Coming Out of Employers’ Homes: Migration, Domestic Work and Health Claims

Sajida Zareen Ally

Department of Anthropology, School of Global Studies, University of Sussex, Brighton, UK

ABSTRACT
Migrant domestic workers in Kuwait live amid structural inequalities, including health disparities, yet little is known about how they manage wellness alongside imperatives to work and earn. In this article, I examine Sri Lankan women’s coming out of employers’ homes through authorized and unauthorized channels and how they use illness and exhaustion to justify their need for more autonomous conditions. Exploring the physical, emotional, and political dimensions of these processes, I highlight the Sri Lankan vernacular notion of “heart-being” within women’s actions to safeguard health and seek existential grounding, as they assert biologicliminate claims to return home or live unauthorized.

KEYWORDS
Kuwait; migrant domestic workers; health and wellness; biologicliminate; illegality; existential

One afternoon, I made my way up to the home of one of my interlocutors, steering past laundry lines and a courtyard that centered a rundown block of flats in Abbasiyya, Jleeb Al Shuyoukh in Kuwait. Naziha had arranged for me to meet her family and close friends over lunch in her one-roomed partition flat. “Come on Friday,” she had said, “see how we enjoy our day off. It’s just like in the ur (village/homeland)1 in Sri Lanka.” Amid the lingering aroma of dried chili and coconut milk, my hosts reflected on their previous experiences of living inside homes as domestic workers or house-drivers. Naziha had worked in her sponsor’s home in Sabah Salem for only seven months until she was returned to her recruitment agent, subsequently entering several unauthorized placements inside homes before eventually being driven out by overwork, fatigue, and chronic abdominal pain. As transmigrants2 in Kuwait can only live outside legally if they have the required visa and authorization from employers, those who enter into illegality are ever fearful of encountering police checks and have no recourse to public health care. Nonetheless, most affirmed that life outside was considerably easier on the body than life inside.

When we were alone later, Naziha reflected on the transitions she had been through:

You know Sajida, I keep asking myself why I am still here, existing like this. My daughter tells me to go back to Sri Lanka to get an X-ray and rest. But for my mouth to receive, my hands need to earn . . . At first I wondered, why is it so important to explain why I came out? But now I am realizing that [she pauses] there is another purpose for me to be outside. Here is where I need to be to look after myself and my family, and to have calm-contentment.

Naziha’s statement, as well as those of others, encouraged me to explore why, despite abandonment by systems of public health, social care, and juridical support, are some migrant domestic workers motivated to leave their employers’ homes and even enter into illegality?
There have been calls within medical anthropology for a new epistemology of the mind-related political, social, and emotional sources of illness and healing (Schepet-Hughes and Locke 1987), and for ethnography that documents both structural and phenomenological dimensions of experiences (Desjarlais 2011; Jackson 2005; Willen 2007), which help to converge discussion on the varied foundations of health. Toward these aims, here I examine Sri Lankan domestic workers’ departures from employers’ homes as a tactic to navigate everyday health in Kuwait. For my interlocuters, the desire for greater control over their health and lives instigated decisions to leave, as it was often the emotions, tensions, and illnesses arising from live-in household work that led women to seek lives elsewhere. Women wanted greater control over their working hours and sought nimadhi (Tamil) or sanasima (Sinhala)3 – the state of calm-contentment experienced when domestic workers were allowed to “sit and simply be.” This enabled them to enjoy suham (Tamil) or saukiya (Sinhala), a pan-concept encompassing physical, mental, emotional, and spiritual dimensions of health, which might be translated as “wellness” and which I use interchangeably with “health” here.

Aspiring toward these optimal states, women’s trajectories of leaving homes centered upon vernacular ideas of “having come out” (veliyle vanditen/eliyata aawa) versus “living inside houses” and underlined physical and spatial concerns. Yet implicit and symbolic meanings were embedded in their descriptions. The “inside” space of employers’ households was private, hidden from the public, and highly regulated, while the “outside” space of self-organized accommodation was relatively more autonomous and better connected to a wider world. The distinction between confined/regulated/hidden lives versus mobile/free/open lives may conjure resemblances with coming out of prison or coming out queer, yet they are contingent on the historical conditions of migrant domestic work. In Kuwait, domestic workers are generally permitted to leave a household before one’s employment contract ends as long as they go through the authorized channels of embassies and police stations. Many enjoy weekly or monthly rest days, and some choose to remain long-term in their households of employment, developing affective relationships within them that spur personal transformations and sense-making (Ahmad 2010). Many of my interlocuters, however, found it difficult to decide to leave a paying job, while others could not receive permission from employers to leave.

The “coming-out stories” that I present examine how health and bodily concerns served as a resource to catalyze and justify departures from employers’ homes among some. Yet leaving was not a one-step process. It was an ability accumulated over years of live-in work and experiences of departures – authorized or unauthorized – that were catalyzed by a breakdown of sorts or the desire to avoid one.

Not unlike migrant workers living under state security apparatuses elsewhere in the world (De Genova 2002), the creation of hazardous conditions among Gulf migrant workers is influenced by biopolitical, structural, and discursive exclusion (Willen 2011). Biopolitically, domestic workers’ wellbeing is jeopardized in particular patterns (Quesada 2012). Long working hours and the lack of sufficient rest, weekly holidays, and protective equipment have been found to give rise to musculoskeletal pain, injuries, headaches, and digestive, respiratory, and skin ailments among returnees in Sri Lanka (Jayaweera and Shlala 2015; Mun et al. 2019), not to mention worry and loneliness. While domestic workers’ health care costs are to be borne by sponsors, some end up paying their own (generally affordable) consultation fees, but also, for costly specialist procedures and tests when sponsors refuse to pay. Health care access is further differentiated for unauthorized migrants who are only eligible for emergency care, although fear prevents many from using these services.

