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Health inequities faced by Ethiopian migrant domestic workers in Lebanon

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A B S T R A C T

This paper investigates the healthcare needs, access to healthcare, and healthcare strategies of Ethiopian migrant domestic workers (MDWs) in Lebanon, drawing on qualitative empirical research. The analysis focusses on four types of health care needs: minor illnesses, pregnancies, serious illnesses (such as cancer, tuberculosis or heart problems), and emergencies (due to accidents, suicide attempts or assaults). Predictably, access to healthcare is distinctly differentiated according to an MDW's status as a documented, freelancer, or undocumented worker. Drawing on the concepts of systemic health inequities and inter-personal racial discrimination, the paper provides evidence for inequitable access to healthcare experienced by Ethiopian women in Lebanon. I identify the specific forms of exclusion they experience and develop a matrix for analysis of systemic inequities in access to healthcare differentiated by migrant status.

1. Introduction

Health-seeking behaviour and inequitable access to healthcare are well-recognised as being differentiated by the socio-economic characteristics of patients such as race, class and gender (Ensor and Cooper, 2004; Hall, 2003; Street et.al, 2007, Braveman and Gruskin, 2003). Such inequities in access to healthcare are often intensified for international migrants as a socio-economic group with less privileged status than citizens (Thomas and Gideon, 2013). Further, migrants with precarious, temporary or irregular status are more vulnerable and marginalised than regular migrants, as they are often unable to avail of formal healthcare services through either the state or the market at destinations (Castaneda, 2009; Cuadra, 2010; Villarroel and Artazcoz, 2012; Boso and Vancea, 2016). Inequities in health faced by migrants may be due to entitlement failures contingent on their migrant status (temporary contract migrants, or migrants with undocumented or irregular status) and/or due to access barriers of gender, class, race and ethnicity, or language.

This paper seeks to deepen our understanding of how marginalised migrants meet their healthcare needs through an analysis of Ethiopian migrant domestic workers' (MDWs) access to healthcare in Lebanon. The healthcare needs of MDWs in Lebanon are mediated by employers and insurance companies, who are legally liable for, but often refuse to bear, the cost of medical treatment for illness or injury. On the contrary, employers may sometimes be responsible for uncaring and even abusive practices (Human Rights Watch, 2010; Jureidini, 2002, 2011). Given this context, the key questions examined here are: How do Ethiopian MDWs meet their healthcare needs when they face minor and major illnesses, pregnancy, accidents and emergencies? How does migrant status shape the experience of accessing healthcare? In what ways do Lebanese policies support or obstruct access to healthcare?

The paper provides responses to these questions by first, situating them within a conceptual framework on migrant health inequities and by outlining the research design and methods of this project. Next, the paper discusses the contours of the migration and healthcare regimes within which Ethiopian MDWs in Lebanon are located. This is followed by a set of narrative vignettes from interviews and ethnographic observation to describe the experiences of MDWs within four categories of healthcare needs: minor illness, pregnancy, major illness and emergencies. The concluding section analyses the inequities faced by Ethiopian MDWs along two the two dimensions of systemic inequities and inter-personal discrimination, and offers an analysis of the access to healthcare by MDWs differentiated by migrant status.

2. Migrant health inequities: conceptual framework and research design

The multiple and often interchangeable usage of the terms 'health inequalities', 'health inequities' 'health differences' and 'health disparities' indicate on the one hand, scholarly agreement that group based variations exist in health achievements and access to healthcare; and on the other hand, the first two terms also indicate a further

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dimension of an ethico-political judgement that such variations in health are not simply attributable to biological differences, are socially produced, and therefore can and should be amended (Isaac, 2012). One of the earliest definitions of the terms health inequality and inequity by Margaret Whitehead is: *"Health inequalities are differences in health that are 'avoidable,' 'unjust,' and 'unfair.' Equity in health means that all persons have fair opportunities to attain their full health potential, to the extent possible"* (Whitehead, 1991). Research on health inequalities has produced a large body of evidence of differences in morbidity, mortality, and access to healthcare among population groups defined by factors such as socioeconomic status (SES), gender, race or ethnicity, much of it focused on the health impacts of race in the U.S and Europe (Kronenfield, 2012; LaVeist and Isaac 2012; Bhopal 2007). Notably, Paradies' systematic review of 138 studies on racism and health found considerable variation in the conceptualisation of racism, and that 'only about half the studies recognised systemic racism (i.e. racism occurring through societal organisations, institutions, laws, policies, practices etc.) as well as interpersonal racism (i.e. racist interactions between people)" (Paradies, 2012: 110). However, this literature on health inequalities has evolved largely in parallel to the literature on migration and health, with little systematic consideration of the areas of overlap and divergence in the usage of the terms race, ethnicity, migrant and immigrant as they pertain to inequities in health (Malmusi et al., 2010). While migrants are often subjected to the forms of discrimination experienced by native born racial and ethnic minorities, they are additionally subject to exclusions contingent on their migrant status, with implications for their health.

