Health stressors, problems and coping strategies of migrant domestic workers: A scoping review

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Abstract

Migrant domestic workers have become a major international target population for issues of human rights. However, little is known about the stressors, problems, and coping strategies surrounding their health issues internationally. A scoping review identified 26 sources matching selection criteria through a systematic search on 10 databases with publications from January 1995 to December 2019. Analysis revealed that stressors to health included abuse, poor health services accessibility, ongoing financial hardship despite demanding working conditions and social isolation. Several physical and mental health problems were identified for which migrant domestic workers largely depended on social network and religion to cope with stressors and health problems. Marginalization in health and social care system was evidenced in various countries that formal health and social care for migrant domestic workers was lacking. Survey on health problems of migrant domestic workers and provision of formal support to them present a significant service gap.

Introduction

Since Hoschschild introduced the concept of the global care chain as “a series of personal links between people across globe based on the paid or unpaid work of caring” (1), migrant domestic workers (MDWs) have become a major international target population for issues of human rights. MDW can be defined as a full-time worker who is tied to an employer either through a regulated work permit or underground contract that allows him / her to work for a single household (2,3). The global care chain initially captured the phenomenon of women migrating from global south to care for children in households of employed women in the global north, whilst those women migrant workers left their own care work in their country of origin (4). Furthermore, the trend of global population ageing created a new wave of the global care chain in which women from less wealthy countries moved across borders to take up domestic care for older adults in more wealthy households (5). There is an estimated 11.5 million MDWs in the world, of which 75% are female (6). The phenomenon of MDWs has raised issues surrounding the rights of (female) migrant laborers and uncovered inequalities on genders, economic classes, ethnic groups and legal status imposed on migrants driven by the global care chain (7,8). To date, support for MDWs’ health-related issues has received little attention around the world (3,9). Presently, little is known about issues surrounding the health experiences of this migrant workforce.

The traditional work of MDWs has generally been characterized as the three Cs: cooking, cleaning and caring (10). Migrants have played a significant role in meeting the escalating demand for social care, particularly home care, in the UK (11). People from Poland have been employed as domestic workers in Germany to take care of older adults (8). In Scandinavia, Sweden provides tax reductions for older adults to pay for “top up” care services from migrant workers (7). Filipina domestic workers have been employed to care for older adults in Cyprus (12), Southern California (13) and Israel (14). The demand for MDWs for long term care of older adults is also extensive across Asian countries. Approximately 14% (n = 183,000) Hong Kong older adults are being cared for by MDWs (15). The number of MDWs hired to specifically care for older adults was projected to increase from 198,000 in 2011 to 300,000 by 2030 (16). Currently,

12.8% of frail older adults in Taiwan are under the care of migrant domestic workers(17) and 17.4% of Israeli older adults received government subsidies to hire MDWs (18).

Alongside the increasing popularity of MDWs worldwide, violations of their human and labor rights have been identified, with ensuing health implications. MDWs are known to have excessively long working hours without compensation and with limited organizational support (5,11). For instance, 11% of MDWs in Hong Kong have reportedly been deprived of their weekly days off, affecting their health and wellbeing (15). Discrimination based on skin color, language and ethnicity have been dominant themes in studies of MDWs (19,20). Being entrapped in a household, MDWs lack structural organizational support when faced with exploitation (21). The role of MDWs has a unique nature, as both employee and caregiver of their employer, requiring MDWs to employ heavy emotional labour in their relationships with care recipients (22). As such, mental health of MDWs is a major issue (23). In actuality, half of MDWs in China reportedly found it difficult to manage negative emotions (24). When the employer-employee power relationship intersects with a lack of social and organizational support, MDWs were highly vulnerable to abuses by employers (21). In fact, abusive behaviors by employers, such as physical and verbal abuse, sexual harassment, and economic exploitation were identified as common stressors that trigger negative emotions among MDWs (25,24). Due to their live-in working arrangements, MDWs provide around the clock care to recipients, potentially having an impact on their physical health status. For example, 52% of MDWs complained of lack of sleep and 73% reported not having regular mealtimes, due to the constant demands of their caregiving work (15). In recent years, attention to the health of MDWs has mainly focused on issues of sexual health, particularly HIV (26). There is a lack of systematic information on the broader stressors and health problems affecting MDWs worldwide.

From a human rights perspective, identifying stressors and subsequent coping strategies used by MDWs to address their health problems is merited. Human rights issues are meant in the first instance to guide the actions of governments and have implications for health policy and practice (27,28). However, around the world MDWs have limited access to health and social protection (21,5). Due to social, cultural and physical isolation, MDWs often face the problem of accessing and utilizing health-related information (3). It has also been highlighted that healthcare professionals (e.g. nurses) and current healthcare services and policies were unable to meet the needs of MDWs (29,3). Failure to protect and promote the health of MDWs may indirectly have a negative impact on the wellbeing of their care-recipients, as well as the global economy. For example, the cost of informal care of older adults with dementia accounts for 0.44% of global GDP in 2015, whilst that of direct medical and social care for older adults with dementia was 0.65% of global GDP (30). The increasing trend of hiring MDWs to provide long-term care for older adults has the potential to further increase the sharing of informal care, aligned with the global trend of ageing in place. Meanwhile, it is well acknowledged that promotion of the health and wellbeing of informal caregivers is crucial for the health and wellbeing of the care recipient (31,32). As such, this scoping review aimed to systematically explore and review the wide range of health and wellbeing issues surrounding MDWs, in order to identify and synthesize stressors impacting their health, their health problems and coping strategies they employed, to inform health and social care practice and policy.

