Interpersonal Ties and Health Care: Examining the Social Networks of Filipino Migrant Domestic Workers in Hong Kong

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Abstract

This paper explores the relationship between the social networks of Filipino migrant domestic workers (FMDWs) in Hong Kong and the accessibility of health resources, especially for migrant women. This study primarily draws evidence from ethnographic interviews with 20 FMDWs in Hong Kong. Likewise, this analysis also relied on field notes from participant observations during formal meetings and informal activities. This paper reveals that FMDWs strategically use their strong and weak ties in managing risks and accessing resources for their health and well-being by deciding among their social network who and what to share regarding health concerns. They conscientiously negotiate their rights and opportunities with their employers, who can also provide access to social and institutional resources. Finally, FMDWs participate in conversations and discourses on health-related policies of their home and host countries with their social network. By focusing on the social networks of FMDWs in Hong Kong, this paper conceptually and empirically broadens conversations about how migration becomes a social determinant of health. Moreover, it illustrates how migrant social networks are organized, activated, and mobilized around discourses on state-crafted health policies towards migrant women.

Keywords

Filipino migrant domestic workers; Hong Kong; interpersonal network; migrant health; social networks

Introduction

In April 2019, Baby Jane Allas, a 38-year-old Filipino migrant domestic worker (FMDW) in Hong Kong, was fired by her employer a month after she tested positive for stage 3 cervical cancer. With her dismissal, Baby Jane Allas lost access to subsidized medical services from the Hospital Authority system, which she needed for her daily radiotherapy and weekly chemotherapy sessions (Carvalho, 2019a). Her case became known because of the online fundraiser for her medical and legal expenses set up by her sister and her sister's employer. The fundraising and awareness campaigns helped Baby Jane Allas foot the mounting hospital bills and win in her wrongful termination complaint, as the Labour Department fined her former employer HK$ 30,000 (US$ 3,800) for damages and lost earnings (Carvalho, 2019b).

What Baby Jane Allas experienced does not just illustrate the structural conditions shaping some of the health challenges FMDWs face; it also demonstrates the importance of social networks composed of their relatives, friends, employers, and community in host countries in advocating for and finding solutions to migrant health. More importantly, Baby Jane Allas' case reveals how migrant social networks, beyond their role as conduits for support, resources, and health care among migrant workers, are also organized, activated, and mobilized around conversations and discourses on state-crafted health policies towards migrant workers.

Previous studies have highlighted the role of informal and personal social networks of migrants (i.e., family, friends, and relatives) as a complex social support system for their integration in destination states (Hernández-Plaza et al., 2006). While there have been abundant studies on migrant social networks as nodes for the circulation of resources and support (Collyer, 2005), its role in health and well-being among FMDWs is still under-explored. There are studies on the relationship between migrant networks and health care provision (Hendrikson, 2010). However, there needs to be closer attention to the conversations and discourses about health from the nuanced narratives of the FMDWs, and the complex processes orchestrated by migrant social networks, especially within the realm of interpersonal flows and dimensions of these links, towards the promotion of their health and well-being.

Situated in the growing evidence of the impact of migration on health and responding to the limited studies on the role of social networks in countries of destination, this paper explores the relationship between Filipino migrant networks and the accessibility of health resources, especially for migrant women in Hong Kong. By inquiring into the health experiences and concerns of FMDWs and how their social networks respond to health issues, this paper addresses the following specific research questions (RQs):

> RQ1: How do social networks function for the health of FMDWs?
>
> RQ2: In what ways do they use and organize their social networks for health?
>
> RQ3: What are the opportunities and limitations present in social networks for health among FMDWs in Hong Kong?

This paper starts with the general migrant conditions of the FMDWs and the prevailing socio-economic and political conditions that shape their health experiences, followed by the

conceptual discussion on migrant social networks and a brief section on the methods. The results section looks at narratives on health experiences and concerns of FMDWs, and the discussion section draws insights from how they organize and mobilize their social networks to address their health. The conclusion synthesizes the key insights and implications.

Background of the study

The overseas deployment of Filipino women as domestic workers started in the 1970s as part of the labor export policy of the Philippine government, which aimed to fill in the global demand for contractual workers for heavy industries and household service sector and to respond to the domestic problems of unemployment and inflation (Asis, 1992). Around the same time, Hong Kong experienced a massive economic upsurge, leading to an increased demand for paid household service to fill in the gap of previously unpaid domestic labor of local women joining the city-state's workforce (Wee & Sim, 2005). By the 1990s, about 10% of all households in Hong Kong hired migrant domestic workers (MDWs) (Constable, 1999).

