social sciences

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Workplace Health Hazards Faced by Migrant Domestic Workers in Spain

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Abstract: The recent enhancement of working conditions and social security for domestic service workers in Spain has enabled the integration of this group of female workers into the same legal framework as other employees. Despite the progress already made and the optimistic forecast that the ratification of Convention 189 in 2022 has opened, domestic workers continue to be one of the groups that suffer the most precariousness in Spain. Added to the laxity of the implementation of legislation is the strong presence of the underground economy and a care management model that facilitates the expansion of the deregulated market and the recruitment of irregular migrant women to occupy these precarious labor niches (live-in domestic workers). This article aims to identify the impact of psychosocial working conditions on the physical and mental health of female migrants who are live-in domestic workers in Madrid and Barcelona, Spain. The research employs semi-structured, in-depth interviews to understand the representations and experiences in migrant women's health, by unveiling the meanings of their experiences through a thematic content analysis. The study concludes with a reflection on which psychosocial, legislative, and policy-level interventions are needed to improve the health and well-being of this population of migrant women.

Keywords: migrant women; domestic workers; physical health; mental health

Citation: Parella, Sònia, Rosa Soriano, Romina Tavernelli, and Iseo Morillas. 2024. Workplace Health Hazards Faced by Migrant Domestic Workers in Spain. *Social Sciences* 13: 651. https://doi.org/10.3390/socsci13120651

Academic Editors: Theodoros Fouskas, Michael Gusmano and Janet McLaughlin

Received: 30 September 2024
Revised: 1 November 2024
Accepted: 11 November 2024
Published: 29 November 2024

1. Introduction

According to ILO estimates, there are 11.5 million migrant domestic workers worldwide (ILO 2015). About 73.4% of all migrant domestic workers are women, and high-income countries amount to nearly 80% of the total. South-eastern Asia and the Pacific hosts the largest share, with 24.0% of the world's female migrant domestic workers; followed by northern, southern, and western Europe with 22.1% of the total; and the Arab States with 19.0% (ILO 2015). An increasing number of these female workers are mothers who leave their families in the villages of the Global South to take up jobs caring for families in the North (Isaksen et al. 2008).

There is limited literature examining the experiences of domestic workers who face critical mental and physical health challenges, especially those who work and eventually live in private homes (live-in domestic service) and have left their families behind to seek better economic opportunities (Hall et al. 2019). These workers operate in private homes, the most hidden of spaces, making it extraordinarily difficult to understand the extent and nature of their issues. They may be exposed to occupational and social stressors, including exploitative working conditions, a lack of access to basic economic and social rights, and abuse and sexual and gender-based violence. All these stressors may negatively impact their quality of life, including their psychological health (Van Bortel et al. 2019). In the absence of clearly defined terms of reference, regulated payment scales and formal status, women migrant domestic workers represent one of the most vulnerable group of workers globally.

The last ten years have seen considerable progress in the regulation of domestic service in Spain, since there have been significant legislative changes, as well as a broad public debate regarding the situation in this sector, led by women's and migrant workers' organizations, which have played a very relevant role in demanding their rights. The current legislation is a consequence of years of struggle to dignify domestic service and equate its working and social conditions with those of other employed professional fields. The objective was to eliminate the most discriminatory and obsolete regimes that mainly affected women and, in recent decades, especially women of migrant origin.

While domestic service regulation has progressed in recent years in Spain, the ratification of the ILO Convention on Domestic Workers, 2011 (No. 189) of the International Labour Organization and Recommendation 201 on decent work for domestic workers only arrived in March 2023 (it has taken 12 years). Domestic workers in Spain (through unions and associations) have made constant demands in the last decade to advance towards equalizing labor rights and social protection with the rest of the employed population. This ratification must guarantee commitment to the highest international standard in terms of labor rights for this group. It will be necessary to modify existing national regulations to achieve equalization of rights.

However, despite the progress and the optimistic forecast that the ratification of Convention 189 has brought, domestic workers continue to be one of the groups that suffer the most precariousness in Spain. Added to the laxity of the implementation of the legislation is the strong presence of the underground economy and a care management model that favors the expansion of the deregulated market and the recruitment of irregular migrant women to occupy these precarious labor niches. Consequently, the intersection between the deregulation of an essential part of this market, together with the characteristics of the Immigration Law, allows for maintaining a constant volume of foreign workers in a highly vulnerable position.

In sum, the field of paid domestic and care work in Spain has historically been and continues to be largely unregulated. This is evidenced by the fact that social and employment rights are less protected than in other sectors. Furthermore, the sector is characterized by discriminatory pay and working conditions, as well as high levels of informal employment. One of the direct consequences of the absence of legal and safe means of entry in Spain for migrants is that workers in an irregular situation are overrepresented in the most precarious modality of domestic work: live-in domestic service. Oxfam (2019) estimates that around 40,000 women in Spain are employed in live-in domestic service positions, representing 7.5% of the total workforce in this sector, and that 92% of them are foreigners. These women live in their workplace, which is none other than their employer's private home. Although the live-in modality is included in the Spanish legislation, the high incidence of irregularity, the high dependence of these women on income and housing, as well as the lack of control and inspections, make situations of abuse and mistreatment prevalent and these workers are not protected by legislation, despite the progress of the last decade.

The aim of the article is to identify how psychosocial working conditions impact on physical health and mental health in female migrants who are live-in domestic workers in Madrid and Barcelona (Spain). The research applies conversational techniques (semi-structured in-depth interviews) to understand the representations and experiences in migrant women's health, by unpacking the meanings of their experiences through a thematic content analysis. The study concludes with a reflection on which psychosocial, legislative, and policy-level interventions are needed to improve the health and well-being of this population of migrant women.

2. Theoretical Foundation

The literature shows different multidimensional social stressors that migrant domestic workers may experience, which are associated with elevated health problems, both mental and physical. In their study, Van Bortel et al. (2019) identify three hierarchical interrelated

themes as causes of stress, including "work and agency", "the pervasiveness of financial need", and "family and obligation".

Concerning "work and agency", Van Bortel et al. (2019) report that the labor conditions act as a primary source of workers' stress, together with the limited agency they have in their workplaces, which exacerbates stress and contributes to other stressors. This dimension includes the power inequalities in relation to their superiors, being subject to their employment contract and the demands of the job itself, and insecurity in relation to their employment. In addition, by working behind closed doors, in isolation, domestic workers are often subject to the shifting demands of their employers—often being incredibly vulnerable to exploitation and abuse—rendering them invisible (Anderson 2000; Chang 2000; Glenn 2010; Hondagneu-Sotelo 2001; Parreñas 2001; Romero 2002; Theodore et al. 2019; Van Bortel et al. 2019; Hall et al. 2019). According to Theodore et al. (2019), the home is embedded in the relationship between domestic workers and their employers as a workplace, as is the complexity of care work and the bonds of intimacy; so that it is possible to develop bonds of trust, mutual dependence, affection, and even love (Theodore et al. 2019). Thus, domestic workers' conditions are compounded by the profoundly intimate conditions of their household labor (Anderson 2000; Theodore et al. 2019). At the same time, the relationship with employers takes on special significance since they have the authority to establish the rules and regulations and the provision of benefits which directly impact the well-being of domestic workers (for instance, being asked to work long hours without the right to a rest day or being exposed to the chemicals found in every household cleaning product) (Hall et al. 2019).

