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# State of occupational safety and health practices at workplace for domestic workers in COVID-19 and possibilities for action





▶ **State of occupational safety and health practices at workplace for domestic workers in COVID-19 and possibilities for action**

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## Foreword

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Safety and health at work are structurally linked to decent work; which includes job, income and wage security as well as access to public health; as they are relevant to reflect upon specific health conditions and practices within the workplace. Providing a normative framework of rights and responsibilities for employers, workers, and governments, international labour standards for Occupational Safety and Health (OSH) can serve as guiding principles of a consultative process, via social dialogue between representatives of workers, governments and employers to form exhaustive policies and effective practice enabling the overall well-being of domestic workers. Additionally, an important standard setting, sector-specific international intervention has been the adoption of Convention 189 on decent work for domestic workers by the International Labour Conference of the ILO in 2011. Its ratification has been a long-standing demand of domestic workers and their trade unions in India as they lay out the minimum standards for upholding recognition of and guaranteeing rights to workers employed in a sector that provides employment to millions of women workers in the country.

While exceptional examples of employer benevolence in the wake of the COVID-19 pandemic are intermittently reported in the media, it has been observed that old forms of discrimination building on stigmatized and underpaid work practiced by employers and Resident Welfare Associations (RWAs) have been supplanted by new restrictions. These include reducing wages, increasing work burden, limiting live-out domestic workers from working in 'too many' households or too many areas, restricting live-in domestic workers from interacting with other workers within the same and other households amongst others. As uncertainties relating to the pandemic continue to prevail and lockdown restrictions become more frequent as an effort to combat the health crisis, this report aims to initiate a conversation on international labour standards and domestic workers' rights in the workplace and from an OSH perspective.

The assumption that domestic workers are carriers of the COVID-19 viruses, and the employers are the ones at risk, reinforces old biases and unequal practices in the workplace. An important point raised by the report is 'the unilateral and non-consultative imposition' of terms binding return-to-work during relaxation of lockdown restrictions and its direct negative impact on the health and well-being of domestic workers. Domestic workers report that these conditions are offered as pre-conditions for return to work. The choice therefore is work with these conditions or loss of employment and income.

Such terms of employment clearly violate international labour standards and norms for workplace safety and well-being of workers. The pre-existing challenges of non-recognition as workers, lack of a legal written contract, paid leave, minimum wages etc. have been compounded by practices that have emerged in pandemic conditions. The report provides a window into the current situation from the perspective of domestic workers and suggests ways in which such workers may be better protected during the pandemic. It also provides us with an opportunity to reflect upon domestic workers' fundamental principles and right at work, the importance of workers organizations in channelizing their experiences for policy consideration, direct responsibilities of employers and the urgent need for policy intervention guided by political will.

**Neha Wadhawan**  
National Project Coordinator, India  
Work in Freedom programme, ILO



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## Abbreviations

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<b>COVID-19</b>	Corona Virus Disease of 2019
<b>EFFAT</b>	European Federation of Food, Agriculture and Tourism Trade Unions
<b>G20</b>	Group of 20
<b>IDWF</b>	International Domestic Workers Federation
<b>ILO</b>	International Labor Organization
<b>KII</b>	Key Informant Interviews
<b>NDWA</b>	National Domestic Workers Alliance
<b>OSH</b>	Occupational Safety and Health
<b>PPE</b>	Personal Protective Equipment
<b>RT-PCR</b>	Reverse Transcription Polymerase Chain Reaction Test
<b>RWA</b>	Resident Welfare Association
<b>WIEGO</b>	Women in Informal Employment: Globalizing and Organizing

## Boxes

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## Objective of the report

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India was under a strict government notified lockdown from the morning of 24 March 2020 for nine weeks to contain the spread of COVID-19. Impact surveys during this period — March-June 2020 — revealed a deep impact on workers (APU 2020, SWAN 2020a, SWAN 2020b). Specific studies on domestic workers marked widespread job losses, reduction in wages, and uncertainty about employment status (Chowdhury et al 2020, SEWA 2020). From July 2020, as lockdowns eased, domestic workers were in a precarious position, needing to recoup lost income and savings. Yet, return to work entailed risk, particularly health risks, for a work sector where Occupational and Safety Health (hereafter, OSH) has always been difficult to design, implement and monitor. There was little deliberation over OSH guidelines between workers and employers in this novel situation, nor particular guidelines issued by state authorities. This report seeks to address this gap.

Domestic work is unique in that workplaces are the homes of other people. Yet, historically, private homes have never easily fit official or colloquial understandings of ‘workplaces’ and many households do not think of themselves as standard ‘employers.’ The novelty of private homes as a workplace and the lack of clarity of the roles of the employer are foundational causes of the difficulties in understanding how the occupational safety and health guidelines should be implemented within this sector. Further, in the context of a pandemic, even if an employer is willing to create a safe and healthy working experience, it is not self-evident, or in his/her knowledge, how to do so. The context therefore is one of layered difficulties: a sector marked by a privatized workplace, low bargaining power, lacunae in accessing legal and protective support systems in case of violence, ease of retrenchment, and lack of enforcing mechanism for standard employment or safety and health practices, that now has to additionally meet pandemic conditions.

It is important to reiterate and historically contextualize that ‘home as a site of work’ was only officially recognized in India by the enactment of the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, which brought for the first time, domestic work in the purview of a social protection policy of the state. There remain challenges in accessing these legal protections for women in India. Finally, whether in the implementation of de jure rights or de facto practices, within the social rubric of urban India and other South Asian nations, domestic work and workers are often multiply disenfranchised by the impact of caste, gender, class and migrant identities.

This report addresses all these contexts. It identifies immediate, incremental OSH practices that should be implemented to respond to pandemic conditions, as well as ideal and more expansive medium-term changes appropriate to re-thinking OSH in a post-pandemic world. Finally, while the report focuses on the health and safety needs of live-out domestic workers, many of the recommendations here would also stand for live-in domestic workers. The goals of this report are to:

1. List current practices that are being undertaken to manage risk by workers and employers in urban India;
2. Offer a guideline to employers to make workplaces of paid domestic work more conducive to safety and health of domestic workers in the presence of COVID-19; and
3. Share advice and expectations from medical practitioners, worker associations and labour unions of improved safety practices in order to help central and state governments address the concerns and needs of domestic workers

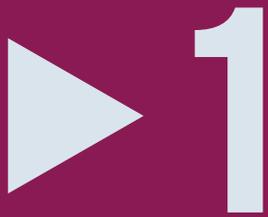
The report is organized in the following manner. Section 1 lays out the general principles that the International Labour Organization (ILO) employs for OSH that define the goals of OSH policies and responsibilities of the various stakeholders. It then describes a widely recognized approach to risk assessment and management used in implementing OSH, particularly in COVID-19. Section 2 then assesses current practices as reported by workers, worker organisations and medical practitioners. With the conditions of work and risk management strategies in mind, we then suggest a framework for practising and demanding incremental improvements that bridge the gap between current practices and the frameworks. Section 3 elaborates on the immediate and incremental improvements, listing specific risks and control measures to address them.