Methods

We employed Arksey and O'Malley's (33) five stage framework and followed the advice of Levac and colleagues (34) to synthesize and analyze a wide range of literature. Arksey and O'Malley (33) proposed five stages to conduct a scoping review: (1) identifying the research question; (2) identifying relevant studies; (3) selecting studies; (4) charting the data; and (5) collating, summarizing, and reporting the results. Underpinned by the framework (33), this study is reported according to the 22-item Scoping Review Checklist (35). Steps one to five of this five-stage framework (33) are described below.

Identifying the research question

The research questions addressed by this review were:

1. What is known about the stressors impacting health of MDWs?
2. What are the health problems faced by MDWs?
3. What are the coping strategies employed by MDWs in response to the stressors and health problems?

Identifying relevant studies

Relevant studies were identified principally by systematic searching electronic databases including Scopus, Web of Science, CINAHL, Medline, PsychInfo, Proquest, PubMed, Garuda (Indonesian Publication Database), Business Source Complete, and China Journals Full-text Database with the publications from January 1995 to December 2019. Various combinations of the medical subject headings (MeSH) with Boolean operators AND and OR were used: "domestic helper", "domestic worker", "migrant worker", "foreign worker", "domestic employee", "health", "well-being", "psych*", "mental", "emotional", "physical", "work life". A second search was also conducted by reviewing the list of bibliographic references of the relevant and included studies. Due to the cultural diversity in the team, we were able to extend our search to literature in English, Chinese and Indonesian languages.

Selecting studies

The review was conducted in accordance with PRISMA reporting (36). In total, 2,377 references were obtained for literatures in English, Chinese or Indonesian, of which 1,511 were eliminated as duplicates. A study team of seven members screened the titles and abstracts of the remaining 866 articles using the Covidence software platform (37). Each articles was screened independently by two team members with disputes resolved by a third team member. After reviewing titles and abstracts, 82 full-text relevant articles were retrieved and screened again. Articles were screened based on the following inclusion criteria: (1) only international peer-reviewed studies and original articles; and (2) research design was quantitative, qualitative, or mixed methods studies. Studies were excluded that (i) only mentioned about social construction of exploitation or abuses on MDWs, or (ii) participants who were migrant workers but not engaged in domestic work. We also excluded commentaries, discussion papers, editorials, literature

reviews and book chapters. Monthly meetings were carried out to clarify the study selection eligibility criteria. After a consensus meeting, studies not focused on the health and wellbeing of domestic migrant workers were also excluded. No Chinese or Indonesian literature met the inclusion criteria. In total, 25 articles were included, and an additional study was retrieved from a reference list of an included article. Therefore, 26 articles were included in the final scoping review. The search process is provided in Fig. 1.

Figure 1 insert here.

Charting the data

Using Microsoft Excel, characteristics of included studies (Table 1) were initially developed to extract data on author, year, study design, research objectives, number of participants, study location, and worker country of origin. In accordance with the inductive nature of scoping review (33), no studies were excluded on the basis of quality. Another table (Table 2) was further developed to extract specific data on stressors on health, health problems and coping strategies. All data charting was conducted independently by two reviewers and results were cross-checked by other team members.

Table 1 and Table 2 insert here.

Collating, Summarizing, and report results

In accordance with the guidance provided by Levac et al. (34), we developed a descriptive summary to collate and summarize the results. The analysis presents a narrative description and synthesis of the existing literature using the research questions as a conceptual framework. Studies were coded and categorized according to their relevance to the research questions. Coding and categories were then synthesized into themes for presentation (38).

Results

The 26 included studies encompassed qualitative studies (n = 8), quantitative studies (n = 13) and mixed methods studies (n = 5). Eighteen studies focused specifically on workers from the Philippines (n = 13), Indonesia (n = 2), Ethiopia (n = 2), Nepal (n = 1), Burma (n = 1) and Russia (n = 1). Other studies included a mixture of participants from Philippines, Indonesia, Colombia, Morocco, Senegal, Romania, Sri Lanka, Burma, Vietnam, Sri Lanka, India and Bangladesh.

Stressors impacting health

Four categories of psychosocial issue, namely: (i) work-related abuse and exploitation, (ii) poor literacy and accessibility to health services and health insurance, (iii) inescapable financial hardship despite demanding working environment, and (iv) social isolation, were identified as dominant stressors influencing the health of MDWs.