The complex relationship between migration and health has largely focused on migrants to Europe, the U.S, Canada and Australia. Such studies have often found evidence of the 'healthy migrant' effect in which migrants are recruited, and self-select, from amongst those who are healthiest, and who initially report better health compared to the native population, an advantage that is, however, observed to deteriorate over time, producing the 'exhausted migrant' effect where migrants may experience an excessive burden of morbidity, disability and mortality (Bollini and Siem 1995). In identifying what happens in between these two temporal points, conceptually, there are four broad categories of factors that can be considered to influence migrant health, briefly outlined below.

First, migrants' status (documented/undocumented, forced/voluntary, skilled/unskilled) is increasingly a critical determinant of their access to healthcare at destinations. Notwithstanding the recognition of health as a fundamental human right in international human rights law, the absence of enforcement mechanisms makes it difficult to make claims, and particularly for migrants, such rights are increasingly contingent on their status as citizens or legitimate, documented residents of the host state. Unfortunately, the portability of migrants' rights to healthcare and other social security entitlements is accessible only to a privileged 23% of all migrants worldwide, who are generally documented, skilled migrants voluntarily moving between countries of the global North (Avato et. al, 2010). Second, the nature of the host society's policies of assimilation, integration or pluralism in providing linguistic and culturally competent health services. For e.g., Giannoni et al. (2016) found that weak or absent migrant integration policies negatively influence migrant health; while a systematic review found pregnant migrant women at risk for worse outcomes in countries with weak migrant integration policies (Bollini et al., 2009). Third, the characteristics of the migrant such as gender, age, education, class, alongside socio-cultural factors such as ethnicity, religion, rural or urban origin, influence ideas and practices around health, illness, diet, and lifestyle. Fourth, work related health problems, particularly for low-wage migrants who tend to be concentrated in '3-D' (dirty, dangerous and difficult) jobs - including occupational hazards due to poor working conditions and lack of compliance with safety requirements, issues of access to care and compensation for work related injuries, the risk of poor mental health due to chronic stress, discrimination and exploitation.

Each of these four sets of factors influences the health of, and access to healthcare by, migrant domestic workers, as a disadvantaged group of international migrants who "find themselves in a more vulnerable position, often exacerbated by their possession of temporary permits or irregular legal status, by lack of language skills, or knowledge of rights" (Carrasco, 2016 :228). Research on MDWs health needs and access to healthcare has confirmed observations of discrimination and other barriers when they seek healthcare (Bedri et. al, 2015; Tshabalala, and Van der Heever 2015; Shlala and Jayaweera, 2016), high-levels of mental stress (Van der Ham et.al 2014), but also, that support from co-ethnic migrant, religious and other social networks plays a crucial mitigating role (Alexandre et al., 2016; Carrasco, 2008; Menjivar, 2001).

Drawing on the concepts of systemic health inequities and interpersonal discrimination (Paradies, 2012), this paper provides evidence for inequitable access to healthcare experienced by Ethiopian women in Lebanon. I identify the specific forms of exclusion they experience and develop a matrix for analysis of access to healthcare differentiated by migrant status. Through this analysis, the paper contributes to the understanding of health inequities faced by migrants in a middle-income country outside the global North, where there are no pathways to long-term settlement and citizenship, and there is no entitlement to state provided health services, rather, the reliance is on the market based provision of healthcare through private health insurance that employers are legally bound to purchase for the MDWs they employ.

The paper draws on empirical material from a qualitative research project that investigates the care needs and practices of Ethiopian migrants. I obtained ethics approval from the University of Melbourne Human Research Ethics Committee, and sought participants' written or verbal informed consent. I undertook field research in Lebanon between July - September 2016, and conducted semi-structured interviews with 35 MDWs and 17 key informants (including representatives of NGOs, government officials, doctors and health professionals. Contacts from previous research with Ethiopian MDWs in Lebanon in 2010 formed the initial starting point for recruitment of MDW interviewees, through a snowball sample. My access to participants was greatly enhanced due to the active support and collaboration of members of *Messawet*, an unregistered[2] Ethiopian organisation of MDWs. *Messawet* was formed in 2014 by a group of MDWs (one of whom I had met during my field work in 2010) as a mutual support group for MDWs. I followed an embedded ethnographic research strategy, in which I accompanied the leaders of *Messawet* in their activities - their meetings, visits to hospitals and detention centres/prisons, visits to church, shared meals and even a picnic. These experiences allowed me to develop a fuller understanding of the lives of Ethiopian MDWs, beyond the parameters of interviews I conducted. The selection of interviewees was purposive, to ensure that different types of care needs, migrant status, age, ethnicity and religion were covered. Semi-structured, qualitative interviews with MDWs were conducted with the assistance of an interpreter (though I speak and understand basic Amharic, the national language). The average duration of interviews was 1 hour, though a few were longer or shorter. Interviews were conducted in the privacy of women's homes, and inquired into the women's migration trajectories, employment, and their healthcare needs, practices and experiences. The present paper presents narrative vignettes from in-depth interviews with Ethiopian MDWs in Lebanon. Although the narratives selected are not intended to be representative, the observations on healthcare needs and access are analyzed in triangulation with observations from key informant interviews and the existing academic and grey literature.

[2] Migrant workers in Lebanon are not allowed to register organisations, unions or associations.

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