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Worker's Hotline
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Kav LaOved Report

Occupational Health Risks Among Migrant Caregivers in Israel

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Occupational Health Risks Among Migrant Caregivers in Israel

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Preface

The Worker's Hotline (Kav LaOved, KLO) was established over 30 years ago to provide individual assistance to populations on the socio-economic periphery and shed light on broad issues arising from individual cases in the secondary labor market, including industries heavily reliant on labor migration. Over the years, Kav LaOved has become almost the sole address for non-Israeli workers seeking to exercise their rights in the labor market. The organization often finds itself at the intersection of labor laws and immigration laws, dealing with both individual and fundamental questions.

Almost since its establishment, the organization has assisted tens of thousands of migrant workers previously and currently employed in Israel as caregivers in the homecare sector. The migrant caregivers department operates with around 15 dedicated volunteers who, for many years, have invested their time and expertise in providing individualized assistance to workers. They possess an in-depth understanding of regulations, laws, and the unique conditions of employment in a patient's home. Most workers seek assistance for consultations and receive help in exercising their rights with their employers and their families, the Population and Immigration Authority, the National Insurance Institute, as well as private recruitment and placement agencies (PRPAs), migrant caregiving manpower companies, and private entities involved in their employment. Requests for assistance are made through various channels, including an online form, WhatsApp, phone calls to the department manager or directly to volunteers[2], a hotline, social media[3], or in-person visits to the office. Naturally, over the years, it has become evident that, in many cases, workers reach out only after their health has significantly deteriorated, often at advanced stages of illnesses, including severe diseases such as cancer.

Kav LaOved does not specialize in securing medical rights or providing medical assistance. However, due to its familiarity with the harsh working conditions of migrant caregivers

2 The phone numbers of volunteers are spread by word of mouth among migrant workers' communities.

3 Kav LaOved's dedicated Facebook page for migrant caregivers had 67,000 followers as of December 2024.

(hereinafter caregivers/caregiving workers)**,** some of which will be detailed later in this report, and because it is often regarded as a safe place where workers can receive answers to questions beyond labor laws, the department sometimes assists them in exercising their medical rights. From our experience, cases involving migrant workers suffering severe illnesses such as cancer are unique, particularly due to the advanced stage of the disease at which they seek medical assistance or reach out to us. Many workers approach the healthcare system only at an advanced stage of their illness, often due to bureaucratic obstacles, lack of awareness of early detection screenings, communication difficulties, or their unavailability due to dependence on their employer (and vice versa).

It should be noted that employers of migrant workers are legally required to provide the worker with health insurance similar to, but not equal to, the healthcare services available to Israeli citizens (as will be detailed later). However, this insurance is contingent upon the existence of an active employment relationship. A worker can extend the insurance independently when transitioning between employers, but only for up to three months. If the insurance company determines the worker has a severe illness, it often summons her for an occupational health examination. If the doctor assesses that she is unfit to work for more than 90 days, she is declared as having lost her ability to work. In such a case, her only benefit from the insurance company is a plane ticket back to her home country. Only if the worker has resided in Israel on a visa for over ten years can she claim a one-time compensation for loss of work capacity, amounting to approximately 90,000 NIS, which she will receive in her home country[4].

However, despite having health insurance, several factors prevent workers from accessing timely medical care. These include a lack of awareness about the importance of early detection, limited availability to attend screening tests, unfamiliarity with Israel's healthcare system,

4 In this regard, we note that Kav LaOved organization filed a petition with the Supreme Court requesting the provision of national health insurance and national insurance (social security) for home migrant care workers, at least for those who have lived in Israel for many years (see Supreme Court ruling 1105/06 Kav LaOved v. Minister of Welfare, issued on 22/6/2014). The ruling instructed the state to improve the healthcare services provided to these workers and bring them closer to the healthcare services that resident citizens are entitled to. As a result, an arrangement was reached offering a one-time compensation to workers suffering from a serious illness.

language and cultural barriers, and, in some cases, a lack of support from the employer's family in the event of illness or absence due to medical appointments[5]. Additional challenges include difficulty scheduling and expediting appointments and navigating treatment management with health funds and insurance companies (such as obtaining Form 17 and securing continued insurance coverage). As a result, workers often turn to Kav LaOved only at the terminal stage of their illness, when, had it been detected earlier or treated more promptly, their lives could have been prolonged or even saved through full recovery.

The high incidence of such cases reported to the migrant caregiver's department at Kav LaOved led us to initiate a study about two years ago with the support of students from the Equity Promotion and Disparity Reduction course at Tel Aviv University's School of Public Health. **The study aims to systematically examine home-based caregivers' working conditions and risk factors to assess the correlation between their employment conditions and their self-reported health status**. As will be described later, the findings are concerning, highlighting significant room for improvement in various areas: prevention and awareness, periodic check-ups, and the overall employment structure contributing to the risks these workers face. The goal is to prevent illness among caregivers, minimize the impact of their work on their health as much as possible, and ensure they can return safely to their home countries upon completing their employment in Israel.

Introduction

According to data from the Population and Immigration Authority, 61,505 migrant caregivers are legally employed in Israel, along with an additional 15,412 caregivers whose visas have expired but who have nonetheless remained in the country[6]. These workers come from Southeast Asian countries such as the Philippines, India, Sri Lanka, and Nepal, as well

5 It should be noted that some families support and provide support to the sick worker, but because these are caregivers of long-term care patients who are dependent on their worker and because it is difficult to hire another worker to replace workers during their illness, more than once the workers were forced to resign, even at the cost of losing the right to paid sick days and losing their place of residence while dealing with the illness.

6 Chart 5, Population and Immigration Authority, Data on Foreigners in Israel, Edition No. 3, October 2024.

as from Eastern European countries like Moldova and Ukraine, and Uzbekistan in Central Asia. A small number also come from other countries, including Romania and Colombia. The recruitment process is largely conducted through unregulated private channels, which require workers to pay brokerage fees in order to secure employment in Israel[7].

Caregiving work involves assisting patients who are not independent in performing Activities of Daily Living (ADL), such as bathing and hygiene, eating and drinking, transferring (from bed and back), toileting, dressing and undressing, and mobility. It also includes assistance with Instrumental Activities of Daily Living (IADL), such as using the telephone, shopping, meal preparation, household chores, laundry, transportation, medication management, and financial administration. Caregiving—especially long-term care—is physically demanding (lifting the patient, assisting with bathing, feeding, toileting, and household management, as well as providing care during nighttime hours), emotionally challenging (offering companionship, encouragement, and listening), and behaviorally complex (managing aggression in certain circumstances, preventing falls, and encouraging eating). Beyond the physical aspects of caregiving, the job requires knowledge in geriatric psychology, emotional and professional maturity, patience, tolerance, empathy, and compassion.

Migrant caregivers came to Israel to provide essential care within the community for elderly patients and individuals with disabilities. In many ways, their work serves as the only solution offered by the Israeli state for dependent patients. Currently, the only permitted employment model in Israel requires caregivers to live in the patient's home 24 hours a day, six days a week (at minimum), with an obligation to sleep in the employer's residence. In fact, migrant caregivers are not allowed to be employed in the sector unless they work under this 24/6 arrangement at the very least—though, in practice, this often becomes a 24/7 work schedule[8].

As will be discussed later, existing literature indicates that these workers are particularly

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7 See for example: Idit Leibovich, Black Money, Black Work, Kav LaOved 2016.

8 For further information about the rights of migrant workers in the caregiving sector as of April 2024, see Kav LaOved's rights leaflet.

vulnerable to workplace exploitation. This vulnerability stems from the intersection of their status as women working in caregiving professions and as migrant workers employed within a private home—an isolated space, hidden from public oversight. However, as will be seen below, their harsh working conditions also expose them to significant risks to their health and well-being. In a survey conducted in 2023 for this study, we asked 534 caregivers about their health status and the impact of their work on their well-being. **81% reported having developed various health issues as a result of their employment in the home care sector.** This report focuses on these workers, examining the challenges faced by migrant caregivers in Israel's home-care sector and offering recommendations to improve their working conditions in order to safeguard their health.

What is an Occupational Disease?

An occupational disease (or work-related illness) is defined by the presence of a causal link between working conditions and exposure to risk factors that contribute to illness. The International Labour Organization (ILO) defines an occupational disease as "a disease resulting from exposure to risk factors arising from work-related activities." International organizations such as the ILO and the World Health Organization (WHO), as well as numerous governmental bodies, recognize three fundamental components necessary for diagnosing occupational diseases: a medical diagnosis, exposure to risk factors in the workplace, and a causal or associative link between the two[9].

Current legislation includes various provisions regulating the enforcement powers of workplace safety regulators, the provision of healthcare services for workers, and the list of health-harming diseases[10] monitored by the Occupational Safety and Health Administration within the Ministry of Labor, which collects reports from medical services. In addition to

9 The Prevention of Occupational Diseases, p. 4; International Statistical Classification of Diseases and Related Health Problems (ICD), p. 1; List of Occupational Diseases (revised 2010), p. 7; The Occupational Health Crisis in Israel, KLO, 2021

10 Occupational Accidents and Diseases Ordinance (Notification), 1945 and also Occupational Diseases Regulations (Obligation to Notify – Additional List), 1980.

the Ministry of Labor, the National Insurance Institute (NII) maintains a separate list of recognized occupational diseases for the purpose of workplace injury compensation[11]. However, despite the prevalence of caregiving work and the significant occupational hazards associated with it, as noted in professional literature, these lists do not include work-related illnesses arising from such risks. This report takes a closer look at the unique aspects of caregiving work performed by migrant workers and offers a valuable contribution to an underexplored field.

As mentioned earlier, migrant caregivers come to Israel to provide care for dependent patients. In doing so, they are frequently exposed to unique occupational health risks. Their illnesses, much like the health issues faced by other women employed in domestic labor, often go unnoticed by the public. International studies indicate that these workers face long-term health consequences and increased morbidity rates[12]. Research has shown that long working hours, lifting heavy loads, and other physically demanding daily tasks place them at risk of developing musculoskeletal disorders, such as back pain and joint problems[13]. Additionally, caregiving workers are exposed to infectious diseases—especially those working in assisted living facilities—and face a higher risk of contact with toxic substances, bodily fluids, and other hazardous materials. Some of the most significant risks they face stem from psychosocial stressors, including demanding work conditions with no clear separation between work and rest hours, the emotional strain of migration and isolation, the mutual dependency between caregiver and employer, high brokerage fees, and vulnerability to abuse and violence, including sexual violence.

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11 National Insurance Regulations (Insurance Against Occupational Injury), 1954.

12 Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: a clinical review. JAMA, 311(10), 1052–1060; Ayalon L. (2009). Evaluating the working conditions and exposure to abuse of Filipino home care workers in Israel: characteristics and clinical correlates. International psychogeriatrics, 21(1), 40–49.

13 Malhotra, R., Arambepola, C., Tarun, S., de Silva, V., Kishore, J., & Østbye, T. (2013). Health issues of female foreign domestic workers: a systematic review of the scientific and gray literature. International journal of occupational and environmental health, 19(4), 261-277.

As will be shown below, our study on migrant workers in the caregiving sector in Israel confirms these findings and presents a concerning picture regarding their exposure to various risk factors and the threats to their health.

Methodology

The present study is based on findings collected through multiple methods:

- An online survey conducted among 534 caregivers in three languages—English, Spanish, and Russian—between January and September 2023. Key demographic breakdowns:

  - Age range of respondents: 45.5% were aged 40–49 (243 out of 534), 28% were aged 30–39 (148 out of 534), 25% were aged 50+ (134 out of 534), and the remaining respondents were aged 25–29.

  - Marital status: 38% were married with one or more children (203 out of 534), 30.5% were unmarried (163 out of 534), 29% were widowed, divorced, or separated (157 out of 534), and the rest were married without children.