Work-related abuse and exploitation

Work-related abuses were typically described in categories of sexual abuse, physical abuse, emotional abuse (including verbal abuse) and exploitation, with varying prevalence across countries or cities. The prevalence of abuses experienced by MDWs in Israel was particularly disturbing: sexual abuse (8.2%), physical abuse (5.9%), emotional abuse (38.8%) and exploitation (64.7%) (39). Their latter study (40) further showed that MDWs (7.4%) were more vulnerable than local care workers (2.5%) to work-related abuses. Another survey of Nepalese female MDWs in the Middle East and Malaysia showed that 40.9% suffered abuses in the workplace, including reports of physical harm (11.1%) and torture or maltreatment (30.8%) (41). In Hong Kong, 20.5% and 34.4% of MDWs experienced physical and verbal abuses respectively (29). One noteworthy case in Thailand revealed that a male MDW suffered sexual abuses by a male employer repeatedly without reporting to officials or friends (42), amidst the feminization of global care chain. Meanwhile, Green and Ayalon (2018) (40) found that MDWs' worker rights were violated in the following ways: (i) did not receive vacation days (58.4%), did not receive paid sick days (76.1%), did not receive written contracts (15.8%), did not receive the financial compensation they were entitled to (39%), and did not receive weekly days off (35%). From North America, Canadian studies suggested that the household, as a private workplace, presented significant difficulties for officials to enforce existing labor laws, leaving MDWs highly vulnerable to abuses and exploitation with sense of powerlessness (43,44).

Poor literacy and accessibility to health services and health insurance

Accessibility to health services and health insurance created difficulties for MDWs across both developing and developed countries - specifically health illiteracy was identified as a contributing factor. The unmet need for health services (18%), unmet need for pharmaceuticals (10%) and high levels of health illiteracy (73.8%) were reported in one Cyprus quantitative study (45). Toyota (42) commented on the impact of health illiteracy in MDW in Thailand, where poor AIDS knowledge left MDWs with extremely restricted options for their own health and wellbeing. Simkhada et al (41) revealed that only 12.9% of Nepalese MDWs received workplace health services in the Middle East and Malaysia and illiteracy was significantly associated with their health problems ($p < 0.001$). In Canada, accessibility to health services for MDWs was dependent upon compulsory insurance coverage provided by employers (46). However, there were cases where MDWs lacked awareness about the legal requirement for employers to provide insurance coverage, resulting in no insurance coverage for health services during their first three months of employment (46). Systemic inequity, in which MDWs were structurally excluded from healthcare system of host countries, was found to be a dominant contributor to their poor accessibility in both developed (e.g. Canada) and developing countries (e.g. Lebanon) (47,44).

Inescapable financial hardship despite demanding working environment

One Singaporean qualitative study revealed that overcoming poverty motivated migrants to join the domestic care workforce in the host countries (48). This was confirmed in a Filipino study where financial (52.8%) and income (43.9%) concerns were dominant among MDWs (49). However, domestic work is

highly demanding, the daily hours of work ranges from 12 to 18 hours (43,41,50). The domestic work was even more demanding if older adults were the care recipients. The daily hours of work increased to 20 hours for MDWs caring for older adults in Singapore (51). Particularly, caring for older adults costed an emotional toll on MDWs (52,52). The highly demanding domestic work is detrimental to the wellbeing of MDWs and does not bring a permanent solution to MDWs' financial problems because the hardship returns upon termination of employment (49). This is best explicated by a participant's quote *"I am so stressed and actually I was on sick leave for 12 days because of the stress but what I keep worrying is about my family, that if I lose my job right now, because I know I'm not happy with it... If I leave this job and I cannot find a job tomorrow then I lose pay"* (44). As such, quitting domestic work is not an option for MDWs, despite enduring (53).

Social Isolation

Social isolation was identified as a major issue related to domestic work in various qualitative studies (52,53,46,51,42,44). Around 48% of MDWs suffered mild to severe level of social isolation in Singapore (54). Employers were found to play a major role in constructing the social isolation of MDWs in various ways from forbidding MDWs to connect with the outside world through telephone, to more extreme measures such as fencing them within the home (42). Meanwhile, the long working hours of domestic care and lack of alternative co-workers contributed to workplace isolation, in which MDWs carried out their work with no-one to talk to or interact with (52,51). Another reported source of social isolation was being separated from family (46), reinforcing their sense of otherness in host countries (53).

Physical and mental health problems

The phenomenon of the "healthy immigrant effect" was identified generally across studies in both Eastern and Western countries (53,44). The healthy immigrant effect refers to progressive health declines experienced by MDWs in host countries, after arriving in their host countries with excellent health (48). In a Canadian study, MDWs commented that the nature of domestic work (e.g., the live-in arrangement, demanding work) created new physical and mental health problems that were absent before migration (46).

