

Utilization and access to private and public health care services by domestic workers in Cyprus: Mapping inequalities and discrimination

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Abstract

Introduction: Domestic workers constitute the largest group of legal migrants working in Cyprus. This research aims to examine the experiences of domestic workers in Cyprus with health and illness and explore any problems or barriers to access and utilization of health care services, focusing on evidence of gender discrimination and inequalities.

Methods: Qualitative research methods were utilized in order to explore the domestic workers' experiences. Face to face interviews with 13 female domestic workers took place using English and Greek.

Results: All participants appeared to share a common experience with health and health care utilization in Cyprus. However, the role of the employer as gate-keeper to health care services and their control over women's access raised the issue of autonomy – or lack of – among domestic workers. Issues of discrimination linked to autonomy emerged through absence of social integration, lack of information on health care services and entitlements, lack of participation in the clinical interaction (interpersonal communication), all associated with issues of *infantilization* and *commodification* of domestic workers within the Cypriot society.

Discussion: Domestic workers in Cyprus are a particularly vulnerable group and due to current agreements fall entirely under the custody of the employer with no overview from the Labour Department. Empowerment of these women is essential for eliminating the issues of inequality and discrimination emerging through the interviews. Education is an important first step but for it to be effective it needs to be directed to both migrant women and employers.

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Introduction

Migration can be an empowering and positive process for women [1]. Evidence has shown however, that for some women a process initiated by hopes for a better future is fraught with obstacles closely linked to their status as women and migrants, experiencing what is known as a “double disadvantage”[2].

Migrant domestic workers are among the most disadvantaged groups of migrants, a group which accommodates the majority of female migrants [2-4]. Between January and October of 2010, 39.4% of third country nationals (TCNs) working in Cyprus were employed as domestic workers in private homes, totaling 24,553 domestic workers in October. The majority of these women come from Sri Lanka and the Philippines¹.

The increasing demand for reproductive labour across the developed world, including domestic and care workers, has been a result of factors such as: rising economic prosperity and disposable income; the “decline of the housewife” [5] and rising numbers of women employed outside the home; demographic changes such as aging population; and lack of welfare policies to support these changes through child care and care of the elderly [6].

The gendered nature of domestic work and the transfer of duties once held by the women of the household to a third-party who is usually a migrant, often results in significant abuse and discrimination towards these women internationally as well as in Cyprus [7-11]. Existing literature has pointed out the absence of regulatory frameworks in receiving and sending countries which in combination with the sanctuary of private homes where domestic

¹ Data from the Statistics Unit of Social Insurance Services.

workers are employed, leave these women completely unprotected and vulnerable to physical and psychological abuse, and even conditions of modern slavery [3-5, 7-8, 10-14]

Despite the ongoing studies investigating abuse and discrimination experienced by the migrant group of domestic workers, knowledge on the experiences of these women on health and healthcare access is limited.

Health inequalities among migrants

It is well accepted that migrants experience inequalities in health status, healthcare utilization and quality of health care [15-22]. Reasons include: accessibility of services; socio-cultural and financial barriers [18]; absence of healthcare insurance coverage [23]; negative attitudes of healthcare providers[24]; and communication problems during the health provider-migrant interaction [25].

Gender inequalities have also been identified, where both women in general [26] and migrant women specifically [27], have been known to experience inequalities in health. So far, research investigating gender differences has focused on (self-perceived) health status and health care utilization [27-29], but none have investigated barriers to access. More importantly, the health and health care experience of this group remains largely underexplored. In the context of Cyprus only one study has been undertaken so far which explored the sexual and reproductive health needs of migrant domestic workers [30], but has not explored barriers to healthcare access.

The current paper aims to present findings of barriers to access in healthcare experienced by migrant domestic workers in Cyprus and evidence of gender disadvantage.

Aims and Objectives

Findings presented in this paper are part of a wider research project undertaken by the Open University of Cyprus investigating the following:

1. Perceptions of barriers to access in healthcare (public and private) of transient migrant domestic workers in Cyprus,
2. Perceptions of quality of care, and
3. The health and well-being of migrant workers

This paper will focus on part of the findings concerned with barriers to healthcare access and more specifically with the issue of capacity for autonomy. A capacity for autonomy has been identified as a barrier to healthcare access, one which is especially relevant to the characteristics of domestic work.

Data collection and Participants

Qualitative techniques of data collection and more specifically face-to-face semi-structured interviews were used. Qualitative methods are being increasingly used within healthcare research and evaluation [31-32] because of their ability to explore and bring to the surface largely unknown issues of the healthcare experience.

