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Scholarly Report Title: The Health Impacts of Domestic Labor on Women Workers in Massachusetts

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Abstract

Title: The Health Impacts of Domestic Labor on Women Workers in Massachusetts
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Purpose: Domestic workers, including housekeepers, nannies, and home health aides, are some of the most critical caregivers in the United States, but are also among the most marginalized workers. National studies suggest that domestic workers face health challenges related to their lack of legal protections. However, since many policies that affect working conditions are enacted and implemented at the state level, it is important to examine health needs state-by-state as well.

Methods: This study used a modified community-based participatory action research (CBPAR) approach to characterize the health and well-being of domestic workers in a large metropolitan area of Massachusetts. Focus groups and key informant interviews were conducted between July 2013 through July 2014 with 32 domestic workers from diverse language and racial/ethnic backgrounds, and three employers. The data was analyzed through a qualitative inductive content analysis approach.

Results: The analysis revealed four main themes: (1) Physical challenges of domestic work, (2) social vulnerability of workers, (3) the role of workers’ rights advocacy, and (4) employers as potential allies for change.

Conclusions: The results suggest that domestic workers in Massachusetts face multiple health risks and could benefit from changes in the workplace and policy. Additional research is needed to examine the health of workers over time and to further characterize the role of employers.
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Section 1: Student Contribution

Design
This project was borne out of conversations between academic researchers and organizers at MataHari, a community-based agency of domestic workers, who identified a common interest in exploring the impacts of domestic work on health and well-being. This prompted an exploratory phase, with the student conducting a literature review to explore previous scholarship on health and domestic work. Juliana Morris, another university researcher who at the time was a 4th year medical school, had established a strong connection with Matahari and had conversations with other organizations including Health Resources in Action. Juliana introduced me to the project. At this time, a study team was formed which included two trained MataHari members, the executive director of MataHari and the three university-researchers including the student and the mentor. It was also decided by the team at this time to conduct three key informant interviews to inform the next steps of the research. The student conducted one of these interviews and another university researcher conducted the two other interviews. The key informant interviews identified a strong interest amongst MataHari members in investigating further the health challenges for domestic workers in Massachusetts. This led to the next phase of the research when the study team met to examine the data and to define the next elements of the study design. The study was designed to have five focus groups with domestic workers and three interviews with employers. The student fully participated in this decision-making. The student was also in charge of developing the materials for the focus groups and recruitment, including: recruitment flyer, recruitment script for domestic workers and employers, focus groups questions for domestic workers, and interview guide for employers. The student wrote all of these documents in both English and Spanish.

Execution
Participants were recruited through the host organization's partner organizations and internal network using snowball methodology. Once Matahari leaders identified a member as interested,
the member was contacted via phone by the student. Utilizing MataHari’s connections to ally community groups, recruitment for employers was done similarly and the student was in charge of contacting interested employers. Out of the five focus groups, the student facilitated three and was a note taker for the fourth one. Another university researcher facilitated the other two and two trained Matahari members assisted with note taking during the groups. The student also conducted the three interviews with employers.

**Analysis and Data Verification**

With permission of the participants, the focus groups and interviews were audio-recorded. Data were analyzed using an inductive content analysis approach to the audio transcripts. The student, along with another university researcher and a trained Matahari member, met to develop a code-book, with the process described more thoroughly on the manuscript below. The student was in charge of listening to all the audio-recordings and coding the data. In addition, the student worked with another university researcher to broaden the qualitative analysis and develop themes based on these codes. The student and another university researcher translated all Spanish quotes from the focus groups into English. This same process was repeated to analyze the data from the interviews with employers. Following the first stage of thematic analysis, the student compiled the data and summarized it into a short report. The student also developed a PowerPoint presentation and presented the findings to Matahari leaders. From this presentation, Matahari members and leaders verified that the themes authentically represented their experiences, and they expressed the desire to share the findings with the broader community.

