



Supporting Mental Well-being of Migrant Garment Workers in Jordan

33

DISCUSSION
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The report draws on and is made better by interviews conducted and discussions with stakeholders involved in our research topic, particularly those working with migrant workers in Jordan's garment sector. These include experts from government entities, non-governmental organizations, international organizations, donor agencies, multinational brands, factory management, labor union, civil society, and academic institutions. We want to say a heartfelt thank you to all those who so readily and candidly shared their insights and experiences with us. We are inspired by your commitment to improving the lives of migrant workers in Jordan.

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EXECUTIVE SUMMARY

The link between employment and worker mental health and well-being is an area of increased interest, with new epidemiological research strengthening the case for the role of work on mental health outcomes.¹ The workplace can positively influence an employee's mental health, contribute to the development of a mental health problem, or exacerbate an existing condition. The impact of mental health in the workplace extends beyond the worker, to employers and businesses that are directly affected through increased costs, reduced productivity, and significant loss of staff morale. More than 450 million people worldwide are suffering from a mental disorder, resulting in an annual productivity loss of 1 trillion USD.² Despite the extensive health and financial burdens, the connection between work and mental health is not fully understood or adequately addressed by employers or national policies. Additionally, the majority of evidence provided on this subject has been obtained from high-income countries, with very little known about low to middle-income countries.¹

Recent cases of worker suicides in the Jordanian garment sector indicate a diminished level of mental health and well-being may be pervasively impacting the migrant worker communities in the sector.³ Jordan's garment industry employs approximately 70,000 workers, of which 75% are migrant workers.⁴ Migrant workers face significant psychological and emotional challenges throughout the migration process, which can stem from the loss of familiar support structures and difficulties integrating into a new environment and community.¹ The migration process exposes workers to additional complexities which makes them particularly vulnerable to mental health stressors and may result in instances of self-harm.

This report aims to understand the role of mental health and well-being in these communities by (i) identifying the overarching factors adversely impacting the mental health and well-being of migrant workers; (ii) evaluating existing mental health services in Jordan and any potential barriers to accessing treatment; and (iii) highlighting gaps in service for the target population to distinguish

¹ WHO (2005a).

² WHO (2003).

³ Data on suicides collected by BWJ

⁴ BWJ (2018a)

capacity building opportunities at the policy and enterprise levels to support worker well-being. The scope of the report addresses general mental health problems, inclusive of mental disorders and subjective perceptions of well-being and self-efficacy. While a more in-depth diagnosis of the mental health issues in the target population would help inform the needed interventions, this paper focuses on high-level trends affecting mental health and emphasizes the services needed to provide immediate and overarching support for workers.

Globally, mental health remains a highly stigmatized and under-resourced topic. The “invisibility” of mental health status makes it difficult to quantify the impact it has on health, economic productivity and the quality of life. In spite of these challenges, “there is growing support to move mental health from the periphery to the center of the global health and development agenda”⁵ as highlighted by WHO’s Mental Health Action Plan 2013-2020. Jordan is no different and has made significant progress in improving its mental health system, with a strong commitment to enhancing development outcomes and economic progress within the country.⁶ Still, migrant workers face significant barriers to accessing treatment and the national mental health network does not offer services specific to the needs of migrant workers.

Research findings in this report are based on 28 semi-structured interviews with key stakeholders and mental health experts from government entities, non-governmental organizations, international organizations, donor agencies, multinational brands, factory management, labor union, civil society, and academic institutions. Primary research was supplemented by an in-depth academic literature review on mental health in manufacturing work environments, mental health and migration, and overall mental health challenges. While direct interviews with workers were not conducted due to the constraints of the research methodology, the primary research findings and data from impact assessment worker surveys⁷ covered different areas of the workers’ living and working conditions. Our findings revealed four categories of contributing factors to mental

⁵ Marquez (2016).

⁶ WHO (2013)

⁷ Survey questionnaires for BWJ workers collected from 2009-2016

health for migrant garment workers and five key barriers to accessing existing mental health services. The impact of the individual contributing factors and key barriers will vary in magnitude depending on the worker's unique mental health status, and are therefore not listed in any particular order. These factors and barriers, in conjunction with the migration experience, create a cumulative effect on the mental health and well-being of the migrant garment workers.

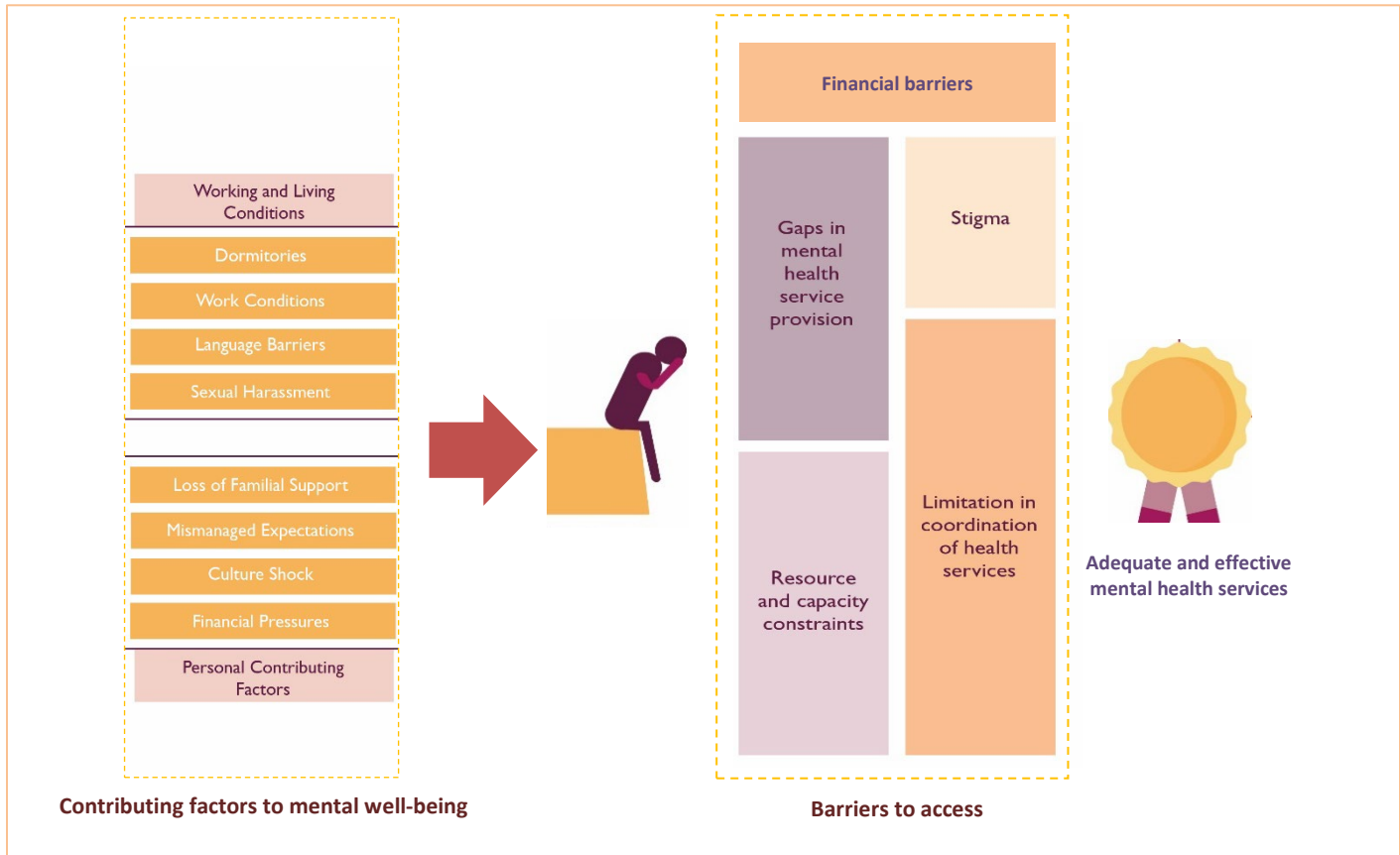


Figure 1: Contributing factors to mental well-being and barriers to accessing effective mental health services

Contributing factors to mental health and well-being of migrant workers:

- 1. Workplace conditions:** Research has shown extended durations of repetitive work, much like the work in garment factories, can adversely affect the mental well-being of workers. High psychological demands of a job and low decision latitude can cause heightened risk

of depression, loss in self-esteem, among other negative health outcomes.⁸ Migrant workers often arrive in Jordan with mismanaged expectations of their work life due to inadequate pre-departure training and orientation. This expectations-reality gap can cause additional stress and anxiety in the post-migration phase.

- 2. Living conditions:** Jordan's migrant worker population is unique in their reliance on the employer for both provision of work and accommodation. While changes in work structure alone have the capacity to shift an individual's lifestyle, additional changes in housing, meals, and the overall community can further impact the mental well-being of an employee. Workers' dormitories are flagged as one of the highest areas of non-compliance within the annual Better Work Jordan (BWJ) factory assessments and have been highlighted by stakeholders as an area of consistent concern.
- 3. Personal factors contributing to mental well-being:** Environmental adjustments of leaving one's home country can be physical, cultural, and emotional. Culture shock, language and communication barriers, loss of familiar support structures, and financial pressures from home are identified as common personal factors contributing to migrant worker well-being.
- 4. Gender dynamics in the workplace:** Although women comprise some 75% of the total workforce in the factories, only 39% of supervisory positions are held by women. Women are not involved in the majority of factory decisions which affect the workplace and its workers. Sexual harassment for migrant garment workers can form another source of acute distress or post-traumatic stress.

The above factors are compounded by the following barriers to accessing effective mental health services:

⁸ Woo (2008).

- 1. Gaps in mental health service provision for migrant workers:** There are no existing services that directly target any migrant worker population in Jordan, despite its substantive proportion of Jordan's total population. Programs targeting non-Jordanian nationals were borne out of the need to address mental health concerns faced by the refugee crisis. The formal nature of a migrant garment worker's immigration status has kept the onus of this group's health and well-being on their employers and outside the scope of services provided by the Jordanian health system and the international donor community.
- 2. Financial barriers to existing mental health services:** Public mental health services are provided to patients of migrant status at a fee. This poses a financial burden on those workers who may be willing to access services outside of the industrial zones where the garment factories are located. Although many NGOs provide mental health services free of charge to all patients, these services are often situated far from the industrial zones where migrant workers live and work, requiring migrant workers to shoulder any transportation costs.
- 3. Resource and capacity constraints in targeting migrant workers:** A lack of capacity exists in the delivery of appropriate, accessible and reliable mental health services in both the public and private sectors in Jordan. This shortage of capacity extends to the potential and future provision of services targeted at migrant workers. Additional capacity constraints apply to the migrant worker population, particularly language and cultural barriers in receiving mental health treatment.
- 4. Limitations in mental health service coordination:** Mental health programming is currently provided by both the Ministry of Health (MoH) and the Mental Health and Psychosocial Support (MHPSS) working group, who leads the coordination of NGOs providing mental health services. Better integration between these two tiers of programming, along with future mental health service providers at the factory-level, is required to ensure optimal capacity and coverage of all population groups in Jordan.

- 5. Stigma and lack of mental health awareness:** The behavioral aspects hindering access to mental health services are inextricably linked to the social, religious, and cultural stigmas attached to mental health within the region. Unlike other illnesses, mental illness is often perceived to be a sign of voluntary weakness and therefore a source of shame and disgrace. The lack of mental health awareness amplifies the stigma and acts as an overwhelming barrier to access.

The report concludes by proposing key recommendations for mental health service delivery and support structures that are both systematic and sustainable for migrant garment workers in Jordan. Gaps and barriers to available mental health services indicate the need for a decentralized mental health service structure at the factory level, along with adequate and consistent training in mental health education and awareness. Interviews across stakeholder groups revealed a fundamental misalignment in the understanding of mental health disorders. This manifested as inconsistencies between different perceptions and the vocabulary used to describe mental health issues, which can be largely attributed to mental health stigma and lack of information. The report advocates for a robust training component to alleviate the burden of shame associated with mental health and to promote a socially acceptable perception of mental health. Long-term policy goals are recommended to increase participation of migrant workers' home embassies and to integrate migrant worker mental health within Jordan's national mental health policy.

