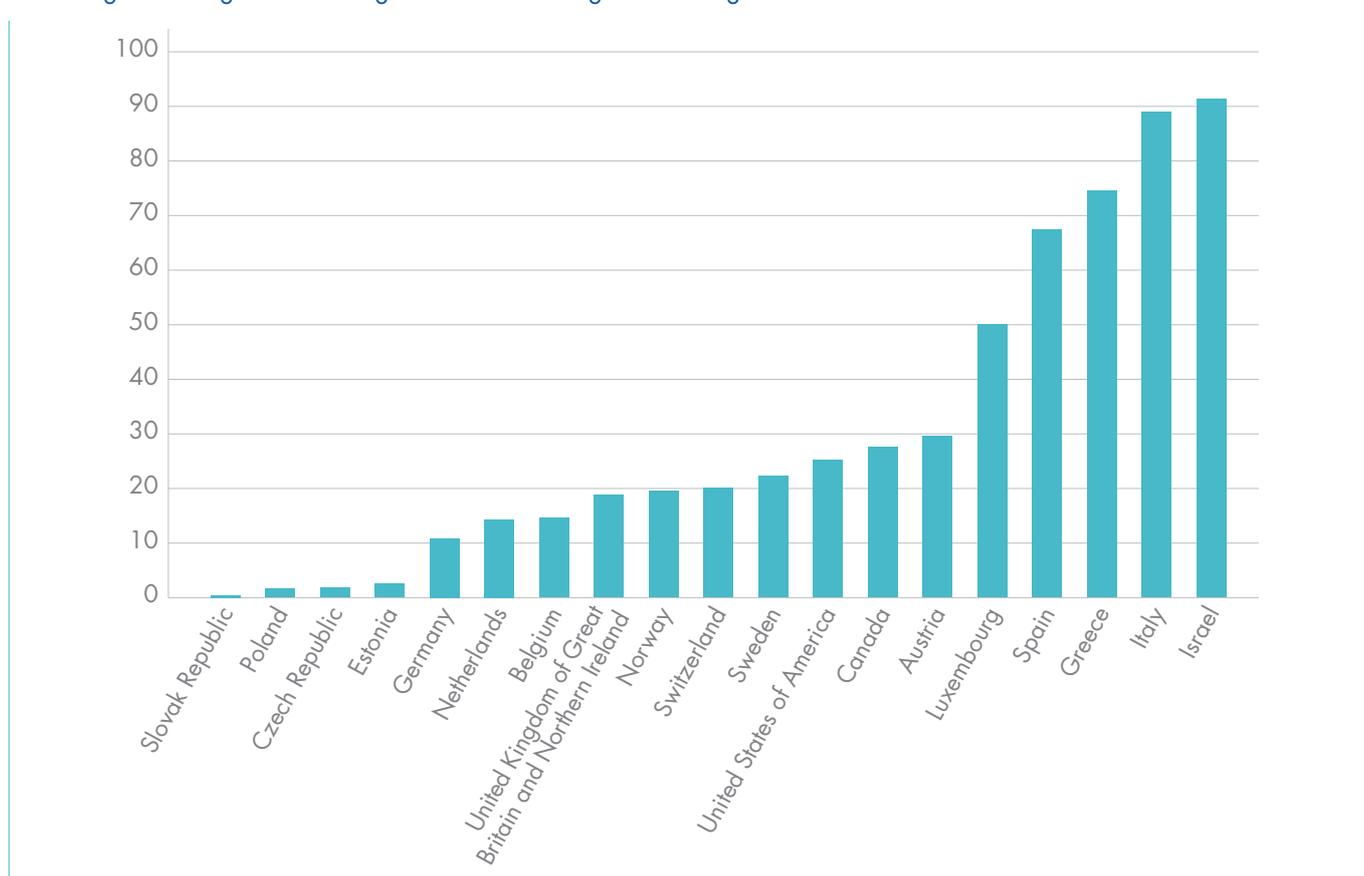
The critical role of care work and care workers for health systems

This Policy Brief focuses on **women migrant care workers** providing home-based personal care. Women migrant care workers play an increasingly prominent role in securing the health status of others and contributing to health systems. Yet relatively little is known about their own health status, their lives as migrant care workers, and their important contributions to health systems. This is particularly significant as a global paradox is emerging in which care workers, who are overwhelmingly female and many of whom are migrants, make a very large contribution to global public health, but are exposed to many health risks themselves while enjoying few labour market and health protections.