Another relevant study that compares the working conditions and their impact on general and mental health in live-in and live-out domestic workers analyses the case of Buenos Aires (Argentina), where most of these female workers come from bordering countries or from Peru (Bauleo et al. 2018). The results indicate a very high prevalence of poor self-perceived general as well as mental health. In addition, it shows differences in work tasks and social support between live-in and live-out domestic employees. Live-in domestic workers are exposed to more unfavorable working and environmental conditions, which are associated with an increased risk of poor general health; although, in general, recently arrived immigrants prefer being a live-in worker to save money on housing and to live under better housing conditions. The leading indicators of poor general health are the experience of verbal or physical violence in the workplace. In the same vein, in the Spanish case, Poch and Torresano (2019) sexual harassment in the domestic and care work sector is particularly notorious given the results of an exploratory survey that has been carried out with 80 migrant women in Catalonia. The survey also shows a considerable distance between technical and declared harassment since only 24% of the women surveyed recognize the situations presented as sexual harassment, with a tendency to normalize situations that we could consider as mild or even severe harassment, such as comments with sexual content, touching, or displaying nakedness before the worker, and marriage requests, among others.

The "pervasiveness of financial need" exacerbates the stresses associated with employment insecurity and results in exploitative situations. The necessity of employment to support themselves and their families contributes to job prioritization and employees' limited agency (Van Bortel et al. 2019). This social stressor is particularly extreme in the case of undocumented workers, who are at significant risk of exploitation and retaliation (Van Bortel et al. 2019; Casademont 2018). Consequently, the legal stressors associated with immigration status and the restrictions relating to their work permits and resident status provoke domestic workers to be afraid of speaking up for better conditions because of their undocumented status or economic constraints, discouraging claims for improving working conditions (Delgado 2017; Van Bortel et al. 2019).

Finally, the stressors associated with gender and families' needs may be considered a gender equality issue, whereby these women experience obligations both as carer and breadwinner; a dual role that is often overlooked (Van Bortel et al. 2019). This stressor

includes the gendered challenges associated with geographic distance. As a result, women who are both migrant domestic workers and have families in their countries of origin may experience stressors associated with isolation and distance from their social networks and cultures (referred to as "mothering from a distance"), and the impact experienced by the families that remain in countries of origin ("left-behind families") (Parreñas 2001).

Delgado's findings (2017), from her study of the health impacts of domestic labor on women workers in Massachusetts, also point out the integral roles of power and social vulnerability. She identifies different mechanisms that can be used to explain the disproportionate burden of work-related health challenges that domestic workers face, such as chronic pain, respiratory problems, and mental distress. Indeed, legal status and economic instability constitute the principal social stressors, but she also highlights "how repeated experiences of unfair treatment, humiliation, and discrimination within the workplace can lead to chronic stress that can impact on mental health and well-being of workers" (Delgado 2017, p. 21). The emotional challenge of being both an integral part of a family while also experiencing a sense of separation and othering produces a chronic stress that leads to a variety of adverse health outcomes, such as cardiovascular disease, decreased immune functioning, and mental illness. But in addition to the adverse conditions prevalent in the workplace and society, domestic workers are also subject to negative consequences for their health outcomes. Delgado (2017) concludes that these effects can be mitigated (in terms of decreasing vulnerability and improving health) through two processes: workers' collective organizing and employer solidarity (Anderson 2010).

As it has been demonstrated, such work environments may increase the risk of exposure to psychosocial hazards, including occupational stressors that impact on mental and physical health. These risks include exposure to physical, sexual, emotional, or financial abuse; financial stressors, exploitation, or overwork including long hours, physically taxing work, lack of days off, or work without fair compensation) (Van Bortel et al. 2019). The critical health problems identified by the research combine both physical and mental harm or effect. As we have seen, the physical demands placed upon many domestic workers render them at risk of musculoskeletal injuries; authors (Briones Vozmediano et al. 2014; Theodore et al. 2019; Malhotra et al. 2013) report health problems including respiratory illnesses, back pain, and musculoskeletal pain in their systematic review of the scientific and gray literature.

Concerning potential mental ill health, (Holroyd et al. 2001), by studying Filipino domestic workers in Hong Kong, identify four different symptom experiences (waking in the early hours, loneliness, worry, and taking a long time to get to sleep) that are directly related to mental disorders. In the same vein, Hall et al. (2019) conclude that Filipino domestic workers in China show poor physical and mental health. While physical health includes musculoskeletal, cardiovascular, respiratory disorders, and reproductive health disorders (Briones Vozmediano et al. 2014), mental health is specifically associated with stress. It is experienced through chronic body pain, dizziness, loss of consciousness, feeling of depression, anxiety, insomnia, extreme fatigue, and suicidal ideation. Futhermore, addictive behaviors have been reported, including the use of alcohol, tobacco, and gambling (Holroyd et al. 2001).

On the other hand, the so-called "care crisis" has resulted in reorganizing the care provision model in various northern countries, including the Spanish State (Pérez-Orozco 2007; Gorfinkiel 2008; Poch 2017; Parella et al. 2023). Although resorting to informal support within the family continues to be the main way of resolving care needs (in 85% of cases), over the past two decades—and because of fundamental socioeconomic changes and public policies that are weak and insufficient—a model of social organization of care begins to take shape that is sustained more and more by the migrant population. Since the late 1990s, which coincides with the consolidation of the Spanish State as a country that receives immigration, there has been a growing process of mercantilization and externalization of care. This has involved the hiring of foreign women, many of whom are in an irregular administrative situation.

Its high informality and precariousness have historically characterized salaried household employment in Spain. It is a sector characterized by a lower level of protection than other economic sectors, is significantly deregulated, and subject to clearly discriminatory working and salary conditions (Veiga 1995; Climent 2011; Nogueira and Zalakain 2015; Sainz 2014). This precariousness has been realized at a legal level. In the Spanish State, the labor nature of this sector was not recognized until 1931. A few decades later, the Workers' Statute (1980[1]) included it as a special labor relationship with a specific regulatory framework. Royal Decree 1424/1985 established that it is a labor relationship of a strictly private nature. The legal reforms of 2011 and 2012, specified in Act Nº 27/2011, Royal Decree 1620/2011 and Royal Decree-Law 29/2012, introduce significant improvements, such as integrating the Special Regime into the General Social Security Regime as a Special System and the improvement of essential aspects of working conditions. The new Royal Decree was adopted as part of a process of updating the standards applicable to domestic workers. In addition, Act No. 27/2011 of 1 August on the updating, adaptation, and modernization of the Social Security scheme incorporates the Special Social Security Scheme for Domestic Workers into the General Social Security Scheme. However, they do not consider the "special" character of domestic work—which is unique because it develops in homes and is based under highly personalized contractual conditions—and maintain elements of structural inequality, to the extent that the right to unemployment benefit is not recognized, and neither is maternity leave or a dignified retirement; in addition, discriminatory measures such as voluntary withdrawal, which allows employers to terminate contracts at their discretion, are perpetuated.

