

# Access to Healthcare, Insurance Provision and Health Status of Sri Lankan Migrant Domestic Workers



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## Overview

Poor health affects Sri Lankan women who migrate overseas for domestic work, while they are abroad and on return to Sri Lanka. Provisions to ensure access to healthcare are failing them, both in their own countries and abroad. There are serious gaps and anomalies in relation to health in the current Sri Lankan policy framework for women migrant domestic workers. Power imbalances between migrants and their employers create a massive obstacle to their ability to receive care and to access justice in receiving countries.

This briefing reports on research conducted in 2014, examining the health experiences of Sri Lankan women domestic workers migrating to Kuwait, Saudi Arabia, Jordan, the United Arab Emirates (UAE), Qatar, Lebanon, Bahrain and Oman. Compared to documentation of the violations of human rights including labour rights of Sri Lankan overseas domestic workers particularly in Gulf States, relatively little attention has been paid so far to their health and barriers in access to healthcare. On the basis of in-depth qualitative interviews with 60 pre-departure and returned domestic workers, and 20 stakeholders representing state, civil society and international organisations, the research has explored the impact of the Sri Lankan labour migration governance framework relevant to health, as well as the impact of receiving country policies and employer practices, on migrants' access to healthcare and health status throughout the entire migration process.

## Background

Women domestic workers currently form around two fifths of total outgoing Sri Lankan migrant workers annually, with nearly all (over 95%) going to the Gulf Co-operation Council (GCC) countries (Kuwait, Saudi Arabia, the United Arab Emirates (UAE), Qatar, Bahrain and Oman) and Jordan and Lebanon, with Kuwait and Saudi Arabia being the two largest receiving countries.

Generally Sri Lankan women who migrate overseas for domestic work have a family history of low income employment and unemployment. Prior to migration,

in-between migration episodes and on return, many women are involved in low paid activities in the informal sector of the labour market. The most important driver of migration therefore is family poverty.

If we have lunch it is very difficult to think about dinner. It is very difficult ... to meet the daily needs. My husband does not have a steady job. He is a labourer. My child also suffers a lot. I always think about this. The house also has no facilities. ... We have to wait for my husband to do some labour work and come back to cook something for dinner. It is a very poor economic life we are leading now. I cannot find a job even to do in this area.

*(Pre-departure migrant, Kurunegala)*

## Key points

- The gaps and anomalies in the governance framework around health that have a negative impact on the women's health and health rights cover several areas across the migration process, including during recruitment, training, medical testing, employment contract, insurance, Sri Lankan embassy involvement in receiving countries, and health support on return.
- The research findings challenge the efficacy of the current Sri Lanka migrants' welfare insurance scheme.
- The domestic workers' working conditions and lack of health support lead to significant deterioration of the health of most in destination countries.
- Migrant domestic workers' health requires viewing holistically, connecting the entire migration journey, and family health as well as the individual migrant's health.
- It is clear that the women knowingly sacrifice their health in continuing the cycle of migration.

However, despite their low wages overseas, their remittances form a very significant part of Sri Lanka's foreign exchange earnings at present.

Over the last 30 years there has been a regulatory framework in Sri Lanka that attempts to address exploitative recruitment practices, provide information and training relevant to migrant domestic workers' roles and rights and welfare entitlements in destination countries, and provide welfare support in destination countries and on return depending on need. This framework is under-pinned by international human and labour rights conventions, and regional dialogue between sending countries, and between sending and receiving countries. Very recently the Sri Lankan government has tried to develop specific labour migration and health migration policies and local level action plans and programmes to take concrete steps, particularly to address continuing issues around recruitment agency malpractices leading to exploitation of workers at both origin and destination, welfare support at different stages and inadequacies in re-integration processes. Nevertheless the sponsorship system (Kafala) in Gulf countries that ties migrant workers to individual employers, the fact that domestic work is performed outside national labour laws in most receiving countries, and the lack of bargaining power that labour sending countries like Sri Lanka have in relation to affluent labour receiving countries in the region, make enforcing justice in relation to violations of health protection and access to healthcare for migrant domestic workers challenging.