**Writing**

The student brought back the feedback from Matahari members and leaders to the other two university researchers. A manuscript of findings was prepared by the university researchers. The student was involved in writing a significant portion of the manuscript and is the first author.
Section 2: Appendix A

The following manuscript has been accepted for publication in *Theory in Action*.

**Introduction**

Domestic workers are simultaneously some of the most critical caregivers and some of the most marginalized workers in the United States. These workers (i.e. housekeepers, nannies, personal care aides, and home health aides) help raise children, care for the elderly and people with disabilities, and free up their employers to engage in other types of productive work (Burnham and Theodore 2012; Theodore, Gutelius, and Burnham 2013). Domestic work refers mainly to three occupations: taking care of children, the elderly, or cleaning. According to the American Community Survey (ACS), in 2010 there were 726,437 domestic workers in the U.S. This number is representative but not exhaustive given that it excludes many workers, such as those hired through agencies or undocumented immigrants who are reluctant to share information with government entities. Others have estimated about 2.5 million women working as domestic workers (Poo 2010). Of these, 95% of domestic workers are women, many are women of color, and almost half are foreign-born. At the same time that these workers are largely needed, they face significant challenges in the workplace, including high rates of underpayment (below the minimum wage), wage theft, hazardous working conditions, and even physical and emotional abuse (Luebker and Oelz 2013; Burnham and Theodore 2012).

The vulnerable situation of domestic workers in U.S. society is a product of historical, social, and political circumstances. In 1935, the National Labor Relations Act was enacted to protect the rights of workers. However, 1930s politicians eager to maintain racial hierarchies explicitly excluded farm labor and domestic work, since the majority of these workers at the time were African American (Perea 2011). Today, this division of legal protections remains. The inequalities experienced by this population are reflective of the growing gaps in wealth and opportunities in the U.S. that are leaving immigrant women and women of color at the bottom (Stiglitz 2013; Burnham and Theodore 2012; Razavi and Staab 2010). In addition, because arrangements are often informal, domestic workers are subject to coercive tactics on the part of employers, sexual and other types of harassment and threats (Gaydos et al. 2011). Isolated workplaces, where the worker often works in the employer’s home with no co-workers, increase the likelihood of domestic workers to withstand abuse and contribute to the poor health outcomes of this population (Burnham and Theodore 2012).
The challenging working conditions faced by domestic workers have important public health implications. Domestic work can be hazardous, with potential exposure to toxic chemicals, injuries, and long hours on the job. A study through the National Domestic Workers Alliance (NDWA), found that 29% of workers had suffered a back injury in the past 12 months, 38% reported work-related wrist, shoulder, elbow and hip pain, and 36% contracted an illness while at work (Burnham and Theodore 2012). These figures are strikingly higher than those of workers in similar industries; the yearly rate of nonfatal occupational injuries and illness for all workers in nursing and residential care facilities, for example, is 7.3% (Bureau of Labor Statistics 2013). The poor health of domestic workers has even broader public health implications, as it puts both the general public and the employers’ families at risk (Gaydos et al. 2011). Even with these dangers, 65% of domestic workers report not having health insurance, and only 4% have employer-sponsored coverage (Burnham and Theodore 2012).

Domestic workers are an important population of interest for the exploration of public health questions because they are actively organizing to change their working conditions. Together, community-based organizations of domestic workers have succeeded in passing state-wide Domestic Worker Bills of Rights in New York, California, Hawaii, Massachusetts, and Connecticut (Healy 2014). Workers are also organizing at the national level through the National Domestic Workers Alliance, and at the global level through the International Domestic Workers Network (Luebker and Oelz 2013). As part of these campaigns, quality information about the impact of current labor conditions on health and well-being has helped enhance public understanding and educate legislators about the experience of domestic workers (Theodore, Gutelius, and Burnham 2013; Gaydos et al. 2011).