The recommendations are divided into five intervention topics. Topics 1-3 focus on the immediate recommendations which establish the programmatic capacity required to promote and deliver mental health services. Topics 4 and 5 focus on strengthening topics 1-3 in the medium to long term, by providing support mechanisms throughout the migration process and integrating migrant workers into Jordan's broader mental health policy. All five topics work together to comprehensively address the gap in mental health and well-being services for garment workers:

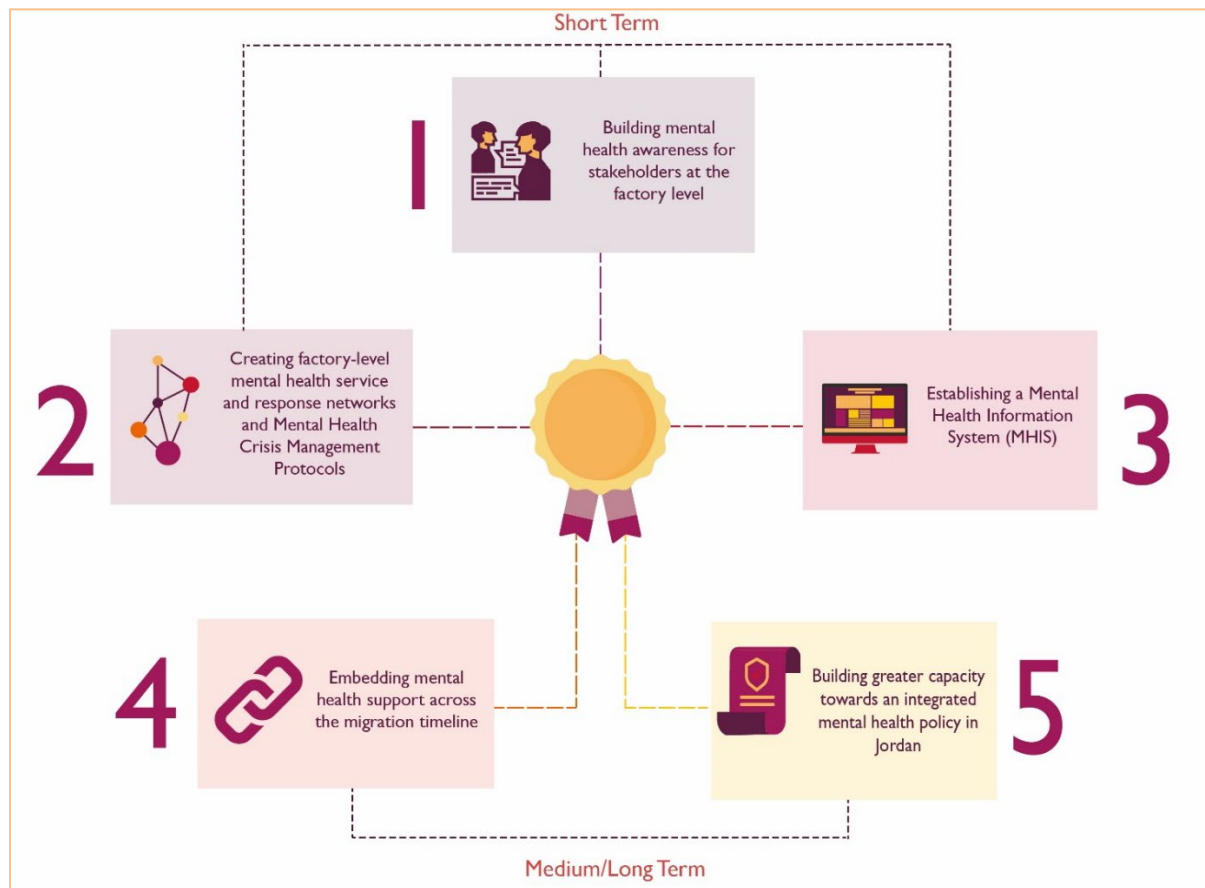


Figure 2: Five key intervention areas to address mental health challenges faced by migrant garment workers

- 1. Building mental health awareness for factory-level stakeholders:** A baseline understanding of the level and type of mental health prevalence among garment factory workers must first be established to design effective interventions. This will also help understand the misalignment across different stakeholders in the understanding and perception of mental health. An initial phase of multi-stakeholder discussions and trainings need to take place to build mental health knowledge for employees and management. This should be followed by a continuous training process to destigmatize and normalize mental health topics.
- 2. Creating factory-level mental health service and response networks through Worker Well-being Networks (WWN) and Mental Health Crisis Management Protocols**

(MHCMP): A decentralized network of mental health services can be established to effectively address the lack of services at the factory level. The Worker Well-being Network (WWN) is one that comprises of three service-delivery components which include 1) one-on-one psychotherapy interventions with a mental health specialist, 2) capacitating factory clinics to offer mental health services, and 3) access to peer counsellors and psychosocial support groups. Each of these components work together to reach workers who may be experiencing mental health challenges, from different angles. The establishment of a Mental Health Crisis Management Protocol (MHCMP) will create a response system for the WWN and factory management to manage mental health crisis cases and provide post-crisis support.

- 3. Establishing a mental health information system (MHIS):** A robust data collection and management system is necessary to monitor and evaluate the progress of program implementation. Collecting and monitoring relevant mental health indicators of the target demographic will help identify learnings to inform programmatic improvements. Most urgently, surveys and focus group studies should be utilized to collect baseline data on the prevalence and incidence of mental health problems within the target group. Focus group studies should ideally be conducted by mental health specialists with immediate access to mental healthcare networks within Jordan. The MHIS will also enable factory management and the WWNs to prioritize resources towards the most prevalent mental health concerns.
- 4. Embedding mental health support across the migration timeline:** An analysis of the complete migration trajectory is required to identify opportunities for mental health support across the migration timeline. Putting mechanisms in place to assist workers with work and life adjustments in Jordan will help optimize mental health outcomes. Recommendations to extend the duration of worker orientation, to establish a buddy system, and to increase on-the-job training, could help migrant workers better prepare for their new environment.
- 5. Building greater capacity towards an integrated mental health policy in Jordan:** To ensure sustainable impact of the proposed recommendations, integrated capacity should be built across the garment sector in Jordan. The establishment of a Factory-Based Task Force

(FTF) on Mental Health Sustainability can help coordinate capacity across and beyond factories to optimize synergies in mental health programming. Enhancing the role of embassies to support migrant worker well-being, integrating factory-level programs into national mental health policy, and developing a WHO-approved Mental Well-being certificate are additional recommendations to build capacity and create better mental health policies.

List of Abbreviations

BWJ	Better Work Jordan
GCM	Global Compact for Migration
GDP	Gross Domestic Product
IFC	International Finance Corporation
ILO	International Labor Organization
IMC	International Medical Corps
JNCW	Jordanian National Commission for Women
mhGAP	Mental Health Gap Action Program
MHPSS	Mental Health and Psychosocial Support
MHU	Mental Health Unit
MNS	Mental and Neurological and Substance Use
MoH	Ministry of Health
MoL	Ministry of Labor
NGO	Non-governmental organization
OECD	Organization for Economic Cooperation and Development
OSH	Occupational safety and health
PHC	Primary Health Care
PTSD	Post-traumatic stress disorder
RMS	Royal Medical Services
SDGs	Sustainable Development Goals
UN	United Nations
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organization

1. INTRODUCTION

Mental health in the workplace is a growing area of focus across labor markets due to the high prevalence of mental health disorders and the consequent loss in labor productivity.⁹ The World Health Organization (WHO) estimates that depression and anxiety cost the global economy approximately one trillion USD annually in lost productivity.¹⁰ Despite the recent increase in awareness, available evidence on the subject is limited and incomplete, with many crucial elements still unknown. Misconceptions continue to be widespread due to the significant stigma and fear associated with mental illness in society and the workplace.

Mental health is an integral part of health and well-being. According to the WHO, one in four people in the world will be affected by mental or neurological disorders at some point in their lives.¹¹ More than 450 million people globally¹² suffer from such conditions, placing mental disorders among the leading causes of illness and disability worldwide.¹³ Mental health problems, such as depression, anxiety, substance abuse and stress, are the result of a complex interplay between biological, psychological, social and environmental factors. These mental health determinants include individual attributes such as the ability to manage one's thoughts, emotions and behaviors, and also contextual factors such as national policies, social protection, living standards, working conditions, and community social support.¹⁴ Workplace can affect an employee's mental health, and in turn, the mental health of employees affect the workplace.²

One labor market investigating the intersection of mental health and the workplace is the garment industry in Jordan, a crucial export sector for the country, reaching 1.3 billion USD in 2018 and employing approximately 70,000 workers.¹⁵ In 1996, the sector began to expand internationally with preferential duty free and quota free access to the United States and has further grown with

⁹ OECD (2012).

¹⁰ WHO (2017).

¹¹ WHO (2001).

¹² WHO (2019).

¹³ WHO (2016a).

¹⁴ WHO Mental Health Action Plan 2013-2020.

¹⁵ BWJ (2018b).

the U.S. Free Trade Agreement in 2010 and Better Work's entry to the country in 2008.¹ Better Work, a collaboration between the United Nation's International Labor Organization (ILO) and the International Finance Corporation (IFC), has significantly improved working conditions and overall collaboration across the garment sector, while continuing to improve competitiveness for the industry. The garment sector currently accounts for approximately 20% of Jordan's GDP.¹⁶

Jordan's garment sector is unique in its reliance on migrant workers, comprising 75% of the workforce, who relocate to Jordan and live in factory-owned dormitories. The majority of the workers are from Bangladesh, India, Sri Lanka, Nepal, Myanmar, and Pakistan and are between the ages of 21 to 35. The remaining 25% of Jordanian workers are largely separated from the migrant workforce in satellite factories, which are smaller garment manufacturing factories outside of the industrial zones. Jordanian garment workers are generally well-educated, with more than 80% being educated at an upper-secondary high school level or above.¹⁷ Satellite factories are located in proximity to local communities experiencing high unemployment in order to attract Jordanian locals. Yet, efforts to increase the participation of Jordanian workers in the garment industry have had limited success and the sector remains heavily dependent on migrant labor. 75% of all workers across both migrant and Jordanian groups are women.²

¹⁶ BWJ (2017a).

¹⁷ BWJ data (2016).