Hong Kong is among the top five destinations for Filipino women as there are around 206,000 FMDWs in the city, comprising more than half of the total population of 386,000 foreign helpers (Census and Statistics Department Hong Kong, 2018; Philippine Statistics Authority, 2019). Like the rest of the 12 million OFWs across the world, FMDWs do not just support their household income, but through their remittances, they also sustain the dollar reserves of their home country. In 2018 alone, OFW remittances amounted to $32.2 billion, accounting for more than 10% of the gross domestic product of the Philippines (Lucas, 2019). As foreign helpers abroad, Filipino women fill the care gap in Hong Kong by servicing roughly 110,000 households and contributing more than $12.6 billion or around 3.6% of the GDP of the territory (Carvalho, 2019c).

The Standard Employment Contract, which regulates the hiring of migrant domestic workers (MDWs) in Hong Kong, outlines the process of renewal and termination of their two-year contracts, their duties and obligations, minimum allowable wage, food allowance, and provisions for accommodations. As of September 2019, the law entitles MDWs to a minimum of HK$ 4,640 (US$ 600) for monthly salary and a monthly food allowance of HK$ 1,121 (US$ 145) (Mok, 2019). With the mandatory live-in arrangement, employers should provide suitable and furnished accommodation for their helpers; and they are also entitled to rest days, statutory holidays, and paid leave (Hong Kong Immigration Department, 2020). Before starting a new contract, the law requires MDWs to return to their country of origin for seven days. When their employers terminate their contracts, they have to follow the two-week rule, which states that they are permitted to remain in Hong Kong for the remainder of the permitted limit of stay or two weeks from the date of termination of their contract (Hong Kong Immigration Department, 2020).

Even with these labor and immigration policies in place, various NGOs have documented cases where MDWs worked for more than 14 hours a day, received salaries below the minimum allowable wage, were deprived of rest days, or became victims of various forms of abuse (Amnesty International, 2013). The Mission for Migrant Workers, an NGO servicing MDWs in Hong Kong, reported the following cases of their clients: 96% experienced long working hours and insufficient rest, 52% suffered from poor accommodation arrangements, 29% complained of lack of food, and 15% endured physical and sexual abuses (Mission for Migrant Workers, 2020).

Adverse work and living arrangements have detrimental consequences to the health and well-being of FMDWs (Malhotra et al., 2013). The Philippine consulate in Hong Kong reported that the top illnesses of hospitalized migrant Filipinos in 2019—stroke cases, other cardiovascular ailments, cancer, and pulmonary diseases—can be attributed to poor working and living conditions (Tubeza, 2019). In addition to physical health, mental health is also highlighted as a primary health concern since they are prone to depression and fatigue (Bagley et al., 1997) resulting from lack of rest and loneliness (Holroyd et al., 2001).

FMDWs are covered by the public health care system of Hong Kong if they are under existing contracts. Their employers, meanwhile, are not required but are "strongly advised to take out an insurance policy with full medical and hospitalization coverage for their helper" (Hong Kong Labour Department, 2021, p. 15). In any case, the Immigration Department stipulates that their employers will be the ones who would cover the cost of medical treatments that FMDWs will incur while in service, which includes consultation, hospitalization, and emergency dental treatment (Hong Kong Immigration Department, 2020). The Labour Department similarly outlines the policies on medical attention, sickness allowance, and maternity protection. The Labour Department also prohibits employers from dismissing MDWs while on sick or maternity leave (Hong Kong Labour Department, 2021).

Even with excellent medical services in Hong Kong, the access of FMDWs to these health resources is contingent on the validity of their employment contracts. Once their employers terminate their contracts (and sometimes due to medical conditions they acquired while employed), they would have to pay the cost of hospitalization (Tong, 2019). In this case, distressed migrant Filipinos can access benefits from the Overseas Workers Welfare Administration and Philippine Health Insurance Corporation (PhilHealth) funds managed by the Philippine consulate in Hong Kong. However, many have pointed out how these "existing social security and welfare benefits offered by the Philippine government are also limited in coverage" (Public Services International, 2015, p. 14).

These many interweaving issues only demonstrate how the migration landscape, which includes both the labor and immigration conditions of the host state and the deployment policies of the home country, shape the many dimensions of the health and well-being of FMDWs in Hong Kong. FMDWs, meanwhile, rely on their social networks and communities to manage their difficulties of living and working abroad, along with structural challenges in accessing medical and health resources.

