Invisible work, unseen hazards: the health of women immigrant household service workers in Spain

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ABSTRACT

Background

Household service work has been largely absent from occupational health studies. We examine the occupational hazards and health effects identified by immigrant women household service workers.

Methods

Exploratory, descriptive study of 46 documented and undocumented immigrant women in household services in Spain, using a phenomenological approach. Data were collected between September 2006 and May 2007 through focus groups and semi-structured individual interviews. Data were separated for analysis by documentation status and sorted using a mixed-generation process. In a second phase of analysis, data on psychosocial hazards were organized using the Copenhagen Psychosocial Questionnaire as a guide.

Results

Informants reported a number of environmental, ergonomic and psychosocial hazards and corresponding health effects. Psychosocial hazards were especially strongly present in data. Data on reported hazards were similar by documentation status and varied by several emerging categories: whether participants were primarily cleaners or carers and whether they lived in or outside of the homes of their employers. Documentation status was relevant in terms of empowerment and bargaining, but did not appear to influence work tasks or exposure to hazards directly.

Conclusions

Female immigrant household service workers are exposed to a variety of health hazards that could be acted upon by improved legislation, enforcement, and preventive workplace measures, which are discussed.

Keywords: immigrant, migrant, household service, occupational health, psychosocial hazards, ergonomic hazards, environmental hazards, wellbeing

INTRODUCTION

Since its transition to democracy, Spain has moved from being a country of émigrés to one that is a net receiver of immigrants (European Foundation 2007). This phenomenon became especially marked in the mid-nineties. The foreign population has increased to about 10% of the total population in 2007, which is a 10-fold increase in the last decade (European Commission 2008).

Spanish law divides workers into six groupings, or Social Security Regimens, according to the kind of work they perform. The laws governing things such as the amount of Social Security taxes paid by employer and employee, unemployment subsidies, injury and illness leave and subsidies, disability compensation, pensions, work hours and vacation time differ by Regimen and are administered by the National Social Security Institute under the auspices of the Ministry of Labor and Immigration (formerly Ministry of Labor and Social Affairs). Workers' contracts are registered with the appropriate Regimen. The majority of workers fall under the General Regimen umbrella. The Special Household Service Regimen covers those workers who are: over 16 years of age; who perform exclusively domestic services for one or several heads of household, or people who cohabitate in one household; whose services are provided where the household members live, and; who receive a wage or compensation for their services (MTIN).

Household service work is often performed by paid immigrant women (García *et al* 2008). Given disadvantageous working and employment conditions in this sector (Brush and Vasupuram 2006, Pla Julián *et al* 2004, May Rivas 2002, Ehrenreich 2002, Anderson 2002) and better opportunities in other sectors, Spanish women are increasingly disinclined to do such work. Of foreigners registered with the Social Security Institute, 7.5% (N=154,125) were affiliated to the Special Household Service Regimen at the beginning of 2008, an increase of 9% in the last year (MTIN 2008). The most recent data show that fully 57% of all those affiliated to that Regimen are foreign (MTIN 2008). Since much household service work is performed in the informal economy, and undocumented immigrants cannot be affiliated to the Social Security system, these numbers probably underestimate the real figures (ICMPD 2003, Economic and Social Council 2004).

Household labor is invisible (Pla Julián *et al* 2004, May Rivas 2002, Ehrenreich 2002, Anderson 2002). It is work no one discusses, and that has generally been taken for granted. When it is paid, it is largely unregulated and regulations are difficult to enforce, because the work takes place in private households. By being unregulated, it has also been invisible in occupational health statistics and in epidemiology, but is not without its risks (Artázcoz *et al* 2004, Artázcoz *et al* 2007, Medina Ramón *et al* 2006, Medina Ramón *et al* 2005, Medina Ramón *et al* 2003). When mentioned in epidemiologic studies, however, household work tends to be mentioned in the context of multiple roles for women who perform

another kind of paid work (Artázcoz *et al* 2001, Artázcoz *et al* 2004, Artázcoz *et al* 2007).

In this study, we examine the environmental, ergonomic and psychosocial hazards and health effects identified by immigrant women working in household service in five Spanish cities.

METHODS

Design: This qualitative, exploratory and descriptive study took place in five mid- to large-sized cities in Spain: Alicante, Barcelona, Huelva, Madrid and Valencia. We used a phenomenological approach, because we were interested in informants´ lived experiences of occupational hazards and their health effects (Patton 1990). As such, few guidelines were imposed on discussions, and researchers acknowledged and monitored their own assumptions and biases throughout the study.

