



Women in Informal Employment
Globalizing and Organizing

WIEGO Social Protection Programme

Occupational Health and Safety & Domestic Work

A synthesis of research findings
from Brazil and Tanzania

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Women in Informal Employment
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Occupational Health and Safety and Informal Workers

The field of Occupational Health and Safety (OHS) does not usually cover informal workers. It focuses on formal workplaces, not on where the majority of workers are active: on the streets, in their own homes, on garbage dumps and landfills, for example. WIEGO is undertaking a four year research and advocacy programme in five countries: Brazil, Peru, Ghana, Tanzania and India. Where possible we work through organizations of street vendors, waste pickers, home-based workers, domestic workers and others. The aim is to find out how to develop OHS in a way that can better meet the needs of informal workers.

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Introduction

In 2009, the Social Protection Programme of the global research and advocacy network Women in Informal Employment: Globalizing and Organizing (WIEGO) began a four year research project on OHS and informal workers, which includes domestic workers. The project aimed to begin thinking about OHS in a new, more inclusive way in terms of informal work and informal workplaces. The study has been operating in five countries (India, Tanzania, Ghana, Peru and Brazil) and includes domestic workers in two of these countries, Tanzania and Brazil. The following report is a synthesis of the project's research findings on domestic workers in these two countries.

Domestic workers make up four to ten per cent of the developing world's total workforce, and, according to the ILO Bureau of Statistics, this number is growing every year. Therefore, domestic work is an important source of employment, especially in poorer parts of the world. Increases in rural poverty and various economic crises have pushed growing numbers of women and girls into the domestic labour market in their own countries and abroad (Chen 2011). Many more women than men are drawn into this occupation, not only because domestic work is often considered "women's work," but also because women are less likely to have alternative ways of earning a living.

A recent survey of Latin American data on the working conditions of domestic workers in 19 Latin American countries showed these workers earn only 41 per cent of the wage others in the urban workforce make, which is a very low figure. The survey also showed women who are domestic workers earn significantly less than other groups of female informal workers (Tokman 2010).

A number of countries, including Brazil and Tanzania, have started to include domestic workers in labour legislation in order to provide them with basic protections such as maternity leave, sick leave and social security. However, it can be very difficult to enforce this legislation in countries where labour inspectorates are under-resourced and information systems are poor. In addition, many domestic workers do not know their rights, so they are unable to demand protections from their employers.

Low earnings and lack of effective labour protections mean that domestic workers are in a vulnerable position. If they become ill or injured and cannot come to work, they may lose their pay or be fired. They may not have savings to pay their medical bills or to keep them going until they find a new job. This situation would seem particularly unfair to workers whose jobs caused them sickness or injury in the first place.

The owners of houses in which domestic workers are active may think their homes are safe places, but the same homes present a number of health and safety risks for the people who work in them. A study conducted in Salvador, Brazil, for example, found women domestic workers experienced higher rates of injury than women workers in other occupations (Santana et al. 2003). Domestic workers are aware their work can be dangerous to their health. A recent study in California showed almost two thirds of the domestic workers who participated considered their work to be “hazardous” (Smith 2001).

Occupational Health & Safety (OHS) regulations, which aim to prevent injury or illness in the workplace, most often protect formal workers in formal work environments such as mines, factories, offices and shops. These regulations do not protect workers who work in private homes, which means that even though domestic work is such an important source of employment, even though there are many health and safety risks involved in the work, and even though domestic workers are vulnerable to poverty if they become sick or injured, OHS legislation in many countries does not cover them.



Photo: F. Msuya, OHS focus group discussion in Zanzibar, Tanzania

The Research Study

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Aims, Participants and Methods

The research study on OHS and domestic workers had two main aims. The first aim was to understand what health and safety problems domestic workers themselves prioritize. Domestic workers know best about the problems they face—they are the experts on their own working conditions, and in any project seeking to understand more about those conditions, it is important to start by talking to the workers themselves. The second aim was to find out more about OHS regulation in Tanzania and Brazil and to see what type of interactions domestic workers had with state authorities around health and safety.