Despite the importance of understanding comprehensive information about the health impacts of domestic work in the United States, there is limited information about the health-related experiences of workers in each individual state. In addition, given the lack of data on the perceptions of domestic workers’ employers regarding workers’ health, there have been few attempts to compare and contrast employer opinions with those of the workers (Gaydos et al. 2011). This study therefore aimed to fill in theoretical gaps and enhance the robustness of our understanding of the health impacts of domestic work by addressing the following research goals:
1. To characterize the self-reported health needs and potential threats for the well-being of domestic workers living in the metropolitan Boston area by: (a) Exploring the workers perspective, (b) Triangulating the perspective of the workers with that of the employers.

2. To utilize Community Based Participatory Action Research (CBPAR) methodology to identify potential targets for intervention that may improve conditions in the short, intermediate, or long term (Lykes 2013).

3. To analyze the implications of the findings through comparison with relevant public health literature.

In Massachusetts this is a particularly timely subject for focused study because of the recently passed Domestic Workers Bill of Rights. This study can assist in defining the landscape where domestic workers work and live and provide potential opportunities for programmatic initiatives and critical organizing efforts by community agencies. In addition, this data can provide valuable information for health providers, employers and others who work with this population.

**Methods**

This research project utilized a modified Community Based Participatory Action Research methodology, which included key informant interviews, focus groups, thematic qualitative analysis, and community report-back. The progression of the research follows the six stages of CBPR described by Horowitz, Robinson, and Seifer (2009).

1. Formative stage

This project was borne out of conversations between academic researchers and organizers at MataHari, a community-based agency of domestic workers, who identified a common interest in exploring the impacts of domestic work on health and well-being. This common interest prompted an exploratory phase in which the researchers conducted a literature review of previous scholarship on health and domestic work, as well as three semi-structured key informant interviews with domestic worker leaders within MataHari. These interviews covered the following four domains: 1) Health impacts of domestic work, 2) access to services and community supports for domestic workers, 3) a vision for improved health and well-being, and 4) opinions on the value and feasibility of focus groups within this population.

The initial phase also involved recruitment of MataHari members who wanted to be trained in the research skills involved in the project. Two members volunteered and were incorporated
into the study team, at which time they received training on IRB protocol, the research tools, data management, and analysis.

2. Study design

Following the initial exploratory research phase, the study team, which included the two trained MataHari members, the executive director of MataHari and the three university-researchers, met to examine the data and to define the next elements of the study design. The information gleaned from the literature review suggested multiple connections between the labor environment and health of domestic workers, but there was little state-specific information for Massachusetts beyond survey data. The key informant interviews identified a strong interest amongst MataHari members in elucidating health challenges for domestic workers in Massachusetts, especially given potential upcoming changes in legislation regulating domestic work in the state.

The study team thus decided to target the gathering of in-depth, granular data that highlighted the stories and complex experiences of workers in Massachusetts. Focus group methodology was chosen as the primary research tool, based on literature suggesting focus groups often facilitate the sharing of more detailed and sensitive information (Lewis and McNaughton Nicholls 2013). In addition, the key informant interviews suggested that a group setting may provide a greater sense of security for participants and promote engagement and build community among the workers.

Given the diversity of the domestic worker population in Massachusetts and within MataHari membership, the eligibility criteria for the study was defined broadly in order to include the perspectives of domestic workers of different backgrounds and within different work environments. While the diversity of the participants may sacrifice some of the generalizability of the study, the research team believed it was important to allow for a broader understanding of the range of experiences of workers for this initial study. Eligible participants were domestic workers ages 18-60 and working within the greater Boston area in house cleaning, nannying, or home care work, such as elder care. Workers with less than three months of experience working in the greater Boston area were excluded. Both English and Spanish speakers were eligible, based on the language capabilities of the researchers involved, and focus groups were conducted in both of these languages. The sample size of 32 domestic workers is consistent with the mean sample size used in qualitative research and in other similar studies aimed at describing issues at
hand for marginalized communities (Cresswell 2009).