Participants: Forty-six women who worked in household service were selected from a larger criterion sample of documented and undocumented immigrant workers, which is described in detail elsewhere (Ahonen 2008) Criterion sampling uses a theoretical framework to guide the selection of participants according to pre-determined criteria (Patton 1990, Miles & Huberman 1994). Selection criteria in the original sample (n=158) were as follows: nationality other than the Spanish, European Union-15, or other highly developed countries; at least one years' residence in Spain; both sexes, both documented and undocumented residency status; at least three months' total working experience in Spain; and to belong to a nationality group with greatest presence in Spain. We sought maximum variation in terms of industry and age. Researchers made contact with participants through organizations who worked with immigrants, the snowball method, posters, and direct recruitment by the researchers in local stores, phone centers, markets and neighborhoods. Furthermore, in the

original sample, potential participants who lacked moderate fluency in Spanish were excluded. As data collection advanced, it became clear that this procedure was limiting data gathered from more-recently arrived individuals from some national origin groups. At that point, individuals from Morocco and sub-Saharan Africa who had language difficulties were included through the use of interpreters. In Huelva, the interpreter was a Spanish male member of the research team. In Barcelona, the interpreter was a Moroccan man who worked as a freelance intercultural mediator and who was recommended by a social worker known to the researchers. In addition, the required time of residence was relaxed in several instances to allow participation of information-rich cases with less experience in Spain. We did not formally keep track of how many individuals refused participation or why they did so. The consensus among the researchers was that most who refused participation either felt they did not have time to participate or were sceptical about participation in research because of their desire to fly below the radar.

From that sample, all women who worked in household service at the time of the study (or if unemployed, whose last job had been in household service) were selected for analysis in the present study. They came from Colombia, Morocco, Senegal, Romania and Ecuador. Thirty-two informants participated in six focus groups, and 14 were interviewed individually. Twenty-eight participants were documented and 18 were undocumented (Table I). Documentation status refers to permission to reside in Spain.

Data collection

Data were collected between September 2006 and May 2007 through focus groups and semi-structured individual interviews, with a topic guide. The topic guide had 11 main themes (Table II), all with corresponding questions and sub-questions to facilitate discussion. Researchers in each city focused on participants of one nationality, except in Huelva, which drew its original sample from multiple sub-Saharan countries. In focus groups in the original sample, informants were separated by sex and documentation status; individual interview participants were sought who fit those four profiles. Sessions took place in community organizations and associations, cultural centers, meeting rooms in urban hotels, and occasionally in the participants´ workplaces or homes if that was their preference. All sessions were audio-recorded and transcribed.

Given the vulnerable situation of many potential participants, protection and confidentiality were discussed before and throughout the study by researchers. To protect participants, we attempted to set up meeting places where they would feel comfortable; in the case of interviews that took place in community centers, it was because the participants had a relationship with that center and felt secure there. In fact, many of the participants were contacted through these same organizations. At focus group sessions, a facilitator and observer were present. At individual interviews only the interviewer was present. We explained the purpose and scope of the study, where financing came from, and that findings

would be published in academic and professional journals and discussed at professional meetings, without identifying information. We explained that the interview or focus group could stop at any time if they so wished. Participants also received an information sheet detailing those issues and providing researchers' contact information. They were given the opportunity to ask questions and get answers about the study; the most frequent questions understandably addressed the confidentiality of data and who would have access to them. A few participants had concerns about the audio recording. After we explained that its use was to capture the information they provided in the most faithful way possible and that recordings would be destroyed after the study, all consented to the recording. Written consent to participate was obtained from every participant prior to participation. Informants received a modest honorarium for their participation except in Alicante, where a limited research budget did not allow for honoraria.

Data analysis

After review of the transcripts for accuracy, data were analyzed using narrative content analysis, with support from the Atlas.Ti® (Scientific Software Development 1997) program. Data were separated for analysis by documentation status in order to examine possible differences between those who were authorized to reside in Spain and those who were not.

Data were sorted using a mixed-generation process: the initial analytical categories were derived from the interview guide and from ideas gained during early readings of transcripts; others were identified in the data and developed as the present analysis progressed. In a second phase of analysis, coded data from the psychosocial hazards category were organized using the Copenhagen Psychosocial Questionnaire (COPSOQ) (Kristensen *et al* 2005), which incorporates concepts from demand-control-support models (Karasek 1979, Johnson & Hall 1988) and effort-reward imbalance models (Siegrist 1996) of workplace stress. Textual segments of data were assigned to the psychosocial hazards dimensions through constant comparison (Tashakkori & Teddlie 1998). Participant quotes used here were translated from Spanish to English by the first author. She is a native English speaker with academic training and professional experience in Spanish. The extracts used here are the translator's best attempt at a rigorous transmission of concept from source to target language rather than a word-for-word rendering of participant statements.

Quality of data

Data were triangulated by methods (individual interviews and focus groups), and multiple analysts (Miles and Huberman 1994). Differences between the two principal analysts were addressed by discussion and by returning to the original data until a consensus was reached regarding categorization and interpretation of the findings. The categorizations and interpretations in written summary form were then subject to critique by the rest of the authors. This process was

especially helpful in the second phase of analysis where psychosocial hazards were addressed.