Defining and recognizing care

In this Policy Brief, we focus our attention on **paid home-based care workers who attend to the varied needs of children, older people, people with disabilities and the disabled and the sick**. We are particularly interested in the role that migrant workers play, most of them women but not exclusively so, as paid carers contributing to health-care systems and as workers whose rights to health care may be contingent on their migration and employment status.

Percentage of foreign-born among home-based caregivers of long-term care



Source: OECD Migration Outlook, 2015:123.

Unprotected and undervalued

Care workers are often contracted through private agencies or informally to work in private households. Some may be migrant health-care professionals who have been unable to find work in formal health-care settings, perhaps because of non-recognition of their credentials and training, and who face significant job downgrading and deskilling as a result¹. Fewer than 15% of home-based long-term care workers are estimated to be formally employed². Those who are hired informally often lack the statutory labour rights accorded to them through a contract, including pensions and benefits, and may receive wages that are significantly lower than those paid for equivalent work in the formal health-care system³.

Migrant women care workers face particular challenges because of the vagaries of immigration laws in various destination countries, which often prevent them from entering the country legally or taking paid employment. This lack of legal status puts undocumented immigrants working in the care sector in many countries at risk of abuse by unscrupulous employers. Moreover, the care sector itself is rendered unable to fully benefit from the work of immigrant workers who may want to provide in-home care but are unable to find a legal path to enter the country or obtain employment.

Many migrants face the challenge that host countries fail to recognize their training and credentials^{1,4} with the result that they end up working in home-based care where they experience deskilling and downgrading of their professional status (see, for example, the plight of Zimbabwean care workers in the United Kingdom)⁵. Migrant care workers generally encounter harsher working conditions and have fewer rights and less adequate health coverage than do native workers. Because care work is frequently relegated to the informal sector, employees find that access to health care or insurance is not guaranteed but granted at the whim of employers. In the United States in 2010, for example, almost one quarter of foreign-born workers employed in health care support jobs, such as nursing, psychiatric, or home health aides lacked health insurance themselves⁶.

Much has been written about the poor conditions that care workers, especially migrants, regularly face, including low wages, long hours, and inadequate housing and food for those who “live-in”^{7,8,9}. Many studies report that such work often entails lack of respect and status and even verbal, physical and sexual abuse^{10,11,12}. In the most extreme instances, when recruiters or employers confiscate workers’ passports¹³ and deduct travel costs and other expenses from their wages (or fail to pay them altogether), care work jobs become a modern form of indenture¹⁴. Surprisingly, however, researchers have paid less attention to the links between different types of care work and migrant care workers’ health.

The physical and mental health status of migrant women care workers

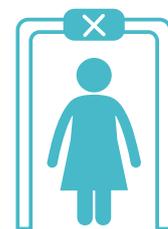
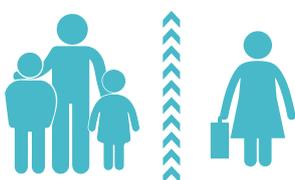
A significant knowledge gap exists when it comes to how migrant care workers’ health is influenced – both positively and negatively – by the labour they perform and the contexts in which they undertake this work.

Existing literature documents specific negative physical health consequences of involvement in care work. The most commonly cited are fatigue, hunger (resulting from insufficient food or inability to prepare dishes of their own culture)¹⁵, falls, and musculoskeletal strain and injuries caused by heavy lifting of bodies and equipment, some of which remained with them long after they returned home¹⁶. This is consistent with a growing body of research focusing on the injuries to which domestic workers are prone, including contusions, lacerations, burns, amputations, eye injuries, blindness, head injuries, musculoskeletal strains/sprains, chronic hand/wrist pathology, backache and leg pains, and exposure to infectious diseases^{17,18}.

