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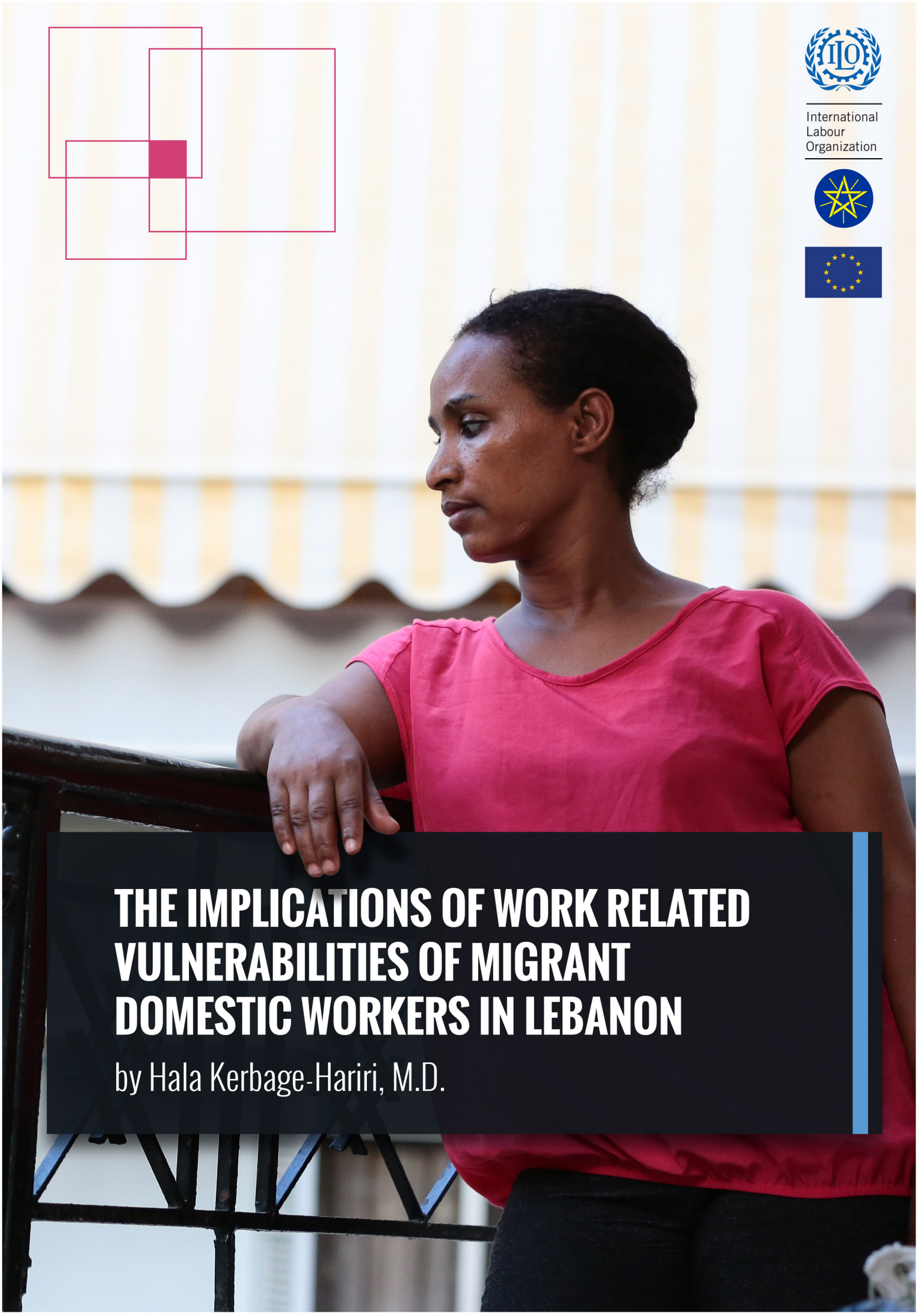

THE IMPLICATIONS OF WORK RELATED VULNERABILITIES OF MIGRANT DOMESTIC WORKERS IN LEBANON

by Hala Kerbage-Hariri, M.D.

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SOMALIA, SUDAN AND SOUTH SUDAN

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FOREWORD

Ethiopian migrant domestic workers (MDWs) are one of the largest groups of migrant workers in Lebanon. Even though many Ethiopian MDWs have positive working experience in Lebanon, there are also numerous reports of mistreatment that has especially intensified in recent years. It is estimated that there are over 70,000 Ethiopians MDWs working in Lebanon households, the majority of whom are within 20 to 30 age groups.

To gain legal status as a domestic migrant worker in Lebanon, one would have to secure official sponsorship by a Lebanese agency or individual employer. The sponsor is responsible for the domestic worker's airfare, employment visa cost, work permit cost, wages etc. This procedure scheme is commonly known as "Kafala system". This system comprises of numerous expected practices, administrative regulations and legal requirements that tie a migrant worker's residence permit to one specific sponsor, kafil. In effect, the system binds the MDWs to their employer in a legal as well as financial reliance, which result in a sponsor having considerable control over migrant's legal status as well as their freedom of movement and employment mobility. As a result, MDWs are exposed to limiting immigration procedures that puts them at danger of exploitation and abuse.

This *Kafala* system gives employers a sense of possessing the worker. The sponsors perceive the advance payments made to the recruitment agency as an "investment," which gives them a sense of possessing the MDW and her time. This paternalistic relationship between the sponsor and the worker is further reinforced by the MDW's dependence on the employer for ensuring her legal status in Lebanon as well as financing her return ticket home. Thus, making the MDW totally dependent on the employer for her legal and economic existence in the country, the Kafala system creates the basis for much of the abuses.

Lack of freedom, abuses of labour and human rights sometimes result in MDWs facing many migration-related stressors that affect their mental health. According to Human Rights Watch, there is one death per week on average from an unnatural cause among MDW in Lebanon, including suicide and falling from upper floors. Conditions of trade, exploitation and abuse of MDW, are now well known in Lebanon: violation of essential rights such as retaining their passport, frequent physical and sexual abuse, frequent being locked at home,

in the absence of any legal control or law regulating their work conditions. All these forms of structural and social exploitation have devastating effects on the psyche. In addition, migration in itself has been correlated to the emergence of psychiatric symptoms, due to the stress of the adaptation to a new environment. Moreover, studies exploring this link reveal a significant association between these symptoms and the perception among migrants of being the target of discrimination and racism. Accordingly this research provides an overview of the challenges faced by Ethiopian MDW's in Lebanon including factors that negatively affect their mental health.

I hope that this study outcomes will contribute to social and policy dialogue with constituents and other concerned actors to shape and implement reform agenda in regards to MDW's. Most importantly, it is hoped that this study will empower all migrants to help them make informed decision, and protect themselves. Finally, we would like to thank the European Union who is funding the ILO project *"Development of a Tripartite Framework for the Support and Protection of Ethiopian Women Domestic Migrant Workers to the GCC States, Lebanon and Sudan, 2013-2016"* under which this study was produced.

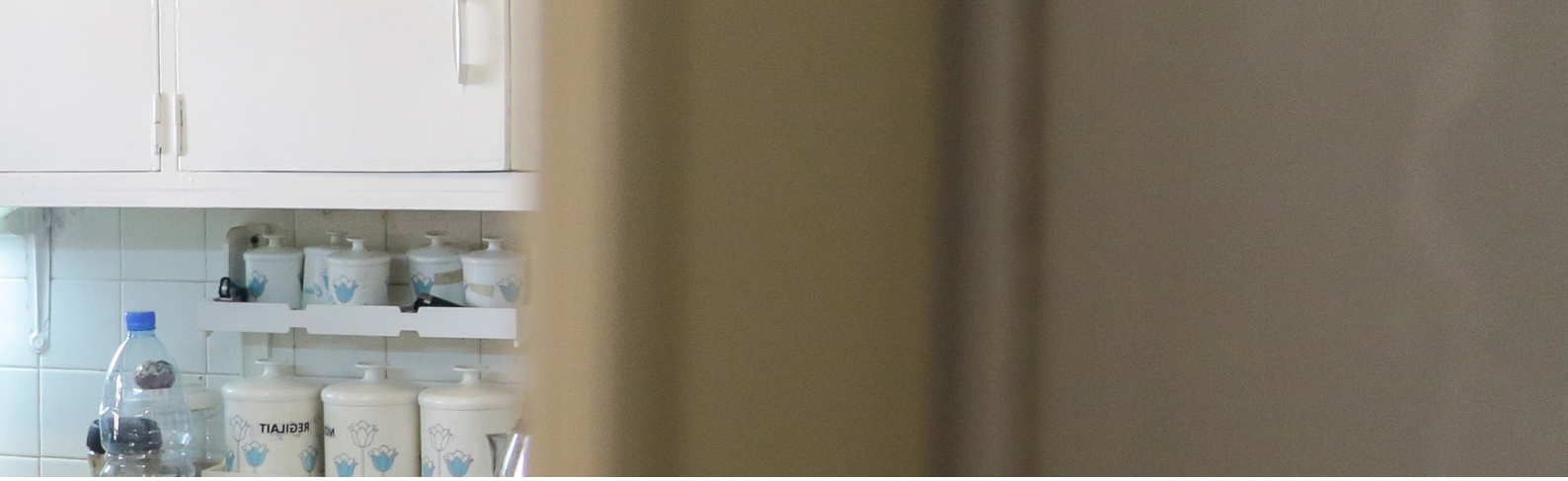
George Okutho
Director
June 2016

INTRODUCTION

The aim of this work is to provide an overview on the situation of migrant domestic workers (MDWs) in the Lebanese households. Lebanon attracts the majority of MDWs and, according to the estimates, over 70,000 mainly between the age of 20 and 30 are working in the country. The admission, stay, and exit, as well as their employment status are governed by the kafala system. This system includes practices, administrative regulations, and legal requirements that tie the residence permit of the MDW to one specific sponsor, called al-kafil. In fact, the system binds the MDWs to their employer both legally and financially; which is also responsible for the domestic worker's airfare, employment visa cost, work permit cost, among other things. The result is a considerable control over the migrant's legal status, freedom of movement, and employment mobility. As a result, the MDWs are exposed to limiting and constraining immigration procedures that put them in danger of exploitation and abuse. In this scenario, the lack of freedom, work abuses, and human rights violations represent the major migration-related stressors that affect the mental health of MDWs. Human Rights Watch exposes a terrible truth: on average, among the MDWs working in Lebanon, it is registered one death per week from unnatural cause, mainly suicide and fall from upper floors (Zahreddine, et al., 2014). The country also exhibits critic conditions of exploitation and abuse of female health workers (FHWs). The violation of essential rights is perpetrated in the absence of any legal control or law regulating the work conditions. Sadly to say, the employers are responsible of frequent physical and sexual abuse, and, even not so, they limit the freedom of worker by locking them inside the house and retaining their passport. All these forms of structural and social exploitation have devastating effects on the psyche, as described in the case of systemic racism (Fanon, 1961).

The emergence of psychiatric symptoms can be directly correlated to the migration process and considered the consequence of the stress provoked by the adaptation to new environments. However, the studies exploring this link reveal the significant impact of the perception of migrants to being the target of discrimination and racism (Martens, 2006).

This study, commissioned by the ILO Country office for Ethiopia and Somalia, analyses the situation of Ethiopian MDWs in Lebanon. In particular, this research explores the major challenges and risks that Ethiopian women MDWs face during the recruitment process and during their employment, their impact on mental health and well-being, and the access to mental health care. Among other things, this work will provide useful findings and



recommendations for social and policy dialogue with constituents and other actors with the aim to shape and implement a reform agenda.
Specifically, the aims of this study are to:

1. examine in retrospect the work experience of Ethiopian MDWs in Lebanon, specifically the recruitment process and the employment conditions, and analyse the causal relationship between work-related vulnerabilities and the emergence of psychiatric conditions;
2. examine the legal context governing the protection of mental health of migrant workers, including MDWs, and their access to relevant services and treatment in Lebanon.

METHODOLOGY

In order to adopt a holistic approach to the study of risk and protection factors, we have chosen a three-level analysis to:
provide an overview of the situation through the literature review of relevant documents and studies;

1. examine the affecting factors through a mixed qualitative/quantitative data collection, including 12 in-depth interviews to MDWs as case studies. This section includes interviews with 10 key informants for the qualitative part, and 200 structured interviews based on close-ended questionnaires for the quantitative part;
2. evaluate the access of MDWs to rehabilitation upon their return to Ethiopia through a qualitative methodology based on interviews with both MDWs and key informants.