Since 2012, Spain has made progress in the formulation, reform, and approval of regulations; especially royal decrees and royal decree-laws. These legislative measures have effectively aligned the labor rights of this group of domestic workers with those of other salaried employees and facilitated the incorporation of foreign workers into the labor market (Gorfinkiel and López 2016). The demands of the ratification of ILO Convention 189 and the CJEU ruling of 24 February 2022 have led to the approval of Royal Decree-Law 16/2022. This reform makes it possible to equate the working conditions of this group with those of other employed workers in the workplace and Social Security by including unemployment protection, a historical demand of these workers.

With the enactment of Royal Decree-Law 16/2022, on 9 September 2022, the exclusion of the special employment relationship of domestic service from the scope of application of the Occupational Risk Prevention Law has been revoked. This change is a significant step in establishing the right of domestic service workers to effective protection in terms of safety and health at work, considering the specific characteristics of domestic work, with special emphasis on the area of prevention of violence against women—given that practically all domestic workers are women—and delegating the specific content of protection against occupational risks to future regulatory development.

Nevertheless, despite all these advances in rights, a report from the International Labor Organization (ILO) indicates that 30% of domestic workers in Spain worked without being affiliated with Social Security (Gorfinkiel 2016). Furthermore, almost half of the work permits granted to foreign women in 2020 were for domestic service work. The poor regulation and control of the domestic service sector, and the absence of sufficient legal channels for migration, has resulted in this sector having the highest number of workers in an irregular situation, estimated at approximately 70,000 women.

Nogueira and Zalakain (2015) confirm that the highest levels of precariousness occur precisely among women who work as interns directly for families (live-in domestic service) and have yet to obtain their first residence permit. These are the circumstances that will influence working conditions, which are already precarious:

- Informality and heterogeneity of contractual relationships.
- Precarious labor relations in a feminized environment, which translates into lower salaries, holidays and unpaid overtime, poor coverage of occupational risks, and difficulties in reconciling personal and work life.

- Confusion of roles and registers that derive from a domestic environment, in which sometimes work or professional relationships are confused with friendly family relationships.
- The separation between rest time and work time is, in many cases, ambiguous. Hourly availability is a constant, considering that for many of these women, this is precisely why some decide to hire someone to live 24 h a day in their home.
- Ethnic discrimination and application of degrading racial and gender stereotypes. Ethnic vulnerability and risks sometimes derive from employers' distrust of employees.
- The type of job insecurity that these employees face hurts their health. It favors the development of severe physical and psychosocial conditions that are often not even recognized as occupational diseases (CMIB 2017).
- It must be considered that the risk of losing the job also entails the loss of the home. Likewise, it is noted that live-in domestic workers often face difficulties in being able to register.

Regarding the profile of people employed in this sector, the presence of foreign people stands out in absolute number and percentage terms concerning the total number of affiliates, representing more than 55% of all affiliations in July 2012 (Figure 1). In general, and despite not making up half of the members in this sector, the proportion of foreign people is close to half of the memberships (Figure 1). This profile is even more definable based on the gender of the affiliates since, in 2023, more than 90% of the people affiliated with this regime were women, reflecting the feminization of said professions and tasks.

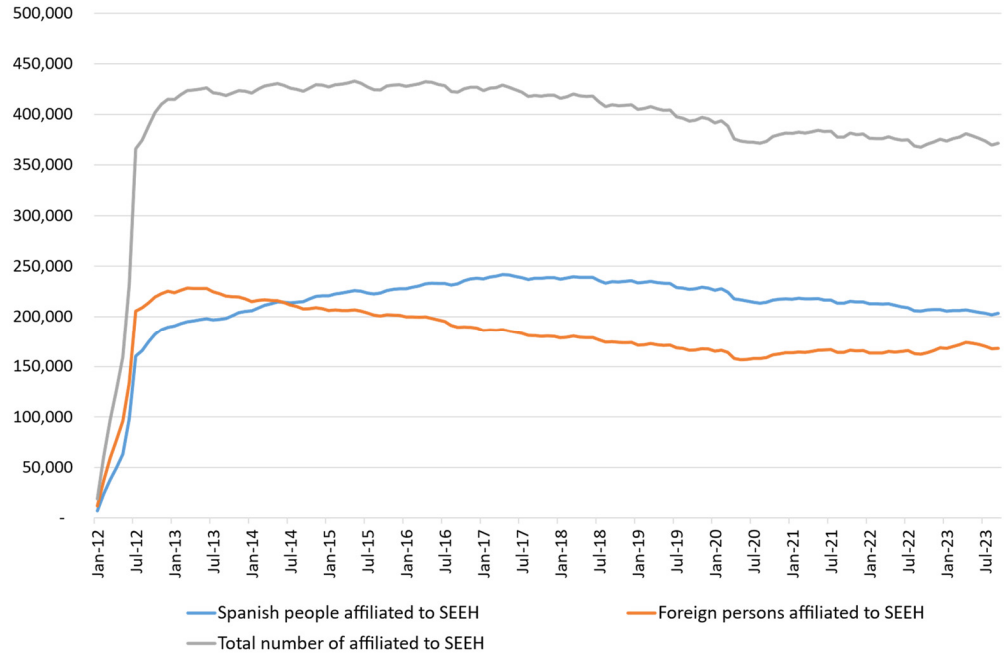

Figure 1. Spaniards and Foreigners as a percentage of the total number of persons affiliated to the Special Scheme for Domestic Workers, 2012–2023. Source: Prepared by the authors based on data from the Affiliation of Workers to the Social Security System. Ministry of Inclusion, Social Security and Migration.

A review of the distribution by age reveals a notable shift in trend over time. While in 2012, people affiliated with Social Security in the Special Regime for Domestic Employees between 25 and 34 years old represented 21.8% of the workforce within this regime, we observe that in 2023, they only represent 9.6% (Figure 2). Likewise, there is an increase in working people between 55 and 64 years old, going from 20.3% to 30.6% of the total working population, reaching 114,375 working people in this age group in 2023. It is also worth highlighting how the number of working people aged 64 or over has tripled, from

1.4% to 4.6%. Therefore, we can observe how there has been an ageing of domestic workers in the last decade.