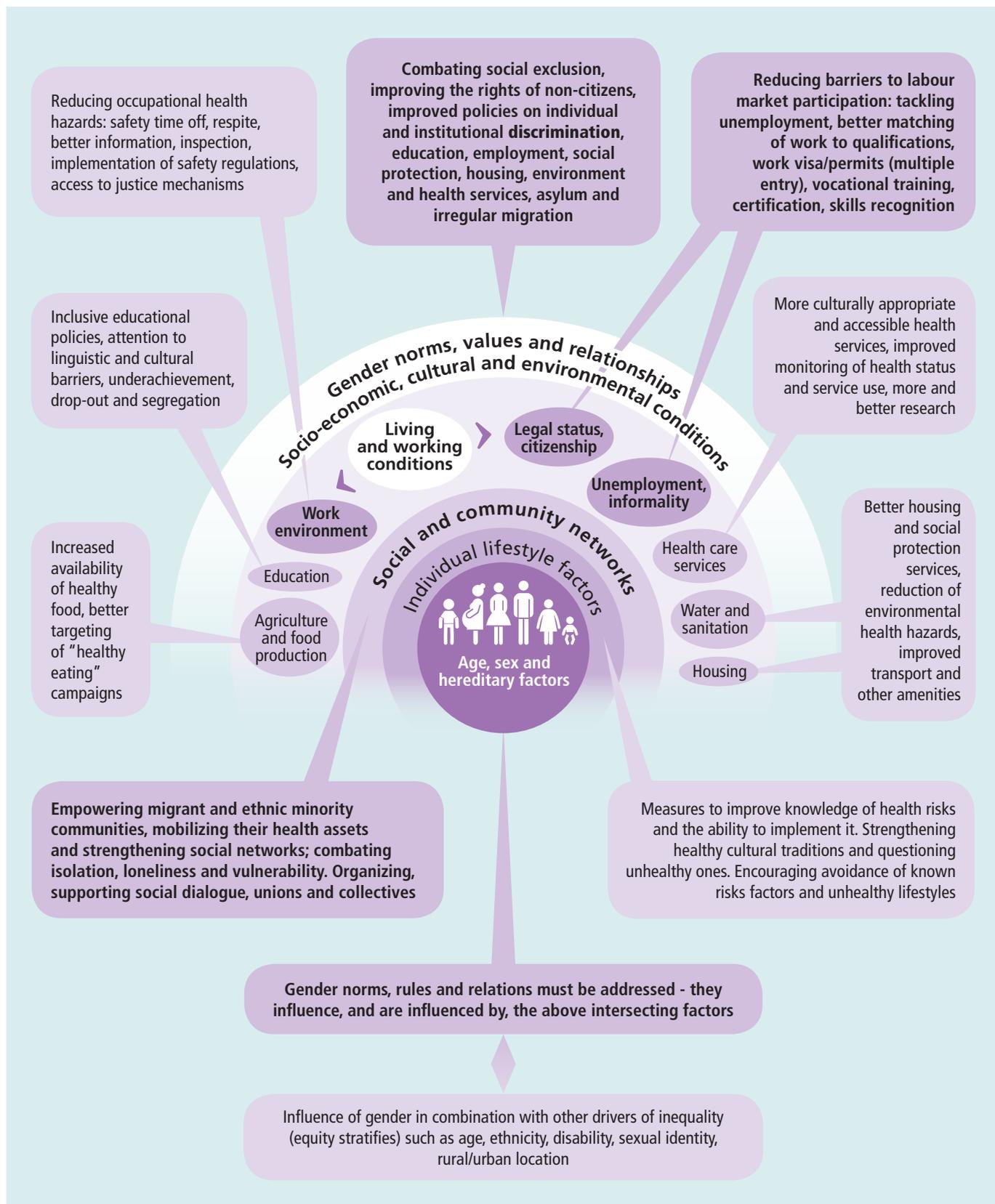
Many migrant women care workers experience poor reproductive and sexual health^{19,20}. There is also ample evidence that they are subject to physical violence, including sexual harassment/assault and regular beatings. For example, 44% of Filipina migrants reported knowing another domestic worker who had experienced physical abuse, 27% knew someone who had experienced sexual harassment, and 22.4% knew someone who had been raped^{21,22}.

