A Health Impact Assessment of the Massachusetts Domestic Workers' Bill of Rights

June 2014

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Suggested citation: Auerbach A, McCabe K, Davenport Whiteman, E. A Health Impact Assessment of the Massachusetts Domestic Workers' Bill of Rights. Health Resources in Action. June 2014. Accessible at: http://hria.org/uploads/catalogerfiles/a-health-impact-assessment-of-the-massachusetts-domestic-workers-bill-of-rights/madwbr_hia_report060214.pdf

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Acknowledgements

Funded by: This HIA was made possible with a grant from the National Network of Public Health Institutes' *Increasing National Capacity for HIAs: Using the Nation's Public Health Institutes* through support from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts.

The views expressed are those of the authors and do not necessarily reflect the views of the National Network of Public Health Institutes, Robert Wood Johnson Foundation, or The Pew Charitable Trusts.

Health Resources in Action would like to thank the following organizations and individuals for their time, support, and guidance throughout this HIA process:

Boston Public Health Commission – Aliza Wasserman, Megan McClaire

Georgia Health Policy Center – Jimmy Dills, Michelle Rushing, Beth Fuller

Greater Boston Legal Services – Monica Halas

Health Impact Project – Kara Blankner

MataHari: Eye of the Day – Monique Nguyen, Juliana Morris

Massachusetts Coalition for Domestic Workers, including
- Brazilian Immigrant Center – Lydia Edwards
- Brazilian Women's Group
- Dominican Development Center
- MataHari: Eye of the Day
- Women's Institute for Leadership Development

Massachusetts Coalition for Occupational Safety and Health – Marcy Goldstein-Gelb

Massachusetts Department of Public Health – Ben Wood

National Network of Public Health Institutes – Erin Marziale

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A Health Impact Assessment of the Massachusetts Domestic Workers' Bill of Rights

The social determinants of health are the conditions in which people are born, grow, live, work, and age.[i] Work is an important determinant of health and the experience of work itself affects both physical and mental health. The health of domestic workers, those who work in other people's private homes, can be substantially improved by taking into consideration the unique conditions and experiences of this workplace.

Health Resources in Action conducted a health impact assessment (HIA) — a process to prospectively assess the health impacts of policies, plans, and projects using quantitative, qualitative, and participatory techniques — on two provisions of the Bill of Rights, the written employment agreement provision and the privacy provision, to predict the potential impacts of these provisions on the health of **domestic workers, their families, and the recipients of their care.** This HIA demonstrates potential for positive health impacts and makes recommendations for how to ensure the greatest health benefits.

The HIA findings and recommendations are intended to inform the language of the Bill of Rights, as well as those entities that will be involved in implementing the Bill (e.g. regulatory agencies, researchers, organizations working with domestic workers and employers) if it should pass.

WRITTEN EMPLOYMENT AGREEMENT PROVISION

Written contracts signify a formal employment relationship and define the wages, hours, tasks, and many other characteristics of a job. Many workers are hired directly by individual households, which often results in an informal work relationship that lacks clear parameters and job expectations. According to the National Domestic Worker Survey, only 8% of domestic workers in the U.S. have written contracts with their employers.[ii]

The written employment agreement provision of this bill would provide domestic workers who work 16 hours or more per week for one employer with delineated:

- Rate of pay, including overtime
- Working hours (including meal breaks and other time off)
- Responsibilities of the job

What are the current wages, hours, and job responsibilities that domestic workers experience?[iii]

- Median hourly wages for domestic workers in U.S are $10.00. However, this rate varies widely by occupation, race, and whether the worker lives in the employer's home.
- Nearly half make below 70% of the standard of living in their metropolitan area.
- 35% of domestic workers work long hours without breaks.
- 24% of domestic workers are assigned work that requires them to work beyond the duties and hours in their job description; 66% are not paid for those extra duties or hours of their time.

How do wages, hours, and job responsibilities impact the health of domestic workers, their families, and recipients of their care?

- Income is one of the strongest predictors of health. Low wages limit a worker's ability to accumulate wealth and move up the health-wealth gradient, in which every ascending rung of the socioeconomic ladder corresponds to better health.[iv]
- Long work hours contribute to reduced availability of time or ability to use time effectively for sleep, healthy activities, and being with family. Long work hours also increase exposure and vulnerability to job demands and workplace hazards.[v]
- Low wages and long or unstable work hours increase stress among workers, which is associated with increases in utilization of health services. Periods of disability due to job stress tend to be very long, contributing to extended work absences and leaving children and elderly without regular sources of care.[vi]
- Among home support workers, workload and lack of control over the job are associated with job stress and higher rates of unhealthy behaviors, such as smoking, and higher risk of chronic physical illness, such as cardiovascular disease.[vii, viii]

- A written employment agreement would provide job boundaries and expectations, and thus workplace stability and security to domestic workers, thus improving mental health and decreasing turnover and on-the-job risk behaviors that could harm workers and employers.[ix]

"The inequality between domestic workers and employers is further accentuated given that few workers have a relationship with their employers in which the obligations and expectations are detailed and clearly defined. Because written contracts are rare and labor standards often do not apply to domestic service, workers frequently find themselves in a thicket of uncertainty and subject to exploitation. Common are stories of workers who lack any job description other than to work as a domestic... the absence of a clear understanding about the job and its duties also means that for many 'live-in' workers, who reside with their employers, their day rarely ends."[x]

PRIVACY PROVISION

A person's privacy is the ability to seclude oneself, or information by or about oneself, from others. Given the nature of domestic work, in which workers are employed in the private homes of other people, domestic workers often do not have privacy in terms of space, communications, or documentation. These conditions are exacerbated for workers who live in the homes of their employers.

The privacy provision of this bill would protect workers against privacy violations and forced labor, such as:

- Confiscation of passports and private documents
- Restriction of personal communication, including phone, email and mail
- Forced labor using threats of violence, sexual assault or verbal abuse

What sorts of privacy violations and forced labor do domestic workers face? [xi]

- 44% of domestic workers with special visas report having their passports confiscated by their employers[xii]
- 31% of U.S. domestic workers report not having any access to private means of communication, such as telephone, mail and email while working.
- 36% of U.S. live-in workers report being threatened, insulted, or verbally abused by their employer.
- Domestic work is the 2nd highest occupation victimized by trafficking.

How do privacy invasions and forced labor impact the health of domestic workers, their families, and recipients of their care?

- Forced labor has severe psychological impacts on workers including PTSD, depression and suicide.[xiii, xiv]
- Domestic workers targeted with verbal abuse have significantly higher odds of depression.[xv]
- Exposure to violence on the job can lead to homicide, injuries, PTSD, anxiety, fear, depression, sleep disturbances and decreased job satisfaction.[xvi, xvii, xviii]
- Depression among workers results in absenteeism of approximately 9 days per year, which impacts the financial security of domestic workers and their families, and impacts the quality and continuity of care provided to employers.[xix]

"I know what it is to receive terrible care. I spent over 7 years in Boston area nursing homes being treated in very dehumanizing ways... Today I am the employer of 3 lovely personal care attendants. They do everything I need to live...Without them I could not live freely again or be part of my community."

— EMPLOYER

Opportunities to Improve the Health of Domestic Workers, Their Families, and the Recipients of their Care through Change to the Domestic Work Industry: HIA Recommendations

The findings of this HIA indicate that if the Bill of Rights were to pass it is predicted to have generally positive impacts on the health of domestic workers, their families, and the recipients of their care. The following set of recommendations suggests ways in which the economic, social, physical, and mental health of these populations can be protected and promoted. Recommendations are segmented by potential implementing entities — organizations that work with domestic workers and employers, researchers, and policy makers and regulatory agencies.

Organizations Working with Domestic Workers and Employers

- To better understand who employs domestic workers in Massachusetts, create a registry for employers of domestic workers in Massachusetts, particularly employers of live-in workers
- To better inform domestic workers of workplace hazards and strategies for contract negotiations, conduct trainings about:
  - *Mental and physical worksite wellness*
  - *Contract development and negotiation*
- To better inform employers and domestic workers of the specific implications of the new legislation, provide "Know Your Rights" Workshops to domestic workers and employers
- Create a hotline to field domestic worker complaints re: violations of contracts, privacy, etc. and develop a communication mechanism to relay the information back to the Attorney General's office and the Massachusetts Commission Against Discrimination
- To increase domestic workers' negotiating power, organize domestic worker cooperatives or collectives

Researchers

- To increase the data available on the current numbers and characteristics of domestic workers, research the economic, social, physical, and mental baseline health status of domestic workers, in collaboration with community-based organizations who have successfully conducted much of the existing research on the domestic work industry
- To better understand how domestic workers are affected by their work and workplace, research the impacts of working conditions on domestic workers' economic, social, physical, and mental health, in collaboration with community-based organizations who have successfully conducted much of the existing research on the domestic work industry
- Identify the mechanisms through which contracts (job security, job control, job expectations) are associated with psychological morbidity
- Identify relevant indicators and monitor the impact of increased labor protections, specifically the written contract and privacy protections, on the health of employers/care recipients of domestic workers
- To address concerns raised by domestic workers about potential implications of the new legislation, document the impact of new regulations on the structure and working conditions of the domestic work industry. Consider adapting the National Domestic Workers Alliance Survey for this purpose.
- Relevant research recommendations should be considered by the occupational health and safety advisory board to be appointed by the Governor.

Policy-makers and Regulatory Agencies

- To address the need for employers to easily identify back-up care workers, and to facilitate training for domestic workers, create a registry of domestic workers in Massachusetts.
- Written employment agreements may be supplemented to address additional needs of domestic workers and employers. For example, nannies may include a clause to allow them to say goodbye to the child for whom they care at the end of their term of employment, thus reducing levels of stress and anxiety of both the nanny and the care recipient.
- Given current exclusions from OSHA, domestic workers and employers should be provided with adequate training that is relevant and specific to the hazards of the employment, including mental health. Materials and support should be provided to community-based organizations with a history of working with and providing training for domestic workers and employers.
- Considering the isolated nature of domestic work and the workplace conditions, create a mechanism for reporting workplace violations that includes a call-in line through community-based organizations to reduce stress associated with reporting.
- Given the long work hours and low wages of domestic workers, paid days of rest would contribute to their health by improving their financial secure, ability to meet basic needs, access to goods and services, and reducing stress.
- To identify and meet the needs of immigrant domestic workers, allow for interested parties to access Immigration and Customs Enforcement (ICE) registration information about employers sponsoring domestic workers through B1 and B2 visas.
- To allow domestic workers to continue to work and remain in the country, allow immigrant domestic workers who are abused by their employers (or who suffer other violations of employment laws) to transfer their domestic worker visas to new employers.

CONCLUSION

Historically, domestic workers have been excluded from many state and federal labor and health laws. The Bill of Rights would afford domestic workers basic standards of protections currently enjoyed by most other workers.

This health impact assessment examined two key provisions – the written employment agreement provision and the privacy provision – and the evidence of their potential impacts on the health of domestic workers, their families, and the recipients of their care. Based on the best available evidence, the bill in its current form has the potential for decreasing stress and anxiety, unmet basic needs, and verbal abuse of domestic workers, among other health impacts. Additionally, the bill has the potential to increase financial security, social connectedness, and access to goods and services for domestic workers. Potential impacts on employers include stress, fear of theft, and costs of employing additional domestic workers.

The Bill of Rights has significant implications for health, both through the provisions examined in this HIA, and the other important components of the bill that could not be covered in the scope of this HIA research. The positive impacts could be enhanced and the negative impacts could be mitigated through the adoption of the recommendations included in this report. Additional research is needed to understand the health impacts of the other provisions of Bill of Rights as well as additional impacts of the bill on employers and care recipients, families and communities of domestic workers, and the general public.

FULL HIA REPORT:

http://hria.org/uploads/catalogerfiles/a-health-impact-assessment-of-the-massachusetts-domestic-workers-bill-of-rights/madwbr_hia_report060214.pdf

HAVE QUESTIONS OR WANT MORE INFORMATION?

Contact Allyson Auerbach at aauerbach@hria.org

This HIA was made possible with a grant from the National Network of Public Health Institutes' Increasing National Capacity for HIAs: Using the Nation's Public Health Institutes through support from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts.

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Introduction

Massachusetts House Bill 4026 is statewide legislation that would establish a Massachusetts Domestic Workers' Bill of Rights (BoR). Domestic workers include nannies, caregivers, and housekeepers. The domestic workers covered under the proposed legislature are vital to the MA economy because their work allows individuals and families to leave the home to participate in the broader workforce. However, because there are few state and federal guidelines and no industry standards, domestic workers are vulnerable to exploitation and abuse. The BoR would amend MA state labor law to guarantee basic work standards and protections:

- 24 hours off per 7-day calendar week;
- Meal and rest breaks;
- Limited vacation and sick days;
- Parental leave;
- Protection from discrimination, sexual harassment, illegal charges for food and lodging, and eviction without notice;
- A written contract;
- The right to privacy;
- Notice of termination; and,
- Government agencies responsible for enforcing these standards.

The BoR has the potential to have immediate, intermediate, and long-term health impacts on domestic workers, their families and communities, and their care-recipients. These impacts are associated with rest and recovery time, wage and income security, and occupational health. Examples of immediate impacts of the BoR include better sleep time and quality; the ability to seek care when sick or injured; flexibility and control over work schedule; understanding of job responsibilities; income; better food quality, costs, and choice; and exposure to health and safety hazards, among others. Intermediate impacts might include cognitive performance and concentration; mental health; physical and emotional fatigue; health care costs; social relationships; and, economic security.

However, this proposed legislation has the potential to affect the health of domestic workers, their families, and communities, and the recipients of their care, health considerations are not explicitly part of the current discussion. A previous HIA on a California Domestic Workers' BoR examined the health impacts of two specific provisions of the bill: amending California's Workers' Compensation legislation to include currently excluded domestic workers who work less than 52 hours or earn less than $100 from one employer in 90 days; and requiring employers to provide eight hours of uninterrupted sleep to domestic workers who work 24 hour or longer shifts or live in their employer's home and provide care to others. With the foundation laid by California, HRiA looked to study new provisions of the MA legislation that would further contribute to the body of literature in the HIA field examining health impacts of labor laws targeting domestic workers, as well as providing new information for MA legislators as they considered the legislation.

Health Resources in Action (HRiA) is a non-profit, public health institute leading the Health Impact Assessment (HIA) process on the MA Domestic Workers' Bill of Rights legislation. HRiA worked closely with the MA Coalition for Domestic Workers (MCDW) to gather input throughout the HIA process. HRiA collaborated with Matahari: Eye of the Day, the organization that coordinates the membership of the MCDW, to convene the scoping session to engage key partners in the HIA, to help define priority issues to assess, identify research questions to answer and gather qualitative data to inform the assessment. Juliana Morris, a graduate student from Harvard Medical School – also a volunteer for MataHari: Eye of the Day – conducted a series of focus groups comprised of domestic workers, which provided some of the qualitative data used in the assessment of

this HIA. Eliza Davenport Whiteman, a recent graduate from the Tufts University Friedman School of Nutrition, assisted HRiA staff with the assessment by reviewing and analyzing literature for the assessment phase.

Among those represented on the HIA Advisory Committee were individuals with varying backgrounds and expertise including domestic workers and employers, public health professionals, human rights advocates and scholars, among others. Individuals represented organizations including the Boston Public Health Commission and the Massachusetts Department of Public Health, the Brazilian Women's Immigrant Center, Matahari: Eye of the Day, Boston College, Cambridge Health Alliance, and the Codman Square Health Center. HRiA also consulted with the legal counsel for the MCDW, Monica Halas, and MCDW director, Lydia Edwards, who drafted the legislation and provided the authors with relative background information for the report, as well as feedback on the feasibility of our recommendations.

Funding for this HIA was provided by Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, through a grant from the National Network of Public Health Institutes. The HIA was conducted between September 2013 and April 2014 and includes the following sections, described in the background section below:

- Background and Screening
- HIA Scope
- Assessment Findings
- Recommendations
- Monitoring and Evaluation
- Reporting
- Conclusion

HRiA presented preliminary HIA assessment findings via written testimony at the Joint Committee on Labor and Workforce Development's November 2013 public hearing. In addition to this final HIA report, we produced an executive summary focusing on specific findings and recommendations related to the two provisions of the bill we assessed. When the HIA report and materials are finalized, HRiA will provide them to the National Domestic Workers Alliance in order to inform related domestic worker initiatives in other jurisdictions and contexts.

Background and Screening

A health impact assessment (HIA) is a practical, evidence-driven tool that brings together data, health expertise, and public input to identify the potential health impacts of a proposed project, program, or policy. The HIA is also used to help craft policy recommendations that minimize risks and maximize opportunities to improve health.

An HIA includes the following process:

1. Screening: Determine whether the HIA is needed and likely to be useful.
2. Scoping: Develop a plan for the HIA and identify potential health risks and benefits.
3. Assessment: Describe the baseline health of people and groups affected by the policy and assess the potential impacts of the decision.
4. Recommendations: Develop practical solutions and strategies that can be implemented within the political, economic, or technical limitations of the policy being assessed.
5. Reporting: Disseminate the findings to decision-makers, affected communities, and other stakeholders.
6. Monitoring and Evaluation: Monitor the changes in health or health risk factors, and evaluate the efficacy of the measures that are implemented as well as the HIA process as a whole.

Source: Health Impact Project

Recognizing that domestic workers are a vulnerable population whose health may be substantially affected by the proposed legislation, HRiA conducted a HIA on the BoR in order to provide the best available information on the law's predicted health effects on domestic workers, their families and communities and the recipients of their services. Given the breadth of the bill, the HIA focuses on only two of its fourteen provisions. According to U.S Census data, domestic workers have four primary occupations: house cleaners and housekeeping cleaners, childcare workers, personal care aides, and home health aides. Estimates of the domestic worker population in Massachusetts range from approximately 20,000 to 100,000, and domestic worker organizations in the state typically cite the population at 67,000. Most of the population are women of color, and many are recent immigrants to the United States. Data indicates that domestic workers, in Massachusetts, nationally and internationally, experience many work-related physical injuries and mental illnesses. Through the BoR HIA, HRiA aims to make more explicit the health impacts of the proposed legislation on domestic workers, their families, employers or recipients of domestic workers' services or care and the Commonwealth of Massachusetts overall. Domestic workers' employment conditions impact the health and safety of all communities; by ensuring the health and well-being of domestic workers and the families they work with, the Commonwealth benefits from a strengthened state economy because more individuals are available to participate in the paid workforce. The BoR establishes labor standards that protect domestic workers' basic workplace rights. The BoR has additional benefits to the families and communities of workers because of the predicted impact of the legislation on time, income, injury and illness. The HIA also takes into

consideration the potential impact of the legislation on the health of employers or recipients of services based on the potential for a change in the quality of care that might be provided by domestic workers.

The HIA builds off existing literature, including a HIA completed in 2011 by the San Francisco Department of Public Health on the California Domestic Workers Bill of Rights, to provide analysis of the health effects of two provisions of the proposed legislation. Based on the analysis of relevant literature and qualitative data, the authors provide recommendations for strengthening the legislation, as well as for its implementation and enforcement.