## Method

The information presented and analyzed in this report was collected between October and December 2020 primarily using two methods. First, a review of documents and manuals on the management of occupational safety and health of workers in general and domestic workers in particular was conducted. The documents and manuals were searched and selected from the website of key actors responding to the subject of OSH among domestic workers. To close any gap in information, representatives of the key organizations were requested to share any other such informational documents on the subject and the report received print and digital material on OSH practices and expectations from several other worker organisations. Together, these sources inform Section 1 and Section 2 and the framework for presentation and analysis in Section 2.

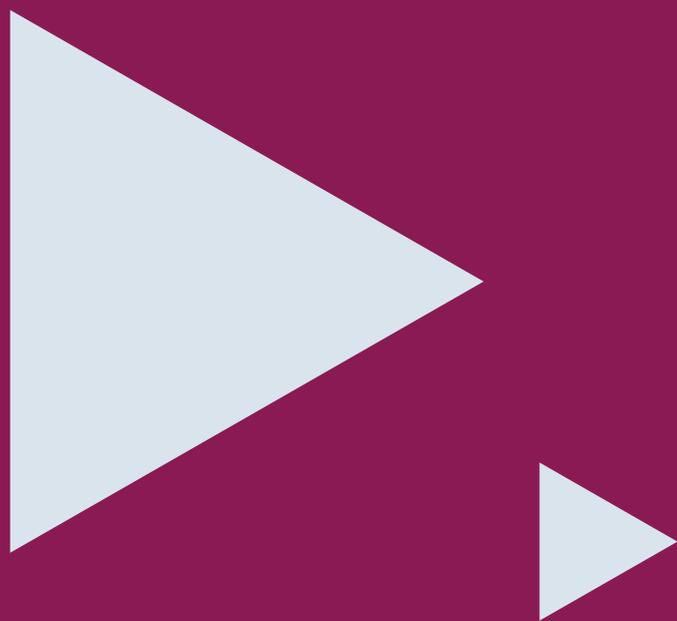
Second, findings from the review as well as absences were explored through a series of semi-structured interviews/consultations with a list of key informants (listed in Annex A). The consultation interviews were divided into two groups — medical doctors and worker organizations. Seven medical doctors were interviewed of whom Dr. Tsuyoshi Kawakami, OSH Specialist from ILO, and Dr. Pritam, an independent activist from Jaipur, are actively involved with workers' issues, with the latter having several years of engagement specifically with domestic workers. The others are experts on pulmonology, pathology, epidemiology, and psychology. These interviews covered three primary topics: the risk of spreading and contracting COVID-19 infection as domestic workers returned to work, control measures to contain the spread of COVID-19 at the workplace, and comments on current practices as reported by worker organizations. The second group comprised of nine worker organizations which included representatives from labour unions of domestic workers and workers themselves as well as activists working on issues of domestic workers. These interviews sought to document and critically assess current COVID-19 practices followed by workers and their employers to be safe from COVID-19 at work.

Interviews were conducted across multiple states in India such as Rajasthan, Delhi, Karnataka, Telangana, Maharashtra and so on. The interviews were conducted largely in Hindi and in English. As they progressed, the authors felt the need to additionally engage subject experts on intersectional issues of gender, OSH and mental health. Additional interviews with such experts were conducted. The interviews inform Section 2 and Section 3 of this document.



# How to approach OSH in COVID-19?

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## 1.1 General principles of OSH

ILO defines occupational health as a multidisciplinary field of healthcare concerned with enabling an individual to undertake their occupation, in the way that causes least harm to their health, by:

- ▶ the maintenance and promotion of workers' health and working capacity;
- ▶ the improvement of the working environment and work to become conducive to safety and health; and
- ▶ the development of work organizations and working cultures in a direction which supports health and safety at work.

Further, the ILO Safety and Health Convention Number 155 (C155) states: "The aim of the policy shall be to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimizing, so far as is reasonably practicable, the causes of hazards inherent in the working environment."

The goal of OSH is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations. OSH frameworks over the years have rightfully expanded to include links to non-standard forms of employment and public health.(ILO, 2019). Doing so has meant that characteristics of informal work – irregular and long hours of work, irregular cycles of pay, ease of retrenchment, lack of contracts, lack of regulation, ineffective OSH management systems – have also become contexts in which OSH outcomes must be delivered and reached. Safety and health at work then are linked structurally to the quality of work, including job, income and wage security, and to access to public health, as they are to particular health conditions and practices within the workplace. International labour standards for OSH provide a normative framework of rights and responsibilities for employers, workers, and governments, which then may or may not be adhered to. We note these briefly:

- ▶ Employers must ensure that, so far as is reasonably practicable, the workplaces, machinery, equipment and work processes under their control are safe and without risk to health as directed by ILO Convention C155. The rights of workers must be safeguarded. This entails a risk assessment and the adoption of a hierarchy of controls to prevent and mitigate risks. Employers are required to provide adequate protective equipment to workers, without cost to the workers themselves. Employers are also responsible for consulting workers and their representatives on OSH, and providing adequate OSH information and training.
- ▶ Workers are responsible for following established OSH procedures and participating in OSH training organized by the employer.
- ▶ Governments are responsible for formulating, implementing and then periodically reviewing coherent national policy on occupational safety, occupational health and the working environment in consultation with the most representative organizations of employers and workers, to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimizing, so far as is reasonably practicable, the causes of hazards inherent in the working environment.

It should be noted that India is yet to ratify several ILO Conventions on occupational safety and health (C121, C130, C155, C161, and others) and the sector specific Convention on domestic workers (C189).

## 1.2 Risk assessments and hierarchies of control

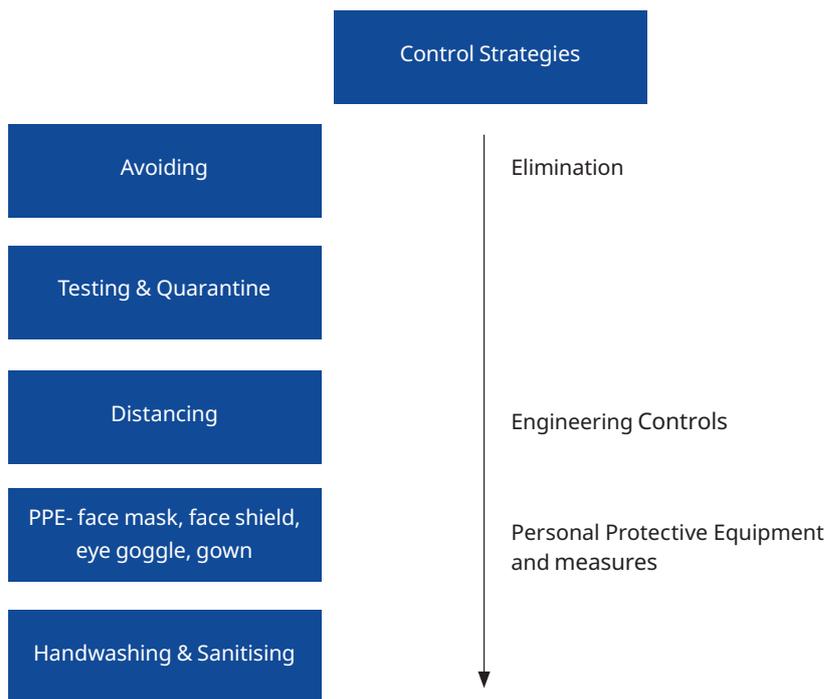
In a policy brief released in May 2020, the ILO argues that safe and healthy physical return to work begins with the emphasis on 'the coordinated action of government institutions [and] the mutually reinforcing role of occupational health services and public health services for the successful prevention

and mitigation of COVID-19'. The framework identifies that return-to-work policies must consider the needs of those in vulnerable situations, prevent social stigmatization of workers who are suspected of being infected with COVID-19, ensure equal access to COVID-19 impact prevention (health or income, whichever is more primary) and ensure protection from discrimination.