RESULTS

Participant quotes are labelled by documentation status and by participation in a focus group (FG) or an individual interview (II), and those relating to hazards and health effects can be found in Tables III, IV and V. In general, hazards and health effects reported by documented and undocumented participants were similar to the extent to which their tasks were similar. Participants believed that being documented or undocumented did not directly affect workplace tasks or hazards, but was used as a source of power within the workplace, especially in terms of employment conditions. Their dependence on their employers, and their ability to bargain for things like better scheduling, hours, and pay, and more personal freedom to leave the job and find another if conditions were especially poor, were things they related to being documented. They also saw documentation, in the longer term, as a way to obtain work in other sectors.

> *Well, my papers came and I told her [employer], 'I've complied with my contract, I'm giving you a month to look for someone else' and I, with my papers, got myself in with a few businesses [employment agencies] to look for work and I got work as a live-in, again, but it's something else entirely, it's phenomenal .* (Documented Romanian, FG)

> *When you want to make a little more money, then you need papers, that's my opinion.* (Undocumented Romanian, FG)

I've always worked in homes, still do, finally I've found a better job by having papers, still in household service, but better than before, because before I worked so far away, they paid me so little. (Documented Romanian, FG)

WHEN YOU GOT YOUR PAPERS, WHAT DID YOU FEEL?
Great happiness, because then one doesn't let oneself get walked all over anymore, because people want to walk all over you when you don't have papers; with papers no one lets oneself get stepped on. (Documented Colombian, II)

It really makes a difference, being legal, more doors open to you, you have so many more opportunities in terms of work and in terms of your future as a person…your life changes when you are legal. (Documented Romanian, FG)

While most saw documentation as a source of empowerment, some participants discussed a negative aspect of greater empowerment. They felt that more newly arrived immigrants who did not have documentation potentially threatened the job security of those who did, because employers could "take advantage" of undocumented women to a greater degree. They felt that was part of the natural progression of waves of arriving immigrants.

> *…they take advantage of that, a lot…because now tons of Bolivian girls are coming, tons and tons of Bolivian people. Now what are the Spaniards doing? They're hiring those people, who come without papers, who give away their work for less money, and they're firing the people who have their papers so they won't have to pay their Social Security…* (Undocumented Ecuadorean, FG)

Four emergent categories are relevant to the results. First, (1) live-in workers, or those who live in the same house where they work, and whose room and board is typically deducted from their monthly salary; and (2) live-out workers, those who live elsewhere and go to the homes where they work (and are paid either an hourly wage or a monthly salary). Second (3) cleaning work; and (4) caring work (usually for children, the elderly or the chronically ill).

Informants perceived risks and corresponding health impacts that fell into three categories: exposure to environmental, ergonomic, and psychosocial hazards. They clearly articulated their concerns about the former two, but by far the most strongly expressed concern was with psychosocial hazards. Accordingly, those data occupy the bulk of the results presented here. Only the dimensions of the COPSOQ that were present in our data are mentioned; the relevant dimensions are indicated in the text with italicized lettering.

Environmental hazards and respiratory and skin reactions

Those whose work responsibilities included cleaning consistently mentioned two products that they felt were hazardous: bleach and ammonia. A few participants also mentioned degreasing agents as dangerous. They believed that such "strong" and "toxic" products made their cleaning work easier, but were hazardous. Some participants expressed a wish to use less toxic products, but said that their employers chose the products with which they worked. A small number of women felt that these products came with the territory of cleaning, and that though they were bothersome, they were the same products they used in their own homes.

Participants explained that the acute physical reactions that they had to the products, mostly dermatologic and respiratory in nature, were an obvious signal of the health effects they caused. They described experiences with burning in their eyes and throat, watery, red eyes, difficulty breathing, "suffocation", and skin burns and irritations.

Ergonomic hazards and musculoskeletal problems

Among all participants, there was consensus that the physical nature of household work was exhausting. They described generalized musculoskeletal pain that came from the demands of their work and from the need to travel between houses if they worked in more than one. Participants discussed specific ergonomic hazards depending on the type of work they did, cleaning or caring. Those whose main responsibilities included cleaning discussed musculoskeletal

strain associated with the repetitive and fast upper body motions used in scrubbing, ironing, and mopping, as well as strain on their backs from moving furniture and making beds, and adopting awkward postures to reach high above their heads to clean windows or doors.

Women whose work involved care of persons with limited mobility were very clear about the physical strain and potential for injury that they faced in tasks of helping their charges to bathe, dress, and move about the household. This often involved supporting the weight of the other person's body or moving the person from one place to another. They stressed the idea that those were activities for which they had no training and that they saw as high potential risks for back injury. In fact, several women had injured their backs while caring for limited-mobility individuals.