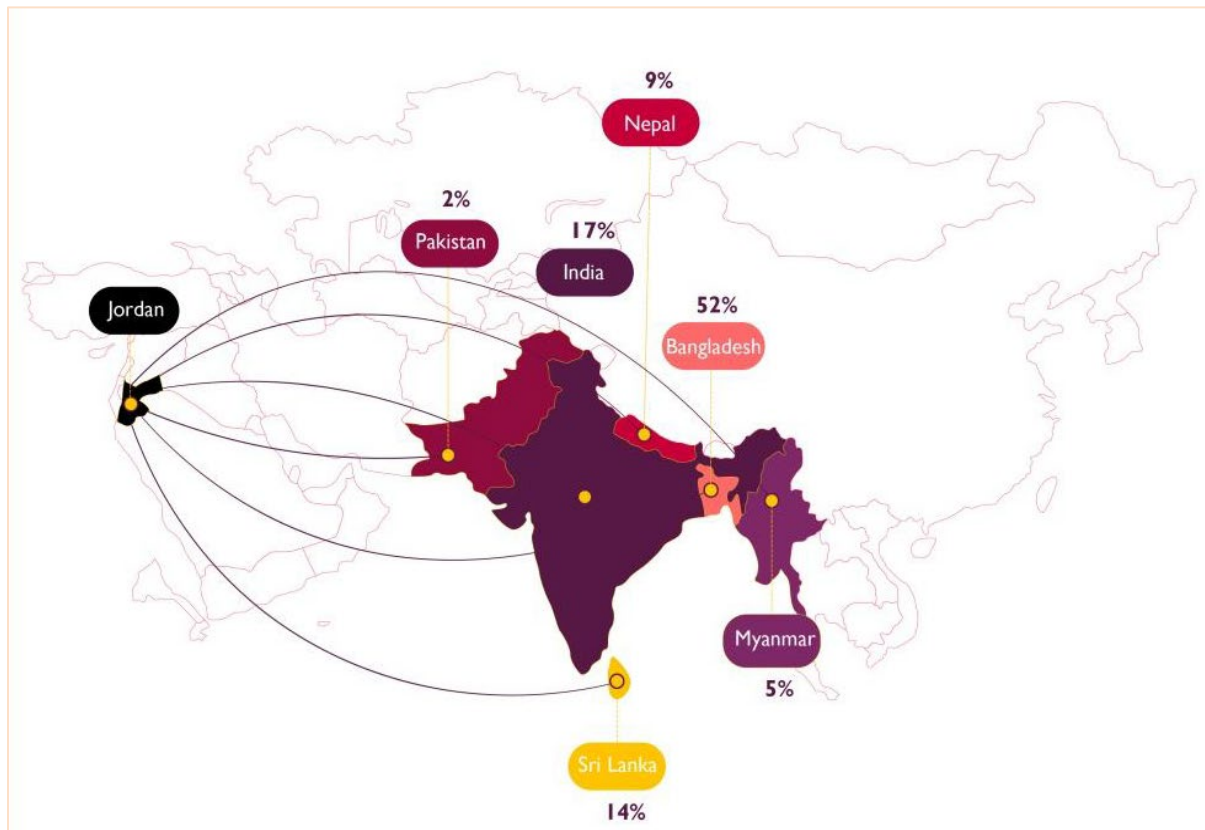


Figure 3: Breakdown of migrant garment workers in Jordan by nationality

Most migrant workers come to Jordan on a three-year contract with the option for renewal. The temporary nature of the garment workers' stay in Jordan has implications on their day-to-day life while in the country. The garment factories and dormitories are located in industrial zones which are geographically separate from Jordanian communities. Unlike other migrant groups, such as domestic or construction workers in Jordan, most garment workers do not speak Arabic and are not integrated in Jordanian society.¹⁸ Given the remote working and living situation of the industrial zones, migrant garment workers depend on these zones to function as their ecosystem for the duration of their employment, similar to the experience of students on a college campus.¹⁹ This reliance on the employer and the industrial zone establishes an additional layer of vulnerability for migrant garment workers in Jordan.

¹⁸ Authors' interviews with Caritas and Tamkeen Fields for Aid, Amman, March 2019.

¹⁹ BWJ (2018a), p. 30.

Migrant workers in any society are at an intersection of immense vulnerability given their political, economic, and social status as an expatriate workforce. Jordanian migrant garment workers are no exception and possess additional points of vulnerability: the majority are young women with low levels of education, they live and work in foreign isolated communities, and lack the support structures of their home environments. They face a unique range of cultural, migratory, and gender specific stressors which can negatively affect their mental-well-being.

Since 2017, the Jordanian garment sector has experienced 7 suicide deaths of migrant garment workers.²⁰ Suicides impact the most vulnerable populations in the world and are highly prevalent in marginalized groups of society. For young people between 15-29 years of age, suicide is the second leading cause of death globally.²¹ The profile of the migrant garment worker in Jordan fits the WHO description for those most at risk of suicide deaths. These tragic incidents have prompted a sector-wide investigation into the mental health of migrant garment workers and the imperative need to tackle the public health problem.

The problem is compounded by the high stigmatization of mental health in both the migrant worker community and the Jordanian cultural context. The perceptions of mental health and mental health problems were heterogeneous across the different stakeholders interviewed for this report. In conversations with factory management, some associated mental health concerns with needing psychiatric attention or inpatient treatment whereas others denied the existence of any such issues all together. Although only second-hand testimony of the workers' complaints and concerns was gathered, it could be implied that their grievances did not explicitly address mental health concerns and were likely not interpreted as such.²²

Less acute symptoms of mental disorder, such as burnout or depression, are normalized among migrant cohorts as common and therefore inevitable stressors.²³ Depending on home country cultures around mental health, many migrant workers may lack mental health awareness and the

²⁰ Data on suicides collected by BWJ

²¹ WHO (2014).

²² Authors' interview with the Workers Center, Amman, March 2019.

²³ Authors' interview with Caritas, Amman, March 2019.

ability to identify their own condition as in need of treatment. Most factories can employ anywhere from 5 to 11 different nationalities in a given facility. Such a multinational workforce invariably leads to significant cultural and language barriers, especially as they may pertain to nuanced topics such as mental health and well-being.

Simultaneously, Jordan's mental health landscape remains fragmented. Mental health is similarly stigmatized in Jordanian society and the institutional capacity for mental health services is insufficient due to a lack of prioritization, coordination, and financial and human resources. Interviews with Jordanian institutional stakeholders revealed the general perception of mental health to be one of psychiatric disorder requiring biomedical attention. The prevalent understanding of mental health is that it requires sophisticated, psychiatric treatment from specialized staff.

The conflation of stigmatization and fear of confined treatment of patients experiencing mental health problems symbolizes the wider conceptualization of global mental health.²⁴ This overall association with inpatient clinics or asylums has generated a strong negative cultural stigma in mental health understanding, which has resulted in gaps in service delivery and uptake. Within the Jordanian mental health landscape, migrant workers fall outside of the scope of services provided to Jordanian nationals or refugees in the country. Beyond formal barriers to access, marginalization is exacerbated by informal barriers, such as insufficient language skills or migrant workers' own cultural stigma around mental health.

The mental health landscape of the migrant worker population in the Jordanian garment sector is defined by a stigmatized understanding of mental health problems and driven by a lack of awareness of mental health. The workers' lack of awareness is compounded by management's lack of awareness, and exacerbated by the lack of awareness in the greater Jordanian context, generating a wider system of misinformation. Hence, the average migrant worker may not have the coping mechanisms or tools for psychological resilience necessary to endure the stressors and challenges of the migration experience. This overarching gap in mental health understanding and awareness

²⁴ White, R., et al. (2017), p. 31.

underpins the problem of unsupported mental health of migrant workers in the Jordanian garment sector. The entire sector is influenced by this gap, and any intervention aimed at ameliorating the mental well-being of migrant garment workers must first bridge this knowledge and awareness gap.

1.1. Why this report?

Since its entry to Jordan, Better Work Jordan (BWJ) and its partners have continuously improved the working conditions and respect for labor rights in the country's garment sector. The multi-faceted program addresses common labor concerns such as forced labor, sexual harassment, occupational safety and health, compensation, and freedom of association and collective bargaining. The scope of traditional labor relations does not encompass workers' mental well-being. In the past two years, BWJ has taken note of the tragic suicide cases that highlight the need for mental health support for garment workers. In response to these cases, this report seeks to inform the sector's understanding of the key issues surrounding mental health challenges. The mental health and well-being of workers is not a unique challenge to Jordan nor to the garment sector. For example, suicide and employment in the Chinese electronics sector has gained global attention and contributed to the momentum resulting in this report.²⁵ Across the international labor community, there is a growing need for a strategy to address mental health and employment, particularly for workforces in vulnerable situations.

This movement corresponds to the 2030 Agenda for Sustainable Development's focus on both the significance of migration, as well as mental health. The 2030 Agenda acknowledges that "migration is a multi-dimensional reality of major relevance for the development of countries of origin, transit and destination."²⁶ Consequently, the Sustainable Development Goals (SDGs) explicitly focus on human mobility, including the necessity to protect migrant workers' labor rights, facilitate orderly, safe, regular and responsible migration, and reduce the transaction costs of migrant remittances.²⁷ Moreover, the SDG agenda corresponds to the newly adopted Global

²⁵ Electronics Watch (2018).

²⁶ United Nations (2015), para 29.

²⁷ 2030 Sustainable Development Agenda (2015).

Compact for Migration (GCM) and its inclusion of mental health of migrant workers. Specifically, objectives 6, 7, 13, and 15 all address the importance of mental health and psychosocial care of workers throughout the migration process.²⁸ Migrant workers can stimulate economic growth and sustainable development in their destination countries, while contributing to the economies in their country of origin through remittances and skills acquired during the migration experience.²⁹ Both the SDGs and GCM seek to promote and protect labor migration in a manner that maximizes benefits for all those involved.

In addition, the SDGs request that countries promote mental health and well-being as health priorities within the global development agenda.³⁰ Target 3.4 seeks that countries: “by 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.”³¹ The promotion of mental health is not only considered important to improve public health outcomes and reduce suffering but also crucial in its ability to reach other SDGs. Further, Target 8.8 directly addresses the protection of migrant workers and the promotion of safe and secure working environments for all workers.³²

Despite this acknowledgement at the international policy level, suicide and mental health remain largely a censored topic in the migrant garment worker community, and the invisibility of the problem further complicates the discussion. Mental health treatment requires a nuanced and individualized approach, one that is not well-suited to generalization across a multinational group of workers. Moreover, the factory setting poses a specific challenge to identifying and treating mental health concerns; the workplace dynamic between management and labor may foster an environment of fear of retaliation instead of a safe space through which to seek mental health treatment. No precedent exists for mental health programming in the garment sector and available research on the topic is limited.

²⁸ GCM (2018).

²⁹ ILO (2018).

³⁰ Cf. SDG target 3.4.

³¹ United Nations (2015).

³² Cf. SDG target 8.8

It is against this backdrop that this report sets out to investigate the intersection of migrant workers, traditional labor relations, and mental health. The report outlines real and perceived barriers to mental health services and the contributing factors to mental health stressors for the migrant garment worker population. These barriers stem from the Jordanian institutional context and the normative culture surrounding global mental health. Contributing factors include workplace conditions, dormitory conditions, personal issues, and gender dynamics at the factory. The report illustrates key insights to the uniquely complex demographic of the migrant garment worker population and the behaviorally challenging objective of building mental health awareness and subsequent acceptance.

The report aims to identify opportunities to build capacity at the policy and enterprise level to effectively improve worker well-being for the Jordanian garment sector. Integrating lessons from global health policies, the recommendations blend labor relations and the health sector to equip workers and management with the necessary systems and tools to build both capacity and resiliency in worker well-being.

1.2. Mental health definition and scope of analysis

The report relies on the WHO definition of mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”³³ Mental health is more than the absence of a mental disorder and encompasses subjective well-being and perceived self-efficacy. Individuals who are mentally healthy can tolerate reasonable amounts of pressure, adapt to changes in their circumstances, work according to their abilities and may still experience emotional distress but in proportion to the situation. “Mental disorder” in this report is defined as mental illness reaching the clinical diagnosis of a psychiatric classification. “Mental health problems” refer to mental disorders but also more broadly to issues of psychological distress that do not reach the clinical threshold of diagnosis. As such, the scope of the report focuses primarily on these common mental health problems.

³³ WHO (2013).

Interviews with stakeholders revealed heterogeneous definitions and interpretations of mental health and mental disorders. Establishing a common definition and understanding of mental health is a necessary component to the improvement of mental health outcomes for workers.

1.3. Structure of the Report

After the introduction, the next chapter will present the research methodology used in this study, detailing the primary and secondary research conducted, along with challenges and limitations to the methods employed. Drawing on existing scholarship in the field of social and clinical psychology, psychiatry, sociology, anthropology, public policy, as well as migration and refugee studies, Chapter 3 introduces a comprehensive framework for understanding the mental health determinants in labor migration. Chapters 4 and 5 present this study's main analysis of mental health issues for migrant workers in Jordan's garment sector.