In Brazil, the research was carried out at the end of 2009, and at the end of 2010 in Tanzania. In both countries, researchers used the focus group method, where groups of workers come together to be interviewed. In Brazil, researchers worked through *Sindoméstico*, a union of domestic workers. In Tanzania, researchers worked with the Conservation, Hotel, Domestic and Allied Workers Union (CHODAWU), which also organizes domestic workers. In total, seven domestic workers participated in the study in Brazil, and 20 participated in Tanzania. All of the Brazilian workers were women, and in Tanzania, 18 of the 20 participants were women.

In Tanzania, we used two interesting ways of gathering information from the workers. The first of these methods is called “hazard cards,” which are flashcards using pictures and words to describe common health and safety hazards. These cards are laid out, and participants are asked if they would like to add any flashcards to the collection. Once

participants add any extra cards, they are asked to rank the cards according to how important they think the problem on the card is. The final ranking of the cards is important, but also important is the debate and discussion the ranking exercise encourages amongst the participants.

Researchers in Tanzania also used a second method called the “health checklist.” People are often hesitant to talk about their bodies and health concerns when they are being interviewed with a group of people they do not know well. In order to get around this problem, some researchers use what is known as a “body map,” where workers are asked to draw their bodies and then map their illnesses and injuries onto the drawing. The union of waste pickers called Kagad Kach Patra Kashtakari Panchayat (KKPKP) in Pune, India, have used this technique very effectively in their research. The health checklist is another way to encourage focus group participants to talk about the ill-health they experience because of their work without having to talk too much about their own personal problems.

Formal places of work often keep health checklists, which are forms listing commonly occurring occupational injuries and illnesses. When workers become sick or injured, they report this occurrence to their workplaces, and it is recorded on the health checklist. This means that occupational ill-health and injury levels are monitored, and if too many people become sick or injured in a specific place of work, trade unions or the government may intervene. During the Tanzanian focus groups, researchers explained the concept of a formal workplace health checklist to participants, who were then asked to create their own health checklist, which would represent the common health problems specific to domestic workers. This method also encourages much discussion in the focus groups.

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Findings

The following three sections report the research findings: health and safety; other working conditions; and relationships with authorities around health and safety.

Health & Safety

In Brazil, the domestic workers said the verbal abuse and humiliation they suffer at their places of work represented their most important health and safety problem. They said they felt they were regarded as slaves, made to do demeaning work, and often shown disrespect as human beings by their employers. As the following quotes demonstrate, verbal abuse and humiliation left with them low self-esteem and the sense the work they do is not meaningful:

*“[The biggest problems are] **name calling, humiliation** and standing up for long periods. I worked in one house where I was only allowed to sit down to eat. If I sat down to rest there would be a fight or complaints, you had to stay on your feet, no one could stay still in her house.”*

*“...**they exploit their housemaid** making her take care of the dog as well, giving it a bath. I do not think that caring for an animal is domestic work...”*

*“We have to do things that we have no idea how to do, that we haven’t learned how to do, how to apply wall filler or how to clean a water tank, but we’re forced to do these things and **this is a type of violence.**”*

In one of the Tanzanian groups, workers regarded sexual abuse as the most important health and safety problem they faced. One woman related a story of how she escaped from such a situation:

*“I was once employed by a certain employer in Iringa Region for about 3 years...**I had a serious problem of sexual harassment** where the father and son tried to force me to have love affairs with them, but I disagreed! What I did, I decided to tell the neighbour. The neighbour told me that it was better to run away; she assisted me to find a job in Dar es Salaam with her relative. This was very risky to me as **I decided to run away without even telling my parents** who are living in rural Iringa...I am no longer working with that employer. The bad thing is that my parents still think I am working in Iringa, since I cannot communicate with them.”*

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For another group of Tanzanian domestic workers, the most important health and safety problem they faced was overwork:

*“I was employed as a cooker. The place was very far from the main road. I had to walk as long distance so as to save money. The job was hard and difficult since the employer forced me to cook both at home and at her hotel and I had no chance to rest. After some time **I developed chest pains and breathing problems**. I had to stop the job and my employer immediately looked for a replacement.”*