  - Country of origin: 25% of respondents were from Uzbekistan, 22.5% from Colombia, 16% from the Philippines, 15% from Moldova, 9.5% from Ukraine, 7% from India, and the remainder from other countries (Sri Lanka, Georgia, Nepal, Peru, etc.).

  - Years of employment in Israel: 63% had worked in Israel for up to 5 years (337 out of 534), 30% had worked for 6–10 years (161 out of 534), 5% had worked for 11–15 years (27 out of 534), and 2% had worked in Israel for over 16 years (9 respondents).

  - Brokerage fees paid to secure employment in Israel: 27% reported paying between $7,000–$10,000 (145 out of 534), 21% paid between $10,000–$15,000 (110 out of 534), 15% paid over $15,000 (82 out of 534), 14% paid between $4,000–$7,000 (76 out of 534), and the remaining 23% either did not recall, paid nothing, or paid less than $4,000 (121 out of 534).

- Four semi-structured interviews conducted in February 2023 with four caregivers (three women and one man).

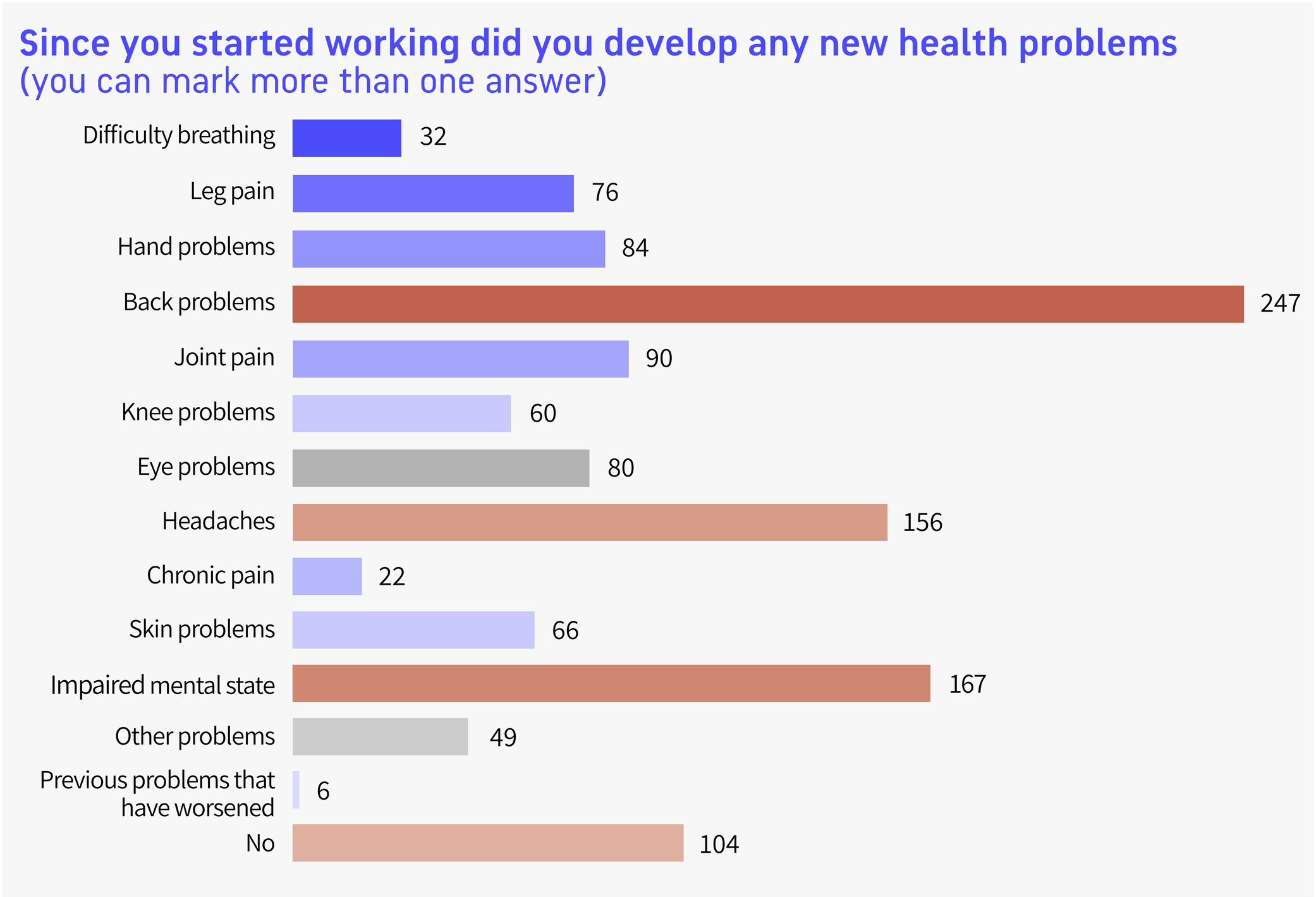
- Doctoral dissertation titled *Elderly Care Recipients and Migrant Caregivers – 'Boundary Work' at Home Under the Influence of the State and Its Institutions*, by Dr. Irit Porat (2017), which included dozens of interviews.

Key Findings

The findings from the survey, semi-structured interviews, and the doctoral research (including the interviews conducted within its framework), indicate that while caregivers are aware of their exposure to occupational risk factors, the extent of their awareness largely depends on their professional education and the training they received prior to their arrival in Israel. However, in most cases, their knowledge is partial and vague, lacking a detailed understanding or awareness of specific health implications.

In the survey, **81% of respondents reported having developed various health issues due to their work as caregivers in the homecare sector**. As illustrated in the following graph[14], most workers reported orthopaedic problems affecting their joints, back, knees, hands, and other areas. Many reported persistent headaches, eye problems, skin conditions, respiratory difficulties, and additional symptoms that emerged as a result of their work. Furthermore, many workers reported mental distress and deteriorating mental health due to their jobs (including stress, anxiety, depression, and other psychological conditions). **This study presents findings from the survey, identifying the various occupational risk factors in caregiving work. Based on the self-reported data from caregivers, the study highlights the primary physical and mental health impacts of their employment.**

14 Only 104 respondents answered "no" to the question of whether new health problems developed as a result of the work, 19% of all respondents. There were however additional respondents who answered "no" and also checked one of the other answers, indicating that they had in fact developed new problems. Therefore, the graph only shows the respondents who answered "no" without an additional answer.



The findings of this study are unequivocal: Almost every caregiver in Israel is exposed to physical and mental health risks. Due to language and cultural barriers that hinder their ability to access healthcare services, their level of protection largely depends on their knowledge, background, and ability to take action to protect themselves and mitigate risks. This is the reality in a sector where workers are recruited from impoverished countries and are often forced to pay exorbitant brokerage fees to secure employment in Israel.

In the following chapters, we will examine the differences and similarities between the occupational risk factors present in the homecare sector and the caregivers' understanding and awareness of these risks. The findings will be presented systematically: each chapter will begin with a brief theoretical introduction to the different types of exposure, followed by the survey results and insights from the various interviews conducted.

Chapter A – Physical and Environmental Risk Factors

Interviews conducted with occupational health professionals indicate that risk factors for occupational illness can be classified into five main categories: chemical factors, biological factors, physical factors, ergonomic factors, and psychosocial risk factors[15]. According to Israeli law, employers are responsible for ensuring the health and safety of their workers, including their occupational health[16]. To fulfill this obligation, employers must conduct risk assessments and address specific hazards present in the workplace to minimize and prevent harm caused by exposure. Additionally, they are required to provide workers with appropriate protective equipment to safeguard them against these risks.

Chemical Substances

Chemical substances are categorized based on various aspects, including the degree of exposure that poses a health risk, their chemical composition, the nature and intensity of their effects on exposed workers, and the types of symptoms they may develop. Additionally, it is important to consider the process that leads to exposure—whether the chemicals are primary substances, by-products of a process, or results from mixing different substances.

For example, discussions with experts from the Israeli Institute for Occupational Safety and Hygiene indicate that nursing home workers may be exposed to chemicals such as formaldehyde, chlorine, and ammonia, which are commonly used for cleaning toilets and bathrooms[17]. Other disinfectants include peracetic acids for mold removal and ethylene oxide, a common component in detergents used for cleaning and dissolving grease, such as laundry powder or dish soap. Another category of chemical substances includes dust, to which uncontrolled exposure in large quantities can pose a risk.

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15 Kav LaOved, Roadmap Report: Health of Palestinian Workers in the Construction Industry, 2022.

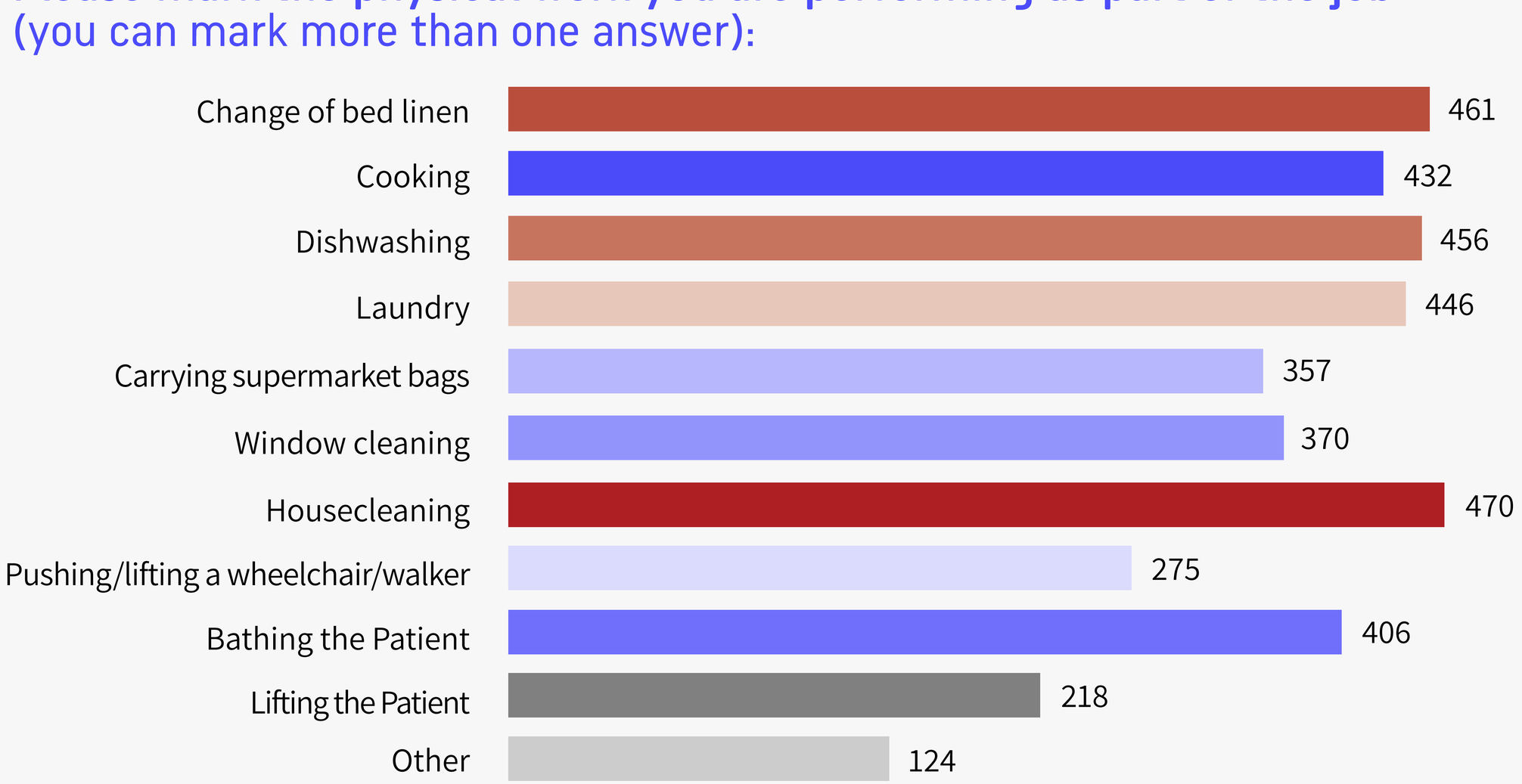
16 Adv. Yuval Samara, Employer's Liability for Worker Injuries, Institute for Occupational Safety and Health, August 2008.