Structurally, conditions within this system are mostly understood through the word kafala, which across the Arabian peninsula often refers to a singular system in which migrants are sponsored by citizens or companies. In reality, the kafala is an assemblage of laws and citizen and non-citizen actors operationalized transnationally (Ahmad 2012; Vora and Koch 2015). Sponsors (kafeels) are legally and economically responsible for sponsoring foreign residents and acting as a “guarantor” of the adherence of state regulations (Shah 2011). Migrants are dependent on them for the right to stay and work, while the difficulty of changing kafeels, combined with financial dependency and the perceived threat of deportation, disciplines migrants to comply (Longva 1997). Kafeels’ position of advantage is
strengthened through the illicit practice of visa trading – an entrenched, lucrative, multi-billion dollar industry that provides work visas in exchange for extortionate fees (Shah and Al-Khazai 2017; Vora 2013).

Discursively, domestic workers who enter the illicit economy often contend with the stigma of their assumed illegality and immorality. Not only are they immediately criminalized for flouting the 2015 Domestic Workers’ Law, but in being low-income and single, they are also often perceived to be engaged in sexual relations given prevailing gender norms that value women living under male guardianship (Ally 2015; Smith 2010). Officials, ordinary citizens, family back home, and even some compatriots morally mark them for contravening, supposedly, Kuwait’s Penal Code that prohibits adultery and extramarital intercourse and relationships (OECD 2019). For many unauthorized migrants, visa trading helped to mitigate the ineffectiveness of the labor assemblage through the provision of visas, albeit through a sponsorship arrangement that was not completely legal. Yet similar to other contexts of illegality, many migrants also preferred to be rendered illegible to institutions of documentation, as their punitive character made them feel more at risk (Asad 2020; Horton 2020).

In examining these coming out stories, I highlight the ways in which mind-related aspects of illness and wellness interact with the politicized, social relations that surround the negotiation of domestic workers’ everyday life and health, reinforcing understandings within medical anthropology of the body being “securely anchored in a particular historical moment” (Schepker-Hughes and Locke 1987:7). Also consistent with the anthropology of Gulf migration and its increasing attunement to the subtler transformations of domestic workers’ lives (Ahmad 2010; Johnson 2011), I detail how self-transformation constantly interplays with the competing dynamics of abjection within migrant women’s negotiation of health and wellness, contrasting more partial presentations that emphasize either abjection or transformative emancipation (Ally 2016). These narratives underline how embodied impulses and the seeking of sufficient treatment, food, or rest (concerns of physical-biological survival), combined with aspirations for dignity, contentment, and the ability to live and work on one’s own terms (concerns of moral-existential worth), unintentionally became political when women leave employers’ homes without sanction, or worse still, live outside of them unauthorized.

Background

A structural-phenomenological approach to migrants’ health

My framing of this article builds broadly on a structural-phenomenological approach within social and medical anthropology to explore migrants’ experiences of coming out and how health was used to justify departures from employers’ homes. Underpinning this approach is “critical phenomenology” (Desjarlais 2011), defined by Sarah Willen as the larger forces that configure everyday conditions of migration and health and migrants’ experience of these conditions, which involve “being-in-the-world, ” socio-political conditions, and juridical conditions (2007:10).

A significant body of research on Gulf migrants’ health within epidemiology, medicine, public health, and psychiatry importantly “evidences” disease and illness, which helps to reduce the silence surrounding migrants’ lives (Gardner 2010) and insert migrants into Gulf population health profiles. Domestic workers in Kuwait have been found to be subject to higher levels of psychiatric morbidity than citizen women (El-Hilu et al. 1990; Zahid et al. 2004), while returnees in Sri Lanka have been treated for depression and other mood disorders (Wickramage et al. 2017). Although existing research highlights migrants’ disproportionate burden of occupational and mental health concerns, morbidity, and suicide compared to Gulf citizens, the reduction of health to biological or material “facts” can be limiting, as is the lack of analysis of the relationships between microlevel, agentive behaviors and macrostructural processes (Qureshi 2013; Shlala and Jayaweera 2016).
The lack of moral problematization in presentations of migrants’ sickness can furthermore lead to a risk of exaggerating migrants’ “trauma” (Fassin 2008), which is extended to migrants’ families, for example, within findings of nutritional deficiencies, neglect, and poor self-esteem among “left-behind” children, and suicide among elderly carers in Sri Lanka (Jayatissa and Wickramage 2016; Knipe et al. 2019; Senaratne et al. 2011). Anthropologists of Gulf migration have cautioned against an over-emphasis on exploitation, hegemony, and exclusion-focused approaches (Ahmad 2012; Osella 2012; Vora and Koch 2015), while migration scholars elsewhere question the usefulness of binary analytical frameworks and stress the stratification of legal statuses that produce differentiated subjectivities (Andrijevic 2010).