A key barrier to access to health services, particularly for migrant domestic workers, is the common inability to obtain **health insurance** in destination countries. Some sending countries have introduced portable insurance schemes to give migrant women care workers access to health care in their countries of destination. However, the basic benefits package covered, the limited duration of coverage, and the extent of costs covered by those schemes may be insufficient to address actual needs. This leaves many migrant workers vulnerable if employment rights and health entitlements are not honoured in receiving country households. Specifically, they can be at risk of not receiving coverage for medical expenses within receiving countries, for illness and injury sustained in escaping from abusive work situations, and for treatment of sexually transmitted diseases such as HIV.

There may be significant disincentives to seek health care. Some migrants had their citizenship applications rejected when health tests found life-threatening illnesses^{23,24}; others reported that test results were provided to recruitment agencies without their consent at both origin and destination²⁵. Migrant women care workers in the Eastern Mediterranean who test positive for HIV/AIDS or pregnancy often face immediate deportation²⁶.



Social determinants of health diagram adapted for migrant women care workers



Source: WHO Regional Office for Europe, 2010. The figure was elaborated for migrant health by T. Koller, with content additions from D. Ingleby, S. Gammage and M. Manandhar, and layout changes by E. Cherchi. The inner rainbow comes from Dahlgren and Whitehead, 1991

Care chains and care drains

As the absolute numbers of those migrating rises, this creates a “care drain” in the global south, in poorer parts of the European Union and other developing regions, and in the rural areas of countries with large internal (rural-urban) migration (e.g. Brazil, China, Philippines)²⁷. This produces a “tilt” of care resources to cities and to the global north. Migrants, and the families they leave behind, seek to address the loss of those who provide care by creating “global care chains”, substituting for the care once provided by those who have left by placing children with aunts, grandmothers, and other relatives (usually women), and hiring paid caregivers. While these global care chains reveal the agency and resilience of migrants and their families, they are also fragile and often break under the psychological and financial stress of extended separations^{28, 29, 30, 31}.

The health and well-being of those left behind

Those left behind in the wake of migration also experience impacts on their health and well-being. Children react to maternal absence in a myriad of ways, depending on their own temperaments and relationships with the absent parent as well as the configuration of their substitute care arrangements and the personalities involved. Their responses to maternal absence may also change over time or according to age: adolescents tend to express negative feelings more vocally than younger children³².

Children are not the only ones affected by the migration of a family member. With migration, many older persons face dual challenges when charged with the care of grandchildren whose parents have migrated, and as persons themselves in need of care. Older people are frequently the main caregivers in many poor households in low- and middle-income countries. Often, they are caring for other older persons and children in their families.



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This role should be better recognized and supported³³. Elderly grandparents in Thailand were often forced to go back to work in order to support left-behind grandchildren³⁴. Parents' ability to cope with added burdens on their own depends greatly on their age and physical abilities.

The practical and psychological consequences of women's absence can exacerbate gender inequalities in sending countries, requiring that other women and girls engage in more caring responsibilities (mostly unpaid) to substitute for those who have left, increasing time burdens and frustrating the achievement of other development objectives. Yet maternal absence may also prompt men to shift gender roles and responsibilities and, in some cases, take up more caring³⁵.

Policies to support the health of migrant women in personal care work

Migration, labour, social protection and health-care policies can converge in ways that compromise the health of migrant women care workers and their families – both accompanying and left behind. For example, visa options for care workers are often temporary and may not allow for those caregivers to access necessary health services for themselves. In many countries, those designated as “non-citizens” cannot access health care and child care³⁶, or it is prohibitively expensive for non-citizens and the uninsured^{37,38}. Migrants may also lack access to basic workers' rights, such as sick leave and compensation, due to an absence of regulated contracts³⁹.

