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Health Meanings among Foreign Domestic Workers in Singapore: A Culture-Centered Approach

Economic migration is integral to processes of globalization, with large numbers of the global poor moving across borders in search of employment in the face of structural adjustment programs and large-scale displacement of the poor from traditional forms of livelihood. One such group are foreign domestic workers (FDWs). In this culture-centered study, we listen to the voices of FDWs in Singapore to understand the key meanings of health held by this group of migrant workers as they negotiate living and working in Singapore. Through the representation of FDW voices at sites where they have previously been excluded, we hope to co-create participatory spaces in national discourse so that policies and interventions can be developed to address the health needs of FDWs. The results represented in this essay are part of a larger project engaging the CCA to foster communicative platforms for structural transformation.

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Economic migration is integral to processes of globalization, with large numbers of the global poor moving across borders in search of employment in the face of structural adjustment programs and large-scale displacement of the poor from traditional livelihoods (Dutta, 2015). A 2010 World Bank report on the member countries of the Association of Southeast Asian Nations (ASEAN)1 informed that as much as one-third of their combined population is comprised of migrant workers (Phua, Hui, Nodzenski, & Bacolod, 2012). One such group of migrant workers are foreign domestic workers (FDWs). These workers move to wealthy economies such as Singapore to perform feminized labor such as housekeeping and childcare, with lodging and meals provided by their employers. Labor migration, such as that undertaken by FDWs, occurs in the backdrop of nations opening up to international trade, with neoliberal development promising to be the panacea to global poverty and poor population health (e.g., structural adjustment programs; see Dutta, 2015). Existing scholarship documents the poor health outcomes and low socioeconomic status among immigrants, attributed to lack of access to local health services, information and resources, and poor quality of health care in the host country (Dutta & Jamil, 2013 Dutta, M. J., & Jamil, R. (2013). These conditions of inaccess are further exacerbated by the abominable working conditions and the lack of safety nets with which migrant workers often struggle amid trying to make a living (Dutta, 2008, 2015). Specifically, in the context of Singapore, the poor health of low-wage migrant workers is affected by adjustment problems, poor living conditions, long working hours, and workplace risks (Humanitarian Organization for Migration Economics [HOME], 2011a, 2011b).

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In the realm of the health of migrant workers in Singapore, a report published by HOME (2011a, 2011b), a civil society organization that works on rights of migrant workers in Singapore, noted that the health needs of migrant workers seem to be overlooked in national policy as there are no health care subsidies for migrant workers (HOME, 2011a, 2011b). The Human Rights Watch (2005) reported at least 147 FDW deaths due to workplace accidents or suicide in Singapore between 1999 and 2005. Additionally, we note that no data on the number of FDWs who face labor and other human rights violations is readily available (Human Rights Watch, 2005). In this backdrop, local non-governmental migrant welfare organizations Transient Workers Count Too (TWC2) and HOME have campaigned for structural changes such as the provision of a mandatory weekly rest day for FDWs, which was finally codified into law on 1 January 2013 (Singapore Ministry of Manpower [MOM], 2012a).

In Singapore, public health planning and policy development are conventionally undertaken by the government, informed by relevant experts. Quah (1984) called this the top-down manner of policy formulation and implementation, where policies are designed and governed by experts. Similar to top-down policymaking processes globally, conceptualizing problems and developing solutions are confined to policy-makers and experts (Dutta, 2015). Migrant workers themselves are often absent from these discursive spaces (Dutta & Jamil, 2013; Human Rights Watch, 2005). Furthermore, migrant worker health issues often receive minimal attention because of the transient nature of their work (Phua et al., 2012), matched by a dearth of peer-reviewed research on migrant worker health in Singapore. Noting this erasure of FDWs from discursive spaces of policymaking and program implementation

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(Dutta, 2008, 2015), we employ a culture-centered approach (CCA) to understand migrant worker health in Singapore (Dutta, 2008). Based on the argument that the absence of migrant workers from structures of articulation constitutes their marginalization, we seek to foster spaces for listening to the absent voices of migrant workers at the margins (Dutta, 2008). In this culture-centered study, we listen to the voices of FDWs in Singapore to understand their key meanings of health as they negotiate living and working in Singapore (Dutta, 2008, 2011). Through the presence of FDW voices in spaces where they have previously been excluded, we hope to co-create participatory spaces in national discourse so policies and interventions can be developed to address their health needs. The results represented in this essay are part of a larger project engaging the CCA to foster communicative spaces for structural transformation.

Foreign domestic work in Singapore

In recent decades, globalization and the proliferation of neo- liberal, transnational trading practices have led to unprecedented population movements worldwide (Dutta, 2008, 2015). Neoliberalism is characterized by trade policies that encourage the free flow of goods, capital, and labor through privatization and the removal of trade barriers such as import quotas and tariffs. The opening up of national economies to international trade has led to a global surge in demand for cheap, low-skilled labor, especially for jobs classified as "3D," dirty, demanding, and dangerous (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2003). Singapore, as a fast-growing emerging economy with a heavy reliance on foreign labor, has been one such country on the receiving end of the global population movement. Migrant workers represent more than 23% of the total population

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(Singapore Department of Statistics [DOS], 2012), a twofold increase from the year 2000 (DOS, 2012). One key trend in global migration patterns has been the growing proportion of women leaving their home countries for employment (Dutta, 2015). The ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (2012) estimates that 49% of global migration is undertaken by women. Migrant female workers are often employed in households to perform duties such as housekeeping, and taking care of young children and the elderly. In 2012 in Singapore, 208,400 FDWs came from neighboring countries such as the Philippines, Indonesia, Myanmar, Sri Lanka, India, Thailand, and Bangladesh (MOM, 2012b).