17 Vianello, F. A., & Wolkowitz, C. (2022). Italian doctors' understandings of work-related health and safety risks among women migrant home care workers. Health, Risk & Society, 1-17. (Vianello 2022 & Wolkowitz).

Exposure to chemical risk factors varies depending on the substance and can occur in different ways. The level of risk is influenced by the type of chemical, the degree of exposure (duration, frequency, intensity, etc.), and the presence or absence of protective measures. While household exposure to some of these chemicals is usually lower, home caregivers are also responsible for household chores in addition to their caregiving duties, and therefore, their risk increases. Without appropriate precautions, uncontrolled exposure to chemical hazards may lead to occupational illnesses.

As published by the Institute for Occupational Safety and Hygiene, the consequences of exposure to such substances are diverse[18]. Starting from the risk of poisoning or the development of allergies due to prolonged and unprotected contact with medications and ointments, through skin irritations and inflammations caused by frequent use of soaps, disinfectants, and detergents, and ending with irritation of the eyes, nose, and throat resulting from exposure to aerosols (gas, vapors, or smoke) emitted into the air from various chemicals, disinfectants, or cleaning agents. All of these can lead to poisoning, allergies, chronic damage, cancer, and in extreme cases, even death.

Please mark the physical work you are performing as part of the job (you can mark more than one answer):



18 The Institute for Occupational Safety and Hygiene, Nursing Caregiver in Institutions and Households – Occupational Risk Information Sheet, 2015.

As evident from the survey results, caregivers are not only responsible for attending to their patients but also perform a wide range of household cleaning tasks (470 of all respondents), 85% (456 caregivers) reported washing dishes, 84% (446 caregivers) reported doing laundry, 69% cleaning windows (370 of the respondents), and additional tasks that involve prolonged exposure to cleaning, disinfecting, and washing agents.

Caregivers were also asked whether they developed new health issues due to their work. The findings show that 32 caregivers (2% of the respondents) reported developing breathing difficulties, 66 caregivers (5%) reported developing skin problems, and 80 caregivers (6%) reported developing eye problems. These conditions may be linked to exposure to chemical substances. Additionally, 156 caregivers (12%) reported experiencing headaches after starting their work as domestic caregivers. However, based on interviews conducted with caregivers, this symptom may also be associated with lack of sleep, as will be discussed later, rather than solely with exposure to chemical hazards.

Biological Risk Factors

According to professionals, domestic caregivers may also be exposed to biological risk factors due to their close proximity to infectious diseases, viruses, and bacteria, as well as other biological hazards such as fungi and mold, which are associated with the nature of their work. Exposure to pathogenic microorganisms in bodily fluids presents a significant risk for infectious diseases such as tuberculosis, hepatitis B, and HIV/AIDS due to the close physical contact required when caring for patients. The nature of caregiving work involves high levels of exposure to biological risk factors, increasing the risk of infection[19]. Research indicates that caregivers are more likely to contract infectious diseases due to unsafe work practices, a lack of protective equipment, limited control over exposure to infections, and insufficient knowledge about how to protect themselves from these risks[20].

19 The Institute for Occupational Safety and Hygiene, Nursing Caregiver in Institutions and Households – Occupational Risk Information Sheet, 2015.

20 Pan, X., Zhu, Y., Wang, Q., Zheng, H., Chen, X., Su, J., Peng, Z., Yu, R., & Wang, N. (2013). Prevalence of HIV, syphilis, HCV and their high risk behaviors among migrant workers in eastern China. PloS one, 8(2), e57258. https://doi.org/10.1371/journal.pone.0057258.

During the peak periods of the COVID-19 pandemic in 2020 and 2021, caregivers continued working in close proximity to their patients, putting their health at risk. Due to the high level of contact and the inability to isolate, the caregiver and patient were considered a single unit (capsule), often leading to mutual infections. In 2022, the European Commission recommended recognizing COVID-19 as an occupational disease, including for caregivers[21].

Exposure to biological risk factors can occur in various ways, including airborne transmission, direct contact, droplet or splash exposure, and ingestion. Exposure may also occur through needlestick injuries from contaminated needles, contact with vomit, blood, or urine, handling soiled bedding or clothing contaminated with bodily fluids, touching contaminated surfaces, and managing medical waste. The level of risk depends on the type of hazard, degree of exposure (duration, frequency, intensity, etc.)[22]. These risks are inherently part of a caregiver's daily tasks, making exposure a natural part of their work. However, to reduce these risks, employers must provide caregivers with proper protective equipment, offer training on minimizing and preventing exposure, and ensure they have a point of contact for addressing safety and occupational health concerns during their work.

During various interviews, caregivers shared experiences of unprotected exposure to bodily fluids and emphasized the need for professional guidance in handling such situations as part of their work.

> For example, M., a caregiver from the Philippines, recounted his experience caring for a patient with a permanent catheter, which required regular contact with blood: *"The family brought gloves because I asked for them… He had constipation several times, and I had to empty his bowels. I did it with my hands. I knew what to do thanks to my experience."*

21 European Commission, Commission recommends recognising COVID-19 as occupational disease in certain sectors and during a pandemic, 28 November 2022.

22 Dr. Meirav Paz, Nursing Homes - Safety and Health Risks, Israel Institute for Occupational Safety and Hygiene, June 2010.

In another case brought to our attention, H., a caregiver from the Philippines, described a negotiation with the patient's son regarding cleaning up after the patient, who would smear feces around the house: *"He spread it all over the bathroom and the entire house. I felt like he was doing it on purpose… It happened every day, as if he was looking for ways to make me upset… Everywhere, with his hands? On the floor, on the walls… I cried so much. Who is supposed to clean this?"*

Physical Risk Factors

According to experts, domestic caregivers are not exposed to unique physical risk factors specific to their work, except for exposure to ionizing radiation while accompanying patients to medical examinations or cases of uncontrolled exposure to extreme cold or heat (such as radiators and hot surfaces, hot or cold water, etc.)[23].

Ergonomic Risk Factors

Ergonomic risk factors, which manifest as excessive strain on the musculoskeletal system, can lead to acute or chronic injuries. According to previous studies, these risks are particularly common among caregivers due to their work, primarily lifting and transferring patients. Patient care requires repetitive movements, prolonged standing, and heavy lifting in constrained or non-neutral postures. These tasks increase the risk of musculoskeletal disorders, including lower back pain, shoulder pain, and carpal tunnel syndrome. Studies have shown that migrant workers in caregiving professions are more likely to experience musculoskeletal disorders due to the demands of their work. If these health risks remain unaddressed, they may have long-term consequences for their health and well-being.[24]

23 The Institute for Occupational Safety and Hygiene, Nursing Caregiver in Institutions and Households – Occupational Risk Information Sheet, 2015.

24 Vianello 2022 & Wolkowitz.

Our survey confirms that caregivers are indeed required to perform tasks involving ergonomic risks, such as lifting patients, bathing them, assisting with toileting, and performing household cleaning tasks. These activities involve intense, repetitive movements, prolonged bending, and postures that require excessive muscle stretching. For example, as shown in the graph above, 40% of respondents (218 caregivers) are required to lift patients, 76% (406 caregivers) assist with bathing, and 88% (470 caregivers) perform household cleaning tasks. All of these are physically demanding jobs.

The survey also found that 19% of respondents (247 caregivers) developed back problems, 7% (87 caregivers) developed hand problems, 7% (90 caregivers) developed joint issues, and 5% (60 caregivers) reported developing knee problems. In nursing institutions, physically strenuous tasks are typically performed by two staff members following established procedures. However, based on our experience, many families of home care patients are unaware that they can introduce assistive devices like patient lifts to help caregivers lift patients. In many cases, families even refuse to allow such equipment in their homes. At present, no criteria exist for bringing a lift or for training home caregivers/family members in its use, which increases ergonomic risks.

N., a caregiver from India, shared: *"A few months ago, my employer almost fell. I caught her from behind to prevent her from breaking her bones, but I hurt my back. The back pain left me bedridden for an entire day. Her family arranged an appointment for me with an osteopath… I felt better afterward, but I still can't bend too much, lift heavy things, or push a wheelchair… When I went back to India for a vacation, I had an X-ray, and the doctor recommended physical therapy and six months of rest from lifting heavy objects. But that is unrealistic. My patient can't walk much… I love the family, and they see me as part of the family. But unfortunately, due to my health condition, I am planning to leave."*

Lack of Training on Physical and Environmental Risk Factors

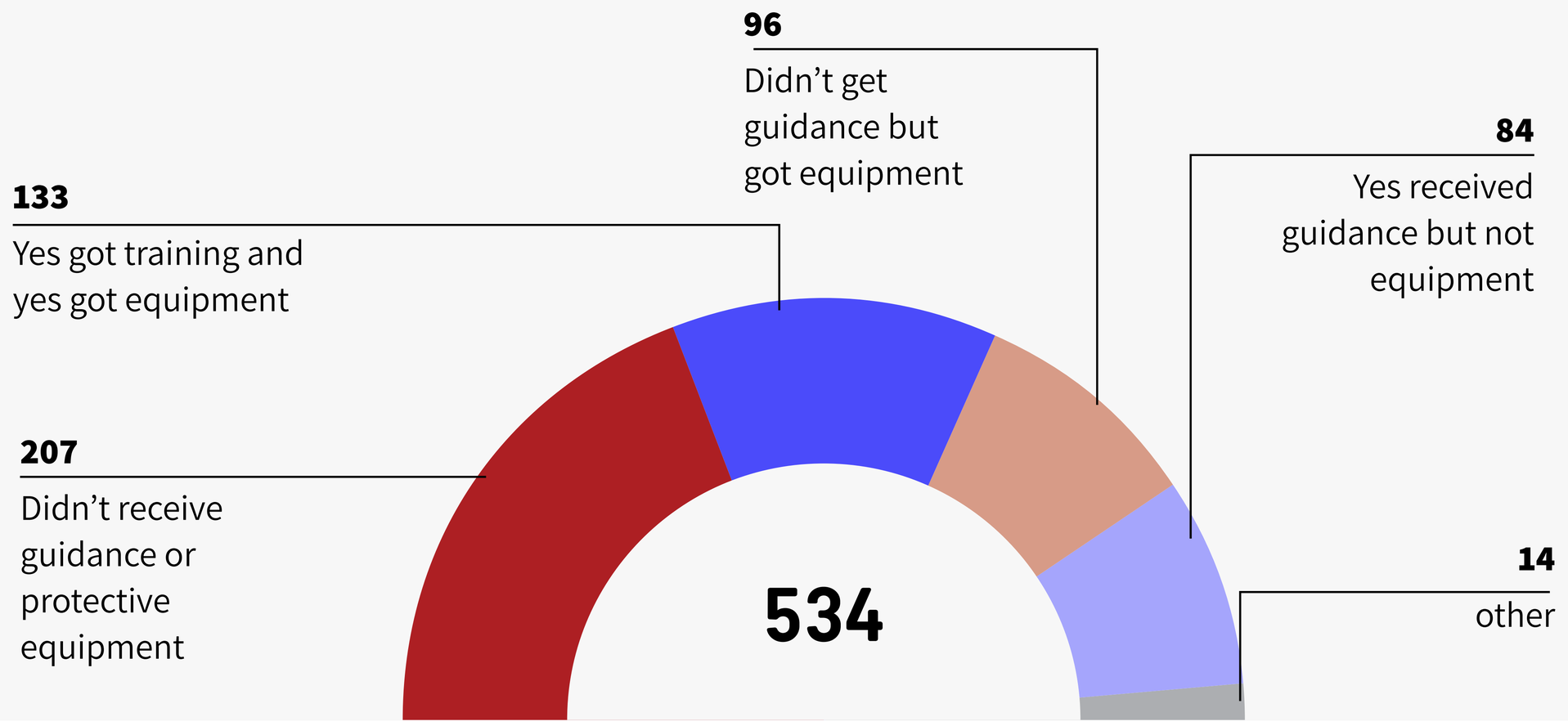
As mentioned, the work of domestic caregivers exposes them to significant health risks. Despite this, Israel does not offer specialized training courses for home caregivers, nor

are there any formal criteria for employment in this field. The responsibility for assessing a caregiver's suitability before arriving in Israel lies with PRPAs that are authorized to recruit migrant workers for the caregiving sector. Once the caregivers arrive in Israel, the responsibility for training shifts to caregiving companies, which manage their professional supervision, support, and guidance. According to the National Insurance Institute requirements, caregiving companies must ensure that at least 30% of caregivers— including migrant workers— participate in training courses[25]. However, some domestic caregivers are employed directly by patients, meaning there is no designated entity responsible for providing them with professional training.

