Chapter 9
'Well-Being' of Domestic Workers in India

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Introduction

A domestic worker is a person who works within the employer's household and completes various tasks such as housekeeping, cooking, laundry, ironing, shopping for food, taking care of children and elderly. Some domestic workers reside within their employer's household, while others live outside and work for multiple employers. The work is often undervalued and demanding. Domestic work sector is unregulated, and domestic workers are subjected to serious abuses. At times, the accommodation provided is not comfortable and they often sleep in the kitchen or other small rooms. The majority of domestic workers in densely populated developing countries like China, Mexico and India belong to rural areas and are employed by urban families (Dube 2003) in cities.

About 48% of total population of India is female and 25.6% of women form the workforce (Census 2011). Census (2011) reported that the number of female workers aged 15–59 increased by 17% from 2001 to 2011. In cities, it went above 70% from around 14.7 million in 2001 to 25 million in 2011. However, according to a report of The Task Force on Domestic Workers, domestic work has increased 222% since past decade. There is still lack of data on the exact figure of domestic workers in India. Women in Informal Employment: Globalizing and Organizing (WEIGO 2014) reported that an estimated over 50 million are engaged as domestic workers in the country. There has been a steady increase in the percentage of women engaged as domestic workers from 1999 to 2012; however, there is a small percentage of males too who are employed as domestic workers (WEIGO 2014). Very few steps have in fact been undertaken by the Government of India to provide legal protection and social security to domestic workers. Domestic workers have been included in The Unorganized Worker's Social Security Act (2008) and the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act (2013).

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Domestic workers often come from marginalized sections of the society, vulnerable communities and backward areas who are largely migrants, uneducated, unskilled and are unable to comprehend the urban labour market (WEIGO 2014).

The sector is heavily plagued with exploitation. The Ministry of Labour and Employment, Government of India, recognized the importance of domestic work and their prevalence in households and the need to regulate the sector to promote decent work to domestic workers. In 2008, domestic workers were recognized as workers in the Unorganized Sector Social Security Act, 2008. Currently, there is no specific single law prevailing for domestic workers in India. The two major hurdles that the sector faces are (i) domestic work is not recognized as actual work and is often taken as an extension of household services which are not even accounted in the GDP and (ii) lack of availability of accurate data. Most of the governments globally find it difficult to estimate accurately the number of domestic workers. Many part-time domestic workers are unlikely to report domestic work as their primary occupation.

The few challenges that plague this sector are (i) no formal contracts that ensure employee–employer relationship, (ii) lack of organization, (iii) poor negotiating power, (iv) lack of legislative protection, (v) inadequate welfare provisions. Since there is a lack of legislative protection and formal employment, often the domestic workers face physical or mental abuse almost every day. Hence, it becomes imperative to study and legislate the 'well-being' of domestic workers. This chapter outlines the concept of well-being, the different models of well-being, issues and challenges faced by domestic workers and suggests well-being initiatives that would promote positive mental health amongst domestic workers.

Concept of Well-Being

Well-being is a complex construct that addresses optimal experience and functioning. This field focuses on the positive aspects of what is right with people rather than on the negative aspects of what is wrong with people. The empirical studies are based on two theoretical traditions of Hedonia (focuses on feelings of happiness) and Eudaimonia (focuses on optimal functioning in individual and social life). Hedonia comprises of life satisfaction and predominance of positive emotions (Diener et al. 1999; Linely et al. 2009) which is equated to subjective well-being, whereas Eudaimonia consists of psychological well-being (includes self-acceptance, personal growth, purpose in life, positive relations with others, autonomy and environmental mastery) based on work of humanistic and life psychologists such as Carl Jung, Abraham Maslow, Gordon Allport, Carl Rogers and Erik Erikson (Lamers et al. 2011).