Theoretical framework

Studies on social networks are concerned with "the web of social relations around an individual" (Smith & Christakis, 2008, p. 407), focusing on the actors and the nature of the ties that connect these actors. Migration studies note the contribution of social networks in facilitating mobility while reducing the risks of migration. For instance, migrant groups, particularly those in Europe, have sometimes undermined formal resources offered by the state actors while utilizing the help and support provided by informal social networks (Hernández-Plaza et al., 2006). A significant concept in examining this aspect is social capital, defined as "friends, colleagues, and more general contacts through whom you receive opportunities to use other forms of capital" (Burt, 1992, p. 9). This definition considers two crucial ideas: the placement of social capital, or "where it resides," and "what it can use to accomplish" its goal (Robison et al., 2002, p. 3). Most studies highlight the benefits of social

capital in developing migrant entrepreneurship (Tata & Prasad, 2015), network governance and corporate social responsibility (Weisband, 2009), and financial resources (Newman et al., 2014). This paper, however, explores social capital embedded in interpersonal networks that promotes health and well-being.

Scholars from the academic fields of social psychology, sociology, and public health have long explored the intricate nexus of social networks, social support, and health. Since the 1970s, researchers have been concerned about the relationship of social networks and the epidemiology of illnesses, distress, disease, and disability, and the behavioral response of people to health crises (Pescosolido & Levy, 2002). Most studies link social networks with physical and mental well-being (Israel, 1982). Interestingly, social networks, established as social support, also exhibit communicative dynamics as they reveal the relationship of supportive interaction and the chances of maintaining health or getting illness (Albrecht & Goldsmith, 2003).

Social networks are "creating new social health experience" (Lefebvre & Bornkessel, 2013, p. 1829). Health care promotion and delivery have become more convenient and accessible, especially for vulnerable groups, because of the linkages with formal and informal channels built within social networks. Focusing on migrant settlers, Kim et al. (2015) conducted a qualitative study on the role of social networks and support in health information seeking of Korean-American adults. The results emphasized the crucial role of social networks through friends, church, and family members in providing recommendations of doctors or hospitals and sharing information about particular illnesses. Overall, these networks that enhance a sense of belonging have also augmented the shared feeling of being physically and emotionally healthy. However, there are also undeniable risks as social networks may propagate misinformation about health issues and compromise healthcare delivery in several ways. For example, Ertel et al. (2009) claimed that networks could either be beneficial or detrimental to health and well-being, depending on the resources, opportunities, and information that flow through these networks.

With the roles of both informal and formal networks as crucial components of social networks in mind, this paper attempted to deepen the discussion by looking at the strategic ties and reciprocity in interpersonal relations. Studies categorize interpersonal bonds as either strong or weak ties. Strong ties include "a relative, friend, or co-worker that the person sees often, and interacts with frequently" (Crowell, 2004, p. 16), while weak ties are composed of persons to whom the point person is marginally connected or has limited contact with (Crowell, 2004; Granovetter, 1973). These ties, regardless of their intrinsic strength, are supported by principles of trust and reciprocity.

Strong network ties provide direct and accessible information as weak network ties offer "resources or opportunities found outside the tightly bounded group" (Pfeffer & Parra, 2009, p. 247), which are often helpful to access the labor market. Nonetheless, weak ties are not necessarily of reduced strength or reliability. Even though these relationships are "superficial and less deep" (Henning & Liegerg, 1996, p. 8), they connect members of diverse groups into a larger social setting (Kavanaugh et al., 2003), affecting social integration within a community. Acquaintances, for instance, connect network clusters (Wilson, 1998) until the network continuously expands over time. This paper examines if these arguments hold for FMDWs in forging networks and ties to access health information and resources.

Methodology

This paper focused on Filipino migrant domestic workers (FMDWs) who have experienced hospitalization during their labor contract period in Hong Kong. First, this research reviewed the government programs and policies concerning the health and well-being of Overseas Filipino Workers (OFW) in Hong Kong. Second, it involved in-depth interviews of 20 FMDWs in Hong Kong. Recruited purposively, the 20 participants were members of contact migrant NGOs and faith-based organizations in Hong Kong. These members previously sought medical services while working and residing in Hong Kong. Table 1 outlines the demographic data of the participant FMDWS.

Table 1: Demographic Data of Participant FMDWs.

