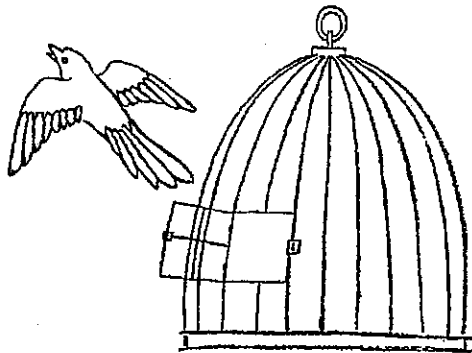
KALAYAAN

justice for migrant domestic workers



King's Fund

Health Project For Migrant Domestic Workers

January 2004-December 2006

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1. 1. Executive Summary:

In 2004 Kalayaan began a three-year Health Project funded by the Kings Fund. Kalayaan is a small advice, support and campaign charity based in London that works exclusively with Migrant Domestic Workers (MDWs) in the UK. These are non-EU nationals who have accompanied their employer to the UK to work as part of their private household. Roles would typically include being a nanny, carer or housekeeper. Statistics from the year April 2005-March 2006 state that 86% of the MDWs registered were women, with the highest numbers coming from the Philippines, India, Sri Lanka, Indonesia and some African countries. Each year Kalayaan registers approximately 400 new MDWs.

Whilst MDWs have the 'right' to access the NHS and other services, they often face multiple barriers as speakers of another language; as members of a BME group; as 'live-in' workers dependent on their employer for accommodation, immigration status and employment; as workers who work unsociable hours and often in isolation. For some workers this can leave them particularly vulnerable to abuse and exploitation. Statistics from the same year show that 70% of newly registered MDWs experienced psychological abuse; 23% physical abuse, 86% reported working over 16 hours per day and 32% had their passports withheld.

It is vital to understand the holistic experience of MDWs before we can understand their relationship to health. The Kings Fund project was specifically aimed at promoting knowledge of health and health issues; promoting knowledge of the NHS and facilitating access to its services; targeting the needs of particularly vulnerable workers i.e. newly-arrived MDWs or workers with limited English skills; and to support those with mental health needs. Importantly, the health project also served as a means to raise awareness of MDWs with health professionals and through networking with health fora.

This report details the outcomes of the project according to the specific objectives outlined its proposal. Both successes and barriers have been explored in detail with explanations for changes to the structure. An example of a significantly altered aspect of the project would be the advisory group that would ensure the project was client-led. The self-elected group expressed the conflict between their desire to feed into the health project against the constraints of their available free-time. In response the advisory groups were changed to focus groups taking place inline with other activities in the centre.

Throughout the entire project there were evident reoccurring themes. Firstly, health was always a secondary or tertiary concern for MDWs. Employment, immigration status and accommodation would always be the prime concerns and it was for these reasons that MDWs came to Kalayaan. Health must be understood in relation to these concerns and the work done on health would always need to factor this in and be understood holistically.

Secondly, MDWs often experience high levels of stress, anxiety and depression. The isolation from their families and the pressures put upon them to send remittances home coupled with their uncertain immigration status and experiences of abuse provide a life of constant uncertainty. The constant preference elicited by MDWs for managing their mental health was for community activities such as English classes and exercise classes. The community and health fair stands out as a real success of the health project in bringing these needs together.

Thirdly, over the course of the project, MDWs encountered increasing barriers in accessing primary health care. The report published in 2004 'National Health Service (Charge to Overseas Visitors)(Amendment) Regulations' added to the normal barriers of language, lack of proof address (i.e. utility bills) and served to create a climate of almost xenophobic hostility to all migrants. Misinterpretation of the term 'ordinarily resident', the status applied to MDWs, seemed central to the debate. In response to these increased barriers, there was an increased demand for advocacy work on both an individual and policy level. I would like to be able to write that this matter has been concluded, however the need for clarification still continues.

Finally, the report closes on what can only be described as a depressing note. The success of the health project is self-evident, but there is much work that still needs to be done, particularly on a policy level and in raising awareness about the needs of MDWs. However, it is with great regret that the Management Committee advised that all health related work should be suspended to be able to focus the organisations time solely on campaigning. In March 2005, the Home Office revealed to Kalayaan their plans to change the domestic worker visa in line with their Managed Migration Policy: Making migration work for Britain. Under the new proposals MDWs will find enter the UK on a 'business-visitor visa'. They will be tied to their employer, with a non-renewable visa for a maximum stay of 6 months. If a MDW flees their abusive employer, they will immediately become illegal, exposed to further abuse and exploitation. Kalayaan firmly believes that, if implemented, these proposals will have devastating human consequences. Changes that will, in effect, be legalising trafficking.

As business visitors MDWs will not be ordinarily resident in the UK. They will have no right to access healthcare in this country. If they run away, their illegal status will make accessing the NHS a virtual impossibility. Again, the potential ramifications of this legislation are nothing short of devastating.

2. Description of the project, its aims and outcomes

Aims

i. To promote knowledge of health issues among our client group using innovative methods and ongoing advice and outreach work.
ii. To promote knowledge of the NHS and how to access the NHS appropriately among our client group (with a focus on language for health and training workshops).
iii. To target the health needs of particularly vulnerable groups of migrant domestic workers (i.e. newly-arrived migrant domestic workers, workers with limited English skills, and under-represented nationalities).
iv. To network with relevant organisations, for and community groups.
v. To support those with mental health needs among our client group and raise awareness of mental health issues among the community.

The aims of the project were broken down into 12 objectives with clear targets and intentions. I have listed all of the 12 objectives and against these written the outcomes including information from surveys and questionnaires and any feedback from monitoring and evaluation.

Where external facilitators have been used their evaluations have been incorporated into the body of the report. Templates of attendance sheets, advertisements for workshops or events have all been placed at the end of the report in the appendices. I have placed only generic example of an attendance sheet in the appendices.

Section 3 is an assessment of the impact of the project.

Objective 1 **To hold 4 half-day forum theatre workshops examining cultural attitudes to health and identifying own health needs.**

Target 1 **c. 10 migrant domestic workers to attend each workshop.**

These 4 half-day workshops will launch the project and will facilitate migrant domestic workers to voice their concerns and questions about health issues. The health project worker will then be able to use the feedback from the workshops to inform the direction of the projects and the particular issues for specific workshops. Those who attend the workshops regularly and express a particular interest in the project will be invited to join the advisory group (see below). Workers from under-represented nationalities will be particularly encouraged to attend. Community interpreters will also be present to assist those who have limited English. The workshops will be co-ordinated by the health project worker and facilitated by 2 forum theatre facilitators. At the workshops cultural attitudes to health and traditional remedies will be explored. Barriers to healthcare in the UK and health needs will then be considered.

Date	Location	Facilitators	Attendance
4th April 2004 1pm-4pm	Wooden Room, St Francis Centre	Claire Fossey	Total:8 Female • 1 Indian • 3 Sri Lanka • 2 Nigerian • 2 Indonesian
18th April -1pm-5pm	St Vincent Centre, Carlisle Place	Claire Fossey & Virginia Clark	Total 13: 12 F- 1M • 5 Indian • 5 Filipino • 2 Sri Lanka • 1 Nigerian
25th April 2004 1pm-5pm	St Vincent Centre, Carlisle Place	Claire Fossey & Virginia Clark	Total 1- F • 1 Indian
9th May 2004 1pm-5pm	Wooden Room, St Francis Centre	Claire Fossey & Virginia Clark	Total 15: 11F-4M • 11 Indian • 1 Sri Lanka • 1 Filipino • 1 Benin

Claire Fossey, a facilitator recommended for her previous work done with Kalayaan, facilitated all 4 workshops, with the support of Virginia Clarke for the final three.

The workshops were advertised in the centre; announced during other workshops and domestic workers who had previously been part of drama workshops were also contacted. An average of 8 domestic workers attended the sessions. Numbers fluctuated dramatically as a result of sudden work demands by employers and other commitments, for example there were particularly low numbers for the 3rd workshop due to a clash with a free legal surgery that was also taking place at Kalayaan the same day.

Despite the fluctuating numbers and irregular attendance, clear and insightful results were obtained which are clearly demonstrated in the excellent report written by the main practitioner (see below). Particular areas highlighted by the workshops were

mental health, health and safety in the workplace, and the difference in medical practice between cultures.
Refreshments were provided at each of the workshops both before and during the event.

Claire Fossey: Drama Workshop Facilitator

Report on Drama Workshops looking at health with Migrant Domestic Workers April – May 2004

Introduction

I was invited to run four drama workshops to launch the health project at Kalayaan and to help ascertain what emphasis the health project should have in order to be most beneficial to the Migrant Domestic Workers. Following conversations and correspondence between the Health Worker Camilla Brown and myself I devised the following Aims and Objectives to help me plan the drama workshops.

Aims

- To identify issues around health that MDWs (Migrant Domestic Workers) feel are problematic.
- To identify barriers to healthcare in UK for MDWs.
- To explore cultural attitudes to health and traditional remedies.
- To promote openness with the NHS and explain that they are there to help.

Objectives

- At each workshop create a safe space for sharing stories and ideas through drama-based group-building work.
- Introduce MDWs to Boal's Image Theatre and other drama skills in a way that gives them confidence to use images and drama to tell stories.
- Use image work and story sharing to identify issues around health that MDWs feel are problematic.
- Demonstrate Boal's Forum Theatre and offer it as a group problem-solving tool where appropriate.
- Employ Boal's Rainbow of Desire techniques to solve internal struggles where appropriate.
- Maintain a relaxed and free atmosphere so that MDWs enjoy the session, not compromising their day off and not pressurizing them to perform.
- Monitor progress of project by recording what is achieved and observed in each session.
- Evaluate each session and ask for feedback from Kalayaan staff and participants.

Drama Workshops

The workshops were devised in accordance with the above aims and objectives but were then re-worked depending on the size and pace of the group and their ability to follow the workshops in English. As drama facilitators myself and Virginie Clarke, supporting the workshops, were flexible to the needs of the workers which often

meant delaying the start of workshops in order for more people to arrive, incorporating late-comers, and allowing for fluctuations in the size of the group when workers had to leave early or come and go throughout the workshops.

A summary of the content of the workshops run, along with our observations taken from these workshops are detailed below.

Sunday 4th April

We had a maximum of eight participants at any time during this workshop. We concentrated on ice-breakers, group-building and simple drama skills such using eye contact and making images before moving on to devising stories from images.
Image theatre is a very powerful tool for uncovering people's attitudes and feelings around a specified subject without the need for complicated language. However, despite trying to use only very simple language I did feel that English was a barrier to us developing this work too much. We began to look at body language between doctors and patients and how patients feel when visiting a doctor. MDWs began to talk about patients being worried because they don't know when they are going to get better[1].

Other than this the only drama work devised by the MDWs in this session were frozen images in pairs that either depicted friends greeting each other or workers and employers engaged in conversation about workers arriving late for work. As this was the first session I had decided to keep the devising very open and avoid leading the workers to create the scenes they thought I would like to see rather than scenes about issues that were really important to them.

The atmosphere was very positive throughout the session, there was lots of laughter and enjoyment although I noted that when having to use more English the workers became tired quite quickly as they had to concentrate very hard. Camilla commented that she was happy with the outcome of the drama work so far, and the feedback from the participants was very positive with MDWs commenting that they felt very happy at the end of the workshop.

Sunday 18th April

We had a maximum of 13 participants at this workshop, although around five people did not join the group till much later. Following the difficulties I had had with varying levels of English at the previous workshop I designed a workshop plan that would build up to image-making and story-sharing much more slowly, sometimes using a particular exercise to demonstrate or teach a key drama skill or word such as freeze, movement, image, emotion or feeling - words that had caused difficulty previously and would hinder progress in this session were they not understood by the second half of the workshop.

This tactic was effective to some extent, although the general language level of the group was much higher than the previous week, but there were still group members who struggled to understand what exactly was asked of them. However, all were able to participate to some degree.

[1] Possible evidence of mental stress associated with illness, where a patient's main concern is how long it will take to get better and will it affect their work?

One of the exercises we did was to brainstorm the word 'Health', what it means to MDWs and what they associate with this word. Virginie recorded the points raised in the discussion and these fell into three categories: Health, Work, and Sickness.

Health

- You have to think positively[2]
- Eat well, healthy food, balanced diet
- Be active
- Happiness affects your health[3]
- Your mind and feelings affect your health[4]
- At the end of the day when you have finished your job your mind is free and that is when you feel healthy[5]
- Being worried is unhealthy.[6]
- Depression, tension and stress are unhealthy.[7]
- Sport, walking, yoga, fresh air and sunshine make you feel healthy.[8]
- You have to pray to God when you get up in the morning and that makes you feel better.[9]

Work

- Sometimes it's hard
- You have to earn money
- It depends on the job whether it's stressful or not
- It can consume your mind[10]
- There are lots of responsibilities[11]
- You have freedom when your job's done[12]
- You have to accept your work and love what you do[13]

Sickness

- Causes problems, makes you upset/unhappy
- Restless
- Worrying[14]
- Weak
- If you are sick you should move around, don't think you are sick, use your mind[15]

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[2] Reference to mental health and positive thinking
[3] Reference to mental health
[4] Reference to mental health
[5] Reference to mental health
[6] Reference to mental health
[7] Reference to mental health
[8] Possible reference to mental health
[9] Reference to mental health and positive thinking. Also revealing of cultural attitude towards how to stay healthy.
[10] Evidence of mental stress
[11] Evidence of mental stress
[12] Evidence of mental stress
[13] Reference to positive thinking
[14] Reference to mental stress
[15] Reference to positive thinking

- Medicine
- You can go to the doctor if you are physically sick but what if you have depression there's nothing they can do (We challenged this comment and discussed whether depression was a form of illness or not and that you can see your doctor for help with depression.)[16]

Following this discussion the group were split in two and one group were asked to make an image of a doctors surgery and the other were asked to make an image of a hospital. Observations made from these images were as follows:

Doctors: The workers that viewed this image took from it that it was a hospital not a doctor's surgery, although this may have been because the group tried to give everyone in their group a role in the image and not leave anyone out. Another reason why the image could have been confused with a hospital was that the image depicted a patient on a couch being attended by a nurse and a doctor. This might suggest that the workers associate going to the doctor's with more serious ailments and injuries rather than minor ailments[17].