We will provide more details on the methodological process in each section.

ETHICAL CONSIDERATIONS

Written informed consent was obtained from all the respondents before data collection. A detailed note explaining the aims and the purposes of the study was either distributed or verbally explained. The respondents were guaranteed that the information would remain anonymous and confidential from the data entry stage to the data analysis (unless the key informants agreed that their names could be mentioned), and the respondents were informed on the possibility to withdraw in every moment. In case of severe distress during the phase of data collection, the respondents were entrusted to a social worker from Caritas Migrant Center in Lebanon in charge of planning and managing the contact with a specialized mental health care service. Despite the intention; this procedure has not always been successfully accomplished.

1. THE SITUATION OF ETHIOPIAN MDWS IN LEBANON: A LITERATURE REVIEW

1.1 RISK AND PROTECTION FACTORS FOR MENTAL HEALTH

All migrants experience migration-related stressors, such as the sense of family loss and homesickness, along with social and economic problems and challenges related to the adaptation to a new environment (Bhugra, 2004). Often, mental health problems may result from these high levels of stress (Bhui, et al., 2003); (Torres & Rollock, 2004). Migrant workers are often recruited from the most vulnerable populations in poor countries and labour migration has increasingly become a structural survival strategy for the migrants and their families. Migrant workers often obtain short-term contracts in the sector of the so-called 3D jobs ¬– dirty, dangerous and degrading – and domestic work belongs to this category (Wolffers, et al., 2003). MDWs are a special group within this category: they are temporary migrants, or contract workers who remain in a country for a limited and defined duration. Among the MDWs, female domestic workers (FDWs) are mostly adult women who voluntarily migrate from one country to another to find work in the domestic-service sector (D'Souza, 2010). In many destination countries, domestic work is not considered formal work and its live-in nature renders the domestic worker vulnerable to isolation, risk of abusive work conditions, and adverse effects on the well-being (Lau, et al., 2009).
Unless specified, we will use alternatively the terms MDW and FDW in this study.

We can identify three phases: pre-migration (decisions and preparations), migration (the migrant worker arrives in the host country) and post-migration (the migrant workers return to their own country). Migration can become a circular process when reintegration is followed by renewed migration. From this study, it emerges that MDWs face mainly financial

and income-related concerns prior to migration and upon their return, while psychosocial factors are most prevalent during the migration phase: loneliness, homesickness, difficulties in the adaptation, and, most importantly, exploitative work conditions. In particular, MDWs identify as negative factors the rigidity of their employers, the lack of food, the lack of rest, and the worries about their personal safety (Ham, et al., 2014).

1.2 THE SITUATION OF MDWS IN LEBANON: THE DYNAMICS OF VULNERABILITIES

Estimates show that Lebanon received more than 400,000 migrant domestic workers in 2009 (Zahreddine, et al., 2014) excluding the illegal trafficking. The Ethiopian nationality occupied the first place, followed by the Philippines, Bangladesh, and Sri Lanka in this order (Jureidini, 2009). Migrant domestic workers represent a vulnerable group, as they bear difficult situations mainly related to the dynamics of exclusion and discrimination. We can divide the risks of discrimination in three types: legal, structural, and personal.

1.2.1 RISK FACTORS RELATED TO THE LEGAL SYSTEM

As previously discussed, the condition to work in Lebanon is being officially under the responsibility of a sponsor (the kafil), manifested by a Lebanese agency or an individual employer. This sponsorship system, here called kafala, increases the risk of human right violations by making the MDW dependent on the employer for what concerns the legal and economic existence in the country. Jureidini (2002) summarizes the three main categories of violations of MDW human rights:

1) Limitation or deprivation of the worker's freedoms through withholding of passport and restrictions of movement. In fact, according to the Caritas Lebanon survey (2005), 54 per cent of employers admit to have the right to lock their MDWs in the house (Irinnews, 2006).

2) Violence from employers, agencies, and authorities like the police and General Security,

as evidenced from the same survey. In fact, 31 per cent of all employers admit to beat their MDWs if they do not follow the instructions given (Huda, 2006).

3) Poor living and working arrangements, withholding of wages, long working hours, absence of rest time, and restriction of food. In addition, Pande (2012) reports the restricted access to public spaces.

It seems that migrants from the Philippines are less affected by discriminatory practices, perhaps because they can rely on a relatively well-established embassy, as well as supportive regional communities (Pande, 2012). In addition, besides their exclusion from the protection of the Lebanese Labour Law, international conventions do not address the needs of MDWs specifically (Ajami, 2007). Therefore, in the absence of regulation, the kafala system represents in itself a mechanism of violence and discrimination. Despite the total administrative, financial, and legal dependency on the employer, the domestic workers are legally responsible for their regular status. Namely, in the case where the employer does not renew the worker's papers, or in the case where the employee leaves the employer, the worker automatically becomes illegal and is subject to arrest or deportation (Jureidini, 2011). This picture allows one to argue that the Lebanese state is complicit in the denial of domestic workers' rights as expressed in the international conventions.

1.2.2 RISK FACTORS RELATED TO THE STRUCTURE OF THE WORK

The type and structure of the work assigned to FDWs within the household constitute by themselves a risk for exploitation and arbitrary domination. Becker (1981) describes the family environment, or household, as a unit of production or "little factory" that produces meals, health, children, self-esteem, skills, and knowledge. However, within the household the personal relationships and bounds play a relevant role and do not conform to the standard employer-employee relationship, which is less personal. Furthermore, Max Weber described the standard bureaucratic organization as allowing a form of rational dominance between the employer and the employee (related to work-hours, workloads, rational demands of performance) restricted and limited to the work environment. The work of MDWs within the household and its live-in nature make them part of the family, but only when considered as a unit production. This peculiarity does not conform to a standard bureaucratic relationship and this mechanism allows an irrational domination based on the whims, personal schedule, and occupation of the employer. It is the expression of a pre-capitalistic form of dominance, where the household is the work environment, this allowing for all forms of requests and orders that are not necessarily logical or expected, and resembles a master/slave relationship.

1.2.3 RISK FACTORS RELATED TO PERSONAL ABUSE

The categories of discrimination described above include personal and individual abuses. Studies in social psychology have shown that attitudes to violence and abuse in the work environment are easier to emerge in lack of a supervision or accountability system, regardless of the characteristics or personality traits of the employer and the employee (Myers, 2012). In this context, if the discrimination against the MDWs is personal and individual, it materializes in physical and sexual abuse, inhumane life conditions, and humiliating treatments. This personal level of discrimination cannot be isolated from the wider legal

and structural framework. Therefore, even when the employer is respectful and generous, the MDW is still vulnerable to experiences of discrimination intrinsic to the structure of the work. The personal relationship between the employer – especially the female employer – and the FDW exhibits particular psychological dynamics. A study by Jureidini (2011) explores the psychoanalytic and social factors in the abuse of MDWs by female employers in Lebanon and shows that working within the private sphere of the family allows the expression of all forms of intense emotions. In this private sphere the individuals may be irrational, may project their deep psychological issues and feelings onto other members of the household, such as their obsessions, guilt, attachment, dependence, vanity, jealousy, hatred, as well as love and compassion. "The personal relationship between employer and employee … [allowing] … for a level of psychological exploitation unknown in other occupations … [It] … enhances the employer's self-satisfaction by having the presence of an inferior … validating the employer's lifestyle, ideology and social world" (Jureidini, 2011).

These risk factors, combined with the effect of class, gender and race difference with the employer, put the MDWs at high risk of vulnerability, abuse and consequent negative effects on mental health.

1.3 THE SITUATION OF MDWS IN LEBANON: THE COPING STRATEGIES

The ability to cope with migration-related stressors is therefore crucial for migrants to protect their well-being. Stressing factors can be environmental, social, or related to internal demands, which require the individual to readjust his/her usual cognitive and behavioural patterns (Thoits, 1995). As these factors accumulate, it becomes more difficult for individuals to react and when the demands exceed the ability to cope, the probability of negative consequences on well-being increases (Lazarus & Folkman, 1984). This highlights the importance of efficient coping strategies. Lazarus and Folkman (1984) describe the act of coping as constantly changing cognitive and behavioural efforts to manage specific external or internal demands. Considering the dynamism of the migration process, migrants are likely to display different coping strategies in the different phases of migration. Cheng & Chang (1999) and other studies show that, often, the reaction of migrants is to seek social support, cultural integration, and religious solace. These coping strategies include (i) keeping busy with work, (ii) talking to their family, (iii) seeking community support, and (iv) praying. However, in the specific case of MDWs, the live-in nature of domestic work, along with the long work-hours, poor working conditions, and restrictions from employers, reduce the coping options and thereby the coping flexibility, and increases the vulnerability to distress.

1.4 MENTAL HEALTH AMONG ETHIOPIAN MDWS

All the forms of structural, social, and personal exploitation have devastating effects on the psyche. The high frequency of reported suicidal attempts and admissions to the psychiatric hospital among MDWs requires to uncover the causal relationship between exploitation at work and the emergence of severe psychiatric conditions, emotional distress, and suicidal

behaviour. Environmental conditions of maltreatment and abuse represent severe risk factors for depressive and anxiety disorders, as well as for the emergence of psychotic symptoms (Beards, et al., 2013). This occurrence has a neurobiological basis, as shown by the studies on neuronal plasticity: life events and environmental changes constantly modulate throughout life the neuronal circuits, which are responsible of perceptive, cognitive,

affective, and behavioural manifestations.

As researchers have shown, the migration process represents a risk factor for mental health in itself. However, the risk of psychosis, depression, and anxiety symptoms associated with migration is especially high when the migrants are chronically exposed to social defeat or constant experiences of discrimination (Cantor-Graae & Selten, 2005). The experience of discrimination leads to the so-called internalized stigma: the victim of discrimination progressively internalizes the prejudicial attributes of the employer, which generates feelings of helplessness and hopelessness leading to a subjective experience of dehumanization and passive resignation. This internalization, in the absence of any possibility to rebel against the abuser, constitutes a major risk factor for the emergence of psychiatric conditions and masochistic and suicidal behaviours, as denounced by Human Rights Watch.

Researchers usually face the scarcity of studies on mental health among non-western migrants in non-western countries, especially in the Middle East, and the lack of epidemiological data available on the frequency of psychiatric admissions, suicidal attempts, and depressive, anxiety or psychotic episodes. Nevertheless, Anbesse et al. (2009) explore the experiences of Ethiopian female domestic migrants to Middle Eastern countries, through focus group discussions. They discover that significant threats to mental health reside in social defeat, particularly in exploitative treatment, entrapment and humiliation, enforced cultural isolation, denigration of the women's sense of cultural identity, and disappointment for not achieving the expectations. Comparisons are made between those with severe mental illness and those with a relatively successful coping strategy. The participants reported that the self-affirmation of their cultural identity and the establishment of socio-cultural supports

helped to face the negative forces. Therefore, having a social network, participating in community activities with other migrants from the same country, maintaining meaningful and purposeful activities that give a sense to their situation seem to fuel useful resilience factors to face the adversities.

1.5 PSYCHIATRIC ADMISSIONS OF MDWS IN LEBANON

We cannot find statistical data concerning the rates of psychiatric hospitalizations and psychiatric disorders of MDWs in Lebanon. In the unique study exploring the issue, the authors illustrate that brief psychotic episodes are the most prevalent diagnosis, while major depressive episodes rank in the second place within the small sample considered. This result is in contrast to the majority of affective disorders diagnosed in the Lebanese control group (Zahreddine, et al., 2014). However, these findings require caution. In fact, no integrative cultural assessment was implemented, and misdiagnosis with a tendency to over-diagnose psychotic disorders and under-diagnose affective disorders among blacks (or minorities) has been debated in the literature (Jackson, 2006). Furthermore, 90.9 per cent of MDWs admitted in a hospital are directly deported after discharge, since no employer is willing to tolerate the risk of mental illness relapse and further expenses. The more frequent and massive use of high-dose medications as well as electroconvulsive therapy on the MDWs hospitalized, in comparison to the Lebanese patients, may be due to the employer's pressure on the medical team, as a strategy to obtain a rapid stabilization and send the patient to the native country. This would also explain the much shorter duration of hospitalization among FDWs, which is not always sufficient for their full recovery (Zahreddine, et al., 2014). Indeed, the medical insurance does not cover mental illness and the employers are not willing to pay additional expenses for the migrant's travel to the home country.