The bill, first introduced in January 2013 was heard before the Labor and Workforce Development committee of the Massachusetts legislature in November 2013. After passing favorably out of that committee, it also passed favorably out of the Ways and Means Committee. On April 2, 2014, the legislation passed through the Massachusetts House of Representatives as part of a larger bill that also includes provisions about the minimum wage, unemployment insurance, and wage enforcement. The Massachusetts Senate is now considering the legislation. If it passes out of the Senate, it will go to Governor Deval Patrick's desk for final approval.

Among the reasons that this legislation is important for the protection of domestic workers is that there are a number of federal laws and regulations that currently exclude domestic workers, including the National Labor Relations Act and regulations created through the Occupational Safety and Health Administration (OSHA). Domestic workers do currently have the right to earn overtime, and they are included in the Massachusetts Labor Relations Act, meaning they already have the right to collectively bargain.

Should the Domestic Workers Bill of Rights in Massachusetts pass, workers would be afforded a number of new labor protections. Upon beginning the HIA in September 2013, HRiA reviewed all the provisions of the proposed in the BoR legislation. Over the course of the last 9 months, the language of the bill, and provisions included, have slightly changed. There are two primary bodies responsible for enforcing and overseeing the implementation of the law:

- The **Attorney General** (AG) will enforce the Bill, except the sections on discrimination, harassment, and parenting leave. The AG will also make rules and regulations necessary for its enforcement. By April 1, 2015, the Attorney General will publish regulations concerning these parts of the bill enforced by that office and those sections will go into effect.
- The **Massachusetts Commission Against Discrimination** (MCAD) will enforce the discrimination, harassment and parenting leave provisions

The table below provides information, accurate as of April 2014, as to the new rights of domestic workers under the bill's current provisions.

Table 1: Key Elements of the Domestic Workers' Bill of Rights

Right	*Additional detail*
Right to **minimum wage** and **overtime**	Domestic Worker can also bring a private lawsuit with triple damages and attorney's fees Law protects Domestic Workers who work 16 hours or more per week for their employer from retaliation for asserting these rights
Right to collect **unemployment** insurance if:	Domestic Worker earned at least $3,500 in the past year, and worked approximately 15 weeks during the prior year;

	Lost job through " no fault", and; Able and available for work (must have work authorization)
Right to collect **worker's compensation** if:	Domestic Worker worked for employer for 16 hours or more per week Right to collect workers' compensation exists regardless of immigration status
Right to be free from **sexual harassment**	Not covered by Massachusetts Commission Against Discrimination (MCAD). Domestic Worker and Personal Care Attendant has to bring a private lawsuit in court.
Right to be free from **discrimination on the basis of sex or race**	Not covered by MCAD. Domestic Worker has to bring a private lawsuit in court.
Right to **unionize** and enter into collective bargaining agreements	
Right to 8 weeks **unpaid maternity leave** if employer has 6 or more employees:	Employee has worked beyond the probation period, or; If no probation period, they have worked full time for 3 months
Right to be **paid for all working time** which includes:	Any time Domestic Worker is required to be on employer's premises or on duty Meal periods, rest periods, and sleeping time unless: ▪ Domestic Worker can leave the premises, and; ▪ Use time for her sole use and benefit, and; ▪ Is completely relieved of all work duties, and; ▪ There is a written agreement not to be paid Employer doesn't have to pay for sleep time if: • Domestic Worker works 24 hours or more, and; • There is an agreement in writing between Domestic Worker and employer, and; • Domestic Worker's sleeping time is not interrupted by work, and; • Employer provides adequate sleeping quarters, and; • Unpaid sleeping time does not exceed 8 hours in a 24 hour period

Right to **days of rest**	If Domestic Worker works at least 40 hours a week, employer must provide at least 24 consecutive hours of rest per week and 48 hours of consecutive rest per month (to coincide with religious worship, when possible) If Domestic Worker voluntarily works over 40 hours per week or during a day or rest, employer must pay overtime for each excess hour worked
Right to **maternity leave**	Domestic workers have the right to take up to 8 weeks of maternity leave for the birth or adoption of a child All other workers in Massachusetts must work for an employer of 6 or more workers to be granted this right, but the legislation will provide this to Domestic Workers even if they are the only employee
Right a bring a private lawsuit if Domestic Worker is **injured on the job** by a fellow employee	
Food: Domestic Worker does not have to pay for food and beverages unless:	Food/beverages is voluntarily and freely chosen and consumed, and; There is a written agreement between employer and Domestic Worker stating cost of food, and; Domestic Worker has ability to easily bring or prepare own food if she wanted to, and; Price accurately reflects cost of food and cannot exceed $1.50 for breakfast, $2.25 for lunch, and $2.25 for dinner
Lodging: Domestic Worker does not have to pay for lodging unless:	Lodging is voluntarily and freely accepted, and; Domestic Worker actually desires and uses the lodging, and; There is a written agreement between Domestic Worker and employer, and; Lodging meets safe and sanitary housing legal standards, and; Price does not result In Domestic Worker making less than minimum wage, and

	Price is reasonable, which means: ▪ It does not exceed $35.00 per week for a room used by one person, $30.00 per week for a room occupied by 2 people, $25.00 per week for a room occupied by 3 or more persons
Right to **privacy**	Domestic Workers are explicitly included under the protections of the state's privacy law which means that domestic workers have the right to expect privacy (which includes right to privacy in the bathroom) Employer cannot restrict, interfere with or monitor Domestic Worker's private communication Employer cannot take any of the domestic worker's documents or other personal effects, Employer cannot search domestic worker's personal belongings
Right to **protection against trafficking**	Employer cannot engage in sex trafficking of domestic workers or labor trafficking called "forced services" Forced services include threatening serious harm, physically restraining an individual, destroying, hiding, or taking any immigration documents, engaging in extortion, or causing or threatening to cause financial harm.
Right to **written evaluation**	A Domestic Worker may request a written evaluation after 3 months and annually thereafter A Domestic Worker may dispute the evaluation under the state's Personnel Records law
Right to a **written employment agreement** at the start of the job if Domestic Worker works 16 hours or more per week.	Agreement must include: • Rate of pay, including overtime • Whether additional pay is provided for added duties/multilingual skills • Working hours (including meal breaks and other time off) • Whether employer provides benefits (earned sick days, vacation days, personal days, health insurance, severance, transportation, etc.) and whether these benefits are paid or unpaid • Fees or costs, if any, for meals or lodging • Responsibilities of the job • Process for addressing grievances and additional pay for additional duties • Right to collect workers compensation

	• Required notice for termination by employer and, if required, by Domestic Worker
Right to **document retention and notice of rights**	Employer must keep all notices and agreements for at least 2 years Employer must provide notice containing Domestic Worker's rights under all applicable state and federal laws
Right to **notice/lodging/severance before termination of live-in Domestic Worker without cause**	Written notice and at least 30 days of lodging either on-site or in comparable off-site conditions or severance pay equivalent to average earnings of 2 weeks Note: no right to notice or severance pay if employee makes good faith written allegation of abuse, neglect or other harmful conduct towards employer, employer's family, or individuals residing in employer's home
Domestic Workers have right to take **sexual harassment** or other harassment claims to Massachusetts Commission Against Discrimination (MCAD)	
Personal Care Attendants have right to take **sexual harassment** claims to MCAD.	

Throughout the HIA process, HRiA engaged a diverse group of stakeholders impacted by the BoR. Among the key partners engaged was the MCDW, who wrote the legislation and has taken a lead in organizing its members to advocate for the legislation. Over eighty legislators have co-sponsored the legislation and over two dozen labor, legal, employer, affinity, and faith organizations and coalitions endorsed the bill. MCDW assisted HRiA with stakeholder engagement by leveraging their existing relationships with domestic workers, legislators, and organizations that have endorsed the BoR to provide input at key points throughout the process.

Scoping

As defined in the legislation, domestic workers include individuals who work in private homes including: housekeepers; house cleaners; home managers; nannies, including people who do childcare and child monitoring; caregivers, including those who provide services for the sick, convalescing, and elderly; and, providers of household services like laundry, cooking, and home companion services. The three broad categories of people affected by the pending legislation are domestic workers, the children and families of domestic workers, and the employers or care recipients of domestic workers. The domestic worker population is highly vulnerable because it is comprised largely of women, many of whom are women of color. A large portion of the domestic worker population in Massachusetts is immigrants, many of whom are undocumented and speak English as a second language or do not speak English at all. The families of domestic workers were also identified as a group of people that will be affected by the Bill of Rights. Among the most vulnerable of this group are the young children of domestic workers. Finally, there are vulnerable populations, for whom the legislation is intended to protect, but who might be affected when/if it is enacted, including the employers and care recipients of domestic workers. This population is comprised largely of the elderly and people with disabilities who rely on personal care attendants and home health aides for support their daily lives. The children of employers who are cared for by nannies also fit into this category.

The authors wanted to add to, and not duplicate, the existing literature, so it was immediately decided not to assess the provisions that were assessed in the HIA conducted by the San Francisco Department of Health on the Health Impact Assessment of California Assembly Bill 889 (The CA Domestic Work Employee Equality, Fairness, and Dignity Act of 2011):

- Requiring employers to provide eight hours of uninterrupted sleep to domestic workers that work 24 hour or longer shifts or live in their employer's home and provide care to others.

The CA HIA also assessed potential impacts on workers' compensation, which domestic workers in MA are already afforded.

The authors convened a scoping meeting in collaboration with partners from the Massachusetts Coalition for Domestic Workers (MCDW), in December 2013. Of the participants present at the scoping meeting, there were domestic workers, public health and medical professionals, human rights advocates and scholars, among others. HRiA and MataHari, an MCDW member organization, began the meeting by providing an overview of the key provisions of the legislation and an introduction to HIA. HRiA also reviewed relevant demographic and health data for the domestic worker population potentially affected by the passing of the legislation. The group then participated in a brainstorming session, which focused on identifying health issues related to the work of the domestic worker population. HRiA staff asked attendees to think broadly about health issues, including environmental, economic, health behavior and health outcome considerations. After the general brainstorm, individuals shared their top three issues that they were most interested in or concerned about. Finally, HRiA led the group through a pathways diagram exercise. The exercise helped attendees and facilitators consider the complex connections between the legislation and potential health impacts. The group chose one provision of the legislation (a written contract) and walked through the potential short, intermediate, and long-term outcomes that might result if that provision of the Bill of Rights was implemented. The Coalition members and other Advisory Committee members at the scoping session made it clear that the written contract was a priority for the coalition members. The health outcome most often mentioned as being connected to the written contract was mental health status, including depression, stress, and anxiety.

Subsequent conversations between MCDW partners and HRiA led to the decision to focus on the privacy provision. Among the reasons that provision stood out as a promising one to assess was that it hadn't already been studied; the provision would likely lead to changes in mental health outcomes which were, again, a

stakeholder priority; and there was a lot of concern, and anecdotal evidence, that employers withholding their employees legal documents was a widespread practice that was particular harmful to the mental health of employees. The Committee hoped that by focusing on these provisions, more light might be shed on the physical and mental health issues affecting the domestic worker population.
Within the two issues addressed in this HIA, the available literature helped frame the pathways in ways that were both intuitive and supported by the existing evidence. For example, within the privacy provision, there are four explicit categories of new rights:

- Domestic Workers are explicitly included under the protections of the state's privacy law which means that domestic workers have the right to expect privacy (which includes right to privacy in the bathroom)
- Employer cannot restrict, interfere with or monitor Domestic Worker's private communication
- Employer cannot take any of the domestic worker's documents or other personal effects,
- Employer cannot search domestic worker's personal belongings

The supporting literature led to the creation of three categories into which these new rights would fit – private space, private communications, and private documents. A similar process, dictated by the availability of supporting literature, was used in the creation of three categories assessed in the comprehensive written contract provision: wages, tasks, and hours. In fact, most of the provisions of the Bill of Rights are subsumed into the written contract provision of the legislation. We narrowed the scope of the provision so that it would be feasible within the parameters of available time for the decision as well as available resources for the HIA. The three subcategories we chose are generally standard to all contracts, regardless of employer, and were considered by the advisory group as essential to the written contract provision.

The scoping session led to the development of the following list of research questions:

1. What is the current prevalence for privacy violations?
2. What is the current prevalence of the absence of core components of a written contract?
3. How would the Bill of Rights impact the health of care recipients, domestic workers, and families of domestic workers?
4. What is the likelihood/direction/extent of the health impacts?

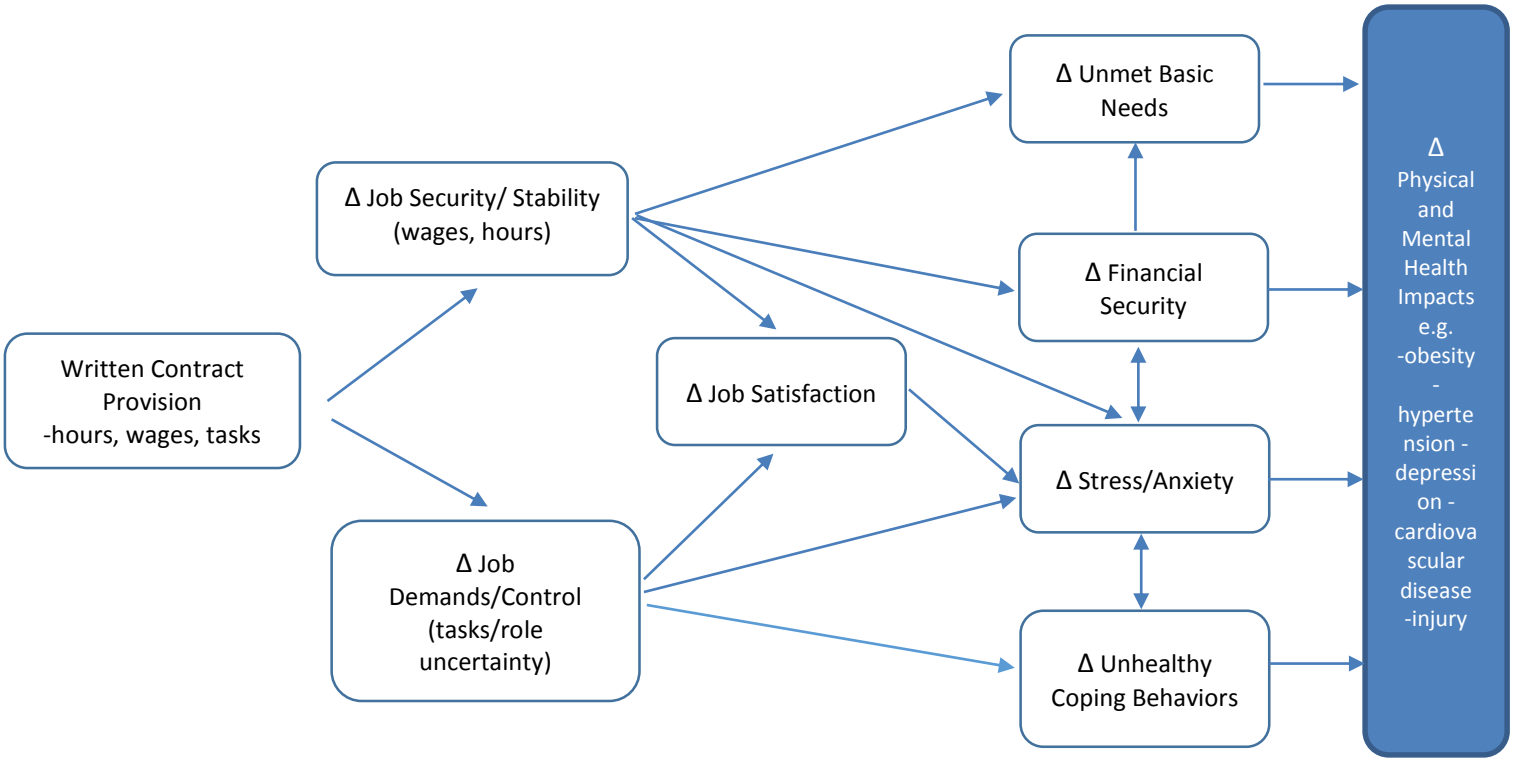
In general, the domestic worker population, their health, and the impacts of labor protections on their health have received limited attention in the public health field. Recently, however, there have been several studies examining issues commonly experienced by domestic workers (e.g. wage theft) and population health impacts, baseline health of domestic workers, and a health impact assessment of the proposed (and now enacted) California Domestic Work Employee Equality, Fairness, and Dignity Act of 2011. Building on these resources, HRiA believed that a review of existing literature and some limited original data collection would provide adequate evidence to examine health impacts of the two priority provisions of the MA Bill of Rights.

In addition to the likely changes in mental health status, we hypothesized a broad range of health impacts and included those in the pathway diagrams. Some of the links are a bit tenuous due to the dearth of evidence, as noted by the dotted lines in the pathway diagrams below. Additional detail about the pathways and supporting evidence is presented in the assessment section of this report.