In Image Theatre it is important to analyse the viewer's interpretation of the image even if this is different to the creator's intention as people project onto images what most concerns or affects them. Analysing what the viewers see can reveal their attitudes and feelings around a subject.

To find out what the viewers reactions were to the image I asked them some questions. Was this hospital in the UK or in their home countries? All agreed it was in their home countries. When I asked why they commented that it must be in their home countries because in England there are never that many people allowed in the hospital. The image showed two worried relatives in the room with the patient. The MDWs said that you couldn't have visitors in hospitals here.[18]

We discussed this, as clearly visitors are allowed in hospitals but we discovered that the problem was that they could only come at certain times (visiting hours) rather than whenever they wanted. MDWs said that at home the hospitals are less controlled and there are more friends and family around and that you are allowed to have a friend or relative in with you when you are being examined.[19] It was said that in the UK relatives/friends are asked to leave when it is time for you to be examined, even if you want them to stay. I asked the workers to change the image to make it into a UK hospital, at which point they moved the relatives right out of the main image and sat them down at the back of the room to wait outside the treatment area.

I asked the viewers if there was anything else they would like to change about the image to improve the situation shown. Changes made included making the patient lie right down on the couch (they had been sitting up before) and to make the relatives look like they were comforting each other more.

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[16] Reference to mental health. Also example of a barrier to healthcare, workers believe doctors cannot help them with depression/mental health problems.

[17] Possible revelation of cultural attitudes towards health i.e. you have to be really ill to go to a doctor; you don't go with just minor ailments. This could also be interpreted as a possible barrier to healthcare, if workers do not consider themselves to be ill enough to seek help.

[18] Possible barrier to healthcare. Workers have perception that you are not allowed visitors in hospitals in UK, which may make them feel vulnerable and more wary of being treated here.

[19] Evidence of cultural difference between healthcare in UK and workers' home countries.

Hospital: This group's image also showed a patient on a couch or bed being attended to by a doctor, with a nurse taking notes and a worried relative by the bed. There were also people waiting outside the treatment area, which the viewers interpreted as being other patients waiting for treatment. This time the viewer's said that it could be a hospital in the UK or in their home countries. I asked them if it depicted an ideal situation in the hospital or if there was anything they would like to change about the image. They decided to move the nurse from the room leaving the doctor to examine the patient and take notes himself, freeing up the nurse to see the other patients who had been left on their own to wait for attention.[20] MDWs talked about how you have to wait a long time to get seen in hospital.

Following this exercise we asked the MDWs to work in small groups to share stories about a time when they had had a problem to do with or because of health, not actual health problems. This was designed as a precursor to devising Forum Theatre where stories must show oppressions or situations that we can try to improve by changing the way we deal with them.

Out of all the individual stories the groups chose the story that had most resonance for them and used this to create an image or short scene. There were three groups and they presented us with the following images or scenes:

1. A series of images showing a woman who slips whilst cleaning the floor and damages her eye.[21] She calls the police but no one comes to help her.[22] She then calls a friend who takes her to hospital where they have to wait for hours to be seen.[23]
2. Image of an employer distracted by her two children who are fighting or playing boisterously, she is holding up her hand to the MDW refusing her permission to take time off to go for a blood test.[24]
3. A scene where an employer is sitting down being very relaxed and happy, there are three workers also sitting down, one is crying because she is worried about someone in her family who is sick, another is on the phone and another is reading a letter from someone in their family.[25]

These images revealed to me several themes connected with Migrant Domestic workers and health. These are as follows:

- Health and safety in the workplace.
- Knowing who to ask for help in an emergency (image 1 showed a worker calling the police rather than an ambulance, there may be confusion between which emergency services are accessible via 999), having to wait a long time for treatment in hospital.

[20] Barrier to healthcare. Workers may be put off going to hospital because they feel they will have to wait a long time to be seen.
[21] Possible evidence of a barrier to healthcare in terms of taking care of one's own health if accident can be put down to poor health safety awareness in the workplace.
[22] Barrier to healthcare demonstrated by calling police rather than ambulance. Is the accessing of all emergency services via one number '999' confusing for migrants?
[23] Possible barrier to healthcare, experience of waiting a long time to be seen might deter workers from using healthcare services in the future.
[24] Problematic issue for workers – not being allowed time off work for health appointments. Also a barrier to healthcare.
[25] This scene showed the mental stress for workers who are separated by long distances from their families, particularly where a family member is unwell.

- Not being allowed to take time off for health appointments.
- A sense that employers are relaxed and happy whereas workers who are often separated from their families are constantly worried about the well-being of their loved ones.

Some of the workers found exploring these problems a little upsetting as they currently had serious concerns for their families. However the workers seemed pleased with the workshop and feedback from health worker Sheela Valavi was also good although she expressed concern that the workers constantly referred back to problems with employers. I think this was a helpful observation as I had also sensed reluctance in the workers to devise work about health rather than about working conditions and had also begun to notice an inextricable link between workers' health and attitudes towards health and their working lives.[26]

One of the exercises we had done as part of the workshop required workers to make images of the activities they did at different times of the day throughout a twenty-four hour period. This highlighted the fact that many of them had little sleep and spent hardly any time during their day away from work.[27]

Sunday 25th April

Turnout for this session was poor and was put down to a number of people having had to cancel and also a clash with the attendance of the lawyer at Kalayaan. Based on the willingness to participate of the worker who did attend and our past experience of a number of people turning up very late, we decided to begin the workshop in the hope that more people would arrive and join in.

I began the session with ice-breaking exercises to create a safe space in the room for story sharing. Through story-sharing a theme emerged of illness drawing people together as you often feel a responsibility towards people if they are taken ill even if you are not close to that person normally.

We made images of a particular problem the worker had concerned with health. We looked at the problem of caring for a sick employer and the stress of worrying what would happen to a worker if their employer died through ill health or old age.[28] Camilla advised the worker of steps she could take to look for alternative work or training options. During this session my attention was once again drawn to health and safety in the workplace, as we discussed types of heavy work workers are sometimes expected to do such as lifting an invalid in and out of bed. Employers can rely on workers do perform such tasks without any training, assistance or lifting equipment.[29]

After one hour and a half of workshop no further participants had arrived and we decided it would be best to end the session, as we were limited to how much we could do with only one person without making them feel pressured or overworked. Camilla commented that she was pleased that we had been able to achieve something despite the small turnout and we discussed how it would be best to proceed to get the most out of the final workshop.

[26] Evidence of mental stress caused by work and work situation.
[27] Evidence of problematic issue related to health. Severe lack of sleep and time away from work could cause ill health.
[28] Mental stress caused by reliance on one employer for work.
[29] Evidence of poor health and safety knowledge, a possible risk to health.

After some consideration and a telephone call with Camilla during the week we decided that it would best to use a number of different exercises to get some more quantative results from the workers and not focus so much on using Forum as our main method to uncover health concerns amongst the workers. Devising Forum with the workers would require more time with the same group of workers attending each session. This is particularly true with the issue of health as Forum is difficult to explain to workers when there is an obvious confusion between oppression to do with health and the oppressive feeling of ill health itself.

<u>Sunday 9th May</u>

Our final workshop began with a large number of workers including a group of four male workers. Unfortunately all the men plus some others had to leave the workshop towards the beginning of the session, leaving us with a group of five workers.[30]

The first main exercise we did to uncover concerns around health was called 'Persuasion'. Workers were put in pairs and asked to decide who should be 'A' and who should be 'B'. I then gave each 'A' the task of persuading 'B' to do something and 'B' the task of resisting and giving arguments of resistance. Each pair was given a different theme of persuasion, which are listed in the table below along with arguments given by 'A' and 'B' in each pair. We then discussed which arguments were a true reflection of what a MDW would say in that situation.

Theme	A (arguments for)	B (arguments against)
Take your medicine	Important to take medicine. Some medicines are very good like Neurofen.	Allergic to medicine. Tastes bad. Side effects, stomach pain, constipation, diarrhoea.[31] Damages/irritates stomach, liver, kidneys if taken regularly or in an overdose. People aren't happy with medicine. Medicine doesn't give you energy makes you drowsy.[32] In this country medicine is very good but it kills energy.[33] Can't understand instructions: complicated and small type.[34] Hard to take medicine when you don't have time to eat as some medicines you have to take with food.[35]
Go to doctors	Better for you to go to doctors than not go. Medicine and	It takes too long to go to the doctors. Even when you have an appointment you have to wait for two hours. You have to get on a bus and sit in traffic and then you are late.

[30] Important to note that the input into these workshops has been primarily from female MDWs, only one male attended a full workshop.
[31] There was strong feeling about the side effects medicines have. Possible barrier to healthcare.
[32] Also strong feeling about medicines making you drowsy, or not giving you energy. Another possible barrier to healthcare.
[33] Further concerns about medicines affecting energy levels. Possible barrier to healthcare.
[34] Important consideration for MDWs who might find language on information leaflets provided with medicines difficult to understand.
[35] Further evidence of lack of rest periods or lunch breaks causing problems relating to health.

	exercise will make you feel better. You might not know if the medicine you buy is right for you, better to see doctor. Painkillers don't take away the problem.	Migrant Domestic workers don't have time to see a doctor. The Doctor's surgery is only open when we are at work. (Sheela raised the fact that there are free NHS 24 hour walk-in clinics)[36] You have to get time off to go to the doctor and it is difficult to get time off.[37] Painkillers make you feel better so you don't need to see a doctor.
Take more exercise	Gentle exercise gives you more energy and will make you feel and look better.	I don't have time I work from 7am to 7pm.[38] My work is already enough exercise for me.
Eat more healthily	It's better to eat more healthily.	I haven't got time to eat three meals and look after employers' baby and do housework. Too busy feeding others to feed myself.[39]

Following this exercise I put the workers in two groups and gave each group the task of drawing the outline of one group member onto the large piece of paper I had given them. I asked them to mark on the drawing with an 'X' any parts of the body where workers were likely to have a health problem or experience pain and then mark on the drawing with an 'O' any areas of the body that might be difficult for workers to talk about.

The markings on both groups' drawings were almost identical, except that one group had marked the head as place that a workers might have a problem and that might also be difficult to talk about and the other group did not mark the head at all.

Areas marked with 'X' were: the hands, shoulders, stomach, back, knees, feet and ankles. The workers explained these markings by saying that their joints are always moving, they are always gripping or carrying something, using their joints, and in particular the back and shoulders.[40] They also have to stand up for long periods. I asked if they had had any training about how to lift safely and most answered they had not.[41]

Workers said they had marked the head area because workers can have a lot of tension in their heads, thinking about work all the time,[42] not having enough sleep,

[36] Barrier to healthcare. Workers are not aware of opening times or existence of out of hours or 24-hour clinics.
[37] Problematic issue relating to health – workers have big concerns about the amount of time it will take to get to see a doctor and about not being able to get time off to see a doctor.
[38] Further example of workers not having enough time to themselves.
[39] Problematic issue relating to health – workers don't have time for meal breaks during the working day.
[40] Areas of the body problematic for MDWs.
[41] Problematic issue relating to health – lack of health and safety training could be detrimental to MDWs keeping healthy.
[42] Mental stress caused by work.

going to bed late, feeling tired,[43] getting headaches and migraines. They also said that workers might experience psychological problems.[44]

They said they had marked the stomach because workers can have stomach problems like ulcers because they eat late, they don't get a break to eat in and they might not eat till they get home at 8pm.[45] Some workers said they took food with them to work and this made it easier for them to eat during the day.

Areas marked with 'O' were the head, the breasts and the genital area. The women talked about how it is important to self-check breasts for breast cancer and said that it was embarrassing to talk about genito-urinary health problems, although they agreed it would less embarrassing to talk to a female doctor and they also mentioned that they could ask to speak to a specialist female doctor.[46]

The next exercise we did was called 'Where do you stand?' I put up five pictures along the wall showing different faces, two smiling, two frowning and one indifferent. I explained that for this exercise these represented Strongly Agree; Agree; Don't Know; Disagree and Strongly Disagree. I then read out different statements and the workers had to choose a place to stand to show their response to the statement.

I has spoken to Camilla in advance of this exercise and consulted her on what statements should be included. She had suggested to me that it might be a difficult exercise for workers to comprehend immediately so I did a number of test statements to begin with to make sure I had explained it clearly. Sheela also helped in the running of this exercise by translating for me where necessary. The results of the test statements were as follows:

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Migrant Domestic workers get too much pay			3 "pay is ok"	1	1
Migrant Domestic workers get too much holiday					5

We discussed the answers with the workers to ensure they understood how to register their response to the statements and also explained that they were just statements for the purpose of this exercise and did not represent my own opinions. The following statements were then read out and the responses recorded.

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
It is easy to live healthily		1		2	2

43 Problematic issue relating to health – lack of available time to sleep affecting MDW's health.
44 Evidence of mental stress suffered by MDWs.
45 Problematic issue relating to health – workers don't have time for meal breaks during the working day.

46 Embarrassment to talk about health problems in these areas could be a barrier to health care for workers but it did not seem to be a major issue for these workers as they were well able to discuss these issues in the workshop and seemed well aware they could ask for a female doctor.

It is easy to eat healthily	5				
It is easy to register with a doctor in the UK[47]		1 (if you tell them the right information)		2 (because they ask for Visa and passport and tenancy agreement)	2 (if you don't have a visa it is very difficult)
It is easy to find a hospital in the UK	5				
Medicines are good for you.[48]	1 (they are good for your health)	1		1	2 (they leave you with no energy and make you feel down)
Traditional remedies are better than other medicines.	2 (I've tried them and they're very good)	1 (I've tried them and they're good)	1 (I never tired them)		1 (I don't have anything to compare them to.)
The Health Service is better is my own country[49]	2 (Too difficult to get medical help here)			1 (They have more money to make home visits in my country)	2 (Better services for emergenci es in my country)
It is difficult to talk to a doctor about depression				2	3

I closed this session with a fun and relaxing drama game, to make sure we left on a positive note and to thanks the workers for their participation. Feedback from the workers was very positive and some commented that they had learnt more about health from the session.

It should also be noted that one of the workers arrived at the workshop feeling unwell and had to leave early, which sparked a discussion about where to get medicine or healthcare on a Sunday and Sheela gave the group information about local walk-in centres and pharmacies.