Policies and laws governing foreign domestic worker health

The rights and entitlements of migrant workers are often regulated by state authorities of the host country (Dutta, 2015). The employment and welfare of FDWs in Singapore fall under the purview of the Ministry of Manpower (MOM), the regulatory body of the government that is responsible for all workforce matters, including foreign labor. In order to be issued a Work Permit by MOM for employment in Singapore, FDWs are required to be between the ages of 23 and 50, and possess a minimum of 8 years' formal education (MOM, 2012c). All first-time FDWs are required to attend a Settling-In Programme (SIP) within three working days of arriving in Singapore. SIP is an orientation course that aims to introduce an FDW to Singapore, conditions of employment, work safety, relationship and stress management (MOM, 2012d). An FDW can obtain their work permits only if she passes a mandatory medical examination within 14 days of their arrival in Singapore; subsequent

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medical examinations are also required every six months to check for infectious diseases such as HIV, tuberculosis, and malaria (MOM, 2012d).

With regard to the health and well-being of FDWs, the Employment of Foreign Manpower Act (EFMA) states that employers must meet standards such as ensuring healthy and safe working conditions, supplying adequate and nutritious food, bearing medical costs, and purchasing and maintaining individual medical insurance (MOM, 2011; Phua et al., 2012). The EFMA also protects FDWs from exploitation, such as late payment of wages, and ill-treatment such as physical, verbal, and sexual abuse. These are also punishable offences by law. Employers are required to maintain a minimum medical insurance of SGD 15,000 per annum for their FDW to cover inpatient care and hospital bills, as well as a personal accident policy with a minimum assurance of SGD 40,000. The Act also clearly prohibits employers from passing on health care costs and other employer financial obligations on to the FDW. Other migrant health care rights include access to emergency health care, general health insurance, and workplace accident rehabilitation and compensation (Hall, 2011).

Challenges for foreign domestic worker health

Migration brings with it challenges in adapting to a new social and physical environment. Resettlement issues such as social isolation, discrimination, and even xenophobia often lead to poorer emotional and mental wellbeing in migrant populations (Dutta & Jamil, 2013). FDWs in Singapore not only face problems with mental health, they are also subject to other issues pertaining to their employment which can negatively impact their health; these include poor living conditions, and sexual and psychological abuse from employers (HOME, 2011a). Despite the policies and legal protections as stated earlier, these

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infractions still and often persist. MOM reported that the number of physical abuse cases against FDWs has fallen from 157 cases in 1997–1960 in 2009 (Hall, 2011). However, HOME (2011b) claims that these statistics, though reflecting a downward trend, underestimate the extent of the problem; many abuse cases go unreported or cases are dropped because of insufficient evidence. FDWs may also be reticent to report employment rights violations to the authorities because many are saddled with debt and live in fear of being sent home prematurely. MOM investigations and court processes are long, lasting up to 2 years—during this period, FDWs are not allowed to be employed as their work permits have been revoked (Hall, 2011).

In addition, HOME interviewed 151 FDWs in 2012 and found that all but two of the participants had been subjected to forms of exploitation such as overworking, dismal working and living conditions, and hazardous work. FDW deaths have also been known to occur due to suicide, workplace accidents, or poor living conditions, although no official population statistics have been released (HOME, 2011a). Overall, the health challenges faced by FDWs in Singapore not only pertain to the physical and mental rigors of moving to and settling in a new country, but also stem from unfair and inhumane treatment during their term of employment.

We can see the symbolic marginalization of FDWs through the absence of their voices in public discourses in Singapore. Our ethnographic archival research suggests that so far in Singapore most solutions offered to protect FDWs typically focus on a top-down approach, frequently focused on the employers as those holding the power. For example, there are new regulations stating that FDWs are not allowed to use ladders in the house

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without the supervision of the employer (MOM, 2012d). Although this policy is targeting the protection of FDWs, it fundamentally grants more control to the employer, while creating an even larger power distance between the employer and FDW. While steps must be taken to solve health issues faced by FDWs in Singapore, we must also take care not to approach problem-solving in a top-down manner, which assumes the passivity of FDWs; otherwise, we risk perpetuating and maintaining the marginality of FDWs (Dutta, 2008, 2015). To address the erasure of FDWs from discursive spaces in Singapore, we adopt a culturecentered approach that allows the voices of FDW to emerge from the margins.

Culture-centered approach and voices of the margins

Culture has been increasingly recognized by scholars for its role in influencing health and health behaviors (e.g., Dutta, 2008, 2015; Dutta & Jamil, 2013). Interest among health communication scholars and practitioners has grown over how culture can be accounted for and utilized in the development of effective health interventions and programs (Dutta, 2008). Dutta (2008) argued that being sensitive to the cultural environment of at-risk populations is insufficient in addressing the health of the margins; ultimately, the health problem and its messaging and programmatic solutions are almost exclusively conceived by experts, with little to no input from the cultural participants. In the culture centered approach, for culture to play a more central role in health promotion efforts, communities at the margins have to be able to articulate and conceptualize the problem on their own cultural terms. The recognition of the target population's context, which according to Dutta (2008), not only includes culture, but structure as well, is key to centralizing culture in health communication research. With an

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emphasis on the agency of communities at the margins, the CCA foregrounds the location of meanings at the intersections of the dynamic interplay among culture, structure, and agency.