Their work took all their physical energy, and left them accumulating fatigue and losing vitality day after day. Some of the women, cleaners and carers, had been prescribed analgesic medications to deal with acute and chronic pain. They believed, however, that these were of only limited utility, given that their tasks continued to aggravate their musculoskeletal complaints.

Psychosocial hazards and health

The informants almost unanimously mentioned the quantity of work they were expected to complete and the time they had to complete it as a stressor

(*quantitative demands*). They were given more work than they were able to manage at a decent pace, and had to work very quickly to accomplish it; they were "always running around". This led to work that was not well-done, or to being given an even greater volume of work in the future if they were able to acceptably complete it. If unable to finish work on time or well, they feared negative employment consequences.

Women whose responsibilities were principally caring for a person described the addition of cleaning or cooking chores to their principal care function, which made work volume unmanageable. Carers also discussed the *emotional demands* that their work placed on them. Demands came both from the personal relationships developed during many hours spent together, and the difficulty of watching the elderly or ill deteriorate and sometimes die.

Many informants had little *influence* over certain aspects of their work. They lacked control over the amount of work given to them, and the way to perform it (for example, control over the choice of cleaning products used). Furthermore, they described difficulty in organizing their work because they were asked to attend to multiple tasks at once.

Informants also reported very little *span of control* over their working time. They could not take breaks because of time constraints in completing work, or fear of being looked upon negatively by their employers. At times, this lack of control

was used by employers; one participant described being unable to leave 10 minutes early if her work was finished, but needing to be available to stay on extra time if she was needed (*predictability*). Informants even reported skipping meals in order to finish their tasks, arrive on time to the next home, or so as to not be perceived as lazy. Some informants also reported that they were unable to take personal or sick time off. A few informants felt that working in private homes afforded more flexibility in that regard than working in other environments.

Finally, informants felt stagnated in their work. Having monotonous jobs in which they often found little *meaning* weighed very heavily on them. They performed repetitive tasks that did not permit personal or professional *development opportunities*, and that made them feel trapped.

Monotony was closely related to workplace isolation. Informants worked without co-workers, with no one to talk to or interact with (*social relation*). This was particularly true for live-in workers, many of whom described not being allowed to leave the house except a few hours a week, being “prisoners” within their workplaces. This brought anguish that was sometimes desperate in its intensity - one participant described an impulse to jump from the balcony of the house in which she worked, so urgent was her need to form “part of the world” outside her workplace.

Informants also described *role clarity* complications. While they were initially hired to clean, for example, little by little more responsibilities and expectations were informally added to their duties. For live-ins, this meant that eventually they were working from the time they awoke in the morning until the time they went to bed. Furthermore, some informants described conflicts about who was able to assign them work. This happened mostly when they were hired to care for an elderly parent by daughters and sons. Initially, the hiring children set the conditions, but often the cared-for person imposed other expectations or rules which were extremely difficult to manage.

The informality of their work meant a great deal of *insecurity* for the informants; their position could be terminated at any moment. Furthermore, informality of a different sort permeated their relationships with their employers. They worked in their employers´ homes, often caring for their relatives. This led to a strange, informal relationship of pseudo-"friendship" between employer and employee that allowed for manipulation. Some of the undocumented informants felt that they owed their employers for the "favor" of having given them work when they lacked work permits. Informality and favors meant limited ability to argue against the addition of more tasks, a greater volume of work, longer hours, or to ask to be paid for extra time.

Almost all informants felt that they were underpaid. Furthermore, many described working while sick because they felt unable to miss work. This feeling

was sometimes intuited and related to insecurity, but often was directly stated by their employers, who also frequently asked informants to find a replacement for the days they would be absent. Besides a lack of appropriate financial compensation, informants lacked other types of compensation. They believed their work, efforts, and sacrifices went unrecognized by the families who employed them.

Beyond not being appreciated, informants often felt badly treated. They were made to eat separately from the household members, or to wait until after they had eaten. Sometimes their employers´ children were rude to them without consequences. A few informants had been obliged to wear uniforms. Such obvious drawing of a line between “us” and “them” meant that they were seen as “less than a person”. Being treated well or badly in the workplace, for these informants, was a matter of “luck” that depended on the personalities of their employers.

Fatigue, discussed in the ergonomic hazards section, was also related to psychosocial hazards. Participants worked long hours under high emotional demands, and felt unable to take breaks or to take time off work for illness. Such presentee-ism further exacerbated their fatigue. They described being unable to appropriately care for their general health as a result.

Feelings of anxiety were frequent. Heavy workloads and an accelerated pace created “nerves” and a state of constant “stress” as they rushed to accomplish all of their tasks. Participants further connected hurrying their work with increased fatigue and potential for musculoskeletal injury. They also experienced anxiety because of insecurity, especially related to the potential for economic strife that would come with job loss. Most had extremely limited incomes, and had family economic responsibilities in Spain or in their country of origin. They carried a burden of money-related pressure, and described insomnia and other sleep affectations related to its weight.