The first pathway diagram (**Figure *1***) focuses on the written contract provision of the bill. The box in the left column of the pathway indicates how we categorized the key components of the written contract. That is, the written contract provision of the legislation will provide workers with a contract, agreed upon in advance of employment, which includes a description of the expected number of hours and schedule to work, the rate at which they will be compensated, and a description of the expected tasks. Should this provision become law, it

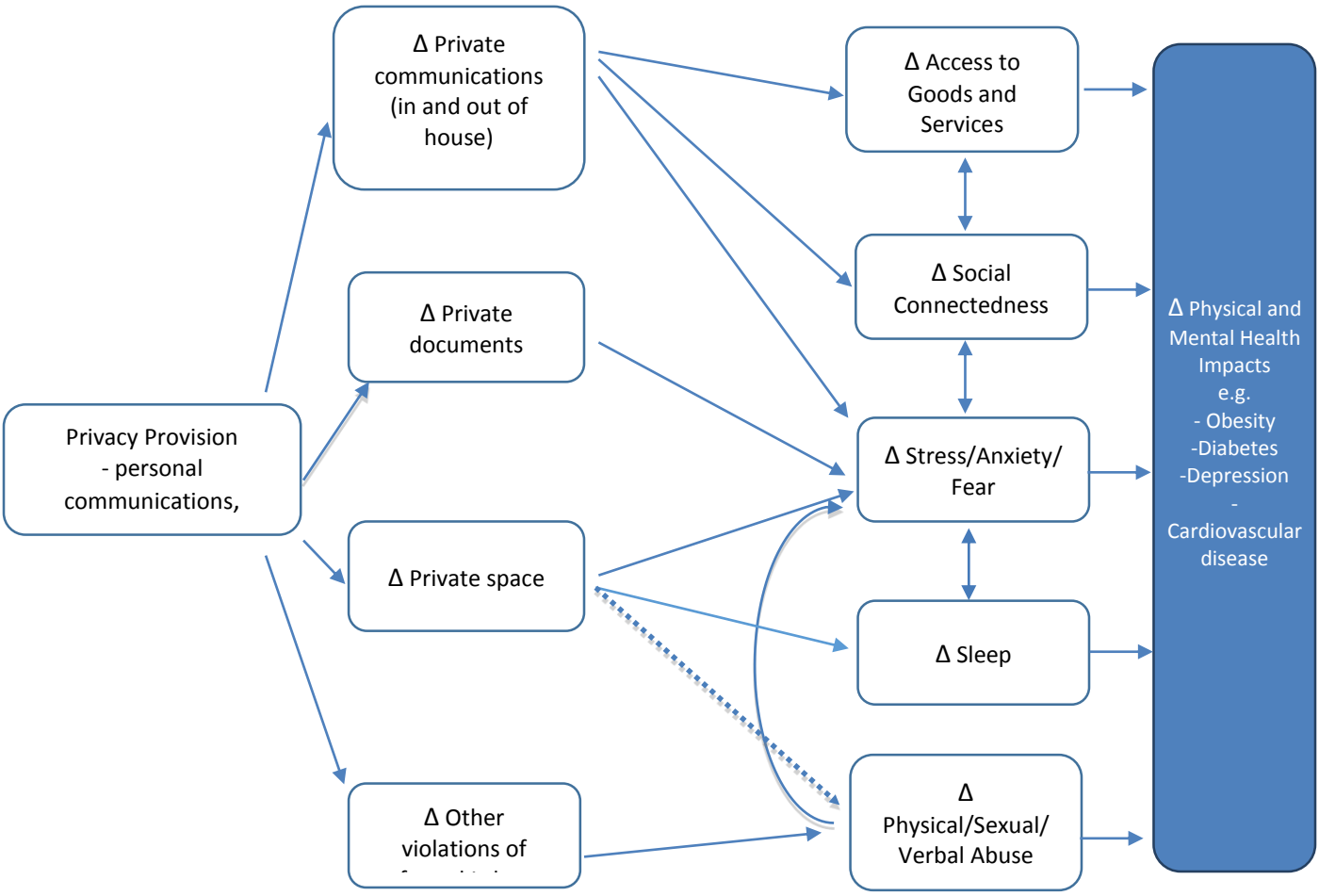
is expected that the contract will result in changes to both job security/stability, including knowledge of wages and hours, and job demands/control, meaning a knowledge of the expected tasks. The changes in job security/stability and job demands/control can be expected to result in a change in job satisfaction. We identified four categories of health indicators that are predicted to change as a result of the projected changes to job security, job demands/control and job satisfaction. They include changes in unmet basic needs, such as the ability to pay for housing and food, changes in financial security, changes in stress and anxiety, and changes in unhealthy coping behaviors. There is significant existing evidence linking these four categories to a variety of physical and mental health outcomes including injury, heart disease, diabetes, and depression, among many others.

Figure 1: Written Employment Contract Provision Pathway Diagram



The second pathway diagram (**Figure *2***) examines the privacy provision, which includes the right to retain personal documents, the right to personal communications and the right to an adequate private space, for live-in domestic workers. The implementation of this provision will lead to changes in the domestic workers ability to maintain personal communications both within and outside of the home; changes in a domestic worker's right to private space, including in the bathroom; the right to retain one's private documents, and protections from other forced labor violations. The pathway diagram shows that there is supporting evidence leading from these provisions of the bill to five main categories of risk, identified by the authors. Those categories include access to goods and services (like the ability to make and attend medical appointments), social connectedness, stress/anxiety/fear, sleep and physical, sexual, and verbal abuse. There is less strong, but some evidence, which supports the connection between the right to private space and physical/mental/verbal abuse. Like in the other pathway diagram, there is strong evidence connecting these risks with physical and mental health outcomes like depression and chronic disease like diabetes and heart disease, among others.

Figure 2: Privacy Provision Pathway Diagram



This HIA utilized mixed research methods, including analysis of secondary data, collection of primary data through focus groups and interviews with domestic workers, and review of empirical literature. This section describes each of the methods used.

1. Secondary Data Analysis: summary statistics available on demographic characteristics, occupational exposures, injuries, and illnesses.
2. Focus Groups and Interviews: 3 focus groups and 6 key informant interviews were conducted with domestic workers using semi-structured discussion guides.
3. Literature Review: review of peer-reviewed and grey literature regarding the domestic worker population in general as well as for the two specific provisions examined in this HIA.

Secondary Data Analysis

To develop a profile of baseline conditions, including demographics, health determinants, and outcomes, HRiA reviewed existing data drawn from national, state, and local sources. In order to define and characterize the domestic worker population in Massachusetts, HRiA attempted to replicate methods developed by colleagues at the San Francisco Department of Public Health, in collaboration with DataCenter, an organization in Oakland that provides research, training, and support to grassroots social justice movements. Secondary data was also compiled from the Bureau of Labor Statistics Survey of Occupational Illness and Injury. Data analyses were generally conducted by the original source (e.g. U.S. Census). Much of the secondary data collected is incorporated into the assessment section of this report. For additional demographic data and a discussion of methodology, see Appendix A.

Focus Groups and Interviews

HRiA, in collaboration with several student researchers and the MA Coalition for Domestic Workers, conducted interviews and focus groups with a variety of individuals in Massachusetts, including domestic workers, employers of domestic workers, and organizations that work with domestic workers and employers. In total, 6 interviews and three focus groups were conducted with over 35 individuals, primarily in eastern MA.

Focus group and interview discussions explored current working conditions experienced by domestic workers, as well as specific experiences and perceptions of how written contracts and privacy impact their health. A semi-structured guide was used across all discussions to ensure flexibility but consistency in the topics covered. Each focus group and interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, interview and focus group discussions lasted 60-90 minutes. The interview and focus group guides can be found in Appendix C. These types of conversations not only collect critical information on the "why" and "how" behind the data, but also identify suggestions and current level of readiness and feasibility for recommendations to be proposed by this HIA. Additional informal interviews were conducted with legal experts and representatives in the MA legislature to discuss recommendations and reporting.

Literature Review

HRiA used a structured literature review approach to characterize the domestic worker population as well as examine the pathway for both provisions, the right to a written contract and the right to privacy. Search terms specific to the immediate and intermediate health determinants as well as the longer-term health outcomes were used in PubMed, JSTOR, Google Scholar, ProQuest, Academic OneFile, and Web of Knowledge. Additionally, HRiA examined reference lists, review articles, and grey literature. Many articles had findings that applied to multiple health determinants, and thus the literature is cited in several different places.

The literature review sought information that showed links between the passage of each provision and each health determinant (e.g. the impact of privacy on job satisfaction), as well as literature that showed direct links

between each provision and each health outcome (e.g. the impact of a written contract on unhealthy coping behaviors).

Limitations

As with all assessments, there are several limitations related to this HIA's methods that should be acknowledged, including challenges related to public data sources on domestic workers as well as methodological challenges of qualitative data collection.

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport conditions, behaviors, injuries, and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. Despite these limitations, most of the national, state or local self-report surveys (such as the Survey of Occupational Injuries and Illnesses) benefit from large sample sizes and repeated administrations, enabling comparison over time.

However, there are a few unique characteristics of domestic workers in general and those to be covered by the Bill of Rights that present specific limitations to data collection. The following is an excerpt from the HIA of the California Domestic Workers Bill of Rights, which describes the limitation of public data sources on domestic workers.

Figure 3: Excerpt from A Health Impact Assessment of California Assembly Bill 889- Limitations of public data sources on domestic workers

> Describing the domestic worker population generally, and the domestic worker population that will be affected by the legislation specifically, is challenged by the limited data collection on the domestic worker industry. With the exception of some Latin American nations, the majority of countries, including the United States, do not have national or regional statistics about domestic workers. A number of critical scholarly reports have been published discussing the working conditions of domestic workers in the United States and abroad (Bonato 2007, HRW 2001, ILO 2010). However, the majority of these reports are case studies, worker testimonials and qualitative research that do not attempt to enumerate the population.
>
> In the United States, the U.S. Census Bureau and the Bureau of Labor Statistics routinely collect data from employers, workers, and tax collection agencies to describe employment and work conditions. In general, both agencies categorize their employment data by industry using the North American Industry Classification System (NAICS) and by occupation using the Standard Occupational Classification (SOC) System. Private household industry data includes diverse types of occupations employed in private households such as gardeners and drivers that have different demographics and occupational exposures. Publicly available datasets on domestic worker-related data by both industry and occupation is highly susceptible to under-counting as employment is often informal and workers may be reluctant to acknowledge that they are employed when questioned (Dresser 2008). Other factors impacting data collection from workers directly include language and literacy barriers, lack of resources and capacity to survey hard-to-reach populations (like live-in workers), worker fear of retaliation and deportation, and lack of institutional commitment to document conditions of domestic work also exist. Although the U.S. Census Bureau and other agencies try to correct for the undercount of marginalized or hard-to-reach populations, researchers acknowledge that these populations are underestimated in national surveys (Ronzio 2007).
>
> Industry data on private households also may provide a partial picture of the demographics and working conditions of domestic workers because industry data are usually gathered through tax information and surveys of employers. A number of individuals employing domestic workers do not view themselves as employers (Associated Press (AP) 2008) and employers may not accurately report domestic worker employees' earnings for tax purposes (Bernhardt 2007). Analysis of industry data is also limited because domestic workers' primary industry, "private households" (NAICS Code 814), is routinely excluded from cross-industry analyses, potentially due to small sample size.

While the focus groups and interviews conducted for this study provide valuable insights, results are not statistically representative of the larger population of domestic workers due to non-random recruiting

techniques and a small sample size. Efforts were made to engage a variety of individuals from the primary occupational categories of domestic workers, employers, and organizations who work with domestic workers and employers; however, not all sides of the issue were represented. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

Finally, much of the empirical research used to analyze the health effects of the two provisions in this HIA was not specific to domestic workers or studied domestic worker populations outside of the U.S. These challenges were taken into consideration throughout this assessment and are generally highlighted in the assessment summary tables at the end of each assessment chapter (Table *5* and Table *7*).

There are a number of significant data gaps that have been identified, many of which we address in the recommendations section of this report. Where there were significant data challenges, we describe the problem and our justification for moving forward with the assessment in the way we did. Among the challenges we want to highlight are

- Complications with using the census data to quantify the population of domestic workers in Massachusetts (see above)
- Bureau of Labor Statistics' Survey of Occupational Injury and Illness data are not stratified by industry, just occupation
- Under-reporting issues on Census and in general with regard to working conditions, especially related to the privacy provision (issues of abuse and other complaints)

Martha Chen, an expert in domestic workers' issue at Harvard University, argues that there are a number of reasons why capturing data for the domestic worker population is challenging. Her research indicates that the challenges we faced with quantifying the population and health outcomes that are predicted to result from the passage of this legislation, are not unique. Among them:

- There is no common definition for the types of activities that should be included as domestic work
- There is no common statistical definition across countries for what/who constitutes domestic work(ers).
- Many domestic workers are undocumented and undeclared
- Some domestic worker are working 'formally' and others are not, meaning they are not contributing to the social security system and their employers are not pay taxes on their services (Chen, 2011).

Key informant interviews and focus groups conducted by the authors and our partners provide some primary data to supplement the gap. However, time and resource constraints limited the ability to conduct a survey. It should be noted that two researchers in conjunction with the National Domestic Workers Alliance conducted a national survey in 2012, which included Greater Boston and 13 additional metropolitan areas. Unfortunately, collection methodology was based on a national sample and there were not sufficient numbers of respondents in the metro areas or states (with the exception of the state of California, where multiple cities were surveyed) to produce results that would be considered valid for Greater Boston.

Assessment: Describing the Impacted Population

In order to understand the potential health impacts of the proposed Bill of Rights, it is important to define the domestic worker population in Massachusetts in terms of size and characteristics.

Domestic workers are employed in the private household industry (i.e. in their employers' homes) and comprise four primary occupations: childcare workers; maids and housekeeping cleaners; personal care aides; and nursing, psychiatric, and home health aides. Only self-employed or privately employed/paid domestic workers are covered by the MA Bill of Rights, though there are many domestic workers who find work through agencies. Additionally, the legislation does not include home health aides or personal care aides financed and hired through the Commonwealth of Massachusetts' MassHealth program. The HIA will present findings from the literature that include all industries, occupations, and employment classes of domestic workers, though secondary quantitative data will focus solely on the domestic workers included in the Bill of Rights.

Describing and Enumerating the Domestic Worker Population in Massachusetts

For this HIA, the domestic worker population is divided into the four abovementioned primary occupational categories for the purpose of description and analysis. It is important to note that many domestic workers experience job duties that span multiple occupational categories (Dresser, 2008 and interview/focus group participants).

Table *2* shows the estimated number and demographic characteristics of domestic workers in MA impacted by the Bill of Rights. Data are disaggregated by occupation and include only those in the private household industry. These estimates are derived from the 2006-2010 American Community Survey, an annual household survey conducted by the U.S. Census Bureau. As noted above, the Bill of Rights includes domestic workers in private households who are employed or paid directly by the homeowner. Additional methodological details can be found in Appendix A.

Table 2: Demographic Characteristics of MA Domestic Workers Covered by the Bill of Rights, 2006-2010

	Maids and Housekeeping Cleaners	Child Care Workers	Personal and Home Care Aides	Home Health Aides
Population Count	7350	5345	3190	505
Female	89.4%	96.9%	84.0%	99.8%
Median Household Income				
Black	4.4%	3.1%	11.4%	14.9%
White	59.7%	83.1%	68.2%	64.4%
Hispanic	15.5%	7.4%	14.3%	19.8%
Asian	1.7%	1.9%	2.8%	0.9%
U.S. Citizen	62.3%	85.2%	83.3%	90.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 2006-2010
NOTE: Data represent only workers within the private household industry who are over the age of 16 and are civilians employed at work

Based on the American Community Survey, an estimated 20,000 domestic workers covered by this bill were working in private households in MA between 2006 and 2010. Of these workers, 5,345 worked as child care workers, 7,350 worked as maids and housekeeping cleaners, 3,190 worked as personal care aides, and 505 worked as nursing, psychiatric, and home health aides. It is also important to note that there are approximately one dozen additional occupations (supervisors or four primary occupations, in addition to

physical therapists, cooks, butlers, grounds keepers, etc.) within the private household industry that could be considered domestic workers. These less numerous occupations comprise approximately 4,000 additional domestic workers in Massachusetts who would be covered by the Bill of Rights, but are not captured in the demographic statistics in **Table *2*** above.

As discussed previously, the population estimate is very conservative given the limitations of quantifying the domestic worker population. The Massachusetts Coalition for Domestic Workers estimates the number of domestic workers in MA at approximately 67,000 and as large as 100,000 depending on whether specific industries of work and classes of worker are taken into consideration. Limiting the population to only those workers within the private household industry results in a population estimate of approximately 20,000, while including all domestic workers within the four major and dozen minor occupations yields a population of slightly more than 100,000 people.

Table *2* above describes the demographic characteristics of domestic workers in MA. Across the four major occupations, the vast majority of domestic workers are women. A higher percentage of childcare workers identify as White (83.1%) compared to the other occupations. Additionally, data for MA indicate that over 80% of domestic workers within the primary occupations are U.S. citizens, with the exception of maids and housekeeping cleaners (62.3% U.S. citizens). Comparatively, national data from the American Community Survey describe the domestic worker population as 95% women, 46% White, 38% Latina, 10% African-American, 6% Asian, 46% foreign-born, and 35% non-citizens. Appendix A gives additional demographic information about the domestic worker population in the U.S. and the sample for the 2011-2012 National Domestic Workers Survey conducted by two researchers in conjunction with the National Domestic Workers' Alliance.

The domestic work industry is one of the fastest growing in the United States. According to the Bureau of Labor Statistics, the occupation of personal and home care is anticipated to grow 49% between 2012 and 2022. Home health care also represents a burgeoning industry as the baby boom population ages and more individuals require assistance or companionship. The home health aide occupation is projected to grow 48% between 2012 and 2022.

Race, Gender, and Class

As seen above and documented in the literature, much domestic work is performed by immigrant women and women of color. Historically race and gender have played significant roles in the domestic labor market. As Gaydos et al summarized, "occupations have developed historically structured by the dynamics of gender, race, and class and the status, remuneration, and protections afforded to certain occupations today are inextricably tied to how these occupations are associated with gender and racial categories and the relative power of individuals in these categories in society today." Quantitative data confirm these ideas. Across all occupations, not only domestic work, women working full time still earn only 77 cents for every $1 earned by men, according to the White House. Domestic work is deeply racialized with respect to occupation and pay, despite progress in the past century to protect civil and women's rights. American Community Survey data indicate that nannies are predominantly White (64%) as are caregivers (55%), while housecleaners are predominantly Latina (52%). Hourly wages also reflect the prominent role of race in domestic work with White domestic workers making wages approximately 20% higher than domestic workers of color (Table *6* in written contract chapter).

Due in part to race and gender, domestic work is often stigmatized and perceived as low status in comparison to work performed in other settings. As one interviewee noted, "our jobs are undervalued. People do not see the purpose, but we free up other people to do their work outside the home." Dresser summarizes the cumulative economic impacts of race, gender, and class. "Discrimination pushes wages down twice here. First, the work is considered to be of very low worth and is paid as such. Second, the women workers who hold the jobs – women of color and immigrants – have fewer job opportunities outside these in-home jobs" (Dresser, 2008).

Immigration Status

Table *2* above shows that between 10% (home health aides) and 38% (maids and housekeeping cleaners) of domestic workers in Massachusetts are non-U.S. citizens. Nationally, 35% of domestic workers are non-citizens and an estimated 22% (Passel, 2005) are undocumented immigrants. Being undocumented and having the social and financial pressures of family far away can cause fear and stress for domestic workers concerned that their employment and presence in the U.S. will be jeopardized. Additionally, current news media and research has shown examples of employers trapping their workers with promises of sponsorship for a visa (Bernhardt, 2007), hiding their documents, or trafficking them (Human Rights Watch, 2001)

Language Barriers

National data indicate that 47% of domestic workers report that English is not the primary language spoken in their home; the percentage in MA is unknown, though is assumed to be comparable. Speaking a primary language different from one's employer poses difficulties for negotiating a contract and conducting daily work within the employer's home. In a study of domestic workers in New York, 18% of respondents reported that language was a factor that contributed to employer abuse (Domestic Workers United, 2006). Research by Bernhardt and others indicates that English proficiency impacts a worker's likelihood of being hired, the amount they are paid, the type of tasks they perform, and violations of minimum wage. (Bernhardt, 2007 and 2009; Romero, 2002)

Other Circumstances of Domestic Work and Characteristics of Domestic Workers Make Them Vulnerable to Adverse Health Impacts

The context of the private home within which domestic work occurs presents numerous economic, social, health, and safety challenges. Domestic workers who live in the homes of their employers face particularly challenging working and living conditions (box below).

Live-In vs. Live-Out Workers

Although the majority of domestic workers live outside the homes of their employers, live-in workers represent a significant, and especially vulnerable, sub-population of domestic workers who often face more challenging work conditions and fewer labor protections (NELP, 2009; Burnham and Theodore, 2012). They are more likely than live-out workers to receive low wages ($6.15 vs. $10.82), work long hours (50% vs. 33%), experience employer abuse (36% vs. 16%), and endure psychological and social isolation (Burnham and Theodore, 2012; Hondagneu-Sotelo, 2007). In the National Domestic Workers Survey, 25% of live-in workers reported that their job responsibilities prevented them from getting at least five hours of uninterrupted sleep sometime in the previous work week.