Central to a critical approach to migrants’ health is Fassin’s (2001, 2010:51) idea of biolegitimacy, which he describes as the linkage of “the matter of living (biological, whether an irradiated or infected body) and the meaning of politics (citizenship, in terms of social and civil rights).” Ong (2006:212), however, emphasizes the ethical and welfare-driven terms of biological welfare and the moral value of domestic workers’ “sheer life,” rather than political discourse on rights to citizenship, in her writing on NGO advocacy in Singapore. In a similar context, migrants in the Arab Gulf cannot make political claims for becoming citizens as their very lack of integration is a defining principle that enables them to be there (Sater 2014). Yet, I suggest they can still make other claims that might be considered as “political,” as “political” action can be defined as the production of subjectivities that hold political significance within the framework of social interaction and experience of moral, self-conscious identity and personal value (Fassin and Rechtman 2009). Subjects can enter a political scene due to their political subjectification, which involves being described (by others) and identified (by themselves) in the public arena (Fassin and Rechtman).

That said, ideas of claim-making insufficiently convey how the mind/body interacts with the body politic in the production and expression of health and illness (Schepers-Hughes and Locke 1987). The phenomenological idea of “existential imperatives,” which Jackson defines as the understanding of human experiences as a “struggle between contending forces and imperatives” helps to address this lacuna (2005:iix). Using a genealogy of literature involving Jackson, Hage, Bourdieu, Spinoza, and Arendt, Willen describes the overarching imperative of the struggle for “being” and how it encompasses “the capacity to preserve oneself, to deploy oneself in the world, or to augment one’s joy” (2014:90). She explains that while the question of being is universal, for Bourdieu and Hage, the capacity for being is related to social capital and may be unequally distributed, and thus, forces individuals to deploy or position themselves in particular ways in their social environment in order to accumulate being (Willen). While Jackson (2005) and Willen (2014) prioritize issues of existential power – questions of coping with life and finding meaning in the face of suffering – over issues of political power, I see both as equally important here (Figure 1).

**Domestic workers’ pathways to illegality in Kuwait**

The existence of a blurred boundary between legal, live-in work and unauthorized, live-out work is a key structural dynamic that helps constitute how migrant domestic workers’ illegality unravels. Once employed in over 90% of households in Kuwait (Shah et al. 2002), migrant women have been a core feature of social reproductive strategies since the Gulf oil boom of the late 1970s and an integral part of Kuwait’s inter-regional past (Eelens et al. 1992; Osella and Osella 2012). Expatriates currently constitute 70% of Kuwait’s 4.7 million population (Arab Times 2019), although Kuwait’s National Assembly has been reviewing a proposed bill intended to dramatically reduce the expatriate population (Kuwait Times 2020a, 2020b). Forming the second largest residency category after private sector workers (CSB 2019), domestic workers are among the lowest paid and most vulnerable within the foreign population (Longva 1997). They are not covered by local labor laws, but they can seek redress under the Domestic Worker Law that obligates sponsors to implement contractual terms of employment, including paying for all recruitment, living, and health care costs. Authorized domestic workers are generally required to live in sponsors’ homes, and this affects capacities to care for health. A study
of returnees in Sri Lanka found that at least half of all respondents were not allowed time off when ill and many sought care upon return, although the sponsors of three-quarters of respondents did reportedly pay for workers’ health care (Jayaweera and Shlala 2015).

Over 100,000 authorized Sri Lankans, and an estimated four to ten thousand unauthorized Sri Lankans, live in Kuwait – the top global destination for Sri Lankan domestic workers in 2018 (SLBFE 2018). Domestic workers are not guaranteed easy movement outside of employers’ homes across the Arab Gulf due to the spatial boundaries that are maintained between foreign and citizen populations in order to uphold the notion of hospitality and the kafala (Gardner 2010). These boundaries are reflected in Bahrain in the spatial design of traditional homes, which Gardner explains assigns interior spaces for hosts and outward-facing spaces for guests to highlight symbolic oppositions – between “private” and “public,” “citizen” and “foreigner” – that map onto the city-Island, wherein migrant enclaves are distinguished from indigenous areas. Domestic workers are among the exceptions to this set-up (Ahmad 2010), but keeping them within citizens’ homes maintains these boundaries and guards against the possibly immoralizing effects of having single, foreign women moving freely. Consequently, women who live out can only do so legally if they satisfy strict visa requirements. To do otherwise would risk their criminalization.

**Research methodology and sample**

This article is part of a larger project that examines how Sri Lankan transmigrants’ health, wellness, and health care are constituted as fields of intersubjective experience and constrained by the assemblage of laws, institutions, individuals, and moral relations that facilitate migration to the Arab Gulf. It draws on aspects of single-case narrative as a way to critically engage with the phenomenological experiences of our ethnographic subjects and direct attention to their agency and situated strategies amid wider frameworks (Farfán-Santos 2019; McQuaid 2014). In highlighting the unique wholeness of a single woman’s story – that of Naziha, a 41-year old Sri Lankan woman living in Kuwait – I convey how subjects construct meaning and connect
experiences toward organized desires and strategies (Good 1994). However, in setting Naziha’s narrative against fragments of other women’s stories, I contextualize her experience and explore experience as individual and collective.

The research is based on 26 nonconsecutive months of ethnographic fieldwork, and several months of remote ethnography (via WhatsApp and Zoom), conducted between 2009–2011 and 2018–2020. Targeting migrant workers primarily and key stakeholders as secondary informants, its key ethnographic foci include: (1) several urban localities in Kuwait where Sri Lankans reside, primarily Farwaniya, Mangaf and Salmiya; and (2) several rural and semi-rural villages in Puttalam in Sri Lanka populated predominantly by Muslim, Tamil and Catholic minorities. A circular methodological trajectory helped to create a transnational profile that cut across ethnicity, space, places of origin in Sri Lanka, and time. My initial spaces of contact were inside family homes in Sri Lanka and shared, partitioned flats in Kuwait, at social and community events, and in Kuwait, also at churches, Sri Lankan shops, restaurants, and concerts. My observations and interviews in these spaces centered on key characteristics of health, such as poverty-related hunger and malnutrition, reproductive events, injuries and trauma, illnesses and disease, health care encounters, as well as understandings of wellness and how health histories interacted with migration history.