The focus group guide was developed based on four domains of interest identified in the key informant interviews. These were: conditions of work, impact of work on health, assets and skills of domestic workers, and potential impacts of the Domestic Worker Bill of Rights. The guides were initially developed by the university-based researchers and shared with the key informants for feedback. A recruitment flyer and phone script was also developed. Spanish translations were obtained for all relevant study materials.

Later in the study, the need for more information on employer perceptions of the health impacts of domestic work was identified, and an interview guide for interviewing employers was created following a similar process as above.

3. Funding and ethics review

Institutional Review Board approval was obtained from our institution prior to initiation of key informant interviews, and approval was re-sought at each progressive stage of the study. Informed consent was obtained from all study participants, who were provided with a consent form detailing the study procedures and the voluntary nature of their participation. All study information was kept in de-identified form in secure files and participation logs were kept separately in a locked cabinet and all study personnel were trained in these ethical procedures.

4. Recruitment and data-gathering

Participants were recruited through the host organization's partner organizations and internal network using snowball methodology. For each focus group, MataHari members were alerted through flyers and recruitment phone calls made by the organization’s leaders. According to Horowitz, Robinson, and Seifer (2009), community-based recruiting is more successful when those within the local organization introduce the research and its potential benefits to those within their own organization who trust them. Potential participants indicated their interest either verbally or by calling or e-mailing a study representative. All potential participants that responded with interest were contacted via phone by a bilingual member of the study team for initial verbal consent and to ensure they met eligibility criteria. Of those initially identified by the organization, approximately one out of every thirty individuals indicated interest and these were contacted by the study team. In total, thirty-six individuals indicated interest, and out of these two were not able to make any of the scheduled focus group times and two did not meet study criteria (for not having worked in Massachusetts in the domestic worker industry for the
specified amount of time).

After the first focus group, the participants were asked to recommend additional contacts that may be interested in participating from within their networks. For subsequent focus groups, flyers were also shared with members of partner community organizations in English and Spanish and a similar process followed. Recruitment for employer interviews was conducted similarly through a snowball approach, utilizing MataHari’s connections to ally community groups. A small amount of study funding was secured to cover costs of transportation, food at focus groups, and gift cards to compensate study participants.

Focus groups were held at various community locations including the MataHari office and two distinct health clinics. Five focus groups were conducted in total between October 2013 through July 2014, three in English and two in Spanish. Each focus group had from 6 to 7 domestic workers. Upon agreement of study participants, audio transcripts were recorded. These focus groups were led by one trained facilitator and were also attended by a trained note taker from within the study team. In addition to the focus groups, the interviews with employers were also held at this stage of the research between July through August of 2014. Employers were also recruited through the host organization's partner organizations and internal network using snowball methodology. Participants were contacted via phone by a bilingual member of the study team for initial verbal consent and to ensure they met eligibility criteria. Eligibility criteria included being the employer of a domestic worker for a minimum of 3 months and living in the greater Boston area. With permission of the participants, these interviews were also audio-recorded.

5. Analysis

Data were analyzed using an inductive content analysis approach to the audio transcripts (Hsieh and Shannon, 2005). The data were thus analyzed through the following technique for each transcript:

1. Initial immersion. Two researchers listened to the entire transcript throughout, working to leave their minds blank and suspend judgment.
2. Initial coding. These two researchers then re-listened to the data, this time independently noting and writing down themes that appeared to stand out.
3. Comparison of codes. The two researchers then compared notes, looking for areas of convergence and divergence, grouping each focused code within coherent categories.
(with the aim of obtaining a maximum of 12 categories per transcript). As needed, the researchers consulted the audio transcript or written notes from the focus group for clarification.

4. *Elaboration of codes.* Now with an agreed-upon code book, the researchers would go back to the raw transcript and count how many times each of the decided codes emerged in the text. They would also write down key quotes that exemplified the meaning of the code at hand.