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[47] These results suggest that the system for registering with a doctor presents a barrier to healthcare for MDWs.
[48] Possible barrier to healthcare – perception that medicines leave you with no energy and are not good for you.
[49] Possible barrier to healthcare – perception that it is too difficult to get healthcare in UK, home visit are difficult here and emergency services are better in home countries.

Analysis

I will now look at how the workshops and my observations from these workshops have met my aims. Of my four aims I feel the easiest to meet was the question of promoting openness with the NHS and explaining that they are there to help. Camilla and Sheela did most of this work for me, as they supported my workshops with information about where and how to access NHS services. However, on Sunday 18th April we did start a discussion about health during which it was expressed that you couldn't go to a doctor for help with depression as there was nothing they could do. This was addressed and the workers were reassured that there are ways of dealing with depression and your doctor can advise you about this.

I also achieved my aim of exploring cultural attitudes to health and traditional remedies as outlined in footnotes 9,17,19,32,48 and 49 which highlight where I have uncovered cultural attitudes towards medicine and healthcare. Other possible examples of differing cultural attitudes towards health are shown in footnotes 2,9,13 and 15, which demonstrate the importance of positive thinking when it comes to staying healthy.

My main aims for this project however have been to identify issues around health the MDWs feel are problematic and also to identify barriers to healthcare in UK for MDWs. I have highlighted these findings with footnotes throughout the notes from the drama workshops but to make these clearer I will summarise the main issues and barriers that I have uncovered.

Issues around health that MDWs feel are problematic:
Mental stress caused by work conditions and separation from families.
Joint pains and problems with back and shoulders. Long hours spent standing up.
Stomach problems caused by stress and irregular eating patterns.
Long working hours, not enough time to eat, sleep, or relax.
Lack of meal breaks during working day.
Not enough time off or flexibility within working hours to keep health appointments.

Barriers to healthcare (and staying healthy):
Perception that it is difficult to register with a doctor or get healthcare.
You have to wait a long time to be seen at a hospital.
It takes a long time to go to the doctors.
Perception that doctor's surgeries are only open whilst MDWs are at work.
Perception that medicines make you feel less energetic.
Concern about side effects of medicines.
MDWs have little or no health and safety training to help protect them in the workplace. The problem of heavy lifting without training is particularly relevant.
MDWs do not have time to rest or eat properly which could lead to ill health.

Conclusion

Although drama is a subjective and non-exact means of uncovering issues amongst MDWs I do feel the workshops have helped to expose some important issues. For

me the findings that require most urgent action are the issues of mental stress and depression encountered by workers; lack of awareness of how to access healthcare; lack of health and safety training; absence of meal breaks and working hours that do not allow a suitable rest break between working days or a suitable number of rest days or holidays.

I should reiterate that this report was based on work with pre-dominantly female workers, male workers being underrepresented at these workshops.

Objective 2 **To form an advisory group of migrant domestic workers to assist in guiding and promoting the project**

Target 2 **At least 5 migrant domestic workers to form an advisory core group to meet c. 3 times each year**

The migrant domestic workers who participated in the forum theatre workshops will also be invited to form a core group to meet throughout the project to discuss the direction and effectiveness of the project. The workers involved will receive expenses for travel and refreshments. They will also have access to training courses (IT, ESOL etc.) if necessary to develop their skills. There will be a preliminary meeting before the forum theatre workshops to explain the project and discuss the year. The core group will take ownership of the health pack (objective 3), take part in the mid-term and final evaluation and also help to promote and organise events. This will help to ensure that the project is client-led and relevant.

Date	Meeting	Attendance	Topics discussed:
15.02.2004	Advisory Group	Total 5: 5F • 1 Sri Lanka • 1 Indian • 1 Filipino • 1 Indonesia • 1 Nigeria	• Introduction to the project in general
05.05.2004	Advisory Group	Total 5: 5F • 1 Sri Lanka • 1 Indian • 1 Filipino • 1 Indonesia • 1 Nigeria	• Health information packs. • Discussed the results and feedback of tl drama workshops.
21.12.2004	Advisory Group	Total 5: 5F • 2 India • 2 Sri Lanka • 1 Indonesia	• Distributed the completed health information packs. • ESOL for health classes • Discussed topics for health workshops: the group identified a need for physical exercise classes which they could atten at reasonable cost in the local area.
4th July 2005	Focus Group	Total 23: (21F: 2M)	• Discussed topics for health workshops • Discussed timing of workshops.
14.11.2005	Focus Group	Total 23 (19F: 4M)	Health Survey • Workshop feedback • Health information request • Activity request
12.11.2006 (1)	Focus Group	Total 26: (25F: 1M) • 6 Indonesian • 9 Indian • 2 Filipino • 6 Sri Lanka • 3 African	True or False- Health Questionnaire Health Survey • Knowledge and experience of health service • Barriers • Concepts of mental health

12.11.2006 (2)	Focus Group	Total 6: (8F) • 3 Filipino • 1 Nigeria • 1 Benin • 2 India • 1 Peru	True or False Health Survey • Knowledge and experience of health service • Barriers • Concepts of mental health
Total number of MDWs participated in Advisory and Focus Groups: 93 (86F: 7M)			

The project began with an advisory group comprising representation of the major nationalities of MDWs (Sri Lankan; Indian; Filipino; Indonesian; African). The group was self-elected via informal discussions after the Monday morning job workshop and during social activities in the centre. The group was able to formally meet twice, however during the second meeting the group expressed difficulties with being able to commit. This was generally explained as to lack of time off; long working hours and changes in employment location. The third meeting involved a more ad hoc attendance during which it was suggested the health meetings should be more flexible and try to merge with other activities already taking place within the centre. Topics discussed in these focus groups can been seen in the table above.

The remaining focus groups took place in accordance with the Monday morning job workshops and Sunday morning ESOL classes. Both these forums attracted a large number of MDWs. The Focus Groups were managed by splitting the large group into three, each facilitated by a staff member or volunteer of Kalayaan. Where possible we tried to group people with people from the same language group so there could be community interpretation for those who do not speak English. There were broad topics all the groups followed, and both qualitative and quantitative date was collected.

Summary of 14.11.2005
On 14th November 2005 the focus group looked at health, immigration, employment and feedback on the community centre. Twenty-three MDWs participated, four of which were male. Nine out of the twenty-three said they were registered with a GP. Only three people could remember attending a 'health' workshop at Kalayaan- these included 'exercise classes', 'information about food with less fat', 'back pain', 'diabetes', 'breathing', and 'information about eyes'. Workers indicated they would like to have workshops about 'healthy eating', 'health and safety', 'worried about winter flu' and 'everything'. 13 people out of the group said they would like exercise classes, and there was unanimous agreement that these should only take place at the weekend, preferably in the evenings.

When later asked if people knew what 'sick pay' was, seventeen of the group said 'yes'. When asked if anyone had accessed this service they found this question quite amusing, with a general agreement that the only option was to 'not get sick'! Workers then explained that if they were sick their employers would probably sack them straight away and the likelihood of getting sick pay remote. It is interesting to note that when asked how many workers had accessed immigration advice at Kalayaan the answer was thirteen compared to the answer of three for health.

Thirteen of the workers said they had accessed classes at Kalayaan, and only two said they had accessed other learning opportunities outside of the centre. The entire group said they were interested in further study of the following list: 'cooking' (18), childcare'

(11), 'first aid' (15), 'numeracy' (9), 'literacy' (15), 'caring' (4), 'driving' (9). When asked what would be the best time to access the classes, eight workers suggested during the weekday evenings, whereas 19 of the group said the best time would be Sunday afternoons.

Summary of 12.11.2006
The final focus group took place on 12th November 2006 comprising a total of thirty-four workers split into four focus groups. Volunteers were recruited for the facilitation and feedback. These particular focus groups were designed to be an overview of the project; to evaluate its successes and to understand what future health work is needed.

The focus group started with a warm up of 'True or False' questions about health topics. This was a 5-minute game that helped people to start thinking about health.
The groups then followed the same broad topics as defined below, with both qualitative and quantitative date recorded:

- To understand MDWs knowledge of and experience of health services in UK;
- To understand the barriers that MDWs face when interacting with health services;
- Understanding and perceptions towards mental health;
- What health activities/support have MDWs been involved with at Kalayaan?
- What health activities/support would MDWs like at Kalayaan?

It is important to note when reviewing the feedback that the workshops took place during the Sunday morning ESOL class and in conjunction with a media training workshop. To this extent the workers who participated in the workshops would, as a generalisation, be described as the least marginalized, with better English skills, and better ability to negotiate bureaucratic systems.

Summary of feedback
Of the 34 participants, 20 were registered with GP's. 10 had accessed other services such as breast screening clinics and opticians. Generally seemed to people know the cost of things 'GP is free. I like my GP. He is a nice gentleman', although many people seemed confused over the cost of dentists and opticians.

Barriers
We then explored the barriers that workers might face when accessing healthcare, starting with language. There was an expected varied response. Some workers said they doctors from the same country as them, which made communication easier but could often pose different problems. Other people said they would try and take someone along to help explain. Feelings towards interpreters were further mixed- some said they were comfortable with this idea although one worker said 'I can use interpreter. But he is bad. My health is private. I do not want to use and interpreter. Do not trust interpreter. Prefer to speak English'. However, it was clear that language was an additional factor to overcome and for some could prove stressful, 'When I go to the doctor I have to prepare what I want to say- I must write it down with the right words', but in more extreme cases it might serve to avoid the appropriate health service altogether, 'I had a headache and tension and so went to hospital. But I am to scared to go to my GP- cannot speak good English for him to understand'.

Surprisingly it was only members of focus group 2, said that time off to go for appointments could prove difficult. I had expected this to be a more commonly held complaint because this was often the feedback from other workshops and individual advice sessions. Again, this might be a reflection of the level of autonomy the workers had in being able to access these workshops in the first place.

Health literacy seemed quite high among the groups. Although there was a confusion about the need to ask for so much information on registration. One worker suggested that if she could afford to go private, then they would not need to ask for this information. There was also confusion over documents required for registration with many workers explaining they hadn't registered because they didn't have a National Insurance number.

Immigration status or 'visa problem' was a factor that had affected all workers at some stage either presently or in the past. Some workers stated 'cannot register with GP until visa renewed', or ' want it but problem with visa. Want to go and see dentist but cannot register- visa problems'. Another worker with a rare category of MDW visa said 'If I have a problem is it free? I don't know where to go, I am confused. My visa is diplomatic. Am I allowed? My employer does not help'.

Lastly proof of address was a possible barrier raised by the facilitators because this had been raised during other health events. One group agreed this had not been a problem, another group said this was a problem because people did not have utility bills in their name, whereas another group said they had been able to register but were then asked for proof of address which they didn't have.

Mental health

In answering 'what is mental health?' all of the groups to chose to focus on mental ill health. Their descriptions varied from association to practical problems i.e. 'no job, no money, house problem' and the pressures of needing to send remittances home, 'sometimes going mad- school fees'. Many people referred it to accumulative pressures 'when all your problems come together and you can't cope', 'I don't sleep at night. Too many worries in my head'. There were also references to a lack of time or rest 'no freedom, not time', 'lack of rest, to much work' and others related it to feelings of isolation 'problems- no-one helping', 'loneliness –nobody to go to when you feel ill'. However, there were some answers which saw it as something that could exist as a separate issue in its own right 'you are crazy- going mad', 'mental health is –madness; stress', and one worker said 'sometimes it is hard to say what is wrong even in your own language'.

There were multiple answers about people's coping strategies with this. These were broadly defined into the following five categories: religion, friends and family; activities; professionals; and medication.

Religion: 'meditation. I am a Buddhist. I meditate. Space to clear the mind', 'I read the Koran when I have problems', 'nobody helps with your worries except God'.
Friends and family: workers displayed strong and conflicting feelings about this with many suggesting taking to friends would be helpful 'good to talk to other domestic workers, they have similar problems', 'being in company is the best way to forget your worries'. Whereas another worker said 'cannot talk to friends' and someone else suggested 'talking to family is bad. It makes pressure worse. Cannot tell them about the problems.'
Activities: a number of activities were listed including 'go shopping', 'listen to music', 'sleep and rest', and 'crying makes me feel better'.
Professionals: one worker immediately suggested that she would 'talk to a psychologist', however most people had not heard of counsellors. When the facilitator in one group explained that they were people who could listen to your problems, half of the people in the group said they would consider going. One worker expressed strong feelings about talking to her GP, 'can't talk to doctor- what will he do? Nothing.'

What health activities/support have you been involved with at Kalayaan?

Very few people could remember being part of health related activities although five out of eight people in one group had joined in the aerobics class. Greater reference seemed to be made to coming to the centre for ESOL classes, immigration and employment advice the main reason given because it was free. One group said they did not think of Kalayaan as a place they could go to it they needed advice about health, although within the same group a worker added they would come to Kalayaan for advice if their doctor could not help.

What health activities/support would you like at Kalayaan?
People mentioned having access to a gym and there were reoccurring requests for exercise/yoga classes. When the facilitators actively sought what health information people would like suggestions included 'we would like a doctor to come and talk to about general health problems', 'someone everyone could ask for advice about where to go for what'. Specific requests such as information on how to eat healthily; registering with a dentist; back problems and blood pressure were also mentioned. However, the main requests that people raised were ESOL classes, computer courses, information about tax and National Insurance etc.

As with the workshop on 25th November 2005, all the workers agreed the best time for them to take place would be Sunday afternoon.

Objective 3 To develop a health pack for all newly arrived migrant domestic workers

Target 3 c. 500 packs to be distributed over project

The advisory group will develop a health pack with the health project worker. Information and feedback from the theatre workshops will be incorporated. The pack will include previously devised health leaflets and information from the local health trust. Where possible leaflets will translated into community languages. The health project worker will also research and/or produce pictorial health resources for clients who are illiterate. The packs will be distributed by the advisory group, the health project worker and other advisers to new clients upon registration at Kalayaan.