Undocumented migrant women care workers may be reliant on their employers and recruitment or placement agencies to uphold their contractual commitments, which does not always occur.

Immigration laws, because of their impact on families – either expediting or, more likely, delaying family reunification – become, in effect, *family laws*⁴⁰. Immigration laws affect families by dictating who constitutes “the family”, who may come in to join and when. They can bar many migrants from entering legally in the first place, thus making it difficult for other family members to join them or, equally problematic for undocumented workers, to travel back to their home countries to visit family left behind because it is too expensive and dangerous, and/or they may be unable to re-enter the destination country again.

Loosening visa requirements to allow migrant mothers to see their children more frequently, or even bring them to destination countries, might alleviate some of these problems. Yet the process of acquiring permission for minor children to join their migrant parents may sometimes take so long that the children “age out” and are no longer eligible to enter the country⁴¹.

Employment law and migration law and practice can also frequently contradict each other, particularly where employment law is not held to prevail for migrants or where migration status can affect access to statutory labour rights such as the right to organize or earn minimum wages or legislate hours of work and rest^{42,43,44}. Similarly, access to social protection is often contingent on migration status and not all workers have the right to accumulate pensions or other social benefits that native workers and citizens hold.

Towards transnational social protection

Social protection at all stages of migration and care work is essential to the ability of women migrants to safeguard their health and well-being while ensuring the care of others (care recipients as well as family in their countries of origin). The portability of social protection (including health insurance for health care), social security and pensions must be ensured across sectors and borders.

In the Asia Pacific region, the Philippines has almost 11% of its population living or working outside the country. When they leave the country, migrant workers are required to enroll with a programme called *PhilHealth*. The Indonesian and Thai governments are negotiating similar bilateral agreements that include minimum standards for wages and benefits and access to health care or health insurance for workers overseas.

Within the European Union, European migrants also have rights to cross-border health care and social protection.

In the Americas, migrants have a right to universal social protection in South American MERCOSUR countries which foster

the free movement of people across national borders, and through which portable pensions benefits have been established through bilateral agreements. The Mexican government has also extended its national health insurance to cover its migrants abroad: “family members still living in Mexico get comprehensive coverage, while people living outside the country can get their primary care at community health centres in California (and when they have a major health problem, they get their catastrophic coverage in Mexico)”⁴⁵. Similarly, in Guatemala, a health insurance scheme is emerging where migrant workers pay a fee into a system organized by the International Organization for Migration so that their families back home can access a specified health-care system⁴⁶.

National Health Policies, Strategies and Plans (NHPSPs) are critical governance mechanisms to achieve progressive realization of universal health coverage (UHC) and the right to health. It is clear, however, that there remains an imperative to redefine health care beyond the basis of citizenship and “reimagine UHC systems that transcend national borders”⁴⁷.

Next steps

This report highlights three key steps for all countries and regions to consider to improve the health and well-being of migrant care workers and their families:

1. Generate evidence on the nature of migrant care work, the contributions to global health care and the terms and conditions of their employment. WHO’s Country Support Package⁴⁸ set of tools, including Health Inequality Monitoring, Innov8, Barrier Analysis and participatory approaches, can be helpful.
2. Improve access to UHC through specific measures to address non-discrimination, promote inclusion and participation of migrant care workers.
3. Promote and recognize care as a global public good that contributes to global health and well-being.

These steps, and many of the strategies proposed within them, **apply to all migrants, men and women alike, as well as those left behind**. They advocate for holistic, universal and person-centred health and social care systems.



We urge governments to **recognize and support paid and unpaid care work, protect migrant women care workers against human rights and labour rights violations, and promote international, regional and country action to ensure access to health for all** in an ethical and transparent governance model.

Without such political leadership and vision, accompanied by robust evidence, strategies and tools for promoting intersectoral action, and the empowerment of migrant women themselves, we will not sustain change for equitable development.

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