Structural conditions need to try and understand the health needs of a target population. In the realm of health, structures refer to the systems of distribution that allocate health care resources, often unequally due to power disparities in society (Dutta, 2008, 2011). These structural constraints, emerging from political and economic conditions both locally and globally, not only shape the individual's perspective of health, they also restrict certain health behaviors while enabling others (Dutta, 2008). In other words, manifested health practices are enactments of a social actor's agency within his/her structural environment. Hence, health behaviors need to be understood in terms of their structural determinants instead of studying isolated, individual actions. With this understanding, we will draw from our conversations with FDWs that articulate their locally constructed meanings of health within cultural and structural contexts during their time of employment (Dutta, 2008). We ask the following research question:

RQ: What are the meanings of health to foreign domestic workers living in Singapore?

Method

We proceeded with our primary method of data collection, a series of in-depth interviews once our interviewing protocol was approved by the university's Institutional Review Board. Our NGO partner, Humanitarian Organization for Migration Economics (HOME), assisted with the recruitment of study participants and with the scheduling of interviews. HOME is registered in Singapore under the Societies Act in 2004, is funded

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primarily through fundraising, and in effect has many outlets for community outreach. HOME provides services such as emergency help lines and help desks, caseworker support, shelters for workers who have experienced abuse, health education, and vocational development (e.g., language classes, care-giving classes, etc.). Based on similar culture-centered studies (e.g., Dutta 2004; Dutta & Jamil, 2013), we interviewed 20 participants. Each interview took place at HOME's shelter and lasted between 30 and 90 min

Participant recruitment

The respondents in our interviews were distressed FDWs who had been working in households in Singapore from 2 to 18 months. Given the nature of the population (FDWs who escaped their employers' homes for a variety of reasons and are currently staying at a shelter at HOME), we recognize that the cases we report are potentially some of the most extreme. However, we also know that these women are most disenfranchised in terms of their access to health care. In other words, we engaged with women who were marginalized because of disparities inherent in policy and health support access in Singapore. We were interested in hearing the voices HEALTH COMMUNICATION 645 of the FDWs' and co-creating resources for open dialogic space for listening to the voices of FDWs (Dutta, 2008).

Interviewing

The interviews were semi-structured, with the following key open-ended questions: What does health mean to you? What are your lived experiences in negotiating health? What are some of the challenges you face in seeking health? How do you work through these challenges? They were audiorecorded and transcribed verbatim for analysis, and the excerpts from the interviews reflect the participants' mixed language use of occasional native

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language (quoted herein with researcher translation) and verbatim non-native English. Throughout the project, the interviewers kept field journals to document our thoughts, feelings, and reflections.

Data analysis

The data was analyzed using open, axial, and selective coding (Charmaz, 2011). At the initial stage of open coding, we kept ourselves receptive to various conceptual possibilities as we examined the transcripts and field journals, line by line, for implied and explicit meanings (Charmaz, 2011). In axial coding, related codes that surfaced in open coding were grouped into conceptual clusters, followed by synthesis in selective coding.

Findings

Material struggles and health

Material struggle refers to the FDW's experience with structural barriers in accessing tangible resources such as food and financial stability that can consequently negatively affect their experiences with health. These material struggles are broadly constituted in economic inaccess. In other words, participants share that one of their key challenges is in negotiating the material conditions of inaccess they find themselves amid. Financial insecurity and food inaccess emerged as structural frames of health, which are also intertwined within the FDW–employer relationship. The structural impediments to health they experience (food insecurity and financial inaccess) are constituted amid the relationships of FDWs with their employers. Food inaccess emerged in several different forms including the traditional sense of not having enough food to eat and having adequate meal times (breakfast, lunch, and dinner), but also,

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many participants discussed food security through a culturally situated lens of access to culturally appropriate foods.

Food insecurity

Participants expressed their understandings of health by explaining their struggles to access food during employment. The most consistent form in which food emerged as a theme was in terms of access to adequate quantity of food. In the following excerpt, Rosalyn2 described an instance when her health was severely compromised. Her employer refused to provide her with adequate nutrition:

> She didn't give enough food, and I was always hungry. She gave me rice one week one time. After that, I mopped all the house with my hands, and I felt tired and hungry. And then, after, after that, my employer Ma'am, I said, can I take the one bread? She said no. The child, the Ma'am's child, she said can I give her the one piece of bread. She [referring to the employer] said no, you must drink only water. You must wait what time you eat. And then after that, my hands and whole body were shaking.

In this story, the absence of food manifests physically in the experiences of the body amid hard physical labor. Given also that an FDW's duties comprise manual and physically intensive labor such as housecleaning and childminding, having enough food becomes important in maintaining health amidst performing the work. For instance, Rona recounted:

> There's not enough food, not enough food, so that's why I realize that, um, it's okay to stay in my country, cause ah, in my country even not enough money but can eat enough number of times and … people there can

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> understand what you feel…. Here, in the morning, not enough food. No bread, no bread. You just drink Milo, like that.