Women who were working in Cyprus under a temporary domestic worker/carer contract and were able to be interviewed in Greek or English were eligible for participation. Initial contact was made through non-governmental organizations (NGOs) and support groups working with migrants, and through personal acquaintances of the research team. Recruitment was based on snowball sampling, where informants and participants suggest other individuals for participation [33].

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Interviews with 13 women took place (See Table 1 for demographic information). Interviews took place between November 2009 and March 2010 and lasted between 30 and 60 minutes. All interviews had taken place at a location chosen by the participant and the majority took place on a Sunday at a public place in Nicosia city centre. All interviews were tape-recorded, fully transcribed and data were managed using NVivo8.0 and analyzed using thematic analysis [34].

Table 1: Demographic information

Participant	Country	Age	Accommodation	District	Years in Cyprus
F01	Philippines	30	Family	Nicosia	7
F02	Sri Lanka	29	Employer	Nicosia	2,5
F04	Sri Lanka	50	Employer	Nicosia	7,5
F05	Bangladesh	38	Friends	Nicosia	6
F06	Philippines	37	Family	Nicosia	5
F07	Sri Lanka	30	Alone	Nicosia	5,5
F08	Sri Lanka	30	Employer	Nicosia	4
F09	Sri Lanka	30	Employer	Nicosia	2
F10	Sri Lanka	56	Employer	Nicosia	13
F11	Sri Lanka	45	Employer	Nicosia	4
F19	Philippines	38	Friends	Nicosia	12
F24	Philippines	50	Friends	Nicosia	10
F34	Philippines	38	Alone	Nicosia	6

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Results

Barriers to healthcare access

A number of problems in access and use of healthcare services were raised by all worker groups. Barriers were categorized into two groups. Migrant-related barriers were associated with specific migrant characteristics such as freedom of movement and decision-making (autonomy), language skills, access to information, cultural characteristics and the financial status of the individual. System-related barriers were associated with supply side characteristics i.e. system characteristics and included insurance coverage and cost-sharing, the cost of services, system organization and structure, ease of access to the services, and system responsiveness i.e. the attitudes of providers towards the service users. These barriers are listed in table 2.

The following section will present the evidence associated with the barrier of autonomy. The reason for focusing this paper on this particular barrier is that it was found to be mostly apparent in the case of domestic workers and was linked to the presence of gender inequalities and discrimination.

Table 2: Barriers to access and quality of healthcare services

Migrant-related barriers	System-related barriers
Autonomy (capacity for)	Insurance coverage & cost-sharing
Language skills	Cost of services
Information	System organization & structure
Culture	Ease of access
Financial status	Provider attitudes / System responsiveness

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Capacity for Autonomy

All participants were limited in their capacity for autonomy by the long working hours which often spread throughout the day and the working week. Almost half of our participants reported living with their employer, something that further limited their capacity for an autonomous existence. With limited physical autonomy and subsequently limited access to information, the employer is then acting as the main gatekeeper to the outside world including healthcare access.

The role of employers as guardians was a prerogative allocated both by the sending and receiving countries. Through the interviews it emerged that at the pre-migration stage women were not given any information on health-related issues. On the contrary women often reported that “[sending country officials] say all employer do, when I am sick agreement also say all do employer” (F02), “if you got problem like that the employer will take to the hospital...” (F07).

The other workers are unaware of this, the health insurance, what is the health insurance for them, what will the health insurance do to them, they are unaware, because the employer doesn't explain and nobody explain (F24)

The Cypriot government also plays a role in maintaining such conditions of employer control, through for example the availability of the health insurance contract in the Greek language only, even though as one might guess, none of the migrants speak or read Greek prior or during their employment in Cyprus.

A capacity for autonomy has been linked to the *infantilization* and *commodification* of domestic workers. Infantilization of women is a concept taken from gender theory which describes the actions taken by a patriarchal society towards the disempowerment of women by stereotyping them as

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weak, helpless and childlike. In the present context, infantilization is often taking place from a woman (the employer) towards another woman (the domestic worker), overturning the traditional concepts of male power. Commodification refers to the transformation into a commodity of something that is usually not regarded as such. In this scenario, commodification is used to refer to the attitudes of Cypriot society towards migrant domestic workers as a commodity which can be bought or exchanged when the owner is not fully satisfied, even though the “product” in this case is a human being.