"Because every home has a never-ending list of tasks to be completed, and because live-in workers are essentially on-call, the limits to work that would normally apply in a job simply do not exist." – Burnham and Theodore, 2012

As noted in the methods section, the National Domestic Workers Survey of 2011-2012 surveyed approximately 150 domestic workers in Greater Boston and over 2,000 in 13 other metropolitan areas across the U.S. While the sample size from Greater Boston is not large enough to report, the results across all 14 metropolitan areas are shown below in Table *3*. The survey asked domestic workers a series of questions about their working conditions, wages, and benefits.

Table 3: Working Conditions, Wages, and Benefits of Domestic Workers Based on Surveys in 14 Metropolitan Areas (including Greater Boston), 2011-2012

	14 Metropolitan Areas
Working Conditions	
Overtime Hours Worked	40% live-out worked 40+ hrs/wk
Hazardous Conditions	50% use toxic cleaning supplies 39% do heavy lifting
Threatened, Insulted, or Abused by Employers	19%
Injured on the Job	64%
Worked While Sick, Injured, or in Pain	66%
Wages	
Wages	48% below 70% of LLSIL
Meeting Basic Needs	60% pay more than half of income on rent/mortgage 40% pay essential bills late in past month 37% pay rent/mortgage late in past year 23% unable to save any money in past month 20% had no food to eat sometime in past month
Overtime Hours Paid	33%
Late or Non-Payment of Wages	33%
Meal and Rest Breaks	50%
Benefits	
Paid Sick Days	18%
Vacation Days	23%
Retirement or Pension Benefits	<2%
Employer Pays into Workers' Compensation Insurance	4%
Employer Pays into Social Security	<9%
Health Insurance Employer-provided	35% 4%

DATA SOURCE: National Domestic Workers Alliance National Domestic Workers Survey, 2011-2012

As seen above, domestic workers face a variety of difficult working conditions. Notably two-thirds report that they work while sick, injured, or in pain, which has repercussions for the worker as well as their families and recipients of their services. Domestic workers also face challenges related to their wages and meeting basic needs. Forty-eight percent of workers report that they earn a wage by their primary employer that is below 70% of the Lower Living Standard Income Level, a measure of economic insecurity that is updated annually and adjusted for regional differences in the cost of living. Finally, few domestic workers are afforded job benefits that many other occupations enjoy.

In addition to the working conditions noted above, domestic workers experience several unique working conditions that may mitigate or amplify the potential health impacts of the Bill of Rights.

Unregulated, Informal, Isolated Industry

"Employed in private homes, behind closed doors, domestic workers endure long hours and substandard pay. There is little economic mobility and almost no financial security." – Home Economics

Unregulated- As mentioned in the background section, private homes are frequently not considered workplaces and thus passed over by state and federal policymakers, agencies, and others. This results in infrequent and inconsistent data collection, monitoring of work conditions, regulations, and enforcement of laws (Chen, 2011).

Informal- Most domestic workers are employed informally, that is without a written contract and often "off the books." The absence of a formal paycheck means that domestic workers do not pay into social security or Medicare, and consequently are less likely to be able to collect these benefits in the future. Additionally, informal employment increases the chances of wage exploitation as domestic workers can be paid a flat rate, work longer hours than agreed upon, or experience "job creep" as additional tasks are added to their workload. As seen in Table *3*, 33% of domestic workers indicated that they were not paid for overtime hours and 33% reported non-payment of wages. Written contracts, and their implications for wages, hours, and tasks, will be discussed in great detail in the section on the written contract provision of the Bill of Rights.

Isolated- Domestic work is intrinsically isolated as most employers employ only one domestic worker. From negotiation of contracts to camaraderie to exposure of workplace abuses, isolation contributes significantly to the working conditions of domestic workers. Live-in workers experience workplace isolation at its most extreme (Box X above).

Occupational Risks

The characteristics and working conditions of domestic workers contribute to and further exacerbate the occupational exposures, injuries, and illnesses experienced by domestic workers. Unmonitored and unregulated workplaces intensify these experiences. Exposure, injury, and illness surveillance data do not provide rates for domestic workers specifically in private households, thus Table *4* below shows incidence rates for domestic workers in both private households and other industry settings, such as medical or education institutions.

As illustrated in Table *4* below, domestic workers face a variety of events and exposures that lead to disproportionate illness and injury rates compared to the general population. Nursing, psychiatric, and home health aides suffer the highest rate (39.5 per 10,000 workers) of violence and other injuries by persons or animals, nearly 10 times the national rate. Personal care aides face transportation incidence at a rate double that of the general private worker population, 10.9 vs 4.7 per 10,000 workers respectively. Maids and housekeeping cleaners experience three times as many falls, slips, and trips as well as exposures to harmful substances or environments than the general private worker population.

Total incidence rates for nonfatal occupational injuries and illness among both maids and housekeeping cleaners (290.4 per 10,000 workers) and nursing, psychiatric, and home health aides (296.1 per 10,000 workers) were more than double the incidence rates for the average private worker population (102.3 per 10,000 workers). Only child care workers experience an overall occupational injury and illness incidence rate below that of the general private worker population. The four major domestic work occupations take between 6 and 8 days of time away from work to recuperate, which is indicative of the severity of the injuries and illnesses. The median days away from work that the general private worker population takes is 8 days.

Table *4* also shows the number of occupational injuries and illnesses among the MA domestic worker population covered by this bill. Applying the occupation-specific incidence rates to the population counts for MA, it is expected that 333 non-fatal occupational injuries and illnesses occurred in MA in 2012. This number is likely an under-estimate given the population estimate limitations discussed previously.

Table 4: Incidence Rates of Nonfatal Occupational Exposures, Injuries, and Illnesses by Occupation per 10,000 full time workers, 2012*

	Maids and Housekeeping Cleaners	Child Care Workers	Personal Care Aides	Nursing, Psychiatric, and Home Health Aides	General US Private Worker Population**
Exposures/Events					
Violence and Other Injuries by persons or animal	3.8	22.7	35.6	39.5	4.0
Transportation Incidents	4.5	1.5	10.9	5.3	4.7
Falls, Slips, Trips	86.0	27.3	32.5	59.1	24.8
Exposure to Harmful Substances or Environments	11.1	1.5	3.4	6.1	4.5
Contact with Object, Equipment	55.8	9.0	14.9	24.8	25.7
Overexertion and Bodily Reaction	125.2	21.3	72.9	159.0	37.4
Injuries/Illnesses					
Fractures	13.6	11.9	8.3	9.4	8.1
Sprains, Strains, Tears	119.4	27.5	87.4	162.9	38.5
Cuts, Lacerations, Punctures	15.2	3.1	5.1	4.7	9.6
Bruises, Contusions	32.8	10.8	13.2	23.0	8.4
Chemical Burns and Corrosions	2.5	-	-	-	0.4
Heat (thermal) Burns	0.4	-	0.5	0.9	1.5
Multiple Traumatic Injuries	6.9	2.4	6.2	5.8	3.1
Soreness, Pain	58.5	16.7	28.2	56.7	14.8
Carpal Tunnel Syndrome	2.8	-	-	0.2	0.9

Tendonitis	0.5	-	0.3	0.7	0.3
Musculoskeletal Disorders	120.4	20.5	69.5	152.8	35.5
Total Non-Fatal Occupation Injury & Illness Incidence Rate	290.4	83.3	170.8	296.1	102.3
Estimated Number of MA Domestic Workers in the Occupation***	7,530	5,345	3,190	505	
Estimated Number of Occupational Injuries and Illnesses Experienced by MA Domestic Workers****	219	45	54	15	TOTAL INJURIES AND ILLNESSES = 333
Median Days Away from Work*****	7	6	8	6	8

DATA SOURCE: Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses, 2012; U.S. Census Bureau, American Community Survey, 2007-2011

* Incidence rates represent the number of injuries and illnesses per 10,000 full-time workers and were calculated as: (N / EH) X 20000000 where N = number of injuries and illnesses EH = total hours worked by all employees during the calendar year. 20,000,000 = base for 10,000 full-time equivalent workers (working 40 hours per week 50 weeks per year).
**General U.S. private worker population is defined as total workers employed in private industries across the United States.
*** Includes workers in these occupations only in private household industry.
**** Calculated by multiplying occupation specific incidence rate per 10,000 workers by the occupation estimate.
***** Median days away from work is the measure used to summarize the varying lengths of absences from work among the cases with days away from work. Half the cases involved more days and half involved less days than a specified median. Median days away from work are represented in actual values. Days away from work include those that result in days away from work with or without job transfer or restriction.
- = data not available

Health Impacts of Proposed Privacy Provision

Passage of the Massachusetts Domestic Workers' Bill of Rights would increase privacy protections for domestic workers including prohibiting violations of anti-trafficking laws, ensuring the right of workers to retain their own documents, and prohibiting monitoring of workers in their private living spaces.

Excerpt of Domestic Workers' Bill of Rights Privacy Provision:

> A domestic worker shall have a right to privacy under section 1B of chapter 214. An employer shall not restrict or interfere with a domestic worker's means of private communication, monitor a domestic worker's private communications, or take any of the domestic worker's documents or other personal effects, or engage in any conduct which constitutes forced services or trafficking of a person in violation of sections 50 and 51 of chapter.

Forced services defined by MA General Law Chapter 265, Section 49 as:

"Forced services", services performed or provided by a person that are obtained or maintained by another person who: (i) causes or threatens to cause serious harm to any person; (ii) physically restrains or threatens to physically restrain another person; (iii) abuses or threatens to abuse the law or legal process; (iv) knowingly destroys, conceals, removes, confiscates or possesses any actual or purported passport or other immigration document, or any other actual or purported government identification document, of another person; (v) engages in extortion under section 25; or (vi) causes or threatens to cause financial harm to any person.

This chapter analyzes how the proposed legal requirements for privacy would affect the health of domestic workers as well as their families and care recipients. These relationships will be explored using the pathway diagram seen in Figure X. The goal of this section is to:

- describe baseline conditions, including the current prevalence of privacy protections as well as what is currently known about invasions of privacy for domestic workers[1]
- discuss the known effects of privacy protections on health, following the health determinants outlined in the pathway diagram
- predict the direction, extent, and likelihood of health effects resulting from the legislative requirement of privacy protections
- describe how the legislation might impact domestic workers' families and care recipients

Baseline Conditions

Domestic workers are often not protected by the laws that govern pay and working conditions given to other employees in the US. In addition, working behind closed doors isolates workers from the support of coworkers and hides working conditions from the outside world. Even in circumstances where domestic workers are protected by legislation, they have limited power to assert their rights. Domestic workers often experience verbal, psychological and physical abuse on the job – a problem that can be exacerbated by nature of the work taking place in private homes (Geiger-Brown, 2007). In the worst cases, domestic workers are victims of human trafficking – often deceived about the nature of their work; exposed to substandard working conditions; paid at wages far below the minimum wage; not allowed to leave the premises of their employer

[1] Baseline health conditions can be found in the previous chapter. Additional baseline health indicators are not available for the domestic worker population.

or to speak with people outside the home; and subjected to physical and verbal abuse (Human Rights Watch, 2001).

Massachusetts General Law defines trafficking as knowingly subjecting, or attempting to subject, another person to forced services. Using language from the General Law, "forced services" can include threats of harm or violence, as well as the confiscation of legal documents or the threat of financial harm. According to the literature, trafficking is defined by the relationship between the slave and the slaveholder: loss of freedom, physical or psychological violence, control, exploitation, non-payment or only subsistence payment for work performed (Bales, 2007).

Thousands of cases of domestic workers are brought into the United States via human trafficking each year – driven by a demand for cheap and household labor. A 2005 study by the Human Rights Center at University of California Berkeley found that 27.2% of cases of forced labor in the U.S. involve domestic workers. This is the second highest group of employees to be victims of human trafficking after prostitution/sex trafficking (Bales, 2004). Foreign domestic workers are a particularly vulnerable population because they are allowed to be brought to the U.S. by their employers, but are not protected by most U.S. labor laws. Visa restrictions for foreign domestic workers require that they remain with their original employers or face deportation, which often discourages workers from reporting cases of abuse or mistreatment (Bales, 2004). In addition, perpetrators of violations against foreign domestic workers are often foreign nationals who can rely on diplomatic immunity as protection against legal violations. A 2008 GAO report identified 42 cases of domestic workers with A-3 or G-5 visas who were abused by their foreign diplomat employers (GAO, 2008).

"The principal methods traffickers use to control victims include: taking away victims' travel and identity documents; repeatedly telling victims local police or immigration authorities will arrest, brutalize, or even kill them if they are found; sexual abuse; physical violence; threats of physical violence or death; isolation; and debt bondage. In cases with groups of victims, traffickers used victims as enforcers to intimidate and control the victims" (Bales, 2005).

Due to the hidden nature of domestic work, the burden of enforcement against abuses and humans rights violations falls to the workers themselves. Without protection from typical labor contracts and laws, however, many fear retaliation for speaking up about working conditions. This is especially true for undocumented immigrants who fear their immigration status will be threatened if they complain. According to Burnham and Theodore, 91% of workers and 85% of undocumented immigrant workers who experienced problems with their working conditions in the prior year did not speak up for fear of losing their jobs or their immigration status (Burnham and Theodore [Home Economics], 2012). Additionally, without the organizational backing and social support of traditional workers, in-home workers are forced to rely on their own resources to face violence and harassment (Barling, 2001).

There are numerous risk factors for all employees in healthcare work. Home healthcare workers have the added risk factors, however, of working alone, behind closed doors, and in homes that potentially have weapons (Geiger-Brown, 2007).

Abuses Suffered

Verbal, physical, sexual and psychological abuse

It is very difficult to accurately estimate the rates of abuse suffered by domestic workers in the U.S. due to underreporting and insufficient monitoring and enforcement practices. Verbal abuse is the most common form of abuse directed against domestic workers (Borling, 2001; Human Rights Watch, 2001). Burnham and Theodore report that domestic workers are more than twice as likely to be yelled at as other workers (Hidden in the Home, 2001). The annual National Domestic Workers Survey from 2011-2012 found that 36% of live-in

workers reported being threatened, insulted or verbally abused (Burnham and Theodore [Home Economics], 2012). In a survey of U.S. domestic workers with special visas, seven percent of workers reported instances of physical abuse including striking or slapping of employees, sexual assault, beating workers and threatening workers with physical harm (Human Rights Watch, 2001). Underreporting is likely a particularly significant problem with regard to sexual abuse due to isolation in the home and heavy cultural stigma (Human Rights Watch, 2005).

A 2007 survey of domestic workers in California found that 20% of domestic workers experienced verbal abuse, 9% were sexually harassed and 9% experienced violence. More than one third of survey respondents (35%) did not respond to the question regarding workplace abuse – representing a much higher non-response rate than for any other part of the survey and pointing to discomfort with the subject matter (Behind Closed Doors, 2007). A similar survey of New York domestic workers found thirty-three percent (33%) of workers experience verbal or physical abuse or have been made to feel uncomfortable by their employers. One-third of workers who face abuse identify race and immigration status as factors for their employers' actions (Home is Where the Work Is, 2006). The sensitive nature of abuse leads to underreporting as do a lack of government monitoring systems and deterrents in the visa systems that impede foreign domestic workers from reporting cases (Human Rights Watch, 2001).

Passport confiscation and privacy invasions

Many domestic workers face privacy invasions by their employers in their daily lives, including withholding of documents, lack of personal space and surveillance. A recent case from the town of Harvard, Massachusetts found a couple guilty of keeping an immigrant woman as a slave in their home for more than 13 years. In addition to paying the woman less than $3000 for all her years of labor, the couple confiscated her passport and intimidated and abused her (Valencia, 2014).

Close to half (19 out of 43) of the workers surveyed in a Human Rights Watch study of U.S. domestic workers with special visas reported having their passports confiscated (Human Rights Watch, 2001). The frequency of passport confiscation was reinforced through conversations with a domestic worker advisory group in the Boston area. By taking away workers private travel documents and intimidating immigrant workers with threats related to their immigration status, employers create a forced labor environment in which workers are reluctant to speak out against abuses for fear of being deported.

> "While it is against all international conventions to seize someone's passport (Jureidini, 2001), this is such a common practice with foreign domestic workers in many countries that it is seen as a normal part of employment procedures" (IOM 2003, 30)

Other surveys of domestic workers have found frequent violations of the right to private space. Workers have reported being forced to share rooms with adult males or care recipients in the home or having employers go through their things and have guests stay in their rooms (Grandea, 2010; Human Rights Watch, 2005). A 2006 study domestic workers in New York State found that 12% of live-in workers share a room with the children for whom they care and 8% sleep in the common areas (Home is Where the Work Is, 2006).

Social isolation:

A frequent form of forced labor violations carried out against domestic workers includes social isolation and trapping within the home. There are numerous reported instances of workers being forbidden to leave the

home or being given very limited opportunities to communicate via the phone, letters or with neighbors (Human Rights Watch, 2005; Human Rights Watch, 2001). The 2011-2012 National Domestic Workers Survey found that 31% of workers reported not having any access to private means of communication, such as telephone, mail and email (Burnham and Theodore, 2012). Other studies have reported cases workers not being given keys to the home in which they lived/worked and cases of workers being locked inside the home (Grandea, 2010).

Health Determinants

As seen in the pathway diagram, this section of the HIA focuses on several health determinants associated with the privacy provision – access to goods and services, social connectedness, sleep, abuse (physical/verbal/sexual) and stress and anxiety. The health impacts of forced labor have not been systematically studied, nor have the impacts of privacy invasions (Bales, 2004). Given the strong public health research supporting impact of abuse, fear and sleep deprivation on health outcomes, it is our hypothesis that forced labor and privacy invasions can have significant negative health impacts and that the primary issue is a lack of research to support this hypothesis.

Social isolation

"Many domestic workers are forbidden from leaving the workplace unless they are in the company of their employer or, for those who are so lucky, on days off. Some domestic workers interviewed by Human Rights Watch reported being locked in their workplace from the outside. More commonly, domestic workers reported that their employers discouraged or prohibited them from talking to neighbors, other domestic workers, or to friends on the phone" (Human Rights Watch, 2005: 43).

Forced labor, such as being forbidden to leave the home or to speak with people outside the home, including having contact with friends, family and neighbors leads to feelings of isolation, shame and betrayal and lack of a social support network (Bales, 2004). Key informant interviews with domestic workers in Massachusetts revealed that some workers find it stressful not to be able to contact or check in on their own families while at work.

Given that the privacy provision of the Bill of Rights will protect a worker's right to private communications, it is predicted that domestic workers will have improved access to social support networks and will experience lower rates of social isolation as a result.

Access to goods and services

In addition to being socially isolated, workers who are trapped in the home or are working in forced labor situations may have restricted access to goods and services. These workers do not have control of their own healthcare decisions and often receive inadequate or unsanitary healthcare in the home environments (Human Rights Watch, 2005).

Additional qualitative information from key informant interviews with domestic workers in Massachusetts revealed that some workers have difficulty taking time for themselves during the day to schedule appointments due to restrictions around phone or email communications while at work.

Given that the privacy provision of the Bill of Rights will protect workers' right to private communications and will explicitly forbid situations that constitute forced labor, it is predicted that domestic workers will be better able to access goods and services outside the home.