In the field of well-being research, understanding and exploring psychological, social and emotional well-being of different sections of society have gained empirical impetus with the advent of positive psychology that aims to enhance psychological functioning of individuals (Diener et al. 1999; Kahneman et al. 1999; Linely et al. 2009). Tehrani et al. (2007) envisaged well-being as a construct that represents a broader bio-psycho-social model that entails the physical, mental and social well-

being that is more than the mere absence of physical sickness. Well-being has been defined in several ways such as '*ability to fulfill goals*' (Foresight Mental Capital and Well-being Project 2008), '*as happiness*' (Pollard and Lee 2003), '*as life satisfaction*' (Diener and Suh 1998; Seligman 2002) and '*state of being comfortable, healthy or happy*' (Shah and Marks 2004). In other words, well-being entails feeling satisfied and happy so that individuals would effectively contribute towards the community. Different researchers have proposed different models of well-being, which are discussed in brief in the next section.

Models of Well-Being

The recent and most important models of well-being are conceptually discussed in this section. The models have been validated in India and globally.

Mental Health Continuum Model

Lately, Keyes (2002) redefined well-being by converging the two traditions together, thus stating that well-being is the presence of emotional, psychological and social well-being. Definition of Keyes aligns with WHO definition of mental health '*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community*' (WHO 2004, p. 21). Thus, the definition indicates that well-being is perceived as effective functioning at individual and community level. Corey and Keyes (2005, 2007) proposes a mental health model with equivalence to mental illness model that focuses on a syndrome of symptoms that emphasizes subjective well-being. Subjective well-being is individuals' perceptions and evaluations of their own lives in terms of their affective states and their psychological and social functioning (Keyes and Waterman). Another integral part of positive functioning is emotional well-being. Emotional well-being is a cluster of symptoms reflecting the presence or absence of positive feelings about life, which is assessed as positive affect and negative affect. Like mental illness (such as depression), mental health is more than mere presence and absence of emotional states. Therefore, Keyes used the term diagnosis to identify mental health categories such as flourishing, moderate mental health and languishing mental health for different components of well-being such as psychological well-being, emotional well-being and social well-being.

PERMA Model

Seligman (2002) proposes three vital elements of well-being: pleasure, engagement, and meaning. His recent theory decomposes the construct of well-being into five components which are essential for people to experience lasting happiness, namely positive emotions, engagement, positive relationships, meaning/purpose in life and accomplishment (PERMA) (Seligman 2011). Seligman (2011) suggests that these five domains can be defined and measured independently; however, they are highly correlated. This model assesses well-being across multiple domains and does not condense the responses to single flourishing score.

Psychological Capital (PsyCap) Model

Seligman and Csikszentmihalyi (2000) states that psychology focused on 'fixing' mental illness and dysfunctional behaviour, rather than on understanding and facilitating normal functioning as well as growth and development in healthy individuals. There was a lack of empirical literature on what makes people healthy, happy, productive, creative, function normally and capable of living, working and loving. This gap was recognized, and a new area of positive psychology was proposed. Large application of positive psychology has been seen in the fields of management and organizational behaviour. Primarily the literature can now be classified into three main areas, namely (i) positive organizational scholarship that emphasizes the positive characteristics of organization that facilitate its ability to function during crisis; (ii) positive organizational behaviour, which is defined as study and application of positively oriented human resources strengths and psychological capacities that can be measured, developed and effectively managed for performance improvement at workplace and (iii) PsyCap which is defined as '*an individual's positive psychological state of development that is characterized by (i) having confidence (self-efficacy) to accept and put in necessary efforts to succeed in challenging task, (ii) making a positive reference (optimism) about succeeding now and in the future, (iii) persevering toward goals and redirecting as and when required in order to succeed (hope) and (iv) when faced with problems and adversity, to sustain oneself and bounce back (resilience) and stretch one's limit to attain success*' (Luthans et al. 2015). The major functions of this model are that it (i) facilitates positive cognitive appraisals of past, present and future events; (ii) predicts satisfaction with work, health, relationships and life in general; (iii) facilitates the processes necessary for attention, interpretation and retention of positive and constructive memories that are conducive to well-being; (iv) has broadening and building effect on positive affective states that can be drawn during adversity; and (v) helps mitigate the prevalent negativity bias and adaptation, sustaining well-being over time.