Sleep affectations were also directly related to a lack of control over working time. Live-ins were often unable to rest because of nocturnal care-giving demands. There were no limits to their work hours, and sleep deprivation added up, leading both to exhaustion and to learned sleep alterations. Several participants mentioned using analgesics prescribed for other purposes or tranquilizers to manage anxiety and help them sleep.

Descriptions of other mood affectations were also very present in the data. Informants described feelings of depression and frustration with the lack of future they saw in their work. Sadness was sometimes overwhelming in the case of being unable to meet the economic needs of their families, or as they were absent from their loved-ones´ lives while they worked within other peoples´ family

circles. Live-ins described becoming depressed over time, saying that one could only last so long working as a live-in before becoming “psychologically sick”.

Finally, some informants believed that work had a positive impact on their mental health, so that work became cause and palliative. There was a certain underlying belief that steady household service work was better than no work. At times, work was even described as a refuge, such that they could “work to not worry”.

DISCUSSION

This study has described significant environmental, ergonomic and psychosocial risks experienced by household service workers. The composition of these risks was similar by documentation status, though participants believed that they had more bargaining power if they were documented. Experiences varied by whether informants´ principal tasks were cleaning or caring, and by live-in or live-out status. However, we were unable to fully analyze these emerging categories because data on them was not available for all participants.

Previous analyses from the larger study (Ahonen et al forthcoming) of immigrant workers performed by this group showed that documentation status was perceived as an influence over working conditions. Undocumented workers were more vulnerable to poor conditions than documented workers, and related gaining documented status with an improvement in working conditions. But documented individuals also related vulnerability due to their status as immigrants; economic necessity combined with dependence on maintaining a job and payments into the Social Security system in order to renew their documentation status.

In the specific analyses of women household workers presented here, the perception of the importance of documentation status was somewhat more nuanced. The informants believed that documentation status had limited influence over the actual conditions involved in their tasks, but that being

documented gave them more bargaining power over things like scheduling and hours, and more personal freedom to leave the job and find another. These beliefs might be explained by the nature of the work they were doing. First of all, household cleaning and personal care is inherently heavy, physically and emotionally taxing work. While modifications can be made in the way the work is done, through ergonomic and psychosocial interventions and the substitution of less toxic cleaning products, the basic character of the work is unlikely to change. However, having more bargaining power to gain such modifications is possible, and one potentially gains that power by becoming documented. It may also be possible that the formality of being documented seems less central to informants within the context of an extremely unregulated and highly informal work sector. In fact, a few participants mentioned being documented as a potential disadvantage. However, the women aspired to a clear progression, which they envisioned as beginning with live-in status shortly after arrival, advancing to live-out worker status, and eventually moving out of the household service sector to another, "better" type of work. Being documented is a necessity for "better" work, and so perhaps the importance of documentation status as it related to working conditions was subsumed within hopes for occupational progression in general.

Ammonia and bleach are known respiratory and skin irritants (U.S. ATSDR 2004, 2002), and were mentioned as such by our informants. The results of this study support previous studies that have situated household cleaners at risk for respiratory symptoms. Medina-Ramón and her colleagues (2003, 2005, 2006)

have examined respiratory concerns in female household cleaners in several studies. In a community-based survey (2003), they found a higher prevalence of asthma (OR 1.46, 95% CI 1.10-1.92) in current and former (OR 2.09, 95% CI 1.70-2.57) household cleaners, and attributed 25% of the asthma cases encountered to household cleaning work. In a nested case-control study, asthma symptoms were associated with exposure to bleach (2005), and in a panel study (2006) which investigated short-term effects of cleaning exposures on respiratory symptoms and peak expiratory flow in household cleaners with respiratory disorders, they reported an association between lower respiratory tract symptoms and diluted bleach, degreasing agents, and air fresheners. A recent qualitative study of domestic and industrial cleaners (Arif, Hughes & Delclos 2008) reported a lack of skills in the household cleaners in terms of job training, chemical exposure and use, and competence as compared to the industrial cleaners. Domestic cleaners also reported more exposures to respiratory irritants and related symptoms than the industrial cleaners. The combination of results obtained by other researches and the data from this study add to the impetus to better understand and intervene appropriately on the risks involved in using extremely common household cleaning chemicals.

Repetitive movements to which female workers are frequently exposed have also been noted elsewhere (Artázcoz *et al*, 2007, Messing 2004). Our informants described chronic pain related to repetitive movements which were central to their work tasks. Combined with the inability to take time off, such chronic strain

is not likely to improve. Moreover, in jobs with similar demands for people-moving, such as nursing, workers are given training and support to avoid injury, and such risks are formally identified as part of the job. These women, in contrast, had no training or support in proper ergonomic practice.