Sleep

The 2011-2012 National Domestic Workers Survey found that 25% of domestic workers were not able to get at least 5 hours of uninterrupted sleep in the previous week (Burnham and Theodore (Home Economics), 2012). For workers who are required to sleep with care recipients or in common areas, getting sufficient, uninterrupted sleep can be particularly difficult, which can lead to physical and mental exhaustion. "Sleepiness and fatigue lead to functional impairments such as slower reaction time, reduced vigilance and deficits in information processing, which have consequences not just for the individual worker but also for the employer and broader society" (U.S. DOT, 1998). Using dose-response studies, relationships have been established between average hours of sleep and health outcomes such as decreased life expectancy, increased risk of diabetes, hypertension, obesity, mental health issues and coronary heart disease (Gangwisch 2006, Di Milia 2009; Hall 2008; Ayas 2003(a); Ayas 2003(b); Geiger-Brown 2004).

Given that the privacy provision of the Bill of Rights will protect a worker's right to private space and will explicitly forbid situations that constitute forced labor, it is predicted that domestic workers will have improved access to private sleeping quarters and will be better able to get sufficient hours of uninterrupted sleep.

Abuse

Abuse – particularly verbal, but also sexual and physical abuse – is one mechanism of forced labor and is commonly experienced by domestic workers. Some evidence exists that domestic work may actually increase the likelihood of abuse. Barling et al found that the isolation of in-home workers leads to a higher occurrence of abusive behaviors and that fear of reoccurrence of this abuse is a primary outcome for workers (2001). The literature also strongly supports the linkage of abuse to negative health outcomes – especially mental health outcomes – among domestic workers and their families.

Verbal and psychological abuse are the most common sources of abuse cited among domestic workers and are shown to belittle, intimidate and further isolate domestic workers (Human Rights Watch, 2005). A study on home healthcare workers found that workers targeted with verbal abuse have four to six times the odds of experiencing depression than those who witnessed no or rare abuse. Those workers who suffered high levels of physical abuse (defined as moderate violence or injury requiring medical attention in the past six months) experienced depression at seven times the odds of those who did not report physical violence (Geiger-Brown, 2007).

Exposure to violence on the job has been shown to lead to numerous negative health outcomes including: homicide, injuries, PTSD, anxiety, fear, depression, sleep disturbances and decreased job satisfaction (Geiger-Brown, 2007; Human Rights Watch, 2005; Barling, 2001). Discrimination and sexual or physical harassment in home healthcare workers has been linked with symptoms of stress, difficulty concentrating, anxiety, bowel problems and heart disease (Denton, 2008). A study looking at specifically at sexual harassment in domestic workers found associates with job dissatisfaction, psychosomatic health issues and PTSD (Barling, 2001). Lastly, the presence of violence on the job can instill fear in workers and fear of abuse or violence in the workplace can be debilitating and has been linked to negative mental health outcomes (Geiger-Brown, 2007).

Given that the privacy provision of the Bill of Rights will explicitly forbid situations that constitute forced labor, it is predicted that domestic workers will experience lower rates of physical, sexual and verbal abuse.

Stress/anxiety/fear

The connections between stress, anxiety and fear and downstream negative health outcomes have been well established in the public health literature. Domestic workers – particularly those subject to forced labor – face high levels of stress and fear on the job.

Work-related stress is a substantial issue for social service providers and studies have found that anxiety levels are especially high amongst "helping" professionals such as nannies and home healthcare workers (Denton, 2002). According to Denton, among home healthcare workers, higher levels of job stress was associated with dissatisfaction with hours, management of difficult clients and exposure to sexual harassment. Stress in the workplace has been shown to lead to numerous downstream negative health outcomes including: nausea, fatigue, sleep problems, anxiety, asthma, fatigue, headaches, blurred vision, backaches, heart disease, diabetes, stomach/bowel problems, irritability, rheumatoid arthritis, unhappiness, and burnout (Denton, 2002).

For immigrant workers without legal documentation, fear of deportation can be a pervasive concern in the workplace. Domestic workers who are victims of forced labor or trafficking often face threats to their deportation and suffer fears of being sent home (Hidden Slaves, 2005). Fear of deportation among immigrant workers has been linked in the literature to numerous mental health outcomes. Cavazos-Rehg found that Latino immigrants with fear of deportation are more likely to report emotional stress (feeling angry) and extra-familial stress, including difficulty finding desirable jobs and being forced to accept low-paying work (2007). In this same study, Cavazos-Rehg found that concerns around deportation were a significant predictor of subjective health status among Latino immigrants.

Forced labor – by effect of isolating and subjugating workers – has quite obvious deleterious effects on workers including severe mental health outcomes. Forced labor leads to loss of personal efficacy and control, which has been shown in numerous studies to have negative mental health impacts on workers (Human Rights Watch, 2005; Syme, 1998). Loss of control in the workplace (due to forced labor) can also lead to increased dependency on the employer and make it difficult for workers to retaliate against unjust working conditions (Burnham and Theodore [Home Economics], 2012). This can further the isolation and denigration of workers and in extreme cases can lead to severe outcomes such as Stockholm Syndrome (Human Rights Watch, 2005). Studies have also shown forced labor to have severe psychological impacts including PTSD, depression and suicide. The symptoms of these mental health effects include nightmares, emotional numbness, irritability, inability to sleep, difficulty concentrating and outbursts of anger (Human Rights Watch, 2005).

Given that the privacy provision of the Bill of Rights will protect workers' right to maintain possession of their private documents and will explicitly forbid situations that constitute forced labor, it is predicted that domestic workers will have greater control over their documents and employment and will experience lower rates of fear (of deportation or abuse), stress and anxiety.

How Would the Privacy Provision Impact Employers/Care Recipients?

On the whole, this legislation will protect the rights of domestic workers and improve the health and stability of the domestic worker population, which will be beneficial to employers and care recipients. According to 2004 estimates by the American Psychological Association, depression among workers results in absenteeism ranges from 9.9-90 days per year (Geiger-Brown, 2007). Loss of work productivity is detrimental to both workers and care recipients, thus legislation that promotes a healthier worker population will provide positive benefit for everyone.

According to Ayalon, there is some documented fear among home healthcare clients that their caregivers may abuse or neglect them (2009). The primary form of documented abuse towards clients by home healthcare workers was financial abuse, however according to Ayalon there is strong evidence to indicate that many of these cases involved circumstances where the workers were being severely underpaid. The use of surveillance may be justified by some employers as a protection against financial or physical abuse of care recipients. This legislation will not impede the use of surveillance in public spaces and rather will simply protect the privacy of domestic workers in their private living spaces.

How Would the Privacy Provision Impact Families of Domestic Workers?

The legislation would provide protection for domestic workers against privacy and human rights infringements such as confiscation of documents or restriction of private communications. Workers who suffer from these human rights violations are at higher risk for negative mental health outcomes such as depression and anxiety. Witnessing violence and psychological stress can have a serious impact on the families of domestic workers as well.

Children who witness the abuse of their parents are at a higher risk for PTSD (Hidden Slaves, 2005). Witnessed violence is also a predictor of aggression, depression, anger and anxiety among children (Johnson, 2002). Psychopathology in mothers is a critical risk factor in the development of emotional and behavioral problems in children in early years (Cimino, 2014). Maternal depression is associated with depressive disorder, social phobia, disruptive behavior, separation anxiety, multiple anxiety disorder and compromised social function in children, while maternal panic disorder is associated with panic disorder, acrophobia, separation anxiety and multiple anxiety disorder in children (Cimino, 2014; Sanders, 2007). Lastly, threats to immigration status or document withholding can impact children and families as well: children of undocumented workers report higher rates of fear, anxiety and sadness than children of documented workers (Human Impact Partners, 2013).

In summary, based on the available evidence and understanding of the domestic worker population and their characteristics, it is predicted that the passage of a privacy requirement for domestic workers would protect the health of a significant and growing group of domestic workers in Massachusetts, particularly live-in workers.

Table 5: Summary Assessment of Predicted Effects of Privacy Provision on Health

Health Determinants	Direction and Extent	Likelihood	Who Impacted			Uncertainty related to limited evidence
			DW	F/C	E/CR	
Physical/sexual abuse	⇓	⇑ ⇑	X	X	X	• Physical abuse and document withholding evidence is limited in US and Canada – much more evidence of it abroad • Limited evidence of sexual abuse in literature (many people probably don't report it) • Uncertainty related to prevalence of people working in homes • We think there are other connections but there are gaps in the literature • People don't want to talk about the privacy provision so it's difficult to get qualitative evidence and will be difficult to do studies about in the future
Verbal abuse	⇓ ⇓ ⇓	⇑ ⇑	X	X	X	
Stress/ anxiety/ fear (of deportation)	⇓	⇑ ⇑	X	X		
Sleep	⇓	⇑ ⇑	X	X	X	
Social connectedness	⇑ ⇑ ⇑	⇑ ⇑ ⇑	X	X		
Access to goods and services	⇑ ⇑ ⇑	⇑ ⇑ ⇑	X	X		

Explanations:
Direction/Extent (combine direction, magnitude, and severity into one measure)

- Severe impact on many = ⇑⇑⇑ or ⇓⇓⇓
- Severe impact for a few or small impact on many = ⇑ or ⇓
- Moderate impact on medium number = ⇑⇑ or ⇓⇓
- Moderate impact on many = ⇑⇑⇑ or ⇓⇓⇓
- Small impact on few = ⇑ or ⇓
- Uncertain = ?
- No effect = "No effect" or "None"

Likelihood refers to strength of evidence showing the causal relationship between the provision and the health outcome:
⇑= limited evidence (one source of evidence (literature or qualitative)
⇑⇑ = limited but consistent evidence (one or two sources but they are saying the same thing)
⇑⇑⇑ = causal relationship established (literature establishes causal relationship which is supported by qualitative sources)

Who is Impacted

DW = Domestic Workers
F/C = Families/Community
E/CR =Employers/Care Recipients – This takes into consideration direct and indirect effects of the provision

Health Impacts of Proposed Written Contract Provision

Passage of the Massachusetts Domestic Workers' Bill of Rights would require a written contract for all domestic workers who are employed by an individual employer for more than 16 hours per week.

Excerpt of Domestic Workers' Bill of Rights Written Contact Provision:

> (l) An employer who employs a domestic worker shall keep a record of wages and hours pursuant to section 15 of chapter 151. An employer who employs a domestic worker for 16 hours or more a week shall, in addition to the information required pursuant to section 15 of chapter 151, provide the following: (i) the rate of pay including overtime and additional compensation for added duties or multilingual skills; (ii) working hours, including meal breaks and other time off; (iii) where applicable, the provisions for days of rest, sick days, vacation days, personal days, holidays, transportation, health insurance, severance, yearly raises, and whether or not earned, vacation days, personal days, holidays, severance, transportation costs and health insurance are paid or reimbursed; (iv) any fees or other costs including, costs for meals and lodging; (v) the responsibilities associated with the job; (vi) the process for raising and addressing grievances and additional compensation if new duties are added; (vii) the right to collect workers compensation if injured; (viii) the circumstances under which the employer will enter the domestic worker's designated living space on the employer's premises; (ix) the required notice of employment termination by either party; and (x) any other rights or benefits afforded to the domestic worker. Failure to comply with this paragraph shall constitute a violation of paragraph (3) of section 19 of chapter 151.

This chapter analyzes how the proposed legal requirement for a written contract would affect the health of domestic workers as well as their families and care recipients. As mentioned in the section on scoping, this examination of the written contract includes three primary components- wages, hours, and tasks- and the potential impacts on health. These relationships will be explored using the pathway diagram seen in Figure X. The goal of this section is to:

- describe baseline conditions, including the current prevalence of written contracts as well as what is currently known about wages, hours, and tasks among domestic workers[2]
- discuss the known effects of written contract components on health, following the health determinants outlined in the pathway diagram
- predict the direction, extent, and likelihood of health effects resulting from the legislative requirement of a written contract
- describe how the legislation might impact domestic workers' families and employers/care recipients

Baseline Conditions

Written contracts signify a formal employment relationship and define the wages, hours, tasks, and many other characteristics of a job. Many workers are hired directly by individual households, which often results in an informal work relationship that lacks clear parameters and job expectations. According to Burnham and

[2] Baseline health conditions can be found in the previous chapter. Additional baseline health indicators are not available for the domestic worker population.

Theodore, only 8% of domestic workers in the U.S. have written contracts with their primary employer, while two-thirds (67%) indicate they had an informal verbal agreement with their employer (Burnham and Theodore, 2012). Most contracts include provisions governing wages (97%), job responsibilities (96%), time of payment (91%), schedule (84%), and hours to be worked (77%). Interview and focus group participants report that written contracts are not very prevalent but are becoming more common, especially for nannies. All assessment participants were in favor of having written contracts. Still, many domestic workers shared feelings of fear related to contracts. For example, a focus group participant stated, "I'm afraid to ask for a contract. I'm afraid that if I ask for a contract they won't give me a job. There is so much competition."

Wages

The table below (Table 6) shows NDWA survey results of median hourly wages for domestic workers across the U.S. Median wages hover around $10-11 for all workers, although further examination of worker characteristics shows wide variation in wages. Across the three primary occupations, domestic workers of color are paid less than their white counterparts. Additionally, undocumented immigrants earn less as nannies and caregivers, but median wages for all occupations are comparable to the domestic worker population overall. Finally, live-in workers earn significantly less than workers who do not live in the homes of their employers.

Table 6: Median Hourly Wage for Occupations by Race/Ethnicity, Employment Arrangement, Citizenship Status, 2011-2012

		Nannies	Caregivers	Housecleaners	All Occupations
Race/Ethnicity	**White**	$12.55	$12.00	$12.50	$12.13
	Latina	$8.57	$10.00	$10.00	$10.00
	Black	$12.71	$10.00	$10.89	$10.99
	Asian/Other	$11.11	$8.33	$10.00	$10.00
Employment Arrangement	**Live-in**	$6.76	$7.69	$5.12	$6.15
	Live-out	$11.55	$10.00	$10.71	$10.82
Nativity/ Citizenship	**US citizen**	$12.51	$10.19	$11.91	$12.00
	US-born	$12.56	$10.30	$12.00	$12.00
	Foreign-born	$12.25	*	$11.58	$11.67
	Documented Immigrant (non-citizen)	$10.00	$9.59	$10.00	$10.00
	Undocumented Immigrant	$9.86	$8.33	$10.00	$10.00
All Workers		$11.00	$10.00	$10.00	$10.00

DATA SOURCE: National Domestic Workers Alliance, National Domestic Workers Survey, 2011-2012
* denotes a sample size too small to report

"*Minimum wages and overtime laws set out wage rates for working time. However, if working time is not defined or not recorded, the hourly minimum wage rates become meaningless." – Greater Boston Legal Services*

Hours

Although the average number of weekly work hours for domestic workers is unknown, 35% of domestic workers surveyed reported working long hours without breaks (Burnham and Theodore, 2012). This was especially prevalent among nannies and caregivers, with 40% working more than 40 hours for their primary employer in the past week. Domestic workers reported that their hours and schedules were the most likely contract items to be violated by the employer. Twenty percent of domestic workers reported each of these violations.

As Moen and colleagues discuss, work overloads and time pressures are mounting as ever fewer employers have homemakers or others who can take care of non-work obligations (Moen, 2013). The National Occupational Research Agenda (NORA) Long Work Hours team developed a diagram to illustrate the impacts of long work hours on health (Caruso, 2006). As seen in Figure 4, long work hours are the result of many factors, including job and schedule options that would be specified in a domestic worker's written contract. Worker and job characteristics moderate the numerous impacts of long work hours, which will be discussed further in the section below.

Figure 4: Health Effects of Long Sleep Hours

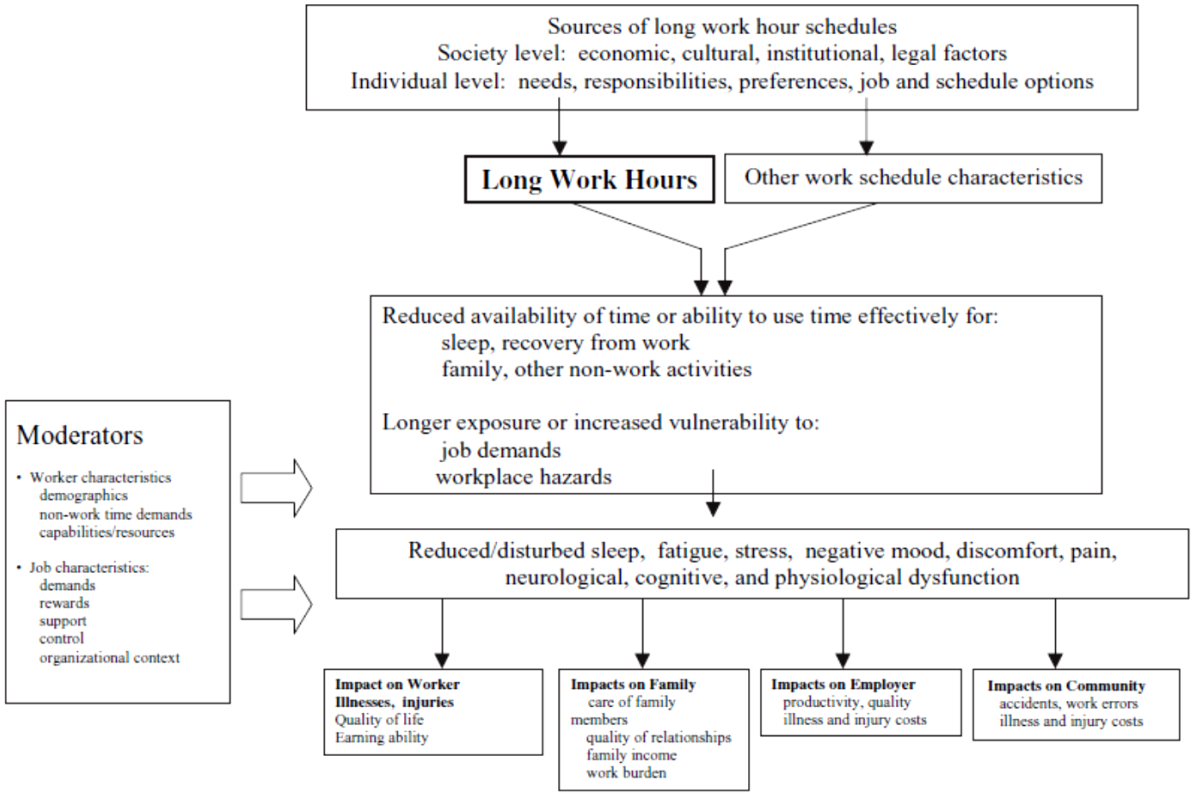


FIGURE 1. Framework for Study of Undesirable Impacts of Long Work. Note: The following significant relationships are not shown in the figure: (1) the influence of the worker and job characteristics upon the schedule; (2) the direct impact of reduced non-work time on the worker, family and community that is not mediated by the other listed acute affects; and (3) the modulating influence or feedback effect of long term outcomes on future acute effects (e.g., severe injury effects on ability to endure long work hours in the future).