Quality of Life (QOL)

The QOL is the general well-being of individuals and societies that outline the negative and positive features of life. The model consists of satisfaction with life and health, social relationships, psychological well-being, physical health and environmental health (WHO 1996; Skevington 2001). The concept of QOL has emerged significantly over a decade. The general QOL is different from the other recent models of QOL such as health-related quality of life (HRQOL) and work-related quality of life (WRQOL). HRQOL is an assessment of the quality of life and its relationship with health, and WRQOL is a multidimensional construct that is closely associated with job satisfaction, job involvement, motivation, productivity, health, safety and well-being, job security, competence development, and balance between work and non-work life. The WRQOL considers that people are trustworthy, responsible and capable of making a valuable contribution to their organization, and they treat other people too with respect (Rethinam and Ismail 2008; Vijaimadhavan and Raju 2013).

Well-Being of Domestic Workers

With the advent of modernization, it was predicted that paid domestic work would cease to exist. However, the prediction has been proved horribly wrong. Rather in few countries, paid domestic work has grown rapidly. In few Asian countries such as India and China, interstate migration has predominantly increased, whereas in other countries such as USA, Canada, Western Europe and Gulf states, migrant domestic workers from other countries have seen a growth (Moors 2003). There is still lack of empirical research on psychological health and well-being of paid domestic work undertaken by academia. Most of the work on paid domestic workers are concentrated on the field of gender studies focusing on gender inequalities, wage disparities, lack of legalization and legal framework for employment, socio-economic conditions, caste discrimination, non-recognition of skills and role of placement agencies.

World Health Organization (WHO) has estimated that mental and behavioural disorders account for 12% of global burden of disease (Division of Epidemiology, St. John's Research Institute, St. John's National Academy of Health Sciences, Bangalore, India). Yet, a lot of attention has been paid to physical health diseases and not to mental and behavioural disorders. In urban areas, employed mothers from low-income groups face a plethora of challenges in their domestic, environmental and working conditions that may affect their mental well-being. Often these women reside in slums and work as domestic workers. Empirical evidence suggested that life stressors associated with poor financial status increase risk of mental health disorders (Parkar et al. 2003; Patel and Kleinman 2003) and women are more vulnerable than men to mental health disorders such as depressive disorders, schizophrenia, affective disorders and self-inflicted injuries (WHO 2005).

A research carried out in urban South India with 26,001 participants demonstrated that 15.1% recorded the prevalence of depression. Depression was observed higher in women who belonged to low-income groups (Poongothai et al. 2009). The probable cause could be their living conditions that are marked with challenging socio-physical environment which can take a toll on their mental health (Gruebner et al. 2012). Kermode et al. (2007) identified that different risk factors such as poverty, poor living, poor working conditions, alcoholic husbands, intimate partner violence and financial difficulties enhanced the chances of depression, suicidal ideation and attempt to suicide amongst women. Silvanus and Subramanian (2012) demonstrated that in urban slums people suffered from serious mental health issues which were related to financial problems, marital conflicts, interpersonal conflicts and housing problems. Similar results were reported on low-income working mothers in Bangalore through a qualitative study (Travasso et al. 2014).

Khillare and Sonawane (2016) studied the impact of work life of women domestic workers on their family life. The results indicated that many women found it difficult to maintain work–family balance. Most of the time, it was difficult and this leads to disputes in the family environment which were often aggravated due to an alcoholic husband. Further, the researchers documented that most of the women worked more than three–five hours daily, their wages ranged from 1,000 to 2,000 rupees and they suffered from various physical ailments and health issues.