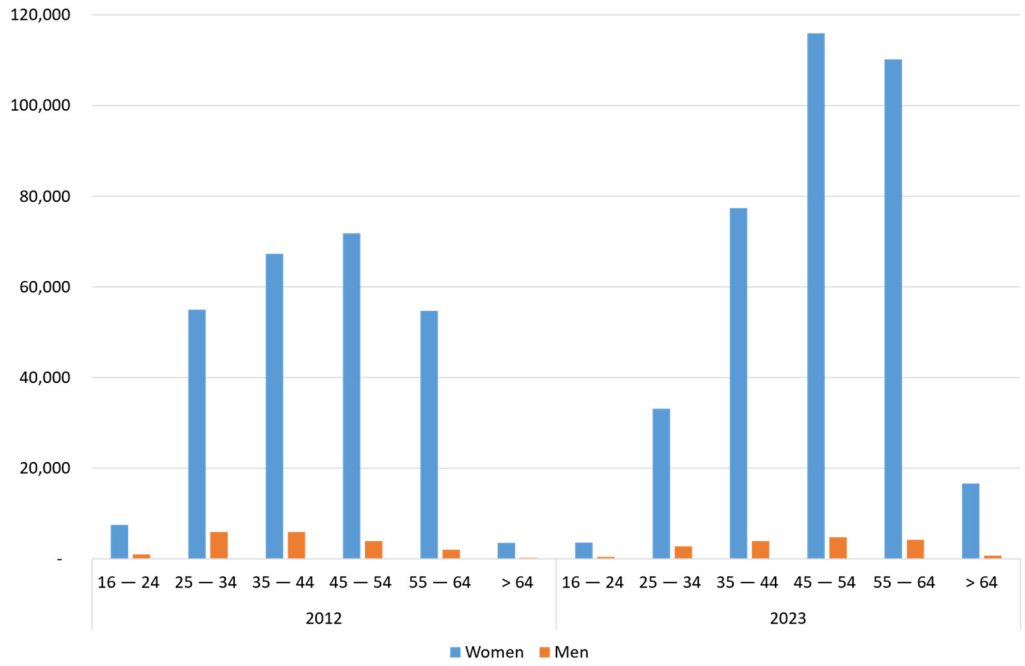

Figure 2. Total Social Security affiliates in the Special System for Household Employees, by age, 2012 and 2023. Source: Prepared by the authors based on data from the Affiliation of Workers to the Social Security System (Ministry of Inclusion, Social Security and Migration).

If we consider the leading countries of the nationality of the people affiliated with the SEEH, we observe that in 2012, the three top countries were Bolivia, Romania, and Ecuador (Figure 3). On the other hand, in 2023, the leading countries for foreign domestic workers are Romania, Honduras, and Paraguay.

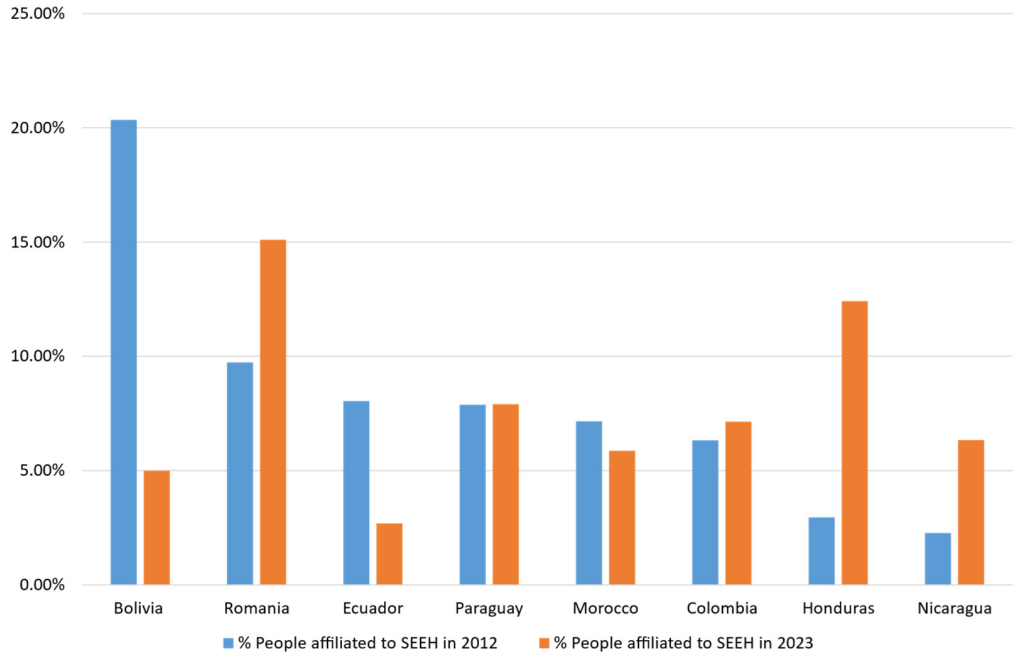

Figure 3. Main nationalities of foreign nationals affiliated to Social Security in the Special System for Household Employees, 2012 and 2023. Source: Prepared by the authors based on data from the Affiliation of Workers to the Social Security System (Ministry of Inclusion, Social Security and Migration).

Concerning the distribution of workers in the domestic employee regime by autonomous communities, it is evident that the autonomous communities with the largest population are also those with the most significant number of foreigners affiliated with Social Security in the SEEH. The Community of Madrid (35% of people affiliated with this regime), Catalonia (17.1%), and Andalusia (8.6%) occupy the top positions in this regard (Graph 5). Thus, these three autonomous communities in January 2023 collectively accounted for over 60% of foreigners affiliated with the SEEH (Figure 4).

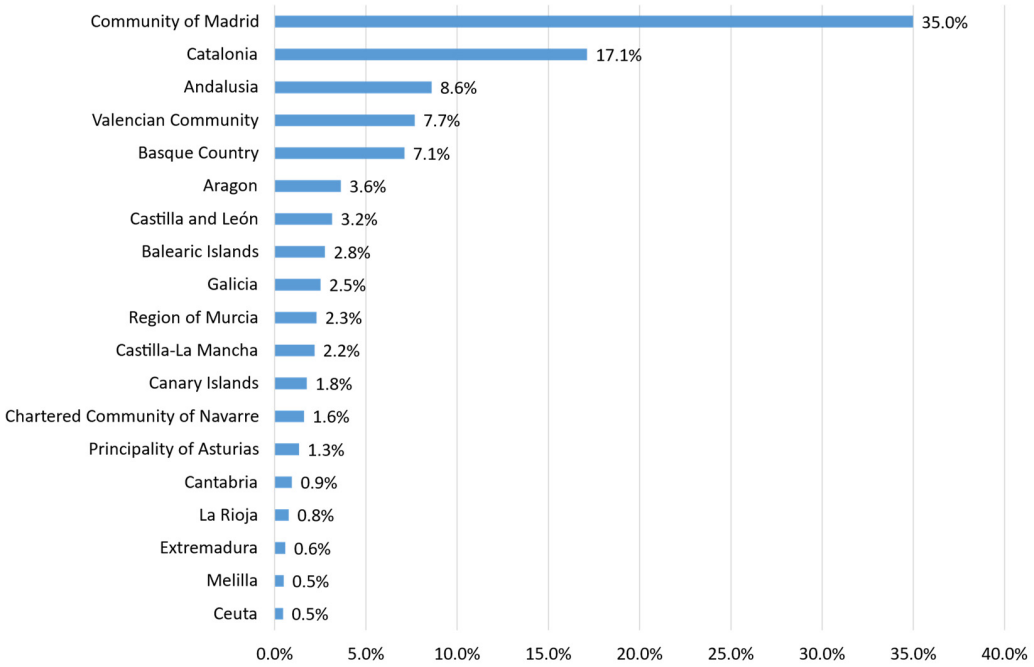

Figure 4. Distribution by Autonomous Community of foreign Social Security affiliates in the Special System for Domestic Employees, January 2023. Source: Prepared by the authors based on data from the Affiliation of Workers to the Social Security System (Ministry of Inclusion, Social Security and Migration).