Melinda struggled in her first month with the scarcity of food. She was not used to just having bread, especially with the heavy work that she did:

> If in the morning, I will say enough, ah the coffee and two pieces of bread is enough for me, but then with work work work then no more, no more, no more energy. […] (Back home) I eat rice three times a day.

With the hard work she did, Melinda felt weak because of not having access to sufficient food. Her depiction of not having adequate food to eat was juxtaposed amid the many hours (often between 14 and 16 h) of hard work that she had to do as an FDW.

For Jane, food was often a problem, especially regarding her access to having timely meals due to the workload. She said:

> My first employer … I think food is a big problem. Because they are full vegetarian. They eat rice once in a week only. They only eat chapati, parantha … Their rice is the parantha, chapati, something like that. And as a Filipino, because in the Philippines, we eat three times a day, rice. Then if sometimes, I don't want to eat parantha, because I think parantha is not enough for me, because that one is, for them it's okay, but for me it's not enough, then I sometimes eat one noodle. One noodle for me is not enough. Because I work too much, I sweat too much. Then I think that not enough for me. In my first employer, food is a big problem. But I just keep silent, because the first month, when they give me my allowance, then I buy bread for me, so when I

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> am hungry, I eat a bit, I eat bread so I didn't feel too much hungry. Until lunch come, then until dinner come. Then when I cook, always scold me, this one, how many days you are here aah, then till now you did not cook perfectly … How come aah?

Jane's experience is situated amid the cultural differences between what she considers to be adequate food and what her employers consider to be adequate food. For her employers, eating breads such as chapati and parantha are considered adequate food, but this is not the case for her culturally. She shares her cultural background as a Filipino, sharing how Filipinos eat rice three times a day. In order to address this structural problem of what she culturally considers to be adequate food, Jane uses her monthly allowance to buy food for herself

Melinda further explained that her employer often limited her access to food:

> Nothing. Wait for lunch. I just wait for my Ma'am. Hinihintay ko yung employer ko na magsabi na kakain na kami, kahit (I wait for my employer to tell me that we can eat already) even if I feel so very very hungry and tired. Sometimes also even if I'm thirsty, *nahihiya akong uminom* (I am shy even to drink without my employer's permission).

Consequently, Melinda asked help from her sister, who is also working as an FDW in Singapore. She sought access to food outside of the structure by reaching out to her sister:

> Then *nung ano na tinext ko sa Ate ko tapos nagdala sila ng pagkain, biskwit* (I texted my sister and she brought food for me, biscuits). So when I feel hungry, I take my biscuit, eat drink, continue again work.

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In some scenarios such as Melinda's, family members or friends (other FDWs) emerge as sources of support for securing access to food. Also, an emphasis on cultural aspects of food access emerged. Since there are cultural differences between FDWs and their employers, the participants often shared that the type of food provided by their employers are not culturally suitable. Alice described:

> Because they not give me enough food. What I mean enough food is the right food for me. Because I have an allergy almost to everything. Spicy and chicken. Now I can eat again. It's spicy. Because the foods in Singapore. The food also cause trouble in your body. Because it's very different from the Philippines.

Alice shared that she often could not eat the food she was given because the food was so different from what she was used to. Similarly, Simone described her cultural struggle in accessing food:

> Our culture and tradition is specially the food is rice, with rice. So, they are mostly vegetarian and eat vegetables. So, with the food, that also okay, but my stomach still looking for the rice. That I ask permission from them ask for respect if they could provide rice for me or cannot…. And I said, if I can buy my own rice, still cannot, because they don't want me to use her rice cooker in her pantry because she said it would waste the electricity.

Simone struggled with not having rice, a cultural staple, and considered as a basic ingredient of food. When she sought for permission from her employer to cook rice, her employer refused, referring to electricity waste. Simone's narrative informs us about the

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ruptures in the cultural construction of food that is structurally situated in the nature of domestic work.

Struggling with the dietary preferences of her employer being imposed on her diet, Maya shared how she was left to eat the leftovers, and often felt she did not have enough to eat. She said,

> My weight dropped. Then they say, how come your weight become lost. Because I say I never eat butter, never eat milk, never take egg. Because they're vegetarian, they don't want some kind of dairy product. So we eat veggie, fish. So I lost my weight. I never eat fried, any kind of fried. They never eat so I also never eat because with this employer, what I cook for them, the leftover was for me. Always. I never cook for myself. When I eat with my previous employers, I think it's not healthy to eat porridge morning and lunch, sometimes lunch and evening. It's not healthy. That's my challenge. If they go outside, just eat bee hoon or give you $2 to buy whatever you want. But only $2 can buy only *bee hoon*. I think it's okay … it's a challenge. I eat … Never mind.

After being asked to describe what is healthy, Mim also defined her food insecurity as based on inaccessibility to sufficient food and also on the pressure to eat whatever the employer prefers:

> … I think also when I go to Singapore my weight is 59 (kg) then I lost, I'm only 52 (kg). Yeah, but I don't know, for me enough food but I think I don't

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like the food of the Chinese food here. Yeah that's why, I lost my weight then I'm going to sleep because I'm so tired.