The first step was to identity the topics to be included in the health information packs. This information was collected from the advisory groups, whilst also incorporating feedback from the drama and health workshops. The following topics were identified:

- Access to primary health care
- Dental Treatment
- Healthy Lifestyle
- Weight management; eating healthily
- Blood pressure
- Back pain
- Stress

There were a number of topics that were not raised by MDWs e.g.: Depression; Breast Awareness; Cervical screening and Sexual health. This could possibly been a result of the taboo nature of these topics and possibly the environment in which they were being discussed- the social area in the community centre. However when these issues were actively raised, people agreed that they would like some information relating to these topics.

Secondly it was important to identify the languages that people would like the information to be translated into it. Workers had discussed the amount of pictoral information they desired, and felt that it was preferable to have as much information translated as possible, so there would be more that people could understand. The following seven were selected: English, Sinhala; Indonesian; Malayalam, Kannada, Tagalog,Tamil. Research revealed that there was almost nothing translated into any of the languages identified therefore it was agreed that to produce a pack initially in English, and for this to then be translated into the identified languages en masse.

The volume of information combined with the number of languages greatly exceeded the allocated budget. As a result, I employed students to translate the booklets. Initial feedback on the translation was excellent, however it has later transpired that the Kannada, Malayalam and Tamil translations have a number of spelling mistakes. However, those who read these particular languages have also said that they can still read the booklets and find them very helpful!

We printed a total of 1650 leaflets to cover 3 years worth of newly registered MDWs based on approximately 400 workers registering each year.

Language	Number printed	Number remaining	Number Given out
English	400	157	243
Tagalog	300	135	165

Indonesian	200	128	72
Konkini	200	165	35
Malayalam	200	116	84
Tamil	150	58	92
Sinhala	200	103	97
Total:	**1650**	**862**	**788**

Over the course of the three years, a total of 788 booklets have been given out, just under half of the total. The booklets were initially given out to MDWs when they registered in the office. We later decided to leave a number of booklets in the main community area where people could take them themselves. We have observed that the booklets are very popular and often find people reading through the material as they wait for their appointment. When we have asked for feedback on the leaflets people have commented 'it is really nice to see something in my own language,' 'I never see anything in UK in my language', 'there are lots of mistakes!'

This has highlighted the need for more information in workers own languages and we have recently raised funds to translate all of the registration material into the workers own languages.

Both in response to the success of the health leaflets and also to reflect the changing demands of the GP surgeries on registration, Kalayaan aims to raise funds to produce another set of leaflets with more up to date information in community languages.

I have attached the English leaflet here and the translated booklets in the appendix.

Objective 4 **To hold 'ESOL for Health' workshops**
Target 4 **Basic English for accessing health systems, together with information on health for newly-arrived workers (12 workshops for approx 15-20 workers)**

All newly-arrived migrant domestic workers will be invited to attend one or more 'ESOL for Health' workshops. Approx. twelve 3-hour workshops will be held during the project with approx. 15-20 workers attending each one. The workshops will be collaboratively planned by the health project worker and a qualified ESOL teacher. A model course will be produced that can be disseminated to other community groups (including registration with GP, when and how to use accident & emergency services, NHS Direct, reading medicine bottles, prescriptions etc.).

In the first year, I met with Lucy Rix a qualified ESOL teacher and it was agreed that the she would take the project on for the next three years. The ESOL teacher had also worked at Kalayaan for seven years previously, so had considerable knowledge of issues affecting MDWs. There was a more holistic focus towards health than identified in the initial project proposal. Topics of importance ranged from how to call the emergency services, how to register with a GP, to how to use public transport in order to get to the GP surgery.

We agreed to structure the twelve classes into three groups of four, with one group taking place each year. The classes were organised to take place on four consecutive Monday's in conjunction with the job workshops. This would ensure the classes would be available to the most vulnerable client group. The aim was for the same 15-20 clients to attend the 4 consecutive classes. Each class lasted 3-hours with a break.

Unfortunately the teacher fell sick after the third class so an additional fifth class in basic literacy was scheduled for the following year. The teacher discovered that whilst many clients had some grasp on basic spoken English, very few were at all familiar with the alphabet and basic literacy. In total an average of 13.5 clients attended each class (slightly lower than our target).

ESOL for health 2004		
Date	**Attendance**	**Topic**
Monday 4th October 10am-1pm	Total 15 • 2 Filipino • 5 India • 5 Sri Lanka • 2 Indonesia • 1 Nigeria	Basic literacy to access healthcare in the UK
Monday 11th October 10am-1pm	Total 13 • 5 India • 6 Sri Lanka • 1 Indonesia • 1 Eritrea	Basic literacy to access healthcare in the UK
Monday 18th October 10am-1pm	Total 12 • 6 India • 1 Nigeria • 5 Sri Lanka	Basic literacy to access healthcare in the UK

Monday 25th October	CANCELLED DUE TO ILLNESS • run additional workshop in next semester

The following year, Lucy Rix explained she could no longer make the commitment so an alternative teacher as found. Unfortunately however he was taken ill at the last minute and was unable to make the commitment.

The classes were rearranged into a series of 12 two-hour classes on Saturday afternoons starting in February. A qualified ESOL teacher, Donalie Halstead, was recruited. Donalie was particularly well suited for the role due to her health background, employed as a Community Health Development Coordinator for Westminster PCT. Again, the aim for the course was to take a holistic approach to health enabling increased social inclusion. In addition the course was aimed at, although not exclusive to, those who were not eligible to access government funded classes (ie those who have been in the UK for less than 3 years).

A total number of 13 different clients attended the classes, 6 of whom attended 60% or more of the classes to whom we gave certificates to acknowledge their commitment (see Appendix). The overall attendance of the classes, on average 5 per class, was significantly lower than the targeted 15-20 per class. Feedback suggested that the time of the class was not convenient for many workers who would have liked to attend, preferring to have the classes take place on a Sunday afternoon. Unfortunately, due to space and financial restrictions we could not find an alternative suitable venue.

Below is the report by the ESOL teacher.

Report on ESOL FOR HEALTH classes held at Kalayaan.

4th February 2006
Greetings and Biographies: (Total 3F)
This being the first class I aimed to establish the levels of English of the different students. Some were stronger at speaking and produced stronger written English Grammar and pronunciation techniques were used in the this first class to illustrate the tasks which included matching words and numbers, finding out about each other and reporting back to the wider class. Writing a paragraph about themselves.
All students were engaged with the tasks and had sufficient time to ask questions.

11th February
Money: (Total 7: 6F:1M)
This class focused on the different forms of money including cash and credit. The lesson covered budgeting and goal setting. These issues were particularly pertinent to the students as some of them budgeted to send money back to relatives. Some said improving their English meant they could also improve their financial position.

18th February
Signs/Form filling (Total: 6: 4F:2M)
Helping students to understand the signs we see in our daily lives such as no smoking, no entry etc. Students completed exercises from pictures, which gave information eg: supermarket parking and Royal Mail collection times.

The second part of the lesson looked at how to fill out application forms for libraries, jobs etc. Everyone found this useful, as they were keen to join libraries and apply for jobs in the future.

25th February

Laying the foundations for a healthy life (Total 6: 4F: 2M)
This class looked at students experience and understanding of a health lifestyle. Students came up with a variety of things such as diet, different types of food, leisure activities and stress. They talked about how they dealt with stressful situations. Some students talked about personal health issues and I was able to give some general information.

4th March

Calendars and dates (Total 5: 4F: 1M)
Students completed exercises on planning and timetabling. Learning that there are two ways of writing a date and that when spoken a date needs st, nd, rd or th at the end of them.

The second part of the lesson looked at 'will' and 'going to'. Students had lots of verbal and written practice.

11th March

Employment Rights (Total 4: 2F: 2M)
Employment Rights were explained to students. The minimum wage and the British education system were also explained. The use of libraries to obtain information was discussed as an example of where to go to obtain information and get free use of the Internet. These topics caused a lot of debate. Some people explained their own personal situation. One person in particular praised all the help she received from Kayalaan when she had issues with a former employer. They were left with the importance of knowing that they had rights and should be aware of them to act their own best interest.

The class also did several exercises on the use of the past tense.

18th March

British Health Care System (Total 5: 3F: 2M)
The health care system was explained to students. Students discussed how to access nurses gps, nurses, dentist's accident and emergency.

The class also covered the vocabulary to do with computers. By the end of the class students were able to identify the words relating to the different functions of a computer. They also completed an exercise that role-played problems with the computer and how to sort them out. This class was very relevant, as some students had been attending computer classes at Kalayaan.

25th March

British Isles. Use of the Yellow Pages (Total 4: 3F: 1M)
An explanation about the United Kingdom and a discussion of the four countries within it, England, Scotland, Wales and Northern Ireland took place in this lesson. This was to help the students get an understanding of how where they lived fitted into the wider picture.

However, most of the lesson was about the use of yellow pages. This was particularly useful as most people in the class were domestic workers. The aim was to give students the skills and confidence to obtain workmen to mend problems in the home such as plumbers.

1st April

Comparatives and Superlatives. Celebrations (Total 8: 6F: 2M)
Students were invited to look at pictures and then begin to make comparisons eg: big, bigger, and biggest. Students completed worksheets and made sentences using what they'd learnt.
Students talked about the festivals and celebrations in their home countries and learnt about British festivals including Easter. Students brought in food and mini Easter eggs were shared.

10. 22nd April
Contracts (Total 5: 4F: 1M)
Students were asked what they understood by the word contract. They all came up with different types including employment and tenancy agreements. They also learnt vocabulary such as employer, employee, and termination. The identified the meanings of these words. Finally they looked at an employment contract and then answered questions about it.
There were ensuing discussions about students' own contracts and whether they had clear guidelines about their duties.

11. 20th April
Drowning in money (Total 4: 3F: 1M)
Students read a newspaper article, which described an island in the south Pacific that due to global warming will be underwater in the next 15-20 years. The islanders sold their Internet domain name to a communication company in California.
Students learnt the domain names for several countries. They learnt vocabulary and definitions, they found information in the text, they did a comprehension check and found adjectives e.g.: very, very small = tiny.
Discussions about different countries and their situation in the world took place.

12. 6th May
The British Electoral System (Total 4: 3F: 1M)
Students were given an explanation of the electoral system in Britain. This included the general elections, European elections and local elections. They learnt how often these took place. Students were informed that local MPs and councillors were also people that could provide help and where to access them.
The second part of the lesson on going over nouns, verbs and adjectives to ensure students could identify them correctly. Students did this by reading a story, explaining to the class what the story was about and then classifying the language.

Students appeared engaged in each lesson. I always received feedback and they asked lots of questions about things they had picked up in their everyday lives but didn't understand.
The lessons took an inclusive approach and had health and well being at it's centre.

Donalie Halstead
May 2006

Objective 5 **To hold seven 2-hour workshops on specific health issues.**
Target 5 **15-20 migrant domestic workers to attend each workshop**

The workshop topics will be chosen by the migrant domestic workers through the advisory group of migrant domestic workers, one-to-one contact with the health project worker, surveys and monitoring of workshops. During the last health project, migrant domestic workers requested workshops on accessing NHS services, mental health, sexual health, back pain, menopause and first aid. Specialised health professionals will be approached to provide workshops (using prior contacts with K&C HA).

The agenda for the workshops were devised from a number of sources: from meeting with the advisory group; using the feedback from the drama workshops; one-to-one advice sessions; and free training and workshops provided by the local Primary Care Trust- Kensington & Chelsea/Westminster.

As previously identified, the ideal time to run health workshops are in conjunction with other events/workshops also taking place at Kalayaan. All of the workshops identified below were run either before or during the 'job workshop' that takes place every Monday morning from 11am in the centre.

In total we ran eleven workshops on health, exceeding the project quota of seven.

Health Workshops at Kalayaan

1 Accessing Primary Health Care: Facilitated by Camilla Brown, Kalayaan
24th November 2005

- What is the NHS?
- Who is eligible for free treatment?
- What services are available under NHS?
- How to register with a GP
- What happens if they reject me?
- What happens when I am registered?
- Translation Services
- Dentists and Opticians
- Emergency Treatment: Minor Injuries Unit/ A&E
- NHS Walk-in Centres
- NHS Direct
- Health advice at Kalayaan

Total: 23: F18, M4 (Indian 9; Sri Lanka 4; African 2; Filipino 6; S. America 1)

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2. ***Cervical and Breast Screening: Kensington and Chelsea PTC***
14th February 2005
Workshop took place in a separate room to ensure it was a female only environment. Facilitator discussed topics in culturally sensitive manner. Information on where to access services were given out. Participants were able to ask questions.

Total: 15 all female (Sri Lanka 6; Filipino 2; Indian 4; Indonesia 3)

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3 *Dentists/Opticians*: Camilla Brown- supported by K&C PCT
21st March 2005

- Understand what is NHS what is Private.
- Who can access what...
- How to find dentist/optician...
- How much will it cost?
- Complaints procedure.

Total: 28 F21, M7 (Sri Lanka 7; India 15; Indonesia 2; Filipino 2; Africa 2)

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4 *Mental Health workshop:* Karen Katz and Tami Green from K&C PCT
23rd May 2005

Migrant Workers Workshop

Report by Karen Katz
Aim:

The aims of the workshops were to:
1. To raise awareness about mental health in particular depression and anxiety; symptoms, causes and stigma.
2. Look at what can be done to encourage mental well being.
3. To provide an opportunity for the members of this group to express and explore their feelings.
4. Provide information about relevant PCT and Community services.

Method:
Symptoms of depression and worry explored through open discussion and small group work.
Options of how to improve mood and well being were explored interactively with the use of case studies and visual aids.
Leaflets about local resources were given out at the end of the session.

Issues Arising:
Many of the participants spoke quite openly about their feelings. The following are some of the reoccurring themes:

- Missing family
- Worry about finding a job
- No energy
- Difficulty sleeping
- Aches and pains
- Money worries

When discussing ideas for improving mental well being, participants expressed interest in the following approaches:

- Relaxation
- Exercise
- Healthy eating options.

There were positive reactions to the idea of talking, to friends or counsellors, about their feelings. This was accompanied by concerns of talking to 'trustworthy' people who would offer good advice and be non-judgemental.

There was less interest in GP involvement in care, or medication.

Comments

Facilitators:

- There was a high level of interaction and engagement throughout the workshop.
- Participants were appreciative and expressed that the workshop had been very useful to them.
- There was a higher level of English then expected, which allowed for a more open debate and discussion than anticipated.
- The workshop raised interest in physical activity – discussions in groups encouraged the starting of salsa classes the following week.