The same study uncovers the significantly higher rate of compulsory admissions among MDWs, even in cases where they had no prior hospitalization or outpatient psychiatric consultation, and the increased use of constraint measures (e.g. the straight-jacket). This raises the serious ethical issue of abuse of power. Indeed, differently from the Lebanese patients, the consent of the family cannot be obtained, and the lack of supervision and accountability does not allow to keep under control the recourse to coercive measures. Additional relevant causes of this situation are the lack of cultural sensitivity in the sector of mental health care and the language barriers that obstacle the interaction between the patient and the medical team.

The study under review provides some important phenomenological observations. Acute severe anorexia was frequently observed among MDWs in the sample, which might be explained as a form of resistance, similar to hunger strike, and described as a suicidal-like behaviour. Severe catatonic attitudes were higher for the FDWs compared to the control group. Catatonic symptoms have been previously found to be more frequent in black migrants, but no conclusive evidence is yet available. Delusional pregnancy was exclusively observed in the MDW group and allowed to classify the psychosis as a psychological reaction, rather than a chronic disturb like schizophrenia. Several factors have been proposed in the literature to explain delusional pregnancy, including (i) rebirth fantasies wish fulfillment, (ii) parental deprivation, (iii) over-identification, (iv) loss of love or loss of a beloved object

(Dutta & Vankar, 1996), and (v) chronic social deprivation.

Despite the absence of other studies, we can address to the media and observe the frequent informal reports on suicidal attempts among the MDWs and on the severe abusive work conditions behind this phenomenon. Kronfol et al. (2014) review both the English and Arabic literature addressing the mental health status of migrant workers in Gulf Cooperation Council (GCC) countries, and find that very few comprehensive or systematic studies have been conducted. The available reports suggest that this population is facing significant mental health problems, including adjustment disorders, mood disorders, psychosis, and ultimately suicide. Although other systematic studies are needed, the available information is sufficient to show that mental health conditions can arise in response to a socially discriminatory context. The recognition of the entrenched link between discrimination and mental health will help inform the activists and the policymakers towards the improvement of decent work conditions for MDWs worldwide and specifically in the Middle East. This recognition requires an in-depth understanding and analysis of the dynamics of discrimination against the MDWs on the three levels described – legal, structural and personal – to envisage practical modalities of interventions. Furthermore, the attitudes and perceptions of the professionals in the mental health sector require a deeper analysis, as they can represent a risk of institutionalized discrimination inside the structures devoted to mental health care and services.

1.6 THE LEGAL AND INSTITUTIONAL FRAMEWORKS SUPPORTING THE PROTECTION OF MENTAL HEALTH AND WELL-BEING

1.6.1 THE SITUATION IN LEBANON

In so far, Lebanon has not adopted a national policy for mental health. The national health services depend on the limited capacity of the hospitals and the vast majority of mental health services, especially outpatient services, is private. In the absence of any insurance coverage at the country level, this proves to be also very expensive (Kerbage, et al., 2016). As defined by the Ministry of Health, the national social security covers the cost of psychiatric consultations and certain medications only for Lebanese nationals. Furthermore, there is no specific legislation in place for the protection and treatment of persons with mental disorders (Kerbage, et al., 2016), and the Parliament has not voted yet for the approval of the mental health draft law recently submitted. Therefore, the inappropriateness of the mental health sector is particularly harmful for Lebanese nationals from low socio-economic background and even more for vulnerable categories. In the case of migrant domestic workers, the use of coercive measures is more frequent, as the absence of any health insurance for mental issues exacerbates the dependency on the choice of the employer. In fact, the employer decides to require a private consultation with a psychiatrist or to ask for the hospitalization. Most frequently, MDWs are admitted in the Lebanese Psychiatric Hospital of The Cross, the most important psychiatric institution.

1.6.2 THE ROLE OF NGOS

Since they lack the normal rights of citizens to access public forms of help and they cannot

rely on family support, the migrants address to NGOs and diplomatic missions to seek assistance. As an example, the Pastoral Committee of Asian-African Migrants (PCAAM), established in 1997, is a NGO that administers social, legal, and religious assistance to MDWs. However, PCAAM does not provide specific mental health and psychosocial support. Caritas Migrant Center is another important NGO, established in 1994, that collaborates with PCAAM. These charities mostly assist women apprehended without valid documents and/or placed in detention centers. They assist detained women to obtain valid documents, to retrieve the passports from employers in cases where the MDW has escaped, they contribute financially to renew expired work/residency permits or repatriation, they provide legal aid, social counselling, as well as medical treatment (Jureidini, 2011). The work of these NGOs indirectly benefits the well-being and mental conditions of MDWs by preventing human rights violations in the context of a legislative vacuum.

The legal changes occurred over time, although still insufficient, are promising. In 1998, the Lebanese government has forbidden the practice of selling migrant domestic workers, who were often released from one sponsor to another (Jureidini, 2002). In addition, since 2004, the agencies are supposedly required to report cases of exploitation and abuse to the Ministry of Labour and Social Affairs (MOLSA) that holds the responsibility to send inspectors to the household (Huda, 2006). In the absence of a proper and effective legal framework, the NGOs play a relevant role and are very active to mobilize the general opinion through demonstrations (e.g. on the International Workers Day) to demand fair working conditions for FDWs, to promote campaigns, media talks, and stimulate the legal agenda.

1.6.3 THE ROLE OF THE ETHIOPIAN CONSUL

The current political relations between the two countries undermine the possibility to establish an Ethiopian embassy in Lebanon. The Consulate is currently understaffed and is not in the condition to give assistance to all the Ethiopian runaways requesting a laissez-passer or in need of legal support. Given the scant resources available, the Consulate relies heavily upon NGOs and other charitable organizations to provide the social, medical, and legal assistance, which anyhow remain insufficient.

As a result of this lacking system, only a few employers/sponsors who have violated their contractual obligations have been prosecuted by the Lebanese Government.

1.6.4 THE SITUATION IN ETHIOPIA: THE NATIONAL MENTAL HEALTH SYSTEM

Ethiopia has adopted a National Mental Health Strategy (2012/13-2015/16) that envisages the integration of mental health services into the primary health care. However, there is only one government hospital – the Amanuel Hospital in Addis Ababa – dedicated to psychiatric diseases that offers a capacity of 268 beds. The hospital has also a large outpatient service, with around 115,000 patients treated each year. Currently, the country officially counts on 40 practicing psychiatrists, 461 psychiatric nurses, 14 psychologists, three clinical social workers and occupational therapists. The most recent Health Sector Development Plan projected to reach the number of 410 psychiatrists by 2010 (Ministry of Health, 2010).

On the positive side, the Government covers the cost of hospitalization for mental illness for over 75 per cent of the patients (Chemali, et al., 2013), and the patients with a

testimonial letter of their low socio-economic status from their local administration have access to subsidized and often completely free psychiatric services. On the negative side, due to the limited availability of specialized workers, the family members are encouraged to stay in the hospital and take care of their relatives during the period of admission. In this context, the supply of proper medications is inadequate and stimulates the use of old-generation psychotropics causing many side effects. Moreover, the rehabilitation facilities and residential programmes for people with chronic mental illness do not exist (Addisu, et al., 2015).

A review of patient admissions to the psychiatric unit between January 2001 and December 2010 was conducted. The study depicts a composite situation: some patients came from the primary care centers or general hospitals, some others autonomously decided to ask for their admission, while others may have been involuntarily admitted in response to the risk of self-harm or harm to others. However, the absence of mental health legislation in Ethiopia does not allow a correct distinction between involuntary and voluntary admissions during the period under study (Addisu, et al., 2015).

A descriptive analysis of the admissions to the Amanuel Psychiatric Hospital revealed that schizophrenia was the most common diagnosis, with 56.1 per cent of cases, followed by bipolar disorder (20.6 per cent) (Abebaw, 2013).

1.6.5 THE EXISTING LEGAL FRAMEWORK ON MENTAL HEALTH, DISABILITY, AND LABOUR

Although Ethiopia has adopted many international and regional human rights instruments – including the Convention on the Rights of Persons with Disabilities, which has extended the protections to persons with mental disabilities – it has not been adopted any comprehensive national law or policy (Addisu, et al., 2015).

The Constitution of the Federal Democratic Republic of Ethiopia , the Civil Code, the Criminal Code, and the Labour Law have incorporated scant provisions addressing the rights of persons with mental disabilities in different forms (Debebe, 2013).

Chapter 3 of the Constitution reports a number of rights that are particularly significant for persons with mental disabilities. The FDRE Constitution, in its article 9/4, guarantees to everyone the right to dignity and to freely develop the personality without harming the rights of others. The equality clause prohibits any discrimination by race, nationality, sex, language, religion, and other status pursuant to article 25. It is also expressed the obligation to progressively allocate increasing funds to promote access to health, education and other social services, care and rehabilitation of the physically and mentally handicapped, elderly, and children who are left without parents or guardian, within the limits permitted by the economic capability of the country (article 41/2 and 4).

The Criminal Code makes provisions for cases when a person with mental disabilities commits a crime, directing the judge to investigate the personal background of the accused and her/his behaviour prior to the offense . When the offense is committed by a person suffering from mental illness, the competent judge must order her/his confinement in a psychiatric hospital for treatment or protection. The health facility holds the responsibility to follow up and report the treatment to allow the court to proceed with the other measures (The FDRE Criminal Code, Proclamation No. 214/ 2004, article 135).

The Civil Code addresses the issue of insanity and limits the legal capacity when the mental health of a person is questioned or when a court decides for a judicial interdiction. The law defines insane a person who cannot understand the importance of her/his actions as a result of insufficient development, mental disease, or senility (The Civil Code, Proclamation No. 165/1960, article 339/1).

The Labour Law prohibits any discrimination against a person with disabilities in employment practices and imposes concomitant responsibilities on the employer. These include taking measures to provide appropriate working and training conditions, and a reasonable accommodation. Particular attention is deserved to measures for women with disability, with the aim to take into account the multiple vulnerabilities of this category and to protect them from sexual violence often occurring in work places (Debebe, 2013).

1.6.6 MDWS AND MENTAL HEALTH IN ETHIOPIA

The number of Ethiopians leaving to the Middle East is unknown as the majority migrate through undocumented ways (Kebede, 2002). According to the estimation of the Ministry of Labour and Social Affairs, around 1.5 million Ethiopians had left the country illegally between 2008 and 2014, while 480,480 were those that legally migrated to the Arab countries during the same period.

The impact of migration on the mental health of Ethiopians is an under-studied phenomenon, despite the massive presence of illegal migrants who face higher risks and are more vulnerable to mental consequences. The reasons are the lack of professionals and researchers who have expertise in this field, the lack of awareness, the creation of a stigma related to mental health, and the lack of attention from actors in various field (Zeleke, et al., 2015). The studies conducted on returnees that have experienced a condition of illegal permanence in the Middle East have mainly focused on the socio-economic impact of this status and have not investigated the impact of this experience on the well-being and mental health of these individuals (Anbesse, et al., 2009); (Abebaw, 2013) (Samuel, 2012).

The migration process takes a psychological toll producing anxiety, post-traumatic stress disorder, and depression, and compromises the quality of life (Kebede, et al., 2003). Mental health problems register a high incidence among the migrant returnees in Ethiopia, with a ratio of nearly one case in four. The mental health status of a sample of 1,035 Ethiopian returnees from the Middle East, where they were seeking employment, has been explored. The study uses the clinical cut-off score of 8 on the Self Reporting Questionnaire (SRQ) scale, where a score above the cut-off point indicates the probable existence of a mental disorder. The results have shown that about 24.1 per cent of the returnees registered a score approximate to the clinical cut-off score or above. In so far, the absence of other studies on the prevalence rate of mental health distress among the population of migrant returnees in Ethiopia does not allow any comparison (Zeleke, et al., 2015). However, Zeleke et al (2015) find that the rate of mental illness is higher than the prevalence of common mental disorder symptoms in the general population of Ethiopia (Fekadu, et al., 2014). The rate is also higher than the prevalence of mental health stressors among migrant women from other developing countries who work as domestic workers in the Middle East (Zahida, et al., 2004).