Any decision to ask employees/workers to come back to work must be made on the basis of a thorough risk assessment and such assessment protocols must be produced in discussion with workers. The same work setting may have jobs with different levels of risk and different jobs or work tasks may have similar levels of exposure. Therefore, ideally, the risk assessment should be carried out individually for each specific work setting and each job or group of jobs. Though, if one does not have the resources to do so, one may seek out established guidelines that are sector or occupation specific.

Risk assessments are then to be combined with a hierarchy of controls. This is an approach to workplace safety and health that structures protective measures in order of most effective to least effective, and includes elimination, substitution, engineering controls, administrative controls and finally, PPE. In the event of COVID-19, the identified strategies of elimination and control of the contagion could be categorized as shown below in figure 1:

► **Figure 1 : Mapping COVID-19 risk management strategies to hierarchy of controls**



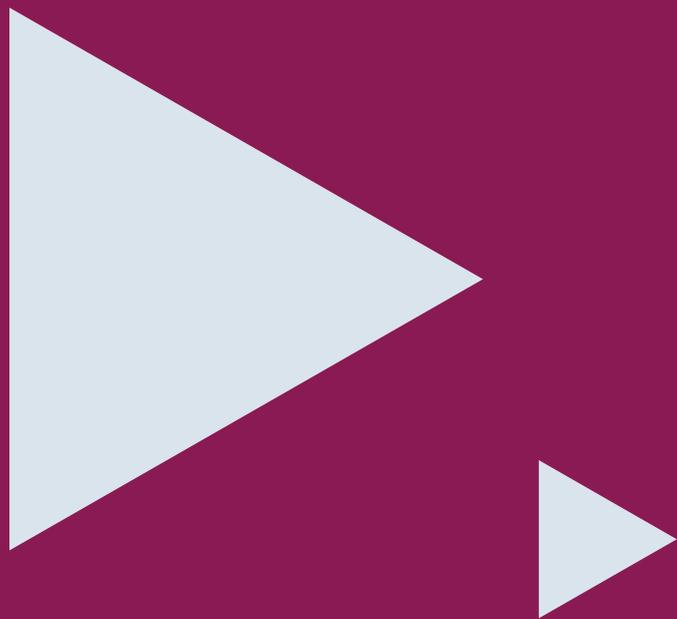
Source: Authors

Risk management requires risk to be managed to a level which is as low as is reasonably practical. Are these two approaches to OSH –risk assessment and control strategies – being adopted within domestic work in urban India?

# ▶ 2

**What are the current practices for OSH within domestic work in COVID-19 ?**

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## 2.1 Current risk assessment practices

The primary finding from the interviews points to a systematic absence of the first principle of risk assessment: transparent communication and joint development of protocols by employers and workers. There is little to no social dialogue between employers and workers about what should be done to ensure safety at work.

Instead, on their return to work, the employer has presented the domestic worker the set of new rules and practices that are to be followed to continue work. Several of these rules – wearing a mask at all times, sanitization/ washing of hands on entering the work-home, and screening at apartment gates – are in line with universal COVID-19 safety guidelines and accepted by all stakeholders as necessary and reasonable. Yet these are often accompanied with other personalized rules for which there are no accepted universal guidelines: requirement to bathe or change clothes before starting work, agreeing to work only at one home (without compensation for losing other jobs), or redesigning work and work schedules to reduce certain work identified as high risk and adjust payment accordingly.

The report discusses these practices in detail in the following section, emphasizing the unilateral and non-consultative imposition of these terms on workers. Domestic workers report that these conditions are offered as pre-conditions for their return to work. The choice therefore is to work with these conditions or be dismissed and face a complete loss of income. In a sector already marked by diminished bargaining power, workers reported that even the limited negotiation spaces they had pre-COVID-19 felt diminished given their urgent need to return to work given the economic impact of the lockdown on household income and savings. As a union worker argued:

“Pehle hi arrangement kar rahe the - ab usmein bhi crisis aa gaya toh koi bhi rasta nahi raha [We were always in an (make do) arrangement, now even in that arrangement there is a crisis and there seems to be few ways out].”

Workers articulated the terms being presented to them as arbitrary and unfair. In their perception, employers place the risk of COVID-19 to themselves at the centre of their decision-making process, undermining the risk to domestic workers from travel, workplace exposure, and the lack of safety measures at work. Many report high levels of stress, anxiety and frustration arising from this lack of dialogue or the impossibility of negotiation over new conditions of work. The nature of some of the new practices and expectations are also perceived as discriminatory and disrespectful. As one worker described it:

“They ask you to wash your hands and face as soon as you enter home. They ask you to wear a mask. Then they ask you to come to their home before going anywhere else. My employer didn't let me inside the home, and asked me to work outside. I would never agree to such treatment and tone. But now, when I really need the money I agree to all her conditions.”

Workers feel uncomfortable with practices such as full-body sanitization, working outside the premises of the house in constricted areas, or of changing clothes and bathing in small enclosures. The assumption that domestic workers are carriers of the COVID-19 virus, and the employers are the ones at risk, has been a source of frustration for the workers. This is compounded by the fact that employers are able to – even more than usual – dictate terms of work within a health and economic emergency where workers have to choose between risking health, livelihood, or dignity.

Economic precarity has put the threat of COVID-19 aside in the worker's strategy with respect to returning to work, as many have felt the threat of acute poverty more sharply than health risks.

A worrying trend is of some workers downplaying the risk to themselves, perhaps as a way to rationalize such impossible trade-offs. As one of the worker shares:

“Corona is a disease of and by the rich people. People like us, who are always physically exerting ourselves, walking and working in the sun, we are naturally immune and better prepared to fight the infection with some rest.”

Continuities between pre-COVID-19 faultlines are unmistakable. Workers perceive the disrespect of being unilaterally handed new terms of work as a continuation of pre-COVID dynamics where their work and personhood would be undervalued, and they would be treated with suspicion by employers. A psychologist who has worked with domestic workers for years said that, in conversations with her, workers articulated that unilateral imposition of new norms made them feel similarly as when employers had used other denigrating language for them in the past: “ziddi hain (she is stubborn), aalsi hain (she is lazy and slow to work), kaamchor hain (shirks work), humesha gaon chale jaate hain (always leaves for her village).” Workers feel, she argued, that there is a continuity of disrespect that allows employers to consider it unnecessary to consult them or consider impacts on them when considering conditions for return to work.

Two other kinds of fractures within risk assessment protocols are worth noting. First is that the household is not always the locus of decision-making. In many cases, it was also noted that decisions regarding return to work were not taken at the household level but controlled by neighbourhood level structures such as building associations and Resident Welfare Associations (RWAs). In several situations, the RWAs are enforcing their rules over the domestic workers, as well as the employers of these domestic workers who may not agree to the rules. For example, in an affluent neighbourhood in Delhi, an RWA had enforced registration of employers who wished to hire domestic workers and allowed residents to hire one worker per household. This was monitored by security guards in the gated colony via gate passes. Such practices were creating widespread impact on employment of a vulnerable population group, thus creating new risks in an attempt to control one. This lack of social dialogue between domestic workers and RWAs was found to be an impediment to the safety and livelihood needs of domestic workers.