General Feedback:

An important point to come out of workshop is the need for community building projects. Everyone really pointed out that one thing that makes them feel happier is coming to Kalayaan- it is a safe place where people understand their problems but where they can also laugh with friends. Everyone said that they would want to have more activities.

Total: 18: F16, M2 (Filipino 7; Indian 6; Sri Lanka 5)

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5 Ethnic healthy eating:* Diane Hawdon/ Eve Bevan from Shepherds Bush Healthy Living Centre *workshop:

6th June 2005

- Discussed and explored how to have a healthy balanced diet.
- Interactive game exploring what people eat in diet.
- Discussed cheaper healthy foods
- Explained about 5 portions of fruit and veg per day
- Explained necessary for most of diet to be from Carbohydrates and Fruit and vegetables.

General Feedback:

Facilitators were excellent. The language used was exactly at right level (although most of DW's that day were of a high level of English). Length of workshop was good- facilitators responded well to clients concentration drift towards end- they invited DW's to eat food and still asked more questions and were available for questions over food.

Facilitators had both travelled to India and Sri Lanka and were helpful in their knowledge of ethnic diets, and asked questions of the comparison between diets in UK and home. Most DW's said they would eat more bread in UK than at home.

- Diana suggested running a workshop on diabetes.

Total: 20 F18, M2 (Filipino 5; Indian 6;Sri Lanka 7)

***6. First Aid Workshop: Basic living saving skills:* Red Cross Hammersmith**

26th June 2005

The course was designed specifically for MDWs incorporating issues around care for children and elderly. In addition the course focussed less on written material factoring in the limited literacy skills of some of the clients.

The feedback from the course was excellent and we have since had requests from those attending for repeated workshops.

One MDW who attended later called to explain that she had been able to use her life saving skills on her elderly employer who was choking. When the paramedics later arrived on the scene they said that the MDW had saved her life.

Total: 9F(African 4; Sri Lanka 3; Filipino 2)

***7. Back care workshop:* Valerie Brandon K&C PCT**
25th July 2005
Valerie discussed the common causes of back pain and brought a skeleton model to show how the back was connected. MDWs enjoyed the workshop and particularly enjoyed being able to ask questions about problems they were encountering. Many MDWs said their backs were strained because they were constantly having to carry children or move the people they were caring for- Valerie was able to show how to lift safely without damaging your back.

Total: 35F (Indian 16; Filipino 7; Sri Lanka 11; Indonesian 1)

***8. Personal Safety in the workplace:* Rif Sharif: Challenge Consultancy Ltd**
12th September 2005
The workshop was organised in response to a number of incidents of assault by employers:
The aims were to:

- Inform clients of places to turn to in case of such an incident; how to report it and what to expect of the police; organisations that can give more specialist support and counselling.
- More general self-awareness and safety consciousness in the workplace
- Discuss issues of power and abuse of power
- Practical information about things like emergency contraception.

All of the clients said they had enjoyed the workshop, although half of the group said they had difficulties understanding all of it. The whole group said they would like more information on this topic.

Total: 38F (Indian 20; Filipino 11; Indonesian 1; Sri Lanka 5; Nigeria 1)

***9. TB awareness session:* Camilla Brown- supported by K&C PCT**
22nd May 2006

Total: 13F: 1M (Indian 5; Filipino 4; Sri Lanka 3; Mongolia 1; Bangladesh1)

***10. TB awareness:* Camilla Brown- supported by K&C PCT**
12th June 2006

Total: 11F: 1M (Indian 6; Filipino 2; Indonesian 2; Sri Lanka 2)

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11. Flu & Antibiotic Health Session: Camilla Brown supported by K&C PCT
30.10.06
Total: 18F: 1M

Objective 6	**To inform GP practices in London, in areas where migrant domestic workers live, of the particular issues relating to migrant domestic workers**
Target 6	**Information sent to 50 GP surgeries**

The health project worker will devise an information pack for GP surgeries on the specific needs of migrant domestic workers (with detailed outline of immigration issues) to inform surgeries and ensure that migrant domestic workers can access GP surgeries. Articles with similar information will be sent to appropriate health sources for GPs (e.g. Doctor, Health Service Journal etc.).

This area of the project has not been completed, however significant work has been done in this area. I have repeatedly documented the increased barriers encountered by domestic workers when trying to access primary health care.

At the start of the project I drafted a letter that MDWs could take with them when they tried to register with a GP. The letter outlined their rights to access primary health care. I would provide the worker the name and address of the four nearest surgeries to them and ask them to try each with the intention of registering with only one. It soon became apparent however that barriers in addition to those of language and proof of address were being presented. Questions over eligibility and documentation were repeatedly being raised. These can be more clearly understood in line with the National Health Service (Charge to Overseas Visitors)(Amendment) Regulations that were published in 2004. The vague guidance on the DoH website with regard to the meaning of being 'ordinarily resident' and conflicting opinions held by practitioners and PCT's prevented me from producing guidance which could later prove to be incorrect.

There is no specific guidance relating to Migrant Domestic Workers on the DoH website. In the Home Office Immigration and Nationality Directorate booklet 'Information about Domestic Workers' on page 8 it asks:
What if I need medical attention?
'You are entitled to free healthcare from the United Kingdom Health service because you are ordinarily resident in the UK. This means you have either come to the UK to work or your have been in the UK for more than 12 months. You will need to register with a doctor to receive free treatment'.

In response to this, in December 2005, I contacted all PALS teams across London to ask for their understanding of Migrant Domestic Workers eligibility to access primary health care. The results were a shocking collection of contradictions and inconsistencies, which again seemed to hinge upon the interpretation of the term 'ordinarily resident'.

'Generally speaking entitlement to NHS treatment centers on establishing whether the patient is 'ordinarily resident' in the UK "Ordinarily resident" is a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled'

The answers ranged in confidence of their own interpretation of the guidance. At one extreme for example *'A court decision as to who can be considered as 'Ordinarily' resident here concluded that anyone staying for 6 months or less <u>would not fulfil that</u>*

criteria. *As a result of this and for practicality the qualifying period of 6 months is applied in considering any registrations*' this same view is supported by another PALS team in their reference the 'LMC guidance which states '*ordinarily resident is anyone that has been in the UK 6 months or more*'. On the other extreme there was a self-professed confusion '*I'm not sure from when the worker would be considered resident - from the outset of his/her residence in the UK or until 6- 12 months had passed!*' and '*However, the guidance is not terribly clear and so it is possible that some practices will take it to mean that someone has to have lived here for six months, before they can be eligible to register*'.

When determining who was NOT eligible certain PALS teams showed a clear personal interpretation of the rules '*With regards to domestic workers or any other person/s here for 6 months or less, I can only say they do not qualify for free elective NHS Primary Care/GP registration. They are however only eligible to emergency care (A&E) or Immediate & necessary care (it is entirely a clinical decision of the health professional). As these category of applicants do not meet the NHS criteria for elective care, I would say the onus is on the family who brought the domestic worker to the UK to provide private health care for their worker for their short stay… Students on a course of 6 months or less are not eligible to free NHS care so I cannot see why one would look at domestic workers here for the same period any differently*'.

There were then further additional requirements highlighted by some PALS teams for example '*I'm sure that you already know that in order to register with a GP the worker must provide evidence that they have a "right to live here" such as a work permit or proof of employment (wage slip, contract of employment etc)*' and '*They can see any patient on a more permanent basis if they intend to stay in the UK for more than 6 months and are contributing through NI contributions*'.

These findings clearly articulate the need for greater clarity.

In response to this I wrote to the Department of Health, including my findings, to ask for greater clarity. The response from the Customer Service Department repeated the definition of 'ordinarily resident'. The only further explanation was the following:

'For the purposes of public health entitlement in the United Kingdom, it is considered to apply to those who spend the majority of any twelve-month period inside the UK. It applies from the date of arrival, although GP surgeries and Primary Care Trusts (PCTs) will often require documentation proving the intention to remain within the United Kingdom for more than six months'.

I replied to this requesting clarity on a number of issues but particularly the period of time:

'If someone needs to provide evidence that they shall remain in the UK for more than 6 months, does this then mean that people who come to the UK on a 6 month domestic worker are NOT entitled to access the NHS? You state that they would need to provide evidence that they shall be here for more than 6 months. What evidence would be sufficient? MDWs are rarely, if ever, provided with contracts stating the length of their position; the Home Office will not provide a statement that the person shall remain in the UK other than issuing the visa after they have submitted their application; the employer can provide a letter to state they wish to continue employing the domestic worker but it shall always be pending the result of the visa application. Similarly someone on a 12-month visa, who is in the latter 6 months of that visa will share the same problem as above'.

The response from the DoH was even more confusing and essentially stated that someone who was on a visa for 6 months or less was not eligible, however the discretion would always lie with the practice:

> *'To clarify the situation, in order to register as an NHS patient at a GP surgery, an individual must prove their intention to remain in the United Kingdom for more than six months. A person with a visa issued by the Home Office for a period of not longer than six months is not usually eligible to register for NHS services, regardless of whether they intend to apply for a visa extension or for more permanent status.*
>
> *GP practices have the discretion whether to accept an application to join their list of NHS patients either as a registered patient or as a temporary resident (i.e. a person is in an area for not less than 1 day but no more than 3 months). If a practice refuses an application, they can offer to treat the person as a private patient. The amount charged is a matter for the practice'*

In following this matter up, I consulted with a number of other organisations JCWI (Joint Council for the Welfare of Immigrants), Medecins du Monde and MEDACT for their advice as to the eligibility of MDWs. There was a unanimous opinion that MDWs were eligible on arrival in the UK. I further contact the DoH Choice and Rights team, who on initial consideration agreed that someone who was 'ordinarily resident' was eligible to access primary health care from the moment they arrived in the UK regardless of how long their intended stay was.

In December 2006 I had the following article published as a Rapid Response in the British Medical Journal:

Rapid Response: British Medical Journal
Published 22nd December 2006

Lack of clarity to entitlement leaves Migrant Domestic Workers excluded from primary health care.

Since the charges for overseas visitors were announced in 2004[50], Kalayaan (www.kalayaan.org.uk), a campaigning charity that gives advice and support to Migrant Domestic Workers (MDWs), has witnessed an increasing difficulty for MDWs to access primary healthcare, principally related to confusion about their immigration status. Many GP practices state that, particularly within the first 6 months, MDWs are only eligible for private treatment. However guidance for MDWs from the Home Office states 'you are entitled to free healthcare in the UK Health Service because you are 'ordinarily resident' in the UK'[51]. This seems to be supported by the DoH guidance: '...on taking up residence in the UK it is advisable to approach a GP practice and apply to register...'[52] However, guidance issued by the General

[50] [50] National Health Service (Charge to Overseas Visitors)(Amendment) Regulations 2004 www.opsi.gov.uk/si/si2004/20040614.htm

[51] Information for Domestic Workers Home Office Immigration and Nationality Directorate revised June 2005

[52] http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/OverseasVisitorsBrowsableDocument/fs/en?CONTENT_ID=4099060&MULTIPAGE_ID=4955459&chk=17j/Ku

Practitioners Committee interpret 'ordinarily resident' as *anyone who is here for a period of six months or more'* [53].

In response to this confusion, I have contacted all the relevant Patient Advice & Liaison Service (PALS) teams across London as to their understanding of a domestic workers entitlement to primary care. No two PCTs gave the same response and most questioned the meaning of the term 'ordinarily resident'. However there was a general consensus that MDWs were **not** eligible on arrival and must be resident for a period of time (which differed according to the PCT) prior to eligibility for registration.

Statistics from Kalayaan show that in 2005-2006, 86% of newly registered MDWs reported working over 16 hours a day; 70% reported psychological abuse; 23% reported physical abuse; 71% reported food deprivation and 56% were not provided with a private room to sleep in[54].

The isolated, dependant and unregulated nature of working in a private household, combined with gender-based and racial discrimination means that domestic workers are particularly vulnerable to exploitative practices. Many domestic workers speak little to no English and often have no knowledge of their rights or of how to navigate English bureaucratic systems.

Karen McColl of Medecins du Monde states that whilst 'the restrictions on access to NHS care are labelled as charges for overseas visitors… in reality, they affect people who are living here, including failed asylum seekers, visa overstayers and anyone without regular status'[55]. The case of MDWs is another case in point. MDWs enter the UK accompanying their employer in order to work for them as a nanny or housekeeper, on a specific visa which restricts them to work only in the private house. In 2005, 17,137 domestic worker visas were issued for entry into the UK, the majority from South and South East Asia, and Africa.

The real danger is to allow any confusion to continue when it is clear that: MDWs are in employment from the moment they arrive in the UK; they are required to pay taxes; and that they are entitled to access primary health care for the duration of their residency in the UK.

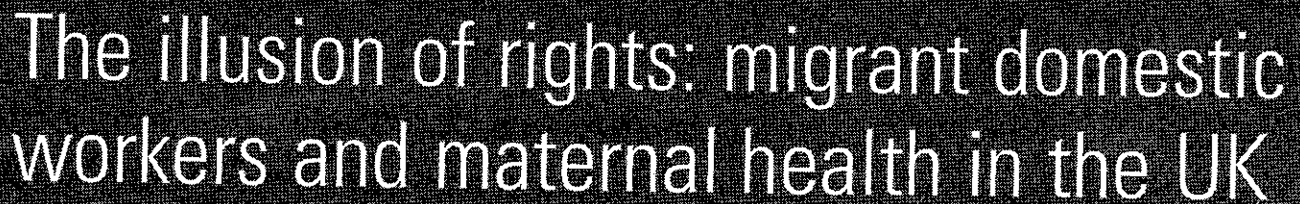
Kalayaan does not expect every receptionist, practice manager or GP to be an immigration expert. We do expect more of the PCT's and better guidance from the the DoH. We recommend that clear and specific guidance concerning MDWs be placed on the DoH website for front line professionals and PCT's. This should take into account that MDWs may have no utility bills or employment contract, and that their employers may keep their passports. We also recommend that more research is carried out into the barriers faced by documented migrants. We further recommend that research is carried out into the specific health needs of migrant domestic workers.