Chapter 4 discusses the specific mental health stressors for migrant workers in Jordan's garment sector. The second portion of the problem analysis in Chapter 5 provides an overview of the mental health sector in Jordan, followed by a detailed analysis of the gaps and barriers to accessing existing mental health services for factory workers. The report concludes with recommendations in Chapter 6 that outline specific interventions at the factory and community-level, as well as with regard to migrants' countries of origin to improve the mental wellbeing of migrant workers in the garment sector.

2. METHODOLOGY

This chapter elaborates on the methodology employed in the study. It presents an overview of the main methods, data sources, sampling strategy and interviews conducted, as well as the limitations of the study at hand.

2.1. Research Methodology

The research process consisted of three iterative steps.

First, the research team conducted an in-depth academic literature review on topics of mental health in manufacturing work environments, mental health

and migration, as well as on the mental health landscape in Jordan. Second, the study analyzed a large-scale survey by BWJ and Tufts University, conducted among 2,000 garment workers in Jordan from 2009 through 2016 on workers' demographics, recruitment, working, and living conditions to verify potential problem areas identified in the desk research. The survey data covered different areas of garment workers' living and working conditions, such as working hours and regularity of salary payments.



Both the academic research phase and the data analysis informed the development of qualitative interview guides for different stakeholder groups [Annex 7.2]. A first round of five initial background interviews in February and March 2019 further guided the development of subsequent interview guides. Interview guides addressed topics around the perception of mental health, the scale of problems, capacity among relevant stakeholders, as well as causes for mental health problems around migrant workers. Qualitative interviews were used to compensate the gaps in the existing academic research as well as in the data analysis and were conducted both remotely and in the field during a research stay in Jordan in March 2019. The interview strategy is described in more detail in the next section. Findings from various rounds of interviews were then triangulated with results from the desk research and data analysis in order to validate the research results presented in this report.

2.2. Interview strategy

Key stakeholders relevant to the research topic were identified through the academic and desktop research phase and an in-depth stakeholder analysis was conducted to establish a primary research strategy. Stakeholders were ranked by level of relevance and influence on the subject matter. This

ranking, coupled with the level of accessibility to the stakeholder, was employed to determine a short list of stakeholders to interview. These included, but were not limited to, government entities, non-governmental organizations, international organizations, civil society, academic institutions, factories, garment industry buyers, and the labor union. Detailed, semi-structured interviews were conducted with a total of 28 stakeholders. Interviews were conducted in person and via video conference.

Interviews with factory management, unions and the Workers Centre were used to gain an understanding of worker well-being in light of the limitations faced by the team in interviewing migrant workers. Various levels of factory management were interviewed across seven factories over three days. Each factory employs between 1,110 and 3,000 migrant workers of anywhere between 5 to 11 different nationalities. Factory owners and high-level management are similarly multinational, including Indian, Chinese, Sri Lankan, and Jordanian nationals.

The seven sample factories were selected with the intention to provide a heterogeneous and comprehensive understanding of the existing environmental and mental health landscape at the enterprise level. A combined purposive and convenience sampling technique is often used for groups difficult to penetrate such as migrant workers.³⁴ Therefore, such technique was employed to reach intended stakeholders who met the objective of the study in order to bypass time and resource constraints, as well as the limitations to accessing migrant workers. Respondents were proactively contacted during the first round of key informant interviews, and referred by BWJ for the qualitative field interview round.

The research team aimed to adopt a case study framework with sequential interviewing, an approach employed to understand the “how or why questions about unknown processes before the start of a study.”³⁵ Each interview was treated as a separate case study, yielding detailed information on factors contributing to or detracting from migrant worker well-being. The interview techniques employed sought to identify multifaceted challenges to address the multi-dimensional

³⁴ Weiss, R. (1995).

³⁵ Small, M. L. (2009).

nature of the problem. It also allowed for identification of nuanced and persistent patterns through the comparison of responses.



Figure 4: Stakeholder Interview List

2.3. Limitations

While the research strategy employed methods that sought to provide a clear snapshot of mental health services and challenges for migrant workers in Jordan’s garment sector, certain limitations need to be noted. In particular, limitations may arise through the use of proxy data for the migrant

workers' perspective, the selection of stakeholder interviews, and the sample size of factories interviewed.

Firstly, an important limitation of the study is that the report's observations are not based on discussions with migrant workers on their mental health experiences. We unequivocally stress the importance of including the voices and experiences of migrant women and men. Though we strongly believe that no intervention regarding mental health services for migrant workers should be planned without their meaningful and extensive participation, our research could not directly engage with this core group of stakeholders, as mandated by the short research period in Jordan, the exploratory character of this research, language and cultural challenges, as well as necessary safeguards for human subject protection in the context of the sensitive and personal nature of mental health. Proxy interviews on workers' experience were conducted with unions as well as with the Worker's Centre but the data gathered in these interviews was intermediated by these organizations. Through these interviews, our research attempted to reduce such intermediation by organizations by asking questions from different angles, asking interviewees to consider workers' perspective, and expanding our interview scope to include stakeholders closest to the target population.

Secondly, the selection of stakeholders for interviews was mostly determined by the existing network of BWJ stakeholders. Focusing on stakeholders that BWJ has close relationships with provided access to relevant interviews and information sources. Given the time and capacity constraints of the research project, the findings are not based on research with organizations from outside the BWJ network. A group of stakeholders that was particularly underrepresented are organizations involved in the pre-migration and migration phase of workers, such as labor agents in countries of origin as well as relevant embassies in Jordan. For such organizations, we sought to include information through desk research.

Lastly, the sample of factories interviewed may not be representative of the overall composition of the Jordanian garment sector. Seven out of 89 factories were interviewed that collectively accounted for roughly 25,000 out of the 70,000 garment workers in Jordan. These factories are larger in scale and larger export-focused factories may face different challenges than

subcontracting or domestic-facing factories. In particular, labor standards are generally improved in BWJ participating factories compared to their non-export facing counterparts.³⁶

3. UNDERSTANDING MENTAL HEALTH DETERMINANTS IN THE CONTEXT OF LABOR MIGRATION: A FRAMEWORK

Mental health issues in Jordan's garment sector touch on a range of research areas in the fields of mental health in migrant communities, gender dynamics in mental health, as well as mental health cultures and barriers. While specific work on mental health among migrant garment workers is a new focus, a large body of literature in social and clinical psychology, psychiatry, sociology, anthropology, public policy, as well as migration and refugee studies has shed light on specific mental health challenges for mobile populations.

The migration cycle consists of three stages that describe an individual's migration process. In the pre-migration phase, individuals decide to migrate and undertake preparations. The migration phase involves the physical relocation and arrival in the host country. In the post-migration phase, the migrant lives in the host country and is exposed to a new country's social, political, economic, and cultural circumstances. The post-migration period of adjustment can vary in length. While rates of mental illness may increase in the latter stages of the migration cycle, mental health stressors may arise in all three stages. The three stages of migration will impact biological, social, and psychological aspects of an individual and trigger specific mental health stressors.³⁷ In addition to the three stages discussed, the re-integration phase poses challenges of its own for many workers after the completion of their stay abroad. While re-integration is not the focus of this report, any capacity building and coping strategies that migrant workers acquire abroad will also help them to deal with mental health stressors after their return to home communities.

The following table provides a first overview across research in the three stages of the migration cycle focused on in this report, followed by an in-depth analysis of each determinant category.

³⁶ Authors' interviews with Tamkeen Fields for Aid and the Workers' Union in Amman, March 2019.

³⁷ Bhugra, D., & Gupta, S. (2011), p. 1-2.

	Pre-migration	Migration	In Host Country
Gender & Sexual Harassment	<ul style="list-style-type: none"> - Predisposition from sexual abuse and trauma 	<ul style="list-style-type: none"> - Verbal and physical abuse by recruiters 	<ul style="list-style-type: none"> - Sexual harassment from host community, coworkers and supervisors
Socio-Economics & Work	<ul style="list-style-type: none"> - Socioeconomic predisposition - Loans for relocation - Economic need - Attraction of financial benefits 	<ul style="list-style-type: none"> - Lower salaries than promised - Unexpected fees 	<ul style="list-style-type: none"> - Informal loans
Recruitment, Contract & Work	<ul style="list-style-type: none"> - Labor agents withhold information 	<ul style="list-style-type: none"> - Contract swapping - Placement in different position or sector - Longer contract duration 	<ul style="list-style-type: none"> - Working hours and labor conditions - Forced labor - Voluntary contract extension
Family & Relationships	<ul style="list-style-type: none"> - Migration decision made by family - Financial goal for family 	<ul style="list-style-type: none"> - Loss of family structure and personal networks - Normalization of stressors 	<ul style="list-style-type: none"> - Family problems - Loyalty and guilt towards family - Communication with family - Romantic relationships - Long intervals between home visit - Friendships among migrants along ethnic groups
Education	<ul style="list-style-type: none"> - Limited formal education - Insufficient pre-departure training 	<ul style="list-style-type: none"> - Lack of knowledge on host country - Lack of training on the job 	<ul style="list-style-type: none"> - Limited language skills - Lack of knowledge on own rights - Illiteracy limits options to seek assistance
Culture & Stigma	<ul style="list-style-type: none"> - Home country stigma on mental health 	<ul style="list-style-type: none"> - Culture Shock - Value conflicts 	<ul style="list-style-type: none"> - Host country stigma on mental health - Isolation from host country population
Access to Mental Health Services	<ul style="list-style-type: none"> - Pre-departure health screening does not cover mental health - No access to mental health services 		<ul style="list-style-type: none"> - Lack of knowledge on mental health - Lack of service provision at factories - Language barriers - Financial barriers

Figure 5: Determinants of mental health among migrant workers across the migration cycle

Mental health pre-dispositions

Migrants' mental health challenges do not always start with the migration process itself. Biological, genetic, and socio-economic factors can influence an individual's predisposition. Prospective migrants' predispositions can have a significant impact on later mental health outcomes. Predispositions and pre-existing conditions can be exacerbated by migration-specific

factors. Biologically, mental illness, including suicidal and self-harm tendencies, are influenced by an individual's brain chemistry.³⁸

Regarding socio-economic factors, specific context in countries of origin matter for individual mental health outcomes. Studies show that migrants from low- and middle-income countries tend to have experienced traumatic events due to widespread socioeconomic disparities, political unrest, weak legal protection, a lack of control over one's living situation, or ongoing conflict.³⁹ Social adversity in early life stages, such as insufficient parental care, has been shown to shape mental health outcomes later in life.⁴⁰ In particular, elevated exposure to traumatic events can lead to higher rates of post-traumatic stress disorder (PTSD) in low-income countries.⁴¹

Among migrants from those countries of origin, women are at a higher risk of having been exposed to traumatic events and subsequent PTSD. According to Bhui et al., traumatic events in female migrant cohorts may include violence, sexual abuse, civil war, or physical injuries.⁴² Women may also have experienced marginalization in their country of origin, which can lead to fears of being marginalized further when mental health issues arise after migration.⁴³ Beyond gender, a history of mental disorders, economic hardship, as well as alcohol and substance abuse are factors for vulnerability during the migration cycle.⁴⁴ The range of factors even before the start of the migration process make it difficult to predict mental health behavior in a general capacity for migrant cohorts at large.

Mental health in the pre-migration phase

During the pre-migration process, individuals prepare for their relocation. The decision-making process is crucial for migrants' capacity to cope with mental health stressors later in the migration cycle. Vulnerability increases when the migration decision was not made voluntarily but, for

³⁸ Arango, V., Underwood, M. D., & Mann, J. J. (2002), p. 443.

³⁹ Atwoli, L., et al. (2015), p. 307.

⁴⁰ McGowan, P. O., & Szyf, M. (2010), p. 66.

⁴¹ Miller, K. E., & Rasmussen, A. (2010).

⁴² Bhui, K., et al. (2003).

⁴³ Chandra, P. S. (2011), p. 214.