3. Materials and Methods

Since the purpose of this research is to understand how the work and migration experience of domestic workers of Latin American origin—especially those who work and eventually live in private homes—affects their mental and physical health, we believe that the qualitative approach using conversational techniques is the most appropriate to answer our question. This choice was made because the main objective of qualitative research is to obtain a rich and deep understanding of people's perspectives, emotions, beliefs; and motivations about specific issues, situations, or phenomena (Álvarez-Gayou 2009). In this way, the authors intend to understand the social reality of live-in domestic workers from their own perspective, unpacking the meanings emerging from their experience.

3.1. Sampling

In order to gather a variety of situations that would allow us to understand the complexity of the research problem, we identified three specific analytical situations that we were interested in understanding in the largest Spanish cities such as Madrid and Barcelona: (1) female live-in domestic workers in an irregular legal situation with less than three years of residence in Spain; (2) female live-in domestic workers in an irregular legal situation with more than three years of residence in Spain; (3) female live-in domestic workers with an employment contract and with more than three years of residence in Spain.

Our interest in understanding such situations in large cities is due to the different findings from other research about the existing debate on the prevalence of mental health

problems in municipalities with high population density and large number of female, young, economic immigrants, with worse lifestyles, poor quality of life, or having limited social activities (Esteban et al. 2012).

To achieve sampling saturation in line with the principles of qualitative research described by (Patton 2014), it was necessary to employ a combination of non-probabilistic, purposive, and snowball sampling methods. This approach enabled us to identify regularities and particularities in the workers' experiences, and led us to the conformation of the final sample, as can be seen in Table 1.

Table 1. Sample configuration.

Interviews conducted in Barcelona							
N°	**Country**	**Age**	**Marital status**	**Year of arrival**	**Legal status**	**Family status. N° of chilldren**	**Children's place of residence**
1	Bolivia	29	Married	2023	Irregular	Nuclear 1 son	Bolivia
2	Honduras	32	Separated	2017	Regular	Single parent 1 daughter	Barcelona
3	Colombia	54	Divorced	2017	Irregular	Single parent 1 child	Colombia
4	Perú	39	Married	2021	Irregular	Nuclear 2 daughters	Barcelona
5	Honduras	32	Single	2021	Irregular	Single parent 1 son	Honduras
6	Perú	44	Married	2022	Irregular	Nuclear 2 daughters	Perú
7	Paraguay	54	Divorced	2021	Irregular	Single parent 1 son and 1 daughter	Barcelona/Paraguay
8	El Salvador	51	Married	2022	Irregular	Nuclear 1 son and 1 daughter	El Salvador
9	Perú	54	Single	2022	Irregular	Single parent 1 daughter	Perú
10	Bolivia	59	Married	2005	Naturalized	Large family 6 children	Bolivia
11	Bolivia	44	Separated	2004	Naturalized	Single parent 1 son	Bolivia
12	Paraguay	70	Separated	2005	Naturalized	Single parent 1 daughter	Barcelona /Paraguay
Interviews conducted in Madrid							
1	Ecuador	49	Single	1998	Regular	No children	-
2	Ecuador	53	Single	2000	Regular	Single parent 1 son	Honduras
3	Honduras	40	Single	2019	Regular	No children	-
4	Colombia	32	Divorcedwith partner	2023	Irregular	Nuclear 2 sons 1 daughter	Colombia
5	Honduras	42	Widow	2022	Irregular	Single parent 3 daughters	Honduras
6	Honduras	63	Single	2013	Irregular	Single parent 2 sons	Daughter: Spain/ Son: USA
7	Honduras	35	Single	2021	Irregular	No children	-
8	Bolivia	66	Single	2006	Regular	Single parent 2 daughters	Bolivia
9	Honduras	21	Single	2022	Irregular	No children	-
10	Honduras	28	Single	2023	Irregular	No children	-

The interviews were conducted over the course of three months, from October to December 2023, in both Madrid and Barcelona. The disadvantages were primarily attributable to the intrinsic nature of the internal regime in which the interviews were conducted, characterized by a paucity of rest hours and days off, which rendered it challenging to coordinate with the participants. Conversely, another disadvantage was the distrust and reluctance of a considerable number of workers to engage in the research process, which proved to be a significant obstacle, particularly during the recruitment phase.

Assuming the existing debate in qualitative research regarding on the optimal number of interviews to be conducted (Baker et al. 2017), we are closer to the approach of (Jensen 2010) by emphasizing that the true value of the research lies in the quality of the analysis, together with the care and time invested in ensuring the analytical process. Finally, 22 conversations were carried out, with an average duration of one hour. All verbal interactions were transcribed, and the interaction context was noted to enrich the subsequent analysis. The conversations took place in cafes, parks, and in women's workplaces. The necessary ethical considerations were made to ensure the women's safety in the contexts of vulnerability that characterize the situation of these workers. Thus, anonymity was guaranteed by providing a secure location for the women. In addition, strict adherence to security standards in the storage of research data has been strictly followed; and assurance that the researchers had the necessary knowledge to work sensitively, safely, and collaboratively with these women was given. This research carefully adheres to the gender, ethical, legal and societal aspects (GELSA) requested by the European Commission; including consent, participant safety, and confidentiality and data protection.

3.2. Development of the Conversation

During the fieldwork, a non-hierarchical and interactive attitude was sought between the researchers and the interviewees, following Ann Oakley's epistemological contributions about the need to create an environment in which the interviewees participate as much as the researchers in the social interaction produced (Oakley 2016). This perspective is in line with the participants' agency in the narrative practice: the interviewee as a source of knowledge and the interviewer as an active collaborator in the co-production of the narrative, e.g., through constant interaction and validation of the discourse (Gubrium and Holstein 2012).

The conversation was circumscribed to four narrative axes: (1) the migratory trajectory of the subjects, including their personal and family projects, from when the initial decision to migrate took shape until the present day; (2) the labor conditions in care work and the home attending to the labor trajectory since arrival in Spain and its impact on the conditions of the labor contract (existing or not); (3) the uses of time and space through the description of the working day/leisure time, as well as social and labor relations in the home; (4) the impact of working conditions on the quality of life and well-being, investigating expectations, migratory project or moment in the life cycle, as well as relations with the environment, the community and the family, favoring the drawing of the global care chain. The narrative of the experiences, the disorder of the interconnections, and the possible incoherencies of conversational interaction were assumed as substantive facts (Maher et al. 2018).