Physical health

Various types of physical problems were mentioned across a number of qualitative studies, including cardiovascular diseases (e.g. hypertension) (46,55,47,44), respiratory diseases (e.g. tuberculosis) (47), chronic pain (47,55), diabetes (55,44), poor sleep (52,46), and fatigue (52,43). Survey data on the above physical problems were absent in the literature that we retrieved. While these physical issues might be attributed to the stressors discussed above (e.g., long working hours) (46), some stressors (e.g., poor sleep and fatigue) were also signs and symptoms of somatization of mental issues (52,56). A study in Hong Kong investigated the oral health status of MDWs in which psychosocial determinants explained 13.2% of variance of caries severity (57). Reproductive and sexual health was also a major concern for MDWs (42). In a study of 1,001 MDWs in Malaysia and the Middle East, 3.1% had fallen pregnant in the

course of their employment; 50% of these cases (n = 16) was the result of rape/sexual abuse, while the remainder of pregnant women had consensual sexual relationships. Such pregnancies created additional problems for MDWs as sexual relations is forbidden in these Muslim countries (41). With poor accessibility to health services, there were cases in Lebanon that pregnant MDWs were denied admission to hospital and were forced to deliver at home (47).

Mental health

Feeling stressed is commonly found in MDWs in various studies (54,58,46,43,59). In Singapore, 52.5% of MDWs reported feeling stress (54). A survey in the Middle East and Malaysia showed that 8.8% of MDWs had mental health problems, although the diseases were not specified (41). Anxiety and depression were frequently mentioned by MDWs in qualitative studies (52,46,55,44). The prevalence of anxiety among MDWs was 17.6% in Macao, China (60). 10.3–18.2% of MDWs suffered moderate to severe level of depression across various countries (58,29,60,50). Two studies in Macao and China showed that post-migration stress was associated with increased anxiety, depression, somatization and post-traumatic stress disorders (61,56). The mental health issues, coupled with poor social support, contributed to additive gambling behavior of MDWs in Macao, China (55,62). Loneliness and homesickness were mentioned in MDWs' narratives (53) with a prevalence of 24.8% in a Filipino study (49). It is noteworthy that 66.7% of MDWs were diagnosed with brief psychotic episodes in Lebanon (50).

Coping strategies

Most commonly reported strategies to cope with stress and to foster resilience were: (i) establishing social networks, and (ii) participating in religious activities. No health or social care interventions have been identified to assist MDWs to cope with their health problems.

Establishing social networks

For Ethiopian MDWs, establishing social networks and contact with peers served the function of sharing information and advice, to engage in religious worship together and comfort themselves just by seeing each other (53). Those MDWs with higher levels of social connection expressed higher levels of quality of life in Singapore (54). Conversely, social network is not always been seen to be beneficial. For MDWs in Macao, China, social support from peers was positively associated with psychological distresses (60,56), mainly as peers shared the same problems and were similarly stressed (55). Some MDWs in Singapore indicated that social support was not helpful (48). Meanwhile, employers were identified as a prominent and first line source of support (inclusive instrumental, emotional and financial) for MDWs in various studies (51,45,49). However, less than 50% of MDWs reported abuse by employers, either formally to officials or informally to friends and family (39). Motivating them to persevere, MDWs also tried to maintain regular contact with their family members through messages, phone calls and video calls (51). In some settings, there were cases where social contact with friends and family was prohibited by employers of MDWs (53). This scoping review did not find any organizational support provided for MDWs.

Participating in religious activities

Religion was a very important aspect for many MDWs and religious activities performed included singing, prayer, going to church and reading religious texts (48). In the Philippines, praying / reading the Bible (55.2%) was a major strategy for MDWs to cope with stress (49), although the stress levels between those who prayed/read the Bible and those who did not showed no differences (63).

Discussion

To our knowledge, this is the first scoping review and synthesis of literature related to the health status of MDWs involving 16 countries or cities globally. As such, it indicates MDWs' health is a global issue and provides a valuable addition to the existing literature, bringing to light the health-related experiences of MDWs. Whilst research on the health of MDWs may be limited, it appears to have grown significantly in recent years. Over half of the resources used in this scoping review date from 2016 onwards. In general, the working conditions of MDWs may vary but similar problems have been identified across reporting countries. As live-in employees, MDWs have consistently been found to have problems of long working hours, social isolation and abuse. As informal caregivers, the factors that account for the highest levels of distress in family caregivers also appear to apply to MDWs, including the fact that the majority are female, with low levels of education, live with their care recipient, spend a vast amount of their time caregiving and have no choice about providing such care (64).