Psychosocial hazards are associated more frequently with jobs performed by women (Artázcoz *et al* 2004, 2007). Household service work, overwhelmingly female, is also highly informal. Informality was an important factor in informants´ psychosocial environments. The point made by informants that, despite often poor conditions, paid household work was preferable to no work, has been previously mentioned with respect to informal work (Portes et al. 1989). It is understandable that, given the alternative of no work, paid work was viewed as positive by informants. Furthermore, some women directly described their work as having a positive impact on their mental health, helping them to keep busy and avoid worry. Despite the known positive health effects of work, given the disadvantages also involved for these workers, their endorsement should be tempered by keeping in mind the absence of other alternatives.

Poor working conditions for household service workers are aggravated by the lack of regulation of the sector. It is a sector denominated “special”, meaning not subject to the same laws that regulate employment relationships in other sectors (Royal Decree 1424/1985). For example, verbal contracts are valid. Though there are legal specifications for the sector regarding days off, vacation, and

hours of work, and hiring and firing practices, the conditions established for household services workers tend to be notably poorer than those established for other worker groups, especially in terms of working hours per day and time off (Spanish General Workers Union, Services Federation, 2001). Additionally, in the case of verbal contracts it is extremely difficult for the workers to register complaints, and tasks are not specified in contracts. Conditions for paid general sickness leave are much poorer than in other sectors. Up to 45% of their salary can be retained for living expenses and food in the case of live-ins. In addition, the sector does not contemplate occupational injuries and diseases, nor are household service workers eligible for unemployment subsidies. Such special treatment means that these workers are especially vulnerable. The European Parliament, in a plenary session in 2000, adopted a resolution that recognized this vulnerability and other issues within the household service sector in need of attention on a European level (European Parliament Resolution 2000/2021(INI)). It called on member states to act to define household service work, provide more detailed information about the work and workers in their countries, to educate workers and employees in the sector, and to recognize this type of work as work, with all rights and protections provided to workers. It also gave direction to member states on how to proceed with that process. Notable within the document is special recognition of the needs of migrant women within the sector.

In recent years, non-profit organizations, unions and some Autonomous Community governments in Spain have also called for reform. The Spanish

government intended to consider such issues last year (2008) (Abellán 2007), but reform was put off. It has been suggested that the Special Household Services Regimen should be abolished, and those workers incorporated into the General Regimen, which establishes better conditions ("Piden" 2008). Such a move would certainly improve the condition of documented workers, though it is not clear how such a move would affect undocumented workers. The idea of promoting contracting of household service workers through employment agencies, as has been done in other countries, rather than on a family-worker level, has also been suggested by the Ministry of Labor and Immigration (Abellán 2008).

While regulatory frameworks do not guarantee compliance nor resolve all working and employment concerns, they provide solid ground from which to begin. In the same way that being documented gave women in this study a greater sense of empowerment, stronger laws would help to prevent abuses, and so we wholeheartedly agree that the first step to driving any improvement in the working and employment conditions of these workers would be an improved regulatory framework.

A parallel organizing strategy would address the complexities of household service work and the consciousness-raising required in employees and employers alike, and might be particularly beneficial for undocumented women. One example of an organizing effort is New York's Domestic Workers United

(DWU). The organization provides training programs to household service workers, direct advocacy with employers, legal services, and builds public support to enact legislation aimed at household service employees. It also provides, on its web site, guidelines and standard contracts for use in hiring (DWU web site) that clearly lay out conditions and expectations. Lacking laws that provide adequate guidelines, such documents might be of great help to those involved in household service.

Immigrant women employed in household service should also be a group given attention in future epidemiologic research. While it seems fairly well-documented (Artázcoz *et al* 2001, Artázcoz *et al* 2007) that employed women's health is negatively affected when the combination of their paid and non-paid labor creates overload, this study suggests that the person hired to decrease the load may incur not only the benefits of paid employment but also the negative health effects of poor working conditions. The legal peculiarities of the sector and the invisibility of the work combined with the risks to which they are exposed makes it an area of important occupational health concern. The need to provide healthy workplaces within private homes carries with it many important complications, but the conditions described here occur within a social structure that, through its lack of regulation and enforcement, currently denies that household service work is work. In that way, the women who perform this type of work are denied the status of workers, with the social and occupational safety nets others enjoy.

Researchers have for some time critiqued the outright absence of gender in the study of work and health or its male- and ethnocentric perspective (Eun-Ok 2000), misperceptions about the nature of women and women's work and hazard exposures (Messing 1997), and have provided recommendations for treating gender appropriately in occupational health research (Messing *et al* 2003). Gender is not the only relevant issue; future efforts to describe and quantify occupational stress in this group should include the sum of multiple characteristics of the workers, such as being female, being ethnic or visible minorities, being poor, and having fewer legal rights as immigrants (Llàcer *et al* 2007). That women of these characteristics frequently perform invisible work does not occur by chance; rather it is a "social phenomenon that needs to be examined" (Neysmith and Aronson 1997).