Different empirical studies have been conducted amongst urban slum dwellers to identify risk factors for depression and suicide. An ethnographic study set in Mumbai slums found that alcoholism amongst husbands, intimate partner violence, financial stressors and poor living and working conditions increased the risk of depression (Parkar et al. 2003), whereas Patel et al. (2010) mentioned that factors including poor financial status, marital conflicts and alcoholism were associated with increased risk of suicide. Another study set in urban Indian slums affirmed the same and revealed that 63.31% of the study sample had serious mental disorders which were related to financial issues, marital difficulties, interpersonal conflicts and housing problems. Similarly, in rural areas, Kermode et al. (2007) found that attempted suicide amongst women increased with husband's alcohol consumption, intimate partner violence and financial difficulties.

Issues and Challenges Faced by Domestic Workers

The domestic work sector is plagued by several challenges since it is not highly regulated by laws. It is important to understand the issues and challenges as these can hamper the mental health and well-being of an individual. Indian female domestic workers usually come from the underdeveloped regions of states of Jharkhand, West Bengal and Assam primarily, who migrate across states and transnationally to seek work as domestic workers in affluent homes. Many of them are under the legal age of working, and their wages are less than the minimum. The employers range from India's elite to upper middle class and even middle class households, who believe

in the traditional hierarchical division between 'servants' and 'masters'. Mental, physical or at times sexual abuse is not a rarity. Often subtle discrimination in the form of eating leftovers after employers have finished their meals, sitting on the floor, is still commonly practised (WEIGO 2014).

The domestic work sector absorbs the unskilled and less educated or illiterate women who have limited job opportunities. Low or no educational level leads to limited negotiating power and hence low earnings. The Ministry of Labour and Employment, Government of India, in the Final Report of Task Force of Domestic Workers (p. 46) stated the following problems that are faced by domestic workers:

i. Lack of decent wages.
ii. Poor working conditions.
iii. Lack of uniformity and fixed monetary and non-monetary benefits like holidays.
iv. Violence, abuse and sexual harassment at workplace. Several cases such as not providing sufficient food to eat, not allowing the domestic worker to sit on a chair and not letting them use the toilet in the house are common employer behaviours that domestic workers have to face.
v. Exploitation by placement agencies.
vi. Lack of benefits such as social security, health insurance benefits, maternity protection and old-age security.

Through empirical evidence and reviewing literature, Chandrashekhar and Ghosh (2007) and Gothoskar (2005) listed few challenges and issues that domestic workers face.

Unregulated and Underpaid: Due to the lack of legal regulation, often the workforce is underpaid. A large number of female participation and location in private space of household and low level of participation of women in formal employment resulted in lack of regulation and underpayment for the services. Though several state governments in India such as Andhra Pradesh, Karnataka, Kerala, Bihar, Jharkhand, Tamil Nadu and Rajasthan have notified the sector under minimum wage, yet fewer attempts and efforts are made to enforce legislation (Chen 2012; Bhattacharya, Sukumar and Mani 2016). In the domain of mental health literature, there is lack of consensus on the linkage of economic indicators and well-being. Hence, it cannot be stated that regulation of payment will enhance the well-being. However, regulation would lead to enhancing their current quality of life, enrolment of children especially girls in primary schools, and a decrease in the dropout rate of secondary school girls.

Caste and Religion: In India, caste and religion still continue to dominate and determine the division of labour and tasks assigned. Often employers arbitrarily associate caste of a domestic worker on the basis of worker's skin colour. Through an empirical study, Chen (2012) reported that women from backward castes are largely employed in cleaning tasks while upper-caste women are employed in the kitchen as cooks or for washing dishes. Furthermore, the study indicated that often women migrated from rural to urban to avoid such caste-based stereotypes. The workers opined that the social transformation of the urban locale which comprised of young professional nuclear households employed workers without prejudice. Also often the migrant

workers preferred to keep their caste identities undisclosed to better their chances of finding employment. Research studies (Corrigan 2004; Contrada et al. 2000; Harrell 2000) have documented that stigma and stereotypes diminish self-esteem, self-efficacy, cognitive appraisal, attributions of an individual, and robs people of social opportunities and social support. Furthermore, Harrell (2000) stated that stereotypes, stigma and racism lead to physical ailments such as hypertension, cardiovascular reactivity, risk behaviour (e.g. cigarette smoking); psychological distress such as depression, anxiety, trauma-related symptoms and hostility; and it also impacts social connectedness, job performance, academic achievement, and parental functioning.