Our survey reveals alarming findings regarding exposure to physical and environmental risk factors, occurring in an unsupervised manner without professional guidance or proper protective equipment. Despite the significant risks of exposure to chemical substances in their work, 39% of respondents reported that they did not receive protective equipment or training (either in Israel or in their country of origin) regarding the substances they are exposed to in their job (207 respondents). 18% stated that they did not receive training but were provided with protective equipment, while 16% reported receiving training (either in Israel or during studies in their country of origin) but were not given protective equipment. In contrast, only 25% of respondents indicated that they received both protective equipment and training regarding the hazardous substances they are exposed to at work (either in Israel or through studies in their country of origin).

25 See, in this regard, Section 51 of the tender for the creation of a pool of home care service providers for elderly individuals eligible for a long-term care allowance, Tender No. M(2038) 2008, National Insurance Institute.

Training or guidance on the dangerous substances that you use for work



In this regard, based on our experience from cases handled by Kav LaOved, training provided to workers in their countries of origin often does not meet sufficient professional standards and fails to address the need for guidance on maintaining workers' safety and health. In contrast, nursing institutions in Israel have various means to assist staff in handling long-term care patients, such as hoists and belts, in addition to personal protective equipment like gloves, masks, and more. However, in private homes, at best, a hoist may be available in a small percentage of households, while purchasing personal protective equipment is typically the worker's responsibility.

S', a Ukrainian caregiver, shared her experience regarding training in lifting patients: *"In my previous job, I cared for a bedridden patient. I didn't receive training, but I developed a method that worked for me through experience. I rely on my personal logical reasoning."*

G', a caregiver from the Philippines, shared: *"At home, I cleaned every day, and I also did her nails. She didn't want to go to the salon in the nursing home, so I did it for her. I bought gloves and protective equipment myself. I didn't receive training on protection; I had training from my studies, but I didn't get any training here."*

M', a caregiver from the Philippines, shared: *"My sister, colleagues, and friends taught me. Also, the previous caregiver had experience; she knew how to do things and guided me... The family bought protective equipment like gloves after I asked them to."*

Chapter B – Psychosocial Risk Factors

Caring for long-term care patients is emotionally demanding work, requiring empathy, patience, sensitivity, and a high level of attentiveness to another person's needs. The unique nature of this work and the tasks required of home caregivers expose them to risk factors from the fifth category—psychosocial risks. In fact, the majority of risk factors faced by migrant workers in the caregiving sector belong to this category[26].

Previous studies have long established the link between home caregiving work and its impact on the mental health of caregivers, particularly migrant workers. Among the factors identified in global literature are the high workload, language barriers, and cultural differences[27]; social isolation and lack of community support, which can lead to feelings of loneliness and homesickness and further deteriorate caregivers' mental health[28]; the social status of migrant workers, which increases the risk of health issues stemming from exclusion and discrimination, potentially leading to feelings of alienation, lack of belonging,

26 In this regard, it is important to note that, according to the literature, there is a reciprocal relationship between psychosocial symptoms and musculoskeletal symptoms. See, for example:
Chanchai W, Songkham W, Ketsomporn P, Sappakitchanchai P, Siriwong W, Robson MG. The Impact of an Ergonomics Intervention on Psychosocial Factors and Musculoskeletal Symptoms among Thai Hospital Orderlies. Int J Environ Res Public Health. 2016 May 3;13(5):464.

27 Adelman, R. D. et al, 2014; Vianello 2022 & Wolkowitz.

28 Malhotra, R., Arambepola, C., Tarun, S., de Silva, V., Kishore, J., & Østbye, T. (2013). Health issues of female foreign domestic workers: a systematic review of the scientific and gray literature. International journal of occupational and environmental health, 19(4), 261-277.

and worsening distress[29]; and barriers and challenges in accessing healthcare and other essential services, including due to language gaps and their status as migrants[30].

As indicated by the findings of our study, about one-third of caregivers reported that their work had a moderate impact on their mental state. As detailed above, many reported psychological distress, such as anxiety, depression, and stress (167 respondents, 13%). As will be presented below, their distress can be attributed, among other factors, to the psycho-social risk factors inherent in the nature of their work, distance from family, loneliness, and more. Their mental distress can also be linked to psycho-social risk factors stemming from their current employment framework, which increases their vulnerability and exacerbates the health risks they face.

As mentioned, **the current employment framework for migrant workers in the homecare sector in Israel operates exclusively under the 24/6 (and effectively 24/7) model, making patients the direct employers of caregivers.** This model presents numerous challenges, as will be discussed in this chapter. It places two vulnerable parties against each other, ostensibly under the pretext of reducing bureaucracy, but in practice, it privatizes essential social services and absolves the state of responsibility. While this employment model aims to reduce costs for the state, it simultaneously causes harm, as will be demonstrated below. In the absence of alternative care solutions, both dependent patients and home caregivers are bound to the existing arrangement[31].

As will be explained in this chapter, some of the psychosocial risk factors stem from the nature of the work itself, while others are external, resulting from policies, regulations, and

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29 Straiton, M. L., Ledesma, H. M. L., & Donnelly, T. T. (2017). A qualitative study of Filipina immigrants' stress, distress and coping: the impact of their multiple, transnational roles as women. BMC women's health, 17(1), 1-11.

30 Ayalon, L. (2008). Subjective socioeconomic status as a predictor of long-term care staff burnout and positive caregiving experiences. International Psychogeriatrics, 20(3), 521-537.

31 For alternative treatment options, see for example:
NIH - National Institute on Aging (NIA), What Is Long-Term Care?, 2023.

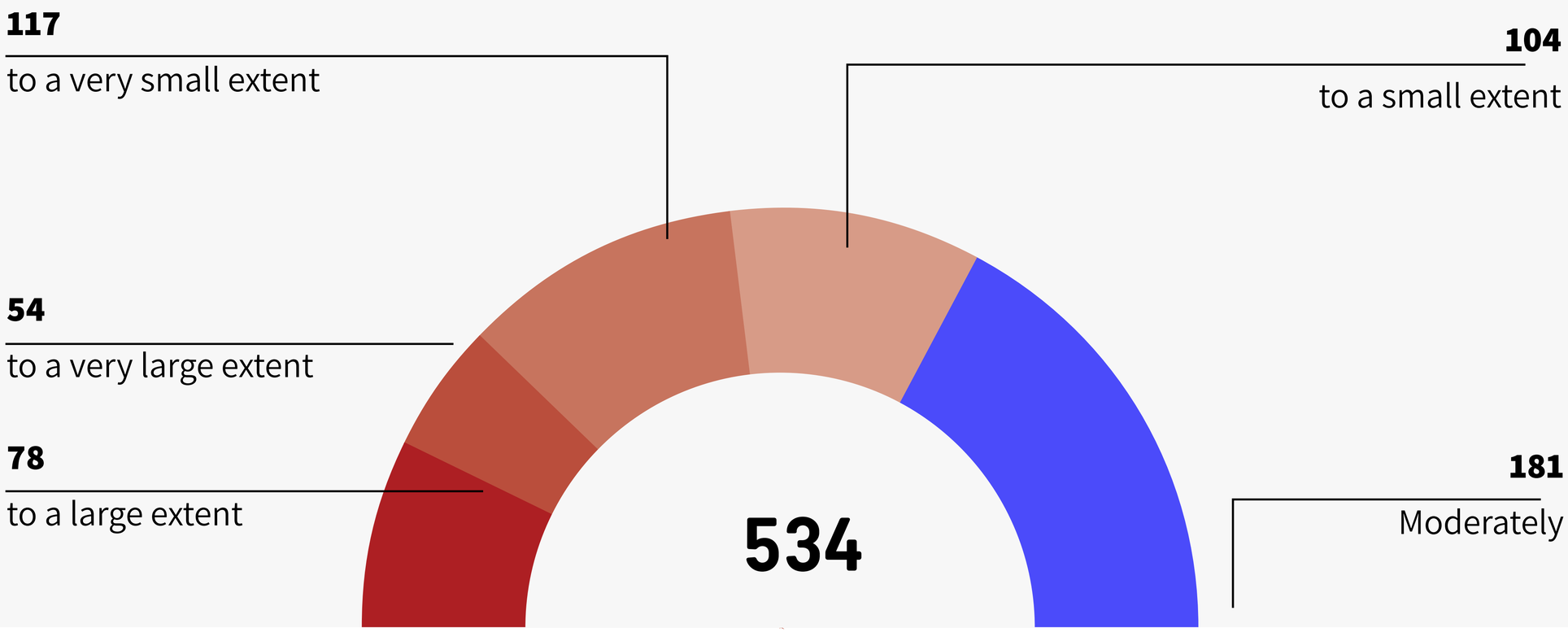
various legal provisions governing the employment of migrant workers in the homecare sector. In this chapter, we will divide the risk factors into **four categories**: risks arising from the nature of the work (loneliness, boredom, the patient's dependence on the caregiver); risks stemming from the 24/6 employment model at a minimum (long working hours, sleep deprivation, lack of free time, absence of defined rest hours, food shortages, lack of access to medical services in Israel); risks stemming from the attitude of the patient and surrounding environment (abuse, sexual harassment); and risks arising from regulations and legal status in Israel (brokerage fees, non-payment of wages, employer replacement).

Risks Arising from the Nature of the Work

Caregivers often report experiencing isolation, loneliness, and a sense of invisibility. There is no clear boundary between working hours and personal time—caregivers do not leave for work; rather, they wake up to it. In most cases, they have no designated free time and are expected to be available for requests and demands from their employer, with their working hours stretching to 24-hour availability, six to seven days a week.

According to the survey, about one-third of respondents indicated that their mental well-being was moderately affected by their work, while a quarter of them stated that their condition was significantly or severely impacted. In this chapter, we will examine the risks associated with the category of psychosocial hazards that stem from the nature of the work, which affect caregivers' mental health and influence their job performance both in the short and long term.

To what extent is your mental state negatively affected by your work?
(directly or indirectly)



A. Loneliness

One of the psychosocial risk factors stemming from the nature of caregiving work is loneliness, as home-based care is inherently performed in the patient's home. As a result, the structural working conditions in this sector involve significant isolation, as caregivers do not share their work with additional staff members[32]. As noted in one of the previous studies we relied on, "domestic work is carried out in private spaces, likely in the greatest isolation in human history."[33] Additionally, caregivers often experience a deep sense of loneliness due to their foreign status in a new country, the geographic distance from their families and homeland, and cultural differences that create a built-in sense of isolation.