1.6.7 PREVENTION AND LEGAL INSTRUMENTS

In 2008, on the Labour Day, the MOLSA has disclosed the human right violations and domestic violence that Ethiopian migrants face behind closed doors in Beirut while they are employed as housemaids, and the Government of Ethiopia has officially prohibited to its citizens to travel to Beirut in search of job. The Ministry declared its will to take strong actions against any employment agency trying to send workers to Lebanon either directly or via a third country. In addition, on the 19th October 2013, the Ethiopian government installed a ban on work migration from Ethiopia to the Middle East in order to examine the gaps in the laws and practices, and to prevent the abuses often suffered from MDWs. Afterwards, two legislations passed. The Prevention and Suppression of Trafficking in Persons and Smuggling of Migrants Proclamation No. 909/2015 in its preamble stresses the importance of the provision of appropriate protection, care, support, and rehabilitation to the most vulnerable groups of the society, with due consideration of age, gender and special needs. The Proclamation further clarifies the treatment of victims in its part 4, article 26/1, declaring that "the Government shall put in place necessary working procedures to identify, rescue, repatriate and rehabilitate victims in partnership with other foreign diplomatic missions, concerned government and non-governmental organizations and other supportive mass organization". Article 26/2b states that "the victims shall be accorded the available health and social services, medical care, counselling and psychological assistance, with care, on a confidential basis and with full respect of privacy". Part 5 stipulates the establishment of a fund to "prevent, control and rehabilitate" the victims of human trafficking. Article 34 illustrates the objectives of the fund, which include the provision of material support and training to victims, the coverage of the expense of relief, rehabilitation, reintegration, and the support to the construction of temporary shelters and other needs. The source of financing of the fund is described in article 33. Article 39 clarifies the establishment of a national committee led by the Deputy Prime Minister, for a better coordination of the activities designed for victims protection, assistance and rehabilitation, to better inform policy making, plans and implementation framework, to accommodate the interest of victims, and to combat the crime of human trafficking and smuggling.

The Ethiopia's Overseas Employment Proclamation No. 923/2016, in its preamble expresses that "it has been found necessary to protect the rights, safety and dignity of Ethiopians who are willing to take-up overseas employment in pursuance of their qualifications and ability". It also declares that "no employer shall directly recruit and employ a worker except through the Ministry or an Agency" (article 6/1). The Proclamation, in part 2 article 7, also states that "any worker who desires to undertake overseas employment shall at least complete the eighth grade of education and possess a certificate of occupational competence". As article 8 proclaims, "the Ministry or the appropriate authority shall undertake regular pre-employment and pre-departure awareness raising about the conditions of receiving countries, the required skill for a job position they are taking, their rights and duties", and shall "conduct continuous national awareness-raising activities targeting the public at large by using mass media and disseminating correct and up to date information regarding overseas employment". Article 62 also states that "the employer shall, from the domestic insurance market, buy life and disability insurance of the worker deployed overseas."

1.6.8 PRACTICABILITY OF THE LEGAL INSTRUMENTS

According to the head of the Social Affairs Office in the Ethiopian Consulate in Beirut, although the Ethiopian government officially banned migration of women to Lebanon, many are travelling through third countries, for instance Egypt. According to unpublished sources, the MDWs willing to travel to Lebanon lean on someone who is already in the country or seek the help of a broker. Unfortunately, the problems frequently begin from the day of their arrival. Many sponsors do not adhere to the terms of the contracts, such as duration, remuneration, and expected hours of work (Ezega, 2008).

Over 400 employment agencies were licensed to recruit Ethiopians to work abroad. However, the government officials acknowledged that many actors were involved in both legal and illegal recruitment and this situation has led the government to ban the export of labour force. Following the October 2013 ban, it seems that irregular migration through Sudan has increased. Moreover, brokers serve as the primary recruiters in rural areas (US Department of State, 2014).

According to the MOLSA, the revised Overseas Employment Proclamation will safeguard the rights of Ethiopians who work abroad and tackle the problems of human trafficking. The revision was necessary to alleviate domestic violence, labour exploitation, human rights abuse, and accidents for Ethiopians working abroad, particularly in the Middle East. The new Proclamation is expected to bridge these gaps through consolidating bilateral relations between governments thereby creating favorable conditions for the migrants. Moreover, the Proclamation defines the roles and the responsibilities of the agencies, which will be questioned by the rules and regulations in case of wrong application. The Ministry will continue to implement the proclamation in collaboration with federal and regional agencies and with other stakeholders.

The Government usually does not provide adequate assistance to the victims of trafficking – both those exploited internally or after migration overseas – and relies almost exclusively on international organizations and NGOs for the provision of assistance and services (US Department of State, 2014).

According to unpublished annual reports, the Good Samaritan Association – a local non-governmental organization involved in rehabilitation of trafficked and abused women from Middle East and Gulf States – up to June 2016, assisted 1,056 MDW returnees with physical and mental disability within its rehabilitation center (GSA, 2016). Agar Ethiopia, another non-governmental charity, thanks to its Trafficking Victims Reintegration Programme rehabilitated 320 MDW returnees with the help of life skill and vocational skill training since 2012 (Agar Ethiopia, 2016). Both reports also revealed the budget and capacity constraints of these organizations that can only partially contribute to solve this dramatic situation.

2. THE FACTORS AFFECTING ETHIOPIAN MDWS MENTAL HEALTH IN LEBANON

2.1 THE QUALITATIVE STUDY

This section describes the collection of qualitative data from MDWs in Lebanon and from key informants.

2.1.1 METHODOLOGY

1st level of qualitative data collection: MDW

Participant recruitment: the sample under study consists of 18 Ethiopian MDWs selected according to the following inclusion criteria: participants shall be female and working, or having worked, as full-time domestic workers in a Lebanese household. The selection procedure is a combination of a purposive sampling, based on personal contacts, and snowball sampling. Out of the 18 respondents recruited, six withdrew at the last minute, saying they feared that shared information could negatively affect the situation with their employer in Lebanon. Out of the 12 final participants, two were recruited from the shelter of a charity organization and expressed the will to remain anonymous. They bore a particular situation as could not continue to work after their suicidal attempt and were waiting to return to Ethiopia. The other 10 respondents were currently working in a household.

Sample characteristics: the women recruited were between 18 and 30 years old. All were orthodox Christian, nine were single at the time of migration, while three had children in Ethiopia. The majority of them had completed high-school education but did not obtain paid employment prior to migration. They considered themselves to have a low socio-economic status.

Qualitative methods: 12 in-depth interviews were performed during several meetings. Special attention has been given to the case of the two FDWs that have attempted suicide and on the description of the subsequent intervention. The interviews were conducted by the author of this study – a psychiatrist with a medical anthropology background – with the help of an Ethiopian translator. The interviews consisted in open-ended questions designed to gather in-depth information about the experiences of migration, the challenges, the

resources, and the perception of mental health conditions and well-being. The interview guide was flexible to allow the interviewer to shape the session to meet the needs of the participant. The interviews were tape-recorded and transcribed in English. Details are in Annex 1.

The interviews were held in the office of the author to avoid any risk of bias associated with the place of work, where the interviewees would not feel free to talk. We asked the authorization of the employer and the availability of the MDW, and provided transport to and from the office. The interviews with the two respondents with a more tragic story (labelled as MDW 11 and MDW 12) were held in the shelter itself. With the support of the Ethiopian translator, all the participants were fully informed on the purpose of the study and expressed their consent.

Data analysis: collected data was analysed to identify common and recurrent features. The author analysed the content and guaranteed the anonymization of the quotes to protect the participants.

2nd level of qualitative data collection: key informants

Methods: the key informants identified included a labour official, a human rights lawyer, a migrant association representative, two social workers from a NGO that provides services to migrant workers, one person working in the Ethiopian embassy, and three mental health care providers (two psychiatrists and one psychologist). More details on the open-ended questions posed during the interviews are reported in Annex 2. Again, the selection combined a purposive sampling, in the light of our findings from the first stage of the literature review, and a snowball sampling. The interviews were held in the workplace of the key informants. The author analysed the data to identify common features and relevant implications.

2.1.2 FINDINGS FROM THE INTERVIEWS WITH ETHIOPIAN MIGRANT DOMESTIC WORKERS

Recurring descriptions of inhumane treatment, cultural isolation, undermining of cultural identity, and disappointed expectations dominated the discussions with the Ethiopian MDWs. Most frequently, the interviewees reported the exploitative day-to-day living and working conditions, which they perceived as a threat to their physical and mental integrity. The women interviewed showed various level of distress and ability to adopt copying strategies, depending on the abuses and the community resources on which they could rely.

Exploitation and abuse

Almost the totality of the women described inhumane working conditions, physical maltreatment (three out of 12 reported also sexual maltreatment), and denial of basic freedoms. They described heavy workloads, long work-hours, and lack of rest since the

very first day of work. Often, they declared to be the only worker to provide services to an extended family and to be expected to be on call 24 hours a day. Furthermore, once employed in a household, many domestic workers claimed to be "shared" with other families without being paid for that extra work. The interviewees admitted to be exhausted and overwhelmed, and to associate this feeling to the development of emotional distress and chronic low mood, sometimes turning into the dissociative defense mechanism of emotional detachment. Beyond the heavy workload, the interviewed women also suffered from food restrictions and sense of segregation, as their eating utensils were separated from the others.

The following extracts testifies this discriminatory and distressing situation.

"You are overload with work. They don't see you as a human being. When you eat they act and comment that you eat a lot. They don't think you may become tired. They treat you as a machine." MDW 1.

"The thing that makes me worry is to not have the time to finish all the tasks I should do. Sometimes I would work on something, for example, clean the kitchen, and then at the same time I am requested to stop everything immediately to make coffee for a visitor. Or for example I would look after the child but I am expected at the same time to be ironing clothes. There is no logic in the work, no continuity, you are requested to do contradictory things at the same time. It is like you should have ten hands and ten feet. And they are impatient. You should answer to their orders right away" MDW 2.

"I cannot eat when I am hungry. I have to wait until she (the female employer) serves me, like a dog. She puts the remnants of the food in a small plate and she expects it to be more than enough for an Ethiopian used to starvation and hunger, as I once heard her to say about me to her friend. The plates I eat in are separated from those used by the family members, as if I was dirty or contagious" MDW 3.

What emerges from the interviews is that, even when the employer is relatively nice and respectful, at least one family member is excessively demanding, with expectations of performances beyond the physical capacities of the respondent.

"Madam was relatively nice with me. She wasn't too harsh on work and would suggest that I rest after a few hours of work. She used to buy me a lot of stuff, like clothes and personal stuff for toilet, and make up and accessories. She would not get mad at me for no reason and she even bought me a phone so I can speak with my family in Ethiopia in my free time. After 7 pm, she tells me I can stop working and do the rest of the work the next day. However, when her son comes to the house, everything changes. He expects me to be at his orders immediately and requests I do several things at the same time. He has unexpected anger outbursts and throws at me things when he gets mad. And she barely does anything to protect me" MDW 4.

As expressed in the previous testimony, most of the women feel that they are a kind of scapegoat for anger or frustration. They claim that, sometimes, a member of the family gets angry for no reason while they are working, and they must hear all the shouts and the offences without understanding the motivation.

"They just make you crazy. You don't understand what they want. How they function. How they think. They are just completely mad and it makes you mad also" MDW 5.

All the respondents affirmed to be aware of other situations where domestic workers had

suffered physical maltreatment, sometimes leading to injury or permanent disability. Understandably, the women were reluctant to openly discuss sexual assault and instead preferred to refer indirectly to non-personal experiences. Nonetheless, the picture that emerges from the discussions suggests that sexual harassment was a common and distressing experience among the women in the sample.

The majority of interviewees originated from a low socio-economic background, and were unemployed or financially dependent on the family before migration. Indeed, most of the women had left Ethiopia with high expectations and hopes to improve their lives and declare they were not aware of the overwhelming working conditions and the exploitation that they are currently experiencing. They feel the pressure of failure and the obligation to help their family to increase their well-being. For this reason, they affirmed to send almost the entire income to their family in Ethiopia.

Cultural isolation and discrimination

Most of the women claimed to be able to adapt to alien cultural practices with minimal difficulties, and to accept the misunderstandings due to the different language as an inevitable and manageable component of migration. Nevertheless, they declared that being far from their families and dislocated from their communities represents the greatest distress, especially for those women with children in Ethiopia. Six respondents affirmed that this situation was exacerbated by the restrictions to their freedom imposed by the employers, which impede the participation in a local network and the access to cultural and community support. Moreover, most of the women reported to be locked inside the house with the justification of being protected. Reportedly, the most common reason to isolation was the employers' unwillingness to allow any contact with other Ethiopians. On the other side, the employers argued that these contacts would have a bad influence, that sexual relationships with Ethiopian men could cause troubles and diseases, or that their workers would share information and be more likely to leave if they had the opportunity.

"They want you to be under their control. They do not want me to see other Ethiopians or attend church on Sunday. In general, they don't want me to come out of the house. Even when they go out, they would only go after locking me up" MDW 3.