The unique employment relationship of MDWs with their employers increases their vulnerability to physical and mental abuse (65). Not surprisingly, studies in this review highlighted issues of abuse and exploitation of MDWs. Globally, MDWs continue to be at significant risk of physical, psychological and sexual abuse in their employment (29). According to our findings, the prevalence of abuses and exploitation ranged from 5.9–64.7%, depending on the types of abuses and the countries. However, the prevalence of abuse and exploitation may be underestimated because of under-reporting with MDW's fearful of repercussions from their employers, such as losing their job (66). This is indicated by our findings that less than 50% of MDWs reported abuses by employers either formally to officials or informally to friends or relatives. Paradoxically, MDWs also identified employers as a major source of social support (51,45,49). For example, a Cypriot study noted that the role of the employers was very important, not only in relation to MDW's access to health services, but also to the quality of care they received (67). As such, our findings agreed with Bauer and Österle (68) that MDWs are dependent on their employers for various aspects, both materially, such as income, and emotionally. This highlighted their vulnerability due to an unequal power relationship (66). Despite difficulties enforcing labour law in private home settings (12), our scoping review did not identify any structured social support for MDWs to mitigate their dependency on employers. Urgent attention should be given to the development of a comprehensive approach to abuse reporting.

Our findings of poor accessibility to health services are supported by those of Weng et al (69), highlighting that time flexibility and language barriers were the main obstacles to accessing health

services for Indonesian MDWs in Taiwan. The vast majority of MDWs have their weekly time off at the weekend, hampering access to routine health services which are generally provided during working days (70). MDWs in Taiwan were even provided with only one day off each month (71). Furthermore, MDWs generally have limited health literacy in their host countries, mainly because of numerous socio-cultural disadvantages, impacting their ability to access and understand health-related information and services (3). According to our findings, MDWs mainly shared information and advice by establishing social networks and contacts with fellow workers (53). However, social networking with fellow workers was not always entirely positive. Peers also shared the similar problems (55). To improve the health literacy of MDWs, Ho and Smith(3) advocated the delivery of health literacy initiatives through a participatory approach working with community stakeholders (e.g., consulate and community nurses).

The 'healthy immigrant effect' was identified as a problematic phenomenon for MDWs in relation to declines in physical health and mental health (23). This scoping review uncovered a research gap that systematic survey data on physical problems, inclusive sexual and reproductive health, faced by MDWs is lacking, despite a vast number of qualitative studies indicating the onset of illnesses after migration. We believe the first step to alleviate the systemic inequality for MDWs to access health services and health insurance is to assess the health needs of MDWs accurately, uncovering the scope of health problems faced.

Furthermore, high levels of stress, anxiety and depressive symptoms were common in MDWs across all geographical regions. One systematic review identified that common stressors which triggered emotional and psychological problems in MDWs included, abusive behavior by employers, sexual harassment, economic exploitation, demanding working environment and recurrent financial hardships (24), all consistent with the findings of our review. In particular, this scoping review identified a range of physical problems, such as chronic pain, fatigue, sleeping difficulties, gambling behavior and suicide, indicating the potential of somatization of mental problems faced by MDWs. However, none of the included studies indicated the availability of any formal supports provided to MDWs with mental problems and its somatization, identifying a significant service gap.

Our findings of social support and participating in religious activities shed light on the importance of resilience for MDWs to protect them against the identified stressors and health problems. Paradoxically, our review also uncovered the fact that MDWs largely depended on internal resources (e.g., religious beliefs) to cope with adversities, while social networks from employer and fellow were not always effective. The World Health Organization highlights the importance of building environments to strengthen resilience (72). However, our review was unable to locate any structural support offered to MDWs. In contrast, our review showed that MDWs were structurally excluded from health and social services (47,44), hampering their resilience. In accordance with Walsh and Shutes (20), our review uncovered the marginalization of MDWs in health and social care system of host countries with service gaps in improving their accessibility to health services, mitigating social isolation, strengthening health literacy, assessing physical and mental health status, and providing health and social care supporting the wellbeing of MDWs.

Despite such marginalization, there is a clear need to listen to the voice of MDWs (73). This review identified a number of qualitative studies which successfully uncovered the health experiences of MDWs through their narratives. However, small sample size and non-probability sampling was common in quantitative studies, highlighting a research gap in current literature to produce more rigorous design to ensure better generalization. Several mixed methods research studies included in this review were designed to capture experiential aspects of the health-related consequences of working as a MDW. We further advocate for a participatory action research approach to actively empower MDWs through co-construction of research programmes for social changes. Bhuyan and colleagues (74) demonstrated an excellent example of advocacy for migration policy changes for MDWs in Canada, using a participatory action research approach. The changes were deemed to be important to ameliorate the structural violence of migrant labor (74). According to our findings, we believe that certain areas of research into MDWs should be prioritized, including areas such as health literacy, abuses and mental health of MDWs. Further international research is required to gain greater understandings of the contextualized health needs of MDWs around the world.

There are limitations in this scoping review. Firstly, the inductive nature of scoping review with the diversity of countries included in this review risks the potential for lack of specificity. Secondly, scoping reviews are designed to map the evidence and generally do not exclude studies on the ground of quality appraisal, hence cautions should be paid when interpreting findings from studies with poor quality. Thirdly, this review only included English language literature as a result of screening on English, Chinese and Indonesian papers. Studies in other language (e.g. Filipino) might provide a more contextualized findings for the readers. Fourth, the COVID-19 pandemic may have exacerbated employment constraints and had a negative effect on MDWs' experiences. For example, increased reports of abuse and exploitation have been linked to stay-at-home employers and job security of MDWs was affected by the pandemic (66). However, this review was unable to provide information on COVID-19 pandemic.