*“I am working as a domestic worker for five years now. At first when I was employed I thought that my work was only taking care of the animals but it was not the case. I am also doing other work. **I am always the first one to wake up and the last one to sleep**. I must wake up at 4 a.m. everyday so as to find grass for the cows.”*

Brazilian domestic workers also considered overwork an important challenge, and they said the lack of defined working hours made this problem worse:

*“We have a time to wake up, but we do not have time to go to bed. One of the things we would like changed, in that sense, is to have a set schedule. Why do other jobs have an eight hour working day while we don’t? If you weigh things up, **we have almost 20 hours of work a day.**”*

One woman in Brazil related how overwork had made her ill:

*“I believe that [my work] caused my health problems, because now I have nervous gastritis... And **now I live with that medicine for your nerves.** I was sick of the work, today I depend on these pills, I get very nervous. So I think my work brought me a lot of trouble really.”*

In both Brazil and Tanzania, workers also prioritized contact with toxic or unhealthy substances as another important health and safety risk. Workers emphasized they are very seldom provided with protective equipment such as gloves or masks when at work:

*“When you go to clean the bathroom, many products get mixed: Ajax, K-Boa, bleach, powdered soap. These mixtures are terrible. **I know plenty of workers who have respiratory problems** from them.”*

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The lack of protective equipment is also a problem when domestic workers are caring for sick members of the household—particularly if the ill have infectious diseases such as HIV / AIDS and / or TB. Other important problems mentioned included carrying heavy weights and being forced to climb up to high places.

The Tanzanian domestic workers compiled a health checklist for domestic workers, which reflect some of the health problems resulting from the above risks:

- Chest pains and respiratory problems
- Leg pain
- Backache
- Stomach problems
- Fungal infections

The Brazilian workers did not compile a health checklist, but they did mention the following health issues as being particular problems for them and their colleagues:

- Psychological stress
- Backache
- Repetitive strain injury
- Respiratory problems
- Flu
- Nervous gastritis
- Anemia

Other Working Conditions

Another finding of this research shows occupational health and safety is not only about the direct causes of ill health and injuries. It may also be related to more general working conditions such as the regular payment of salaries and the presence of a work contract. For example, one domestic worker in Tanzania talked about how her employer had not given her a salary “for the reason that the employer is keeping it for me.” This withholding has contributed to her levels of psychological distress.

In Brazil, domestic workers are entitled to social security. However, they are only able to access it if their employers agree to sign their work papers. All of the Brazilian participants had experienced working without signed papers at some point in their lives, and one woman had been working in this way for 16 years. For many participants, the fear of losing their jobs made them unwilling to pressure their employers to sign the papers.

Interactions with Authorities Around OHS

Both Brazil and Tanzania include domestic workers in labour legislation. In Tanzania, the Employment and Labour Relations Act No.6 and the Labour Institutions Act No.7 of 2004 both recognize the rights of domestic workers to freedom of association, collective bargaining, maternity leave and minimum wages. In Brazil, domestic work is regulated by law #5.859 and its decree # 71.885 of 1973 under the Brazilian labour code, which should provide domestic workers with basic labour protections.

In terms of OHS legislation and regulation, Tanzania and Brazil are both progressive countries. Tanzania has recently passed an OHS policy that follows ILO Convention 155 in defining any place in which people earn a livelihood

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as a workplace, which means private homes can be defined as workplaces and are subject to OHS laws. Brazil has established a system of primary public health care that includes occupational health and safety services for all workers, whether formal or informal, and has a system of labour inspection that includes homes.

Considering the progress made at the regulatory level in these countries, a striking finding of this research is that neither the domestic workers in Brazil nor in Tanzania had experienced any contact with state OHS institutions. Some of the Brazilian workers said this was because lawmakers, being employers of domestic workers themselves, did not really care about improving their working conditions. Many of the Tanzanian workers interviewed were completely unaware they had any labour rights at all and did not think about reaching out to state institutions to solve their problems. Those who had experienced serious abuses of their rights had relied on help from their employers' neighbours to escape the situation.