The importance of family and community ties largely appears in the reactions of the interviewees to any attempt to undermine the image of Ethiopia and its culture. Some of them became very emotional in describing how their employers held stereotypical views of poverty and hunger as if they were the only things Ethiopia could offer. They reported to have heard their employers talking with friends and other members of the family about them, laughing and saying they are living in paradise comparing to their miserable life in Ethiopia. Some of them reported to have experienced a great difficulty in controlling their feelings of sadness and anger, and a great desire to show to their employers that they are migrants simply to improve their lives, as many others do.

Reportedly, social discrimination is a very humiliating and stressing factor. For instance, the respondents testified the existence of public places where their presence is not allowed, and affirmed to be completely ignored when they accompany their employers to visit other people.

"It is very humiliating to be treated as a slave. Sometimes I would accompany madam to the beach (to stay with the children while she is swimming) and then we would discover that

MDWs are not allowed in this specific private beach along with dogs! This is very humiliating and I would cry without being able to retain myself. Luckily, my employer was a nice woman. She refused to enter this beach and would refuse to go to any place where MDW are forbidden to entry. She tried to console me and tell me that some people are racist but I should not care about these stupid people" MDW 7.

Thus, even when the employer is respectful, the social discrimination is still perceived as a powerful stressing factor that provokes feelings of shame and humiliation.

Coping mechanisms

Among the women who exhibit less emotional distress, the discussion concentrated on their strategies to resist to the demands of the employers and to cope with abusive situations. What emerges is that, apart from self-assertiveness that could be successful if the employer is not abusive, the support of the Ethiopian community is the most important support.

"They were planning for me to work in another house, in addition to the work that I was doing in their house. I started to challenge them, saying: 'I am not employed to work in the other house and I can't work in another house. I am employed to work in your house.' So finally, due to this, I didn't work as they had planned." MDW 5.

"There were Ethiopian women I met in church that saw me weeping once. I told them about my problems at work. They were advising me how I could keep myself away from these sorts of problems. So, when I discussed my problems with Ethiopian people my worry was relieved. I realized I was not alone in this" MDW 8.

The possibility to keep in contact with the family in Ethiopia is another relevant source of support. The employer sometimes does not permit the possession of a phone, and the domestic workers must rely on the collaboration of other MDWs in the Ethiopian community.

"My employer lets me go to church every Sunday, so I have a half day of rest in the week. I meet with other Ethiopians there, we can discuss our problems and this is of great help to me. One of them gives me regularly her phone so I can call my family in Ethiopia and this relieves me a lot. I live all week just waiting for these two hours on Sunday" MDW 7.

Perception of mental health and well-being

The vast majority of respondents, included those who experienced the greatest distress and attempted suicide, claimed to be in good health prior to migration. Only one had a personal history of depression and some potential factors predisposing to mental disorders were present in four cases: two women reported a family history of serious mental disorder (psychosis and/or suicide) and another two reported to have experienced parental loss and/or divorce during early childhood.

However, the women emphasized the extremely distressing external circumstances they were facing, and considered them a serious threat to their mental health and well-being, much more than any inherent individual vulnerability.

"It is just too much. You are placed in a contradictory situation constantly. They want you to do something, and than at the same time they want something else. They imagine you are like a robot capable of doing a million things at the same time. Sometimes, I would get so frustrated I would cry or get on hunger strike but they don't care. They would say to me: 'If you're not happy, just leave'. How would I leave? They have my passport and all my important stuff" MDW 9.

"It would drive anyone crazy. Even when you have time to rest, the rest can be interrupted at anytime by a new request. So there is never really a time when you can rest. Sometimes I hear madam talking about me about her friends and mocking me. This is so humiliating" MDW 10.

Eight out of the 12 interviewees described feelings of helplessness, chronic sadness, chronic fatigue, and somatic diseases.

"I often have these headaches and muscular aches all over my body. Madam took me to a doctor who examined me and said there was nothing physical but that I need to rest a few days. Madam let me rest for two days but then she was very suspicious of me. She thought I was simulating all that in order to have rest" MDW 2.

"I often thought about throwing myself out of the window. Sometimes I just don't know what to do. I feel trapped. I think about my daughter in Ethiopia and I try to calm myself. But it is so hard. I just don't feel motivated to do anything and I work like an automaton" MDW 7.

Even in the case of a respectful and nice employer (four cases in our sample), some women still claimed to feel sad most of the time, to have somatic complaints without an underlying physical disease, to have trouble to sleep, and to feel self-depreciation.

"Madam is so nice to me. She lets me to rest, buys me stuff, gives one day off on Sunday. She bought me a phone, I have access to internet and I can always call my family when I want. But still, I feel trapped somehow, away from my family. I have trouble sleeping at night, overthinking and worrying about my future, how long should I stay here, how long should I do this work?" MDW 9.

Another woman, although she never attempted suicide, described suicidal thoughts. She affirmed that, to overcome these disruptive thoughts, she seeks support from other Ethiopians and concentrates on the desire to improve the life of her children in Ethiopia.

The cases of the MDWs with suicidal behaviour

MDW11 and MDW12 associated their tragic reaction to their adverse living condition and exploitation. Both were subject to severe maltreatment from their employers and described deep feelings of humiliation, entrapment, helplessness, hopelessness, and a profound feeling of defeat. They said that, initially, they tried to rebel, but they were so harshly treated for that, with physical abuse and violence, that they could only accept their reality. They became continuously more submissive until a point where they could not see any relief other than death. One of them had two children in Ethiopia, but even that thought was not enough to mitigate her sense of despair and to give her the hope for a different solution.

"I couldn't stand it anymore. The shouting, the beating, the mockery, the humiliation, the constant humiliation. One day, my employers were out of the house, I just did what I was thinking of for a long time. I took a lot the medications that my employer takes for his hypertension and I just swallowed them without thinking. At a certain point, I remember feeling dizzy and sleepy, and when I woke up I was in the ER. Madam has discovered me lying on the floor when she came back with her husband and they took me to the ER. The doctor asked if I took any medications and I said yes. They monitored me for a few hours and then the police came to take me, as my employers wanted to admit me in a psychiatric hospital after they knew it was a suicidal attempt. I was in the police office for two days before a social worker from Caritas came and explained to me she was going to accompany me to the psychiatric hospital" MDW 11.

"I planned my suicidal attempt for a day where my employers would have not been at home and would have taken the children with them. I did not want to do it while I was guarding the children

or in front of the children. When they were gone, I just took a knife and began cutting myself, I just wanted to die. But then, I remembered my children, I tried to stop the bleeding. I was already dizzy. I was taken to the ER and then to the psychiatric hospital. But, at least, I was released from my employers, they did not want to take me back after my suicidal attempt, they were afraid I would do it again. I was released they finally let me go, even though now they still have my passport and Caritas is trying to negotiate with them to let me have it and come back to Ethiopia" MDW 12.

Frighteningly, both women did not regret their suicidal attempt as they saw it as a release from their employers and the maltreatment they suffered. They are aware of the high risk they have taken and relieved they did not die. However, they still argued that it was the only way to escape their employers. Although they were in a precarious situation, waiting to be deported to Ethiopia and wishful to escape the exploitation they were living, they admitted to be frightened about their return to their home country, due to the sense of failure they were feeling.

"I had never thought of suicide in my life before. I am a believer, a Christian, I have faith in God. I thought suicide was only for weak persons. But then, when I was at my employers' house, I was desperate. I tried to resist first, to rebel, but it got worst. I was humiliated every day. They treated their dog better than me. They did not treat me as a human being. When I think about my suicidal attempt, I really realize it was the only way to escape, as I could not even run away, I was always locked at home. Either I die or I escape. But not stay there" MDW 11.

"I heard the employers say to the police officers: 'She is a bit crazy. She has always acted weird, she does not talk much, and she has those crazy eyes sometimes, she scares the children. We don't want her anymore.' So I was the crazy one. I was the one who needed treatment, they did not even think for one second that they were pushing me every day to this edge until I completely fell" MDW12.

As a sad conclusion, we can affirm that both women were then very conscious and perceived the loss of their life as the only way to escape their situation. Moreover, they had no psychiatric condition prior to their migration and clearly related their suicidal attempt to the abuse and maltreatment they suffered at work.

Access to mental health care

All the women in the sample affirmed they did not have any autonomy to consult professionals or to seek medical help when they were ill. The reasons are multiple: they cannot move freely, they do not have financial independence neither medical insurance, and, in case of illness they are accompanied to the doctor by the employer, which remains during the entire consultation. The MDWs interviewed did not perceive themselves as being mentally ill or in need of a psychologist/psychiatrist, instead they associated their emotional distress to their work conditions. Under the control of their employer, they had never thought to consult a psychologist or a psychiatrist, even if they wanted to, and the only strategy to feel better was the support of the Ethiopian community.

MDW11 and MDW12 had the first contact with a mental health service after their suicidal attempt. They were under the responsibility of Caritas Migrant in coordination with the Internal Security Forces.

"I stayed in the psychiatric hospital only for a few days, as my employer was paying the hospital fees. The psychiatrist barely talked to me and we could not really understand each other. They gave me a lot of medications and I was sleeping all the time. Then they told me I would go to a shelter for a short

period of time before going back to Ethiopia. There were many other foreign domestic workers in the hospital where I was. Some of them really went "crazy", with delusions of persecution and reactions of excessive fear" MDW11.

All the interviewed women were completely not aware of the structure of mental health services in Lebanon, and did not know where to find help and who to contact in case of emergencies or extreme distress and despair. They considered the adverse life conditions and exploitation the real causes of their psychological disorders.

2.1.3 FINDINGS FROM THE INTERVIEWS WITH KEY INFORMANTS

Working conditions

According to the interview with the labour official, the live-in structure of domestic work requires to set specific and targeted labour standards and regulations. Either in presence or in absence of a contract, the MDWs suffer from very adverse working conditions. Usually, the absence of any effective supervision allow the employers to violate any agreements. The length of the contracts vary between one and three years and the employer has the responsibility to provide the employee with an airline ticket to the home country within the conclusion of the period. The situation reveals the fact that many women work illegally without a contract, as well as valid work and residence permits. Moreover, some become illegal due to the negligence of their employers who do not renew their papers not to pay the taxes required.

The human right lawyer argued that *"many human rights lawyers have been attempting to convince MDWs to seek redress in the courts for violations of contracts, offering their services free of charge. However, very few have been willing. Too often, they are simply unaware of their rights and unprepared to test them in Lebanon. They either leave the country to put their traumatic experience behind them or search for other possibilities of employment before returning home."*

According to the information collected by the social workers, the remuneration depends on the employer and does not exceed 350 dollars per month for Africans (whereas, for example, it can be up to 800 dollars for Filipinos). The work-hours also vary, but MDWs are usually expected to be on call 24 hours per day.

From the interviews with the social workers it also emerges that the physical abuse is not as frequent as it seems. Rather, the restriction of movement, the retention of passports, and the belittling have become "common practice" among the Lebanese employers. They also affirm that "it is important to recognize the willingness of these women to sacrifice years of their lives for their families. As a consequence, many of them suffer marriage failures and separation from their children. However, as they want to economically improve their lives and the lives of their families, they tend to look at the economic benefits unless the psychological, moral and physical costs are too high".

Role of NGOs and the Ethiopian Consul

The NGOs working with MDWs offer their help in terms of legal assistance, social support, and medical aid, including *"assistance to detained women to obtain valid documents, to retrieve passports from employers and to repatriate; provision of legal counselling; provision of shelter and medical treatment; provision of social counselling and welfare; relations with the diplomatic representation; provision of help to MDWs who have run away from their employers"*. The most

active NGOs in the field are Caritas Migrants and the Afro-Asian Migrant Center.

The Ethiopian Consul claimed that the consulate is understaffed and overwhelmed by the number of cases of Ethiopian runaways who need legal assistance. Reportedly, the Consul can rely on only two lawyers who work without charges. From this interview, it emerges that the Ethiopian migrant domestic workers are victim of major human rights abuses in comparison with MDWs from other countries. Furthermore, he said that the majority of Ethiopians in Lebanon were recruited by unknown agencies in Addis Ababa and have entered the host country illegally without a contract.

Impact on mental health and access to mental health care

Both psychiatrists interviewed said they observed a high rate of psychiatric admissions of MDWs, with the highest occurrence among African natives. The psychiatrist who works in one of the biggest psychiatric hospitals in Lebanon reported that the most frequent diagnosis is acute psychosis, with behavioral disturbances, delusions, psycho-motor hallucinations, and agitation.

However, the psychiatrist claimed that the diagnostic assessments are usually not done in a rigorous manner.