⁴⁴ Moussaoui, D., & Agoub, M. (2011).

example, by relatives who decide to send younger family members abroad.⁴⁵ In the opposite case, women may decide to work abroad against the will of their family.⁴⁶ The literature on the New Economics of Labor Migration highlights the importance of households as key units of analysis for migration and economic decisions. Often, the decision to work abroad is linked to a specific financial goal for the family. Such aspirations and goals in the pre-migration phase can have a strong impact on self-esteem during workers' stay abroad. If financial aspirations cannot be achieved, stress and psychological distress will likely increase.⁴⁷

Needs and expectations that are financial and material in nature, such as securing housing or educating one's children, can turn into psychological distress for migrant workers. It is also well documented that migrants often accumulate debt to finance their migration.⁴⁸ These feelings are exacerbated if it seems as if there is no way out of financial insecurity, and if insecurity turns into fear of the future. Yet in other cases, economic drivers may disguise underlying factors such as a difficult family situation, abusive relationships, or pressure from society that incentivize workers to migrate.⁴⁹

Once a migration decision is made, the pre-migration phase is crucial for expectation management and information gathering on the destination country. Migrants' educational level and professional skills have been shown to facilitate their integration into the host country.⁵⁰ Pre-departure trainings have the potential to facilitate the expectation management process and convey information that will help migrants adjust after their relocation. However, these trainings are mainly held by private providers and are not standardized in content, in particular when it comes to topics of health and mental health.⁵¹

⁴⁵ Moussaoui, D., & Agoub, M. (2011); Frantz, E. (2008).

⁴⁶ Hettige, S. T., et al. (2012), p. 28.

⁴⁷ Moussaoui, D., & Agoub, M. (2011), p. 102.

⁴⁸ Naujoks (2018), p. 95-96.

⁴⁹ Hettige, S. T., et al. (2012), p. 27.

⁵⁰ Moussaoui, D., & Agoub, M. (2011), p. 103.

⁵¹ IOM (2015), p. 20.

Mental health during the migration phase

During the process of relocation to another country, migrants, especially females, are regularly exposed to verbal, physical, and sexual harassment by labor agents, who organize their travel to the destination country.⁵² Beyond these immediate factors of distress, migrants go through a range of physical and psychological stressors. Leaving one's home country, in many cases for the first time, implies environmental changes, such as changes in climate and food. Bhugra and Gupta emphasize the mutual influence between physical health, stress, and mental health.⁵³

Environmental changes, as well as continuing stress and cumulative life events, may trigger biological, psychosomatic, and psychological responses. The stage of migration also entails emotional and structural losses. A very shaping loss is that of language and, potentially, of the confidence that comes with expressing oneself in one's own language or dialect.⁵⁴ Immediate loss of migrants' family structure and social support networks also generates an impactful effect. In most cases, family members, spouses, and children of migrants stay behind, which can lead to anxiety or, in the long-term, social difficulties.⁵⁵ Wojcik and Bhugra find that grieving for such losses is a natural and healthy reaction to migration. Different cultures of origin may have distinct ways of expressing and dealing with loss. It is only when symptoms cause disproportionate distress or persist for a long period of time that mental health services may be needed.⁵⁶

Mental health in the post-migration phase

Experiences during the migration phase, including feelings of loss and grievance, may carry over into the post-migration phase. When adjusting to a new country, migrants face a range of mental health stressors, whose impact may vary depending on individual vulnerabilities and coping strategies.⁵⁷ Stressors may include physical working and living conditions, a lack of support networks, barriers to accessing services, including language barriers, marginalization and discrimination in the host country, as well as culture shock.

⁵² Hettige, S. T., et al. (2012), p. 35.

⁵³ Bhugra, D., & Gupta, S. (2011), p. 2.

⁵⁴ Bhugra, D., & Gupta, S. (2011), p. 3.

⁵⁵ IOM (2015), p. 51.

⁵⁶ Bhugra, D., Wojcik, W., & Gupta, S. (2011).

⁵⁷ Moussaoui, D., & Agoub, M. (2011).

Housing and living conditions shape migrants' immediate environment in the host country and are important social determinants of mental well-being.⁵⁸ Evans found that housing quality and overcrowding may incite negative psychosocial processes, which in turn can affect mental health.⁵⁹ Housing circumstances are also key determinants for potential isolation from the host society. Living and working conditions are one dimension on a range of economic, cultural, political, and religious factors that can cause culture shock in migrants. Culture shock encompasses the process of adapting to a new culture, while experiencing loss of one's own culture and conflicts between the two. Culture shock has been identified as a major factor for psychological distress.⁶⁰ The extent of cultural bereavement and culture shock depends on the pace of acculturation, with individuals responding differently under similar circumstances.⁶¹

When mental health problems arise, migrants encounter a lack of knowledge on and access to existing services. Workers reported to lack the time, knowledge, or resources to use health services.⁶² Even if physical accessibility needs are met, emotional accessibility remains a barrier for many migrants. A sense of entitlement to mental health services will vary across cultures of origin. In the host country, service utilization is dependent upon language skills and acculturation.⁶³ Bhugra and Gupta also illustrate the importance of different host country cultures around the identification of mental disorders. The level to which migrants are impacted by the host culture, their presentations, and care pathways into the health system are crucial determinants of access to mental health services.⁶⁴

Help-seeking behavior depends on health and mental health literacy, as well as on the identification of mental health problems.⁶⁵ One barrier to identifying mental health problems can be the perception that everyone in a larger cohort of migrants is going through the same situation. Migrant

⁵⁸ Mangrio, E., & Zdravkovic, Z. (2018).

⁵⁹ Evans G. W., Wells N. M., & Moch, A. (2003).

⁶⁰ Moussaoui, D., and Agoub, M. (2011), p. 102.

⁶¹ Bhugra, D., Wojcik, W. and Gupta, S. (2011).

⁶² IOM (2015), p. 48.

⁶³ Ingleby, D. (2011), p. 231.

⁶⁴ Bhugra, D., & Gupta, S. (2011), p. 2.

⁶⁵ Ingleby, D. (2011), p. 231.

workers may normalize their stressors within their cohort instead of seeking help.⁶⁶ In the extreme case of suicide, bandwagon effects have been established that show heightened suicide thoughts, attempts, and depression rates among the peers of suicide victims.⁶⁷ The availability of therapeutic and psychosocial services, especially during the first year after losing a peer, is crucial.⁶⁸

Given the persisting barriers to service access, social support is imperative for migrants. Social support networks considerably contribute to migrant workers' mental health outcomes and are inversely correlated with depression, anxiety, and stress.⁶⁹ Hernández-Plaza et al. analyzed that informal social networks were migrants' primary source for help and prevailed over the use of formalized social support interventions.⁷⁰ In Jordan, migrant workers mainly formed such networks with coworkers from their own country of origin.⁷¹ However, ethnic density, that is the concentration of an individual's ethnic group, does not necessarily represent a social support network.⁷² Regarding relationships with family in the home country, loved ones can catalyze strengths in migrant workers when going through difficult periods. Simultaneously, when family relationships become threatened or suffer during workers' stay abroad, they can be a significant source of distress and cause emotional damage.⁷³

Women may suffer from a disproportionate lack of social support, given their likely marginalized role in both the home and host country social structures which can stimulate a fear of being alienated further.⁷⁴ Regarding gender dynamics in migration, female migrants experience different challenges and coping strategies for mental health stressors.⁷⁵ Women face particular vulnerabilities and hardships abroad, including irregular payment of salaries, long working hours, physical and sexual abuse, and obligations back home.⁷⁶ Personal stigma around mental health is

⁶⁶ Joachim, G., & Acorn, S. (2000).

⁶⁷ Feigelman, W., & Gorman, P. S. (2008).

⁶⁸ Feigelman, W., & Gorman, P. S. (2008), p. 181.

⁶⁹ Wong, D. F. K., & Leung, G. (2008); Tonsing, K., Zimet, G. D., & Tse, S. (2012).

⁷⁰ Hernández-Plaza, S., Alonso-Morillejo, E., & Pozo-Muñoz, C. (2006).

⁷¹ Frantz, E. (2008), p. 626.

⁷² Moussaoui, D., & Agoub, M. (2011), p. 102.

⁷³ Hettige, S. T., et al. (2012), p. 36.

⁷⁴ Chandra, P. S. (2011).

⁷⁵ Chandra, P. S. (2011).

⁷⁶ IOM (2015), p. 20.

exacerbated for immigrant women. A strong sense of loyalty for relatives can increase barriers to accessing mental health services. Mental illness can stimulate guilt towards the family that is being financially supported for being sick abroad and ‘letting them down’.⁷⁷ These findings also align with what Chandra identified as the main stressors for mental health issues. Home and family problems, together with relationship problems, were found to distress female migrant workers more than the working and living conditions abroad.⁷⁸

Across all phases of the migration cycle, vulnerabilities, barriers, and coping strategies for mental health problems vary across migrant groups due to both individual and structural factors. The scholarship cited above informed the research design, interpretation of data, and recommendations made in this report. Subsequent sections aim to corroborate the literature review with primary research to crystalize specific insights and corresponding recommendations for the multinational workforce in the Jordanian garment sector. Understanding the large system of stressors and determinants is important in order to design meaningful interventions for the improved mental health outcomes of the migrant garment workers in Jordan.

4. CONTRIBUTING FACTORS TO MENTAL HEALTH AND WELL-BEING OF MIGRANT GARMENT WORKERS

While barriers to mental health services illustrate the difficulty in treating mental health issues, understanding the root causes and principal factors that influence mental health outcomes is necessary in order to effectively address such issues. Building on the framework in Chapter 2 that spelled out various potential mental stressors during the migratory process, our primary research sought to understand contributing factors specific to the migrant garment worker’s experience in Jordan. Although our research was not designed to fully evaluate the determinants, expert interviews generate direct lines of inquiry into the conditions that exacerbate the mental stress of workers. These conditions will need to be validated by further research, most notably with the migrant workers themselves.

⁷⁷ Chandra, P. S. (2011), p. 214.

⁷⁸ Chandra, P. S. (2011), p. 213.

As discussed in Chapter 3, there are many factors that determine the outcome and success of migration. The effect of migration on an individual's mental well-being is multilayered, affecting the individual physically and psychologically. The process of migration itself involves a series of losses, ranging from emotional losses with family and friends, to societal and structural losses with culture and language. Grieving for this loss is a necessary reaction and natural consequence of migration; however, the severity of symptoms differs based on the individual.

Depending on existing coping skills, past experiences, and overall emotional resilience, every worker will have a unique subset of mentally triggering circumstances. This section aims to illustrate more generally common themes discovered over the course of the primary research phase, particularly during factory site visits. As discussed in Chapter 2 above, our study was unable to include the voices and preferences of migrant workers. While capturing their views and the existence of stressors through direct research with and of these populations is crucial for an in-depth understanding of the ground realities, our research is based on the information gathered in key informant interviews, site visits at factories and dormitories, other studies on such stressors, and the analysis of available data on relevant factors. Based on this data, our research found that the main contributing factors impacting the mental well-being of migrant garment workers can be categorized across four themes: workplace conditions, living conditions, personal factors, and gender dynamics at the factories. These contributing factors will affect each worker distinctly and, therefore, individual factories must validate their areas of prioritization with feedback from the workers. As such, the factors are listed below in no order of importance or significance, and convey a cumulative effect on worker well-being. Our findings may lay the groundwork for future investigative research needed on the specific contributing factors to mental health and well-being of the target demographic.

4.1. Workplace conditions

As the primary reason for migration, the role of work in the lives of the migrant workers is a significant one, important enough to uproot and transplant their lives entirely. Consequently, the conditions of the work itself and the expectations of the migrant worker pre-arrival all contribute to the mental well-being of the individual. Past research using BW data found that working

conditions have a significant impact on worker's perception of well-being and mental health, particularly as it relates to life satisfaction and measures of depression and traumatic stress.⁷⁹ While aspects such as wages, working hours, and occupational safety and health all contribute to the working conditions that influence the mental well-being of any employee, this study highlights two elements of the migrant garment worker's experience that may be unique to their employment status.