## Key findings

### *Welfare Insurance*

There are gaps and anomalies in the Sri Lankan governance framework around the health of migrant domestic workers in both origin and destination countries. Most significantly the compulsory welfare insurance scheme operated by the Sri Lankan Bureau of Foreign Employment (SLBFE) excludes coverage of important health areas and conditions for which many domestic workers need support given the lack of enforcement of their employment rights and entitlements in receiving country households. Lack of coverage includes medical expenses within receiving countries, illness and injury sustained in escaping from abusive work situations, and treatment for sexually transmitted diseases such as HIV. The period of insurance coverage is limited to two years and can only be extended by re-registering with the

SLBFE, a requirement which can be difficult if not impossible for migrants remaining overseas for longer periods to fulfil. Among the migrants interviewed in this research, the majority did not have full information about their entitlements under the insurance scheme, and very few had tried to make claims or obtained compensation despite the fact that many had endured injuries or illnesses as a result of poor working conditions or accidents abroad.

I got a receipt. Though there is no health insurance, the SLBFE gives an insurance. The agency pays for it. The contents were not well explained at the time. Only what we learnt in the training programme. The signing was done in the office in a hurry.

*(Pre-departure migrant, Kurunegala)*

### *Employment contract*

Most women interviewed had signed a 'standard' employment contract at the SLBFE prior to migration, but some had also signed a second contract with the employer on arrival which had less favourable employment terms. According to the accounts of interviewees, they were compelled to endure employer violations of many of the health-related provisions in the contract such as adequate rest times and food, limitations on working hours, and humane treatment generally. The findings on health fit in with broader evidence from other studies pointing to the impact of a lack of systematic and effective monitoring of employer compliance with contract terms, exacerbated by the absence of national labour law coverage of domestic work in most of the destination countries.

I never thought that I would have to do bakery work after going to do domestic work. But, I had the brains to learn all that. The maid who did not learn was beaten and tortured. There was no end to the work we had to perform. At the slightest mistake we were scolded saying that they are paying us to do all this work and not to idle. I thought medical treatment would be provided in case of sickness. They did not care about illnesses. Even the burns were ignored. No clothes were provided to wear during extreme cold. I thought warm clothes would be provided. Things were different to what I expected.

*(Returned migrant, Kalutara)*

I could not take care of my body. I could not bathe daily. The food given was unpalatable. There was nothing called sick leave. There was no separate place for me to rest.

*(Returned migrant, Kalutara)*

## Health governance

There are other weaknesses in the design and implementation of the Sri Lankan governance framework relevant to health as revealed through interviews with migrants as well as health professionals and other stakeholders. Women reported having medical tests conducted and reports provided to agencies without their consent. Those returning from work abroad with known physical and mental health problems did not receive adequate long-term care. Sri Lankan embassies in receiving countries provided limited oversight, preventative strategies or support.

I did not get the medical report. They had sent it to the agency. When I inquired from the agency they said that all the reports were good. It is good if they give us a copy, we also like to know that we are healthy.

(Pre-departure migrant, Kalutara)

The women interviewed also did not seem to benefit a great deal from the support of civil society organisations at any of the stages of the migration process, instead relying on colleagues, friends and family for information and help.

## Health status and access to healthcare

Physical and mental health challenges for both the interviewees and members of their families were present prior to migration, arising for the most part from levels of poverty that meant basic family needs were not met. Migrants knowingly leveraged or traded their health through multiple cycles of migration for poorly regulated and gruelling work predominantly in an attempt to meet family economic, social and health needs. Poor working and living conditions in receiving countries and lack of health support – for instance sick leave - led to significant deterioration of their health. Interviewees most often reported heavy lifting and carrying that led to musculoskeletal strain and injury that remained with them long after return home, and use of chemical cleaning agents that resulted in respiratory difficulties and eye damage. The pre-departure training they received encouraged them to take and use home remedies and practice mindfulness and prayer as preventative and curative strategies rather than seek justice for inhumane treatment. Access to medical treatment, although stipulated in the employment contract, was in practice provided at the discretion of employers, and interviews revealed cases of serious neglect. Isolation, and worry about family health and wellbeing in Sri Lanka compounded negative experiences of work and life in employers' households.

I took Panadol for minor ailments. I massaged my head for headache and drank warm water for cough ... As a practice I used to take Panadol with me whenever I went somewhere. So I thought that I should take Panadol with me for an emergency in an unknown country. I drank warm water without the knowledge of Madam. I refrained from eating unnecessarily. I did not suffer mentally. Sometimes I retired into my room and rested. I remained in one position with eyes closed. I kept myself clean. I was careful about bathing.

(Returned migrant, Kurunegala)

Return to Sri Lanka, while sometimes a joyful relief, often did not allay health worries and financial anxieties. In some cases, the existence of physical and mental health problems remained undetected through a pattern of re-migration and circular migration.