"We must be careful however, while assessing Ethiopian MDWs who are brought to the psychiatric hospital by their employer or by the social worker of Caritas, as we do not usually rely on a thorough cultural assessment, there is often the barrier of language, so we rely more on what we observe and the information we gather from the social worker or the employer. Maybe we tend to over-diagnose psychosis while it might be cultural specific manifestations of a certain form of emotional distress. Moreover, we do not always have access to the subjective experience of the MDW herself."

Suicidal attempts are also a rather frequent motive for hospitalization.

"Usually, suicidal attempts and psychiatric admissions of MDWs in Lebanon are treated by the employer, sponsor and Internal Security Forces members as if the MDW was to blame, because she is "unstable" or "crazy", therefore justifying their hospitalization before the rapid deportation back to their country of origin. In practice, suicidal attempts and psychiatric episodes among MDWs tend to be viewed as a purely individual vulnerability or neurobiological disease".

All the three mental health professionals interviewed agreed that the adverse social conditions and the work related vulnerabilities that the MDWs are facing create a high-risk environment and expose them to mental illness. They emphasized that the link between an adverse environment and the emergence of psychiatric conditions, even for those psychiatric conditions that have well-known biological predisposition, have been shown in many studies. As the psychologist said *"to the extreme, one can imagine that mental illness ultimately saves the most extremely maltreated MDWs, as it is a kind of resistance they develop to their environment. In case of abuse and maltreatment, mental illness breaks the cycle of abuse, as it obliges the employer to bring the employee back."*

"It is the feelings of helplessness and hopelessness, of being entrapped without a hope of getting out of it that are the most relevant predictive [factors] of a suicidal behavior in these situations. So the suicidal attempts are very much linked to exploitation and maltreatment and will be seen among MDWs who are maltreated by their employers."

Concerning the treatment in the psychiatric hospital, both psychiatrists admitted that they are usually pushed to use higher doses of medications or sismotherapy (ECT) to obtain a

rapid stabilization of the patient.

"We are very pressured by the employer as he covers the fees of the hospitalization. He wants a rapid improvement so the deportation back to Ethiopia can happen fast."

"Sometimes, it raises serious ethical concerns, especially in regard to the consent of treatment. In case of ECT, most of the times, MDWs are not informed about the treatment, the risks, and their informed consent is usually never gathered, as if the hospital administration systematically considered them to be unable to consent and they only needed the consent of the employer."

It also emerges that the contact between the MDW and the mental health system only happens through psychiatric admission to the hospital in case of a serious mental health problem, such as suicide attempt or acute psychosis, as the employers have the responsibility to hospitalize the MDWs in these circumstances. In fact, MDWs usually do not know how to access the community mental health services or the outpatient services.

"The mental health national system in Lebanon is mostly private so it would be very expensive for them to seek professional help. However, there is currently an initiative of the Lebanese Ministry of Public Health to reform the mental health system, which plans to integrate mental health care into primary health care, which would be more accessible to the population. In its National Mental Strategy, the MOPH emphasized the importance of promoting access to mental health care for vulnerable groups, and MDWs were listed among them. However, no practical step has been implemented yet."

In conclusion, based on the interviews with the key informants, despite the absence of formal data, it seems clear that the rate of psychological/psychiatric diseases among Ethiopian MDWs is relatively high.

In addition to the work-related causes and the serious ethical concerns, what emerges from this study is the absence of any community based or outpatient mental health services available, although a reform should be implemented soon.

2.2 THE QUANTITATIVE STUDY

2.2.1 METHODOLOGY

The population under study consists of Ethiopian MDWs selected according to the following inclusion criteria: participants must be female and work as full-time domestic workers in a household in the Lebanese capital. A total of 300 interviews based on close-ended questionnaires were administered. The structured interviews explored and assessed a set of socio-demographic variables, and allowed to calculate the score of the effort-reward imbalance. The effort-reward imbalance questionnaire has been used in various studies and validated in different cultural contexts (Siegriest et al, 2014). It measures the effort done at work and the reward for the work accomplished as perceived by the worker. This perception is considered one of the main measures of work-related stress and one of the most important predictors of work-related vulnerabilities (Siegrist et al, 2014). The effort is measured according to six items that depict the demanding aspects of the work environment. The respondents are asked to indicate how much the items reflect their typical work situation. The rating procedure envisages higher ratings corresponding to higher efforts, according to a four-point Likert scale: (1) strongly disagree, (2) disagree, (3) agree, and (4) strongly agree. The effort scale varies between 6 and 24, with higher score indicating higher effort. The reward is measured according to 16 items that depict the rewarding aspects of the work

environment. The rating procedure is defined as previously, with lower ratings pointing to lower rewards, according to a four-point Likert scale: (1) strongly disagree, (2) disagree, (3) agree, and (4) strongly agree, except for items 9, 10, 11, and 12 where the coding is reversed. The reward scale ranges between 10 and 40, with higher score indicating higher reward.

The ratio between the effort and the reward scale captures any potential imbalance and the formula is:

ER = k E/R

where E is the effort score, R is the reward score, and k a correction factor that adjusts for the unequal numbers of items.

Assuming that one effort item is equivalent to one reward item, we can define the correction factor k as follows:

K = Number of reward items/number of effort items

For ER = 1, the person reports one effort for one reward, for ER < 1, one effort is smaller than one reward, and for ER > 1, one effort is bigger than one reward.

Sampling: 300 households were randomly selected from five main areas of the capital Beirut: Achrafieh, Hamra, Furn-El-Chebbak, Verdun, Mar Elias. A trained inquirer, supported by an Ethiopian translator, was appointed to each area with the aim to select 60 households and obtain a meeting with both the employer and the migrant domestic worker to explain the structure and the objectives of the study. The quantitative data was analysed with excel.

2.2.2 FINDINGS

Socio-demographic variables

Table 1 reports the percentage of Ethiopians among the category of migrant domestic workers in five different areas of the capital Beirut. Overall, 35.6 per cent of the MDWs interviewed are Ethiopian.

Neighbourhood	Percentage of Ethiopians
Achrafieh	11.67%
Hamra	21.67%
Verdun	38.00%
Mar Elias	42.00%
Furnelchebbak	65.00%
Average	v35.60%

Table 1. Percentage of Ethiopians MDWs in five regions of the capital

Age	Percentage
less than 18	1.87%
18-25	46.73%
25-35	46.73%
35+	4.67%

Table 2. Age distribution of Ethiopian MDWs

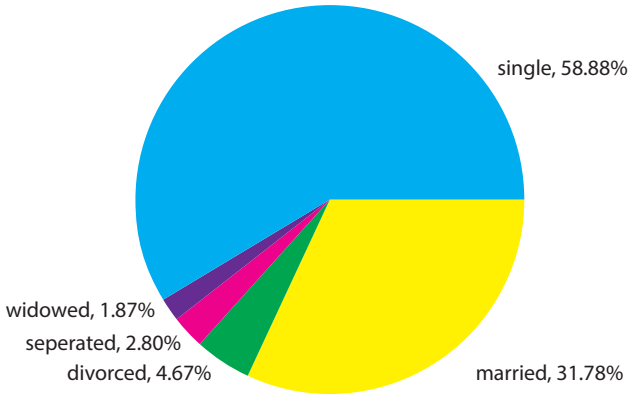


Figure 1. Marital status distribution among Ethiopian MDWs

Stay in years	Percentage
Less than 1	19%
1 to 3	30%
More than 3	51%

Table 3. Length of stay in Lebanon among Ethiopian MDWs

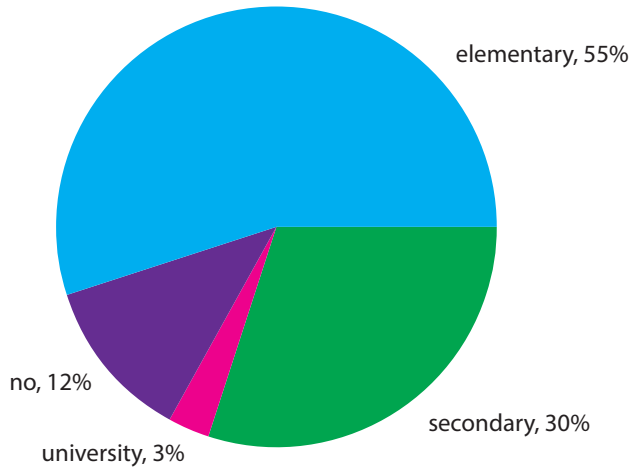


Figure 2. Distribution of the education background among Ethiopian MDWs

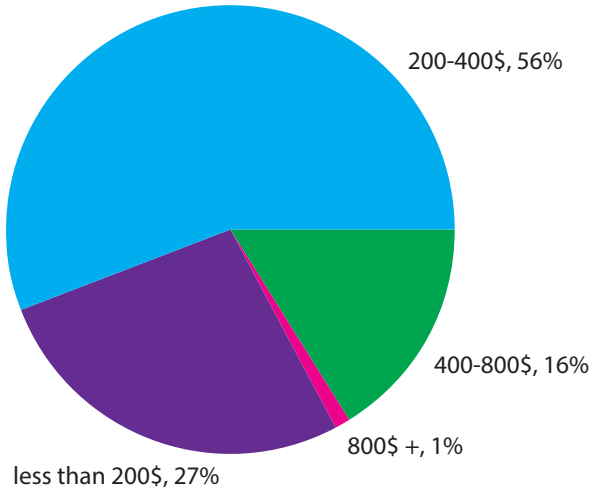


Figure 3. Distribution of the monthly salary among Ethiopian MDWs –the average monthly income is 268 US dollars

Effort and reward scores and ratio

From the answers of the interviewees, the average score for the effort is 18.06, while that for the reward is 19.5. Thus, the average E/R ratio is 1.61 and indicates that the average perceptions testify a higher effort in comparison to the reward obtained, as an expression of the low satisfaction and the highly demanding work environments. The average scores for each respondent are the following:
Average ER1 = 2.98; Average ER2 = 2.89; Average ER3 = 3.24; Average ER4 = 2.74; Average ER5 = 3.12; Average ER6 = 3.09; Average ER7 = 2.53; Average ER8 = 2.44; Average ER9 = 1.80; Average ER10 = 1.40; Average ER11 = 1.68; Average ER12 = 1.54; Average ER13 = 1.86; Average ER14 = 2.39; Average ER15 = 1.97; Average ER16= 1.88

3. ACCESS TO REHABILITATION IN ETHIOPIA

3.1 METHODOLOGY

This section discusses the qualitative interviews with six key informants and seven MDW returnees. The group of key informants include labour officials (Ministry of Social and Labour Affairs), representatives from rehabilitation centers (Good Samaritan Association; Agar Ethiopia), lawyers (Ethiopia Women Lawyers Association), and representatives of the International Organization for Migration.

Again, the selection of participants is a combination of a purposive sampling, based on the findings from the first stage of the study, and a snowball sampling. Three MDWs were recruited at their arrival at the airport, two were selected from the Good Samaritan Rehabilitation Center, and one from the Agar Rehabilitation Center. One returnee, who was working in her beauty saloon, was recruited through snowball sampling. The composition of this sample testifies the intention to grasp the experience of those newly arrived and those who had been in Ethiopia for a certain period of time. The interviews were performed by a local consultant in coordination with the author, and consisted in open-ended questions shaped to gather relevant information on the rehabilitation of Ethiopian returnees once back in their home country. The details are reported in Annexes 3 and 4. The collected data was analysed to identify common and recurrent features, assessed and ranked depending on their frequency and severity.

3.2 FINDINGS

3.2.1 INTERVIEWS WITH MDW RETURNEES

Among the seven MDWs interviewed, four affirmed to have been victims of exploitation and abuse, which in one case also included sexual harassment, during their permanence in Lebanon. On the contrary, the remaining three MDWs said they had good employers who treated them very well and were respectful. Out of the seven women, two were treated for mental illness (considered psychosis) in a psychiatric hospital in Lebanon before being deported to Ethiopia. It also emerges the case of another returnee who, to escape the sense of failure and shame, has committed suicide after her arrival to the Agar Ethiopia Rehabilitation Center. The respondents witnessed that suicidal attempts among MDW returnees from Middle East and Arab countries are frequent.

All the women claimed that the most difficult aspect of migration was the distance from their usual community, and the subsequent social isolation. In fact, those who had Ethiopian friends and were allowed communication with their family coped with the difficulties relatively better than those who were completely isolated. Importantly, even in the case of a respectful employer and in the absence of any maltreatment or abuse, social isolation still represented a significant burden.

In addition, it emerges that faith has a great importance: many women considered the role of the church and the priests they have encountered in Lebanon very helpful.