Conclusions

This scoping review has highlighted a multitude of health-related problems in MDWs across three broad areas, namely stressors to health, physical and mental health problems, and coping strategies. It uncovers the lack of formal health and social care support for MDWs in various host countries. Our findings presented an urgent need to design policy and health promotion programmes to mitigate the marginalization of MDWs.

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Tables

Table 1 Characteristics of included literature

Authors	Qualitative / Qualitative / mixed methods	Research objectives	No. of sample / participants	Study conducting countries	Origin countries of MDWs
Ahonen EQ, Lopez-Jacob MJ, Vazquez ML, Porthe V, Gil-Gonzalez D, Garcia AM, et al., 2010	Qualitative	To examine the environmental, ergonomic and psychosocial hazards and health effects identified by immigrant women working in household service in five Spanish cities.	46 immigrant women in household services	Spain	Colombia, Morocco, Senegal, Romania, Ecuador
Anbesse, Hanlon, Alem, Packer, & Whitley, 2009	Qualitative	To explore experiences of female Ethiopian domestic workers employed in Middle Eastern countries and illuminate potential threats to mental health	19 female domestic workers (two groups with severe mental illness and one mentally well group)	Middle East (Lebanon, Saudi Arabia, Abu Dhabi, Yemen)	Ethiopia
Anjara, Nellums, Bonetto, & Van Bortel, 2017	Quantitative	To investigate factors impacting on female domestic workers' health and quality of life	182 female migrant domestic workers	Singapore	Philippines, Indonesia, Myanmar/Sri Lanka
Bagley, Madrid, & Bolitho, 1995	Quantitative	To investigate stress factors, satisfaction and mental health adjustment of female domestic helpers	600 female domestic helpers	Hong Kong	Philippines
Carlos & Wilson, 2018	Qualitative	To examine perceived changes in health and barriers to accessing healthcare services	21 temporary female live-in caregivers	Canada	Philippines
Cheung, Tsoi, Wong, & Chung, 2019	Quantitative	To explore experience of physical and verbal abuse and reporting behaviors; and associations	105 female foreign domestic helpers	Hong Kong	Philippines

		between abuse experience and depression-level			
Fernandez, 2018	Qualitative	To investigate healthcare needs, access to healthcare and healthcare strategies of migrant domestic workers	35 female domestic workers and 17 key informants	Lebanon	Ethiopia
Gao, et al., 2014	Quantitative	To explore the social determinants of oral health of foreign domestic workers	122 female domestic helpers	Hong Kong	Indonesia
Garabiles, Lao, Xiong, & Hall, 2019	Quantitative	To explore comorbidity between anxiety and depression among migrant domestic workers	355 female domestic workers	Macao, China	Philippines
Green & Ayalon, 2016	Quantitative	To explore the help-seeking behavior of migrant home care workers exposed to work-place abuse	85 home care workers (86% female)	Israel	Philippines
Green & Ayalon, 2018	Quantitative	To assess the working conditions and prevalence of abuse and exploitation of live-in and live-out migrant home care workers	338 migrant live-in home care workers (84% female) and 185 local live-out workers (92% female)	Israel	Russia (live-out workers) Not stated for live-in workers
Hall, Garabiles, & Latkin, 2019	Qualitative	To identify key health issues faced by migrant domestic workers and the social determinants	22 female domestic workers; 7 key informants	China	Philippines
Hall, Pangan, Chan, & Huang, 2019	Quantitative	To investigate the relationship between discrimination and anxiety and depressive symptoms, and	131 female domestic workers	Macao, China	Philippines

		social capital as a moderator			
Heng, Fan, & Chan, 2019	Qualitative	To explore caregiving experiences and coping strategies of female domestic workers caring for older people in Singapore	11 female domestic workers	Singapore	Indonesia, Philippines, and Burma
Hill, Dorow, Barneston, Martinez, & Matsunaga-Turnbull, 2019	Mixed methods	To examine the occupational health and safety experience of migrant live-in carers	112 female domestic workers (8 interviewed)	Canada	Philippines
Kantaris, Theodorou, Galanis, & Kaitelidou, 2014	Quantitative	To investigate the conditions of access and utilization of health services by domestic helpers	625 domestic helpers (98.9 % female)	Cyprus	Philippines, Vietnam, Sri Lank, India and Other
Lo, Chang, Hayter, & O Yang, 2019	Quantitative	To explore stress levels, social support requirements, and perceived quality of life among foreign care workers in home care settings	157 foreign care workers (99.3% female)	Taiwan	Indonesia
Mendoza, Mordeno, Latkin, & Hall, 2017	Quantitative	To examine the role pf social network support in buffering the impact of postmigration stress on mental health symptoms among female domestic workers.	261 female domestic workers	Macau, China	Philippines
Simkhada, van Teijlingen, Gurung, & Wasti, 2018	Quantitative	To explore the health problems of Nepalese female migrant workers working in the Middle East and Malaysia	1010 female migrant workers	Middle East, Kuwait, Saudia Arabia, Malaysia	Nepal
Toyota, 2006	Qualitative	To explore the	3 female	Thailand	Burma