Repetitive work adversely affecting mental well-being

Studies have shown that the most adverse reactions of psychological stress occur when psychological demands of a job are high and the worker's decision latitude in the task is low.⁸⁰ The combination of these two characteristics define the repetitive and physically demanding nature of the work in the garment manufacturing factories. Other health outcomes and negative spillovers from repetitive work include a four-fold increase in depression, loss of self-esteem, a more passive and restricted leisure behavior, exhaustion, reduced emotional availability, irritability, and increased nervousness. Consequently, the sense of belonging to a significant group and emotional well-being can be severely impaired, further isolating the worker in an already foreign community.

Mismanaged expectation of nature of work and work life

The high stress nature of the work and the physical characteristics of the factories are often not communicated to the migrant worker prior to arrival. Consistent with the literature review, lack of infrastructure around pre-departure training was a recurring theme across our interviews with stakeholders.⁸¹ Our primary research revealed pre-departure training is not uniform across worker experiences and workers with a large aspiration-reality gap tend to struggle most in adjusting to life in Jordan. Upon arrival, the orientation process lasts one or two days at maximum before the worker is fully integrated into the factory workstream.⁸² Some migrant workers were unaware of what sector they would be employed in, while others had no information on their working conditions or had been promised higher salaries. Mismatched expectations and short formal

⁷⁹ Adler, P., Brown, D., Dehejia, R., Domat, G., & Robertson, R. (2013).

⁸⁰ Isaksen, J. (2000), pp. 85-86.

⁸¹ Authors' interviews with Tamkeen Fields for Aid and with the Workers' Center, Amman, March 2019.

⁸² Authors' interview with Tamkeen Fields for Aid, Amman, March 2019.

acclimation periods may exacerbate existing stressors from the migratory experience and cause shock upon arrival in Jordan.⁸³

4.2. Living conditions

Jordan's migrant worker population is unique in their reliance on their employer for both provision of work and living accommodations. While changes in work structure alone have the capacity to shift an individual's lifestyle, additional changes in housing, meals, and overall community can further impact the mental well-being of an employee. The need to ensure decent living conditions for migrant workers in Jordan's garment sector was highlighted as a priority among stakeholders of the industry during Better Work's most recent multi-stakeholder forum.

Dormitories

Housing is important for the inclusion of individuals in the life of a community and plays an important role in the quality of life, health, and overall well-being of individuals.⁸⁴ Regarding housing accommodations, the garment factories provide gender segregated dormitories for their migrant workers. On average, rooms are shared between eight workers and individual space is divided by bunkbeds. The quality and capacity of these dormitories varied across factories visited, differing in the structure of dorm management, shared common spaces, green space, and overall layout.

National regulations and standards generally guide the monitoring of workers' accommodation. According to Better Work Jordan's 2019 Annual Report, non-compliance rates under worker accommodation (audits from 2016-2018) remain high. Forty-eight percent of factories were found non-compliant with the measure of accommodation cleanliness and protection against disease carrying animals or insects. Forty-three percent were found non-compliant on the measure of whether accommodation is protected against heat, dampness, and cold. Dormitories were one of the highest areas of non-compliance within the annual report.

⁸³ Ibid.

⁸⁴ Vingilis, E., & State, S. A. (2011).

The relationship between housing and mental health is positively correlated, with housing being one of the best-researched social determinants of health outcomes.⁸⁵ Studies have found associations between elevated levels of psychological distress and stress-related housing conditions, including high residential density measured as persons/room⁸⁶ and related unwanted social interactions⁸⁷, physical quality of housing⁸⁸, and insecurity from crime⁸⁹. In 2016, Jordan's Ministries of Health and Labor signed a Memorandum of Understanding that entrusts labor inspectors to inspect the housing units where garment migrant workers reside. Currently, minimal standards are enforced in dormitory structure and quality. The majority of suicide cases reported since 2017 occurred in the dormitories.

Interviewed stakeholders, including buyers and government ministries, expressed serious concern over the quality of the dorms, with one buyer specifically pointing to the quality of living conditions in Jordan as the company's primary cause for concern in Jordan. The sector has seen some improvement with the dorms, with a reduction in the number of workers assigned to a room from 15 to 8 workers per room. However, the overall condition of the dorms remains poor and ultimately up to the discretion of individual factories. In light of these factors, a healthy community environment—one that encapsulates a safe and comfortable living and working space—is of great importance to mental well-being

4.3. Personal factors contributing to mental well-being

Beyond the physical conditions in workplace and housing, additional personal factors specific to the migration experience may adversely affect the migrant garment worker's mental well-being.

Environmental adjustments

Leaving one's home country (the first time for many migrants) to a new and foreign environment, requires many physical and psychological adjustments. Environmental changes can be physical, such as a change in climate and food, as well as cultural and emotional, such as experiencing

⁸⁵ Taylor. L. (2018).

⁸⁶ Lepore, S.J.; Evans, G.W.; Schneider, M.L (1991).

⁸⁷ Saegert, S. (1982).

⁸⁸ Galea, S.; Ahern, J.; Rudenstine, S.; Wallace, Z.; Vlahov, D. (2005).

⁸⁹ Cohen, D.A.; Mason, C.; Bedimo, A.; Scribner, R.; Basolo, V.; Farley, T.A. (2003).

culture shocks and feelings of unmet expectations. All these factors may contribute to emotional and physical distress which can have a major impact on a person's mental well-being.

Expert interviews cited culture shock as one of the more common stressors experienced by migrant workers during the adjustment period.⁹⁰ Researchers have found that 'culture shock' comprises five distinct aspects, including the strain of adapting to a new culture, a sense of loss of one's old culture, confusion in role expectations and self-identity, a feeling of being rejected by members of the new culture, and anxiety and feelings of impotence due to an inability to cope with the new environment.⁹¹ It is likely that migrant workers will experience one or more of these five aspects, particularly given the distinctive cultural environment of the migrant worker communities located within the industrial zones, which are neither fully Jordanian nor predominantly of any migrant nationality but rather a diverse mix of multiple national cultures in an isolated setting. To cope with culture shock and the new environment, many workers actively engage on social media. Stakeholders mentioned that via smart phones, workers are able to access Facebook to maintain ties with friends and family back home.⁹² In one factory, Skype sessions with agencies in the home country are provided to alleviate the initial difficulties of culture shock.

Language and communication barriers

Migrants' capacity to communicate with others from different backgrounds, both verbally and non-verbally, impacts their sense of belonging⁹³. In the factories, Bangla, Hindi, Tamil, Arabic, Urdu, and English were among the main languages spoken. Communicating across languages, particularly between management and workers, was noted by various stakeholders as a challenge. The inability or difficulty to learn a new language has been established as a predictor of mental health risks, specifically for female migrant workers.⁹⁴ The stage of migration also entails emotional and structural losses. A very shaping loss is that of language and, potentially, of the confidence that comes with expressing oneself in one's own language or dialect.⁹⁵

⁹⁰ Authors' interview with Tamkeen Fields for Aid, Amman, March 2019.

⁹¹ Pantelidou, S, & Craig T (2006), pp.777-781.

⁹² Authors' interviews with factory management and with the Workers' Center, Amman, March 2019.

⁹³ Bhugra, D., & Gupta, S. (2011), pp. 243-258.

⁹⁴ Chandra, P. S. (2011).

⁹⁵ Bhugra, D., and Gupta, S. (2011), p. 3

Studies show that language skills and their development are a key element for a positive migratory experience. Communication barriers were noted as a challenge between management staff and workers of different nationalities. One factory stated that well-being officers were hired for every language spoken in the factory so workers could express grievances in their native tongue. However, this effort is not the norm and any provision of multi-level services is at the discretion of factory management. In the case of another factory, the dorm matron spoke only one language and stated that due to language barriers, she could only communicate with the women who spoke the same language as her. As a result, workers may not feel empowered or equipped to share if they have concerns or issues of a general nature.⁹⁶ For issues that are emotional or of a vulnerable nature, language is particularly important in conveying nuanced ideas or sentiments.

Loss of familiar support structures

Alienation from one's family can bring feelings of isolation that impact an individual's sense of belonging⁹⁷. Usually, spouses and children of Jordan's migrant workers stay behind, and as such, the migrant worker experiences anxiety or social difficulties due to loss of social family structure. Various stakeholders that work directly with workers also pointed out that physical separation and working hours present additional challenges to communicating with family back home.⁹⁸ In many cases this is the migrant's first time away from home, so depending on the duration of the worker's contract in Jordan, the family ties may weaken, leading to exacerbated isolation and homesickness.⁹⁹

Financial pressures

Financial pressures arise from migration-related expenses and pre-existing financial goals related to the migration decision, such as the improved financial support of relatives and family. Both factors can become a tremendous source of stress. In our interviews, stakeholders emphasized that many women come to Jordan to earn as much money as possible in several years, then go back to

⁹⁶ Authors' Interview with Columbia University, School of Social Work, March 2019.

⁹⁷ Cacioppo, J. T., & Cacioppo, S. (2014), pp.58-72

⁹⁸ Authors' interviews with factory management, Amman, March 2019.

⁹⁹ Authors' interviews with factory management, Amman, March 2019.

their home country with their earnings. Workers may work overtime, extending their workday up to a total of 12 hours a day, to maximize income during their time in Jordan. “Yes, the women want to work more hours, but that is also physical stress that really reflects on mental stress,” stated one interviewee that works directly with workers. “Sure, there is a choice officially but they also need the money and, in fact, they *do not* have a choice.” Overtime becomes a normalized aspect of work within the migrant worker communities and a refusal to work overtime may be negatively perceived.¹⁰⁰

An additional challenge stems from unclear financial arrangements between the migrant worker and the family back home. Several stakeholders mentioned that workers may feel frustrated if they learn that their family has been using the remittances in a different way than they intended.¹⁰¹ A welfare officer at one of the factories stated that there have been several instances when he has been in touch with workers’ families to help resolve family financial problems.¹⁰² To alleviate the burden of financial stress on workers, one factory instated a financial literacy workshop for workers to gain the skills they need to manage their income and family expectations around finances.¹⁰³

4.4. Gender dynamics in the workplace

A key theme that arose across interviews was the role of gendered experiences in the workplace. The status of women in the garment sector reflects larger societal gender imbalances, which depend on economic and cultural factors, as well as working conditions. According to Better Work Jordan’s 2019 Annual Report, almost 49,000 women were employed in various capacities in the 79 factories surveyed for the report. Of the nearly 49,000, about 75% of the workforce in direct exporters were women, about 50% among subcontractors, and almost 91% in satellite units. That being said, overall, women make up only about 39% of the total 3,951 supervisors. Therefore, although women represent about 80% of the workforce in the garment sector worldwide, they are

¹⁰⁰ Authors’ interview, Amman, March 2019.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Ibid.

concentrated in the lowest-paying, lowest-skilled occupations. As a consequence, women are not as involved in the factory decisions affecting workers. “Women hold less than 8% of leadership positions and we don’t have a clear methodology for women getting to these leadership positions,” said one government stakeholder. Several factories interviewed discussed efforts to shift the gender inequality in management. In one factory (the gender ratio of this factory in aggregate level is men 40% and female 60%), all the line managers are female.¹⁰⁴

Another gendered issue that arose in interviews as a contributor to mental well-being is sexual harassment. Sexual harassment occurs not only between employer and worker, but between workers and in the host communities. Because workers are from a range of different cultures, there exist heterogeneous understandings of relationships and sexual harassment.¹⁰⁵ In 2018, the Jordanian National Commission for Women’s (JNCW) released findings from a study that found that 75.9% of women in Jordan were subjected to some form of violence in their lives. Interviewees stated that female workers are hesitant to discuss verbal abuse or sexual harassment, even sometimes among their peer group, for fear of retaliation. A Better Work training initiative on sexual harassment prevention, for example, cites the fear of speaking out as one of the greatest challenges uncovered by the training.¹⁰⁶ Multiple stakeholders that work directly with workers stated that women who experience abuse at work are often confronted with additional stigma and marginalization, especially if seeking access to support services.¹⁰⁷ Sexual harassment can be a major source of acute stress or post-traumatic stress.¹⁰⁸ This could potentially lead to significant disability and reduced work performance. The shame and stigma associated with sexual harassment may prevent a worker from reporting the incident, allowing the mistreatment to continue. Both reported and unreported cases of sexual harassment can be significant contributors to the mental well-being of workers.