While the interlocutors of my larger study formed four main groups – 1) Domestic workers and cleaners in Kuwait (N = 46); 2) Returnee domestic workers in Sri Lanka (N = 133); 3) Migrants of other job categories and sectors in Kuwait (N = 24); and 4) Secondary stakeholders (156 in Sri Lanka; 20 in Kuwait), I focus here on a subset of 59 female domestic workers whose health and migratory histories I sought to understand in further depth. I got to know these women over six to 19 months (and with a dozen of them, over a decade), which enabled me to utilize a long-term ethnographic perspective. They were aged 22 to 63 years and had been living in Kuwait for two to 19 years or had returned to Sri Lanka within two years. Women’s trajectories of leaving or staying in employers’ homes followed three broad patterns. More than half (33/59) had chosen to leave employers’ homes by either coming out to live unauthorized (19/33) or going through the legal channels of police stations, government shelters, or embassies (14/33). Fewer than half (26/59), however, had never left their jobs at all.

**Everyday ailments and the “need to tolerate”**

In the Kuwaiti households situated in urban clusters that speck the Arabian desert, domestic workers’ everyday actions, bodily rhythms, physical movements, and mental states are heavily influenced by their conditions of work. Experiences within homes instilled subjectivities that shaped ongoing and future capacities to care for their bodies and deploy the self to reduce the “inequal distribution” of being (Willen 2014:90). Daily schedules of around 14–18 hours typically involved cooking, cleaning, washing, ironing, and caring for children, though conditions varied within households depending on employers’ class, lifestyle, family size, and benevolence. While many women said they had been treated well by at least one employer in their migration history, and a handful had worked for the same family for a decade or more, the conditions of domestic work weighed heavily on the body. Sarina, a 41-year old woman who had been in the same household in Abu Khalifa for a year, described a typical workday:

By 6.30am, I need to prepare breakfast for the children, iron uniforms, and get them on the school bus. I then clean the first floor, and in between, I make madam and bawa [male boss] coffee and breakfast and iron their clothes. By lunchtime, I prepare food for everyone and clean the second floor. After resting for 30 minutes, I wash and iron, sweep the garden, and prepare children’s dinner … madam is kind and tells me to rest, but I often don’t have time to sit for more than 10 minutes … After putting the children to bed, I make madam’s dinner. There is an hour of cleaning before I can bathe and go to my room, normally that’s 10.30 pm. But when there is diwaniyya [public-private gathering in a home’s reception], it’s much later.
Women are routinely tired from this everyday schedule and some developed new or worsening ailments. They commonly used English words to describe conditions such as “gastric,” “pressure,” “cholesterol,” and “sugar” (although these do not map automatically onto biomedical conceptions), and vernacular terms to discuss conditions such as pain, stomach heat, imbalance, fever, phlegm, cough, and dizziness. Dry skin, allergies, breathing difficulties, wheezing from constant exposure to cleaning agents or air conditioning, and menstrual concerns were other ordinary occurrences. But some women reported more serious affictions – torn ligaments from carrying gas cylinders, fractures from falling or slipping, and sleep disturbances, as well as biomedical diagnoses of thyroid disorders, stomach ulcers, pneumonia, and epilepsy.

When I asked Chamila, a 47-year old returnee from Kurunegala, if she set boundaries to what she could accept, she responded, not without annoyance, “We are going there to work, aren’t we? What do you think Sajida? We need to tolerate . . .” Chamila’s sentiment, one shared by many, represented a form of “common-sense reality” among domestic workers, whose rhythms of everyday life reorganized the lifeworld by re-calibrating bodily needs (Scarry 1987:127). Migrants justified these adjustments as they felt they had been granted a “chance to migrate” to support themselves and families back home. When 23-year old Kareema, who had returned to Sri Lanka, told me that she “simply needed to migrate again” despite the pervasive loneliness and pain she had experienced when working in Kuwait for five years for an abusive employer, she implied that tolerating difficulty and illness was not only a matter of money, but also one of seeking to improve life chances (Jackson 2013).

Enabling this imperative to migrate and tolerate whatever conditions were given was the ability among some to intersubjectively sense and follow the needs of employers. Chamila explained:

We need to understand what makes the madam angry and adapt ourselves. If we know how to do this, they will have respect. If we respect each other, we can work in their home for longer.

Chamila believed in the Buddhist, karmic ideal of being good to others in order to be treated well and described how she followed impulses from her “heart-being” to direct her behavior. In Sri Lankan vernacular, “heart-being” – hitta or manasata in Sinhala, manassu in Tamil – is the locus of the self and the emotional-spiritual heart, which works with the mind to elicit affect, perception, intelligence, and moral possibilities. Chamila felt her cooperation had helped her to create a better workplace among demanding employers who ended up rewarding her for “understanding their ways.” This was evidenced when Chamila required major surgery to remove part of her liver, and her employers paid her two months of sick leave, covered medical expenses, and encouraged her to return to the job after a paid holiday in Sri Lanka. While such behavior could be read as compliance, women often learned to recognize the boundaries of the self within such negotiations (Figure 2).