For these reasons, a feminist research perspective should be considered (see, for example, Campbell and Wasco 2000 for an overview). Such a perspective would be useful because of the central aspects of feminist research, which: values the experiences of all women, uses qualitative and quantitative methods to gain fuller understanding of a phenomena, uses research to connect women to other women, minimizes the hierarchical relationship between researcher and 'researched', and recognizes emotion both in women's lives and in science, with the goal of respecting, understanding and empowering women through research (Campbell and Wasco 2000, Eun-Ok 2000). Such consideration within an occupational health framework may also require specific tools developed with

appropriate measures for the risks involved in household service tasks and for immigrant populations (Messing 2004). As this study has shown, depending on whether principal responsibilities were cleaning or personal care, the tasks involved could be quite different, and tools to evaluate hazard exposures should take into account this variety of tasks as well.

Finally, Messing and Grosbois (2001) have suggested that research, policy, practice and ultimately women's occupational health will be advanced through successful stakeholder collaborations that cut across social class and gender lines. Their call for collaborations among feminists, working class organizations, researchers, and women workers could not be more appropriate than in the case of women immigrant household service workers. The inclusion of immigrant rights groups might also be useful.

CONCLUSIONS

It is time to look beyond measuring risk exposures in the traditionally hazardous, often male, occupations. As these data have shown, female immigrant household service workers are also exposed to a variety of health hazards that could be acted upon by improved legislation, enforcement, and preventive workplace measures. This, however, requires our prior recognition of people employing household workers as employers, and household service as work, in order to recognize those who perform it as workers worthy of protection.

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Table I Demographic and educational attainment information of female immigrant informants employed in household services, by documentation status, in qualitative ITSAL study, Spain, 2006-2008.

Origin	Age Range [years]	Range of time in Spain [years]	Educational attainment	Docum. Status*		Total participants from origin
				Doc.	Undoc.	
Colombia	28-55	4.0-7.5	Unknown	0	0	**7**
			Primary school or less	1	0	
			Secondary school	5	0	
			Some university studies, professional training or university	1	0	
Morocco	26-53	1.0-22.0	Unknown	0	0	**8**
			Primary school or less	3	1	
			Secondary school	1	1	
			Some university studies, professional training or university	2	0	
Senegal	33	3.0	Unknown	0	0	**1**
			Primary school or less	1	0	
			Secondary school	0	0	
			Some university studies, professional training or university	0	0	
Romania	20-50	0.6-5.0	Unknown	2	2	**23**
			Primary school or less	0	0	
			Secondary school	3	9	
			Some university studies, professional training or university	5	2	
Ecuador	20-43	3.0-7.0	Unknown	0	0	**7**
			Primary school or less	2	2	
			Secondary school	1	1	
			Some university studies, professional training or university	1	0	
Total range	**20-55**	**0.6-22.0**	**Total participants**	**28**	**18**	**46**

* Doc. = documented, authorized to reside in Spain Undoc. = undocumented, not authorized to reside in Spain

Table II Interview topic guide for focus groups and semi-structured individual interviews with immigrant workers. Qualitative ITSAL Project, Spain, 2006-2008.

Migratory process
Occupational background in country of origin
Current work situation
Income
Occupational history in Spain
Administrative/legal status
Treatment and discrimination
Labor union participation and/or associative patterns
Health
Occupational hazards
Future prospects

Table III Quotes related to environmental and ergonomic hazards and health effects, female immigrant informants employed in household services, by documentation status. ITSAL study, Spain, 2006-2008.

	Hazard	Health effect
Environmental	*Every day there are more products [available] and of course, they´re good, but they´re also toxic.* (Documented Romanian, FG)	*I had to do 3 houses in one day, I left one, all of them wanted me to clean the bathrooms with ammonia, and I left there poisoned, now every time I have contact with ammonia, my whole face burns, my hands were cracked, they were bleeding.* (Documented Romanian, FG)
	P: Do you think that [the use of chemical cleaning products] could produce any health effect? *A: No, because we use them in our houses, too. In my house I use them all over the place. So, no, I don´t think so.* (Documented Moroccan, II)	*I used a lot [of ammonia] at once and…I was starting to get desperate.. I knew that it was because of that [ammonia], because in that moment I couldn´t even breathe. I realized it myself.* (Documented Moroccan, II)
	…they like it when you clean with ammonia, which is pretty strong, and bleach, which are really strong products… (Undocumented Colombian, II)	*With the problem I have with my eyes they tell me to be careful `be careful with the chemicals (laughs)´, and that´s it…my eyes get red as if I were crying.* (Undocumented Moroccan, II)
	…bleach does harm and the degreaser hurts me, because I´ve got sensitive skin, you know? (Undocumented Moroccan, II)	
Ergonomic	*A person who weights 90 kilos [and you have to move him], you`ve gotta realize, and really floppy…I didn´t even have the strength to walk.* (Documented Romanian, FG)	*I got a muscle spasm in my back…because I lifted up an 86 year-old woman who was too heavy, lift her up, set her back down, all that.* (Documented Moroccan, II)
	1. Your back… *2. Yes, you have to move all the things in the house, to clean, to mop, all that, ouch.* (Undocumented Romanians, FG)	*Lots of bone pain, because cleaning work is a little tough…bone pain, lots of tiredness, varicose veins…I think more than anything it´s bone pain and lumbar pain.* (Documented Colombian, II)
		It weighed a lot and I had to pick it up, and my back hurt, and I had to iron two or three loads of laundry…(Undocumented Romanian, FG)