¹⁰⁴ Authors’ interview, Amman, March 2019.

¹⁰⁵ Authors’ interview with the Workers’ Center, Amman, March 2019.

¹⁰⁶ Better Work (2014).

¹⁰⁷ Authors’ Interviews with Caritas, with the Union, and with Tamkeen Fields for Aids, Amman, March 2019.

¹⁰⁸ WHO (2005).

5. BARRIERS TO ACCESSING MENTAL HEALTH SERVICES FOR MIGRANT GARMENT WORKERS

Based on the framework linking mental health and labor migration presented in the previous two chapters, Chapter 5 provides an overview of the existing landscape of mental health services in Jordan and assesses the extent to which migrant garment workers experience barriers in accessing such services. Although mental health concerns are not unique to the experience of the migrant worker demographic, both within and outside of the garment sector, the following analysis focuses specifically on barriers faced by migrant workers within the garment sector.

Despite the adverse effects on health and overall well-being, major gaps still exist worldwide in dedicating resources to mental health, with less than 2% of health budgets dedicated to mental health in low and middle income countries.¹⁰⁹ Jordan has been identified by WHO as a country in need of intense support for strengthening the mental health system.¹¹⁰ It was selected as the first country to implement WHO's mental health action programme (mhGAP), which aimed to scale up mental health services and integrating mental health into primary health care.

Jordan is divided into twelve governorates or *muhafazah* – first-level administrative division of many Arab countries (equivalent of provinces) – which are further divided into districts (*Iiwa*) and sub-districts (*qda*).¹¹¹ Its health system is composed of overlapping health care providers with Ministry of Health (MoH) facilities serving approximately 60% of the general population, the Royal Medical Services (RMS) serving around 40%, the private sector being accessed by approximately 50%, and the university sector serving approximately 5% of the general population. Additionally, the United Nations Relief and Works Agency (UNRWA) provides primary health care services to approximately 1.6 million Palestinian refugees¹¹².

¹⁰⁹ WHO (2016b).

¹¹⁰ WHO (2019).

¹¹¹ IMC (2017).

¹¹² WHO (2011).

Mental health and psychosocial care in Jordan are provided by the government, the military, the private sector, universities, and NGOs, who deliver both inpatient and outpatient care at different levels. However, no single entity has sole policy-making or budget-holding responsibility of the mental health sector.¹¹³ The MoH, RMS, and private sector have previously been the main providers of mental health service in the past, whilst a large presence of NGO's exists today due to the influx of refugees in the past decade.

Jordan's public mental health system previously focused strongly on a biomedical model of care with little resources dedicated to psychosocial or community-based services. Recent years have seen an increased commitment to improve mental health care in Jordan. The Jordanian Ministry of Health, with the support of the World Health Organization office in Jordan and in partnership with the Jordanian Nursing Council initiated the reform in 2008 to scale up mental health services for Jordanian and refugee populations, focusing on a bio-psychosocial and community-based approach. This reform led to the establishment of a central governance unit for mental health - the Mental Health Unit (MHU) within the Primary Health Care (PHC) Directorate at MoH. It also saw the establishment of two coordination groups, mainly the National Technical Committee and the Mental Health and Psychosocial Support Working group to advise the MHU and provide coordination among service providers, respectively.

Despite the reform and continuous plans to improve the mental health landscape in Jordan, non-refugee migrant workers are excluded from the serviced population. Expert interviews indicate this is predominantly due to a lack of awareness on the demand for mental health services within the garment migrant worker population. This gap in service provision is further exacerbated by the resource and capacity constraints faced by existing mental health service providers.

The demand side barriers to mental health services for the migrant garment worker population are two-fold: 1) A gap in mental health service provision for migrant workers combined with 2) the geographical and financial challenges faced by these workers in accessing existing services. Barriers in supplying effective mental health services to garment migrant populations include: 3)

¹¹³ UNHCR (2018).

resource and capacity constraints of the existing health system, 4) weakness in coordination of existing services, and 5) stigma and a lack of sufficient mental health awareness. As discussed earlier in the report, stigma functions as an overarching barrier that affects both the willingness of migrant workers to seek out available services and increasing the supply and coverage of effective service provision by mental health service providers. The following section will provide a detailed analysis of the five key barriers faced by migrant workers in accessing mental health services. They are listed below in no particular order.

5.1. Gap in mental health service provision for migrant workers

There are an estimated 440,000 to 540,000 migrant workers in Jordan, of which approximately 315,000 are officially registered and over 60,000 are employed by the apparel industry. The number of migrant workers is comparable to the number of officially registered Syrian refugees within the country (approximately 655,990).¹¹⁴ There are no existing mental health services that directly target any migrant worker population, despite its substantive proportion in relation to the total population in Jordan (9.5 million).

Both the latest Mental Health and Psychosocial Support (MHPSS) *Who is Doing What Where and When (4Ws) in Mental Health and Psychosocial Support in Jordan* report (which provides a mapping of mental health and psychosocial support service activities within Jordan¹¹⁵) and information gathered through expert interviews¹¹⁶ suggest mental health specific programs were borne out of the need to address mental health concerns faced by Syrian refugees and Jordanian nationals. NGOs within the MHPSS network prioritize both Jordanians as well as refugees, with its distribution of beneficiaries composing of Syrians (31%) Jordanians (22%), Iraqis (17%), Staff/Volunteers (14%) and Others, which include Palestinian, Yemeni, Somali, and Sudanese refugees (16%)¹¹⁷.

¹¹⁴ ILO (2017).

¹¹⁵ IMC (2017).

¹¹⁶ Authors' interviews with Jordanian ministries and NGOs, Amman, March 2019.

¹¹⁷ ILO (2017).

Most interviewees were not aware of the sheer size of the migrant population or the demand for mental health services within this population.¹¹⁸ In addition to this, another possible explanation for the lack of services can be attributed to the lack of responsibility for migrant worker health. Various expert interviews suggested it is the factory's responsibility to provide all health-related services to its employees, particularly if the workers' migrant status is legal. The formal nature of the migrant garment worker's immigration status has kept this group outside of the scope of the mental health and psychosocial support services provided by the international donor community.

5.2. Financial barriers to access existing services

As mentioned in section 4.1. above, there are currently no mental health services being provided at the factory level and services outside of the Industrial Zones do not target migrant garment workers. Factory workers can access mental health services within MOH clinics outside the Industrial Zones. Migrant workers are charged for services provided by public clinics and hospitals. This poses a financial burden on those who may be willing to access services outside of the Industrial Zones but cannot afford to do so. An NGO expert interview confirmed that although mental health services would be provided at no cost to every patient regardless of their nationality, they rarely treat migrant workers due to geographic barriers. Public mental health services on the other hand are open to patients of all nationalities, but the services are not free-of-charge for patients of migrant status.¹¹⁹

5.3. Resource and capacity constraints in targeting migrant garment workers

A lack of capacity exists in the delivery of appropriate, accessible and reliable mental health services in both the public and private sectors in Jordan. This shortage of capacity extends to the potential provision of services targeted at migrant workers. Whilst many stakeholders, including the MHU and various NGOs, expressed interest in further understanding and addressing the mental

¹¹⁸ MHPSS (2017)

¹¹⁹ Authors' interview with Jordanian Ministry of Health, Amman, March 2019.

well-being of migrant workers, they acknowledged capacity constraints as the leading concern for why it may be difficult to do so.¹²⁰

The Director of the Mental Health Unit (MHU) noted the lack of capacity and funding as the main barrier to supporting migrant workers, particularly those working in the garment industry. The non-refugee migrant population is not a priority when resources are limited and existing capacity is focused on improving the overall mental health system. Moreover, the various waves of refugee migration in the last decade have overwhelmed the Jordanian mental health system, establishing a secondary market of service providers from the international donor community.¹²¹ Refugees are understood to need specific mental health support given the trauma generated by conflict and much of the service provision in Jordan is directed at the refugee population.

Our findings indicate different levels of capacity constraints in the provision of mental health services to migrant workers. These include the lack of appropriate human resources, financial resources, and infrastructure.

Human resources

Inpatient services are currently provided by a total of 7 psychiatric units throughout the country – three MoH psychiatric hospitals (one of which focuses on the treatment of substance use), one psychiatric unit under the Royal Medical Services and three inpatient units in three separate general hospitals (King Abdullah Hospital, Jordan University Hospital and Ma'an Governmental Hospital). There is also a total of 39 hospital outpatient clinics, health centers and prisons, provided by a network of psychiatrists under the National Center for Mental Health. These services exist throughout all governorates for an average of 1-2 days per week and focus on psychotropic drug treatment. While there are some mental health professionals working with international and national organizations to provide psychosocial services to refugees, few are working directly with migrant populations.

¹²⁰ Authors' interviews with Jordanian ministries and NGOs, Amman, March 2019.

¹²¹ WHO (2016c).

Another unique capacity barrier exists specifically for garment migrant workers. Expert interviews¹²² have suggested the importance of providing mental health professionals who speak the native language of migrant workers. Successful mental health treatment requires a strong trust alliance between doctor and patient and a language barrier may preclude the worker's ability to participate in or benefit from treatment. The use of an interpreter contaminates the more personal rapport required for this level of trust to be established. Jordanian law prohibits doctors who have not passed the Jordanian medical exam board, from legally practicing medicine in the country. All factory managers have indicated the legal requirement to hire Jordanian doctors and nurses for the factory health clinic. This limit poses a barrier on the appropriateness of mental health service providers, in light of the diverse demographic makeup of migrant workers in the garment industry.

Financial resources

Most low and middle-income countries do not assign adequate financial resources for the care of Mental and Neurological and Substance use (MNS) disorders. Almost every expert interview cited a shortage of financial resources as one of the biggest challenges to the sustainable and long-term scale-up of mental health services in Jordan, resulting in the need to prioritize their respective mandates over potential interventions targeted at migrant workers. There are a large number of international NGOs and UN agencies intervening in Jordan in the field of mental health and psychosocial support, although these projects are often funded on a short-term basis.¹²³ This along with the lack of coordination poses risks to the sustainability of existing mental health interventions, especially as mental health and psychosocial support may require continuous treatment.

5.4. Limitations in coordination of mental health services

The establishment of the Mental Health Unit (MHU) within MoH was done so with the purpose of providing central governance on the provision and scale-up of mental health services within Jordan. It also helped launch various coordination mechanisms, including the National Mental Health Policy in 2011 and the establishment of both a permanent National Technical Committee

¹²² Authors' interviews with Jordanian ministries and NGOs, Amman, March 2019.

¹²³ WHO (2016c).

to support the MHU and the Mental Health and Psychosocial Support (MHPSS) working group to lead the coordination of NGOs providing mental health services.

Although there is strength in having achieved these coordination mechanisms, the shortfall lies in the practical implementation of these structures. The MHPSS task force is currently co-chaired by International Medical Corps and the World Health Organization. It is yet to be taken over by MoH, despite the 2011 mental health policy document indicating plans to “assume leadership for this group.”¹²⁴ A WHO stakeholder claimed that long term effectiveness and sustainability of mental health reform can only be achieved through integration of all mental health programmatic activity under the leadership of MoH. The lack of coordination results in siloed and duplicated efforts and misses opportunities for synergies within the mental health sector. Formally integrating these service provision structures into the national health policy of Jordan creates the institutional oversight and accountability required for any sustainable health programming.