As they grappled outwardly with everyday work and pain, inwardly, they were consumed by the existential questioning of being apart from families. “My only worry is not being close to my children. I miss them too much,” explained 45-year old Chandani. “But I don’t feel lonely because Lakshmi [her co-worker] is here with me [in her workplace]. Once a month we take our day off together and have a nice time in the city [Kuwait City]. But still, sometimes my mood is not okay.” While the latter refers to anything from feeling alone, to pathos, to mood swings, others fared worse with “strong pain,” which could be physical, emotional, chronic, or body-wide. Even more difficult was the sustained anguish of “pain in the heart-being” (mana vartham/hitta vedanava), which had led Kareema to question why she had sacrificed her health and youth to work abroad. While her heart-being was where pain resided, she explained how it was also a source of guidance:

When I have time to rest, my heart-being has a little nimadhi (Tamil, calm-contentment), I can tolerate the difficulties. I talk to Allah inside my heart-being. I ask what I should do to remove my pain. I do this until my heart-being calms and I can fall asleep.

The notion of heart-being was used by migrant women across religious lines in descriptions of health and wellness, although these varied according to specific beliefs and metaphysical entities, such as Buddha, God, or Brahma, destiny, karma, goodness, or patience. Perceptions arising from heart-
being helped in decision-making regarding what could be endured – physically, mentally, and emotionally. For these Sri Lankans, heart-being was infinite due to its connection to metaphysical entities, which despite its need for safeguarding, exists even in the absence of care, contrasting Jackson’s discussion of a limited “being” which “must be actively sought, struggled for, salvaged, and safeguarded.” (2013:3)

Domestic workers who had only worked inside homes tended not to demand greater labor and spatial mobility, but they all articulated desires for more time and space for sleep, rest, self-care, speaking with their families remotely, and accessing remedies and health care – issues fundamental to proper functioning of the body. They stressed that when these needs were not met, heart-being was detrimentally affected and they were less able to manage stressful situations and more likely to neglect their bodies, although a few of them – like Kareema and Chamila – described consciously engaging heart-being even under duress to position themselves in relationships with employers.

These examples allow us to understand not only the bodily impact of live-in domestic work, but also how these outcomes can detrimentally affect heart-mind to have knock-on consequences for women’s management of health and everyday life. Some decided to leave their jobs when things were going relatively well – like Chamila, who returned home after recovering from liver surgery. Others continued working until, like Kareema, their bodies had been pushed to their limits. As overwork is deemed normal both by employers and families back home, live-in workers began learning how to use their bodies as a resource to justify their migratory and work aspirations. They stressed either bodily strength to comply with the normalization of overwork, or ill health to resist ableist discourse.

In contrast with the recruitment agent cited by Frantz, who suggested that a good workplace is determined by luck and “where her dice fall” (2008:614), I argue that Sri Lankan domestic workers’ trajectories are also determined by their ability to negotiate the limits of their endurance inter-subjectively. These negotiations involved the interplay of heart-mind, bodily concerns, and the structural conditions of the sponsorship system in the production and expression of health and illness. Yet for many, the refusal to negotiate or endure rendered leaving live-in work a crucial alternative.
Biological survival as a catalyst to come out

Out of my 33 interlocutors who decided to leave employers’ homes before their contracts ended, 14 exited workplaces via official channels, with some leaving abusive conditions that had caused serious or even debilitating health conditions. I now return to Naziha’s narrative to examine the common pattern of coming out authorized as a tactic for safeguarding health, as her first departure from an employer’s home was through official means. She retrospectively recounted her story to me when she was living unauthorized in her flat in Abbasiyya.

Naziha and I had first met on a crisp, February morning in 2011 outside the Sri Lankan embassy in Jabiya, while she was accompanying her sister who was contemplating turning herself in to return home during an official amnesty for unauthorized migrants. Chatting to her about her hometown of Beruwala in Sri Lanka’s Western Province, she had examined me thoughtfully before smiling and warmly inviting me to her home. Despite the dark circles contouring her eyes and the “permanent temporariness” (Vora 2013) of her fifth stint of Gulf migration, Naziha epitomized calm determination. Having first migrated in her mid-20s to the UAE, Kuwait, and Saudi Arabia to support her four children given the “uselessness” of a violent, alcoholic husband, she described being tricked by destiny after the 2004 tsunami destroyed all that she had used her Gulf earnings to build – a house, a small restaurant, and a shop. Re-starting from scratch, Naziha migrated again in 2005 to Kuwait straight from the displacement camp where she had been living.

During her second stint in Kuwait, Naziha faced a new dilemma when her abdomen began to hurt in an area where she had previously undergone a cesarean section:

The work in that house was difficult, and there was little to eat or drink… After a few months, I started having terrible pain. I could not eat. Then, I could not work. Because of that, I came out. I asked madam to leave me at the agency, but she refused… She did not purchase medicine or let me see a doctor. I tried explaining, ‘I had an operation, didn’t I? After that operation, I need to be careful’… For seven days I could not eat because of the pain… I could only sip water. The whole area of my stomach [she embraces her abdomen] would just hurt… I lay like that in bed, crying, for seven days. Slowly, I felt my heart-being fading.

With her heart-being “fading,” Naziha felt agitated and said she could not think straight. But she was clear about one thing when she said: “there was no point pushing myself to endure if my body couldn’t handle it.” She thus decided to come out. Similar to many other live-in workers who described the difficulty or impossibility of seeking treatment inside employers’ homes, Naziha knew that leaving her household-workplace, even for a walk or day off, could be a source of contention (Moors et al. 2009). She planned her exit carefully. When her employers were asleep one morning, Naziha found her way to a police station. A sympathetic policeman called her boss in, reprimanded him strongly, and made him agree to send her back to Sri Lanka. However, the boss took her to the recruitment agency, where she was placed in a back room with the agent:

With his shoes on, he [the agent] flexed his leg and kicked me so hard, here in my chest… But I told him, ‘I will not go back to that house. I’ve had an operation. I was given too much work. I have pain. I wasn’t given food or treatment. And now my health is bad. For me to work is impossible! I need to go back to the ur [village/homeland].’ Then he took a broom and started hitting my arms and legs… My knee started to throb… He wasn’t Arab, he was Sri Lankan. I looked at him fiercely and said, ‘Sri Lankan, are you? And you hit me like this?’ He ordered me to wash my face and apologize to bawa [male boss].