Anne described a similar struggle in negotiating the right to choice of food when she said, "Then I stay, I think I don't have choice, I have to eat that because I don't want to have, to request them for another thing just only for me. I tried to manage myself to what they eat I will eat." Mim described her experiences with food insecurity by expressing her exclusion from the right to food because she did not have a say in the buying process: "Then the one, the youngest, he said to me, 'You cannot eat the food huh? You cannot eat because you never buy that.' Like that food is for that family only." The access to food thus is situated amid buying choices, access to decision-making, and exclusion from the sites of participation. The accounts of insufficient food shared by the participants expressed the difficulty for them to perform their work well. Access to food is multidimensional in that it is not solely about the quantity of food, but it is also about meal times and the cultural components of food choice.

Financial (in) security

Financial need is the most common motivation for FDWs migrating to Singapore and a driving force for their resilience in their work in spite of the hardships they experience. Kena shares, "I am always worried about money. So all that worry gets into my body. That's what I think of when I think of health." Some FDWs are motivated by the need to support family back home, some are forced into the structure by a sudden need of money for an incidental cause (such as a health crisis), and others are looking for financial opportunity based on recruiters' promises. Being away from their family, negotiating financial stress (particularly regarding paying off agency debts that they are required to take in order to

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emigrate as FDWs), and their desperation to achieve some form of financial security are intertwined with the FDWs' conceptualizations of health, both physical and mental. Whatever the case, the FDWs communicated the structural barriers they face in achieving financial security, and this being the key challenge to health. For instance, Jennifer described her financial insecurity:

> … financial break down again. Then I ask the agency to help me to come … My father has a lung problem and my parent is with me and my son…. Until now, my father is under the lung observation, it costs 550 dollars a month medication. So if I work here, I could earn 500 dollars, which is not enough of course … Then if I go back to the Philippines, I will never receive my salary [Jennifer is unable to go back to the Philippines to see her ailing father because she is currently paying off the debt to the agency through her work and only earning an allowance. If she goes back, she would have to switch employers, and this would mean she would have to pay for additional deductions]. Because if we change employer, the agency will top up [deductions] for two months. Additional two months for deduction. We came here for six-month deduction. If you want to transfer, you have another two months of deduction. So we come home empty handed. We only earn thirty dollars a month for allowance [the money paid to her in the months when her salary is being deducted].

Jennifer's sharing of her financial insecurity brings forth the sense of indebtedness in which FDWs continue to perform their work. They state that the agency fees and monthly

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deductions essentially mean that they have to work for between 6 and 8 months to pay off the agency fees, and this impacts their health and well-being. In their narratives, it becomes evident that an FDW stays in a health-threatening situation often because of this financial insecurity.

Money is a strong impetus for FDWs coming to work in Singapore. Consequently, for the participants, finances become intertwined with their perceptions of health. Rosalyn, for example, describes her unstable financial situation during her employment in Singapore: "And then, I finished paying the loan. Finishing the loan in six months again. Six months again. Because my agent said every time you transfer, your loan is even higher." This for her is the main threat to her health as it keeps her under stress. For Tina, even though staying in Singapore would mean being away from home, she endures the distance for the simple reason that she can get a better salary here for the position of a domestic worker:

> I have experience in Malaysia also, working laundry. If Singapore took laundry, Malaysia is dhoby. Working as dhoby in Malaysia. I also maybe want to do business like that, but I have no money. Maybe if I had money, lot of money, I can do business, but I must earn money first. I think I go to Singapore to earn. I want to earn money, I want to keep for my future, because my children are everything I sacrifice for. But this always make me stressed.

Tina's experience of stress is situated amid her financial insecurity and her need to support her children and her dreams.

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Anne described the structural forces that are impeding her from reaching financial security, outlining the reasons why she has to continue working as a domestic worker, staying away from her family and from her children:

> Before I came to Singapore, when you sign the contract there, that would be your, your salary. So I believe in that. And 450 [Sing $] in our place would be good enough to save also money because before I left the Philippines, I put up a small loan actually. And then, um, then after knowing the 200 salary deduction, 200 dollars only

Anne describes how the deductions she has to pay are a source of stress for her, on top of the stress of being away from her children. Some participants further explained the constant struggle with getting out of debt as a barrier to feeling healthy. Rona explained:

> Because my agency called already to the Philippines and to my mother, that uh, that they ask money, they ask money, 100,000 pesos in the Philippines, that's worth here, I think $3,000 if I want to go back home. Then, my mother don't have enough money for them to pay because I'm here. I go here to work to earn money, so, so, my mother also has a problem in the Philippines.

She noted, "Just like that, my agency asked the money from my mother so then how can I be health (begins crying) because I think that I came here to work, then my agency how come to ask the money from my family?" Throughout the narratives, the financial stress of the debt that FDWs have to pay to come to Singapore is a recurring threat to health. Amid these materially grounded structural impediments, participants shared their experiences with expressing their agency in negotiating health.

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Health as an expression of agency

Agency in health manifests as the conscious decisions that individuals make within the constraints of their structural environments (Dutta, 2011). The participants narrated stories of the choices they make in enacting healthy behaviors, suggesting their involvement in everyday health. For example, Sandy, Anne, and Alice suggest that health is a personal responsibility. Sandy explained, "If I don't get sick, no pain, how to say, just take care of myself. A bit dizzy or what, take medicine, like that. Like that take care." Similarly, Anne discussed her responsibility in managing her health, saying, "Because I am the one who can manage myself regarding the foods and the detergents, I should be careful." Finally, Alice echoed the importance of self-care, "You care for yourself. You are the responsible one for yourself. That is the first thing. Then, especially the personal hygiene here is very good. A lot of water. And the ambiance is good. This is only about how you care about yourself." Health, for these women, resides in their agency in making healthy choices.