*Standardization of code-book.* With each successive transcript, the researchers revisited the initial codes and added/revised/regrouped as necessary. The resulting code-book was modified after each subsequent focus group. After coding the fourth focus group, it was noted that similar themes were being repeated and only minimal revisions to the code-book were necessary, and after the fifth focus group was conducted, the sample size was considered to have met saturation. The end result was a code-book that was descriptive and relevant for all five focus groups, as well as a characterization of relevant themes and frequency of themes.

The Spanish language focus groups quotes were translated into English during the analysis process by the researchers. All researchers participating in this phase were bilingual in English and Spanish. Audio-transcripts were listened to in Spanish and then coded into English-language codes upon agreement of both investigators. Quotations were recorded and translated into English based on the agreement of both investigators. Back translations were not conducted, however any inconsistencies noted in the quotes further along were investigated by returning to the initial audio file for verification.

This process was repeated for the employer interviews. Special attention was paid to how these themes compared and contrasted to those described throughout the focus group analysis.

6. Dissemination/Conclusions

Following the first stage of thematic analysis, the data were compiled and summarized into a short report. This report was then taken back to MataHari leaders and members to verify that the themes authentically represented their experiences. The leaders attended a twenty-minute presentation with highlights of the data, then they were asked to review the initial written report and provide feedback. All leaders described the results as relevant and representative of their experiences. They also expressed a desire to share the findings with a broader segment of the community.
Consistent with CBPR principles, the study team developed and implemented a collaborative plan for dissemination of findings to a wide array of stakeholders including: consolidating the data and framing the results in the context of existing scholarship on the subject of domestic workers, development of a report geared to the community and development of a training that can prepare MataHari leaders to share the information in workshop settings out in the community.

Results

SAMPLE: The domestic workers that participated in this study were between the ages of 30-65. Participants were fluent in either English or Spanish, with most being foreign-born. Of the 32 workers that participated, the vast majority (30 workers) worked as nannies. The other two workers worked as a housecleaner and a home health aide, respectively. The three employers that participated each lived in the greater Boston area. One was bilingual in English and Spanish and the other two were Spanish speaking.

The themes drawn from this qualitative analysis were grouped into four main categories: (1) Impacts on physical health and well-being, (2) perceptions of unfair treatment and vulnerability, (3) the role of basic worker rights and advocacy, and (4) the potential for employers as allies for change. Each of these categories included a number of sub-themes that will be described in detail below.

1. Direct impacts on physical health and well-being

*Workplace safety and health concerns*

The impact of domestic work on the physical and mental health of domestic workers was a commonly reported concern by all of the participants. Workers described how their day-to-day activities, such as carrying heavy equipment, including strollers, laundry baskets and heavy children, placed a significant toll on their backs and shoulders. The women often reported that the work not only led to acute injuries but to deteriorating physical health and chronic pain. As one worker described, “I have pain every single day of my life…and it is not going to go away” (nanny, Spanish-speaking).

In addition to chronic pain, workers worry about acute injuries and illnesses acquired at the workplace. On the job, housecleaners are exposed to hazardous cleaning substances and nannies are at a higher risk for infectious disease:
I take him to daycare, and he comes back with diarrhea and vomit. Then the little girl had it and then I had it. I got sick because of them, they gave me the virus. And after working for them for three years without missing one day, when I came back the father tells me, ‘Why didn’t you come to work? Only because you had vomit and diarrhea?’ (nanny, Spanish-speaking).

The increased risk of infectious disease is aggravated by not having the benefit of paid sick days, a common theme for many of the workers.

The employers interviewed in this study also recognized the significant health risks workers face. Employers highlighted the physical strain domestic work can cause, as well as the exposure to hazardous chemical substances. However, the employers were not well informed on what cleaning products or activities would expose workers to a higher risk of illness and how these could be changed.

*Personal time and a healthy lifestyle*

The majority of workers reported the lack of personal time as a significant concern. Taking care of young children leaves little time to take a break even when a worker is in pain or needs to use the restroom. As one worker described, “When you have a lot of kids with you and you want to go pee, you can’t because you have the kids. And the kids’ safety is more important… and then you realize your bladder is full!” (nanny, English-speaking).