Photo: A. Quiroga, OHS focus group in Accra, Ghana

Discussion and Conclusion

The ILO Convention concerning Decent Work for Domestic Workers (Convention 189), which was passed in 2011 at the 100th session of the International Labour Conference, includes in its text an article relating to Occupational Health and Safety. Article 13(1) states the following:

“Every domestic worker has the right to a safe and health working environment. Each Member shall take, in accordance with national laws, regulations and practice, effective measures, with due regard for the specific characteristics of domestic work, to ensure the occupational safety and health of domestic workers.”

For this right to become a reality, however, it is clear many changes will have to take place. This small study has shown that even in countries where domestic workers are covered by OHS regulations, in reality little is done to protect them from the serious health hazards they face at work.

To ensure that there are more effective ways of ensuring health and safety in the workplace, some important changes will have to occur at the national level. Brazil is already experimenting with different ways to accomplish these changes. The country now has a law giving employers a tax discount if they sign a contract with their domestic employees. Despite this law, this study shows that many domestic workers in Brazil are still working without a contract. The idea is a good one though, and it is something other countries could consider when looking at regulatory reforms around domestic work.

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However, it will not be enough to focus only on government regulation of workplaces. The Tanzanian study in particular showed that many domestic workers are simply not aware of their rights in relation to health and safety. This problem exists because so many domestic workers are from poor backgrounds, often have little education, and are isolated from other workers. This means both government and organizations of domestic workers have to make a concerted effort to educate domestic workers about their rights and to ensure these rights are upheld.

Still, this education cannot stop with domestic workers. It was clear from the study that domestic work, like much of the work that is traditionally considered “women’s work,” is not given value by society. Domestic work’s low status contributes to employers treating domestic workers poorly. Yet caring, cleaning, shopping and cooking are all very important activities in our everyday lives. Domestic work is important work, and this message needs to be sent clearly to the public as a whole and to employers of domestic workers in particular. A good place for this education to start is in the national campaigns for the ratification of Convention 189.

Much more research needs to be done specifically in OHS. For example, very few scientific studies exist that show the impact on their bodies of activities like lifting, pulling, pushing, sweeping, bending over, and standing for long periods, as domestic workers commonly do. This kind of research may help convince policymakers and employers that protecting the health of domestic workers at work is important. Academic institutions and organizations of domestic workers should promote and support this research.

Convention 189 represents an important step forward for domestic workers around the world. However, the Convention is not enough to ensure that the right of domestic workers to a healthy and safe work environment is realized. Much work still has to be done in this regard, and only through strong domestic workers organizations, working together with their supporters, will this be achieved.

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Appendix 1:

WIEGO Social Protection Occupational Health & Safety Programme Focus Group Exercises

Two very effective techniques that we have used during the OHS Focus Group Discussions (FGDs) are 1) hazard cards and 2) the health checklist. Here is a step-by-step guide to using these techniques in FGDs. We are very eager to get feedback from you as to how well the exercises worked, and what you would do to improve them.

1) Hazard Cards

The aim of this technique is to stimulate free flowing discussion about risks and hazards in the workplace amongst the FGD participants. If it works well, the FGD facilitator is able to step back and allow the discussion to unfold without a great deal of prompting.

“Hazard cards” are flashcards onto which are pasted pictures and words describing common health and safety hazards in the workplaces of certain sectors of the informal economy. Left is a picture to illustrate what your cards could look like.

To create your hazard cards, do the following:

1. You need card/paper, glue and marker pens.
2. Cut the card into flashcards (about A5 size).
3. Clearly write the “hazard” onto the card in large letters (for example: FIRE, RUBBISH, CHEMICALS). You will know what the common hazards are either from your own experience/previous work with these sectors or from reading articles about health in this sector. Don't worry if you feel you don't know ALL the hazards – the point of these cards is to start the discussion, not to provide all the answers.
4. Find/Draw a picture to illustrate the hazard – pictures can either be drawn or cut from newspapers/magazines. If you have internet

Photo: L. Alferts, Hazard cards developed during a focus group exercise with street and market traders in Accra, Ghana. Picture illustrates what your cards could look like.