## 2.2 Current risk management practices

### 2.2.1 To reduce contact

#### Practices among employers

A extended quotation from one of the workers interviewed in the study captures the many dynamics of employer practices:

“Pehele mooh haath dho, mask lagao. Pehle humaare ghar mein aao, fir dusre ke ghar mein jao. Agar pehle humaare ghar mein nahi aa sakte toh mat aao, ghar pe raho, aur pagar nahi milega. Koi achcha milti hain toh uske yaha dusra jaate hain. Bohot log ghar ke bahar kapda bartan rakhti hain hain ab - ghar mein ghusne hi nahi dete. Paise chahiye, aadmi ka kaam nahi hain, makaan bhaade ka hain, bimaari phail gayi hain - isliye hum khadoos logo ke yaha bhi kaam kar rahe hain ab - majboori hain. Pehle 10 ghar mein kaam karti thi, ab sirf 2 ghar mein.”

“First wash your hands and face, wear a mask. First come to our house, then go to other homes. If you can't come to our house first then don't come at all, just stay at home, and we won't pay wages. If you find a good employer someone else grabs them. Many people leave clothes and utensils outside their house – they don't even let us in! [I] need money, my husband doesn't have work, the house is on rent, illness is spreading so we work with unreasonable people also – it's a necessity. First I used to work at ten houses, now just two.”

Employers are trying to reduce exposure to risk by reducing the number of workers they hire and limit the number of other homes that the domestic worker also works in. For the former, households that employed multiple workers for different activities have reduced the number of workers. For the latter, Employers expressing preference for and, as discussed in the previous section, only retain workers that agree to either work only at their home, or agree to come to their home first. There is no compensation for work lost in other homes should the worker accept this condition. Workers have been managing these situations by negotiating with a ‘more understanding’ employer to report to their home later but report difficulties in doing so given the reductions in work opportunities.

Employers are also re-structuring work. As domestic workers return to work, employers are limiting them to a set of activities seen as low-risk, such as cleaning, and still not re-starting activities with forms of contact such as child care. Workers report that this reduction of activities has also meant reduced incomes, particularly since some of the work duties perceived as higher risk, such as care for elderly residents and children, are also more remunerative.

Older workers, defined broadly as anyone above the age of 40, reported that employers avoid hiring them as a more aged population is seen as prone to health complications from COVID-19. Employers, they say, fear the repercussions and responsibility of such health complications of a worker, and hesitate / refuse to be involved. Another worrying trend is reports of reduced access to toilet and water as part of the redesigning of work to limit contact with a worker. Such re-redesigning of work includes spatial practices of separation. Several interviews described how employers, for example, laid out utensils and clothes in a verandah/washing area outside the home in order to restrict entry into the main house. Two community leaders from a worker's organization shared their concern and confusion over these practices, once again relating them to earlier forms of prejudice:

*"They don't give us water. They don't let us use the bathroom. They don't let us in the house, and they refuse to touch us. It feels as if all our progress to overcome untouchability has been undone. We feel a similar disregard today, as we felt under those practices."*

This is a pivotal echo that once again links pre-COVID-19 prejudices and structural imbalances in work conditions that now seem legitimized under the guise of risk management even as the latter is unilaterally decided and often has little basis in scientific practice. The term 'social distancing' rather than 'physical distancing' within a caste-stratified society is itself indicative of the way in which risk management overlays with other techniques of discrimination and social exclusion. The absence of collaborative risk assessment or any dialogue on the basis of these practices further allows such perceptions to have no other explanation or narrative that allows workers to not feel disrespected.

### Practices among workers

Workers who perceive COVID-19 as a substantial risk to health would willingly avoid or reduce work temporarily if they could. But, their financial conditions do not allow such a line of action. Indeed, labour unions and workers both report having attempted to look for alternative sources of income and employment. Yet given the widespread nature of the lockdown's impact on work across the informal economy (APU 2020), a shift away from domestic work was not possible. Indeed, other studies of domestic work during the pandemic also indicated that movement out of the profession was not a dominant response (Chowdhury et al 2020).

Instead, workers have chosen to resume work with caution. The cost and effort of these cautionary practices, however, fall entirely on them, with little or no support from either employers or the state. For example, workers reported changing their mode of travel to walking as much as possible to avoid public transport. When taking public transport, they opt for less crowded options at an extra cost to themselves, such as taking a solo ride in an auto-rickshaw instead of a shared ride. The cost of safe travel is high as a domestic worker from Mumbai accounts:

*"I used to make 10,000-12,000 rupees in February. I was earning 700 rupees when lockdown opened (July), and 2000 rupees now (December). I have to walk, take a public bus, and take the local train for just this much salary. Does it make any sense? I am paying a part of my salary in various transport fares and buying masks. Overall this kind of a situation in work is a total loss for me."*

To reduce contact, workers also report limited social contact with other workers, friends or neighbours. Even as employers can see them as a source of risk, working at middle class houses is also seen as a high risk activity by workers, as well as others in their neighbourhoods. This has led to changes in their everyday lives and a reduced sociality precisely at a time of crisis.

## Practices among governments

Some state governments identified domestic workers as vulnerable workers and extended cash transfers to them. Such direct cash transfers to domestic workers assisted in delaying contact with employers and also went towards covering partial costs in procuring PPE kits for the domestic workers. The State Government of Tamil Nadu directed domestic workers to register with the state domestic workers welfare board to receive a one-time cash transfer of 1,000 rupees. The State Government of Rajasthan identified domestic workers in the city of Jaipur with the support of a labour union of domestic workers and extended cash transfer of 2,500 rupees.

### 2.2.2 Sanitisation and hand-washing

Workers are directed to wash hands immediately on entry to the work-home, and some employers are cautious to ask them to wash hands on their way out as well. Workers follow any request for hand sanitization using sanitizer at apartment gates or work-home, though some report rashes and a burning sensation from excessive use. Some workers reported that what they described as a 'burning sensation' worsens as they use washing detergent, washing soap, and other chemicals with the bare hands. Many employers have replaced hand washing with sanitization. This could be so for its ease and popularity, as it is the common practice on entering public areas such as offices, shopping complexes, and other apartment complexes. However, the use of sanitizer isn't common among workers as they are pegged at a high price. Medical doctors also advise against using sanitizers if soap and running water is available.

Many employers direct the worker to take a bath and/or change their clothes upon entry. While workers and medical doctors found it a reasonable precaution for a full day of work or care work, it is perceived as an unreasonable demand for live-out workers who come in for a specific and shorter time period to an employer's home. Although workers prefer to change and bathe at their own homes after work, rather than changing at work (if working with multiple employers), they would, hesitatingly, follow any rule of changing clothes or bathing at their work-home if required by the employer. In rarer cases, some workers reported being subjected to full-body sanitization using a spray, which they felt was an unacceptable practice. In exceptional cases, some workers reported blisters and rashes on the body after such full-body sanitization.