(Caruso, 2006)

Tasks/Job Expectations

Job tasks and expectations vary based on occupation, experience and expertise of the domestic worker, and needs of the employer. The National Domestic Workers Alliance survey found that 19% of domestic workers

experienced a breach of contract related to the agreed upon scope of job responsibilities and 24% reported that in the last week alone they had been assigned work beyond their job description. Of these workers, 74% believed they could not refuse the additional work and 67% were not paid for their extra time (Burnham and Theodore, 2012). A report on New York's domestic work industry reinforces that the expectations and presumptions of clients can often creep and expand, leaving the domestic worker hard pressed to draw a line (DWU and DataCenter, 2006). Among focus group participants, job creep was the most frequently cited issue. As one nanny noted in a focus group, "They start out with one thing, then a lot has been added. They will start slipping things in: empty the dishwasher, do the laundry, other house chores." Further, many of these additional tasks are not compensated. "That needs to be restated," said one child caregiver. "If we're doing housekeeping on top of childcare, we need more pay. If my boss had stated to me in the job description, 'for this extra job, you get this much pay above the childcare,' I would consider that part of my job and that would make me feel better doing it."

> *"The inequality between domestic workers and employers is further accentuated given that few workers have a relationship with their employers in which the obligations and expectations are detailed and clearly defined. Because written contracts are rare and labor standards often do not apply to domestic service, workers frequently find themselves in a thicket of uncertainty and subject to exploitation. Common are stories of workers who lack any job description other than to work as a domestic… the absence of a clear understanding about the job and its duties also means that for many 'live-in' workers, who reside with their employers, their day rarely ends."* (Peggy Smith ILO, 2011)

Overall, 30% of domestic workers who had a written contract indicated that in the past year their employers disregarded at least one contract provision (Burnham and Theodore, 2012). Additionally, in a survey of household employers, 48% responded that domestic workers should not be entitled to a contract and 45% opposed providing domestic workers with fixed working hours (D'Souza, 2010). The existence of a written contract does not protect against workplace violations, but it can provide guidelines for both employer and employee. Burnham and Theodore state, "These documents are an important step towards increasing the transparency of the employment relationships, and when workplace disputes do arise, they can be helpful in monitoring them." In the absence of laws governing employment in the private household industry, a written contract becomes the primary way for workers to protect their rights at work.

Health Determinants

As seen in the pathway diagram, this section of the HIA focuses on several health determinants associated with the written contract provision –financial security, unmet basic needs, stress/anxiety, and unhealthy coping behaviors. These determinants can be directly impacted by the written contract, but more often mediated by the (psychological?) factors of job security, job demands/control, and job satisfaction.

"It's important that the employer realizes that the best way to get good service in the long term is to have concern for the health of her worker." – housekeeper interviewee

Financial Security

The written contract would specify the wages, including overtime pay, which domestic workers could expect to be paid for the services they provide to their employer. Although domestic workers in Massachusetts are covered by the Commonwealth's minimum wage and overtime laws, these wages are not enough to support a high cost of living. The U.S. Department of Labor has developed a Lower Living Standard Income Level (LLSIL),

a measure of economic security that is annually adjusted and takes into consideration regional differences in cost of living. The National Domestic Workers Survey found that nearly half (48%) of domestic workers surveyed are paid hourly wages below 70% of the LLSIL for their geographic region. Further, 23% of workers surveyed were unable to save any money for the future from the previous month.

Income is one of the strongest predictors of health. Low wages limit workers' ability to accumulate wealth and move up the wealth-health gradient, which shows that the highest income earners have longer, higher quality of life (RWJF). Well-paying jobs represent greater economic security and ability to accumulate wealth, enabling individuals to meet basic needs, as discussed below (CBHA, 2008). Wages and job insecurity make it very difficult for workers in precarious jobs, such as domestic work, to provide for their financial security (Towson, 2006- New Frontiers of Research on Retirement).

The evidence of the effects of work hours, also a proposed component of the written contract, on financial security are mixed. The assumption is that the more hours worked the greater the income of the worker. However, wage theft and other moderators make this relationship more complex (Caruso, 2006). As Figure 4 shows, long work hours have long-term financial impacts on workers, including increased personal expenses for health care and assistance with non-work activities, reduced capacity for work and income, work disability, and early retirement.

Additionally, stress at work, associated with wages, hours, and tasks (as discussed below), is a costly problem in modern workplaces. According to the National Institute of Occupational Safety and Health, high levels of stress are associated with substantial increases in health service utilization and periods of disability due to job stress tend to be very long, contributing to extended work absences (CDC, 2011). Among domestic workers, these absences are often without pay and could be cause for job termination (Burnham and Theodore, 2012).

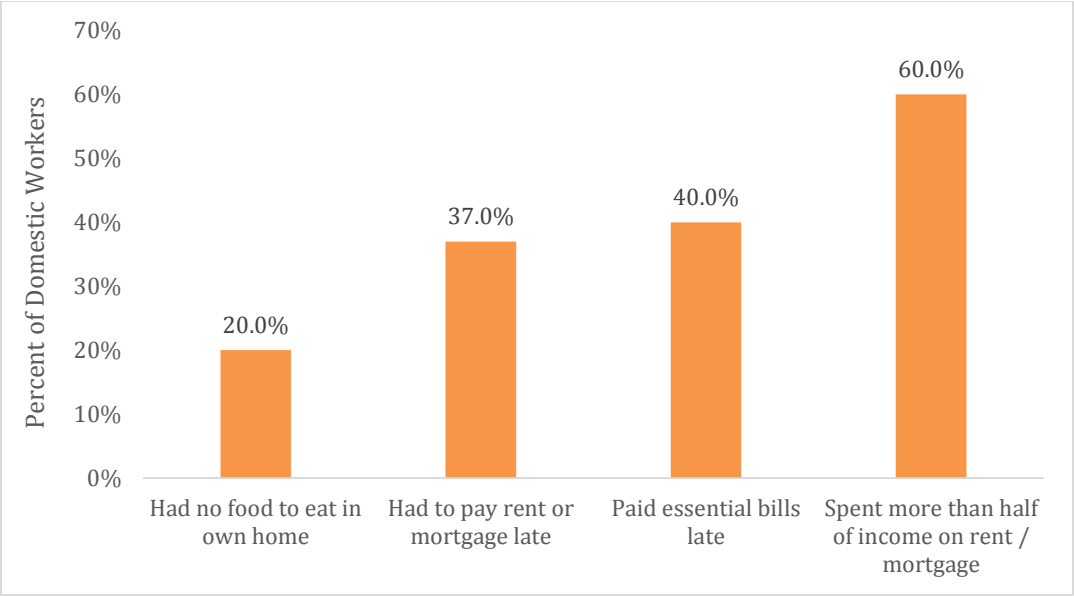
Spillover is a process by which attitudes and behavior carry over from one role to another. Spillover between work and family life can be regarded as negative (i.e., work-family conflict) or positive (work-family enhancement). "These two dimensions of spillover might co-exist to some degree. For example, a job that provides a high degree of negative spillover in the form of long hours and psychological stress carryover into home life, at the same time, could provide a high degree of positive spillover in the form of family financial security and opportunities for personal growth that make for a better family member." Although this literature does not pertain to the domestic worker population specifically, qualitative data collected indicate that many domestic workers currently experience negative spillover and limited financial security without a written contract (Westman, 2005).

Given that a written contract will specify wages, giving domestic workers assurances of their level of income, it is predicted that financial security among domestic workers will increase as a result of the passage of the written contract provision.

Unmet Basic Needs

According to the National Domestic Workers Survey, many domestic workers are unable to meet a variety of basic needs (Figure 5). Thirty-seven percent of domestic workers had to pay their rent or mortgage late within the past year. Twenty percent of domestic workers had no food to eat in their own homes within the past month. Forty percent of domestic workers paid some of their essential bills late in the past month. Sixty percent of workers spend more than half of their income on rent or mortgage payments.

Figure 5: Percent of Unmet Basic Needs among Domestic Workers, 2011-2012



DATA SOURCE: Burnham and Theodore, 2012. National Domestic Workers Survey, 2011-2012.

Research shows that **wages**, which would be specified in the written contract, significantly contribute to workers' ability to meet their basic needs. One nanny confirmed, "With a contract then you'll know what to expect each week, what pay you'll have to live on." With limited income, families often cut food budgets, contributing to food insecurity (Valentine, 2005). Families of domestic workers are also impacted, as discussed in the section at the end of this chapter. Wages also contribute to workers' ability to meet basic housing needs. Inability to pay rent or mortgage can lead to unhealthy housing conditions, including overcrowding, lack of safe drinking water or hot water, ineffective waste disposal, inadequate food storage, rodent or insect infestations, environmental noise, and risk of fire (US Conference of Mayors, 2008). These conditions impact infectious diseases, including respiratory and ear infections.

Bernal and Meleis state that poverty among domestic workers, most of whom are women, prevents mothers from providing adequately for their families, including food, clothing, medications, and recreation. Additionally, low wages make domestic workers spend more time at work and less time with their own children and family, which stresses them and raises concern over unhealthy behaviors of their own children (Bernal, 1995). Interviewees reinforced this saying, "you don't have time to take care of your own family. It's hard because you don't have your own domestic worker to rely on." Thus, **working hours** also impact domestic workers' ability to meet basic needs for themselves and their families. As discussed by Van Horn, time control captures time adequacy or an employee's assessment of having enough time for themselves, for being with their family, and for participating in their communities (Van Horn, 2001). Schedule variability and workers' ability to predict and control their work schedules can moderate the risks of working long hours, because they affect workers' ability to plan for medical visits, child care, and other family responsibilities (Smith, 1998; Van der Hulst, 2001).

Given that a written contract will specify wages and hours (including work schedule), which will provide domestic workers' income and time, it is predicted that domestic workers will be able to better meet their basic needs as a result of the passage of the written contract provision.

Stress/Anxiety

Widely described in the literature is the idea that work-related stress is a central health issue for community-based health and social service providers (Denton, 1996; Bartoldus, 1989; Prentiss, 1992; Walcott-McQuigg, 1994) and anxiety levels are particularly high among the helping professions (Jones, 1991). In a survey of home care workers in Ontario, Canada, Denton found that stress was extremely common. Results included that 75% of workers felt exhausted at the end of the day, 51% had no energy on the job, 36% were burnt out, and 35% were not able to sleep through the night. Focus groups and interviews conclude that baseline stress is high among domestic workers. Exacerbating the work-related stress, low wages and long or unstable hours are typical characteristics of home care work (Morris, 1999; Bartoldus, 1989; Donovan, 1989; Feldman, 1990; Donovan, 1993; Eustis, 1994; Suprin, 1994; Crown, 1995) and are often a source of job dissatisfaction (Denton, 1996; OWD, 1989; HSABC, 1990)

Wages result in stress upon workers as well as their families and care recipients. For workers with low wages, stress can cause disturbances in sleep, resulting in abnormal function of a worker's cardiovascular, respiratory, nervous, endocrine, and immune systems (Ulmer, 2009; Frank, 2006) and longer-term health outcomes related to cardiovascular disease, obesity, depression, injuries, and accidents. Disturbed sleep from stress and long work hours also causes mistakes on the job, which negatively impact both workers and their care recipients (Sparks, 2001). Interviewees generally concurred, with one noting, "it's very hard on the immune system to not get enough rest and not have time to stop and eat."

Perceived balance between worker's efforts and rewards (earnings, benefits, esteem, job security) has been shown to influence health, particularly mental health (Stansfeld, 1999). Imbalance of high efforts with low rewards has been associated with poor physical functioning and increased incidence of coronary heart disease as well as elevated risks of impaired mental and social functioning and onset of mild psychiatric disorders (Stansfeld, 1998; Kuper, 2002; Stansfeld, 1999). Denton's research on home support workers demonstrated that those who feel they are paid fairly are more satisfied with their jobs (Denton, 2008) and thus less stressed and more likely to stay in their jobs. Low wages and lack of benefits are a major source of job dissatisfaction and cause for work resignations for home care workers (Denton, 1996; Feldman, 1990)

Shift work, defined as work in which half of the worker's hours are between 4pm and 8am, which is commonplace for live-in nannies and personal care aides, is associated with significant mental health impacts, especially for women working as caregivers. Workers working double shifts had three times increased risk of depression and almost two times increased risk of anxiety (Geiger-Brown, 2004). This same research also showed that multiple schedule demands, such as working over 50 hours per week and two weekends per month increased the odds of depression four-fold among nursing assistants.

Working hours, to be specified in a written contract, have been shown to significantly impact workers' mental health, with more immediate effects on stress and anxiety. As shown above in Figure 4, long work hours impact mental health in a variety of ways. Several studies of foreign domestic workers have shown that depressive symptoms are related to the number of care hours provided to the recipient (Lin, 2012; Rosa, 2008). A meta-analysis showed small but significant correlations between hours of work and both psychological and physical health outcomes (Sparks, 1997).

Long work hours can lead to domestic workers having limited time or ability to use time effectively for sleep, recovery from work, family, and other non-work activities, which may provide stress relief (Caruso, 2006). Further, research has shown that injuries and illnesses from sleep deprivation are exacerbated by high

workload and shift work, both characteristics of domestic work. Research by Bernal and Meleis supports the framework developed by NORA and suggests that the impacts of long work hours extend beyond the worker to her family (Bernal, 1995). Additionally this relationship is multi-pronged, meaning the worker's long work hours directly impact the worker's health, but also indirectly impact the worker's health through the effects on the worker's family. Domestic workers often experience stress associated with not being able to meet the basic needs of their families. Among the common concerns is the inability to spend enough time with their own children to prevent things like drug use, and inability to take time off of work to take their children to the doctor. Thus, the domestic worker copes through emotional/psychological means (no sleep, loss of appetite), distraction (listen to music, walk), social support (talking with friends), taking time for self, talking with children, substance use, (Bernal and Meleis, 1995). In the long term, long working hours have been associated with adverse impacts on health (van der Hulst, 2003), including increased job stress (Spurgeon, 1997), excess cardiovascular disease risk (Landsbergis, 2004). Shift work is also associated with increased risk for obesity, diabetes, and cardiovascular disease (Steenland, 2000; Scheer, 2009) as well as poor mental health status in the long term (Artazcoz, 2009; Virtanen, 2011).

In addition to number of hours worked, work schedule will also be stated in the written contract. Work schedule refers to the specific hours and days during which work is to be performed. Research by Denton indicated that workload and dissatisfaction with hours are associated with higher levels of job stress among nurses and therapists (Denton, 2008). Similarly, workload was shown to be significantly associated with stress among home care workers (Denton, 2002). Work schedules not only affect domestic workers but also impact those who receive their care. Sleep deprivation due to long hours or shift work leads to decreased concentration and lower cognitive performance and can cause mistakes that negatively impact employee's health, work, or both (Sparks, 2001; Spurgeon, 1997).

Additionally, Moen and colleagues suggest that control over work time, hours, and schedule to be negotiated in a contract, may be especially important for the health and well-being of contemporary employees, given the increasing time pressures, time speed-ups, and work-family time conflicts many are experiencing (Moen, 2013). Time control captures time adequacy or an employee's assessment of having enough time for themselves, for being with their family, and for participating in their communities (Van Horn, 2001). Research has shown a significant correlation between time control and psychological distress among workers (Moen, 2013). This is supported in additional studies, which have found that poor health and psychological distress were more prevalent among women in the lowest quartile of work-time control (Ala-Mursula, 2006). Domestic workers interviewed recognized the benefits of work hours being written in a contract for themselves and their employers. "A contract gives stability to both sides. You [employer] know when I'll be there and I know what hours I'll work and get paid for," stated one full-time nanny.

Given that many domestic workers work overtime, which is often unpaid, it is essential to consider the potential impacts of this interaction of wages and hours on health. Delp and colleagues found that each unpaid overtime hour is associated with slightly greater odds of being less satisfied with work (Delp, 2010). Job satisfaction affects, among other outcomes, domestic workers' mental health (Denton, 2002). Time control, including flexible work hours and regular hours of work, were especially important indicators of job satisfaction when working in homes (Wagner, 1991). In addition, insufficient hours of care (discussed below) may force home care workers to choose between providing less than optimal care or working unpaid overtime, creating stress in their relationship with their care recipient (Delp, 2010)

While long work hours and varying schedules pose potential mental health threats to domestic workers, instability of work hours does as well. A study among home care workers found that unstable work hours were related to resignations among home care workers, which can have impacts on worker stress, financial security, and ability to meet basic needs (Denton, 2002). Worker resignation also impacts care recipients who are then left without their regular source of care.

An individual worried about limited work hours or losing a job may experience stress due to anticipation of the problems associated with a job loss, mental strain associated with being powerless, and ambiguity about the future (Heaney, 1994; Joelson, 1987). Workers responses to the stress of perceived job insecurity can be emotional (anxiety, tension, dissatisfaction) in the short term, while longer term consequences stem from the accumulation of these responses and result in more permanent manifestations in mental and physical ill-health (Gazzaniga, 2003; Heaney, 1994). In one study, perceived job insecurity was statistically significantly correlated with psychological symptoms, which was stronger among those permanent employees with a contract. (Kirves, 2011). Further, job insecurity adversely affects psychological health of the worker and also increases poor self-reported health, workplace injuries and accidents, sickness absence, and health service use (Ferrie, 2008).

On the other hand, research by Delp and colleagues has shown that domestic workers *with* job security, associated with a written contract, are 1.5 times more likely to be very satisfied with their job and thus less stressed (Delp, 2010). Though not specific to domestic work occupations, other studies have shown that fixed-term employment, with specified hours and length of employment, predicted better self-rated health and less psychological stress (Liukkonen, 2004). Further, permanent contract workers are shown to have fewer depressive symptoms and greater job satisfaction (Kompier, 2009).

Not only does the job security, or insecurity of wages and hours, impact worker stress and anxiety, but the **job demands and control** also do. Job demands are the tasks and expectations of a job, which incorporate physical and psychological demands (Delp, 2010). Job control is the discretion of skills and latitude and authority over decisions related to how a worker does her job (Delp, 2010). Degree of control (job demands and latitude in making decisions about work) that workers feel they have over working conditions is thought to be major factor contributing to health (Karasek, 1990; Sparks, 2001). Research among workers in general and domestic workers specifically supports this link. A study by Moen et al found significant correlation between decision latitude (job control) and psychological well-being and emotional exhaustion among workers (Moen, 2013).

For home support workers, workload and lack of control over the job are associated with job stress (Denton, 2008). Denton also found that limited control of tasks and scheduling are a source of stress among home care workers (Denton, 2002). Workers, such as domestic workers, whose jobs make high demands yet offer little decision latitude experience job strain, defined as low control and high demands. Job strain contributes to psychological distress and creates higher risk of chronic physical illnesses such as cardiovascular disease and unhealthy coping behaviors such as smoking (Karasek, 1990; deLange, 2003). As one house cleaner commented, “it’s a stress because you get frustrated. You say, ‘why is this happening to me? Why are they adding all these [tasks] on me?’” Anticipation of a stressful event (not knowing expectations of what job will hold) represents an important source of anxiety and ultimately reduced wellbeing (Lazarus, 1998). Another nanny confirmed this noting, “the work to take care of kids is very emotional and physical. It’s important to know and state the tasks involved today and in the future, because it adds up.” Research on job control further supports these ideas. Control or security is likely to positively affect the employee’s experience of work and well-being (DeCuyper, 2007; Fugate, 2004; Marler, 2002). Additionally, workers who feel in control of their tasks may reduce unfavorable consequences of perceived job insecurity (Sverke, 2002), suggesting that domestic workers with job tasks and expectations delineated in a written contract may have some reduced stress that is associated with unstable hours or pay.