		health and welfare concerns of cross-border domestic maids in Thailand	domestic workers		
Vahabi & Wong, 2017	Mixed methods	To explore work-related experiences and mental health of female domestic workers	30 female domestic workers	Canada	Philippines
Van Bortel, Martin, Anjara, & Nellums, 2019	Qualitative	To explore the perceived stressors and coping mechanisms of female migrant domestic workers	182 female domestic workers	Singapore	Philippines, Indonesia, Myanmar, Sri Lanka.
van der Ham, ujan-Batangan, Ignacio, & Wolffers, 2014	Mixed methods	To explore factors that contribute to resilience in female domestic workers and the relationship with stress and well-being	500 female domestic workers	Philippines	Philippines
van der Ham, ujan-Batangan, Ignacio, & Wolffers, 2015	Mixed methods	To assess stress and coping of female migrant domestic workers from the Philippines in different phases of the migration process	500 female domestic workers	Philippines	Philippines
Yi, Huang, Lam, Latkin, & Hall, 2019	Quantitative	To investigate the prevalence of gambling disorders in Filipino female domestic workers in Macao	1,194 female domestic workers	Macao, China	Philippines
Zahreddine, et al., 2014	Mixed methods	To assess psychiatric morbidity of female domestic workers	33 female domestic workers and 14 Lebanese females (control)	Lebanon	Ethiopia, Bangladesh and Philippines

Table 2 Data Charting on Stressors, Health Problems and Coping Strategies

Authors	Stressors	Health Problems	Coping strategies
Ahonen EQ, Lopez-Jacob MJ, Vazquez ML, Porthe V, Gil-Gonzalez D, Garcia AM, et al., 2010	<p><i>Work environment:</i> Demanding work and emotional toll from caring for older adults</p> <p><i>Social isolation:</i> Long working hours and lack of interaction with co-workers contributes to social isolation. Separation from family reinforces sense of otherness in host country</p>	<p><i>Physical health:</i> poor sleep and fatigue related to mental issues</p> <p><i>Mental health:</i> anxiety and depression</p>	NA
Anbesse, Hanlon, Alem, Packer, & Whitley, 2009	<p><i>Financial hardship:</i> MDW must endure demanding work conditions as unable to quit domestic work due to financial hardship</p> <p><i>Social isolation:</i> Major stressor</p>	<p>Progressive health declines post-migration</p> <p><i>Mental health:</i> loneliness and homesickness</p>	<i>Social support:</i> Establishing social networks and contact with fellow workers and engaging in religious worship together, though social contacts may be prohibited by employers
Anjara, Nellums, Bonetto, & Van Bortel, 2017	<i>Social isolation:</i> Major stressor	<i>Mental health:</i> stress	<i>Social support:</i> higher quality of life for more socially connected MDWs
Bagley, Madrid, & Bolitho, 1995	NA	<i>Mental health:</i> stress; anxiety and moderate to severe depression	NA
Carlos & Wilson, 2018	<p><i>Access to health services:</i> Lack of health insurance coverage – low levels of knowledge of MDW entitlement to compulsory health insurance from employers</p> <p><i>Social isolation:</i> Separation from family contributes to social isolation.</p>	<p><i>Physical health:</i> cardiovascular diseases and poor sleep post-migration</p> <p><i>Mental health:</i> stress, anxiety and depression</p>	NA
Cheung, Tsoi, Wong, & Chung, 2019	<i>Work-related abuse:</i> physical and verbal abuse	<i>Mental health:</i> moderate to severe depression	NA

Fernandez, 2018	<i>Access to health services:</i> Poor access to healthcare arising from structural exclusion from healthcare system	<i>Physical health:</i> cardiovascular and respiratory diseases and chronic pain post-migration. Reproductive health concerns due to lack of access to health services.	NA
Gao, et al., 2014		<i>Physical health:</i> poorer oral health post-migration linked to psychosocial determinants	NA
Garabiles, Lao, Xiong, & Hall, 2019		<i>Mental health:</i> increased anxiety, depression, somatization and post-traumatic stress disorders associated with post-migration stress	NA
Green & Ayalon, 2016	<i>Work-related abuse:</i> sexual abuse, physical abuse, emotional abuse, and exploitation	NA	<i>Social support:</i> Low reporting rate of abuse to formal or informal supports
Green & Ayalon, 2018	<i>Work-related abuse:</i> migrant domestic workers more vulnerable to abuse than local care workers. Abuse of workers' rights (e.g., lack of written contracts, vacation and sick leave, financial compensation and time off).	NA	NA
Hall, Garabiles, & Latkin, 2019	NA	<i>Physical health:</i> cardiovascular diseases, chronic pain, diabetes post-migration <i>Mental health:</i> anxiety and depression, moderate to severe depression. Mental health issues coupled with poor social	<i>Social support:</i> Peer sharing of same problems and stresses can have negative impact on MDWs