### 2.2.3 Use of personal protective equipment during work

Workers are expected to wear a mask at all times, and they try to adhere to it. Given the public health guidelines, they must also wear it at all times during their travels to and from work.

There is general awareness of the requirement for quality masks, either the generic surgical mask available in the market or multi-layer cloth mask, but what they own is shaped by what is readily available in local markets at an affordable price. Mostly, these are a range of cloth masks, from two layer cloth masks to meshed cloth masks. While there is general awareness of the requirement for regular washing of cloth masks, it is unclear what the general practices in handling masks are.

Workers reported discomfort from constant mask usage in hot and humid conditions, amidst physical exertion, and without a brief, safe window of time for taking off the mask for fresh air at work or during their commute. Workers reported that the attitude of police and employers towards a worker not wearing a mask in public or at work felt to them as disproportionately harsh. Fearing a backlash, they avoid taking it off even in open areas to take a breath of fresh air. This, they say, occasionally creates a foul smell, nausea, and a feeling of constriction. The smell further stigmatizes the worker in public. One of the respondents said:

*"I know wearing masks is good for us. But we have to wear masks for up to eight hours a day, while walking, travelling, and during work. The nature of all this work is such that it creates sweat. The masks we have are not 'fancy' (good quality) so they become wet, come off during work and start giving off a foul smell. I feel very anxious about not being able to take it off for such long hours and keeping it on*

with the sweat and smell it accumulates, as the employer and the police can react very badly when they see that it is coming off.”

In sharp contrast, workers consistently reported that employers and the members of their households do not wear masks when they are working. Some workers have been provided gloves at their work-home, but it is a rare practice. No other PPE was reportedly used.

#### 2.2.4 Testing and quarantine measures

Testing for COVID-19 is rarely a component of return to work. In the early days of the pandemic, the price of the test, the lack of clarity on the use of the tests and stigma associated with visiting a testing centre and testing positive were an active discouragement. The costs of private tests are still too high for workers and employers are reluctant to pay for them even when they wish the worker to be tested. Public tests are available for free in certain locations, but access represents difficulties in lost time and workers report fear of exposure at crowded public testing centres.

A union member from Mumbai reports:

“Employers were asking workers to bring negative test results to start work again. Workers found it unreasonable as they didn’t have any money for food and rent, they couldn’t spend on a test. Workers agreed to go through a test if the employer was ready to pay for the test and do it from a trusted centre. Other than the cost of the test, workers were also worried that if they tested positive or if the result was mixed up they would be taken away and put in unknown conditions. In fear of this, if anyone was asking for a test, workers stopped going there to ask for work altogether.”

Across any of the interviews, there were no reports of employers testing themselves and sharing that information with workers. No workers reported asking employers to be tested before they returned to their homes, a fact unsurprising given the absence of negotiating power detailed in the previous sections. Workers also reported fearing that if they or an employer tested positive and that information was shared, quarantine protocols would have to be followed. They felt unable to ask for quarantine leave fearing loss of work or wages, as there is no clear communication on payment of wages during a quarantine period. Workers read the lack of clarity as a likelihood of wage cuts having already experienced not receiving wages during lockdown even in the month of March. As a worker shares from the discussions with her colleagues:

“If they didn’t pay us in March and April, when we couldn’t go to work as there was a strict lockdown all over the country, we don’t expect them to pay us when we have to take leave for quarantine. They will cut our leaves and wages from the monthly income.”

There is no clear information and knowledge of appropriate practices to disclose health status as well as on protocols of quarantine, isolation and testing. The mistrust between the employer and the worker further complicates communication and agreement on shared protocols. Cases of retrenchment following sharing even minor symptoms, let alone test results, reinforce this fear to bring up testing or quarantine protocols. For example, in Jaipur, a worker employed for 12 years with the employer was asked to terminate her employment overnight because she mentioned that her neighbour had a mild cough and cold. Instead of the employer offering quarantine leave or requesting a negative test result, there was an immediate loss of livelihood. Such anecdotal narratives are shared widely among workers, creating hesitancy and fear, and impacting the possibility of information exchange or shared protocols.

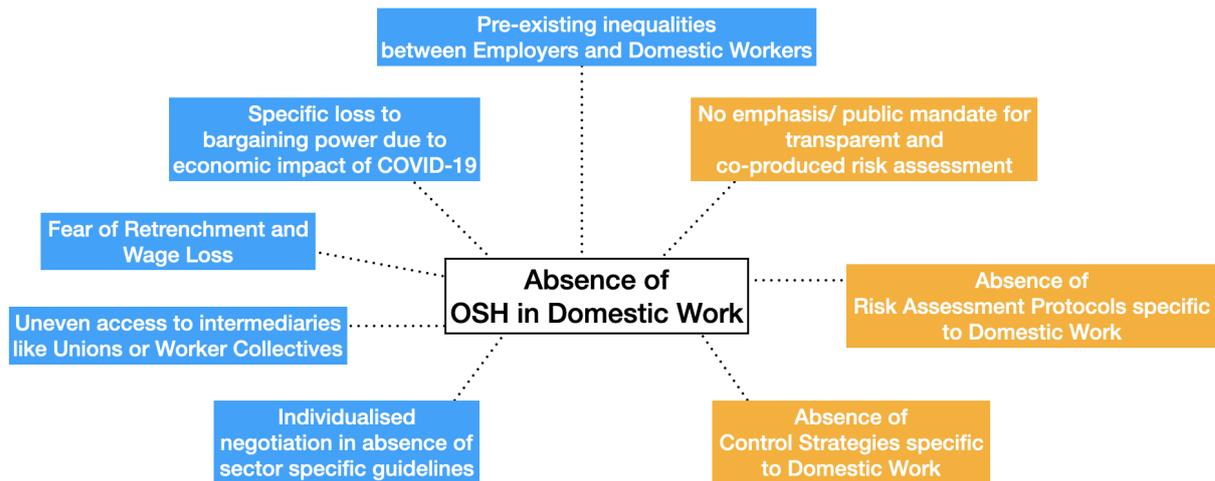
On the other side, employers have asked workers to come to work even when there is a COVID-19 positive case at home against their wishes, assuring them that the patient is in isolation. In Hyderabad, a worker reported being asked to continue her services despite a family member testing positive in the house on the assurance that the patient was in isolation. There was no offer for supporting medical expenses if

she were to be infected due to this situation. In some cases, it is reported that workers are not told about COVID-19 positive patients in the employer household.

### 2.2.5 In summary

Findings in this section emphasize that the shortcomings in OSH for domestic workers are a function of undermining risk to domestic workers, cost and time savings practices of employers, perceived risk from domestic workers, and a lack of information as well as willingness among employers to learn about creating safe working conditions for domestic workers (Figure 2 summarizes). Workers, on the other hand, feel unable to articulate expectations or negotiate conditions for return to work with employers. Instead, they adopt coping strategies that they themselves report to feel inadequate. They articulate a deep imbalance in being able to develop shared risk assessments and control strategies, particularly due to the severity of economic risk they face. They articulate this imbalance as a continuation and worsening of pre-COVID structural inequalities of their terms of employment. Return to work is an employer-centric process both in terms of whose safety is at priority and who has ease of adopting new practices.