Health as physical self-care

The participants discussed the various steps they take to keep themselves healthy. Even within the confines of their houses, work schedules, and working conditions, the women communicated about their participation in healthy behaviors such as exercising, eating nutritious foods, getting enough sleep, drinking water, and self-medication through formal and informal methods. Many participants voiced that exercise is a key component of maintaining physical health. Tina noted a range of purposeful actions that she undertakes to keep herself healthy: "… healthy is, if must exercise, then can be healthy. Must eat food also, must eat healthy food … no so many, so much oil. Sometimes, can eat rice, veggie and fruits,

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milk, like that. Don't so many eat ah coffee, don't so many eat oil, and must do exercise … and can be healthy and can be fit." These choices, Tina explains, are limited by the constraints of work, and yet are important. She therefore discusses various strategies she comes up with, such as making sure she drinks enough water, and making sure she gets enough exercise by 648 M. J. DUTTA ET AL. walking while doing chores. While FDWs have heavy workloads, they discussed how they still find ways to keep themselves healthy within the structural constraints of their employment. Their concept of health is thus deeply tied to the confines of their work schedule. Liz described how she can still exercise while doing her housework:

> I walk the staircase and that's how I get my exercise. I bring the thing [load she has to carry] upstairs, bringing downstairs in the staircase. I feel I am less stressed. Also I do in shelter now. If I feel stress, I go to second floor.

Like Liz, Tara defined health as a way of everyday life, which involves drinking lots of water as well as engaging in regular exercise, configured into the chores she has to perform.

> More I water, drink water, water, a lot I drink. Water also I like. I exercise also. So this is how I take care, you know, every day. I take care of my ah ma, cannot walk, cannot sleep, so I lift her, I transfer her to wheelchair, transfer her to bed. Everyday exercise already (laughs) you know … I run, run, run … I am cleaning also, mopping also … so later … she doesn't want to … I'm trying also … then I lift her. Every day, I don't need to exercise. I am cleaning also, taking care also, everyday exercise already

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Also, Puput voices, "drink water and only drink water." Similarly, note the conversation with Gina:

Interviewer: So, when you cannot breathe, what do you do?

Gina: Drink more water.

Interviewer: Drink water. It cures you?

Gina: Yes. Drink water, and sit down at the back. At the laundry room. Sit there. Then lay back. Drink water.

Interviewer: Okay. So you have never visited any doctor when you are in the house?

Gina: No. I never visit … I am scared. I am scared also. Sometimes, because I bring the Philippines medicine. Every day, after work. I take. Before I go to sleep, I was in a lot of pain.

Similar to Gina, when formal medical access is not available, Puput described the importance of getting enough rest to stay healthy:

Puput: No. I think, I just sleep only.

Interviewer: If you feel sick, you have stomach ache, you just rest?

Puput: Yes

Interviewer: No need for medicine?

Puput: Yes.

Interviewer: You do not ask ma'am?

Puput: No. I do not ask ma'am. […]

Interviewer: In Indonesia when you are sick, what do you do?

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Puput: I go to doctor.

Similarly, Sara stated the significance of finding solutions to health problems on her own first before consulting a doctor or taking allopathic medicine.

> I take care of the food I eat. You know, nose blood came out. I cannot walk also. So I lie down. I be like that, one hour, two hours. Pass motion, I drink the water a lot. So I also okay. No need to take the medicine. I pass urine … sometimes, it's very painful. Cannot pass urine. So I drink water, a lot drink. So it's okay, you know.

The importance of self-care highlights how participants address their health needs amid the structural constraints. Seeking medicine is an important act of agency for some of our participants. Rinah decided to self-medicate when her employer hit her with a broom and denied causing the injury. She decided to go to a shop nearby and asked the staff for a suitable medicine on her own:

Rinah: I had to buy it myself because my Madam did not believe me. My madam said that she did not hurt me that hard.

Interviewer: How did you purchase the cream?

Rinah: I told the cashier that I wanted to buy a cream for my swollen head.

Interviewer: You paid for this item yourself?

Rinah: Yes, because my madam did not believe me.

Interviewer: How much did you pay?

Rinah: For a small one, it was $3.50.

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Melinda describes that when she feels sick, taking medicine that she brought with herself is the solution, "*Uhm oo, uminom ako ng gamot kasi may dala ako na gamot* (Yes, I take medicine because I brought my own medicine). I rest, I rest for a little while then going to work again."

Moreover, many of the participants expressed a strong belief in the speed and effectiveness of home-made solutions to common health problems like headaches, stomach ache, and body pain. Gina feels that going to the doctor is a waste of time and money, and that traditional healing methods are much more cost effective as well as help cure the problem fully. This is yet another way in which domestic workers like Sam exhibit agency in order to keep healthy. This is what she said:

> Sometimes, if I ask ma'am, I have a headache, and my employer asks to go see a doctor, but I don't want to see a doctor because only headache, I can take Panadol. I only take care of myself if I sometimes have a headache, if I am not feeling well, then I don't want to go to see the doctor. Because if I go to a doctor, waste money. I only do like that…only one day, I have headache, cannot work… I take oil and I take coin and do like that … all my body, I do and then … I some fit … I take coin and oil. Some more oil … balm, some tiger also can … yeah, so easy. I no need to use my employer's money. My employer talks to me to go see doctor, but I don't want to go. I only take Panadol and some more like that. Tomorrow, I'm healthy. My employer also follows me like that. If you have a headache, you sometime you think the

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> sleeping is wrong, the pillow is wrong, you only can do like that. I only like that. No need to see a doctor.