Pseudonym	Age	Length of Stay in Hong Kong (Years)	Origin (City/Province) in the Philippines
Adelina	38	2	Leyte
Ana Marie	32	4	Bataan
Andrea	36	15	Bulacan
Beth	47	20	Pangasinan
Carmi	31	4	Iloilo
Celestina	35	1	Nueva Vizcaya
Diana	38	4	Albay
Faye	42	23	Agusan del Sur
Gina	52	27	Bohol
Grace	40	8	Legazpi
Helen	34	5	Abra
Isabel	35	10	Cavite
Lina	42	10	Negros Oriental
Maria	44	16	Laguna
Maricris	42	6	Mountain Province
Rachel	37	15	Manila
Risa	38	10	Cebu
Rose	30	4	Pangasinan
Tecla	43	18	Abra
Tina	56	24	Iloilo

Each recorded interview, which lasted for 45 to 90 minutes, inquired about the general labor conditions and the health experiences of FMDWs, including their narratives of sickness and hospitalization. We interviewed the participants using Filipino or a mixture of Filipino and English, depending on the preference of the interviewees. Then, we transcribed, translated into English, and analyzed the recorded interviews for emerging themes related to the health and social networks from the participants' narratives. And to further understand the dynamics of social networks within their community, we also included observations of their weekend activities in their public gatherings in Chater Road, Christian churches, migrant community centers, and non-profit offices and facilities where they volunteer.

Before data collection, we secured ethics approval from the Research Ethics Review Committee of De La Salle University's Research Ethics Office, with approval code DLSU-

IR.001.2017-2018.T3.CLA. We also obtained informed consent from FMDWs before starting the interviews.

With the social network as the conceptual anchor, we considered interviewees as nodes or actors that tap into their social ties with family, relatives, friends, and employers. We analyzed the network relations between these nodes identified by Wasserman and Faust (1994) as friendships, resource flows, information flows, and social support. While this paper does not focus on quantitative densities of social ties and the complex webs of networking, it offers an in-depth analysis of the discursive formations occurring within the social network embedded in lived experiences of migrant Filipino women. This study emphasized the interpersonal network of individual migrants and the role of their informal social support systems, composed of family, relatives, friends, and employers, in the upliftment of migrant conditions, in response to the growing scholarly interest in informal social support systems and interpersonal relationships in social networks (Baig & Chang, 2020; Wright, 2016). This paper argues that FMDWs strategically tap into their interpersonal connections with family, relatives, friends, and even employers to access health care services and connect to various institutions toward migrant health and well-being. Social networks also construct and shape discourses of migrant health, enabling individual migrants to assess and respond to the perceived health issues and concerns.

Results

Health conditions vis-a-vis working and living conditions

In the interviews with the respondents, this paper inquired about their health concerns and managing their health and well-being in Hong Kong through their social networks. When asked about their health issues, most interviewees complained about common colds, mild fever, and recurring body pains. However, they also claimed that these are just normal in their line of work; they do not usually consult doctors unless these ailments last for several days or hamper them from working. Some participants experienced migraines, hypertension, work-related injuries, asthma, anemia, and appendicitis. This paper also had two recovering cancer patients as respondents. Even though the respondents did not directly correlate their working and living conditions to the health problems they are facing, they described some of the work and living arrangements that may have caused their vulnerability to ailments.

Rachel, a former student-athlete, claimed that she started "to feel weak" and "prone to becoming sick" because of working long hours with her former employer. Risa detailed her accommodation with her former employer when narrating how she developed asthma:

> *The maid's quarter was a bed suspended over a washing machine. The bed was just big enough to fit me lying straight, from head to toe. There was a small window in the room, no aircon, just a small electric fan. And the window and fan were never enough during the summer. I am thinking: that will surely your health, right? At first, I felt like I had no use for my medical insurance, as I did not get sick enough to go to a doctor. But later on, I started to fall ill all the time. You will not know the effect right away, right? Now, I have asthma. I did not have it before, even when I was a kid.*

Isabel talked about food arrangements with her former employer as she was explaining how her anemia recurred during her first contract period in Hong Kong:

> *I ate noodles three times a day. It was the only thing my employer handed out and the only thing that I could buy with how little my food allowance was. Back then, I was thin. I used to be anemic in the Philippines, but I recovered from that through medications. When I came here, it got back and became worse.*

Aside from their living and working conditions contributing to some of the physical health issues of the participants, others expressed how their social relationships with their employing families in Hong Kong and their left-behind families in the Philippines affect their mental health. Commonly shared among the interviewees was their struggle against stress and depression, citing tensions inside their employing household or problems with their family in the Philippines as causes. Diana, for example, said that working for a big family of five, even with a higher salary, brings her more stress than the previous family of three she worked for because "there are more people [she] has to go along with," while Tecla narrated how her set-up with her employers causes her stress:

> *They have four cameras (CCTV) in their small apartment. There is even a camera inside the bedroom of my ward. I do not even have a key to their unit, so I have to call them to let me in each time I come home from the market or my rest day.*

Carmi, meanwhile, said that homesickness and marital issues while abroad have triggered her depression: "Sometimes, your mind is adrift because you are already stressed. You feel depressed because of your family, but you still have to work."