> R., a caregiver from the Philippines, said: *"I'm in a good place, but the reason for my loneliness, or maybe sadness, or maybe both, is the fact that I'm in a new country, dealing with a different culture, different customs, and carrying the burden of responsibility in my work."*

One of the biggest differences between working in a home setting versus a nursing institution is the aspect of loneliness. When a caregiver is employed in an institution, they work alongside team members who share the workload, provide advice, and offer an outlet for sharing difficulties. In contrast, home-based caregiving is carried out in complete isolation, without professional colleagues, guidance, or support. Moreover, loneliness also stems from policies that treat migrant caregivers as temporary residents[34]. One of the fundamental conditions for a migrant worker's entry into Israel is that they do not have a spouse or children in the country. Regulations further prohibit them from forming romantic

32 Folbre, N. (Ed.). (2012). For Love and Money: Care Provision in the United States. New York: Russel Sage Foundation.

33 Arat-Koc, S. (1989). In the privacy of our own home: Foreign workers as solution to the crisis in the domestic sphere in Canada. Studies in Political Economy, 28, 33-58.

34 Ayalon L. (2010). Intention to leave the job among live-in foreign home care workers in Israel. Home health care services quarterly, 29(1), 22–36.

relationships, and there are strict restrictions on childbirth and raising children during their employment in Israel[35]. As a result, beyond loneliness being a psychosocial risk factor, it may also affect caregivers' performance and the quality of care they provide. This feeling of isolation can be intensified in cases where a close bond with the patient does not form due to various reasons, such as working with non-verbal patients.

R., a caregiver from the Philippines, shared: *"The patient doesn't speak at all… and if I talk to her, she just repeats what I say… so I just let her sit, and after two hours, every two hours, I take her to the bathroom. That's why, before I had internet access, I felt so lonely and so bored."*

B. High Dependency on Employers

Another risk factor stemming from the nature of the work is the caregiver's high level of dependency on the patient and their family. As previously mentioned, the employer is the patient, and the workplace is the patient's home, which also serves as the caregiver's living space. This work environment is foreign and isolating for the caregiver, lacking internal monitoring or supervision mechanisms regarding the employer's treatment of the worker. The job itself is physically demanding and consists primarily of providing personal care to another individual. This employment structure creates scenarios that are uncommon in other professions: concerns over privacy invasion and personal life interference (who the caregiver talks to on the phone, who they go out with), excessive supervision (restrictions on water use, bathroom access, phone usage, food consumption), blurred lines between work and rest hours, endless tasks, lack of boundaries, constant readiness, insufficient sleep, vulnerability to exploitation, and more. As will be discussed further, the inherent dependency in this type of work exposes caregivers to risks of economic, physical, and psychological exploitation, and sometimes even violence—including sexual violence in extreme cases.

35 See, for example: Ilan Lior's article, The State Acts to Prevent Romantic Relationships Between Migrant Workers – Haaretz, 2017.

While the dependency in the caregiving relationship between a migrant worker and a patient can be seen as mutual—the patient and their family rely on the caregiver for daily tasks, and she, in turn, enables their well-being—it is evident that most employers have access to support systems that the caregiver does not have (even if these systems are insufficient). This dependency often extends to emotional dependency and blurs the line between work and family, with the caregiver being regarded as "part of the family." If she wishes to leave, the patient and their family may perceive it as abandonment of the employer, even though it is her full right.

> M., a caregiver from the Philippines, shared: *"I don't feel (job) security at all... maybe 90% or 80% because my visa is for five years, and my stay in Israel depends on my employer."*

C. Lack of Privacy and Invasion of Privacy

Another challenge arising from working in the patient's home is the lack of privacy. Families often install cameras in the home to address concerns about potential neglect or abuse by the caregiver. However, beyond this, the very nature of performing work in the patient's home places caregivers under constant surveillance, blurring the lines between personal and professional life, as well as between private and shared spaces. These factors further increase the vulnerability of already at-risk workers, exposing them to potential exploitation, as will be discussed later. While placing cameras in caregivers' private rooms is prohibited, there have been cases where patients' families have installed cameras in these areas as well. In many instances, due to the small and intimate nature of the patient's home, caregivers are forced to live and operate in shared spaces without privacy.

> R.S., a caregiver from the Philippines, shared: *"I don't have a problem with the camera, I don't mind, because I know I'm not doing anything wrong, but why did they put the camera in my room? What about my privacy? I told the family that I don't mind if they put cameras everywhere in the house, but not in my room, please, I told them. But they even put a camera in the bathroom."*

G., a caregiver from the Philippines, shared: *"My employer didn't want me to use my phone. I have two hours in the afternoon when I stay in my room, but she doesn't want me to call or do video calls, because she says I'm spying on her for Arabs or soldiers in Israel. There was one time when she wanted me to go to Russia and talk to Putin. So I don't talk to my kids much, I only talk to them on Fridays when it's my day off. I only started going out for my two-hour rest after six months with her, because if there's an emergency, I can't talk to my children."*

2. Risks Related to the 24/6 or 24/7 Employment Model in the Patient's Home

A. Long Working Hours

Protective labor laws in Israel state that labor laws apply to all workers, regardless of their status or position in the country, as long as an employment relationship exists. The Hours of Work and Rest Law, 1951, defines and regulates, among other things, the length of the working day, weekly rest, overtime work, and breaks. However, the Supreme Court ruling in the Gluten case determined that the law, in its current form, cannot be applied to home caregivers[36]. The case was brought by Kav LaOved on the issue of compensation for overtime work, and despite the Supreme Court's instruction to the state to promote a more tailored regulation for the home caregiving employment model, after 15 years, no such regulation has been adopted, and workers are still employed 24 hours a day in the patient's home without special compensation or legal regulation of working hours.

The use of the term "24-hour employment" refers to a person's work (not in a shift format) without predefined rest or regulated breaks. The round-the-clock employment pattern that has become the standard in the homecare sector in Israel contributes to dehumanizing the workers and allows the family to demand continuous work from them, 24 hours a

36 HCJ 1678/07 Yolanda Gluten v. National Labor Court, P.D. 63(3) 209 (published in Nevo, 29/11/2009) (Gluten case).

day. Additionally, long working hours **contribute to burnout, and studies have shown, for example, that working more than 55 hours a week increases the risk of stroke by 35%, and the risk of ischemic heart disease by 17%[37]. Needless to say, being available 24 hours a day, only amplifies these risks**.

In a specific case that came to our attention, a worker was required to do laundry, clean, and wash dishes not only for the elderly woman she was caring for but also for the woman's two sons, daughter, and son-in-law. When she refused to continue after a year and a half of work, the daughter responded, "You work here 24 hours." When the worker reminded her that she did not work 24 hours a day, the daughter filed a complaint with the Population and Immigration Authority.

B. Sleep Deprivation

According to the literature, a lack of sleep negatively affects both mental and physical functioning. When a person does not get the necessary amount of sleep regularly, this **can sooner or later lead to weight gain, high blood pressure, diabetes, depression, heart disease, and sometimes even a stroke**. Sleep deprivation can also lead to **high anxiety, irritability, unstable behavior, impaired cognitive function, reduced daily functioning, and even psychotic episodes. Chronic sleep deprivation has a detrimental effect on the brain and cognitive performance.[38]**

According to the survey findings, about 53% of the respondents reported getting 6 hours of sleep or less, 27% reported getting only 4-6 hours of continuous sleep, 11% reported getting at least 8 hours of continuous sleep, and 9% reported getting less than 4 hours of continuous sleep at night. From our experience, sleep deprivation is one of the main complaints of migrant workers in the caregiving industry, and it is also one of the most

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37 See: David Ziv, "World's First Study of Its Kind: Long Working Hours Increase Deaths from Heart Disease and Stroke," Institute for Safety and Hygiene, 22/8/2021.

38 Khan MA, Al-Jahdali H. The consequences of sleep deprivation on cognitive performance. Neurosciences (Riyadh). 2023 Apr;28(2):91-99.

common reasons for resignation. Some employers dismiss these complaints, arguing that availability during the night is part of the job duties (for example, assisting the patient to the restroom, or patients with cognitive decline characterized by frequent awakenings).

G, a caregiver from the Philippines, shared: *“After two weeks with her, I noticed that she didn’t sleep at night. She would wake up at 11 or 12 and stay awake all night. Sometimes, she would go to the lobby to ask someone to take her. The family didn’t bring her medication for her illness, even though she had a prescription from 2012. She didn’t get the treatment she needed... During the year I worked there, I only had 2-3 hours of sleep, and I always had a fever. I wanted to earn money, so I didn’t take a break... When I returned to the Philippines, I fainted and didn’t wake up for 10 minutes... The doctors told me I needed to rest... After that, I asked to take my day off every week. But I still didn’t sleep enough, and when I stood up, I was dizzy; everything was spinning. Once, I fainted for 30 minutes, and then the employer didn’t want me to come back because she was afraid it would happen again.”*

D, a caregiver from the Philippines, cared for a woman who had been bedridden for 16 years, did not speak, was unable to feed herself, and had a complex medical condition. She shared: *“After two weeks of working with the elderly woman, her husband returned... from the hospital, after having both legs amputated... He called me every five minutes, and when I didn’t come, he complained to his son that I wasn’t taking care of him. So now I’m taking care of two elderly people, the woman and the husband... When I said that I wasn’t sleeping well, that I was always dizzy, the elderly man said he didn’t want to sleep... The social worker told his children they need two caregivers, and when I said I wanted to leave, they threatened to call the police...”* After four months, D left the family.

S., a caregiver from the Philippines, asked her patient's son for help at night because the patient cried out in pain, and she eventually collapsed due to sleep deprivation: *"I told the son that I hadn't slept for three nights, and if no one came to replace me, I wouldn't be able to continue working... He couldn't find anyone. I couldn't just run off and leave the elderly woman crying at night. No one in the family would take over from me. I only asked for someone to replace me at night. But they have three children… they have no time at all. So what happens? The caregiver is responsible for everything."* The result was increasing stress, resentment, and anger, and after a long period during which the relationship deteriorated, S. resigned and sued the family in labor court.

C. Lack of Control Over Time and Space

In addition to the risk factors detailed above, another significant risk stemming from the employment model for migrant caregivers is the lack of control over time and space. Caregivers who reside in the patient's home and are required to be available around the clock struggle to manage their time according to their own needs. This includes scheduling medical appointments, social gatherings, annual vacations to visit family, emergency leave (such as in the case of a death or illness in the family), and more. The inability to control their schedule and manage their life independently can negatively impact their sense of capability and self-worth. In extreme cases, when combined with the other risk factors outlined below, it may even lead to a state of learned helplessness.[39]

M., a caregiver from the Philippines, shared his experience of lacking control: "I don't like going to the hospital because the family thinks they bought the caregiver. They ask him to sleep at the hospital without a shower or food. I'm not a robot; I'm a man."

39 In this regard, see for example:
Jayne Leonard, medically reviewed by Lori Lawrenz, PsyD, What is learned helplessness?, Medical News Today 9/12/2024.

Learnedhelplessnessisapsychologicalstateinwhichapersonperceivesthemselvesaspowerless and incapable of coping due to repeated experiences where they feel they have no control over negative events affecting them. Individuals experiencing learned helplessness are at a higher risk of developing depression, anxiety, and difficulties in adapting to and functioning in new and stressful situations. Moreover, those affected by learned helplessness tend to have lower motivation as they struggle to believe in their ability to achieve or improve their performance. This condition can also make it difficult for workers to adhere to treatment routines or maintain a healthy lifestyle due to their lack of belief in the possibility of change or improvement.