Clearly, there is much work to still be carried out in this area as is evident from the following action plan:

[53] http://www.lmc.org.uk/guidance/overseasvisitorsmarch06.doc
[54] Kalayaan Annual Report and Financial Statements April 2005- March 2006 http://www.kalayaan.org.uk/
[55] McColl Karen A 'No health safety net for failed asylum seekers and others in the UK. BMJ2006; 333; 259-doi:10.1136/bmj.333.7561.259

1. Draft a legally worded document to explain the entitlement of MDWs.
2. Contact a member of Royal College of General Practitioners to champion health campaign of MDWs; to disseminate information concerning MDWs in relevant fora e.g. available on websites accessed by GPs/ health workers/ BME health forum.
3. Produce article concerning rights of MDWs and health needs of MDWs for publication in GP 'comics'.
4. For all information to be accessible on Kalayaan website.

Access to maternity care was another area which often proved problematic for MDWs. An article on this topic was published in the Internal Planned Parenthood Federation magazine- Choices: addressing access to sexual and reproductive health for vulnerable communities in Europe. This can be seen on the following page.



The illusion of rights: migrant domestic workers and maternal health in the UK

By Camilla Brown
Health and advice worker, Kalayaan

Migrant domestic workers (MDWs) are people who have accompanied an employer to the UK on a 'domestic worker visa' to work as part of their private household. A typical role would be as a nanny, housekeeper, cook or chauffeur. The majority of these workers are from South and South-East Asia and Africa. The isolated, dependant and unregulated nature of working in private household, combined with gender-based and racial discrimination means that domestic workers are vulnerable to exploitative practices. They can face physical, psychological and sexual abuse, discrimination, low pay and long hours. Migrant domestic workers are often unfamiliar with the UK system and unsure of their rights in the UK. Kalayaan works with its clients to overcome these barriers and improve their quality of life. In 2004–2005, 92 % of MDWs registered at Kalayaan were women.

Once in the UK, MDW's are allowed to change their employers so long as they continue to work inside a private household. This is a relatively new rule (1998), and comes as a result of the British Home Office recognising that MDW's experience 'abuse and exploitation'. Typically their first visa will be for six months, after which they will be given a renewable one year visa. In order to renew their visa they will need to provide the Home Office with some evidence of their employment relationship. This is usually a letter from the employer confirming they wish to continue employing the domestic worker, and a form outlining the terms and conditions of the job. MDW's are required to pay tax and national insurance contributions on the money they earn and in turn are protected by UK employment law. They also have free access to primary healthcare.

On paper, it seems that MDWs are protected by law and should enjoy the majority of rights as British citizens. However, in practise, this is not always the case. In 2004, of the 322 newly registered MDW's at Kalayaan, 74 % reported psychological abuse; 82 % reported working over 15 hour days with no days off; 25 % reported physical abuse (being beaten, kicked, or having things thrown at them); and 5 % suffered from sexual abuse. It is not uncommon for MDW's to tell us that their bed is a rolled mat on the floor of the children's room, or even the kitchen floor and perhaps they are not allowed to use the same cutlery and crockery as their employers for fear of 'contamination'. The psychological abuse is most frequently name calling such as 'dog' and 'donkey', but it can also become a much deeper form of psychological control that the employers uses over the MDW. MDW's often have little to no knowledge of the structures that exist in the UK. Many speak hardly any English, and

have had it reinforced to them that they are 'illegal', or at least would be were they to leave their employers, and were such a thing to happen the police would catch them and send them home. This problem is magnified when employers withhold MDW's passports. In many countries this is required by law; however, when an employer withholds a MDW's passport in the UK, they are prohibiting them from accessing basic services such as healthcare.

Maternity rights and the Migrant Domestic Worker

Kalayaan has recently registered a number of MDW's who have become pregnant whilst in the UK. As stated above, MDW's are protected by UK employment law, which includes statutory maternity pay, protection against dismissal and against sex discrimination. They are also deemed as 'ordinarily resident' in the UK, therefore as the Department of Health guidelines state, "Any person living in the UK lawfully and on a settled basis is regarded as a resident in the UK and therefore entitled to free primary medical services." However, they must be in employment at the time they wish to access medical services.

On paper this could seem confusing. Does somebody have to be actually in employment when they have their baby in order to have free maternity care? Accessing protection prescribed by employment law often requires going to an employment tribunal – are these women in a position, physically, psychologically and status wise, to do such a thing? If the employer has not paid tax and national insurance contributions, does this automatically mean they are not entitled to maternity pay? Is it not unfair that MDW's bear the burden of unscrupulous employers? These individual testimonies highlight the situations many female MDWs face in the UK.

MDW 1

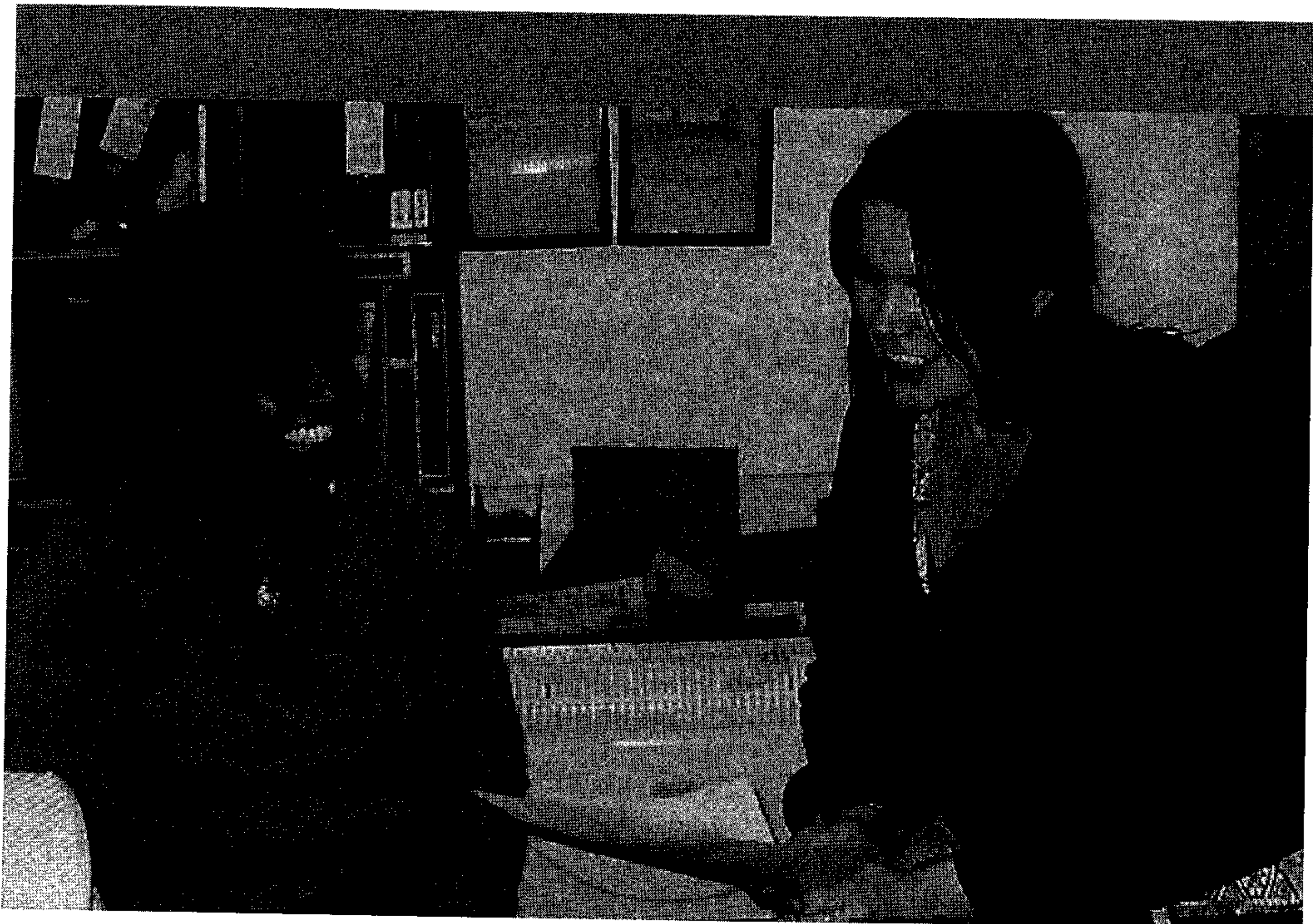
MDW 1 was given full maternity care by a hospital in the UK. However, after she had the baby, she started to receive letters asking for approx £3000 of payment to cover the healthcare costs incurred. When she had given birth her visa was still valid. Since giving birth, as a result of not being able to work and being unable to pay for childcare costs, her visa had expired. When enquiries were made to the health trust to understand why these charges were being billed to her, their response was that the visa allows her to access healthcare whilst in employment, and it is reasonable to assume that she was not in employment at the time of giving birth'. This was true, her job had been terminated, she was not working anywhere and she was not receiving maternity pay. Immigration lawyers advised that this was inappropriate, even racist, of the health trust to take the hard line. However, they also said in order for her to argue the case it would become public that her visa expired, and she therefore would suffer from the risk of deportation in trying to challenge the health trusts decision. She has now submitted an application to the Home Office to renew her visa.

MDW 2

This MDW had her baby in London. She had separated from her partner, she had little to no financial support and her visa had expired before she had given birth. She has not been billed (to-date) for the medical care she received; however the nurses were concerned about her situation and referred her to social services. Social services wanted to help her return to her home country. The MDW did not want to return to her home country and felt like she was being treated like 'a criminal' just after she had had her baby. The pressure from social services, combined with fear and a mixture of emotions caused her to run away from the temporary hostel that social services had provided for her. She then came to Kalayaan for help, but was so afraid that she would not leave any contact details and has not been back since.
She had no money and nowhere to live. It was obvious that she required support, her mental health had been seriously affected by the pressures she now found herself in. However, she was only assessed by social services on the basis of her immediate immigration status and the only option presented to her was to return back to her home country.

MDW 3

MDW 3 was working up until the 8th month of her pregnancy. She had been sleeping on the floor, working 7 full days each week, being given inadequate food to eat. She was paid no money for her work, and was very scared and confused. She had already been to see her doctor and been to an antenatal clinic. Her employer asked her to leave when she knew MDW 3 had no other support in the UK. Physically she was not in a position to take her employer to the employment tribunal and the priority was her immediate needs: those of food, shelter and money. Kalayaan helped her access a religious organisation that would provide her with accommodation and support. No other organisation would provide any help. Social services were very unwilling to help: she had no right to access their support as they were under the remit of 'public funds', however they do have a responsibility to her unborn child. Again, the fear was that once the baby was born they would support her to return to her country of origin as her only option, or potentially separate her from her baby (whilst this only occurs in very extreme circumstances, the fear alone acts as a powerful preventative measure in accessing their support).



Conclusion

On the one hand, there is a lack of continuity in the support provided to pregnant MDW's as in the example of MDW (1) being the only person who was asked to pay healthcare costs. The potential that healthcare costs could be billed at any point must lead to a very different maternity experience and clouds an already emotionally charged event with insecurity. However, the fact which unites all MDW's is that as a result of their immigration status, they were not provided any post-natal support and the majority were so terrified of the consequences of accessing social services support that it has forced them and their baby into the potentially permanent condition of an illegal migrant. This underground world does not even have the pretence of rights or protection and results in abuse and exploitation being commonplace.

A question we may ask ourselves when reading the case studies is whether these women were acting irresponsibly by having a baby in the first place. But as soon as we pose that question, we have fallen into the trap of classification of rights, and the exclusivity of reproductive rights. If someone is British they have the right to choose to have a child, as well as receiving support, but if someone is not a citizen, then they have a different set of rights. Despite the claims that MDW's are protected by employment laws, these are not as easy to access for a migrant as a British citizen, and can easily become illusory.

The British government is currently revising its immigration policy. This will have significant implications for MDW's such as attaching MDW's to their employer – so in cases of abuse and exploitation the only option would be to return to their country of origin, and possibly reducing any free access to the National Health Service (NHS) on the grounds of their non-acquisition of British nationality. If these policies come into practice we are in grave danger of taking all human rights away for migrants in the UK and in particular MDW's. If the rights that exist to protect MDW's are only an illusion, then we can no longer say that they have these rights and we need to collectively understand that MDW's have become a commodity that is only of interest to us as long as it is useful.

Kalayaan is a UK registered charity established in 1987 to provide advice, advocacy and support services in the UK for migrant domestic workers.

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Photos: Kalayaan/UK

Objective 7 **To support clients suffering from mental health problems and ensure that they receive appropriate NHS support**

Target 7 **Approx. 3 to 5 migrant domestic workers to be supported each year**

Kalayaan is already having to assist migrant domestic workers suffering from mental health problems. We feel that we do not currently have the necessary time or resources to deal with this important area properly. The health project worker will be able to devote specific expertise and time to working with individuals and the mental health community teams, so that migrant domestic workers with mental health problems are supported. It is also envisioned that one of the specialised health workshops will be devoted to mental health issues.

During the course of the project there have only been two successful referrals to mental health professionals. One was through her GP, and the other was through the 'Kalabaash Forum' for women who have experienced domestic violence. One of these workers have fed this back and commented on how much this has helped her.

However, despite discussing accessing support with many MDWs there was a reluctance to take this up. Similarly, when a representative from Henna Asian women's 'listening service' came to Kalayaan to do a workshop many women were very enthusiastic and said how much they wanted to access the service. This seemed particularly suitable because they lady was able to speak in many of the Indian languages. As result, a number of follow-up appointments were made for the listening service, however out of 8 appointments made none of the workers actually attended the centre as agreed.

I was keen for this topic to be explored in the mental health workshop, particularly after the issue of mental health being so clearly raised in the drama workshops. Whilst MDWs recognised that they can feel unhappy and isolated and could sometimes need more support, very few MDWs said they would seek professional help in these circumstances. The most important solution identified was to find a good job. However the MDWs did identify the following options of the best way to deal with feeling 'unhappy': exercise- (yoga/walking/dancing), talking to friends, watching videos. All of the MDWs pointed out that it makes them feel very happy when they come to Kalayaan centre as this is a place where they can talk openly about their issues because other people understand and it is where they feel safe.