Even though these concepts appear simple or straight forward, in reality the relationship between employer and employee is far more complex than that suggested by these definitions. Analysis has suggested that harmonious and caring relationships might coexist with circumstances of abuse and refusal of basic rights, and the migrant might have to tread on thin lines in order to maintain the equilibrium. The following quote is from an interview with a domestic worker where she describes her uneasiness in discussing healthcare rights with her employers in case this raises conflict within the relationship.

I wanted to know but I was a little bit afraid because if there is a problem then I will not be happy here [... because] I don't like to answer to so many questions like that. [...] that is why I am not talking with them too much (F09)

The contradiction is illustrated in the following quote of a domestic worker describing her perceptions of her employer: “sometime she don't care because she is good but she don't care” (G04)

What follows is a presentation of the findings around the two themes of *infantilization* and *commodification* of domestic workers and their implications for access to healthcare services.

Infantilization of domestic workers

Employer control over the migrant's actions was generalized to all aspects of life, including the use of healthcare services. Living with one's employer was described to involve constant scrutiny over one's actions, often transforming the relationship between the employer and the domestic worker into one of parent and child.

when I ask from my employer to go out, he is asking me where do you go with whom like that like that, you know I am not a baby... One day I asked from my employer to go out for party and he told me you will have a fever you will have a cough like that like that, there is a flu like this, like that but they are going out everyday (F09)

This paternalistic relationship could sometimes evolve into a situation of confinement, where the domestic worker was forbidden from socializing with other members of her community and the goal was often to stop the woman from integrating into the social environment, socializing with members of her ethnic group and obtaining information.

They [the employer] just say, you just work, stay in my house you don't know anything, they don't even let their maids to talk to a fellow like us, don't talk to her, don't talk to strangers (F06)

Domestic workers, were prevented from having relationships during their work in Cyprus and pregnancy emerged as especially reproached by employers whether within or outside marriage.

I know one of my country girl, [...], she is pregnant, her husband who is a student now moved here, they are happy,[...], she has work permit here, she is pregnant, her employer didn't like it. [...] she already start terminate this child. [...] she said you need to have an abortion, otherwise you need to go back to your country. (F05)

The emotional implications raised because of these limitations are very well

illustrated in the following narrative of a domestic worker expressing her desire for the right to have a social and private life, and the impact the absence of one had on her mental health.

I am alone here...No one is here. Sometimes I want to talk with someone, I need someone to share my feelings. You know when I feel like that I have a pain here in my heart. [...] if we have a boyfriend we need some freedom... We have to... you know the thing is... between two persons...but this way we can't do that. That feeling also makes us sick...I think you can understand that because we are just humans [...] If we had a life like that separate life then it will be ok more than this... because when we go somewhere we are thinking "when we go back, when we go back" if am late they will ask like that, they will ask like that (F09)

Attempts to challenge such infantilization were few and women were often terrorized by the fear of being repatriated, an issue discussed in the following section.

Commodification of domestic workers

"Commodification" of domestic workers, with women being viewed as objects of work and pleasure not entitled to certain human rights was a theme emerging both through discussions of healthcare access and discussions of sexuality and sexual ownership, i.e. women's (lack) control over their body.

When participants experienced cases of illness, their employer was one of the first points of reference enquiring about health-related information especially in cases where women had limited social networks outside their working environment. Domestic workers first had to argue the validity of their illness and then to negotiate their access to health care in order to receive either over-the-counter medicine or access to medical treatment. For some domestic workers this process was relatively straight forward.

my madam... first, she give me some medicines but if it is not ok she takes me to the hospital (F09)

For others however a more intense process of negotiation had to take place.

I told my employer I want to go to the hospital to see what happen and they said ok. But I'm waiting like 2-3 months they didn't take me. Then I told them you cannot take me to hospital I'd like to go from here ... [then I got a] release [paper] from there (F07)

In these situations the lack of legal or other frameworks able to protect the employee from abuse meant that women were contingent to the employers' good intentions and her own coping resources. The general perception among participants was that Cypriot employers are indifferent to their domestic workers' well-being and refuse access to healthcare because women are viewed as objects for domestic work.

employers don't care about us, they thinking we are like robot, you came for work you have to work, she told to me one day, I said madam here too much painning I am not lie madam please, she don't care (F04)

Only a small minority described their negotiation into health care services. The vast majority of women submitted to their employers' commands and treatment with over-the-counter medicine or used self-treatment. Job insecurity, the constant fear of deportation and lack of accurate information were behind domestic worker's submission into the employers' wishes.