The two women hospitalized did not perceive themselves mentally ill, but rather “mad” or “lost”, and clearly associated that condition to the troubles and estrangement they had suffered in Lebanon.

Not surprisingly, the interviewees argued that one of the hardest challenges upon their return to Ethiopia was the consideration that the community had about them, as we can read:

"Here in Ethiopia, they think every returnee is a prostitute or a psycho. It is very difficult to find a job or a perspective when you come back." The social pressure intensifies the perception of disappointment of their families and the delusion for not having saved enough money to improve their lives, and exacerbates the lack of perspectives. Three interviewees affirmed they had thought not to return and four admitted they felt the pressure from their families and the obligation to provide them support. Moreover, the majority did not see any opportunity for a decent work in Ethiopia and expressed the intention to come back to Lebanon (except those who suffered extreme abuse) despite the hard working conditions.

3.2.2 INTERVIEWS WITH KEY INFORMANTS

The incidence of mental illness among returnee migrant domestic workers is high and correlated with the cultural shock, abuse, and exploitation they faced after migration. Agar Ethiopia and the Good Samaritan Association explained that most of their beneficiaries returned to Ethiopia because of episodes of mental illness arisen before the end of their contract, and reported that anxiety disorders, schizophrenia, depression, and epilepsy are the most common mental health issues.

The interviews with the key informants testifies a growing attention on the importance of rehabilitation for mentally and physically disabled returnees. This is proved by the fact that, according to the Ethiopian Airport Enterprise, a dedicated figure is in charge to identify returnees who need support upon their arrival at the airport. These dedicated nurses categorize the mental illness of returnees based on the information provided by the airport officials at the departure and on their behaviour at the arrival. In case of potential mental problem, the MDW is entrusted to the Good Samaritan Association or Agar Ethiopia. According to the considerations of the key informants, these non-governmental charities are the only associations that consider MDWs their target beneficiaries and try to meet their

needs by providing temporary shelter, support during the reintegration with the family, counselling, and liaison with the Amanuel Psychiatric Hospital.

Although mental illness requires intensive care and long-term rehabilitation, the Amanuel Psychiatric Hospital does not provide services specifically targeted to MDWs, also due to its capacity constraints. Despite the immense contribution they provide, the managers of the two rehabilitation centres illustrated their constraints in terms of budget, lack of trained mental health expertise, and small-size shelters to accommodate the growing number of returnees in need of rehabilitation.

According to the International Organization for Migration (IOM) and the MOLSA, considerable efforts are being deployed to facilitate the economic reintegration of returnees. These include the training provided by the Government in collaboration with the technical and vocational education training centres, the presence of credit and saving institutes and of financial support for business start-up capital, and the provision of working premises and linkages with the market. The Good Samaritan Association also provides economic support to the families of returnees to sustain the therapy, where needed.

According to the Ethiopian Women Lawyers Association and the Good Samaritan Association, the Ethiopian MDWs should be entitled to a legal redress for the abuses and exploitation that occur in other jurisdictions. Actions are needed to strengthen and empower the Ethiopian Consuls and the labour attachés to ensure the right of Ethiopian citizens are respected. Both the MOLSA and the IOM urge for improvements in data availability, law enforcement, networking, and information sharing among the stakeholders for an effective implementation of the Prevention and Suppression of Trafficking in Persons and Smuggling of Migrants Proclamation No. 909/2015 and the Overseas Employment Proclamation No. 923/2016. Improvements also pertain to the legal system that must be more responsive to sanction the agencies that do not respect the rights of this category of workers.

4 FINAL DISCUSSION

4.1 CONCLUSIONS

The qualitative data clearly depict a very difficult situation for the Ethiopian MDWs working in Lebanon, and the frequency and severity of exploitation, abuse, cultural isolation, and discrimination. The live-in nature of the work poses severe limitations to freedom, and results in contradictory and demanding duties, often perceived adverse and stressful. However, some of the women could react relatively well and were willing to make sacrifices with the aim to financially improve their lives and help their families in Ethiopia. Reportedly, the most predominant coping mechanism was the support of the community and the family. In fact, the women in contact with other Ethiopian MDWs and included in a good network were less vulnerable.

Most of the women perceived any mental and psychological health disease as directly related to their living conditions and affirmed that their feelings of distress and sadness were a consequence to their adverse work conditions. It also emerges that they did not know about how to access the mental health services and where to seek help. The totality of interviewees were financially dependent on their employers, and could not afford to seek private psychological/psychiatric help. In the majority of cases, they did not perceive any need of mental health care, some declared to be resigned to their living condition and considered it a necessary and temporary phase in order to improve their lives. In fact, the reasons behind their choice to migrate are mainly economic and relate to the impossibility to find decent paid jobs in Ethiopia.

The two most dramatic cases of women who attempted suicide, who did not suffer from any prior psychiatric condition, shows that this extreme reaction has been the consequence

of extreme exploitation and abuse at work. In fact, both migrants described their suicidal attempt as the only way to escape the inhumane treatment in the absence of any community or familial support.

The qualitative data found a confirmation in the quantitative analysis that revealed the prevalence of high effort/reward ratios, as an additional proof of the perceptions of demanding and constraining work against the insufficient moral and financial reward. Surprisingly, the ratio was lower than expected, but this result can find an explanation in the fact that the quantitative study was performed in the house where the MDW was employed. This condition might have represented a bias towards an underestimation of the negative aspects, as the respondents might have been afraid of potential repercussions on their workplace.

The qualitative study shows that one of the most critical factors faced by the returnees is their social representation. Once returned to Ethiopia, unemployment and lack of perspectives challenge their success in rehabilitation. This adverse situation often results in a renovated desire to undertake a new migration, even towards Lebanon.

4.2 RECOMMENDATIONS

In the light of the previous discussion, this study recommends to:

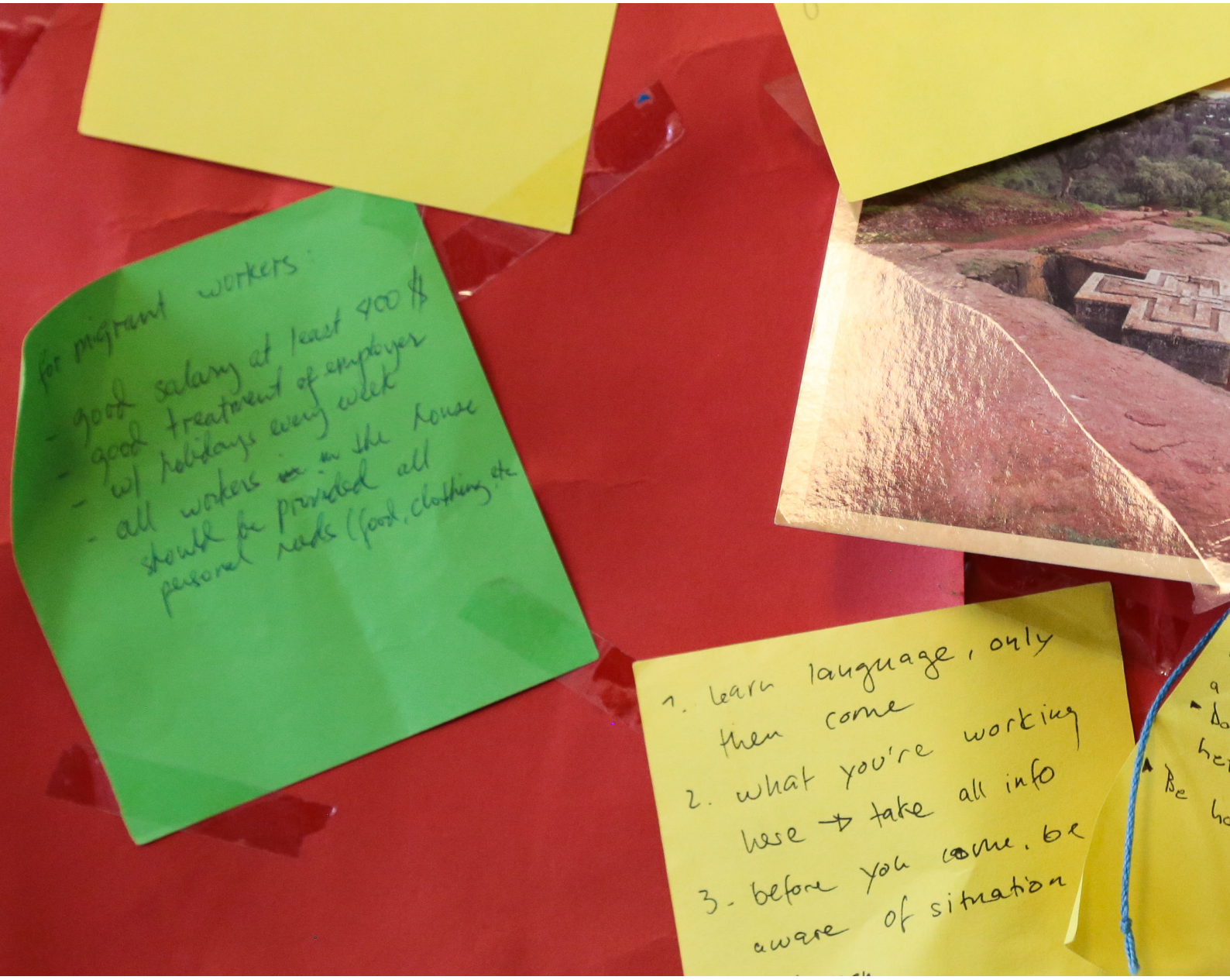
elaborate a referral mechanism in order to prepare the transition of the MDW returnees, secure the access to rehabilitation in their country of origin, and avoid discontinuity in health care. Indeed, most frequently, no specific referral from Lebanon to Ethiopia is present even in cases of hospitalization in the host country;

increase information on the available services and resources, mainly through the Consul of Ethiopia and the Ministry of Public Health. In fact, the lack of information and transparency

undermines the access to protection and rehabilitation mechanisms in Ethiopia and in Lebanon;

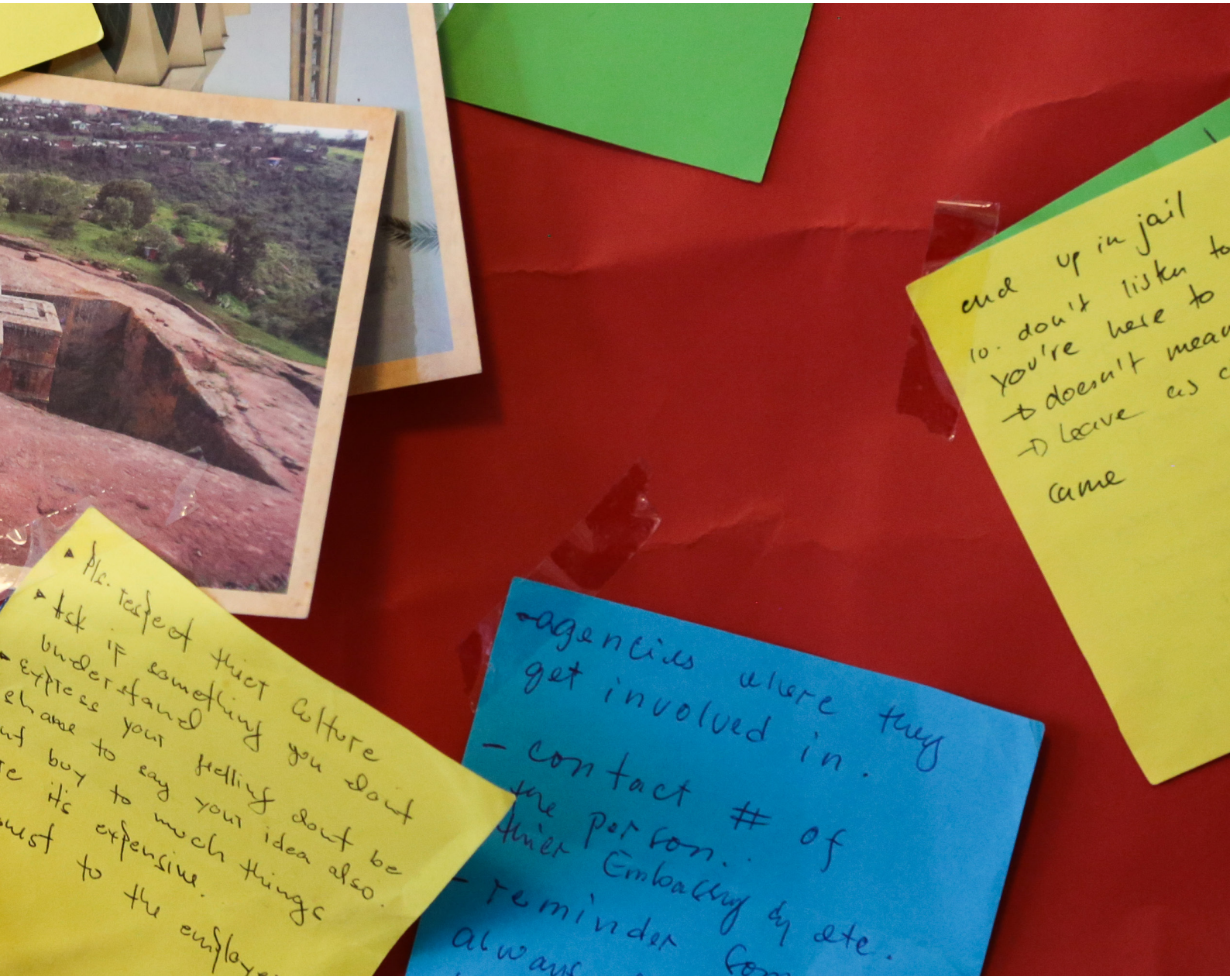
reform the institutions and enable the government and its ministries, especially the MOLSA, to manage rehabilitation centres and provide protection mechanisms. In fact, the work of the NGOs is necessary and very important but still insufficient to cover all the demands;