▶Figure 2: Underlying conditions for absence of OSH in domestic work



Source: Authors

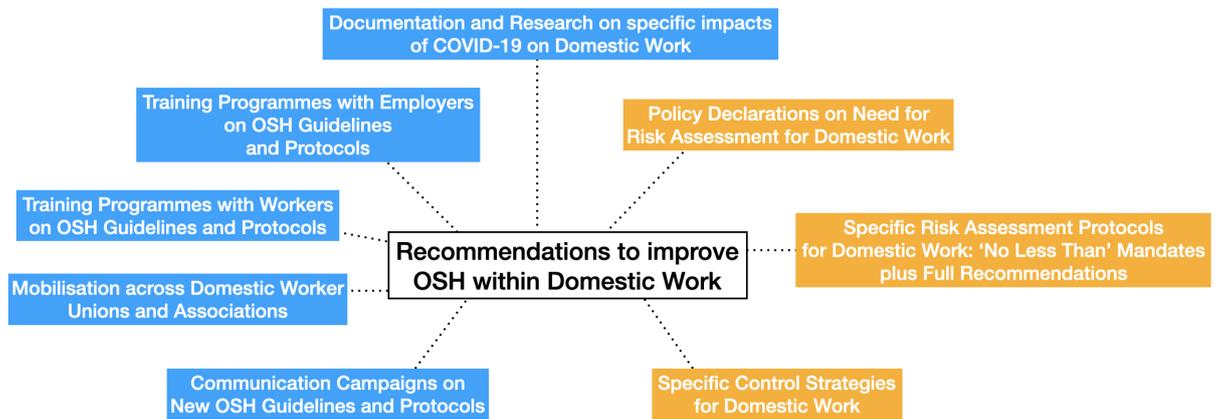
This imbalance persists in part because of the absence of public mandates, published guidelines or protocols issued by early institutions of authority, i.e. government, international organizations, worker organizations. The absence of protocols of risk assessment and control strategies that address the specific conditions of domestic work means that employers cannot be held accountable, even notionally, to benchmarks of expected practices. Worker organizations emphasized that there were gaps in knowledge on OSH for domestic workers even pre-COVID-19, and that the pandemic reveals as well as exacerbates these gaps. The need for such protocols is repeatedly articulated by worker organisations:

“Caution and precaution against COVID-19 at home and at the workplace is key to managing the present situation for domestic workers and their families. They are facing a precarious employment situation, the access to health services has always been weak; a health shock in this situation would be a health and economic crisis for the entire family.”

Subsequent sections of this report articulate the contours of such protocols based on a three-pronged approach (Figure 3 summarizes):

- An immediate public declaration of a “no less than” protocol, a set of minimum practices for working conditions of domestic workers that has an appropriate enforcement and complaint mechanism.
- An immediate declaration and policy messaging stressing the need for transparent and collaborative risk assessment, followed by support material and toolkits on how to conduct them within employer homes.
- An acceleration of medium term efforts to support and facilitate expansion of adequate working conditions to enable the full range of recommended OSH practices post-COVID-19.

► **Figure 3: Recommendations to improve OSH within domestic work**

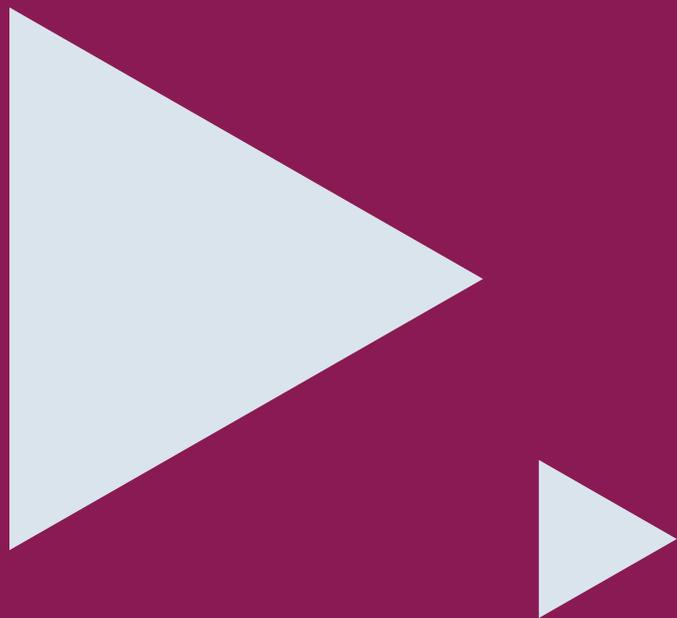


Source: Authors

# ▶ 3

## Practices to improve OSH for domestic workers in pandemic conditions

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### 3.1 Public and transparent risk assessment

The principle as well as practices of shared risk assessment between employers and workers must become a stated expectation and part of policy guidelines. This would mean creating space for social dialogue on OSH and paid domestic work. Policy announcements for workers and addresses by state leadership spoke of not retrenching workers or holding back wages, but no statements, guidelines or directives exist that ask workers to undertake a consultative risk assessment. Even if difficult to immediately and universally enforce within private homes, a guideline or recommendation may still encourage some employers to shift currently inadequate practices of risk assessment. Equally importantly, the presence of such public announcements and protocols could expand the possibilities of negotiation by workers.

It could also allow worker organizations a platform from which to negotiate conditions of return to work by acting as an external reference of expected practices.

Protocols, toolkits and simple visualizations of risk assessments produced by state authorities, worker organizations, unions, or researchers may aid in enabling willing employers to undertake collaborative risk assessments. In our consultations, worker unions suggested that such documents be the focus of direct awareness campaigns by government agencies and international organizations, and be supplemented by training for workers to understand the full range of demands they can make, as well as the framework of risk assessment and control strategies.

Worker organizations have a consensus on the need for meaningful awareness programs and training. Fish Ip, from International Domestic Workers Federation, articulated this, saying that “[working guidelines and awareness of employers and workers in their language is key to manage the pandemic](#)”. These guidelines should share information and techniques in short capsules in a local language, with the knowledge of local context. Worker organizations claim that these could remove fear, vagueness, the feeling of being burdened with new and changing rules and regulations, and identify improper and unreasonable behavior from employers. Instead, the new clarity would develop the confidence and rationality to adjust to new modes of working.

#### ► Box 1: Example of a risk assessment and management toolkit

An example of the broad contours of a risk assessment and management approach are the guidelines at Health and Safety Executive, Government of the United Kingdom. These guidelines emphasize that the employer of a domestic worker has the same health and safety responsibilities towards them as any employer in a formal organization. Risk management is the first step. This assessment process must begin by inviting workers to express their ideas and voice their concerns about the health risks they face at their place of employment. Further, it requires risk to be managed to a level which is as low as is reasonably practical. The following six-step approach to the assessment of risks in the workplace can be used:

- Identify the hazard: Identify what work activity or situations might cause transmission of the virus.
- Identify who might be harmed and how: think about who could be at risk, decide how likely it is that someone could be exposed.