I hope to see a doctor soon for the pain in my legs especially because I hope to go abroad again soon ... Although my earning abroad has helped us to ease our problems gradually, it is a great mental stress to leave my three daughters with my husband. Yet, there is nothing else I can do. I do my work there with lot of pain within me. My husband is good, so I trust him and leave the children with him.

(Returned migrant, Kurunegala)

## Recommendations

Recommendations arising from the research are mainly directed towards the Sri Lankan government, and the SLBFE as the state agency empowered through law to manage the export of labour. While there is an urgent need for policy and practice reform in the treatment of migrant domestic workers in GCC countries, Jordan and Lebanon, many actions can be taken by Sri Lanka to improve the health of domestic workers. As the migration infrastructure is state controlled significant change can be achieved through state action:

- *Health insurance.* Examine and address immense gaps and anomalies relating to health coverage of migrant domestic workers in the existing SLBFE insurance scheme. This could be done for example through expanding the current insurance provisions to include healthcare in receiving countries, thus reducing domestic workers' dependence on employers. The way in which health insurance can be funded requires serious consideration to ensure that the cost of premiums is not borne by the workers.
- *Employment contract.* Press for a revised employment contract similar to that between

the Philippines and some Gulf countries, which includes requirements for employers to provide more comprehensive healthy working and living conditions to domestic workers in private homes. As the current Chair of the Colombo Process, a regional co-operative process between labour sending countries on the management of overseas employment, Sri Lanka should advocate for receiving country governments to monitor and enforce employer adherence to the terms of the employment contract to provide necessary healthcare in a timely manner.

- *Medical testing.* Regulate and monitor pre-departure medical testing practices in testing centres to ensure that women's privacy, dignity and confidentiality are maintained as set out in the National Labour Migration Policy, and to ensure their right to access their medical reports. Systemic pathways of referral should be set up for women detected with health problems at testing stage.
- *Psychological health.* Implement the action point in the National Migration Health Policy to meet both the mental and physical health needs of returning migrants through long term follow up after return. A confidential psychological assessment for returnees, co-ordinated by the Ministry of Health working with local hospitals and health professionals, is desirable.
- *Pre-departure training.* As part of pre-departure training programmes provide clear and detailed information to women on separate health provisions listed in the employment contract and in the SLBFE welfare insurance scheme, and on healthcare entitlements according to policies and health systems in different receiving countries. In all three cases, information given should include redress mechanisms in the case of violations by employers, recruitment agents and Sri Lankan officials. Pre-departure training provided by the SLBFE and other SLBFE regulated providers should be conducted in safe, hygienic, comfortable, relaxed environments where the expressed needs of trainees are respected.
- *Embassies and consulates.* Extend the creation of accessible migrant resource centres associated

with all embassies and missions in destination countries, following the Philippines welfare assistance model, and disseminate information about these to migrant domestic workers. Use modern technology to collect and provide information necessary to keep contact with migrants so that they can easily communicate with Labour Attaches in embassies if they have problems.

- *SLBFE board.* Enable and/or increase the representation of migrant workers on the SLBFE board and Sri Lankan migrant resource centre advisory groups in receiving countries. This would allow recognition of the agency and decision-making capacity of migrant domestic workers within difficult circumstances in both sending and receiving contexts, and ensure their voice is heard in policy making and implementation processes at local, national and international levels.
- *Domestic Workers' Convention.* Sri Lanka should ratify and implement the ILO Domestic Workers' Convention (C.189) applicable to local domestic workers. This would enable more leverage internationally and regionally, to ensure the health and labour rights of women migrating for domestic work abroad.

### About the research

The research reported in this briefing was funded by the International Migration Initiative of the Open Society Foundations. Primary research was conducted in Sri Lanka through in-depth qualitative interviews with 40 returned migrants, and 20 first time pre-departure migrants who had been through training, medical testing and registration procedures. The participants were purposively selected in two districts, Kalutara and Kurunegala, in which a significant number of migrant domestic workers originate. Interviews were also undertaken with key stakeholders in national and local government in Sri Lanka, recruitment agencies, medical testing centres, international organisations represented in Sri Lanka, trade unions involving domestic workers, and civil society organisations working around the rights of migrant workers; and with labour migration and health experts from the UAE, Kuwait, Jordan and Lebanon.



**The full report is available at <http://cenwor.lk/> and [www.compas.ox.ac.uk](http://www.compas.ox.ac.uk)**

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