The social relationships of FMDWs to their employers and, to some extent, even to their families back home can have either positive or adverse effects on their living and working conditions in Hong Kong, which, in turn, also shape some of their health issues. Their arrangement with their employer dictates the amount of work, length of working hours, and provision for food and accommodation. Their economic and emotional duties for their families in the Philippines can also affect the quality of their life in Hong Kong. Thus, the aspect of social networks of FMDWs is significant not just in understanding their physical and mental health concerns but also in managing them. It is also clear from the narratives that strong ties—while being a source of motivation and strength—may inflict emotional stress on these migrant women. Interestingly, agents of weak network ties—their employers, elderly clients, neighborhood and church friends, and organizations—compose the most frequently encountered network of the FMDWs.

Health seeking behaviors and social networks

Migrant Filipino women utilize both personal strategic and network influences to manage their health and well-being. When asked about how they maintain their health despite work-related challenges, many of them focused on developing healthier diets and ensuring that they are getting nutritious food. While some attributed the tense relationship with their employers to their health concerns, some FMDWs claimed that their employers influenced them to become more health-conscious. Grace mentioned that since her employer is strict about food preparation, discouraging her from using too much oil and salt when cooking, she

also learned healthier food preparation which she has shared with her family in the Philippines. Helen also acknowledged how supportive her employer is in terms of her health and welfare: "She forces me to go to a clinic even for normal ailments like headache and mild cough. And she pays for everything. She even brought me to a dermatologist, even if the insurance does not cover it."

While there are cases like Helen, where supportive employers actively work with their FMDWs to ensure their health or at least cover their medical bills and insurance, some participants had different experiences. Rose narrated how her employers not only failed to pay for her health insurance but also did not disclose the transmissible medical condition of her elderly ward: "They did not care about my welfare when I confronted them. For three months, I went to the clinic on my own and paid for the series of blood tests because they did not pay for my health premium." The case of Rose shows how unsupportive or uncaring employers may cause detrimental effects on the management of their health.

Some FMDWs have also developed active lifestyles with their fellow friends in their organization during their rest days. Ana Marie jogs around their neighborhood with other FMDWs while Maria goes hiking with friends from time to time as part of the social activities of her group. Helen also asserted that even doing work with her group for their organization is already a good exercise because it involves physical activities.

Beyond their work in their organization, many participants also claimed that they became more proactive in accessing health services because of their social network. Ana Marie attributed this to her trusted close friends in the organization: "I always ask my friends where it is best to go for a check-up, then I will tell it to my employer, so that is where I go. I only listen to my trusted friends in the org." Helen expressed a similar health-seeking behavior, as she tends to ask for advice from other members of her organization for some of her health concerns. She also claimed that some of the seminars and discussions that her group organized were very helpful in cultivating proactive health behavior: "I learned a lot from those seminars I attended. There is information about health available, but it is up to you to get it and not just hang around doing nothing on your day off."

Crucial to these positive changes towards health-seeking behavior is the availability of resources in Hong Kong. As Adelina claimed, "Here, our insurance pays for everything, from medical check-up to medicines. If you have an HKID and visa, you only pay a small fraction compared to those with a tourist visa. Your employers also reimburse your expenses." Faye said that she would have depleted all her savings had she been hospitalized in the Philippines since the health insurance that she paid for in her country was not as cost-effective as the ones they are enjoying in Hong Kong.

Despite these issues, some FMDWs would still choose to have their medical treatment in the Philippines. Celestina explained that "it is hard to be admitted in a hospital here because you do not have your family with you. I have a sister here, who is also a helper, but she cannot stay 24/7 to take care of me." These considerations shape health decisions of where and how to seek medical services for many migrant Filipino women. They also stated that many of their friends and relatives in Hong Kong are afraid of undergoing medical check-up because they fear that their worries will only be confirmed or that their prospective diagnosis might cause job termination. Just as they seek advice and solicit information about health from their friends and relatives, they encourage other FMDWs to talk to their employers and consult a doctor as soon as they feel ill. As Lina said, "When friends complain about being sick, I tell

them to talk to their employer and go to a clinic. If you do not know your problem, how will you know how to solve it?"