In addition, domestic workers face a challenge when trying to stay active and eat healthy meals. Preparing a meal demands time and staying active requires workers to exercise after some have completed ten to twelve hour shifts. As a participant mentioned, “Well it's very hard on the immune system to not get enough rest and not have enough time to stop and eat. And when you do get a chance to grab something on the fly is it going to be something healthy?” (nanny, English-speaking). On the other hand, a few workers mentioned that they liked that their jobs required them to be active, either running behind the kids at home or playing with them at the park.

*Stress on the job*

Most of the domestic workers commented on the stress and anxiety experienced on the job. Taking care of a crying infant or an active toddler can cause significant distress, and more so if it is someone else’s child and this is done every day for long hours at a time:
A friend of mine took care of a child, and the child had the habit of hiding... Once my friend could not find the girl. She searched everywhere for her, she almost died of anxiety. When the parents came home she was crying and crying, and the mom just laughed and said ‘did you look for her under the bed?’ And there she was. Well, my friend quit the same day. It was horrible. It affects our nerves (nanny, Spanish-speaking). Only a few of the workers felt empowered to speak to their employers about this level of stress and leverage the conditions of employment based on these stressors.

2. Social vulnerability and perceptions of unfair treatment

*Housing and economic instability*

Since many domestic workers are newcomers to the United States, some need to rely disproportionately on the support of their employers. A few reflected on this experience. One participant shared the experience of another worker, a live-in nanny who was told to leave her home during the winter holidays, “You brought her from another country, signed her up, bring her here and she knows nobody, and now you’re telling leave out [leave her room] because my family’s here, and then when you need her bring her back… it’s close to slavery” (house cleaner, English-speaking). The analogy to slavery is a common one workers make, more so if they are immigrant and have no family to go to when needed for support.

Economic instability was another theme reported by most of the workers. The lack of a written contract enables employers to adjust the hours of their employees as they wish, which is detrimental for workers who depend on this income. One worker describes her experience:

Actually it was Thanksgiving, the Wednesday before Thanksgiving and they were going to go on vacation next week. They didn't tell me! They told me on Wednesday, “Well, we don't need you Friday and next week you'll be on vacation and we're not paying you” (nanny, English-speaking).

Without formal signed agreements, workers are subject to abusive practices by employers without a means to advocate for themselves.

*Fear of speaking up, isolation, and immigration status*

In addition to being part of informal agreements which limits their rights, for some workers who are undocumented fear of deportation and of being fired without the possibility of finding another job causes them to stay in working arrangements that they might otherwise abandon. As one worker put it, “I don’t have family here. If they know you don’t have papers,
they are abusive. I don’t have papers. They did not give me a contract, they did not do anything” (nanny, Spanish-speaking). Another worker described her feelings at work, “I feel suffocated, oppressed, and abused” (nanny, Spanish-speaking). Although not all workers had to experience this, most agreed that this is a pressing issue for this community.

Workers link immigration status with liberty and opportunity. One worker who recently obtained legal permanent residence described this experience, “Having a green card now does it change anything? Yes it does, I feel free” (nanny, English-speaking).

*Unfair treatment*

Almost all workers reported challenges related to their relationships with employers and their perceptions of feeling disrespected. One worker described her frustration after being scolded by her employer when trying to call out sick: “We are human, do not think of us as being sub-human” (nanny, Spanish-speaking). Another worker inquired rhetorically during the group session, “Who am I to you? Do you see that I take care of your kids...Do you appreciate what I do? Do you consider me in any way? Do I mean anything to you?...Am I a person or just a thing?” (nanny, English-speaking). The workers shared with the group how they felt as less than human when disrespected by their employers. The employers interviewed were aware of the mental health toll a non-supportive working environment can have on the workers. “They want to be treated as humans and not servants” (employer, English).