3.3. Analytical Approach

A thematic content analysis was chosen to understand the underlying meanings of the experiences of migrant domestic workers in Madrid and Barcelona. We opted for those categorical procedures that help to deepen the material produced, making it (con)textualizable and legible, i.e., interpretable from the recognition of the conditions in which the narratives produced have emerged (González and Velázquez 2022). For this task, the reading of the conversations and thematic identification was carried out by two researchers (separately). Subsequently, the team discussed those key incidents found in the interviews that allowed the coding process to be initiated by the researchers who had

previously worked the interviews. This second analytical process favored the discovery of the underlying categories by the research team, creating the key dimensions in the women's experiences that endorsed the findings regarding the mental and physical health of the workers.

We would like to account for the quality of our research design through the steps recommended by Roller and Lavrakas (2015). As can be seen, a flexible and thoughtful coding process was carried out, to identify meanings that could be overlooked by more general analytical techniques that would overlook those details that are more invisible in contexts of vulnerability, as exemplified by the present research.

To summarize, the following steps have been carried out in the analytical process:

1. Unique codes have been developed through a thematic matrix that pays special attention to the analysis context.
2. A dynamic coding process has been carried out incorporating pre-testing of codes, inter-coder checks and recycling of coders, whenever necessary.
3. Categories that share an underlying construct have been identified to establish patterns (or not) in the analyzed experiences.
4. Coded and categorized data have been interpreted, as well as auxiliary materials such as coders' coding forms (with their comments), and other supporting documents including the existing literature.

4. Results[2]

A prevalent assumption among the interviewees is that employment as a domestic worker entails significant personal sacrifices and has adverse effects on their well-being.

> *"I feel like I'm sacrificing a lot by doing this internship. Maybe, to be honest, I don't know if there are people who are satisfied. I'd like to meet someone who says: 'I'm happy, I'm doing great' and all that. I would like to ask... It's that you stop being yourself. And even worse, if someone, let's say, doesn't understand you, doesn't put themselves in your place, doesn't try to make you feel the way you should feel, comfortable in a job..." (MAD. E01. Bolivia)*

A clear correlation has been identified between the mental and physical experiences reported by participants. Somatization represents a pivotal aspect of the participants' experiences. A multitude of mental states and sensations, including worry, stress, confinement, and overwhelm (prevalent in most of the working relationships encountered by our interviewees), have precipitated the development of physical pathologies, spanning from minor ailments such as occasional headaches to the emergence of chronic pathologies such as hypertension and an elevated risk of myocardial infarction.

4.1. Physical Health Disorders

Situations of labor exploitation, including the absence of fixed working hours and the consequent impossibility of fixed rest periods, the right to holidays and public holidays, and wages set at the discretion of the employer, are present in the experiences of women workers to varying degrees. Such circumstances have direct consequences for the physical health of the workers in question, with symptoms including joint pain, general exhaustion, hip pain, as well as bumps, falls, and slips that are attributed to fatigue. These symptoms are often caused by factors such as flexible working hours, an unannounced increase in working hours, or insufficient time to attend to their own care needs.

> *"But it was a lot of not sleeping. I say anything goes, but not sleeping... I think it's a lot of work. I think it's a lot of work (...) But you couldn't be, let's say, resting for two or three hours in your sleep because she was already calling you with a little bell, she had like that and you had to be there for her as soon as they called you with the little bell". (BCN. 01. Bolivia)*

In addition to the working conditions, age and its impact on physical change represents another factor that influences their health. Those with longer working careers report noticing differences in performance and fatigue because of age.

> *"Age? Well, it's just that with time you get more tired, it's not like before, when I used to run and run and all that, but until now I'm more tired and I can't get there". (MAD. E02. Ecuador)*

Several occupational or work-related illnesses were attributed by many interviewees to years of domestic work. These included dust allergy, herpes, dermatitis, muscle and joint pain, headaches and chest pains, migraines, dizziness, heartburn and hiatal hernias, cardiovascular diseases, blocked arteries, and high cholesterol.

> *"My health is bad. Because I've got, I've got… What's it called? Inflamed shoulder cuff. And then, that's what I go up and down the hoovers, because I'm in a villa. There's only one hoover in the three-storey house. There are a lot of people, I mean, five people. A lot of laundry to iron and the routine moments spoil you. So, my shoulder cuff is inflamed. In other words, no matter how much you do it, they infiltrated the cuff. But since I left the hospital quickly to go to work… Because the orthopaedic surgeon told me: 'it's OK and go on with your routine life'. It doesn't seem to have had any effect because I still have the same cuff". (MAD. E02. Ecuador)*

Furthermore, health issues are identified that are related to the inability to treat pre-existing ailments that the workers had contracted prior to joining the sector, and to perform regular check-ups and follow-ups (such as periodic analyses, tests, and examinations); or to access specialized medical care that does not involve recourse to emergency services.

In this regard, the prospect of obtaining publicly funded healthcare is not always within the financial reach of these workers. For the case mentioned above, the favorable treatment and intervention she received from the family doctor constituted a pivotal moment in her professional relationship.

> *"The doctor gave me a receipt with time of arrival and time of departure. And she said 'Madam, I am writing to you. Your caregiver has been here with a disturbance in her arterial pathways. Her heart could have exploded if she had stayed at home at 200. You must be a bit more compassionate, eh? You must be very careful because people like that are at risk of cardiac arrest". (MAD. E03. Honduras)*

Nevertheless, positive experiences are infrequent. The negative experiences reported include concerns about the deterioration of the healthcare system in urban areas such as Madrid and Barcelona, as well as instances of discrimination based on ethnic or racial origin.

> *"Health care here in Madrid… it's very complicated, it's not easy. You see someone who arrives at the health centre with a passport and no papers, and they attend to them differently". (MAD. E03. Honduras)*

A significant proportion of the population ultimately elects to procure private insurance coverage, as it is more aligned with their occupational requirements. Appointments are often more expeditious, and there is less of a time lag. In certain instances, this is due to the inherent complexities of their administrative arrangements and the inability to register.

> *"Because in the end, imagine, I don't have time, I had to ask for permission to come to the doctor and of course my boss was worried. So, I opted for private insurance". (MAD. E07. Honduras)*

A further crucial factor in the well-being of women workers is the degree of empathy and support they receive from their employers. A wide range of experiences have been identified, with the most frequent being the employer's disregard for the employee's health problems. This reflects the submissive and passive role that is often ascribed to women in the workplace.

"You get sick not when you want to, but when it's your turn. And besides, I was ill. . . and I could already see it. The day before, he said to me: 'but don't go to the doctor, I have to go to the hairdresser". (MAD. E01. Ecuador)

"I had a sick leave a long time ago because my optic nerve was inflamed, and I was admitted to hospital in Castellón for 15 days. But that was horrifying because three months went by, and they kept telling me that I had spoilt their summer holidays". (MAD. E01. Ecuador)

Regarding the possibility of taking medical leave for health reasons, the way this is accomplished is contingent upon the attitude of the employer. This is particularly relevant given that a significant proportion of employers lack the necessary accommodation to enable employees to take time off work and rest. One of the interviewees had cancer and underwent two surgical procedures. She was on sick leave for a period of three months, during which she resided with the elderly individuals in her care. She recalls the treatment she received with gratitude.