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access, Google Images is a good place to find pictures. Go to Google, and type “Google Images.” Once in Google Images, type “fire” or “chemicals,” and a selection of images will come up. From there, you can choose an image that you think best illustrates the hazard, print it out and paste it onto the card.

5. Leave at least five of the hazard cards empty. These will be filled in by the workers themselves during the FGD.

To use your hazard cards during the FGD, do the following:

1. Lay out the hazard cards, including the blanks, on a table or floor.
2. Explain to the participants that you have done some reading on their working conditions, and these are some of the health and safety hazards you think they might face during their work.
3. Then ask them if there are other hazards they face at work that are not included in your cards. The participants must then draw/write the hazards onto the blank cards.
4. Next, ask the participants to place the cards in order from the hazard they consider to be the most important to that they consider to be least important.
5. The point of this exercise is not so much to create a “list” as to get the participants arguing over risks and hazards in the workplace. Often, there will be disagreements. It is important to remember that the point of the FGD is NOT to get everyone to agree. It is rather to listen and to record the differences in opinion and to find out more about why these disagreements exist.



Photo: A. Quiroga, Hazard card session working well during a focus group discussion in Accra, Ghana

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2) The Health Checklist

The health checklist was developed as a method to draw out information on workplace-related physical ill health and/or injuries of the FGD participants. Often, participants are unwilling to talk about their personal problems – especially problems relating to their bodies – in a group setting. The health checklist addresses this issue by creating a more impersonal way of talking about bodily experiences of ill-health and injury.

To use the health checklist during the FGD, do the following:

1. Get a large sheet of card and a marker pen.
2. During the FGD, explain the concept of a workplace health checklist to the participants in the following way: “In formal workplaces, like factories and offices, a health checklist is kept to make a record of illnesses or injuries that are caused by the work that people in that workplace do. We want to create a health checklist for workers who work in [markets, plantations, homes]. What do you think should be on this checklist?”
3. Record the responses of the participants on the large card. Participants may also wish to write on the card themselves. Remember to ask the participants what they think causes the specific health problems they wish to record, and record this next to the particular ailment (e.g., fever caused by blocked drains, which means mosquitoes can breed). It is important to also record the discussions and arguments that occur in the process of creating the checklist.



Photo: Health checklist being used during a focus group discussion in Ghana

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Below, an example of a health checklist from a FGD at Madina Market in Accra:

Health Checklist for Traders

- a. Reduced water in the body/ system (dehydration from sitting in the sun)
- b. Headaches (from car fumes, dust, heat and thinking too much)
- c. Waist pain (lower back pain)
- d. Back pain
- e. Neck pain (from bending over shoes to clean them)
- f. Disorganized mind (when people call you, but you don't hear them because you are thinking too much)
- g. Diarrhoea (from food poisoning)
- h. Vomiting (from food poisoning)
- i. High blood pressure and heart palpitations (from thinking too much)
- j. Malaria (mosquitoes breed in the stacked sacks of rubbish, the blocked gutters and stagnant puddles)
- k. Dizziness (too much heat)
- l. Fever (too much heat – possibly heat stroke related)
- m. Vaginal infections (from dirty toilets)
- n. Skin and nail infections on hands (from handling second hand shoes which may have been worn by people with “foot rot”)
- o. Sore ribs and chest (from shouting for long periods in order to sell wares)



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About WIEGO: Women in Informal Employment: Globalizing and Organizing is a global research-policy-action network that seeks to improve the status of the working poor, especially women, in the informal economy. WIEGO builds alliances with, and draws its membership from, three constituencies: membership-based organizations of informal workers, researchers and statisticians working on the informal economy, and professionals from development agencies interested in the informal economy. WIEGO pursues its objectives by helping to build and strengthen networks of informal worker organizations; undertaking policy analysis, statistical research and data analysis on the informal economy; providing policy advice and convening policy dialogues on the informal economy; and documenting and disseminating good practice in support of the informal workforce. For more information visit: www.wiego.org