Another component of job demands and control is related to the role of the domestic worker, in other words what tasks and expectations the job will comprise. Role stressors (role uncertainty, ambiguity, or conflict) have repeatedly been shown to be associated with a variety of negative outcomes, including emotional exhaustion and vital exhaustion, which are risk factors for coronary heart disease and tension/anxiety (Beehr, 2005; Appels, 2004; Ortqvist, 2006; Jackson, 1985). Additional research has shown that higher role uncertainty

is associated with more pronounced cortisol stress reactivity, even when controlling for confounders such as cardiovascular disease. High cortisol stress reactivity has been shown to predict coronary artery recalcification (atherosclerosis) leading to higher coronary heart disease risk (Hamer, 2010; Hamer, 2012). Stress due to job demands and control can lead to further mental health impacts as well as other physical health conditions. A review by Schnall et al found significant associations between job control and cardiovascular disease outcomes in 17 of 25 studies (Schnall, 1994).

It should be noted that physically demanding daily tasks and uncomfortable working positions, which would be specified in a written contract, can lead to physical strain and injury, also increasing risk of long-term absence from work, which has health and financial implications for domestic workers, their families, and care recipients (Lund, 2006). Jobs requiring repetitive movements and those with high physical workload, including lifting, pushing or pulling put workers at higher risk for musculoskeletal injuries and disorders, overextension and repetitive strain injuries (O'Neill, 2001). While this does not fall into the pathways being examined in this HIA, it is important to highlight that tasks delineated in a written contract will have a significant impact on physical health, specifically injury. Stressful work situations and repeated physical and mental stresses over time can damage immune defenses and vital organs particularly associated with cardiovascular disease (McEwen, 2006; Steptoe, 2002). One nanny summed this up stating, "knowing the tasks I'll be doing helps me know what the stresses will be on my body and I can plan and expect those going into the work."

Given that a written contract will specify wages, work hours and schedule, and tasks and expectations, which also allows domestic workers job security, job control, and job satisfaction, it is predicted that stress and anxiety among domestic workers will decrease as a result of the passage of the written contract provision.

Unhealthy Coping Behaviors

Workers exhibit unhealthy coping behaviors directly due to limited **wages**, but also because of the stress associated with low wages, long or unstable working hours, and limited job control and high demands. Low-wage workers often experience physically demanding work, psychosocial stressors, time pressures, and do not have the extra income to purchase more expensive healthy food options or engage in physical activity opportunities (MassCOSH, 2012). These challenges are further exacerbated by work hours.

As discussed previously regarding domestic workers' abilities to meet basic needs, time adequacy captures employees' assessments of having enough time for themselves, being with their families, participating in their communities (Moen, 2013). Long work hours have been shown to impact workers' health behaviors, including physical activity, smoking, alcohol and drug abuse, and diet (Caruso, 2006; Bushnell, 2010). Additional research supports the link between work hours and smoking (Artazcoz, 2009; Virtanen, 2011). Interviewees reinforced this connection to healthy behaviors saying that the existence of a contract allows them to budget time and money to engage in extracurricular activities, including exercise.

Long **hours** affect not only the health of domestic workers but also their families. In addition to the stress of working long hours, workers experience stress associated with not being able to meet families' needs. They feel that they do not have time to properly raise their own children, causing concern about drug use and other unhealthy behaviors among their children. To deal with this stress, domestic workers cope in a variety of healthy and unhealthy ways- emotional/psychological (no sleep, appetite), distraction (listen to music, walk), social support (talking with friends), taking time for self, talking with children, and substance use (Bernal and Meleis, 1995). The impact on substance use is supported by Frone's research, which indicated that workers with stress due to spillover of work to family life are more likely to suffer from substance use and dependence (Frone, 2000).

Workers' responses to stress of perceived job insecurity in the shorter term can be emotional and behavioral (drug use, absenteeism, lack of concentration), while longer term consequences stem from the accumulation of these responses and result in more permanent manifestations in mental and physical ill-health (Gazzaniga, 2003; Heaney, 1994). Emberland and Rundmo have found that the perceived level of job insecurity is related to employee on-the-job risk behaviors, which impact care recipients as well as domestic workers themselves (Emberland, 2005). Schedule variability and workers' ability to predict and control their work schedules can moderate the risks of working long hours, because they affect workers' ability to plan for sleep, exercise, and other healthy behaviors (Smith, 1998; Van der Hulst, 2001).

Finally, the concepts of **job control and demands** have been shown to impact unhealthy behaviors. Workers whose jobs make high demands yet offer little decision latitude experience job strain (low control and high demands). Job strain contributes to unhealthy coping behaviors such as smoking (Karasek, 1990; de Lange, 2003). A cross-sectional and longitudinal study analyzing 2004-2005 data of employees from a large pharmaceutical company showed "that individuals with more flexibility also have healthier lifestyle behaviors," such as better sleep and self-appraised lifestyle. The results implied that "when employees are given the flexibility they need, they will in turn participate in healthier behaviors and presumably reduce negative health-related outcomes such as sickness-absences, stress, and other work-related impairments" (Grzywacz, 2008).

Given that a written contract will specify wages, hours (including work schedule), and tasks and expectations, giving domestic workers resources, time, and job control, it is predicted that unhealthy coping behaviors among domestic workers will decrease as a result of the passage of the written contract provision.

How Would the Written Contract Provision Impact Employers/Care Recipients?

The written contract provision of the proposed Bill of Rights would impact care recipients in a variety of ways. Sleep deprivation and stress among domestic workers, due to long hours or shift work, leads to decreased concentration and lower cognitive performance and can cause mistakes on and off the job that negatively impact a domestic worker's health, work, or both and thus impact those to whom they provide care (Sparks, 2001; Spurgeon, 1997).

On the other hand, insufficient hours of care may force home care workers to choose between providing less than optimal care or working unpaid overtime, creating stress in their relationship with their care recipient (Delp, 2010). A study among home care workers found that unstable work hours were related to resignations among home care workers, which can have impacts on worker stress, financial security, and ability to meet basic needs (Denton, 2002). Worker resignation also impacts care recipients who are then left without their regular source of care.

Finally, perceived level of job insecurity among workers is related to employee mental well-being, turnover intentions, and on-the-job risk behaviors, which can leave care recipients at risk or without care (Emberland, 2005). Other studies support the idea of workers' job security impacting care recipients. When employees don't have their expected level of job security, it is predictive of how involved employees are in their job (Kuhnert, 1991) and the extent of their commitment (Davy, 1997). Uncommitted workers are not as likely to provide high level care. Perceived job security has impacts on trust between employee and employer, as well as on employee performance and turnover intention (Sverke, 2002). On the other hand, the written contract provision will specify the working hours for domestic workers and thus may result in employers' needing to hire additional workers to meet their needs. This will be the case for employers of live-in workers in particular. It should be noted that employer costs should not change assuming all hours are paid for.

As discussed in the assessment above, the written contract provision is predicted to improve hours and wages of domestic workers, and will thus have several positive and at least one potential negative impacts on employers/care recipients.

How Would the Written Contract Provision Impact Families of Domestic Workers?

Employers are not the only recipients of care from domestic workers. The children and families of domestic workers are also predicted to experience impacts as a result of the written contract provision of the legislation. As noted in the above assessment sections, domestic workers are often unable to achieve financial security or meet basic needs, which also affect their families. Most domestic workers do not earn a living wage and are thus unable to provide sufficiently for their families. Literature shows that children in food insecure households experience two to four times as many individual health problems (weight loss, fatigue, headaches, etc.) as children with greater food security (FRAC) as well as illness absences from school (FRAC), which has negative impacts on academic success and future income (RWJF, 2009). In addition to food insecurity, housing insecurity, due to limited wages, can lead to chronic stress in children, as well as poor child development and school performance (Ross, 1999; Krieger, 2002; Evans, 2004).

Additionally, low wages also make domestic workers spend more time at work and less time with their own children and family, which stresses the worker and raises concern over unhealthy behaviors of own children (Bernal, 1995). Domestic workers also noted that unstable schedules or long hours do not allow them time to take their children to the doctor. Thus, working hours also impact domestic workers' ability to meet basic needs for themselves and their families. These issues are also cyclical as the inability to achieve financial security and meet basic needs for their families causes additional stress to domestic workers.

As described above, the written contract provision is predicted to improve wages and hours for domestic workers, and consequently have positive impacts on their families as well.

In summary, based on the available evidence and understanding of the domestic worker population and their characteristics, it is predicted that the passage of a written contract requirement for domestic workers would protect the health of a significant and growing group of domestic workers in Massachusetts who work more than 16 hours for an employer.

Table 7 provides a summary judgment of the direction, extent, and likelihood of the health impacts and the uncertainties related to the limits of available evidence. A quantitative estimate of the magnitude of health impacts related to the written contract is not possible due to the following data limitations:

- Limited data on the number of domestic workers with a written contract
- No data on the number of domestic workers who work 16+ hours for an employer
- Limited existing research specifically examining how contracts affect health
- Limited existing research specific to the domestic worker population

Table 7: Summary Assessment of Predicted Effects of Written Contract Provision on Health

Health Determinants	Direction and Extent	Likelihood	Who Impacted			Uncertainty related to limited evidence
			DW	F/C	E/CR	
Stress/ Anxiety	⇓ ⇓ ⇓	⇑ ⇑ ⇑	X	X	X	• Limited data on # of domestic workers with a written contract • No data on # of DW who work 16+ hours for an employer • ¾ of the studies aren't on domestic workers • Other factors play into the severity of the impact • Many studies support the likelihood, although specific unhealthy coping behaviors did not come up in interviews and focus groups • limited literature that makes the connection directly between the contract itself and these outcomes (more so showing links between the contract components and outcomes)
Unhealthy coping behavior	⇓	⇑ ⇑	X	X	X	
Unmet basic needs	⇓ ⇓ ⇓	⇑ ⇑	X	X	?	
Financial security	⇑ ⇑ ⇑	⇑ ⇑	X	X		

Explanations:
Direction/Extent (combine direction, magnitude, and severity into one measure)

- Severe impact on many = ⇑⇑⇑ or ⇓⇓⇓
- Severe impact for a few or small impact on many = ⇑ or ⇓
- Moderate impact on medium number = ⇑⇑ or ⇓⇓
- Moderate impact on many = ⇑⇑⇑ or ⇓⇓⇓
- Small impact on few = ⇑ or ⇓
- Uncertain = ?
- No effect = "No effect" or "None"

Likelihood refers to strength of evidence showing the causal relationship between the provision and the health outcome:
⇑ = limited evidence (one source of evidence (literature or qualitative)
⇑⇑ = limited but consistent evidence (one or two sources but they are saying the same thing)
⇑⇑⇑ = causal relationship established (literature establishes causal relationship which is supported by qualitative sources)

Who is Impacted
DW = Domestic Workers
F/C = Families/Community
E/CR =Employers/Care Recipients – This takes into consideration direct and indirect effects of the provision

Recommendations

The findings of this HIA indicate that if the Bill of Rights were to pass it is predicted to have generally positive impacts on the health of domestic workers, their families, and the recipients of their care/services. The following set of recommendations suggests ways in which the economic, social, physical, and mental health of these populations can be protected and promoted. Recommendations are segmented by potential implementing entities- organizations that work with domestic workers and employers, researchers, and policy makers and regulatory agencies.

Recommendation	Associated Evidence	Who is responsible
Organizations Working with Domestic Workers and Employers		
To better understand who employs domestic workers in Massachusetts, create a registry for employers of domestic workers in Massachusetts, particularly employers of live-in workers • Incentivize participation through a tax credit or direct pathway to mediation in case of legal situation related to employment of a domestic worker	There is limited data and information on who employs domestic workers in Massachusetts.	Community-based organizations, with support from Hand in Hand National Network of Domestic Work Employers
To better inform domestic workers of workplace hazards and strategies for contract negotiations, conduct trainings about: • Mental and physical worksite wellness • Contract development and negotiation	Because domestic workers are not professionalized, there is not any required training or education about workplace hazards, employment rights and benefits.	Community-based organizations
To better inform employers and domestic workers of the specific implications of the new legislation, provide "Know Your Rights" Workshops to domestic workers and employers	The new legislation would create a new set of requirements and benefits for employers and employees that need to be communicated to those affected by the changes to the law.	Community-based organizations
Create a hotline to field domestic worker complaints re: violations of contracts, privacy, etc. and develop a communication mechanism to relay the information back to the AG and MCAD.	Domestic work is isolating and the nature of the workplace does not allow a mechanism for reporting workplace violations.	Community-based organizations

To increase domestic workers' negotiating power, organize domestic worker cooperatives or collectives	Co-ops help domestic workers negotiate with employers. They protect them from abuses and have been shown to increase wages and benefits.	Community-based organizations
Researchers		
To increase the data available on the current numbers and characteristics (economic, social, health) of domestic workers, research the economic, social, physical, and mental baseline health status of domestic workers	There is limited data on the number of domestic workers with a written contract and who experience privacy violations; Much of the literature used in this HIA is based on studies of other types of work and does not focus specifically on exposures, determinants, and health outcomes among domestic workers	Researchers, in collaboration with community-based organizations
To better understand how domestic workers are affected by their work and workplace, research the impacts of working conditions on domestic workers' economic, social, physical, and mental health	Many studies support the likelihood of the connection to economic health and some related to environmental exposures, although additional specific health outcomes, especially mental health, has not been widely studied. While mental health came up repeatedly in focus groups and interviews, physical health was not mentioned often.	Researchers, in collaboration with community-based organizations
Identify the mechanisms through which contracts (job security, job control, job expectations) are associated with psychological morbidity	There is limited literature that makes the connection directly between the contract itself and health outcomes. There is more showing links between the contract components and outcomes.	Researchers
Identify relevant indicators and monitor the impact of increased labor protections, specifically the written contract and privacy protections, on the health of employers/care recipients of domestic workers	Few existing studies included assessment of impacts on recipients of care/services from domestic workers.	Researchers, in collaboration with community-based organizations

To address concerns raised by domestic workers about potential implications of the new legislation, document the impact of new regulations on the structure and working conditions of the domestic work industry • Consider adapting the National Domestic Workers Alliance survey to address future needs and topics as the Bill of Rights gets implemented	Several interviewees expressed concerns that new regulations on the industry will change who, how, and where employers engage domestic workers	Researchers, in collaboration with community-based organizations
Relevant research recommendations should be considered by the occupational health and safety advisory board		Occupational health and safety board to be appointed by the Governor
Policy-Makers and Regulatory Agencies		
To address the need for employers to easily identify back-up care employees, and to facilitate training for domestic workers, create a registry of domestic workers in Massachusetts	There is no formal mechanism for employers to find back-up care in the event that an employee needs take days of rest, medical leave, etc.	MA Attorney General's Office
To allow enough flexibility in written employment agreements so that individual needs of domestic workers, employers and care recipients are met, require the use of core components for the written employment agreement, but allow for the addition of tailor-able, mutually-agreed upon clauses	During the HIA interviews and focus groups, many domestic workers expressed concern that the standard language of a written employment agreement might not allow them to negotiate clause important to their mental health - or that of the care recipients. For example, nannies cited a desire for a clause that would allow them to say goodbye to the child for whom they care at the end of their term of employment, thus reducing levels of stress and anxiety of both the nanny and the care recipient.	MA Attorney General's Office
To better inform domestic workers of workplace hazards, domestic workers should be provided with	Because domestic workers are not professionalized, there is not any required training or education about	Department of Labor and Workforce Development, in collaboration with

adequate training that is relevant and specific to the hazards of the employment, including mental health hazards.	employment rights and benefits.	community-based organizations
To facilitate the reporting of complaints and workplace violations, support the creation of a hotline to field domestic worker complaints re: violations of contracts, privacy, etc. • Work with community-based organizations to develop a communication mechanism to relay the information back to the AG and MCAD.	Domestic work is isolating and the nature of the workplace does not allow a mechanism for reporting workplace violations.	MA Attorney General's Office and Massachusetts Commission Against Discrimination
To address financial security, productivity, and health of domestic workers and employers, include a provision for paid rest days	Given the long work hours and low wages of domestic workers, paid days of rest would contribute to their health by improving their financial security, ability to meet basic needs, access to goods and services, and reducing stress.	MA Legislature
To identify and meet the needs of immigrant domestic workers, allow for interested parties to access Immigration and Customs Enforcement (ICE) registration information about employers sponsoring domestic workers through B1and B2 visas.	Anti-trafficking advocates do not have access to data that would help with the monitoring and prevention of trafficking.	U.S. Congress
To allow domestic workers to continue to work and remain in the country, allow immigrant domestic workers who are abused by their employers (or suffer violations of other employment laws) to transfer their domestic worker visas to new employers.	If a domestic worker has to leave a troublesome employment situation, their visa are not currently transferrable to a new employer.	U.S. Congress

Evaluation and Monitoring

HRiA will consider the following evaluation questions for this HIA:

- What resources were used by HRiA and key partners (MCDW) to complete this HIA?
- To what extent were affected populations involved and engaged in this HIA process?
- What were the successes and challenges of this HIA process?
- Did MA legislators find the HIA process valuable?

HRiA has developed the following questions to monitor the impact of this HIA:

- How did this HIA influence the decision-making of the MA legislature?
- What aspects of the recommendations were included in the final language of the Bill of Rights?
- What aspects of the recommendations were included in the implementation of the Bill of Rights one year after its passage?

Additionally, one way that the health determinants and longer term outcomes of this HIA could be monitored is through regular surveying of domestic workers across Massachusetts using the National Domestic Workers Alliance Survey. The survey can also be adapted to address future needs and concerns of MCDW as the Bill of Rights gets implemented. Over time, the survey can indicate whether predicted improvements on the health determinants were achieved. In addition, complementary data can be compiled from sources that already collect several monitoring indicators of interest, namely the Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses.

Reporting

This report will be presented to the MCDW and other advisory committee members through an in-person presentation. The executive summary and full report will be provided to the MA legislature. This report will also be provided to NNPHI and Health Impact Project as part of the grant requirements for this project. Other intended forms of dissemination include a presentation at the American Public Health Association Annual Meeting and the National HIA Meeting. Additional avenues for disseminating this HIA will be discussed among MCDW, HRiA and NNPHI/Health Impact Project.

Conclusion

Historically, domestic workers have been excluded from many state and federal labor and health laws. The Bill of Rights would afford domestic workers basic standards of protections currently enjoyed by most other workers.

This health impact assessment examined two key provisions – the right to privacy and the right to a written contract – and the evidence of their potential impacts on the health of domestic workers, their employers, and their families. Based on the best available evidence, the bill in its current form has the potential for decreasing stress and anxiety, unmet basic needs, and verbal abuse of domestic workers, among other health impacts. Additionally, the bill has the potential to increase financial security, social connectedness, and access to goods and services for domestic workers. Potential impacts on employers include stress, fear of theft, and costs of employing additional domestic workers.