involve governmental parties, especially the Ministry of Public Health (MOPH), the Ministry of Social Affairs (MOSA) and the Ministry of Labour and Social Affairs to strengthen and implement the protection mechanisms. This can be achieved through improvements in the coordination between the three parties. In particular, include domestic work in the Lebanese Labour law so that the MDWs can obtain the same protection of the other workers. Promote access to mental health care and information about available community services through awareness campaigns promoted by the MOPH; as well as access to social protection



enable migrant returnees to have access to mental health services targeted to their needs; improve the accessibility to health care through careful and well-supervised decentralization, including integration into general hospitals, development of appropriate alternatives to hospital admission, such as day care and limited community-based services. Increase the number of staff, engagement with patients, and psycho-educational and supportive interventions with families.

investigate the presence of exploitation and abuse in presence of mental health conditions, given the correlation between exploitation at work and mental health conditions. For involuntary hospitalizations, a judicial third party should supervise and regulate the hospitalization to prevent any abuse, especially concerning the use of electroconvulsive therapy. Psychiatrists working in the main psychiatric hospital that receives MDWs should be aware about the importance of this judicial regulation and work to promote the protection of the rights of MDWs.



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ANNEX 1.
INTERVIEW GUIDE FOR MDWS IN LEBANON

The purpose of the interview is to solicit the experience, opinions, and attitudes of MDWs working in Lebanese households, and explore the challenges and psychosocial stressors that might affect their mental health as well as their strengths, resources, and coping skills. Each interview must be confidential.

At the beginning of each interview: a) provide context for the interview (i.e. who you are, how this particular study came to be, etc.); b) remind participants about the purpose of the interview; c) let participants know that what they say will remain confidential and anonymous. The interview is qualitative, based on a medical anthropological approach, thus it is crucial that the participant is at ease, while the researcher should ensure and inquire throughout the entire interview that the participant is comfortable and adjust the interview according to the needs expressed by the participant.

Interview guide

1) Exploring the narrative and past history:
   a) How long have they been in Lebanon and in what circumstances did they arrive to Lebanon?
   b) Did they suffer from any psychiatric/psychological condition in Ethiopia? Were they treated? In what way?
2) Exploring the experience in Lebanon and the psychosocial stressors:
   a) How is their experience with the work in Lebanon? How do they describe their living conditions?
   b) How do they perceive the attitude of the employer towards them?
   c) What are their perspectives for the future?
   d) What are the main challenges they perceive in their situation and that they face on a daily basis?
   e) Do they perceive themselves as experiencing any kind of abuse or exploitation? In case of a suicidal attempt, what was their motivation? How do they perceive the suicidal behaviour and the mental health intervention that followed (if there was any)?
3) Exploring the perceptions on mental health and the coping mechanisms/strengths:
   a) What are their usual ways to cope with distress at the community and individual level?
   b) What are their main sources of relief, and type of resources (social, spiritual, psychological, familial…)?
   c) Do they feel these usual resources are available in their current living/setting in Lebanon?
   d) What are their perceptions of the expression "mental health and illness"? What are the main strengths that they perceive relevant to their situation?
   e) Do they feel they have a support system in Lebanon? (including any available formal or informal assistance, the role of the Ethiopian embassy or consulate) Have they ever been in contact with a mental health service?

ANNEX 2.
INTERVIEW GUIDE FOR KEY INFORMANTS INVOLVED WITH ETHIOPIAN MDWS IN LEBANON

The purpose of the interview is to solicit the experience of key informants involved with Ethiopian MDWs in Lebanon. These include labour officials, human rights lawyers, migrant association representatives, workers from NGOs providing services to migrant workers, persons working in the kafala system, in the Ethiopian embassy, and mental health care providers. Each interview must be confidential and carried out with the professionalism. At the beginning of each interview: a) provide context for the interview (i.e. who you are, how this particular study came to be, etc.); b) remind participants about the purpose of the interview; c) let participants know that what they say will remain confidential and anonymous and that the duration of the interview is between 30 and 45 minutes. The interview is qualitative, based on a medical anthropological approach, and thus it is crucial that the participant is at ease, while the researcher should ensure and inquire throughout the entire interview that the participant is comfortable and adjust the interview accordingly.

Interview guide

1) Exploring the status and responsibilities:
   a) Description of their responsibilities in the relevant organization and their kind of work or contact with MDWs.
2) Exploring the situation of MDWs in Lebanon and the main psychosocial stressors they face:
   a) How they describe the situation of MDWs in Lebanon?
   b) What do they think are the main psychosocial factors affecting Ethiopian MDWs mental health and well-being?
3) Exploring access to protection and rehabilitation for MDWs in Lebanon:
   a) Do they think there are frequent mental health conditions among MDWs in Lebanon? What kind of mental health condition is the most frequent in their opinion?
   b) What are the mental health services and interventions available for Ethiopian MDWs and what do they think of their effectiveness?
   c) What do they think are the major obstacles of the system that prevent access to protection and rehabilitation for MDWs in Lebanon?
   d) Do they know about any available informal assistance mechanisms and what is its effectiveness?
   e) What is the role of the Ethiopian embassy and/or consulate in Lebanon, including what role they play, if any, in facilitating Ethiopian MDWs access to rehabilitation and justice?
   f) What are the service providers/agencies/initiatives available to protect and support

MDWs and the role they play in facilitating access to therapy and justice in Lebanon.

g) Do they know about any other key informants that might be of help for our study?

h) Other comments/remarks based on the answers to the above question.

ANNEX 3. INTERVIEW GUIDE FOR KEY INFORMANTS INVOLVED WITH ETHIOPIAN RETURNEES

The purpose of the interview is to solicit the experience of key informants involved with access to rehabilitation for Ethiopian MDWs upon returning home, including labour officials, human rights activists, lawyers, and mental health care providers in Ethiopia, and the main challenges they face.

Each interview must be confidential and carried out with the utmost professionalism.

At the beginning of each interview: a) provide context for the interview (i.e. who you are, how this particular study came to be, etc.); b) remind participants about the purpose of the interview; c) let participants know that what they say will remain confidential and anonymous and that the duration of the interview is between 30 and 45 minutes.

The interview is qualitative, based on a medical anthropological approach, thus it is crucial that the participant is at ease, while the researcher should ensure and inquire throughout the entire interview that the participant is comfortable and adjust the interview accordingly.

Interview guide

1) Exploring the status and responsibilities:

   a) Description of their responsibilities in the relevant organization and their kind of work or contact with MDWs.

2) Exploring the rehabilitation options of MDWs upon their return to Ethiopia:

   a) What do they identify as being the different rehabilitation options that MDWs have upon returning home?

   b) How do they evaluate the effectiveness of the different rehabilitation systems for migrant workers in Ethiopia?

   c) Do they think that the Ethiopian system should seek legal redress for Ethiopian MDWs for abuse and exploitation that occurs in other jurisdictions?

3) Exploring the mental health condition of MDW upon their return to Ethiopia:

   a) How do they evaluate the mental health condition of the MDWs upon their return to Ethiopia? What is the most frequent psychiatric diagnosis encountered, if any?

   b) Do they know about cases of MDWs with mental health conditions that have recovered upon their return to Ethiopia?

   c) What do they think are the main strengths, coping skills, resources, as well as vulnerabilities of Ethiopian MDWs upon their return?

   d) What are the main challenges that they face while working with MDWs upon their return?

e) Do they know about cases of suicidal risk/attempt of a MDW upon her return? What do they think is the main cause?

f) Do they know about any other key informants that might be useful for our research?

g) Other comments/remarks based on the answers to the above questions.

ANNEX 4.
INTERVIEW GUIDE FOR MDWS RETURNEES

The purpose of the interview is to solicit the experience, opinion and attitudes of MDWs who have worked in Lebanese households upon their return to Ethiopia, and explore the challenges and psychosocial stressors that might have affected their mental health as well as their strengths, resources, and coping skills. Each interview must be confidential.

At the beginning of each interview: a) provide context for the interview (i.e. who you are, how this particular study came to be, etc.); b) remind participants about the purpose of the interview; c) let participants know that what they say will remain confidential and anonymous. The interview is qualitative, based on a medical anthropological approach, and thus it is crucial that the participant is at ease.

Interview guide

1) Exploring the narrative and past history:

   a) How long did they live in Lebanon and in what circumstances did they arrive to Lebanon?

   b) Did they suffer from any psychiatric/psychological condition in Ethiopia before migration? Were they treated? In what way?

2) Exploring the experience in Lebanon and the psychosocial stressors:

   a) How was their experience with the work in Lebanon? How do they describe their living conditions?

   b) What was the reason of their return to Ethiopia? Was it a personal choice or were they obliged to come back?

   c) What are their perspectives for the future in Ethiopia?

   d) What are the main challenges they perceive in their return to Ethiopia?

   e) Did they perceive themselves in Lebanon as experiencing any kind of abuse or exploitation?

   f) Did they ever think of running away? Or have they tried?

   g) In case of a suicidal attempt, what was their motivation? How did they perceive the suicidal behavior and the mental health intervention that followed (if there was any)?

3) Exploring the perceptions on mental health and the coping mechanisms/strengths:

   a) What are their usual ways to cope with distress at a community and individual level? What are their main sources of relief, and type of resources (social, spiritual, psychological, familial…)

b) Do they feel these usual resources were available in their living/setting in Lebanon? And in Ethiopia? What are their perceptions of the expression "mental health and illness"?

c) Do they feel they have a support system in Ethiopia?

ANNEX 5.
EFFORT/REWARD IMBALANCE QUESTIONNAIRE

The following items refer to your present occupation. For each of the following statements, please indicate whether you strongly agree, agree, disagree or strongly disagree

- ERI1 I have constant time pressure due to a heavy workload. ☐ ☐ ☐ ☐
- ERI2 I have many interruptions and disturbances while performing my job.☐ ☐ ☐ ☐
- ERI3 I have a lot of responsibility in my job.☐ ☐ ☐ ☐
- ERI4 I am often pressured to work overtime. ☐ ☐ ☐ ☐
- ERI5 My job is physically demanding. ☐ ☐ ☐ ☐
- ERI6 Over the past few years, my job has become more and more demanding.☐ ☐ ☐ ☐
- ERI7 I receive the respect I deserve from my superior or a respective relevant person.☐ ☐ ☐ ☐
- ERI8 I experience adequate support in difficult situations.☐ ☐ ☐ ☐
- ERI9 I am treated unfairly at work.☐ ☐ ☐ ☐
- ERI10 My job promotion prospects are poor.☐ ☐ ☐ ☐
- ERI11 I have experienced or I expect to experience an undesirable change in my work situation.☐ ☐ ☐ ☐
- ERI12 My employment security is poor.☐ ☐ ☐ ☐
- ERI13 My current occupational position adequately reflects my education and training.☐ ☐ ☐ ☐
- ERI14 Considering all my efforts and achievements, I receive the respect and prestige I deserve at work.☐ ☐ ☐ ☐
- ERI15 Considering all my efforts and achievements, my job promotion prospects are adequate.☐ ☐ ☐ ☐
- ERI16 Considering all my efforts and achievements, my salary/income is adequate.☐ ☐ ☐ ☐

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