- Evaluate the risk and identify and decide on safety and health risk control measures: Act to control risk. This may entail redesigning work activities to reduce exposure, identifying and implementing practical measures needed to work safely and providing personal protective equipment.
- Record who is responsible for implementing risk control measures, what the time frame is, and who will bear the cost in money and time.
- Record the findings, monitor and review the risk assessment and update when necessary. The assessment should be discussed and reviewed whenever there is a significant change to work practices or the COVID-19 situation at the level of the neighbourhood or the city/town.
- The assessment must include practical recommendations to control the risk. Once recommended controls are implemented, the risk and impact should be assessed and discussed to determine if it has been lowered to an acceptable level, and if it had any unforeseen consequences

## 3.2 Control strategies

### 3.2.1 Immediate “no less than” declarations

An immediate declaration of minimum practices with an enforcement and complaint mechanism could include:

- ▶ Employer to facilitate that everyone – workers and employers - wear masks at workplace. This includes providing adequate number of quality masks to workers if they are unable to procure them, and ensuring everyone at home wears a mask while a domestic worker is doing their activities.
- ▶ Employer to facilitate frequent hand washing. This includes providing access to soap and water whenever the worker may need to use it.
- ▶ Employer to facilitate physical distancing. If the size of the work-home does not allow ideal distancing, the employer must still try to maintain as much distance as possible.
- ▶ Employers to mandatorily their disclose health status, particularly COVID-19 positive cases, within the household.
- ▶ Employers to offer paid leave for pandemic and testing related quarantine periods.
- ▶ Worker to avoid touching their face, eyes, nose, mouth at workplace.
- ▶ Worker to adhere to the reasonable stipulations, such as wearing a mask and frequent hand washing.
- ▶ Workers when having COVID-19 like symptoms must be allowed paid leave and rest. Employers must not retrench a worker for these reasons, and must provide support for swift diagnosis, treatment as well as return to work after recovery.

Such a baseline set of demands is necessary in a context of limited negotiating power, individualized negotiations with often unwilling employers, and the shown reluctance of employers to undertake even basic measures. A “No less than” protocol, however, falls short of the recommended control strategies detailed below, and therefore must be seen as a short-term, pandemic measure to begin moving towards holistic OSH practices.

### 3.2.2 Recommended control strategies

Table 1 summarizes the control strategies emerging from the consultations based on the nature of activity within domestic work and particular forms of risks. It has been simplified down to easily identifiable practices and knowledge for use in information and awareness protocols and guidelines, and as aid to risk assessment and management.

► **Table 1: Recommended control strategies**

Nature of Activity/Risk	Particular guidelines for control measures to tackle these risks
<p>When working with water and soap there is an urge (or habit) to frequently touch face, nose, mouth, and eyes</p>	<p>Ensure everyone at the workplace wears a mask. This includes:</p> <p>If a worker is unable to procure an adequate number of quality masks, the employer must provide them. Ideal scenario: Either provide three N95 masks, such that one mask is worn after a gap of 48 hours or three triple-layer cloth masks to be washed after every use.</p> <p>Ensure all household members are wearing a mask when the worker is doing her work activities.</p> <p>Ensure access to water and soap for frequent hand-washing.</p> <p>Provide other required PPE such as safety eye goggles, safety shirt, and gloves.</p> <p>Workers should avoid touching their eyes, nose, mouth and face as much as possible.</p> <p>Workers should wear a mask during work.</p> <p>Workers should wash hands as frequently as needed, especially after touching personal belongings of others or touching surfaces they may presume as risky.</p>
<p>Personal items that touch mouth, nose, eyes and face — utensils, clothes, toys, glasses — are prone to more risk than other high-touch surfaces</p>	<p>Employer and worker to redesign work to the extent it is possible, such as not asking to clear toys or clothes or touch personal belongings for dusting.</p> <p>Workers to be alert not to touch their face while handling personal belongings.</p>
<p>Cooking</p>	<p>Employer must not enter the kitchen for an hour before the cook arrives and an hour after they leave to effectively protect both.</p>
<p>Washing utensils</p>	<p>Employers must rinse plates and spoons they have used and add liquid detergent on them before the domestic worker washes them.</p>
<p>Buying produce from market</p>	<p>Reduce this activity as much as possible. Keep it flexible for the worker to choose the time to visit marketplaces.</p>
<p>Cleaning and sweeping: the most high risk category as domestic workers will enter virtually every part of the house</p>	<p>Rotate rooms every day. The employer can stay in one room while the domestic worker cleans the rest of the house. If not possible the employer can leave the house an hour before the worker arrives.</p>

Nature of Activity/Risk	Particular guidelines for control measures to tackle these risks
Cleaning toilets and bathroom	Make cleaning toilets and bathrooms a little more infrequent. Make sure that the worker is wearing masks throughout and post cleaning, has access to the bathroom to wash hands and so on.
Lack of distancing if the worker is constantly supervised	Employer to restrain from constant supervision of the worker and maintain 2 metres or as much distance as possible.
Shared public transport	Employers give additional allowance to the worker to avoid shared public transport, when possible.
Lack of allowance to buy as much detergent and hand wash as required for sanitization	Employers give additional allowance to the worker so they can follow the requirement of frequent hand-washing and laundry at home as well.
Symptomatic-infected	Employer to provide paid quarantine leave, in either case, if the worker or anyone in the employer's own household has symptoms of COVID-19; to resume work only after a negative RT-PCR test or a 7-14 day quarantine, as agreed by the worker and the employer.
Asymptomatic-infected	Quarantine after every event of high-risk gathering or contact.
Lack of paid quarantine leave	Employers must provide paid leave during quarantine requirements on account of public health.
Lack of clarity on quarantine rules	Employers must clearly communicate the provision of paid leave during quarantine requirements, overcoming worker's hesitation due to fear of losing income or job.
Side effects of frequent hand-washing, use of cleaning chemicals such as bleach, and hand sanitizer.	Workers apply moisturizing substances such as hand moisturizer, vaseline or coconut oil on their hands. Employer to ensure that there is proper ventilation during use of strong chemicals. Employer to ensure that the proportion of bleach to water is no more than 1:99.
Side effects of wearing mask for long hours.	Employers give short breaks to the worker if required, to be in the open (such as balcony or garden) and take off the mask.  Worker to take off mask when possible.  Worker to procure more masks if they deem wearing one mask for the entire day is giving a foul smell. This can be bought on one's own or one must ask the employer to provide it.
Risk of COVID-19 from activities related to work, such as travel, or tasks given to the worker in the common areas of a building/layout, or from anyone in the employer's household.	Assurance of medical support when required.  Provision of medical insurance.  Employer to follow adequate quarantine and testing protocols as per World Health Organization (WHO) guidelines.

**► Box 2: Some popular practices that are essentially ineffective to curtail COVID-19 infection**

In addition to the recommended practices above, reported practices that are ineffective and possible harmful to workers should also be discontinued. These include:

- Spraying sanitizer over clothes, or the over the full body of the person. Instead: distance, mask and hand wash
- Require changing clothes or bathing for workers that do not live-in or come for a full work day. Instead, distance, mask and hand wash. A shirt can be worn over the worker's clothes that then can be washed.
- Prohibit the handling vegetables or cooking because of a perception of these as high risk activities. Instead, wear a mask during these activities. With a mask on, these activities do not present heightened risk.
- Distrust worker's reporting of their health status. Instead, have a social dialogue for information sharing in both directions and lay clear rules for testing, quarantine leave, and protocols to facilitate information sharing.