The Bill of Rights has significant implications for health, both through the provisions examined in this HIA, and the other important components of the bill that could not be covered in the scope of this HIA research. The positive impacts could be enhanced and the negative impacts could be mitigated through the adoption of the recommendations included in this report. Additional research is needed to understand the health impacts of the other provisions of the Bill of Rights as well as additional impacts of the bill on employers and care recipients, families and communities of domestic workers, and the general public.

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Appendices

APPENDIX A- Data Analysis of Domestic Worker Population, Industry, and Occupation

In its HIA of California Assembly Bill 889, the San Francisco Department of Public Health, in collaboration with Data Center, developed and utilized a methodology for quantifying and characterizing the domestic worker population in California that would be covered by the proposed AB 889. When possible, HRiA attempted to replicate the methodology used in California, applied to the domestic worker population to be covered by the proposed Bill of Rights in Massachusetts. HRiA sought guidance from San Francisco Department of Public Health (Megan Gaydos, June Weintraub), Boston University School of Public Health (Jennifer Masdea), Massachusetts Coalition for Domestic Workers (Lydia Edwards, Monique Nguyen), and U.S. Census Bureau (Andy Hait, Alexandra Barker, Tim Olson).

HRiA used data from the U.S. Census Bureau's American Community Survey (ACS) and the Bureau of Labor (BLS) Statistics' Survey of Occupational Injuries and Illnesses to conduct the baseline assessment presented in this report.

The American Community Survey (ACS) is an ongoing statistical survey conducted by the U.S. Census Bureau sent by mail to approximately 3 million addresses annually. ACS data were extracted from the U.S. Census Bureau's American Fact Finder in April 2014. 5-year estimates (2006-2010) were used to provide a larger sample size than that of a single year.

For each of these databases, when possible, we selected private households as the industry (NAICS Code 814) and four primary occupational categories – maids and housekeeping cleaners (SOC 372012), childcare workers (SOC 399011), personal care aides (SOC 399021), and nursing, psychiatric, and home health aides (SOC 311010) – as the universe of the domestic worker population covered by the Bill of Rights. The geography variable was all Public Use Micro data Area (PUMA) codes for Massachusetts. Other population variables included age (16 and older) and employment status recode (civilian employed, at work).

Industry

Private Household Industry- According to the North American Industry Classification System, industries in the Private Households subsector (part of the "other services, except public administration" sector) include private households that engage in employing workers on or about the premises in activities primarily concerned with the operation of the household. These private households may employ individuals, such as cooks, maids, butlers, and outside workers, such as gardeners, caretakers, and other maintenance workers.
Occupations within two additional industries could be considered as part of the domestic worker population covered by the Bill of Rights. These include Home Health Care Services Industry (6216) and Individual and Family Services Industry (6241). These industries account for approximately XXXX additional domestic workers.

Occupations

SOC- The 2010 Standard Occupational Classification (SOC) system is used by Federal statistical agencies, such as the U.S. Census Bureau and the Bureau of Labor Statistics, to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data.

The following SOC occupation categories were included as the primary occupations of Massachusetts domestic workers:

- Maids and Housekeeping Cleaners (SOC 372012)
- Childcare Workers (SOC 399901)
- Personal Care Aides (SOC 399021)

- Nursing, Psychiatric, and Home Health Aides (SOC 311010)
    - It is not possible to disaggregate this category to allow for the separation of home health aides as its own occupation. However, the assumption is that individuals working within this occupation in the private household industry are likely home health aides, as opposed to other industries, which would be more likely to include nursing or psychiatric in other workplace settings.

Within the private household industry, the following occupations were also included in overall population counts:

- Dietitians and nutritionists 3030 (SOC 291031)
- Physical therapists 3160 (SOC 291123)
- Registered nurses 3255 (SOC 291141)
- Licensed practical and licensed vocational nurses 3500 (SOC 292061)
- Chefs and head cooks 4000 (SOC 351011)
- Cooks 4020 (SOC 352010)
- First-line supervisors of housekeeping and janitorial workers 4200 (SOC 371011)
- Janitors and building cleaners 4220 (SOC 372011)
- Grounds maintenance workers 4250 (SOC 37-3010)
- First-line supervisors of personal service workers 4320 (SOC 391021)
- Personal care and service workers, all other 4650 (SOC 399099)
- Maintenance and repair workers, general 7340 (SOC 499071)

These occupations account for approximately 930 additional workers according to the ACS 5-year estimates for 2006-2010.

Class of Worker

APPENDIX B- Methodology for National Domestic Workers' Survey (Burnham and Theodore, 2012)

Much of the baseline data for this HIA was derived from the National Domestic Workers' Survey conducted in 2011 and 2012 by the National Domestic Workers Alliance, which was reported by Burnham and Theodore in their *Home Economics* report. Below is a brief description of the methodology for the study.

The National Domestic Workers' Survey employed a participatory methodology in which 190 domestic works and organizers from 34 community organizations collaborated in survey design, the fielding of the survey, and preliminary analysis of the data. Surveyors were extensively trained in their native languages to recruit and survey participants. They recruited participants primarily through snowball sampling, a technique that asks each interviewee to identify future participants from among their acquaintances. Surveyors went to parks, transportation hubs, churches, and shopping centers to ask nannies, housecleaners, and elder caregivers about working conditions in private households.

Between January 2011 and February 2012, they surveyed 2,086 domestic workers in 14 metropolitan areas: Atlanta, Boston, Chicago, Denver, Houston, Los Angeles, Miami, New York, San Antonio, San Diego, San Francisco, San Jose, Seattle, and Washington, D.C. These metropolitan areas represent every region of the country, and collectively are home to 243,370 nannies, caregivers, and housecleaners, according to the 2005-2009 American Community Survey. In addition, 29 semi-structured and focus group interviews were conducted, and 52 testimonies were collected from members of domestic worker organizations.

To ensure that the survey represented the domestic worker labor force in each metropolitan area, they derived targets for each city in the survey from the American Community Survey's 2005-2009 five-year sample. Interviewers were given demographic and occupational targets specifying the rate/ethnicity, nativity, and occupation (nanny, caregiver, or housecleaner) or workers to be sampled. Although the domestic workers in the sample were extremely diverse racially and ethnically, for the purpose of the survey, they elected to use four racial/ethnic categories: white, Latino, black, and Asian-Other (encompassing Asian and Pacific Island groups as well as those who identify as "some other race.") Respondents self-identified and were given the option of choosing more than one category. The final sample was weighted to be representative of the demographic and occupational characteristics of the workforce in each of the metropolitan areas.

Interviews took 45 to 60 minutes to complete and were conducted face-to-face in nine languages: English, Spanish, Portuguese, Polish, Tagalog, Mandarin, Cantonese, Haitian Creole, and Nepali. In total, workers from 71 countries were surveyed. Respondents received a $20 incentive for their participation. Surveyors were also compensated for each survey completed.

Potential respondents were screened and required to meet four conditions for inclusion in the survey:

- They had to work in a private home(s) during the previous week for a minimum of six hours as a nanny, housecleaner, or caregiver.
- They received pay for their domestic work job(s) directly from a member of the employing family, rather than, for example, from an employment agency, government entity, or cleaning service.
- They were at least 18 years of age. (This is consistent with the population of domestic workers who would be covered by the Massachusetts Domestic Workers' Bill of Rights)
- They lived in one of the metropolitan areas included in the survey.

The survey instrument guided the interviewers to ask about work schedules, job tasks, wages and earnings, health and safety in the workplace, training, and demographics. The survey did not presume any knowledge of employment and labor laws on the part of workers. To reduce bias in relation to knowledge about and exercise

of employment rights, workers were disqualified from the survey if they were members of organizations that advocate for the rights of workers.

APPENDIX C- Focus Group and Interview Guides

Promoting Health for Domestic Workers and Their Clients: A Collaborative Needs Assessment Focus Groups - Facilitator's Guide and Questions

Tips for facilitators

- Set the tone by being relaxed, respectful, honest and non-judgmental.
- Work to achieve active participation of *all* focus group participants
- Reflect back in the language given by participants. "What I heard you say was …"
- Some probing statements to foster open discussion include: "Does anyone see it differently?"; "Are there any other points of view?"; "Would you explain further?"; "Can you give me an example of what you mean?"; "Is there anything else?"

INTRODUCTION (Co-facilitator A and B) (10 min)

1. **Welcome**

Introduce yourself and the notetaker, and send the Sign-In Sheet with a few quick demographic questions (age, gender, cadre, yrs at this facility) around to the group while you are introducing the focus group.
Review the following:

- Thank you for agreeing to participate. We are very interested to hear your valuable opinion on the impact of domestic work on health and well-being.
- You have already filled out a consent form prior to this session. We will provide additional copies during this session and will review some of the key points now:
  - The ultimate goal of the research is to improve the health of home care workers and their clients. The purpose of the current project is to listen to the ideas and experiences of home care workers as a starting point for future efforts.
  - The information you give us is completely confidential, and we will not associate your name with anything you say in the focus group.
  - We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed upon completion of the research. Do we have the group's permission? If so, we will start recording after introductions.
  - You may refuse to answer any question or withdraw from the study at any time.
  - We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality. That means no one will discussion anything that anyone says in the focus group outside of the focus group.
  - If you have any questions now or after the focus group is over, you can always contact a study team member like me, or you can call the faculty advisor whose names and phone numbers are on this form.

2. **Explanation of the process**

Ask the group if anyone has participated in a focus group before.

About focus groups

- Appreciate input, want to hear from all of you about experiences at work and how those experiences might relate to your health
- There are no right or wrong answers—please be as honest and complete as you can
- Not trying to achieve consensus, we're gathering information
- Respect for one another's voices—one person speaks at a time
- My role is to guide the discussion – focus on some questions and let folks tell their stories
- Sometimes might have to move folks onto another question so we can get through it – or to give everyone a chance to speak - Please don't take it personally!
- Have gift cards to compensate for participation - will distribute at the end – want to show appreciation for participation

Logistics

- Focus group will last about 90 minutes
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments

3. Ground Rules

Ask the group to suggest some ground rules. After they brainstorm some, make sure the following are on the list.

- Everyone should participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don't have side conversations
- Turn off cell phones if possible
- Have fun

4. Ask the group if there are any questions before we get started, and address those questions.

PHOTO ICEBREAKER[3] (Co-Facilitator A) (30 minutes max, shorter if possible)

Note to facilitator: Write the following list of bullet points on a flip chart or a white board: 1) type of work you do 2) tasks you do each day on the job 3) number of employers and number of hours you work for each one per week?

Note to facilitator: Spread photos on a table or on the floor. After instructions are given, invite participants to get up and walk around to examine and select photos. You should be prepared to give an example of describing how one of the photos represents how you feel about your work.

Note to notetaker: Create diagram identifying seat position/number and denoting approximate age and type of work. Use seat position number to identify speaker during notetaking.

We want to get some general information about your experience on the job. Think of a feeling, emotion, or attribute related to your work, and choose the picture that best represents it. You can share photos if you need to. We are interested in hearing about both positive and negative aspects of your job—there are no right or wrong answers.

We will go around the room and introduce ourselves. Please state briefly:

[3] For more background on the Photo Icebreaker and Cartoon Activity, see:

[3]Baron, S., Ayala, L., & Gong, F. (2009). Formative research in occupational health and safety intervention for diverse, underserved worker populations: a homecare worker intervention project. *Public Health Reports.* 124(1).

[3]

- The type of work you do and the other pieces of information on this flip chart/board
- How long you have been employed as a domestic worker
- Show us your photo and describe why you chose it.

Please try not to take longer than 2 minutes for your explanation. We will keep time to help everyone have a chance to speak.

******Turn on Tape Recorder******

Note to facilitator: Discussion begins, make sure to give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

CONDITIONS OF EMPLOYMENT (Co-Facilitator B) (10 mins)

Thanks so much for your introductions. As you can see, there's a wide range of experiences in this room and we look forward to better understanding certain aspects of those experiences. We would like to begin by asking about your working conditions and terms of employment. We are going to start the recorder now to make sure we record your comments accurately.

1) Does your employer(s) follow through with the terms of your original agreement for employment?

Probes:

- Do you have a written contract?
- Does s/he pay you what was promised?
- Are you ever asked to perform tasks that were not part of your original agreement?

2) Do you receive any benefits through your work – for example, paid sick days, time off to take care of sick relatives, time off to go to doctor's appointments, weekends or other set days off during the week, paid vacation time, overtime pay, use of a car, etc?

Probes:

- how long you've received the benefit
- whether you have experienced any difficulties using your benefits (for example, the employer initially agreed to provide you something but doesn't let you take/use it?

HEALTH AND WORKING CONDITIONS (Co-Facilitator A) (10-15 mins)

Now we would like to hear your thoughts on health issues – physical and mental health – faced by domestic workers.

3) What are the aspects of your work that most affect your health?

Probes:

- What work tasks or activities make you feel healthy or unhealthy or injured?
- Which of those tasks or activities have the biggest impact on your health?
- Have you experienced a health problem or risk specifically due to unreasonable hours, lack of time off, or job demands?
- Was this something that could be prevented?

4) What aspects of your work do you find the most stressful?

WORKER EMPOWERMENT (Co-Facilitator B) (10 mins)

5) What special skills do you bring to your work?

Probes:
- Do you have artistic, musical, teaching capabilities, or medical knowledge that you apply in your work?
- What parts of your work do you take the most pride in?

6) Currently, most domestic workers find their jobs informally, through word of mouth. How would it change the work to make this process more formalized, such as using a worker-led cooperative? (Note: in this context worker-led refers to a group of domestic workers that joins together to make a business together; they work together to promote their services, make sure their rights are being respected on the job, and negotiate terms of employment up-front with employers)
Probes:
- What would be the advantages to creating a worker-run cooperative?
- What would be the disadvantages?
- What factors would help make this type of cooperative successful?

IMPACT OF PROPOSED POLICY (Co-Facilitator A) (10 mins, as time permits)
As you may know, there is a plan to introduce legislation next year that would give domestic workers the right to labor protections such as right to days of rest, earned sick time, right to written employment agreement, and access to multilingual outreach and training.

7) If this legislation were passed in 2014, how would this help domestic workers?
Probes:
- specific situation where such a protection would have helped you?
- health benefits of these labor protections?

8) If this legislation is passed, what resources, materials, or organizations could be helpful to help domestic workers both learn about their rights and exercise their rights?

9) The bill also contains provisions to combat human trafficking. This refers to when people are hired work in exchange for some other service, such as entry into the United States, but are not paid and are essentially stuck in the job with no alternatives. Some people who are trafficked end up being forced to exchange sex for survival. *(re-emphasize confidentiality)*
Probes:
- Is human trafficking an issue in the greater Boston area?

10) Any final thoughts you would like to share?

Key Informant Interview Guide

Hello. My name is _____, and I am with Health Resources in Action, a non-profit public health organization in Boston. Thank you for speaking with me today.

We are working with MataHari and the MA Coalition for Domestic Workers to undertake a health impact assessment to gain a greater understanding of the health impacts of the proposed Domestic Worker Bill of Rights, specifically the two parts of the legislation about a written contract and privacy in the workplace. As part of this process, we are conducting interviews and focus groups with domestic workers in MA to understand different people's perspectives on these issues surrounding the Bill of Rights. We greatly appreciate your feedback, insight, and honesty.

Our interview will last about 45 minutes [EXPECTED RANGE FROM 30-60 MINUTES, DEPENDING ON INTERVIEWEE]. After all of the interviews and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during the discussions, along with what we have found in the literature. We will not include any names or identifying information in that report. Nothing that you say here will be connected directly to you in our report, and you should feel free to not answer any question or end the interview at any point.

Any questions before we begin our discussion?

Written Contract

1. What's your occupation?
2. How long have you been in your job? In the field in general?
3. Do you live in your employer's home?

4. Do you have a written contract?
    a. If yes, how did you develop the contract?
        i. Who initiated the process?
        ii. Please describe what is in your contract.

    b. If no, why would you want one?
        i. What would you want to have spelled out in a contract?

5. (If not already discussed) How important is it to know your wages, hours, and tasks when starting a job? Why?

6. What do you see as potential disadvantages to having a written contract?

7. How do you think a written contract could affect your health? [PROBE ON WAGES, HOURS, TASKS/EXPECTATIONS, AND KNOWLEDGE OF THESE 3 ISSUES]
    a. How do your hours/wages/tasks affect your ability to meet your basic needs (sleep, food, medical care, transportation, housing, education)?

    b. How do your hours/wages/tasks affect your ability to engage in healthy behaviors? (healthy eating, exercise, smoking, drinking, time with family/community)?

    c. How do your hours/wages/tasks affect your financial security?

d. How does knowing your hours/wages/tasks upfront affect your mental health (stress, anxiety, depression)?

Privacy

8. How do you feel about the level of privacy at your work?

    a. Personal (physical or sexual abuse)

    b. Space (bedroom, bathroom, etc.)

    c. Communications (email, cell phone, mail, etc.)

    d. Documentation (ability to keep documents)

9. You mentioned (issue) related to privacy. How do you think that affects your health? [PROBE ON EACH ISSUE MENTIONED. DOES IT AFFECT YOUR SLEEP? ABILITY TO EAT? GO TO THE BATHROOM?]

10. How do you see your ability to ___ (have personal space, communicate with family, leave the house, keep documents) affecting your health?

11. How does your lack of privacy affect your mental health?

Thank you so much for your time. Please sign the stipend form. We will be in touch when the final report is available so you can see the product of the assessment that you contributed to.

APPENDIX D- Additional Demographic Information about the U.S. Domestic Worker Population from American Community Survey and National Domestic Worker Survey

		Domestic Workers		
		In the US*	In the 14 Metropolitan Areas*	In Our Sample
		Percent	Percent	Percent
Occupation	Housecleaners	57%	62%	61%
	Nannies	25%	24%	25%
	Caregivers	18%	14%	14%
Sex	Female	95%	95%	97%
	Male	5%	5%	3%
Age Group	18-24	18%	12%	7%
	25-44	38%	43%	46%
	45-64	38%	40%	44%
	65 and older	6%	5%	4%
Race/Ethnicity	White	46%	24%	23%
	Black	10%	9%	9%
	Latina/o	38%	59%	60%
	Asian and Other	6%	8%	9%
Nativity	US Born	54%	24%	22%
	Foreign Born	46%	76%	78%
Citizenship Status	Citizen	65%	44%	34%
	Not a Citizen	35%	56%	66%
Documentation Status of Foreign Born	Documented Immigrant	n/a	n/a	53%
	Undocumented Immigrant			47%
Educational Level	High School Degree	34%	30%	31%
	Some College	20%	15%	15%
	Associates Degree or Higher	14%	15%	15%
Ability to Speak English	Speaks only English	53%	25%	n/a
	Speaks very well	11%	15%	
	Speaks well	12%	19%	
	Speaks, but not well	16%	28%	
	Does not speak English	8%	13%	
Marital Status	Married	40%	39%	32%
	Widowed	5%	5%	5%
	Divorced or Separated	21%	21%	17%
	Never Married	33%	35%	56%
Living-in status	Live-in	n/a	n/a	11%
	Live-out			89%

* *Source: American Community Survey, 2005-2009 5-year sample*