Related to the urban spatial and institutional arrangement that emplaces foreign women in the private spaces of citizens’ homes, citizen-sponsors are empowered by the state to take responsibility for the interests of their domestic worker (Gardner 2010). While keeping a foreign worker in a situation of neglect breaches the employment contract, some employers abuse their power to prevent workers from leaving, meaning that workers must often actively claim their right to present themselves to a police station or embassy, even if it is legally authorized. Fassin describes how “life is used as a resource to obtain rights which certainly cannot be reduced to their biological dimension: because they are precisely rights and not obligations, they must be regarded as political” (2010:93). Naziha was thus forced to present her “suffering body” (Fassin) – “that’s why I came out” – by reiterating her
surgery, pain, and deprivations in order to assert her right to seek treatment and return home. She challenged prescribed categories of domestic workers in doing so, but as it did not suffice, she continued her assertions:

I didn’t wash my face. I went straight to bawa while crying and said, ‘You’re Muslim, aren’t you? So am I. So why are you doing this injustice to women? Is this how you treat your own women?’ I said this to him nicely in Arabic. Only then did he agree to send me back … But only when I sat on the plane a week later did I feel some calm-contentment inside my heart-being.

Upon her return home in Sri Lanka, Naziha was diagnosed with an abdominal hernia for which she underwent treatment over four months, while her knee and heart-being also recuperated. Her story is of one person, yet it also relates to the experiences of many others who described being fearful or unsuccessful in requesting health care, rest time, or a reduction in workload. In rejecting unfair working conditions that are normalized for low-wage, racialized women, Naziha’s narrative complicates predominant views of Asian domestic workers as individuals devoid of moral agency, including Ong’s (2006:210) presentation of NGOs as the main actors who “give moral value for bare life by defining the maid’s biological existence in relation to political space.” What is unique about Naziha’s story is not that she asserts her own health needs – others seeking to escape mistreatment also did this – but it is in how she did this by making a biological claim as a moral-social person. She imposed shame on her boss and agent by asserting her deservingness as a co-ethnic and blurring the boundaries of her Otherness, rather than succumbing to its lack of entitlement, underlining how a domestic worker might represent her own interests and act politically.

Women like Naziha may not seek to engage with polity or extract obligations from the state, but the mode of being that is drawn from her narrative is that of transforming self-conscious identity instigated by the experience of illness and pain. Butler (1997:2) explains how agency is initiated and sustained through “becoming subordinated by power as well as the process of becoming a subject,” yet such discussions do not always involve how the body is being experienced. The above vignette underlines the interplay of experiential and political dimensions of health in illustrating how some women need to invoke bodily concerns to justify departures from workplaces – “that’s why I came out” – by foregrounding deteriorating ailments within explanations. As overwork and neglect tend to be judged by employers and family back home as inadequate reasons for terminating a paying job, these women presented sickness and exhaustion, potentially, to seek empathy and guard against social censure. I now turn to what happens when health is not the main instigating factor, but one of many stressors that prompt women to come out into illegality (Figure 3).

Figure 3. Outside migrants’ apartment building in Abbasiya, Jleeb Al-Shuyoukh, Kuwait.
Coming out to safeguard health and escape “being sold like cows”

More than half of my interlocutors who came out of employers’ homes had left through unauthorized channels, and almost two-thirds of these women had cited health among the reasons that prompted them to come out, alongside placement into illegal work and/or abusive conditions. Unlike those who had come out primarily to earn more or to engage in intimate relationships, the exits of the women discussed in this section had not been planned from the onset. 43-year old Farida said she came out because her employers would verbally “torture” her: “You don’t know how to clean. You’re just a Sri Lankan, what should I expect!” She also suffered from arthritis in one knee and struggled to work “without even a moment to sit,” so she decided to accept her sister-in-law’s offer of room-sharing in Abu Khalifa.

Others came out due to other labor infringements combined with the fear that their health would worsen. 36-year old Jansila had been seriously disturbed by the surveillance cameras installed in her bathroom and bedroom while she struggled with 16-hour workdays, epilepsy, chronic ankle pain, and the early effects of “sugar” and “pressure.” Mary had been underpaid for months. Sugandani left after her sponsor’s son propositioned her for sex. And 52-year old Sonali, who was grappling with chronic back pain, diabetes, and early menopause, came out after being falsely accused of stealing. Vandana, Farhana, and Dakshika sought to escape after unknowingly being issued temporary resident visas and illegally placed inside homes, a situation that caused Vandana to have migraines and nightmares. Although these women tended to have better health than those who had returned home due to severe ill health, bodily concerns were ever-present in their stories, silently reflecting the uncertainties, fears, and rigors undergone.