Finally, the expression of "living well" emerged as healthy choices enacted by the participants to maintain physical health. Living well is constituted by making hygienic and nutritious food choices amid the structural limitations. For Melinda, health means having proper hygiene and eating nutritious food such as fruits and vegetables.

> Proper hygiene is so important. We should make ourselves be comfortable. Take a bath every day, brush our teeth, and eat vegetables and fruits to maintain our body health.

For Maya, being healthy is about eating and living well. She defines health as:

> Health means like your body healthy, eat well, live well. That's all. If you're sick, you must go to the doctor. Live well means you're happy with your work. You're happy with the environment that you're working in. That's it. Then the food that you eat is good. Healthy, then enough. Enough food and healthy food. That is the meaning of health for me.

Health as mental self-care

In addition to these physical and behavioral manifestations of self-care demonstrated by some of the participants, a number of the participants shared strategies of remaining mentally strong and seeking health in the midst of the structural constraints. They discussed strategies that help them feel peace of mind. Achieving peace of mind is depicted as being involved in activities, or seeking out and maintaining connections with friends. Rona described her experience after coming to the shelter and being involved in activities: "We

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have peace of mind. Because [at the shelter], we have some more activities like have the yoga [class], then have the cooking [class], baking [class], like that. So much fun. Then, you can take rest, you can refresh your mind again. Then the food is enough; so the food is very nice there, then can, enough, enough." Mim described how she feels healthy when she participates in activities and laughs with friends: "We, all of the girls in shelter participate in activities, play like that then you never feel sad. Yeah, you feel better, all your friends laughing."

Similarly, Anne defines happiness as being involved in something that she is proud of:

> And then, one thing that make me happy here is the time I became a singer in the choir…I feel so proud of it. And then, we sing also in the Harbourfront on the HOME anniversary and then going to school at UWC (United World College, a private international school where self-improvement classes are offered for FDWs on the weekends) taking some cooking lessons, have some sports, computer.

For Meera, getting a day off from work is very important to being healthy, not only as a way of resting the body, but also as a way to relieve herself of all the tension and stress.

Other ways the participants described their enactment of healthy behaviors within the structural parameters of their work schedules are through singing, laughing, joking, and sharing stories with friends. Angeline described:

> Yeah, singing and laughing, joking with friend. This can be healthy. The heart can be healthy because singing and laughing, no stress. Yeah! singing, laughing, joking, still young. This also can be healthy. Yeah, every time I

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> sing, I relax. I like joking with friends like that. I listen to songs. After that, I sing. Before I sleep also, I sing … Sometime, I remember my memory, my family, my children like that … No need to cry, just sing, sing and can, no stress. Only laugh, sing, and joke, this can still keep you young.

Sandy echoed enacting similar strategies. When she feels stressed, she uses singing as her coping strategy: "I sing … If they are not in the house, I sing loud, loud. Like I cry also." Similarly, Mim describes: "[I cope by] just crying, then sometimes I tell myself, no, I don't want to cry because I know I can handle this."

Health as spiritual self-care

Another manifestation of agency FDWs enact is through spiritual self-care, referring to health as being inseparable from their faith. For instance, Jane discusses spiritual health in the following way, "Most important for me I think is … the most is spiritually … because I think, if you have spiritual health, then it pushes the other health so that it can grow. Because, if spiritually, God help us, for our physical and especially emotional. That one what I know." When asked what she means by spiritual health, Jane responded:

> Spiritually, is for example, strong faith in God, because I am a Protestant. Yeah, so because before I come here in Singapore, I am not too much. Maybe, I go to churches, but I am not strong faith in God, maybe, something like that because maybe, sometimes I am weak, then I have a trouble, then I think 'aaah how come aah,' like this one. I don't know if I can do this one but some trouble comes in my life, then I think only the one who help me is God. Yes, like the other people, like HOME, help me because they provide me my

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things but I need also to commit my life to God so that he can help me to continue my life too so that I face all the struggles in my life.

Like Jane, Anne discussed finding strength through faith in God. She described God as the one giving her strength and peace, and narrated her story about how she copes with feeling alone or sad, "When you feel that you are already alone, and you're with God. Um, you are that strong enough. You need no more suffering, what more is so, what more to feel afraid?" Faith in God is also talked about through the manifestation of the power of prayer. Simone discussed her faith in God and prayer as a source of strength. Talking about her interaction with one of the MOM officers, she discussed how she found a sudden transformation in the officer's attitude toward her, which she attributes to the power of her prayers: "Which is the same officer, may be, I pray to God and touch her heart. She was talking to us properly like a human." She brings to light her belief in prayer as a healing power and as a route to regaining health:

Interviewer: But how do you keep your body healthy, like do you exercise?

Simone: No, no, no.

Interviewer: Dancing or singing?

Simone: Only one answer. You know how? Prayers.

Interviewer: Prayers? Also, you pray?

Simone: Pray to God

Interviewer: Pray to God, you pray to God all the time?

Simone: Yes, that's the only one. That's the only one I could answer, because you know, I have been sick for six months.