Finally, FMDWs understand the importance of having social support from their relatives, friends, and employer when facing critical health issues. The respondents who are cancer survivors best illustrate this point. Maricris, diagnosed with stage 2 breast cancer, said that the support from her friends and employer became her key to successful therapy and recovery from the illness. At the start, her friends already advised her to explain her situation and negotiate with her employer. Because of this, her employer "agreed to shoulder the more expensive testing option which is PET SCAN worth 13,000 HKD (1,700 USD)." Tina, a stage 3 breast cancer survivor, also attributed the support of her employer and relatives in seeking available resources from the Hong Kong government for her medical expenses. Her employer facilitated her application with the Social Welfare office for an expensive target testing and chemotherapy worth 200,000 HKD (26,000 USD), which eventually was approved. Furthermore, according to Tina, "my employer allowed me to stay with my sister while I am recovering so that I will have someone taking care of me." In these ways, the interpersonal connections of migrant Filipino women are not just conduits for exchanges of health information, resources, and support but also access points to health institutions and services.

The respondents' narratives reveal strategies and agency in deploying their social networks to navigate risks and opportunities for their health and well-being. FMDWs tap into their social support system when seeking help for their health concerns or disseminating health information within their social network. Their social network also intervenes with other stakeholders, particularly in enlisting the support of their employers, thereby expanding the support system of an individual migrant and capacitating her access to health resources. Finally, their social network upholds their health and well-being by mobilizing and organizing migrant women around state-crafted programs for health care in the home and host countries.

Discussion

Strategic ties and reciprocity

Filipino migrant domestic workers (FMDWs) have maintained interpersonal networks in both sending and host countries. These networks evolve depending on the utility of the network and the social bonds shared by both parties. Formal networks of migrant organizations play a crucial role in providing health support by offering emotional and psychological support to migrant women, serving as avenues for health counseling and medical advice, and provisioning resources to augment the health and well-being capacity of migrants.

While organizations provide such resources, FMDWs still rely on their informal social support. This paper reveals that informal networks usually present more convenient and accessible health information for migrants. Friends, extended family, relatives, and fellow Filipino domestic helpers within their social environment are the usual sources of information about health and well-being. These are the social circles where FMDWs share their ideas, experiences, and perceptions about their health, well-being, and emotional conditions. In a study of the health and quality of life of migrant women in Hong Kong, Holroyd et al. (2001) estimate that domestic helpers have an average of 10 people providing them with social

support. While this paper agrees with these findings, it argues that the strength of ties also affects the health access of FMDWs.

Migrant Filipino women strategically manage their social networks for health, especially in dealing with close kin in the Philippines. The interviewees expressed their hesitation to share health conditions with their family members for two reasons: first, they do not want their family to worry about them, and second, they are aware that their family members will not be able to directly offer help considering the geographical distance between the Philippines and Hong Kong. The principle of familism is also relevant as migrant women assert that they should provide financial support to their families and not the other way around. In this context, it is interesting to see how the idea of reciprocity is negotiated or even undermined by FMDWs. The principle of reciprocity holds that migrant women should disclose their health conditions to strong ties actors for practicality and possible reciprocal effects. This disclosure then may result in family members encouraging FMDW to file vacation leave or family members expecting lower remittance so that FMDW can focus on her medical issues. However, in most cases, FMDWs decide for the family without expecting anything in return.

This viewpoint changes when they face a grave health crisis which may require returning to the homeland for immediate care. In these situations, they tap into their family members in the Philippines as care support during hospitalization or treatment. There are still exceptions, like Faye, who claimed that hospitalization in the Philippines would drain her savings, which is why she explored the available health resources recommended by her friends and support groups. The case of Faye suggests that weak ties with good social capital on health resources may even undermine familial-based care when they face serious illnesses. In short, adequate health information on state and organizational support may persuade an FMDW to seek medical treatment in Hong Kong instead of disrupting their contract and returning to the Philippines.

Although manifesting less intimate or personal interaction, weak ties may have more potential to provide access or bridges to other networks or contacts (Crowell, 2004; Granovetter, 1973; Ryan, 2011). Aware of the possible benefits of engagement with weak ties, FMDWs strategically explore this network to discover potential solutions to their health issues. Acquaintances, friends from the organizations or people or institutions referred to them by their organizations or religious groups can address simple concerns about hospital recommendations, alternative treatments, available health programs, and other basic health information. When they lack bargaining resources, they seek help from a community migrant organization that connects them to proper state authorities. Religious groups also serve as a crucial resource in providing spiritual, emotional, and even material support in times of sickness.