		support contributed to addictive gambling	
Hall, Pangan, Chan, & Huang, 2019	NA	<i>Mental health:</i> anxiety	<i>Social support:</i> Social network peer support associated with psychological distress
Heng, Fan, & Chan, 2019	<p><i>Work environment:</i> Demanding work and daily hours, particular when caring for older adults</p> <p><i>Social isolation:</i> Long working hours and lack of interaction with co-workers contributes to social isolation</p>	NA	<p><i>Social support:</i> Employers were identified as first line source of support. Maintaining regular contact with family through messages, phone calls and video calls</p>
Hill, Dorow, Barneston, Martinez, & Matsunaga-Turnbull, 2019	<p><i>Workplace abuse:</i> vulnerability of MDW to abuse and exploitation as private workplace presents challenges for enforcement of labor law</p> <p><i>Work environment:</i> Demanding work and daily hours</p>	<p><i>Physical health:</i> increased fatigue post-migration</p> <p><i>Mental health:</i> stress</p>	NA
Kantaris, Theodorou, Galanis, & Kaitelidou, 2014	<i>Access to health services:</i> Unmet needs for health services, pharmaceuticals and low health literacy	NA	<i>Social support:</i> Employers were identified as first line source of support
Lo, Chang, Hayter, & O Yang, 2019	NA	<i>Mental health:</i> stress	NA
Mendoza, Mordeno, Latkin, & Hall, 2017	NA	<i>Mental health:</i> increased anxiety, depression, somatization and post-traumatic stress disorders associated with post-migration stress	<i>Social support:</i> Peer sharing of same problems and stresses can have a negative impact and result in psychological distress
Simkhada, van Teijlingen,	<i>Workplace abuse:</i> physical harm, torture and maltreatment	<i>Physical health:</i> poorer reproductive and sexual health post-migration	NA

Gurung, & Wasti, 2018	<p><i>Access to health services:</i> low rates of MDWs receiving health services and poor health literacy associated with health problems</p> <p><i>Work environment:</i> Demanding work and daily hours</p>	<i>Mental health:</i> mental health problems	
Toyota, 2006	<p><i>Workplace abuse:</i> Sexual abuse by male employer of male worker</p> <p><i>Access to health services:</i> low health literature (e.g., poor AIDS knowledge)</p> <p><i>Social isolation:</i> Major stressor. Employers play major role in constructing social isolation.</p>	<i>Physical health:</i> poorer reproductive and sexual health post-migration	NA
Vahabi & Wong, 2017	<p><i>Access to health services:</i> Poor access to healthcare arising from structural exclusion from healthcare system</p> <p><i>Financial hardship:</i> MDW must endure demanding work conditions as unable to quit domestic work due to financial hardship</p> <p><i>Social isolation:</i> Major stressor</p>	<p>Progressive health declines post-migration</p> <p><i>Physical health:</i> diabetes post-migration</p> <p><i>Mental health:</i> anxiety and depression</p>	NA
Van Bortel, Martin, Anjara, & Nellums, 2019	<i>Financial hardship:</i> Motivation to join domestic care workforce	Progressive health declines post-migration	<p><i>Social support:</i> Social support not always helpful for coping</p> <p><i>Religious activity:</i> participating in religious activity coping strategy for stress</p>
van der Ham, ujano-Batangan,	NA	NA	<i>Religious activity:</i> praying/reading bible a coping strategy for stress

Ignacio, & Wolffers, 2014			(though actual impact not demonstrated)
van der Ham, ujan-Batangan, Ignacio, & Wolffers, 2015	<p><i>Financial hardship:</i> Income and finances dominant concerns of MDWs</p> <p><i>Work environment:</i> Demanding work is detrimental to well-being and does not provide secure long-term solutions to financial hardship</p>	<p><i>Mental health:</i> loneliness and homesickness</p>	<p><i>Social support:</i> Employers were identified as first line source of support</p> <p><i>Religious activity:</i> praying/reading bible a coping strategy for stress</p>
Yi, Huang, Lam, Latkin, & Hall, 2019	NA	<p><i>Mental health:</i> Mental health issues coupled with poor social support contributed to addictive gambling</p>	NA
Zahreddine, et al., 2014	<p><i>Work environment:</i> Demanding work and daily hours</p>	<p><i>Mental health:</i> moderate to severe depression. Two-thirds of MDWs diagnosed with brief psychotic episode.</p>	NA

Competing Interests

The authors declare no competing interests.

Figures

Figure 1

PRISMA Flow chart