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Participants also define health by upholding their commitment to faith in God in different ways. Anne demonstrates this commitment through voicing her responsibility to forgive her employers so she will not stay angry and find peace instead:

> I am always praying to God that I am thankful that I have my new life once again because that time, I don't know if I'd live again because of the suffering. And then I already forgive them because what for to keep angry, what for? Because if Lord God can forgive, how you could, how could be me only that could not forgive them?

Mary also talks about how it is important to not lose that commitment to God irrespective of one's lived experiences. "Good or bad, one must stay committed to God." She says,

> Even also sometimes I forget. Sometimes I'm getting okay already, just relax, sometimes I forget also to pray. Forgot also to thank God. Then when I have a problem, why? Maybe, she asks: why you forget me when you're in good shape? Why, when you're down, you're asking for my help? Then now you're good why you forget me? Maybe that one makes me want to pray every day.

Discussion

In sharing their understanding of health, the FDWs we interviewed highlighted the location of health as the interplay of structure and agency, with everyday meanings of health serving as anchors through which participants come to understand their situation and act in finding as well as practicing health solutions (Dutta, 2008). The precarious nature of

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domestic work is contextually located in the setting of domestic work, carried out within households and therefore, limited structurally by the invisibility of the work. The health threats of domestic work are marked by this invisibility, hidden from sites of policy implementation and regulation. Participants negotiate their agency amid these structural constraints, reflecting the key theoretical argument in the CCA about the location of meanings at the intersections of structure and agency (Dutta, 2008). The meanings of health thus emerge as sites of articulation of structures that constrain health, and the agentic expressions that negotiate these structures. Throughout the interviews, the FDWs express many points of agency as they work within the sociopolitical structures of domestic work in Singapore, make sense of these structures, and voice the various pathways through which they negotiate these structures. Agency/agentic action and the structural forces governing access to food and financial security emerged as a significant theme in defining meanings of health as co-constructed by FDWs. Discourses of access to healthy food are situated amid the structural impediments of inaccess to food for many FDWs. Amid the structural contexts of not having access to sufficient, culturally appropriate and nutritious food, participants, for instance, discuss the ways in which they drink water to keep themselves healthy. The negotiations of health choices thus are contextually embedded, constituted within the everyday negotiations of securing access to food. Additionally, the negative health outcomes experienced by FDWs are situated amid the structural pressures that create cycles of maintaining the status quo in Singapore. The agentic action of the FDW, despite the structures that marginalize them, is a reality that is in opposition to the mainstream

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perceptions of FDWs' health decisions, and lack of agency as we have seen in news articles and policy discussions.

The FDW accounts of insufficient food expressed the difficulty for them to perform their work well. Access to food is multidimensional in that it is not solely about quantity, but also about meal times and the cultural components of food choices that are available for FDWs. Finally, defining health by linking it with wages provides a link to discussing how this material access is further manifested through financial insecurity as well. Being away from the family, negotiating financial stress, and the desperation to achieve some form of financial security are intertwined with the FDWs' conceptualizations of health, both physical and mental. These narratives highlight the power of the structure to further marginalize FDWs in Singapore, limiting the extent to which FDWs can negotiate their financial security. Because of the financial insecurity, the FDW's enactment of agency plays out in developing pathways for seeking support and praying that mitigate the experiences of stress.

Agentic action manifested throughout the interviews in the following three categories: Health as physical self-care, health as mental self-care, and health as spiritual self-care. These various forms of self-care depict the strategies that the participants put in place in negotiating structures. While FDWs have heavy workloads, they discussed how they still find ways to keep themselves healthy within the structure of their employment. Self-medication is presented in the form of two different strategies: (a) when they are faced with barriers to accessing healthcare, and (b) as a preferred alternative to seeing a doctor (need to be given the space to practice health behaviors that will be most beneficial to the FDW). The participants demonstrate agency as negotiation of the structure (climbing stairs, dancing

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while doing chores, etc.), depicting the pathways of everyday care amid the various constraints experienced by FDWs. The broader culture-centered project built on this recognition of agency to design white papers, advocacy tools, photo exhibit, drama, media placement, and a national-level campaign conducted via traditional and digital media (reported elsewhere) in collaboration with an advisory board of FDWs.

This study suffers from several limitations. First, our sample size of 20 participants limits the extent to which the narratives may be widely extrapolated to the broader population of FDWs. Also, our strategy of recruiting FDWSs from the HOME shelter meant that we were mostly interviewing FDWs who were facing struggles with their employers. Therefore, the extent to which these findings may be generalized to the broader population of FDWs needs to be explored in future research. In addition, future research may look at the ways in which the experiences of FDWs in Singapore juxtapose in the backdrop of the experiences of FDWs in other countries such as Hong Kong, the United Arab Emirates, the UK, and the USA.

In conclusion, this study depicts the structural constraints and cultural contexts within which FDWs in Singapore make sense of their health and participate in making health choices. Whereas on the one hand, food insecurity and financial insecurity emerge as two key features of the structural context of health of FDWs in Singapore, on the other hand, agentic actions such as exercising while doing chores, drinking plenty of water, self medicating, participating in communal activities, and praying emerge as expressions of agency. The negotiations HEALTH COMMUNICATION 651 of health among this subsection of migrant workers depict the interplays of culture, structure, and agency amid migration and work.

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