Sexuality issues were raised overtly by a minority of participants. It is unlikely that women would readily discuss issues of sexual harassment, since as one participant put it "sometime you know we are scared about job"(F05).

One participant perceived a widespread attitude from the employers and other Cypriots including in some cases health providers that domestic workers had a promiscuous nature and sexual favours were part of their role.

99% of housemaids have this is big problem here, employer think he is allowed to have sex. [...] and main thing is not only employer, is also

anywhere we go they treat us this way, all right but why they treat us like a sex slave? (F05)

Another participant described her experience of sexual harassment from the agent who arranged for her employment in Cyprus.

Agent, of course this agent he is not very good agent because I have to say he is, play with girls, when he bring first time from Larnaca he ask for me you go with me a restaurant, we sleep together [...], I said if you make like this I go exactly I go immediately police I say, I speak I am not afraid, I speak good, agent didn't make anything, that's why he angry is still now he angry with me (F04)

This participant described how refusing to sleep with the agent led to difficulties in her subsequent employment in Cyprus, where the agent refused to help her find another employer after experiencing abusive behaviour by her employer. Employers could also sometimes ask for sexual favours in return for a more privileged treatment.

employer said all right have sex with me and I will give you these papers, this this and that things, indirectly is also that way, and main thing is not only employer, is also anywhere we go they treat us this way (F05)

Fear of deportation was again the main factor for women being afraid to demand their rights or report violations of their rights. Women's legal status is linked to their employment visas, which means that if employers decide that they want to stop the employment contract of their domestic worker for any reason, they can do so, resulting in the repatriation of the worker.

Some people they afraid because maybe tell, maybe after she is angry maybe she send me back Sri Lanka, like this some people, (F02)

The indifference of employers towards the needs of their domestic workers was perceived by participants to be encouraged by the easy swap of one domestic worker for another when the present one no longer fulfilled

expectations of “competent” domestic work.

²Most madams don't help, nor care, the most they will do is give some medicine they have at home, if it is more serious then they send the girls back to their countries and get another girl (F01)

Discussion

Access to healthcare appears to be influenced by several barriers related both to the individual characteristics of migrant workers and those of the overall healthcare system. Even though the majority of barriers are common between migrant groups, the capacity for autonomy or a lack of has been largely concentrated to the group of migrant domestic workers and the gendered nature of the work.

Limited autonomy is found to have direct implications on the healthcare needs of women, since in cases of illness domestic workers have to argue the validity of their illness with their employer, who was often unsympathetic to the woman's needs. Access to health care services has to be negotiated with the employer mainly because they control access, transport and financing of care and also act as middle-man between health provider and worker. Self-medication and use of over-the-counter medication supplied by the employer was common among participants. Fears of deportation, exacerbated by lack of knowledge of employment and healthcare rights was found to infiltrate all decisions for assertiveness and claims of fairer treatment from the employer. Society, government and employers of domestic workers seem to sustain a notion of these women as disempowered beings who need to be under the authority of the employer.

Similar research has illustrated how migrant domestic workers who displayed

² Authors' translation from Greek to English

assertive behaviour towards their employers refusing to accept a “process of infantilisation” were accused of being “immoral”, “ungrateful” and to exhibit “criminal” conduct [11]. In Cyprus employers have been known to “choose” the ethnicity of their domestic workers based on stereotypes, with migrant domestic workers from Asian countries being preferred over Central and East Europeans precisely because of their perceived timidity and non-threatening presence in the household resulting in lack of assertiveness over employment rights [35]. Any displays of refusal to comply with employer demands, no matter how abusive or discriminatory they were, have been reported to lead to accusations of inappropriate behaviour of the domestic worker and this set in motion a series of events resulting in non-renewal or termination of contract [11].

Racism has been evident towards these women who are called “mavrou” meaning “little black girl” attributing gender and ethnic connotations to domestic work [6]. Vassiliadou in her research on the reconstructions of women by women in Cyprus, reports that Cypriot middle-class urban women do not view domestic workers as women [36]. Negative attributes are attached on domestic worker’s sexual morality and decency which are perceived as doubtful because they have left their families in order to find employment abroad. Vassiliadou reports that these women are marginalised because of being women, being poor and being employed in low-paid and low prestige work. At the same time they are stigmatised because of their failure to behave as Europeans, something that is viewed highly by Cypriot women who perceive “European modern behaviour” as an improvement in their lives and highly desirable [36].