Non-recognition of Skills: A patriarchal notion that a women worker is inherently unskilled is still prevalent in modern India. A hypocritical attitude prevails such as domestic worker cooking food is considered to be unskilled, but a chef cooking in the hotel is considered skilled; such attitudes have resulted in undervaluing and consequently in underpayment of domestic workers (Bhattacharya, Sukumar and Mani 2016). The non-recognition of skills is likely to affect self-concept, self-esteem, achievement motivation and increase hostility and aggression in a person. However, there is lack of empirical documentation in this area and further work is required.

Working Conditions: Through a participatory research, Bhattacharya, Sukumar and Mani (2016) demonstrated that domestic workers often chose their work hours according to the employer's family needs. Thus, newly married and younger domestic workers went out to work while their husbands were at work or children were at school and they worked in more households, whereas older women worked with fewer households. The women claimed to abstain from taking leaves and hardly any weekly off. Often women took leave only on important occasions such as to visit a native place or when they or their children were sick. Women claimed that they regularly received a festival bonus and annual bonus. Due to visiting several households in a day, the women faced physical health problems such as a backache, aching limbs, colds and fevers, skin infections arising due to unsafe corrosive detergents, instances of kidney stones as a consequence of lack of adequate access to drinking water and acute anaemia. The women workers expressed displeasure for excessive supervision by female employers. Workers felt uncomfortable and irritated when there was a continuous demand for perfection in work and employer closely watching the speed, accuracy and quality of their work.

The Centre for Civil Society reports (Tandon 2012) that apart from issues and challenges, the domestic workers aspire for education for themselves; education for their next generation; less commission to agent and more wages to maid; land/property/house of their own; sanitation facilities; engage in skill-building activities like stitching and get decent square meals daily. Dar and Rani (2014) reported vulnerable conditions of domestic workers in Punjab. Through an empirical study, the different reasons for vulnerability documented were casteism, gender-based discrimination, poor financial status, irregular work, very little or no bargaining control, lack of credit facilities, substance abuse/dependency amongst male family members, the death of a spouse, and lack of property.

The challenges that plague the sector have a damaging effect on the mental health of the domestic workers. To the best of the knowledge of authors, there is lack of Indian empirical evidence with respect to the application of well-being models for domestic workers. The research studies have identified the different factors that affect the social and non-cognitive skills of domestic workers. However, there are no intervention programmes yet designed for domestic workers. A few NGOs work closely with issues of domestic workers. These NGOs primarily cater to the full-time domestic workers who reside with the employer or the domestic workers who are registered as part of a placement agency. The issues of part-time domestic workers who work in multiple houses are not addressed, and their mental health is rarely discussed. The succeeding section recommends few well-being initiatives for addressing and enhancing the well-being of domestic workers.

Well-Being Initiatives

Few studies (Balaji et al. 2012; Patel et al. 2010) have demonstrated that effectiveness of small-scale initiatives is necessary to provide community-based mental health services in India. However, there is still an ongoing need to design customized well-being initiatives for different population groups. Travasson et al. (2014) suggested that well-being initiatives should address the issue of intimate partner violence since it is associated with alcohol and is one of the most frequently reported causes of poor mental health. Globally, a strong relationship between intimate partner violence and depression is widely reported. This is also a cause of suicide ideation and suicidal attempts (Koenig et al. 2006). This is being tackled by several NGOs who have started counselling services and shelters for abused women but awareness remains low coupled with uneven access. Challenges that NGOs face in delivering such services are numerous. There is a need to address community and structural drivers such as women's power, male identity, social and community norms, family elder's roles in family income generation and investigation of partner violence (Jewkes 2002; Krishnan et al. 2012). There is a huge need in India to identify the intimate partner violence and mental health support services (Kermode et al. 2007) to avoid mental stress and as a consequence the tendency towards committing suicide.