3. Basic worker’s rights and advocacy.

A prevailing theme throughout the conversations with domestic workers was the importance of advocating for themselves. Most workers highlighted the need for a written contract, paid sick days and health insurance. One of the workers stated that workers must claim their rights:

Your academic level should not matter, or the color of your skin, or the fact that you are a woman. Your work and what you do is going to be valued when you believe it is important... But this does not mean that they will treat you well, because there is also discrimination just by the fact that we are women, by the color of our skin and where we are coming from (housecleaner, Spanish-speaking).

The reflective nature of this comment was often present in conversations with the workers. The workers understood that other forces (i.e. discrimination based on classism, sexism, racism) were also significant barriers for them to achieve their rights as workers.
Although they are isolated from other domestic workers in their daily lives, they described how joining together gives them collective power to demand their rights. As one participant emphasized, “We have to fight for our rights, and fight for our health…We have to stick together, that is why I am talking about the nanny family!” (nanny, English-speaking).

4. Employers as allies

Interestingly, the employers interviewed for this study all expressed a desire to support the rights of domestic workers. They recognized the value of their workers and spoke highly of them. As one employer described, “This was a woman with an impeccable ethics, I cannot possibly say enough good things about this human being” (employer, Spanish-speaking). This is representative of a small sample of employers who, as expected, are respectful of their employees as they volunteered for this study. However, it was interesting to note that they not only respect their employees but wish to go beyond this and support their full rights as workers.

In addition, employers commented on their efforts to make the working environment a safe space for the workers, being flexible with hours and sick days. One employer who worked with several domestic workers spoke of her efforts to discuss workers’ rights with her employees, “I started telling the women what minimum wage is in this country” (employer, Spanish-speaking). The interviews with employers highlighted the gap in knowledge some workers have around their labor rights; through key informants, in this case an employer, workers can gain access to valuable information.

The employers in this study reported that they only had verbal agreements with their employees, but highlighted the importance of a written contract to prevent worker abuse and were willing to make arrangements to begin a written contract with their employees. Overall, there was a clear agreement among employers that only a select few knew about the rights of their employees and that employer education was necessary moving forward.

Discussion

This study adds to a growing literature on the health impacts of domestic work by describing the particular health challenges and opportunities faced by a set of workers in the greater Boston area. The findings are consistent with prior studies conducted at national and state levels that show domestic workers risk exposure to workplace injury, chronic pain, and infectious disease, and how often they do not get sufficient time off and breaks to have appropriate self-care (Auerbach, McCabe, and Davenport Whiteman 2014; Burnham and
Theodore 2012; Gaydos et al. 2011). A physical illness is often accompanied by significant stress from both having to miss work and from not complying with employers’ expectations that domestic workers have to go to work even if they are sick or injured. In most industries, there are designated break times. However, domestic workers face the dual challenge of caring for dependent individuals while working alone, and therefore have no back-up coverage. Our results supported our hypothesis that domestic workers are aware of and interested in discussing the connections between their work and their health.

Our findings also point out the integral role of power and social vulnerability in determining the disproportionate burden of health challenges domestic workers face. This occurs through a variety of mechanisms. Firstly, the lack of legal protections and social vulnerability workers experience increases the chance that they will be exposed to risky situations that put their health in jeopardy on the job. Workers described being afraid of speaking up for better conditions because of undocumented status or economic constraints. Studies of domestic workers in a variety of other countries, including Hong Kong, Spain, and South Africa, have similarly shown that the social vulnerability of domestic workers exacerbates the risks and potential duration of work-related health problems, such as chronic pain, respiratory problems, and mental distress (Ahonen et al. 2010; Razavi and Staab 2010; Lau et al. 2009; Holroyd, Molassiotis, and Taylor-Pilliae 2001).