Cases of abuse, racism and discrimination against domestic workers have been reported internationally [3, 7-8, 10, 13], and authors have described the circumstances experienced by migrant domestic workers as “contract slavery” [10]. Women are tricked into conditions of slavery by the existence of an employment contract which they sign under the impression that it is a legally

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binding document. They soon find out however that no agency oversees if its terms and conditions are upheld by employers, making this contract a “legal fiction” [10].

In Cyprus EU laws and regulations which theoretically need to be abided to by the government, do not filter down and are not applied on a societal or grass-root level. This is mainly because the development and application in practice of integration strategies is not considered by policy makers as a priority for the wellbeing of migrants or of the host society [6]. Recognizing this reality Panayiotopoulos comments: “One paradox of modern servitude is the coexistence of the most oppressive worker-employer relations with extensive social legislation meant to protect immigrant workers” (pg 127: [11]).

Steps towards empowerment

The World Health Organisation has claimed that the right to health cannot be distinguished from other human rights [37]. The present findings illustrate how the “contract-slavery” conditions [10] experienced by these women exacerbates the inequalities experienced in healthcare provision and access. Their employer could be humane or inhumane, but still remains a gatekeeper to access determining when it is time for them to receive medical treatment and where. The emancipation through empowerment of women is one, arguably the most crucial step towards alleviating some of these inequalities.

Empowerment is a concept which has received widespread attention both in socio-cultural and health care contexts [38-41]. It has also been given alternative definitions, and within the area of health it has been conceptualized to consist of three major domains, namely: the individual managing their own health on a daily basis; interacting with health service providers when in need of medical assistance; and finally being affected by health policy and systems [41]. Based on the findings discussed in this paper, domestic workers are a group which has been dis-empowered and power has been shifted to the employer and to the receiving society.

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Women in this research have themselves expressed their need to be empowered on issues regarding healthcare delivery. Access to information was minimal unlike the case of male workers and students who had more personal freedom. Source of information was mostly their peers, with some mentioning the employer as an informer. Small but crucial changes are important with one example being the translation of the health insurance contract in English or even in the main migrant languages.

Another step is making changes to the healthcare system. A culturally competent healthcare system ensures that there is a culturally and linguistically appropriate service provided in order to achieve equality and equity in access and health outcomes [42]. Changes in the system of delivery such as migrant information centres or out-patient clinics open during friendly hours including Sundays are a good way to make information and care more widely accessible. Restricted access to primary care does not only impact on health outcomes of migrants themselves, but has consequences on the healthcare system itself. International research has shown that migrants make increased use of A&E services compared to the native population [43] something that has been linked to restricted access to primary care [43-44].

Adaptations to the system of delivery towards a culturally competent healthcare system have been tried and tested in other countries and have proven to increase quality of healthcare and patient outcomes [39, 42, 45]. A good example is the training of health advocates from within the migrant population to act as interpreters, educators and advocates of migrants [45].

An additional aspect not raised in previous research is the need for induction training schemes for the employer who might be as ignorant of legal and administrative procedures as the domestic worker themselves. Many participants described a positive relationship with their employer and felt part of their family. Still, these women did not enjoy more freedom of movement or access than women who did not have such a positive relationship with their

employer. Dissemination of information about the rights of employees to employers is an area underinvested by governments [13] but which could improve the living conditions of these women and also lead to better meeting their healthcare needs.

Conclusions

So far migrants, and in particular transient migrants, working in Cyprus have been kept to the periphery of social and civic life by laws and policies which preclude them from civic participation and ultimately prohibit their integration into Cypriot society [46]. Women migrants are doubly discriminated upon [47] whereas the case of domestic workers is worsened by legislative and administrative practices which exclude them from: worker trade unions; Labour office inspections; the right to obtain the Long Term Resident status in Cyprus; and place them under the control of the employer. These women are also vulnerable to sexual harassment and at the same time the nature of their work leaves them isolated and vulnerable to depression.

This research has illustrated how the infantilization and commodification of domestic workers resulting from socio-cultural as well as legal and administrative procedures have serious implications for healthcare access and consequently for the health outcomes of this population.

Acknowledgements

The research team would like to acknowledge Dr Michalinos Zembylas for invaluable advice and comments on methodological issues of the research, and Elena Vasiliou for her help in conducting and transcribing some of the interviews. The research team is grateful to all the women who gave up their precious time during their one day off to talk to the interviewers.

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