Table IV Quotes on perceived psychosocial hazards and health effects, female immigrant informants employed in household services, ITSAL study, Spain, 2006-2008.

Hazards
You´re shut up 20 hours a day, you don´t have contact with other people, you can´t shower, only once a week, you can´t eat what you want… (Undocumented Romanian, FG)
So then I make the food and I leave, I don´t have the right to an hour´s break, right? No, I don't, so I´m leaving and she [boss] says to me, `But [informant´s name], you have to be here to serve the table´. I say, nobody told me I had to be a waitress, too, I´m paid for other services… (Documented Romanian, FG)
In homes, how they take advantage of a person, really…at first the woman was thrilled with me because I cleaned her house really well and everything, and she got up with the kids to take them to day care and everything and I said I´d help her dress the kids so she could get out fast…and sometimes when I couldn´t help her with the kids or something she got angry with me…they always want one to do more than one can. (Documented Colombian, FG)
Yes, he was a person who couldn´t do anything for himself…you have to get up many times during the night, then begin again at 8[a.m.], the same every day for 600 euros [aprox. $900]…when you get yourself into a house as a live-in, you´re making food and cleaning and everything, and on top of that you have to care for a sick person… (Documented Romanian, FG)
What, a live-in can´t leave the house? (voices) You want to work as a live-in, not as a prisoner in a penitentiary, right?...they treat you as if you were a prisoner. (Documented Romanian, FG)
More than anything it´s the way one is treated, because they don´t treat one well, they don´t treat one with respect that is deserved…whoever one is, whether one has or doesn´t have money, one has to be respected, right? At least that´s my way of thinking. (Undocumented Ecuadorean, FG)
Supposedly I worked four hours a day from Monday through Friday, but the majority of the time I had to stay with the child on Saturdays or Sundays, or I got out late because the woman [employer] had something to do. (Undocumented Colombian, II)

Table V Quotes about perceived health effects related to psychosocial hazards, female immigrant informants employed in household services. Qualitative ITSAL study, Spain, 2006- 2008.

Health effects
Physically, you work, you get tired, and when you can't you don't get out of bed, but here where you really get worn down is in your head. (Documented Romanian, FG)
The only problem an immigrant finds when she comes isn't an illness, but it's depression…. HAVE OTHERS HAD DEPRESSION? *I have.* *Yes, often.* ALL OF YOU? *I did for two years.* *It's inevitable.* *A sadness…* (talking) *Lots of anxiety, all that.* *I had to take pills.* *In my country the term depression isn't firmly established. She says sadness, but I ask you, does that sadness last a week?* *No, depression isn't an illness, in my country someone in psychiatry [psychiatric treatment], well she's crazy, that's all…* (talking) *Cleaning houses and getting depressed* (laughter) *Child, you clean well, clean, clean, so you'll get depression and migraines and anything else you want…no, seriously, sadness that is prolonged is depression, really.* (Documented Romanians, FG)
When I saw my children and my husband here sometimes I wanted to go outside a moment, on the balcony, to be outside a moment…get some air, and I got this anguish, I wanted to jump, to run away, yes. I said, `I can't stand this job anymore, I can't stand this job anymore, my job is killing me, my job is killing me`…a sick person transmits their sickness to you, even if it's psychologically, we end up sick… (Documented Ecuadorean, FG)
When you don't have money, yes, it's hard to sleep, you can't sleep because you don't have money, you don't have food, you don't have money for the rent. (Undocumented Romanian, FG)
I want to work to not think. (Undocumented Romanian, II)
If you take a few more days [to recover from illness], as you should, until you're well, so you can work better…you're out on the street, and that's it. So one has to make a superhuman effort and say…`well, I guess I feel a little better…I'm going to continue`, and that's all there is to it. (undocumented Ecuadorean, FG)
I need to work. Beyond needing the money, it's that I can't be idle. I can't, I can't. I get sick (laughs). It's true! SURE *The more idle I am, the sicker I am.* (Documented Moroccan, II)