"At times when I have had a health crisis, I have been able to resolve it with my own means and because of my bosses, who are always looking out for me as well". (MAD. E04. Colombia)

"So, they said to me, 'If you need something at night, you need help'. So, tell them. I don't know, but I'm a bit embarrassed (. . .) I mean, I didn't want to ask them for anything. I mean, I didn't want to depend on her. I wanted to fend for myself". (MAD. E02. Ecuador)

Additionally, there have been reports of serious risks to the physical integrity of the workers, including instances of sexual aggression, physical aggression, and attempted aggression with a knife or other bladed weapon, as well as cases of attempted drowning. Such violent episodes often result from a complex interplay of factors, including classism and a servile imaginary, as well as the behavioral manifestations of individuals with dementia in care.

"I always told him I don't know how to swim. When we moved into the villa, he came and threw me into the pool without me knowing how to swim. He had to dive in because I was drowning. . .. If I had worked with more people, I would have had the strength and then I would have even denounced him. Because that is mistreatment". (MAD. E01. Ecuador)

"The lady assaulted me, forced me out of the flat. She didn't recognise me, which is quite normal for Alzheimer's patients, but if she had been well medicated, if she had been able to control all that, then the police were called. I was very scared". (MAD. E05. Honduras)

4.2. Mental Health Disorders

In general terms, the economic needs of their families back home constitute the primary motivating factor behind their migration, driving them to accept employment that entails a range of risks to their psychophysical well-being, particularly given the confined nature of the internship and the distance from their families. Such circumstances give rise to a range of emotional consequences, including frustration, stress, despair, boredom, sadness and despondency.

"I have two daughters. Oh, I miss them a lot. And I don't like to talk about them because every time I talk about them, they break. . .it's something that breaks me (cries) But now I'm happy because they're both at university". (BCN. E01. Peru)

"Yes, yes, obviously the confinement. And then you start to think, am I doing well? I'm doing one thing and why don't I do something else. . . time goes by. Then you don't feel like you're not moving. It's like a slump, as I say". (MAD.E07. Honduras)

Female workers in this sector demonstrate remarkable resilience in the face of adversity, striving to meet the care needs of their families and achieve personal goals. These may include reuniting with their children, financing their education, and in some instances, securing housing in their home country or caring for elderly parents.

> *"Yes, I am calm, because even if not, well, sadness is always there. Because what I love and adore most in my life are my children. But I cope with it because I take refuge in my work and that's where I'm surviving until I can bring them to me. The sadness won't go away, but I'm always talking to them". (MAD. E10. Honduras)*

> *"I take care of my mother's health in my country and that is priceless to me. It doesn't matter if I have to stay locked up here for the rest of my life, but it's worth it". (MAD. E07. Honduras)*

The absence of instruments to regulate their emotional states, both at the individual and collective levels, leads many to "retreat to work" as a means of evading introspection. An alternative method is to maintain contact with friends, family, or colleagues through virtual means. It has been documented that numerous cases exist of women workers who participate in an association or collective, wherein they receive support and care from the network of individuals with whom they interact.

> *"Of course, you don't know the level of stress! It hit me here. A level that you can't even imagine between my son's adolescence, this and everything. I got sick, I got sick, I got a depression that I wasn't even aware of, I didn't know what it was like when I lived in my country". (BCN. E03. Bolivia)*

> *"It is a family for us, because the association, well, for everyone, not just for one person, one goes there with problems, but one is well supported, because they open their doors and their hearts to us. And together we fight for everything". (MAD. E08. Bolivia)*

Nevertheless, stress and anxiety are pervasive throughout the experiences of the interviewees, attributable to a multitude of factors. These include elevated levels of demand, an excess of tasks, an unfavorable work environment, poor relationships with employers, a lack of leisure time and intimacy, and the individual's personal circumstances. It is evident that stress and anxiety are prevalent, accompanied by a range of symptoms including insomnia, loss of appetite, binge eating, hair loss, mood swings, nervousness, headaches, chest pain, dizziness, nausea, skin herpes, an increased risk of heart attack and hypertension.

> *"If I have a health problem, let's say? That's why I've been putting up with it and until a month ago I told him that I no longer feel well that I feel in my body a desperation to go out, that I have anxiety, my hair is falling out, things like that". (BCN. E01. Bolivia)*

> *"I couldn't sleep. I couldn't sleep because I don't know if the work has been too hard for me, I don't know. It was. . ., I'll never forget it! January, February, March, April. . . In May I recovered, not all of me, but a part of me". (BCN. E01. Bolivia)*

Anxiety is linked to several serious disorders, with depression being the most prevalent. The symptoms of depression include a depressed mood, a sense of detachment from one's own personality, an avoidance of reality, feelings of sadness, crying, a sense of melancholy, a longing for loved ones, a lack of interest or motivation, and even suicidal thoughts.

> *"Because I just came home from work. I didn't eat or anything and I would go to work. And I would cry and cry and cry and cry and so that my nephews and the others wouldn't hear me and so on, I would put a pillow over my head. And one day, leaving there, I went to the sea. La Barceloneta. And I was there. And I said, 'What if I don't go out? I mean, suicidal thoughts". (BCN. E06. Honduras)*

Some cases of depression can be attributed directly to mistreatment by employers, including instances of insult and humiliation.

> *"That you are too fat, that I don't know what, that I don't know how much. (. . .) harassed and verbally assaulted because of my physique. Because he always thinks he has the right to shout at me, to talk to me loudly. (. . .) In the past, I didn't know, I didn't have the courage. I was blocked as a person to the point of no return. Imagine the point I reached. . .. I became depressed, anxious. I went to the doctor, and I started to cry, to cry.*

I was practically living like a zombie. . . Because when I ate, I gave back. I felt so bad, because the food didn't come in, it stayed here. Of course, because I didn't speak, it was pure psychological abuse, hard and pure". (BCN. E11. Peru)

4.3. When Health Is Not a Priority

It is a common phenomenon among domestic workers to neglect their own health and well-being. The subalternity and otherness that they experience because of their position within the social and cultural environment are internalized by them and act as a control mechanism. The most pervasive obstacle is economic. The reliance of their relatives on them to maintain the flow of remittances presents a significant obstacle to ensuring their own well-being. In prioritizing employment over their own health, they fail to recognize the importance of their own well-being. A significant proportion of the interviewees indicated that, despite experiencing pain and discomfort, they are reluctant to request time off work to attend medical appointments.

"Because you say, if I get sick, what will happen to my family who are very sick? All the pressure. . . I mean, like we don't have the right to get sick". (BCN. E05. El Salvador)

In addition to the fear of falling ill and losing their jobs and source of income, other barriers to good health exist. These include widespread food problems due to a lack of supply from employers, a lack of time to make medical appointments or engage in sporting activities, difficulties in obtaining public health coverage due to a lack of registration in the city, and a lack of financial resources to pay for private healthcare.

The strategies employed by these individuals to maintain their health are typically self-managed. The practice of self-care is pervasive among domestic workers, largely due to the absence of a support network capable of addressing their healthcare needs. However, their network (comprising association members, colleagues in the sector, friends, family members and partners) provides moral support and demonstrates concern for the workers' health. Some of these forms of remote care include the sharing of home remedies, expressions of concern regarding the health of others, and the monitoring of health-related progress.