After she had recuperated in Sri Lanka, Naziha migrated to Kuwait again and remained there until the time of our first meeting. She worked with a legal sponsor for seven months before she was “sold” back to her recruitment agency after her employer’s old worker returned. The agency immediately placed her with a couple who took over her sponsorship, but they picked fights and “behaved like dogs.” Within a month, Naziha asked to leave. The couple tried initially to prevent her departure by physically abusing her before eventually returning her to the agency, but without her passport and an official release, as the agent refused to return the recruitment fee. Subsequently, Naziha was (unlawfully) sold to another agency for KD 400 (US $1300). She described what followed:

Do you know what these people did? They then sold me again to a family in Sabah Salem for KD 550 (US $1700) . . . I had no calm-contentment, there was just too much work. My abdominal pain started to come intermittently. I remembered how bad it had been – I did not want to suffer like that again. I managed for ten months because I wanted to get paid. But after that, I asked madam to send me back to Sri Lanka. She said she’d take me to the agent and ask for her money back . . . I knew what would happen. I couldn’t handle being sold and re-sold in front of my own eyes.

In 18 months, Naziha had helped two recruitment agents generate at least KD 1850 (US $6000) in fees, while she had only been paid KD 300 (US $980) for six of the 18 months she had worked. Refusing to be continuously re-sold, she eventually heeded the advice of a friend to go live with her. Friendships that she had built on the phone were crucial in informing her that “life outside” was possible.

Like many others, Naziha’s coming out into illegality was preceded by an existing illicit situation. Her sister, Farhana, a self-confident woman in her 30s, had been working in three different houses before realizing she was unauthorized:

The agent told me that no matter what the difficulties, I had to stay for three months inside each house. So, who benefits from this? Not me! It’s the agent who benefits from us being sold like cows . . . You see Sajida, the Sri Lankan agent colludes with the Kuwaiti. They sell us, take the money, and make us work . . . The only thing we can do is come out to find good employers ourselves. Outside, we can have a bit of calm-contentment. But in the house, we have to work 24 hours a day. Outside, we can live like in the ur [village/homeland] – as long as we find work.
There was a sense of proud accomplishment that tinged Farhana’s expression as she spoke. “Living as we like” and finding calm-contentment were things both sisters had worked hard to enjoy.

For these women who came out into illegality, there was a double-edge to their visibility and documentation status which, Horton (2020) argues, are tools to access rights and also techniques of control and surveillance. This dyad affected unauthorized domestic workers’ sense of risk and empowerment in contradictory ways. They began living in conditions of relative protection (in the moral economy of households and authorized migration) and visibility (to the institutions of the state and sponsorship), yet they were also hidden to the world outside the private domain of the household-workplace. They then came out into relatively more autonomous and public conditions of life and work after having weighed the risks of remaining inside homes and being at the hands of visa traders and agents, against the risks of leaving the system altogether.

Naziha’s sense of wellness improved after having time once again for herself:

Now at the end of the day, I can rest my legs completely. I can also pray . . . Praying in my own flat is completely different from praying inside [employers’ homes]. I finally feel hope inside my heart-being . . . it’s now easier to manage my pain and find work.

As immigration systems can reduce immigrants’ opportunities for material and social well-being (Asad 2020), health is among the complex of factors that instigate domestic workers to seek lives unauthorized. Embodied memories of past pain and the desire to prevent another breakdown (“I remembered how bad it had been”) motivated Naziha’s decision. Other women only realized how their bodies had been affected after coming out and having time for self-care, as did Vandana after her nightmares ceased, and Sonali after she consulted a private doctor to treat her diabetes and pain. Without denying the forms of empowerment that arise through coming out and visibility – as stressed in queer politics (see for example Cisneros and Bracho 2019; Sedgwick 1990) and in coming out “undocuqueer” (Seif 2014:87) – what I would like to stress here are the politics of invisibility that implicitly contributed to improved health among migrants.

Invisibility to the authorities also made it easier in some respects for these women to move freely and live unattached to men, unlike women on dependent visas who had to evidence marriage or those on private sector visas who were attached to a sponsor. Those who lived outside the legal boundaries that distinguished them from citizens, for example in shared flats of their choice rather than in sponsor-designated housing, were difficult to police and thus threatened state-citizen efforts to contain the foreign population (Gardner 2010). These tensions created other embodied vulnerabilities, such as the moral stigma associated with being a single, autonomous foreign woman. When Naziha questioned in the opening vignette, “why I am still here, existing like this,” she was referring to the pervasive experience of sexual harassment from male neighbors that she and Farhana had to safeguard against. Although they eventually managed to deflect this unwanted attention by dressing more conservatively and asking a close, male friend to pose as their nephew and visit regularly, they had to constantly adjust themselves, emotionally and physically, while connecting to heart-being. Speaking through the body may have been a way to justify their need to create their own living space, while navigating the tensions that sought to push them out of existence (Figure 4).