D. Lack of Free Time

The employment structure for migrant workers in the home care sector is, as stated, 24/6, with workers residing in the patient's home. Employment permits for migrant caregivers are only granted under this framework. As a result, this structure inherently leaves caregivers with little to no free time for relaxation and personal respite.

According to the literature, a low number of rest days negatively affects mental health. The social and health consequences of lacking free time have been widely discussed in Israeli[40] and international research[41]. The Israeli Institute for Occupational Safety and Hygiene has shown that work-home conflicts are highly likely to contribute to severe burnout.[42] As part of the International Labor Organization's Centenary Declaration on June 21, 2019, all member states issued a joint statement addressing the future of the labor market. Among other things, they emphasized the need for a better work-life balance (free time) by encouraging workers and employers to negotiate solutions, including work hours, that consider the needs and benefits of both parties.[43]

40 See for example: Dr. Hani Ofek-Gandler (currently a judge at the National Labor Court), "'Anucha' - Between Work and Rest in the Digital Age, TAU Law Review 50(1) 2017.

41 Eshak, E.S. Mental Health Disorders and Their Relationship with Work-Family Conflict in Upper Egypt. J Fam Econ Iss 40, 623–632 (2019). https://doi.org/10.1007/s10834-019-09633-3

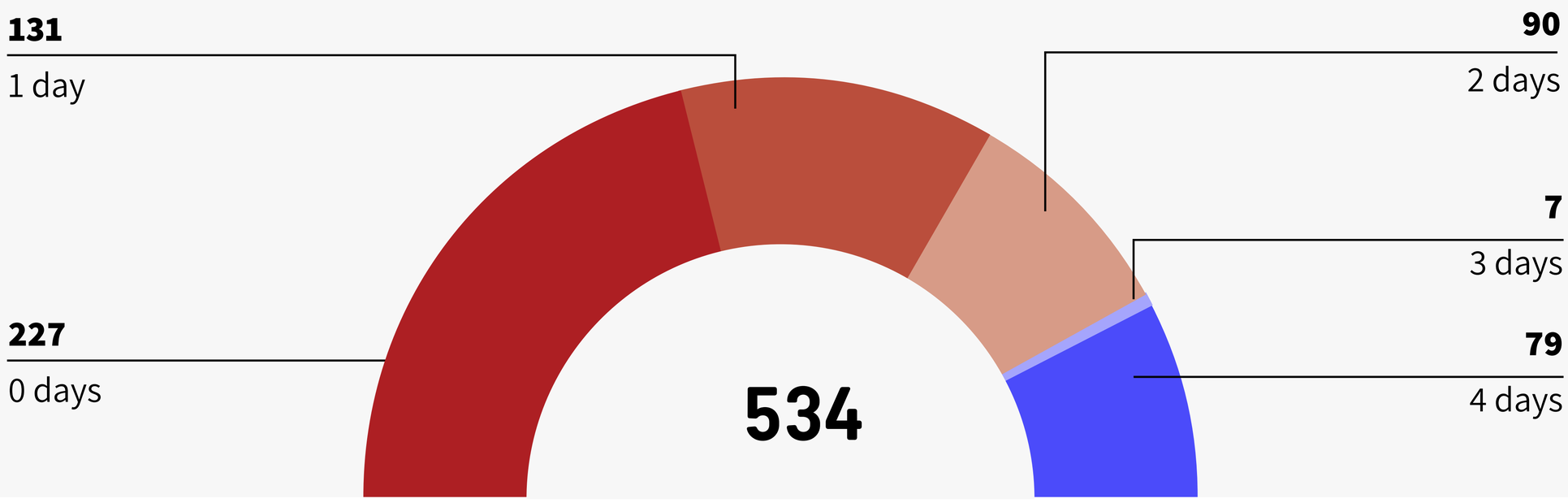
42 Dr. Laliv Egozi, Dr. Asher Pardo, "Vocational Survey and Occupational Health 2023," The Institute for Occupational Safety and Hygiene, January 2024.

43 ILO, ILO Centenary Declaration for the Future of Work, 26/6/2019.

Nevertheless, the employment structure of migrant workers in the homecare sector, as well as the recruitment and immigration process to Israel, creates a market failure that effectively prevents obtaining an employment permit, except under the 24/6 model. The recruitment process and high brokerage fees compel workers to agree to work even on their designated rest day to repay their debts. According to testimonies we have received, some patient families do not allow caregivers to take their weekly rest day and require them to work regularly on that day. Additionally, some workers, desperate for any extra income—partly due to the high brokerage fees they paid to come to Israel—voluntarily forgo their rest day, as will be further illustrated.

This is also reflected in the survey findings, where a significant percentage of workers reported having zero rest days per month (42%), while another 42% reported having only 1-2 days off per month.

How many rest days do you have per month?



Sh, a caregiver from the Philippines, shared: *“When I started working even on Fridays and Saturdays, she started saying I don’t deserve a break because she is paying me... Until today, if I need a break, I take one every 2-3 months... If I even talk about taking a break, she makes the environment unbearable... I haven’t taken sick leave or anything like that for almost two years, only very few free days that I can count on my fingers... I’m also a person; I get tired, I don’t feel well, I’m sick, and all that, but she doesn’t understand it;*

she's not sympathetic or anything like that; she doesn't understand my situation. And still, this is my last job; I can't change because I have been here for over 4 years and 3 months. Honestly, sometimes it's very, very difficult mentally, physically – it's nothing – but mentally, I'm trapped here. I really feel trapped."

E. Food Shortage

Living in the patient's home, as mentioned, gives the patient control, and in extreme cases reported at Kav LaOved, one of the areas where control can manifest is over the worker's food, which can lead to significant distress. According to testimonies, some employers do not allow workers to bring in food that they purchase themselves (this is often related to keeping a kosher home); some employers limit the amount of food their caregiver is allowed to consume and even forbid them from eating some of the food available in the house (especially food considered expensive, such as meat, fish, and fruits); some demand that the worker only eat the food they prepare for the patient (without spices or salt) and prohibit spices from their home country. For example, one of the workers who contacted Kav LaOved shared that she lost 9 kilos in the months after starting her job in Israel.

D, a caregiver from the Philippines, shared: *"I once asked, 'Can I take a banana?' because I was so hungry and exhausted. 'Okay, take one,' he said. Then, while I was holding the banana, he added, 'Then Ruthie will kill you.'"*

The lack of privacy and intrusion into personal life, along with increased supervision and the absence of boundaries, extend even to the dining area. Beyond the physical consequences in cases of inadequate nutrition, the issue of food becomes a point of contention with patients, causing much distress and mental strain for workers.

G, a caregiver from the Philippines, shared: *"She doesn't want me to cook there. So I only eat outside. There's a Filipino woman at the nursing home who cooks, and I pay her 25-30 shekels to eat. In the morning, I eat just bread and drink coffee. For dinner, I also order*

from her. Every day, I spend between 50 and 60 shekels on food. At first, it was okay, but after two or three months, the smell bothered her, even though it was just tomato sauce, which she also eats."

F. Difficulties in Access to Healthcare Services

The Foreign Workers Law, 1991, stipulates that migrant workers must be covered by health insurance funded by the employer. However, the insurance is purchased from private insurance companies and not through the National Health Insurance Law, 1994, under which the policyholder is the employer, not the worker. The health services covered by the private insurance companies are not as comprehensive as those available to individuals covered under the National Health Insurance Law, such as the lack of coverage for pre-existing medical conditions. Furthermore, the worker has no control over their insurance. A worker cannot insure themselves if the employer violates their obligations under the Foreign Workers Law, but only during the transition period between employers (and even then, the worker is allowed to insure themselves for only up to 90 days, with no possibility of an extension)[44].

Moreover, if the worker's medical condition deteriorates to the point where they can no longer continue the work for which they were brought to Israel for more than 90 days (according to the determination of an occupational physician), the insurance company is entitled to terminate their health insurance due to loss of work capacity. In such cases, the worker will only be entitled to a return flight ticket to their country of origin. In cases where the worker has been employed in Israel for more than 10 years, and an occupational physician determines that they cannot work for more than 90 days, they will be entitled to a one-time compensation from the insurance company, which is currently approximately 90,000 shekels. However, this is conditional on them leaving Israel and returning to their country of origin. In effect, the State of Israel exports the financial and social burdens

44 In this regard see: Neta Moshe, "Healthcare Services for Foreign Workers and Stateless Individuals," Knesset Research and Information Center (11/6/2013).

associated with the care of a worker who has fallen seriously ill or been severely injured, back to their country of origin, often leading to a disruption in continuity of care and denying life-saving treatments.

Furthermore, although the worker technically has the option to activate their insurance and seek medical treatment or undergo routine screenings, many workers refrain from doing so, partly due to the lack of free time, the intense need to earn a living and repay debts, as well as language barriers in accessing health services and other essential services that are provided only in Hebrew and are therefore not accessible to diverse populations. Additionally, workers often lack familiarity with the bureaucracy required to make appointments and receive services in Israel, in contrast to the systems in their countries of origin.[45]

In response to one of the posts on Kav LaOved's Facebook page regarding the importance of early cancer detection, a caregiver replied: *"Thank you for the support and the suggestion, but the healthcare system is so slow. We have to wait a month or more for an appointment, and after getting an appointment, we have to wait a long time for the results. Due to a lack of time, we often give up on the tests halfway through and suffer."*

G, a caregiver from the Philippines, when asked if she had any recommendations for improving the protection of caregiving workers in Israel, said: *"...When you go to the clinic, you need an appointment and to schedule a time. Even if it's an emergency, you still need to arrange an appointment. This happened to me. When I went to the Clalit clinic in Kfar Saba because of chest pain, they asked me if I had an appointment and then told me to schedule one, but all the doctors were fully booked. Only when I fainted did they send me an ambulance. But at the clinic, you need an appointment first. In the Philippines, you can just go, wait a little, and then they take you in. But here, everything is scheduled."*

45 Ayalon, L. 2008.

3. Risks Arising from Patients' Behavior and the Environment – Workplace Harassment, Violence, and Sexual Assault

Since the caregivers' workplace is in their patients' homes, which also serve as the caregivers' residences, there is a blurring of boundaries between the private and shared spaces. This leads to increased vulnerabilities to workplace harassment, sexual harassment, and, in extreme cases, various forms of violence.

Our survey found that 44% of the respondents reported experiencing workplace harassment or abusive behavior. That is nearly half of the caregivers experiencing harm in their workplace. Of those, 63% reported that they were harmed by their patients, 18% by their patients and their family members, 17% solely by family members, and 2% by others in their workplace environment (neighbors, representatives from the PRPA, or other individuals). These caregivers are not provided with any support, protection, or assistance in coping with or preventing the harmful behavior, and many are forced to continue working with their patient for the reasons mentioned earlier.

In addition to abusive behavior and workplace harassment, 36 respondents to the survey reported experiencing sexual harassment from one of the parties involved. Of these, 50% were harassed by the patient (18, half of the respondents). This constitutes criminal behavior that significantly impacts the caregivers' well-being, occupational health, and ability to continue working in the same environment. Although they represent only 6% of all respondents to the survey, there is significant underreporting on this issue, as many workers do not file complaints regarding sexual harassment or assault that they experience.