Barriers to accessing mental health support services included lack of services available in workers language; difficulty of getting time-off particularly at the consistent time slot each week; stigma; shortage of funds for travel to session. In addition, many of the workers who were most in need were often undocumented and found it particularly hard to access primary care services.

The mental health workshop enhanced my understanding of the connection between community, health and more specifically, mental health. I therefore felt that it would be appropriate and responsive to the feedback generated in these forums to focus more resources in developing community activities that bring MDWs together.

<u>Community Activities at Kalayaan:</u>

Date(s)	**Topics**	**Facilitators**
20.06.05	'Your Story'- confidence and self expression	BBC, as part of RAW Stories programme

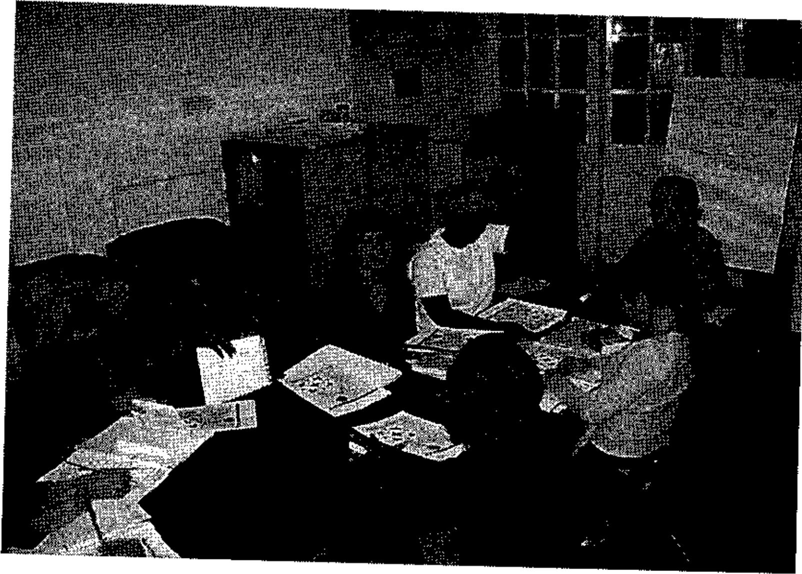
23.04.06	The Enneagram. Self discovery and expression	Margaret Healy and Pilar Vasquez
9 & 16.07.06	Your Rights at Work	Kalayaan and TUC
Summer 2006	We ran a series of 10 free aerobics classes on Sunday afternoons with a volunteer teacher. Owing to the success and feedback of these workshops we successfully applied to Sport Relief for funding to cover a year of classes.	
Ongoing: Jeevan for life: gentle exercise video's were shown monthly during the Monday morning job workshops. The workers really enjoyed these videos and always found them very amusing!		
Ongoing: Every Tuesday a volunteer who has been coming to the centre for over twelve years brings cheese and snacks and a well established social time has been created where people can share stories and drink tea		

English classes at Kalayaan:

Kalayaan runs regular ESOL classes for MDWs. These are coordinated by the Community Support Worker at Kalayaan. The number of ESOL classes available at Kalayaan have increased over the last year- in response to demand for classes and particularly for classes which are accessible to all workers (i.e. not the government funded classes which are available only to workers who have been here three years or more). This provides access to those who are most in need and importantly provides access to the community, facilitating networks and friendship groups. Each week around 90 students access ESOL classes at Kalayaan.

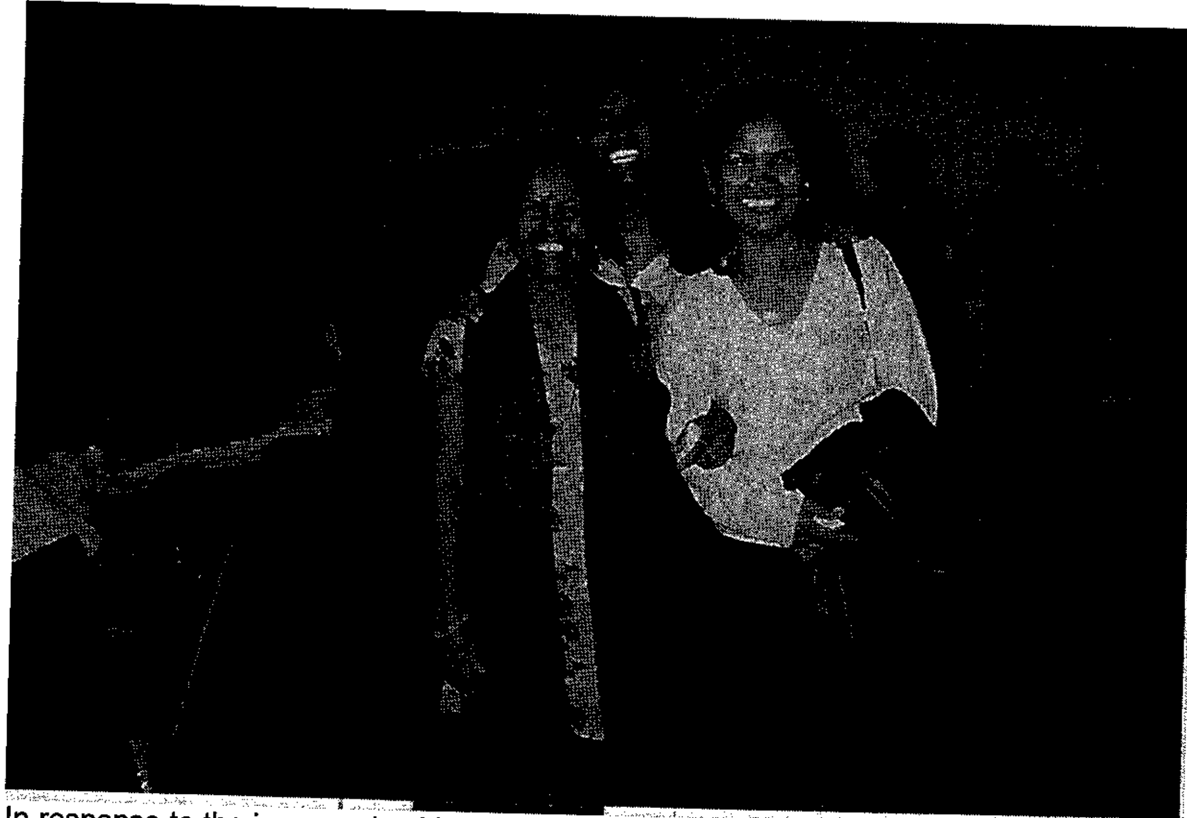
ESOL classes at Kalayaan	
Day	**Time**
Tuesday	7.30-9pm volunteer run
Thursday	7-9pm volunteer run
Sunday	10am -1pm Volunteer run
Sunday	1-3pm Workers Education Association
Sunday	3-5 WEA
Sunday	1-3.30pm Kensington & Chelsea College
Sunday	3-5pm K&C

Voluntary ESOL class at Kalayaan



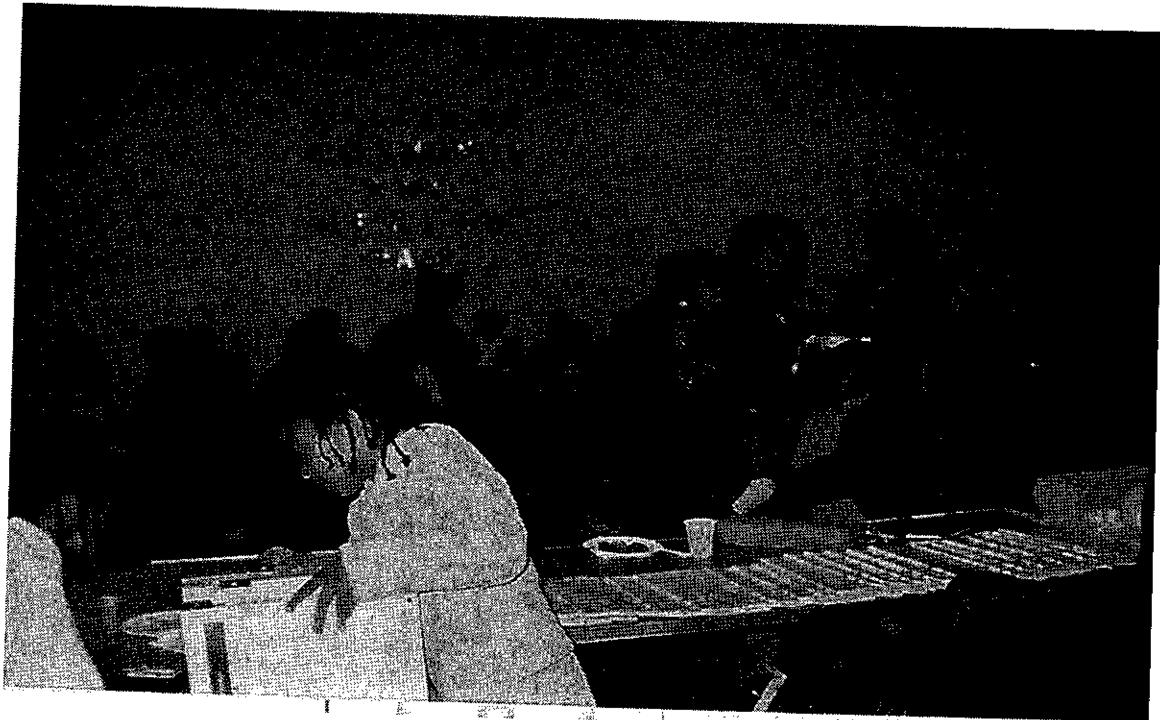
Objective 8 **To hold a half-day health fair**
Target 8 **40-50 clients to attend**

The health project worker will organise a half-day health fair at which information about healthcare is made available to migrant domestic workers. Other organisations/ individuals will be invited to the health fair to network and, where appropriate, promote themselves. Alternative and holistic treatments can also be publicised. Migrant domestic workers will be invited to speak about healthcare in their home countries.



In response to the issues raised in the mental health report of Objective 8, we decided the health fair would become a health *and* community fair. We would invite a range of organisations including health professionals; a range of community organisations; local statutory representatives and religious groups to the centre to meet migrant domestic workers, understand about the life and work of migrant domestic workers in the UK, and to build relationships that will connect migrant domestic workers with the community. Our aim is to promote both knowledge of health and access to services whilst also encouraging the community within Kalayaan and connections to the community outside of the centre. This is based on the awareness of mental health issues amongst MDW specifically that which is caused by isolation .

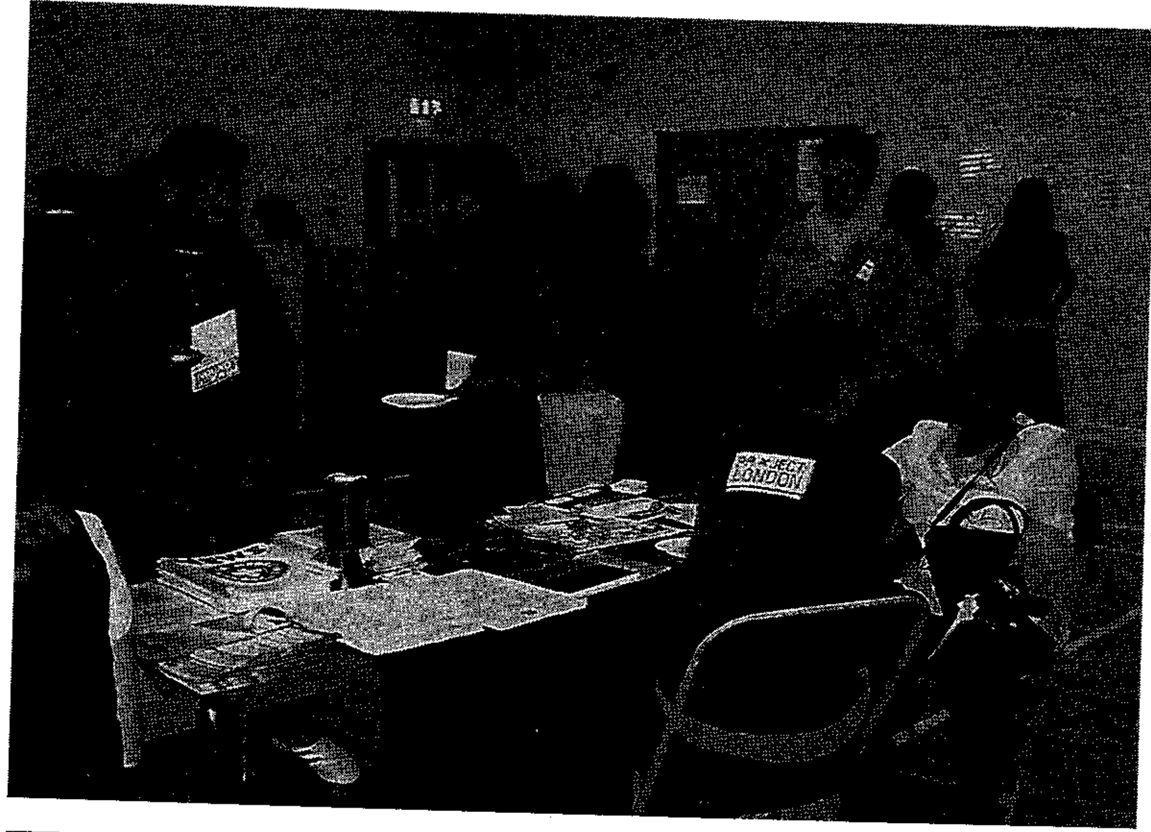
We scheduled the Community and Health fair for 26.11.2005, a Saturday afternoon. We invited over 85 organisations and health professionals. However the response was poor with only 2 organisations confirming attendance, neither of these were health related. Whilst we were forced to cancel the fair the practice of organising the event was positive. Most professionals cited the reason for not coming was short notice and lack of availability on a weekend. I replied that weekends are the ONLY time that MDWs are free which highlighted the barriers they encounter in accessing basic services. This has prompted assurances that with more prior planning, the health professionals would commit to a weekend fair.



The Health & Community fair was held on 9th April 2006. I invited a total number of 81 individuals from 61 organisations including health professionals; community organisations; local government and the police. Representatives of 8 organisations came to give advice including 2-health professionals- an osteopath and a dietician; Medicins du Monde attended and gave out information about their services and to support workers to access primary health care.