Conclusion

In this article, I have elaborated the ways in which Sri Lankan domestic workers’ coming out of employers’ homes plays a central role within women’s negotiations of everyday health, wellness, and work in urban Kuwait. Many live-in workers use their knowledge of social and legal structures in connection to health to navigate the systemic inequalities that pattern the normalization of overwork and delimit health-seeking, including self-care and access to health care. They presented illness and fatigue as means to make moral claims to come out and enjoy better health, drawing on abilities honed by earlier experiences of live-in work and departing through authorized channels, which shaped subsequent actions of coming out into illegality.
The notion of “heart-being” runs through the coming out stories presented, illustrating how being interacts with the mind alongside other Sri Lankan Sinhala and Tamil notions (“calm-contentment,” “wellness”) to guide how women made decisions about work and asserted greater autonomy over their bodies as part of trajectories of “being inside” versus “being outside” home-workplaces. While pain and exhaustion may have challenged their abilities to sense the impulses of heart-being in order to manage the work-body-mind complex, some learned to recognize the limits of their endurance so that they could cope with or even resist overwork. Coming out of employers’ homes was thus an extension of this tactic that enabled them to refuse working conditions that eroded health, wherein women reestablished better control of their mind, self, and bodies. In being able to “feel heart-being” once again after coming out, many women increased their capacity for social being, which mitigated what Hage referred to elsewhere as the effects of unequal distribution of being (2003:5–16, cited by Willen 2014:90). Yet what distinguishes the heart-being of my Sri Lankan originals from Jackson’s (2013) “struggle for being” and Hage’s finite being (Willen 2014) is its infinite and renewable source that arises from metaphysical entities. In feeling heart-being spiritually aligned to something greater than themselves (karma, Allah) through reflection, prayer, or meditation, some women could care for their bodies, and this placed them in a better position to maneuver work amid sociopolitical inequalities, indicated by Naziha’s statement: “it’s now easier for me to manage my pain and find work.”

As Naziha’s first coming out illustrated, the legal confines of the sponsorship system does not always guarantee domestic workers’ right to leave employers’ homes at will even if departing through authorized channels. Consequently, coming out often had to be actively claimed, as obtaining treatment, food, and rest – issues of physical-biological survival – inadvertently became political and moral when women left against their employers’ wishes. Those who came out into illegality faced
the additional contentions of their legalization and assumed immorality. In both scenarios, I have demonstrated how women referred to sickness and exhaustion to justify the necessity of their coming out. Even if health may have only been one of several concerns instigating these departures, it was always involved in at least two ways: firstly, as a source of continued contention, as women had to adjust embodied behavior in the public domain to counteract assumptions of their immorality; and secondly, it was involved positively, as the body could restore itself, heal, and enjoy wellness relative to previous housebound incarceration.

Unauthorized migrant women’s understanding of their exploitation thus initiated the crafting of capacities to speak out and create lives of their own. Illustrating the interplay between values, intersubjective meanings, material needs, and actions among individuals, these stories elucidate how experience involves far more than simple adjustments to given environments, but “endless experimentation in how the given world can be lived decisively” (Jackson 2005:xxii, emphasis in original). Women followed imperatives to restore the proper functioning of their bodies, feel connected to heart-being, and instill calm-contentment in their turbulent lifeworlds. They were thus motivated by both affective meaning and existential power. Yet by rejecting the neoliberal logic of visa trading and the lack of entitlement it involved, their subjectification was also ethical, involving a partial but direct expression of the creation of rights (Balibar 2004) to work more independently and care for themselves in the absence of institutional support. These stories reinforce understandings of the unexpected ways in which non-citizen women craft belonging as “insiders” who can shape their materialities and intersubjectivities (Vora and Koch 2015) – even if they may be unwell, “illegal,” or at the bottom of social hierarchies. Though a far cry from organized labor, the silent effects of domestic workers’ newfound subaltern autonomy was felt viscerally and emotionally.

My reading of these stories have directed me toward an analytic approach to health that incorporates social and emotional wellness and has the potential to disrupt the tendencies of some epidemiological studies to medicalize and individualize migrants’ health (Scheper-Hughes and Locke 1987). In underlining the important role played by mind, society, and politics in shaping understandings of migrant domestic workers’ health behaviors, I have brought issues of social inclusion and non-citizen claim-making – core questions within Gulf migrant studies – into conversation with medical anthropological concerns of how health and illness is produced and expressed. While the inseparability of migrants’ health from socio-legal and political realities has been increasingly asserted by critical medical anthropologists, mind-related aspects in the management of health have been less prominent beyond studies that focus on migrants’ mental health and existential experience. The interconnections underlined in this article between the heart-mind and the physical body and how broader wellness has a direct bearing on physical health – illustrated so thoughtfully and generously by Naziha and other women – make an initial, albeit modest, attempt to link phenomenological concerns with those of medical anthropology.

Finally, in focusing on a slightly ambiguous research context – namely the transitions between living inside employers’ homes and coming out – these findings contrast studies on domestic workers’ health that have selected the more extraordinary research settings of shelters, hospitals, psychiatric wards, or detention centers. My focus on the liminal space of coming out has enabled the identification of health-related concerns and behaviors that are otherwise obscured by hegemony, disease, trauma, and immorality and brought attention to coming out as a tactic to safeguard health and prevent illness. It is in this elaboration of the biological and political that we can comprehend domestic workers’ motives for coming out as part of projects of ethical self-care and agentive health-seeking, which in turn can recast moralizing communal judgments of them.

Notes
1. The term “ur” is a Tamil word that has multiple meanings such as homeland, community, and place of origin.
2. Following Levitt and Schiller (2004), transmigrants are mobile subjects who have multiple social relations with societies of origin and residence, whose social expectations, values, and patterns of human interaction are shaped by social, economic, and political systems across borders.
3. Unless otherwise indicated, all stated migrant vernacular terms are stated in parentheses at first mentioning in Tamil first and then Sinhala.
4. While Willen uses critical phenomenology to examine experiences of migrant “illegality”, I draw on her definition to explore migrants’ experiences across legal statuses.
5. See e.g., Al-Maskari et al. 2011; Anbesse et al. 2009; Joshi et al. 2011.

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**Notes on contributor**

*Sajida Zareen Ally* is Research Associate at the University of Sussex and Lecturer in Anthropology and Global Health at the University of Bristol.

**ORCID**

Sajida Zareen Ally [http://orcid.org/0000-0002-7318-8214](http://orcid.org/0000-0002-7318-8214)

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