A closer analysis of how weak ties operate suggests that FMDWs are more inclined to navigate this network in addressing their health issues, especially when they need connections to institutions where they can obtain health support. In exploring this social space, they also consider not only the opportunities but also the imminent risks. The agents operating in weak ties networks who have potential linkages to supportive institutions can also connect to the employers, migration industries, and power structures that may potentially disrupt if not damage their migration plans. In other words, while weak ties may foster connections to targeted institutions, there are surrounding risks that may lead to unintended consequences. For instance, the interviewees discussed cases of some FMDWs who lost their contract when their employer or agency discovered their serious illness. Such is a pressing concern for those who reached out to organizations or state agencies that, in turn, may contact their employers.

Also, as weak ties are convenient sources of health information, the reliability and effectiveness of non-expert medical advice are questionable. Such information may even have unfavorable effects on the health and well-being of FMDWs.

As the prevailing network contact of the migrant Filipino women, weak ties do not guarantee access to needed health resources. As Pfeffer and Parra (2009, p. 247) pointed out, it depends whether the contact has "advantageous market access or not." In this case, it merely depends on how the employers, acquaintances, church leaders, and NGOs strategize and utilize their connections to health resources. Social capital is also a crucial factor. As Marume et al. (2018) reported, higher social capital translates to positive health-seeking behavior and better quality of life. Ultimately, this paper reveals that amid the imbalanced social bonds, FMDWs benefit from weak ties with more access to social and even political (in the case of NGOs) capital, and the willingness of these actors from weak network ties to serve as bridges to address the resource gaps needed by the migrant women.

Supportive employers in social networks

The role of employers as a potential node in the social network of an individual migrant is largely under-studied, considering how they can either pose as a resource or a constraint towards their health. Bernadas and Jiang (2016) point out that "employers are key stakeholders in the health and well-being of FMDWs" as they can potentially open channels to medical services and reduce financial barriers to available health resources (p. 886). However, such a possibility is contingent on the favorable or unfavorable relationship that migrant workers have with their employers (Pérez et al., 2012).

The relationship and arrangements with employers, who are part of the weak ties of FMDWs, can affect their health. In the first place, employers are crucial in shaping the kind of work and living conditions of FMDWs, which, in turn, contribute to some of the health concerns they face in Hong Kong. Once employers do not follow their contractual obligations to their helpers, they create unfavorable working and living conditions that increase health risks and challenges to migrant women (Iyer et al., 2004; Nakonz & Shik, 2009). As cited in this paper, conditions like working for long hours without rest and problems with accommodation and food provision have mid- or long-term adverse effects on their health and well-being. Moreover, conflict and tensions in the employer-employee relationship and the heightened surveillance and enforced control of employers over the movements of FMDWs inside and outside of the household can result in stress and mental health issues.

Meanwhile, even those FMDWs who faced critical medical conditions stated that the support of their employers is crucial in dealing with their illnesses and managing their recovery. Once employers ensure favorable working and living conditions or receptive employer-employee dynamics inside the household, FMDWs also feel secure about their health because they are confident that they can access health resources through the help of their employers. Moreover, employers may also have a positive influence on the health-seeking behaviors of their foreign helpers. Many FMDWs become more health-conscious as they adopt the healthy lifestyles of their employers, which they share with their left-behind family and friends in Hong Kong. Finally, employers can either become the primary provider of health resources or facilitators of access to formal health care institutions for migrant women. As the cases of cancer patient-respondents show, employers pay for the health insurance of their helpers, cover additional medical costs, or reduce financial barriers to medical treatments.

In examining the narratives, the idea of a supportive employer is repeatedly invoked by FMDWs when talking about their health concerns and their sense of health vulnerability or security. They would say that they do not have serious concerns about health because they have a supportive employer. A supportive employer covers a range of descriptions for bosses that a) ensure favorable working and living conditions; b) encourage positive health-seeking behaviors; and c) financially assist or reduce medical costs for FMDWs. If they are uncertain whether their employers are supportive, their social support system encourages them to discuss and negotiate with their employers. Supportive employers can be a capacitating node in social networks for the health and well-being of FMDWs. As FMDWs reach out and enlist their employer as part of their social support system, they also practice agency that enables them to access health care services in destination countries.