The underreporting and inadequate handling of sexual harassment/assault of caregiving workers has been raised for many years in discussions in the Knesset and various studies. For example, in a discussion held over a decade ago in the Parliamentary Subcommittee on the Fight Against Trafficking in Women, it was noted that migrant workers rarely file complaints despite their high level of vulnerability and that violence and sexual assault are a "common phenomenon" in the caregiving sector. This includes violence from patients with Alzheimer's and dementia,

violence from patients' family members and friends, as well as sexual harassment and assault by male patients and their family members.[46]. However, even though the background to verbal or physical violence may often be related to the medical condition of the patient and whether they are receiving appropriate medical care, this does not justify the abandonment of the workers. The issue was raised again in recent years by the Special Committee on Foreign Workers, where it was also suggested that caregiving workers who experience sexual harassment or assault should be given a real opportunity to recover and receive proper treatment instead of being immediately sent to a new employer or back to their country of origin.[47]

According to data received from the Population and Immigration Authority under the Freedom of Information Law of 1998, in 2023, 96 complaints were filed with the Chief Supervisor of Social Workers at PRPAs regarding suspected sexual harassment/assault of migrant workers in patients' homes. Of these, 33% were related to a patient's family member (32 out of 96), and 67% were related to the employer/patient (64 out of 96). The Chief Supervisor received all complaints through social workers from PRPAs. As a result of the complaint, 75% of the workers ended their employment with their employer (72 out of 96). The Population and Immigration Authority imposed sanctions on only 16 employers, with permits revoked in 10 cases, while in 6 other cases, the permit was restricted to employing male workers only.

Migrant workers are in Israel on their own, disconnected from their homeland, and unfamiliar with local customs, language, labor laws, and other legal frameworks (such as the law prohibiting sexual harassment). They are burdened by the need to repay loans taken to cover brokerage fees, live and work in their employers' homes, far from any oversight. Therefore, the low number of complaints does not reflect a low rate of abuse but rather stems from continued underreporting and unaddressed cases of rape, assault, and violence among caregiving workers.[48]

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46 Gilad Natan, (2010) Sexual Offenses Against Foreign Workers, Knesset Research and Information Center.

47 See, in this regard, the statements of Adv. Meytal Russo, former Head of Kav LaOved's Migrant Caregivers Department, and Adv. Dina Dominitz, National Coordinator for Combating Human Trafficking and Polygamy at the Ministry of Justice, during the Special Committee on Foreign Workers' "Follow-up Meeting on Authorities' Handling of Sexual Violence Against Foreign Workers," held on 21/2/2022.

48 Also see Kav LaOved's position paper Prevention and Handling of Sexual Offenses Against Migrant Workers in their Employment, 18/10/2021.

4. Risks Related to Legal Status (Worker Rights, Residency Conditions)

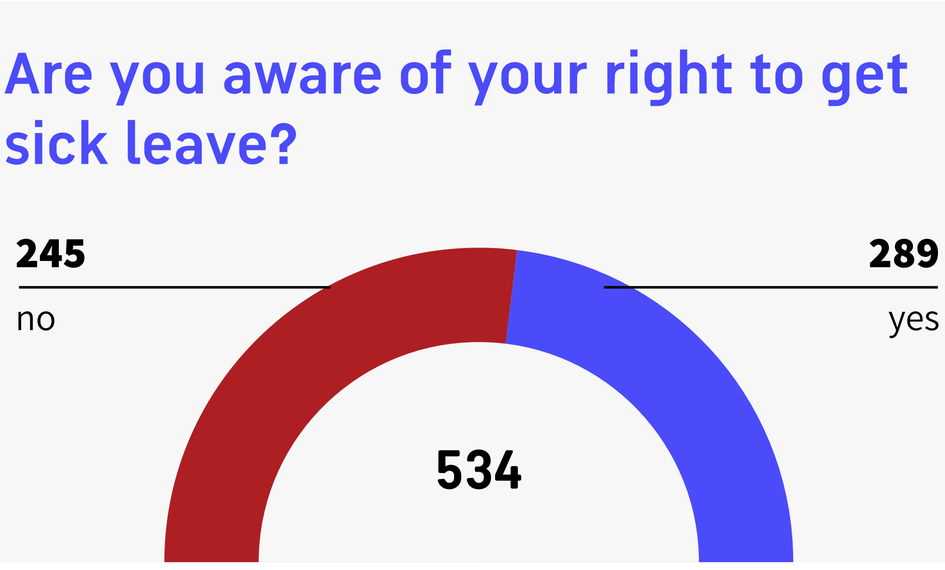
A. Low Awareness of Rights, Difficulties in Enforcing the Law

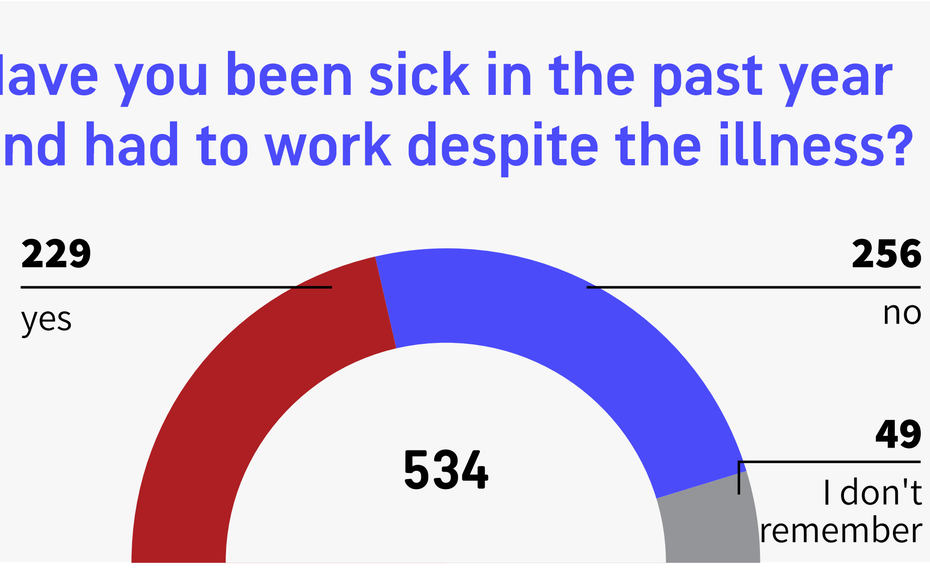
In addition to the challenges in accessing healthcare services mentioned above, caregivers in Israel are often unaware of the available legal framework in Israel or their labor rights due to a lack of training and information. In addition to the insurance requirement mentioned earlier, the Foreign Workers Law regulates other employment conditions for migrant workers and the duties of their employers, such as providing a written contract in the worker's language. Israeli labor protection legislation establishes the social rights to which workers are entitled, such as the right to sick pay, annual leave, the right to receive a pay slip, compensation for delayed wages, and more. Despite this, many workers are unaware of their right to paid sick days or avoid taking sick days to prevent leaving their patients without a replacement.

The literature indicates that the phenomenon of "presenteeism" (working while sick) is prevalent and depends on various factors such as industry and gender. For example, a recent study shows that presenteeism is more common among women, partly due to their sense of responsibility towards work and colleagues' workload and fear of accumulating tasks. Additionally, various stressors, such as job insecurity, can lead workers to come to work even when they are ill.[49]

According to the survey findings, the phenomenon of presenteeism appears to be common among migrant workers in home care. About half of the respondents (46%) were unaware of their right to paid sick leave, even though 43% of them reported being sick in the past year. Despite their health conditions, workers reported continuing to work.

49 Haim Bleikh, Working While Sick: The Phenomenon of Presenteeism in Israel, Taub Center, December 2024, pp. 8-10.





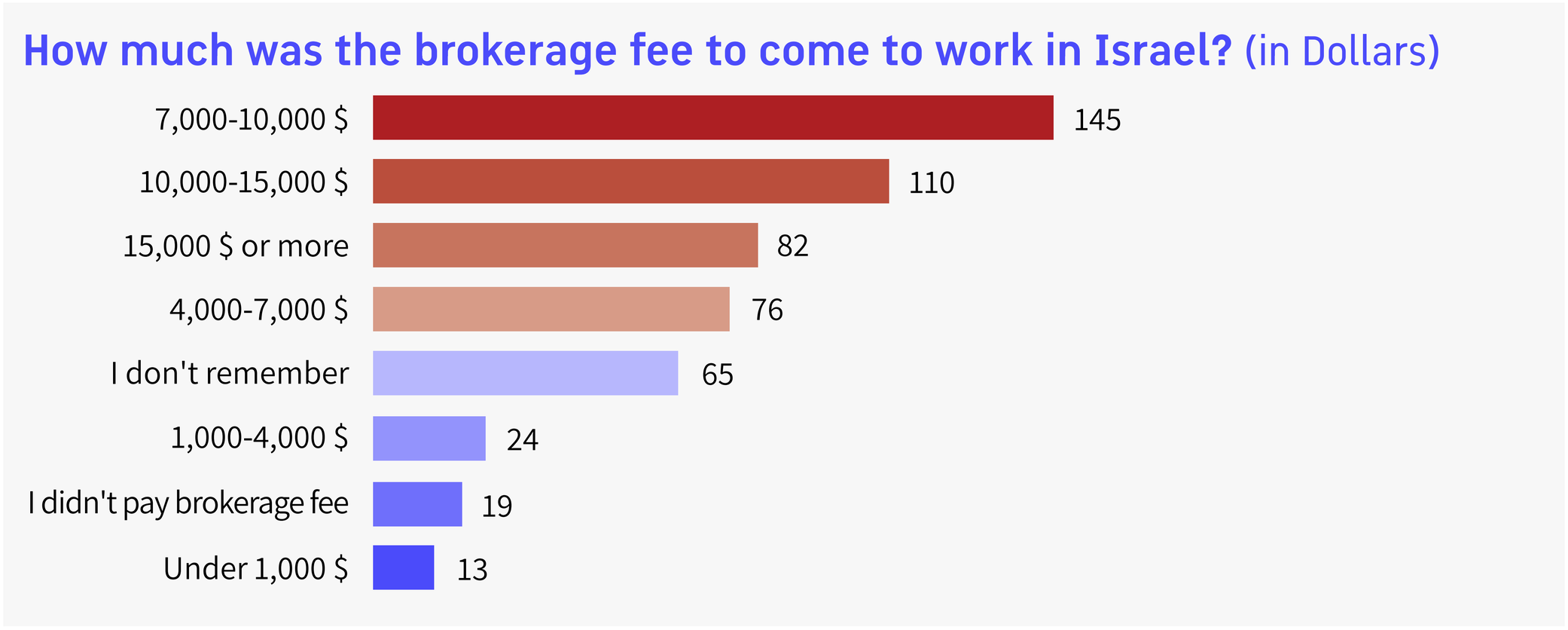
For example, G., a caregiver from the Philippines, shared that one day, she fainted for over 30 minutes at her employer's house and was taken to the hospital. When she was discharged from the emergency room, they told her she needed to rest. The cause of her fainting was work-related – G. had been working for over a year at the patient's home, almost without any sleep. As a result, the employer fired her. *"The trigger for this was the lack of sleep and stress... The doctor in the emergency room told me the same thing. He said I needed to go to the Clalit Health Services and get a sick note. But when I returned to the patient's home, she told me she no longer wanted me because she was afraid this would happen again..."*

B. Brokerage Fees

In the caregiving sector, which employs about 45% of all migrant workers residing in Israel on a visa[50], there is currently only one active bilateral agreement for Sri Lankan workers. Other workers are recruited through private agencies in the country of origin that coordinate with licensed PRPAs in Israel, which recruit the candidates for work in Israel. The process of finding workers is not regulated and leads to migrant caregivers paying exorbitant and illegal brokerage fees directly to the agency in their country of origin. As a result, upon their arrival in Israel, workers are in significant debt, which forces them to work more to earn