Dil Mil intervention is currently taking place in Southern India that identifies the participants through primary health clinics and aims to provide intergenerational counselling sessions to daughters-in-law and mothers-in-law. The sessions are based on participatory learning and action principles and involve stories, role play and discussions. Co-counselling which aims to build peer support and empathy through dyadic peer counselling interactions within the groups is practised (Kauffman and New 2004; Krishnan et al. 2012). During the course of *Dil Mil* intervention, it was noted that domestic violence was seen to be a private family matter and external sources of support were largely not encouraged by family members.

Lack of child care facilities burdened women which affected largely their mental health and well-being. Many of them received little to no help from their spouses or

other family members. However, given that the ratio of women working in informal sector in India, there is a need to uplift the child care facilities along with providing support services such as creating a platform to share experiences that could help reduce feelings of social isolation (Kingsnorth et al. 2011; Ainbinder et al. 1998) with strong linkage and referral systems to mental health professionals who can provide access to psychiatric services. It is important for the women to be employed as it is not only economically benefitting but also promotes positive mental health for women especially when their children are of school age.

Government of India policies such as Public Distribution System (PDS), Mahatma Gandhi National Rural Employment Guarantee (MGNREG), Indira Gandhi National Old Age Pension Scheme (IGNOAPS), Indira Awas Yojana (IAY), Rashtriya Swasthya Bima Yojana (RSBY), Universal Health Insurance Scheme or the National Policy for Domestic Workers address the biological aspects of well-being models. The psychological or social aspects of well-being model are largely not addressed. The physical health, food and housing needs are covered by the different schemes. However, the domestic workers face complex psychological problems compounded by health issues which are rarely addressed. Thus, there is a strong need to not only identify the problems but also address the same through intervention and awareness programmes.

Recommendations

There is a need for government and other institutions such as educational institutions and NGOs to consider mental health crucial to the overall health of the population since it has an influence on national development. Integration of mental health research (preventive model) is required with health research systems (curative model) to enhance interactions and avoid inefficiencies, gaps and replications. The government needs to establish a national and regional mental health organization to identify and monitor research gaps, formulate priorities, advocate for international funds, assess research capacity, establish networks, disseminate information and provide technical and financial support. The government needs to invest in mental health research capacity strengthening, particularly through research training and incentives for mental health professionals. Additionally, mental health training needs to be included in curriculum or as training programmes for police personnel, medical professionals and para-professionals, teachers and *Anganwadi* workers.

Interaction of mental health professionals and social workers is most important. Together they can conduct regular mental health interventions and awareness programmes that would focus on increasing physical activity, reducing stress, effective time management, improving interpersonal relationships with a focus on the family environment. The presence of efficient functional *Anganwadi* too helps women to combat stress. Often *Anganwadi* workers are the first available point of contact outside the community. *Anganwadi* centres in rural and urban slum areas can prepare customized intervention programmes with the help of mental health professionals.

Conclusion

Even if the domestic work sector is plagued with unregulated low wages and lack of policies, it is essential to understand the well-being and mental health of domestic workers. Through different empirical studies, it has been observed that these largely women domestic workers suffer from depression, anxiety, suicide ideation and suicidal attempts. They face a plethora of interwoven and complex web of problems that range from intimate partner violence, alcoholic male family members, lack of child care facilities, financial burden, and inter-relationship conflicts and many more. Thus, addressing issues related to their mental health and well-being becomes imperative. However, there are very few intervention programmes being conducted to cater to their mental health problems. In future, mental health programmes addressing these issues need to be designed and documented scientifically and need to be pursued diligently in the modern welfare society.

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