Lastly, the narratives suggest that supportive employers, despite various cultural terrains, may potentially traverse from the domain of weak to strong ties. Perceptions and feelings of being treated like family members of the employers heighten the degrees of mutual trust and reciprocity and reduce the sense of contractual obligations. This tendency impacts on health conditions and decisions of the FMDWs. The set-up of employers becoming part of strong network ties provides significant health resources during illnesses: financial, medical, and moral support. However, this can also pose limitations and restrictions as FMDWs depend on their employers, reduce or even avoid interacting with family members, and limit information resources from those that are coming from the supportive employers.

Policies, networks, and health decisions

While previous sections discuss the role of social networks in acquiring health information and support from the surrounding networks of FMDWs, the final part of the discussion emphasizes the roles played by strong and weak ties that transcend geographical spaces in making health decisions. State actors contribute to the discursive formations that affect migrant decisions. In Hong Kong, the government has provided policies such as the Standard Employment Contract and Employment Ordinance to protect the FMDWs from abusive employers. Because of these government policies, it is reasonable for these migrant women to seek medical treatment in Hong Kong. While proper mechanisms are in place when FMDW are availing healthcare services in the host country, migrant decisions do not respond to state-sanctioned discourses alone since those evaluations, especially health-related choices, are shaped by the complexities of interpersonal ties.

To illustrate, FMDWs who need medical attention for their serious illnesses must decide whether to get treatment in Hong Kong or the Philippines. As explained in the previous section, they do not want to cause any burden to their family members in the Philippines, hence the option to avail treatment in Hong Kong. However, many FMDWs have also heard inaccurate information and unverified sentiments from their strong and weak ties networks. Several respondents talked about some misinformation that they learned from their circle of friends and acquaintances – that Hong Kong hospitals have a reputation for committing diagnostic mistakes, prolonging treatments, or accumulating money from patients. Such misleading information and other unfounded observations from fellow FMDWs have discouraged them from getting medical treatment in Hong Kong. In addition, some interviewees have also expressed their concern about their situation in Hong Kong, where no family member or relative will accompany them during hospitalization. They will stay with their employer during the recuperation period after hospital treatment, which is not a

conducive set-up for recovery. Thus, FMDWs would prefer to have their treatment done in the Philippines.

Conversely, choosing medical treatment in the Philippines entails economic and social costs too. While some employers allowed their Filipino helpers to reimburse the medical cost spent in a Philippine hospital, other employers would refuse to pay for hospital charges outside Hong Kong. Medical expenses without health insurance are financially damaging to FMDWs. Moreover, they are worried that treatment in the Philippines would cause a burden to their close family members as their lives would be interrupted during hospitalization. Therefore, hospitalization in Hong Kong may also be a strategic choice for the following conditions: (1) If the employers support the decision to do the treatment in Hong Kong; (2) If the policy resources (government-mandated work leave, health insurance, and other support) are available; or (3) If support groups are committed to their welfare. In other words, the decision to obtain a major medical procedure in Hong Kong entails more challenges and risks, but they may choose this option if both the weak ties and strong ties support this undertaking. Surrounded by actors composing their weak network ties in Hong Kong, FMDWs operate on mutual trust and the social norm of reciprocity in forging this decision. While weak bonds prevail, strong ties (both family members in the Philippines and close friends in Hong Kong) provide motivation and a sense of familism as they go through a very personal ordeal.

This situation illustrates another dimension of strategic utilization of social networks in availing health services. FMDWs are not passive to state-sanctioned health discourses which institutionalize health provisions in Hong Kong. Instead, they negotiate the information shared through interpersonal networks according to social and economic opportunities and costs. When making health decisions, they also carefully evaluate the direct consequences of their decision and its implications on their employment status in Hong Kong.

Conclusion

Drawing from their narratives of health concerns and health-seeking behaviors, Filipino migrant domestic workers (FMDWs) strategically use their social networks, especially their interpersonal connections with their relatives, friends, and employers in Hong Kong. They deploy their social support system to access and disseminate health information, find resources outside the formal institutions to supplement provision towards health care, and organize themselves to discuss state policies on health care from their origin and host countries. Through their social support system, FMDWs demonstrate their agency in managing risks and resources for their health and well-being in host countries. Aware of the risk of navigating both the strong and weak ties within their interpersonal connections, they decide among their social network who and what to share regarding health concerns. They conscientiously negotiate their rights and opportunities with their employers that can also be potential providers of social and institutional health resources. Finally, FMDWs participate in conversations and discourses on health-related policies of their home and host countries with their social network. Therefore, understanding how migrant social networks organize and mobilize toward health care is crucial in thinking through the limitations of state policies for migrant health in their home and host countries.

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