50 See chart 5, Population and Immigration Authority, Data on Foreigners in Israel, Edition No. 3, October 2024.

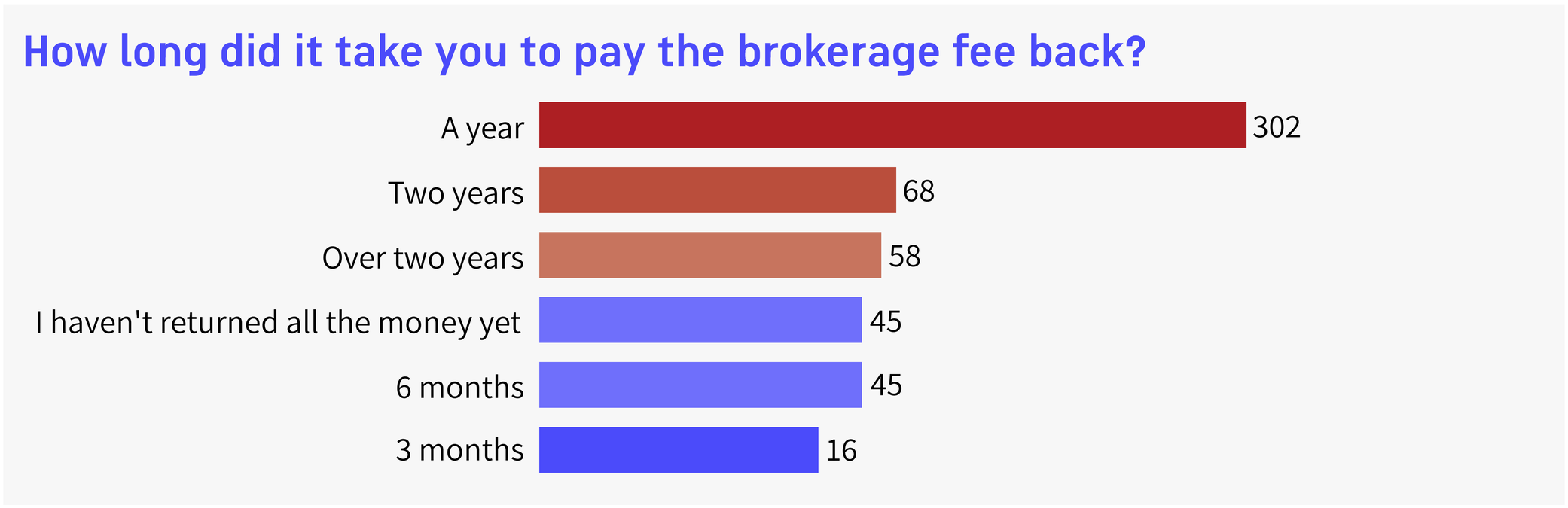
higher wages and, of course, creates substantial psychological distress. Workers who pay brokerage fees (as mentioned, almost all caregivers) may end up being coerced laborers.[51]



As can be seen above, according to the survey findings, based on workers' reports, up to October 7th the brokerage fees paid to come to work in Israel were as follows: 27% of the respondents reported paying between $7,000–$10,000 (145 out of 534), 21% paid between $10,000–$15,000 (110 out of 534), 15% paid over $15,000 (82 out of 534), 14% paid between $4,000–$7,000 (76 out of 534), and the remaining 23% either did not remember, did not pay, or paid less than $4,000 (121 out of 534).

About 57% of the workers reported that they managed to pay back the brokerage fees within a year, but a significant portion indicated that it took them longer to repay the debts they incurred to come to work here. Over 10% mentioned that it took them more than two years of hard work in Israel before they could repay the brokerage fees.

51 Hana Kupfer, Human Trafficking: Current Trends, Detection, Identification, and Treatment Methods, Population and Immigration Authority, March 2018.



The result of paying brokerage fees is an increase in inequality and power imbalances between worker and employer due to a significant fear of dismissal and an inability to bear a period of unemployment. These difficulties further weaken the workers' ability to take care of their social, occupational, health, and mental needs, thus exacerbating their dependence on their employer. The need to repay the debts incurred by the worker due to the brokerage fees essentially forces the worker to agree to work under more difficult conditions in order to repay the debt. For example, as mentioned above, high brokerage fees encourage workers to forgo their right to take time off in order to increase their salary or to work while sick and not utilize sick days. As stated, a low number of rest days negatively impacts mental and physical health and affects the workers' performance. These risk factors likely contributed to the 81% who reported developing health problems resulting from their work.

Conclusions and Recommendations

This study indicates that the work patterns of migrant workers in the homecare sector may have implications for their health. They are exposed to economic exploitation, sexual exploitation, practices that exploit their labor resources without limiting working hours, psychological violence, food scarcity, physical harm due to work overload, and burnout. Additionally, institutional and social barriers prevent migrant workers from using legal means to protect themselves. They may face challenges in accessing healthcare services and other essential services due to language barriers and their status as migrants.

Due to the complexity of the work, one might expect the State of Israel to ensure proper training for caregivers, inform them about the risks they are exposed to, and guarantee the provision of personal protective equipment to ensure their safety and health while working. However, according to our survey, over a third of the respondents indicated that they did not receive training on the risks they face in their work, training, or equipment for lifting patients, nor did they receive protective equipment against chemical or biological hazards. An additional third reported not receiving training on harmful materials they might work with or any protective equipment.

Due to the interdependence between migrant caregivers and people in need of care, the essential nature of their work in the homecare sector, and the lack of alternative solutions for elderly and disabled individuals in Israel, one would expect the state also to promote policies that benefit migrant caregivers—establishing mechanisms to ensure their safety and health, as well as advancing their rights to rest and access healthcare services during their employment in Israel. Simple logic suggests that in the caregiving sector, the well-being of both the workers and their employers is closely linked. They are not opposing sides but rather partners in a shared effort to improve care and mutual well-being. However, contrary to this logic, the state's policies treat these workers as invisible, disregarding the impact of their work on their safety and health.

In light of this, we recommend policy changes to reduce risk factors and improve the protection of the health and safety of migrant workers in the home care sector in the following areas:

A. Promoting Prevention:

1. Raising Awareness:

- **Among the Workers:** Information should be disseminated through PRPAs and caregiving manpower companies, and any other means (such as social media advertisements and dedicated applications) to educate workers on the importance of periodic medical check-ups, raise awareness of risk factors, and inform them of their rights in relevant languages.

- **Among PRPAs and caregiving manpower companies:** It should be mandatory for these entities to report to regulators after home visits regarding the physical workload imposed on caregivers, the protective equipment provided to them, existing risk factors, and whether they are able to sleep at least seven consecutive hours per day and utilize their weekly rest period. Additionally, a quick weekly review mechanism should be established to assess key issues such as the patient's functional status, availability, and condition of protective equipment.

- **Among Patients and Their Families:** Awareness should be raised regarding various risk factors, their obligation to provide workers with protective equipment, and their duty to allow weekly rest, breaks, proper meals, and access to medical check-ups. Families should be encouraged to assist workers in scheduling medical appointments, purchasing or renting ergonomic equipment to prevent musculoskeletal injuries52 and be made aware that the worker's role is to care for the patient, not to serve the entire family

2. Professional Training and Matching Workers to Patients:

- The state must ensure that migrant caregivers receive the same training and

52 The Institute for Occupational Safety and Hygiene, Safe Work Guidelines for Caregivers in Geriatric and Nursing Departments, September 2017.

instruction provided to Israeli caregivers by caregiving manpower companies. Additionally, occupational safety and health (OSH) topics and workplace risk factors should be incorporated into the training curriculum, alongside guidance on risk reduction and the use of protective equipment.

- Efforts should be made to better match caregivers to patients based on functional level, age, weight, and other relevant characteristics. This will help minimize risk factors, particularly ergonomic hazards, to the greatest extent possible.

3. Alleviating Loneliness:

- A structured support system should be established to alleviate loneliness among caregivers. This initiative should aim to reduce feelings of personal, emotional, and social isolation while ensuring access to resources for coping with loneliness and emotional or psychological distress.

4. Annual Leave:

- Caregivers should be encouraged to take their legally mandated annual leave. Employers must be reminded of their obligation to allow caregivers to take their vacation without placing the responsibility of finding a replacement on them.

B. Access to Healthcare Services:

1. Routine Screenings and Periodic Health Examinations:

- **Caregivers should be encouraged to undergo regular health screenings,**[53] funded by health insurance providers. A reminder system should be established to assist caregivers in scheduling these check-ups, considering their limited free time and their 24/6 availability for patients.

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53 In general, this includes hematology and chemistry tests, general urine tests, a doctor's examination, blood pressure, lung function, vision, and hearing. Additionally, once a year, one of the following tests can be performed: ergometry, mammography, gynecology, bone density.

- **Mandatory periodic health examinations should be considered for caregivers at high risk of musculoskeletal injuries.** These exams, conducted by a specialist, would help prevent cumulative damage and the onset of inflammatory conditions caused by common ergonomic hazards in their work environment.

2. Encouraging vaccinations and hygiene training to prevent the spread of diseases:

Similar to the vaccination programs for healthcare students and healthcare system professionals54, caregivers should receive vaccinations and hygiene training to prevent disease transmission—from patients to caregivers and vice versa.

3. Health Insurance:

Increasing the enforcement of the Foreign Workers Law so that employers insure the workers with complete transparency from the first day of employment, providing the worker who has contracted a serious illness or been injured with the opportunity to remain in Israel and receive the life-saving medical treatments they need, rather than exporting the illness to the country of origin.

4. Improving Linguistic Accessibility in Healthcare Services:

Access to medical services should be enhanced for caregivers who do not speak Hebrew. Bureaucratic barriers preventing them from exercising their medical rights should be reduced to facilitate their access to necessary healthcare services.

C. Improving Regulation:

1. Updating the lists of occupational diseases, particularly regarding musculoskeletal disorders.

54 For details on this, see the program information on the Ministry of Health's website here.

2. Adopting and implementing a standard for safety and hygiene in homecare

- (e.g., adapting essential equipment, adjusting the number of caregivers according to the complexity of care or the number of patients, and setting a criterion for mandatory lifting equipment). Regarding this issue, it should be noted that although the Israel Standards Institute has adopted Standard 12296 for manual handling and transferring of people in the healthcare sector, it is currently not a mandatory standard[55]. It must be ensured that the standard is implemented as a binding requirement within the caregiving environment in Israel and applied with the necessary adaptations to home care[56]. At the same time, caregiving manpower companies should oversee the implementation of the standard through supervision.

3. Working Hours and Rest:

- **Regulating the framework of working hours and rest periods** within in-home caregiving (ensuring workers' rights to uninterrupted sleep, leisure, and rest, shift work arrangements, etc.).

- **Expanding the employment option under the LIVE OUT system,** where the caregiver resides outside the patient's home.

- **Encouraging shift-based work** to allow caregivers time for breaks, refreshment, and rest without shifting the burden onto patients or requiring the caregivers themselves to arrange replacements during their absence.

4. Prevention of Sexual Harassment / Assault:

- Adopting a procedure for cooperation between the National Insurance Institute

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55 Dr. Joanna Geiger, Israeli Standard 12296: Ergonomics - Manual Handling and Moving of People in the Healthcare Sector, The Institute for Safety and Hygiene, 2017.

56 For the implementation of the standard, see the position paper "Implementing an Ergonomic Approach in the Healthcare System," National Council for Occupational Health and the Israeli Human Factors and Ergonomics Association, 13/9/2022.

and the Population and Immigration Authority to share information regarding elderly patients suspected of sexual harassment or assault of Israeli workers before the patient is granted approval to employ a migrant worker in caregiving.

- Clarifying procedures within the Population and Immigration Authority regarding informing the supervisor of Social Workers about sexual harassment/assault, following reports of harassment or sexual assault, and about the results of the administrative investigation process within the authority.

5. Brokerage Fees:

- It is necessary to promote the recruitment of workers exclusively through bilateral agreements in order to prevent the phenomenon of brokerage fees and its consequences.

March 2025

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Worker's Hotline
عنوان العامل

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https://www.facebook.com/MigrantCaregivers