"I'm one of those who's always: 'How are you, how are you? So, I'm always saying to the girls: "If you're ill. . .", 'Have you been to the doctor? Because there are girls who don't go to the doctor because they don't ask for permission or because they say: 'Oh, I don't know'. . . 'Go to the doctor, because when they are ill, they do go'. We are people, with different jobs, yes, but we are people. We also get sick. . . So: 'Go to the doctor. Go to the doctor, please". (MAD. E01. Ecuador)

These women often neglect their health by prioritizing the needs of their employers and families. Many migrant women domestic workers work long hours and live far from their families and communities. Self-neglect can exacerbate this isolation, making it difficult for them to establish support networks and seek help when needed.

. . . you can't afford to get depressed because it doesn't do any good, on the contrary, you get depressed, you get sick, and if you get sick, who helps you? No one. (BCN. E12. Peru)

Early discussions of self-neglect about domestic work can be traced back to the broader literature on the health and well-being of migrant workers. Spitzer et al. (2023) discuss the intersectional situation of migrant domestic workers and the stressors they face, which can lead to self-neglect, as they often adopt inappropriate self-care practices such as postponing medical care, which can lead to health complications.

. . . I didn't go to the doctor (for my muscle pains) and by the time I was too tired I had become anaemic. (BCN. E11. Perú)

The pressures of work and family obligations can lead to neglect of personal health, which resonates with the notion of self-neglect. Deshingkar (2021) highlights that many women migrate burdened by debt, turning to intermediaries and recruitment agencies who

often exploit their financial desperation. This pattern not only places them in precarious employment situations, but also contributes to a cycle of self-neglect, as they prioritize debt repayment over their health and well-being.

> *"Within the first week of starting work, I couldn't do it anymore because my head hurt, my eyes were swollen, but I thanked God for giving me a job and for being alive". (BCN. E01. Bolivia)*

In short, this behavior, which manifests itself as self-neglect, results in the renunciation of necessary health care and personal well-being in favor of fulfilling their roles as caregivers and providers for their families.

> *I wouldn't go out, because grandpa is there immobilized and how can I leave him. . . that would be abandonment. (BCN. E11. Perú)*

However, this strategy has long-term negative consequences for physical and mental health. Self-neglect can lead to problems such as chronic fatigue, sleep disorders, malnutrition, and an increased risk of developing chronic diseases. In addition, the stress and anxiety associated with self-neglect can trigger mental health problems such as depression and anxiety.

> *"When changing nappies I was sick to my stomach. I couldn't stand that smell. But eventually you get used to it and you lose the disgust and all that". (BCN. E07. Honduras)*

5. Discussion

This article describes and examines how psychosocial working conditions continues having a substantial negative impact on physical health and mental health in female migrants who are live-in domestic workers in Madrid and Barcelona (Spain). Gender, ethnicity, and working conditions—linked to servilism and discriminatory practices that are specific to this work niche for migrant women—impact participants' health, both physical and mental (Parreñas 2000). These results are consistent with other studies referring to the case of Spain (but also to other contexts) that conclude that whether the domestic workers live in or outside the home is one of the most relevant dimensions regarding exposure to negative impacts on health, together with legal status (Ahonen et al. 2010; Triandafyllidou 2013; Moré 2018; Fouskas 2021).

Our results also show that social network is the core capital at this stage of their labor trajectories (as live-in domestic workers upon arrival) in terms of preventing the health effects through collective practices to cope with social isolation (Del Rey et al. 2019; Munt 2021). Thus, personal relationships can sharpen women's strategies to resist and navigate, and positively mediate the health effects of working conditions (Briones-Vozmediano et al. 2020).

The impacts on health described also reveal the vital link between mental health and physical health. It is necessary to deepen understanding of the mediating effects of precarious working conditions and migrant status (legal situation or economic needs of their families back home) in the relationships between physical and mental health in domestic workers. As a future line of research, it should be important to investigate the impact of these physical and mental health disorders, which are intertwined, on future labor trajectories. According to Del Rey et al. (2019), the typical trajectory in domestic service begins with live-in work, then becomes external (often after family reunification processes) and, for those with more human capital, even leads on to other sectors of activity.

During the COVID 19 pandemic, migrant women were the leading providers of care and domestic work in the homes where they were confined. However, despite the critical progress Spain has made in recent years in the approval of regulations to improve the working conditions of these workers and the symbolic recognition of domestic work as "essential labour" in public discourse, labor market hierarchies and unequal relations that define domestic service persist (Pandey et al. 2021).

In the case of Spain, the solutions offered by public policies to mitigate this issue are scarce. It would be appropriate to call on public agents to be concerned about this unequal reality. In this regard, the recently approved Royal Decree 893/2024 (10 September), which

regulates the protection of safety and health in the field of domestic service within the family household and develops and implements Articles 5 and 13 of ILO Convention 189, constitutes a good starting point, although still insufficient[3]. This Royal Decree regulates and develops the right of domestic workers in family households to receive information, training, and participation in matters of occupational safety and health, monitoring of their health status, and, where applicable, the cessation of activity in the event of serious and imminent danger. It also establishes the obligation of employers to conduct the necessary risk assessments, adopt appropriate preventive measures, and provide suitable work equipment and personal protective equipment (PPE) (ILO 2024).

Although it is too early to estimate the effects of this Royal Decree 893/2024 on migrant domestic workers, in the meantime, according to (Arrieta 2024) it is possible to identify some limitations. First, an important weakness is the lack of business entity of the employer. In this sense, all the obligations attributed to employers are little or not at all adapted to their reality and possibilities, which could even lead to the promotion of informal employment and the fact that compliance with these new rules would depend on the good will of employers (for instance, if it was necessary to remodel the home). Secondly, the notion of "serious and imminent danger" is not sufficiently precise in the text. Lastly, we must consider that this Royal Decree does not conceive of any disease linked to psychosocial risks, which, as our results have shown, are those that domestic workers are most likely to suffer from.

Author Contributions: Conceptualization, S.P.; methodology, S.P. and R.S.; analysis, R.T. and I.M.; writing, S.P. and R.S.; review and editing, R.T. and I.M.; supervision, S.P. and R.S. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by Instituto de las Mujeres, Secretaría de Estado de Igualdad y Contra la Violencia de Género, Ministerio de Igualdad, Gobierno de España. Grant number: 22-1-ID22.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and an ethical protocol has been followed in accordance with the procedures indicated by the Ethics Committee of the Autonomous University of Barcelona (UAB).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data are unavailable due to privacy or ethical restrictions.

Conflicts of Interest: The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

Notes

1 From Boletin Oficial de España. https://www.boe.es/buscar/doc.php?id=BOE-A-1980-5683 Acceced on 12 September 2024.

2 All the extracts of the interviews have been translated by the writers from Spanish into English.

3 BOE-A-2024-18182 Real Decreto 893/2024, de 10 de septiembre, por el que se regula la protección de la seguridad y la salud en el ámbito del servicio del hogar familiar.

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