Protocols outlined above can also draw from materials being produced by worker organisations. International worker networks have responded to the risk of OSH and OSH related employment issues. Relevant examples include an international membership based organization of women workers in informal economy— WIEGO— and a federation of labor unions of domestic workers, the International Domestic Workers Federation (IDWS). These two organisations have analyzed the risks for domestic workers and published recommendations for workers, employers, and the government. 1,2 These recommendations asked employers to not terminate or suspend employment or income, continue to give paid sick leave, provide PPE, follow quarantine measures, limit their contact with other people, provide money for switching to safest public transport and give them some flexibility of time to manage their day. They asked the government to continue and extend social security to domestic workers, identify the impact on their livelihoods and manage unemployment periods with compensation, and work towards better communication, awareness and monitoring for effective OSH. They also advised international organizations to include domestic workers in their policy recommendations and recovery programs. Figures 4-7 present the recommendations through illustrative diagrams.

►Figure 4-7:



source: [https://idwfed.org/en/covid-19/the-idwf/advocacy/idwf-policy-brief\\_final-eng.pdf](https://idwfed.org/en/covid-19/the-idwf/advocacy/idwf-policy-brief_final-eng.pdf)

### 3.3 Specific information campaigns targeting stigma

One other specific recommendation that emerged from the interviews was the need for rapid research efforts that chronicled actual risk in a pandemic context within domestic work. As there is no information on the distribution of COVID-19 cases across population or occupation groups, the stigma of domestic workers as carriers is unfounded but difficult to counter with employers.

The actual degree of risk at the workplace for domestic workers remains unclear, especially in a comparative perspective to work in formal offices, industries, or indeed as essential workers in other

sectors. Rapid studies that objectively assessed the risk and offered effective and specific control strategies could greatly counter the notion of domestic work and workers being disproportionately associated with health risks in the minds of employers. Such studies could also aid the case of domestic workers being considered essential workers and being offered the same protections, compensation and care options within public health systems even if not through the employer.

### 3.4 Improving bargaining power

One of the key findings of this report is the weak and diminishing bargaining power that domestic workers have with employers. We also found, however, that workers with access to unions or collective worker organizations had the highest likelihood of addressing unfair conditions imposed on them when they returned to work. Access to a union was clearly associated with relative increase in bargaining and negotiating power. However, in the absence of public guidelines, mandates and protocols specific to the sector, interventions by worker unions were limited to case-by-case actions rather than being able to impact the sector more widely.

COVID-19 has underlined the importance of institutions, unions, collectives and organizations that enable collective bargaining by workers. Medium term responses that anticipate the next crisis must invest in expanding the reach and presence of such worker-led institutions as a key lesson from COVID-19. Creating space for social dialogue on OSH and domestic work between workers, employers, governments and worker organisations is critical. OSH adoption in the sector cannot be only a matter of information, guidelines, enforcement and compliance – it must be seen as part of addressing structural power imbalances between worker and employer.

### 3.5 Extending health safety nets to domestic workers

The COVID-19 pandemic has highlighted the urgent need to recognize the role that domestic workers play in care work. Various unions, international organizations and national governments have responded to the need to extend health and safety nets to domestic workers. For example, the European Federation of Food, Agriculture and Tourism Trade Unions (EFFAT) released joint statements with the IDWF to the European Parliament (EP) and G20 on protecting the rights of migrant workers, especially domestic workers during COVID-19. In the United States of America, the National Domestic Workers Alliance (NDWA) set up emergency funds for out of work domestic workers. Similar directives have been issued by the Ministry of Manpower in Singapore and so on.

As discussed in Section 1.1, in the context of informal employment safety and health at work are linked structurally to the access to public health. In the Indian context, to improve the access of domestic workers to public health one must address the need for:

1. Provision of medical insurance for domestic workers by employers or governments.
2. Access to free vaccinations by domestic workers.
3. Improving the public health infrastructure in states.
4. Recognizing paid domestic workers as vulnerable workers in all social protection policies.
5. Setting up of domestic workers welfare boards in every state to address the challenges faced by domestic workers and interventions in cases of delayed or no payment of wages and retrenchment and direct cash transfers where necessary.
6. Special focus on improving access to basic services as well as affordable and adequate Housing.

### 3.6 Collective Social Protection

Our final medium term recommendation is to reinforce recent calls to strengthen social protection for informal workers, taking the impact of COVID-19 and the lockdowns as a wake-up call for the urgency of such measures. For OSH, access to unemployment insurance, relief packages that compensate for lost income, access to public health systems, among others, would have enabled workers to negotiate and bargain for acceptable conditions for return to work. In the absence of any collective social protection access or ability to delay new earnings, workers felt they had no choice but to accept employer-centric conditions for return to work and could not negotiate any of these conditions. Social protection systems enable workers to mitigate short-term risk independent of income. COVID-19 is a sharp reminder that OSH practices within non-standard forms of employment like domestic work cannot succeed without increasing the relative standing of the worker within the employment relationship.



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## Annexe A: List of consultations

Labour Union/Activists		
1	Fish Ip	International Domestic Workers Forum, Asia-Pacific
2	Rekha Singh	Gharelu Kaamkaaji Mahila Union, Delhi
3	Anita Kapoor	Shehri Mahila Kaamgaar Union, Delhi
4	Anita Juneja	Union member , Delhi
5	Sister Kirti and Pooja	Union member, Udaipur
6	Indira Gartenberg, Jija, and Nirmala	LEARN Mahila Kaamgaar Sangathana, Mumbai & Nashik
7	Karen Pape	WIEGO
8	Meva Bharti	Rajasthan Mahila Kaamgaar Union, Jaipur & Ajmer
9	Geeta Menon	Labour Activist, Bengaluru
10	Sister Lissy Joseph	Union member, Hyderabad
Medical doctors		
11	Dr Ajay Lall	Pulmonologist, Max Hospital
12	Dr. Tsuyoshi Kawakami	OSH Expert, ILO
13	Dr Prabha Chandra	Psychologist, NIMHANS
14	Dr. Rajani Surendar Bhat	Intensive Care Pulmonologist
15	Dr Pritam Pal	Independent activist and medical doctor
16	Dr. Uma Chandra Mouli Natchu	Epidemiology, St Johns
17	Major Felice Faizal	Pathology, Indian Army
Others		
18	Capt. K. Pooja Vasanth (Retd.)	Operations, IIHS
19	Ms Aya Matsuura	Gender Specialist, ILO
20	Dr Neha Wadhawan	National Project Coordinator, Work in Freedom – India, ILO



## Annexe B: Clarification of technical details

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N95 with nose clip and tight bands, protects both, the public and oneself



Other mask options

There are these 3-layered masks available nowadays which have two cotton layers with a synthetic surgical mask sandwiched in between. They are appropriate, washable and usable for at least a fortnight with intermittent washing.

Otherwise, a cotton mask is also fine, provided it goes over the surgical mask. Only concern is fitting, in that it should minimize any crevice between the mask and skin. Preferably, avoid synthetic masks as they don't soak sweat all that well, and also irritate the skin.

Safety eye goggles



Shirts as safety aprons



Proper hand-washing methods



Correct way to wear masks







International  
Labour  
Organization



**Work in Freedom** is an integrated development cooperation programme aiming to reduce the vulnerability to forced labour for women migrating for garment and domestic work. The programme works along migration pathways in India, Nepal, Bangladesh, Jordan, Lebanon and Gulf countries. It is funded by UK Aid from the Department of International Development. However, the views expressed in this policy brief do not necessarily reflect the department's official policies.

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