Activities included a tombola, followed by an example aerobics session with a volunteer instructor; a Salsa and Meringue dance demonstration. All of the MDWs participated enthusiastically in the exercise and dancing and all of the participants requested exercise classed at Kalayaan. We recorded a total number of 80 MDWs who attended the event: 27 Indian; 7 Filipino; 10 Sri Lankan; 9 Indonesian; 2 Nigerian; 1 Mongolian; 2 Egyptian; 2 Pakistani; 1 Ivory Coast; 1 Morocco. 4 volunteers were recruited to assist with decorating the room and the running of the event.
Home cooking was provided by 3 workers of different nationalities.

- Owing to the success of the fair we have successfully raised £1500 Methodist Community Grants for two similar events in 2007.



Objective 9 **To target particularly under-represented BME nationalities throughout health project**

Target 9 **1 nationality to be targeted**

Kalayaan is aware that certain nationalities are more involved as participants in our projects and events. The health project worker will make take specific actions to ensure that one under-represented nationality (or group of nationalities such as African women) is targeted during the programme. This may be done through having one or more of the specialised health workshops focused on issues that particularly affect one nationality or group of nationalities (e.g. female genital mutilation etc.). The health project worker will also target under-represented nationalities through community development work, interpretation, and written invitation to improve inclusion.

The table below shows the percentage of new clients by nationality registered at Kalayaan between April 2005 and March 2006. 86% of those who received advice over the course of the year were women.

New clients 2005-2006

India	40%
Philippines	32%
Sri Lanka	13%
Indonesia	5%
Nepal	3%
Pakistan	2%
Peru	1%
Bangladesh	1%
Kenya	1%

The table below shows the people who attended the workshops as defined by their nationality over the course of the 3-year health project.

India	44.5%
Philippines	18.5%
Sri Lanka	26.5%
Indonesia	4.5%
African	4.5%
S. America	0.5%
Bangladesh	0.5%
Mongolia	0.5%

A comparison between the tables shows there has been a high African representation in all of the health workshops. I had consulted with the African advisory group representative to see if specific workshops could be organised, however she only expressed an interest in accessing exercise classes in the centre.

I feel that the most underrepresented group amongst the MDW's is men. Men were consulted in the focus group workshops and asked if they would like any specific health information. I think, however that this might have been a challenging forum for them to raise any personal issues due to mixed gendered group, and this may have been enhanced by all of the staff at Kalayaan being female. I did place notices in the centre

asking men to make contact with me if they would like any specific workshops. However no men raised this any concerns or responded to the poster.

Objective 10 **To advise on health issues and refer individual migrant domestic workers to appropriate services**

Target 10 **Approx. 7 hours of advice / outreach work to be provided weekly for approx. 27 months of project**

The health project worker will hold regular health surgeries at Kalayaan to advise on specific health issues and refer clients to appropriate services. This will be ongoing throughout the programme. Sometimes, where necessary, the health project worker will accompany clients to health services or carry out hospital visits etc.

Individual Health Advice Given		
Health Advice 2004		
	Male: 9; Female 55: Total: 64 Filipino: 20 India: 23 Sri Lanka: 13 Indonesian: 1 African: 6	Type of Advice given: Register with GP: 58 Other: 6
Health Advice 2005		
	Male 8; Female 19: Total 27 Filipino: 4 India: 15 Sri Lanka: 5 Indonesian: 1 African: 1`	Type of Advice: Register with GP: 24 Other: 3
Health Advice 2006		
	Male 4; Female 28: Total 32 Filipino: 6 India: 17 Sri Lanka: 4 Indonesian: 3 Other: 2	Type of Advice Register with GP: 24 Referral: 7 Other: 2
Total Health Advice over three years: 123 individual advice appointments (102F: 22M)		

Over the course of the project there were seven allocated hours of health advice per week. The times of these advice sessions were clearly publicised around the centre and clients were made aware of these when they registered at Kalayaan, and during health workshops. All health advice given was monitored on the health advice sheet recording date; name; contact details; nationality and type of advice.

In the first year health advice was given in 67 individual sessions however this decreased to 27 in the second year and 32 in the third year. 86% of the advice sessions focused on registering with a GP. The reduction in advice sessions reflects the increased barriers encountered by MDWs in accessing primary care services as referred to in Objective 6. Information about accessing alternative health information services such as Medicins du Monde were available outside the office for people to access at their convenience, in addition to active signposting and referral to their drop-in surgeries.

In cases where there were barriers provided to MDWs in registering for GP's ongoing advocacy work would be carried out to ensure the MDW could access the appropriate service. An example of such advocacy is as follows:

> Selina:
> Selina's employer contacted Kalayaan to say after accompanying Selina to *his* surgery they were told Selina would not be able to register because she had no recourse to public funds. I then called the practice and summarised the story to which I was asked: does she have a National Insurance number? Clearly shocked I explained that both these questions were irrelevant to someone accessing primary healthcare, the health worker explained that these questions were 'procedure' and should I have any questions I should contact the practice manager.
>
> I wrote to the practice manager asking for a copy of their guidelines, which she promptly faxed through. The guidelines made no reference to either 'recourse to public funds' or to National Insurance numbers. I later discussed this with the practice manager who told me to take my case to their local PALS team.
>
> The PALS team had not encountered a MDW before and initially took the view that they were not eligible to access primary health care for free. I urged them to investigate the matter based on my experience at Kalayaan. They then contacted the Choice and Rights team in the DoH who confirmed that the MDW was eligible to register with a GP. The PALS team called me back to say it was fine and I should encourage them to try again.
>
> Selina successfully registered with the practice.

Accompanying clients

There was little demand for this type of advocacy. It was deemed impractical to try and accompany every worker when they needed to register with a GP; this is a reflection of the broad geographical area covered by workers both in London and outside.

Over the course of the project three workers were accompanied to hospital appointments. In each of these follow-up visits were made by the health worker.

There was one particular case that was very distressing for the staff and the MDW community. A Nepalese MDW had kept her illness a secret both from her Doctor, her friends and the staff at Kalayaan. She knew she was seriously ill but was so worried that revealing this illness might cause the government to withdraw her domestic worker visa and forced her to leave the country. As a result, she kept her illness a secret and when she eventually collapsed in her workplace was rushed to hospital. Sadly, she died in less than a week.

The case highlighted, in the most brutal and extreme form, the secondary role health will always play to immigration status. The fear of being ill is directly related to the fear of being dismissed which would entail a loss of earnings (and subsequent remittances sent home); and being unemployed would leave the MDW unable to fulfil the obligations imposed by the terms and conditions of the visa. The only way a MDW can renew their visa is by proving the existing employment with the support of their employer. Failure to provide this evidence would result in the application being refused and being asked to leave the country.

Objective 11 **To join/network with appropriate health networks/for a and/or other community groups working on health**

Target 11 **Contact approx. 3 to 6 other networks or groups and discuss potential networking/collaboration**

The health project worker will ensure that Kalayaan is a member of relevant health networks and fora and will represent Kalayaan at them throughout the year. The health project worker will also contact some local community groups (e.g. Moroccan Women's Association) to discuss the project and share experience and expertise on community health work.

BME Health Advocacy standards pilot project: Kalayaan was chosen as a pilot site to test the core advocacy service standards for BME communities developed by the Kings Fund. We are one of 10 chosen sites. An added feature of this involvement is our ability to network with the other organisations.
BME Health Forum: a health forum for health professionals and BME community groups in Kensington & Chelsea and Westminster. They run a health network on email which we have used regularly. We have also submitted a number of articles to their quarterly publication Embrace
Kensington and Chelsea PCT have provided a number of training opportunities for staff to deliver in house training on the following topics: Access to Primary health care for BME communities; Hygiene and Health training; TB training.
Kalabaash: A forum for women working with women experiencing domestic violence to meet and discuss best practice; to provide support and for possible partnership working.
Also provide counselling services to women experiencing domestic violence in conjunction with Ashiana project
Joint Council for the Welfare of Immigrants: http://www.jcwi.org.uk - have been assisting with research into eligibility for MDWs accessing primary health care.
Medecins du Monde: a London based organisation who provide information and support to help people reach mainstream health services. They also provide some basic healthcare attention and advocates on behalf of people who have problems accessing mainstream healtcare.
Henna Asian Women's Group: Provide free listening services to Asian women
Church Army Day Centre: Provide advice and support to all women in relation to health/housing and benefits.
Open-Age project: Have health/crafts and community activities and projects for people over 50
New Start 50+: Help people over 50 get back into work- supportive environment.

Objective 12 **To research and investigate possibilities for conversion courses for migrant domestic workers who are qualified as nurses, midwives and health workers**

Target 12 **To produce a brief report to inform Kalayaan advisers and other community groups about this issue and to provide advice to clients on an individual basis**

Kalayaan is aware that a number of our clients are qualified nurses, midwives or health workers. We are also aware that there are appropriate conversion courses that our clients may be able to access. The health project worker will research this issue and produce a brief report. This will enable Kalayaan to give expert advice on this area. As part of this objective, the health project worker will research possible training courses in health areas for clients who have got ILR, and wish to move out of domestic work.

The number of MDWs who have expressed an interest in these particular conversion courses where less than predicted in the report guidelines. MDWs represented a wide skill base including teachers, chefs as well as nurses or midwives. After researching conversion courses for various individuals it appeared that there were a number of other organisations who already provided expert advice in this field and to whom it would be more appropriate to refer MDWs to.

To this end, I have compiled a list of possible referral or contact organisations as follows:

Praxis: Pott St, London, E2 OEF, 0207729 7986 www.praxis.org.uk

Employability Forum: 2 Downstream, 1 London Bridge, London SE1 9BG,: +44 (0) 20 7785 6270, www.employabilityforum.co.uk

Workers Education Association: www.wea.org.uk

Red Kite Learning: www.rkl.org.uk

3. **Assessment of the impact of the project**

- What plans have been made for continuing the work that has been started by the project?

MDWs will still be able receive advice on how to access healthcare in one-to-one advice sessions. Links with organisation such as Medicins du Monde will be strengthened to be able to refer MDWs who need more ongoing support. As we focus on the campaign workshops on health will not be the priority, however we will still provide workshops supported by Kensington and Chelsea PCT on TB and flu & antibiotics. In addition, involvement in networking groups such as the BME health forum will continue, although with lower overall attendance.

Consultations with MDWs will continue using focus groups. These will again look at the holistic needs of MDWs and to see how we can manage our services so they more effectively meet client needs.

Community activities such as ESOL classes, aerobics classes and community building workshops will remain priorities at Kalayaan. The latter aspect of 'organising' within the community takes precedence at the time of such a crucial campaign. This process is being facilitated in conjunction with the Transport and General Workers Union.

- What remains to be done and how will it be carried out?

Advocacy on a policy level is the main point for future work on health. The targets of raising awareness were not adequately met, however I think this was a reflection of the changing climate around access to health care and so required a revision of the immediate aims of the work. As stated in Objective 6, a broad strategy has been devised, however, due to the focus on the campaign, it is not possible to say when this be carried out.

- Is there any evidence that the project has been beneficial to the health of the local/national population?

The project has been hugely beneficial to the MDW community. Over the course o f the project 788 people have received a health information booklet with detailed information about health in their own language; languages for which there was no other information available in the UK. 43 MDWs accessed ESOL for health classes. 219 MDWs participated in the workshops on health. 80 workers enjoyed the health and community fair where they could access information about health, an where they could exercise, dance and have fun with free food. 123 MDWs received individual health advice on health care, 106 of which was providing support to register with a GP. Therefore, during the 3 year health project a total number of 1253 MDWs received information or advice on health from Kalayaan. In comparison to the number of newly registered MDWs each year, 400, we can see that the health project has been able to access a significant number of MDWs relative to the size of the community.

- Has the project been successful in influencing the organisation and delivery of health care, either at a local, London-wide, or national level?

The project has been successful in advocacy work at a local level where a MDW has encountered difficulties in accessing health care. Also, our links with Medicins du Monde has ensured that their service providers are aware of the issues affecting MDWs. This is reflected in their leaflets incorporating the main languages of the MDW community. Early involvement with the BME Health Advocacy standards pilot project enable the concerns of MDWs in accessing health care and other basic

services to be fed back to a wider audience. However, the change in climate around access to health care has created the needed to lobby at a national level to ensure equality of access for MDWs. As yet, this target remains incomplete.

- What has been learned about promoting developments in health services; have successful methods of bringing about change been identified; how far are these methods specific to local circumstances and how far might they be more widely applicable?

Ensuring the project is client-led and meets the needs of the community have been key to the success of the project. This need has been reflected in all aspects of organising the project, particularly in understanding the best times for events to take place, and what is the best format for the event. The health and community fair was a good example of a health oriented day that grew into a community event and looked to address a wider remit that solely health promotion. Underlying this is the basic principal that health promotion can be fun. The multiple stresses faced by MDWs coupled with their lack of free time means that activities tried to have a dual aspect of being informative whilst also being a community activity which people could engage with as much as they wanted to. The open nature of the workshops and drop in advice sessions ensured that there was a flexible and non-prescriptive approach to health promotion.

- Did your grant from the King's Fund enable you to successfully apply for additional funds from other sources e.g.) local authorities, health authorities, other trusts? If yes, we would like to receive details.

We raised £2,600 from Sports Relief to run aerobics classes for one-year.
£1,500 was raised from the Methodist Church group for 2 further health and community fairs to take place in 2007.
The presentations supported by Kensington and Chelsea PCT raised sufficient funds to buy yoga mats and resistance bands for the aerobics classes.

- Is it possible to summarise what has been learned from the project in a way that will be helpful to others trying to achieve similar aims?

The project has demonstrated a number of important factors which are beneficial to health promotion. It has been important to understand the political climate around health and how this impacts upon the MDW community. The grouping of migrant communities with asylum seekers and refugees has become problematic in terms of access but also in terms of addressing the relevant needs of the community. Therefore awareness-raising in health networks has been a constant feature of the project, however there is still much work to be done in this area. In the same theme, developing the MDWs ability to self-advocate has been crucial. In realising the practical constraints of not being able to accompany every MDW to register with their GP it has been important that MDWs increase their own health literacy and knowledge of their rights so that the promotion of health can be both an empowering and informative process.