Secondly, repeated experiences of unfair treatment, humiliation, and discrimination within the workplace can lead to chronic stress that can impact the mental health and well-being of workers. The workers in this study described feeling undervalued and treated at times as if they were less than human. The emotional challenge of being both an integral part of a family while also experiencing a sense of separation and othering has been described in depth by Macdonald (2011) in her study of nannies in the Boston area. The chronic stress that these types of challenges provoke has been shown to lead to a variety of negative health outcomes, such as cardiovascular disease, decreased immune functioning, and mental illness (Williams and Mohammed, 2013; Williams, Mohammed, Leavell, & Collins, 2010). In addition, our study was largely composed of foreign-born domestic workers, and our findings are consistent with prior studies on the increased mental health risks for foreign-born domestic workers in the U.S. (Truman, Sharar and Pompe 2012).
Finally, our findings are in line with prior research that suggests domestic workers are more likely to experience disadvantage at a broader societal level than many other sectors (Luebker and Oelz 2013; Razavi and Staab 2010). The domestic workers in our samples described their experiences with housing and economic instability. Given the high proportion of women of color, undocumented immigrants, and limited English proficient people in our sample, they are also at risk of experiencing discrimination and racism in the community, social isolation, and detention/deportation. Domestic workers are also at risk of human trafficking and modern-day slavery (Williams 2015). These social determinants of health have strong correlations with negative health outcomes, due to barriers in access to resources, exposure to violence, and the stress-health pathways described above (Krieger 2012; Navarro 2009; Robert Wood Johnson Foundation [RWJF] 2009; Solar and Irwin 2010; Williams et al, 2010).

In addition to describing the mechanisms by which negative conditions in the workplace and society lead to negative health outcomes for domestic workers, our results more uniquely suggest that these effects can be mitigated through two processes: workers’ collective organizing and employer solidarity. Examples provided by the study participants included joining together to work for collective self interest and establishing work contracts. Workers and employers can therefore both make concrete change in the workplace, society, and policy environment that decrease vulnerability and improve health. While other studies have looked at the ways worker involvement in campaigns for domestic worker rights can lead to concrete improvements in their working conditions (Anderson 2010; Poo 2010), this is the first study, to our knowledge, that links worker and employer advocacy activities, such as community organizing for workers and educating the women on minimum wage by the employers, to positive health outcomes. Per our results, figure 1 illustrates the influences shaping the conditions of domestic work and their interaction with immediate and long-term outcomes.

This study was strengthened by its community-driven approach, since this allowed us to capture the authentic voices of domestic workers, while also contributing information that can help educate the local community on the particular challenges facing workers in Massachusetts. The information gathered was also utilized to inform legislators and policy advocates about potential health benefits of the Massachusetts Domestic Worker Bill of Rights. Finally, the CBPR methodology built enduring capacity for the community partners involved.

While the study was also strengthened by the inclusion of domestic workers of a variety
of socioeconomic statuses and employers, its conclusions are limited by the small sample size and lack of language and gender diversity (since only Spanish and English speaking women were included). Given the community based approach, we used snowball sampling with a small number of participants, which may create participation bias and limit the representativeness and generalizability of our data. However, the small sample size of 32 domestic workers is consistent with the mean sample size used in qualitative research. Further research is needed to better examine the health impacts of domestic work in more diverse populations and language groups. Additional research to better characterize the role of employers could also be helpful. It is likely that utilizing community-driven approaches in other states in addition to Massachusetts could be effective for future research efforts.

Finally, the health impacts of domestic work will only change with policy change and worker empowerment, to get at the root causes of exploitation. We therefore recommend that health and public health professionals pay close attention to legislation impacting the rights of domestic and other low-wage workers, and support campaigns that will likely promote positive health benefits. Furthermore, continued support for domestic worker organizing and leadership development efforts can play an important role in improving health for marginalized populations.

**Statement of original work**

The contents of this article have not been published elsewhere and have not been submitted simultaneously for publication elsewhere.

**Declaration of interests**

Authors have no conflicts of interests to disclose.

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Section 3: Appendix B

Figure 1. The vulnerability and lack of legal protections many domestic workers experience in the workplace today can lead to both immediate and long-term health impacts. These impacts may be modifiable, however, through workers’ collective organizing and employer solidarity.

Section 4: Acknowledgements

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