5.5. Stigma and insufficient mental health awareness

Beyond physical and financial barriers to mental health services, migrant garment workers also face cultural and normative barriers. Mental health stigma, defined as the “devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses,”¹²⁵ is a barrier to mental healthcare around the world. Despite the fact that many countries, like Jordan, are slowly acknowledging the issue of mental health, the concept is still accompanied by considerable social shame, leading many individuals to avoid seeking treatment or support¹²⁶. The behavioral aspects hindering mental health service provision are inextricably linked to the social, religious and cultural stigmas in the region. Unlike other ailments, mental illness is socially perceived to be a sign of voluntary weakness, and therefore a source of shame and disgrace. Expert interviews revealed the role of religion in the mental health context; some described mental health challenges

¹²⁴ National Mental Health Policy (2011).

¹²⁵ Abdullah, T., & Brown, T. L. (2011).

¹²⁶ WHO (2016c).

as “tests from God” and could be overcome through piety.¹²⁷ This lack of mental health awareness amplifies the stigma and functions as a formidable barrier to accessing services.

The stigma extends into the institutional realm: mental health is deprioritized at the policy level partly because of the negative bias associated with mental illness and therefore a shortage of mental health professionals and services exist in the country. The persistent cultural stigma prevents those needing care from seeking it out, thereby reducing the demand for services. Despite the prevalence in mental health issues, the negative stigma generates a lack of sufficient mental health awareness and creates a feedback loop with service delivery and uptake. As such, the problem remains invisible, further perpetuating the stigma and the lack of awareness.

Cumulative impact on mental health and well-being

The aforementioned contributing factors and key barriers illustrate the multidimensional vulnerability of the migrant garment worker in Jordan. Adding this set of elements to the individual mental health and coping skills of each worker will result in a unique reaction, but one that may be at a high risk of self-harm. Given the profile of the average migrant garment worker in Jordan and the cumulative effect of the migration experience, contributing factors, and key barriers, it is clear that the target population would significantly benefit from added support structures to help them adjust to and cope with their new working lives in Jordan.

¹²⁷ Authors’ Interviews with the Columbia University School of Social Work and with BWJ Staff, New York/Amman, March 2019.

6. IMPROVING MENTAL HEALTH AND WELL-BEING OF MIGRANT GARMENT WORKERS: A COMPREHENSIVE AGENDA FOR ACTION

Based on the analysis of the previous chapters, this chapter provides suggestions for a comprehensive agenda for action to address existing gaps in mental health services for migrant garment workers in Jordan. Improving mental health outcomes requires a comprehensive approach of integrated services. These services should encompass awareness creation, prevention, diagnosis, treatment, and continued management of mental health patients through post-treatment follow-ups and psychosocial support (see figure 1 below). As established in section 1.2, the scope of proposed mental health services at the factory level will address common mental health disorders whilst more acute mental health cases should be referred to a mental health specialist in the Jordanian health sector. The proposed interventions aim to reduce feelings of isolation in workers and build individual and collective capacity in addressing a broad range of mental health challenges.

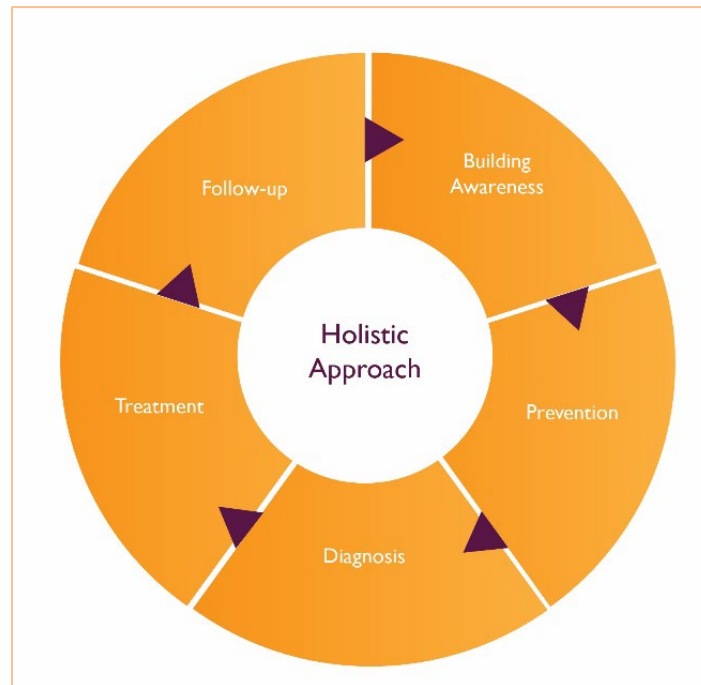


Figure 6: A comprehensive approach to improving mental health outcomes

The list of barriers and gaps in mental health services from Chapter 4 and contributing factors to mental-wellbeing from Chapter 5 can be simultaneously addressed by this comprehensive agenda for action.

This chapter provides recommendations on the following five intervention topics:

The five topics work together to comprehensively address the gap in mental health services for garment workers. Recommendation topics 1-3 are related to programmatic capacity and intend to directly address the mental health service gap through the creation of a decentralized mental health care system. These three recommendations work comprehensively and would ideally be implemented simultaneously during the first phase of intervention. Recommendation topics 4 and 5 focus on strengthening Recommendations 1-3 in the medium to long term, by providing support mechanisms throughout the migration process and integrating migrant workers into Jordan's broader mental health policy. Each recommendation is explored in further detail below.

6.1. Building mental health awareness for stakeholders at the factory level

The first barrier to address in mental health service provision is the stigma associated with the topic. Our study shows a certain misalignment in the understanding and perception of mental health across stakeholders at the factory level. As such, all levels of the garment factory require activities to promote awareness and a less stigmatized understanding of mental health. The creation of curriculum content and distribution to factory management are suggested to be the responsibility of Better Work Jordan in collaboration with a contracted mental health specialist.

Establishing the factory as a "safe-space"

Mental health training will establish a baseline capacity for management and employees to identify and address mental health concerns. The training will also work to establish the factory as a safe-space to discuss mental health topics and teach basic coping skills to help workers adjust to and tolerate negative events or emotions. It is recommended that a mental health curriculum be created by a mental health specialist and be included in the core orientation training for new employees. The formal training will help define and normalize mental health while also encouraging workers

to engage in mentally healthy behavior, including seeking mental health services if and when necessary. Behavior change, particularly around a sensitive subject like mental health, is difficult to initiate across a multinational community. Therefore, trainings should be conducted by an individual workers trust, whether it is a clinician, a factory manager, or a fellow employee. Identifying the voice workers will listen to will be a critical data point to collect through focus groups suggested in section 6.3 below. Awareness raising activities aim at 1) informing workers and factory management on the importance of mental health, the identification of mental health problems and available services, 2) demystifying misperceptions of mental health problems, and 3) generating a safe community through which workers can speak openly about mental health topics without fear of social or employer retaliation.

All training and programming should clearly communicate to workers that any mental health issue, regardless of the degree of severity, will be strictly confidential without any risk of retaliation, discrimination, or termination. It is imperative that both employees and management be trained on this point, and subsequent training and programming adhere to this privacy policy. Successful implementation of training and programming relies on workers feeling safe enough to come forward and access mental health services without fear of discrimination or other retaliation.

Using mental “well-being” instead of “health”

Training sessions should be tailored to the language and cultural group receiving the curriculum. Language around mental health can also be adapted to disassociate from the stigma. While the exact nomenclature to be used should be discussed in future focus group discussions with migrant workers, our study suggests that using a term such as “mental well-being” may induce more workers to use service and benefit from trainings, as compared to services labelled “mental health.” Written and verbal communication should use more accessible language when possible to reduce the risk of negative bias.

Continuously reinforcing mental well-being message

Iterative trainings will need to be provided over the course of employment to maintain levels of understanding and continue normalization of mental health topics. Formal training alone will not resolve the negative stigma associated with mental health. Thus, factories should offer media

content in the form of posters on factory walls or social media outreach to further promote awareness and social acceptance around mental health. For example, occasional SMS messages can be sent to workers' phones to remind them to prioritize their mental well-being. Studies have shown that SMS reminders can increase treatment adherence, which in this case is behavior change.¹²⁸

Training factory management

In addition to awareness workshops for workers, factory management should be trained on mental health awareness and sensitivity. Understanding management's role in the mental health outcomes of workers will be necessary to establish the desired safe-space in the factory. Similar to sexual harassment training, management should be required to undergo formal training on how the interpersonal work dynamic and imbalance of power may affect the mental well-being of employees, on how to address such issues without stigmatizing and alienating the worker and on the services that are available, both inside and outside the factories.

The aim of the training is not only to build foundational capacity at the factory level, but also to generate a culture of awareness and promotion of mental well-being within the factory. Given that mental health awareness is a new topic in Jordan's garment sector, training needs are diverse and relate to all levels at the factories. This process will need to be continuous in order to induce cultural shift and the desired behavior change. A robust mental health information system (MHIS) will inform future phases of training with feedback from workers and management. Throughout the entire employment timeline, employees should participate in awareness raising activities.

6.2. Establishment of Worker Well-being Networks and Crisis Management Protocols

As highlighted in chapter 4, there are no existing mental health services which target migrant workers within or beyond the factory level. There is an immediate need for the provision of tailored mental health services for this target group. Applying the primary health care model is most appropriate to address the decentralized and communal nature of this target group. The WHO

¹²⁸ B-hub (n.d.)

defines primary health care (PHC) as “providing essential health care which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. It refers to care which is based on the needs of the population. It is decentralized and requires the active participation of the community and family”.¹²⁹

Given the lack of mental health awareness and services in the industrial zones, the implementation of a PHC service network would prove beneficial not only through its ability to diagnose and treat workers with mental disorders but also to establish prevention strategies, follow-up procedures and continued support of mental health patients. The PHC network could serve as an intermediary health sector for common mental disorders. More severe mental disorders, such as those requiring psychiatric diagnosis and/or treatment, is required to be referred to a specialist in the national Jordanian mental health network. This comprehensive approach has been adopted worldwide for its capacity to reduce stigma, improve access to care, and allow for improved social integration.¹³⁰

Two recommendations, which target different components of the PHC network, are outlined below. They seek to tailor the comprehensive set of services unique to the PHC structure and specific to that of the garment migrant worker community. Additionally, this structure aims to address the various barriers outlined in chapter 4 by bringing services close and free of charge to the migrant workers. It minimizes human and financial resources through a decentralized model of care with improved case finding outcomes and linkages to care. It can leverage the learnings and capacity of existing PHC mental health services within Jordan’s public health system and provide an opportunity for closer coordination with national mental health services. Additionally, it builds on the mental health awareness training through continued education and involvement of the broader community.

As per the PHC model, we first propose the establishment of a Worker Well-being Network (WWN), a three-tiered network of mental health services for garment workers living in the industrial zones. The three mechanisms comprise of (1) building mental health treatment capacity at the local factory health clinics, (2) recruitment of mental health specialists to conduct one-on-

¹²⁹ WHO (2008).

¹³⁰ WHO (2008).

one interventions, and (3) training of peer counselors (PCs) to run psychosocial support groups and function as intermediary support to the worker and the WWN. The three separate services work in an integrated system to build capacity and synergies across the entire network and maximize opportunities to reach workers and improve upon their mental well-being.

Second, a Mental Health Crisis Management Protocol (MHCMP) should be established to address mental health emergencies intra-crisis and post-crisis or death. Creating a system to immediately support and minimize risk in the event of an emergency will help strengthen the WWN and streamline its capacity and resources. One important factor to consider in developing the WWN is the need for confidential communication channels to protect the privacy of workers. Workers should feel safe coming forward with any mental health concerns and ensured anonymity in all cases. This is necessary in order to protect workers from fear of potential workplace retaliation, whether from coworkers or management.

The success and sustainability of the WWN is dependent on employing a key stakeholder to manage the coordination and drive the implementation of the initiative. Better Work Jordan is well-suited to fulfill this role given their unbiased position and extensive network in the sector. However, the overall management and maintenance of the program, including recruitment of specialists, should be carried out by the factories.

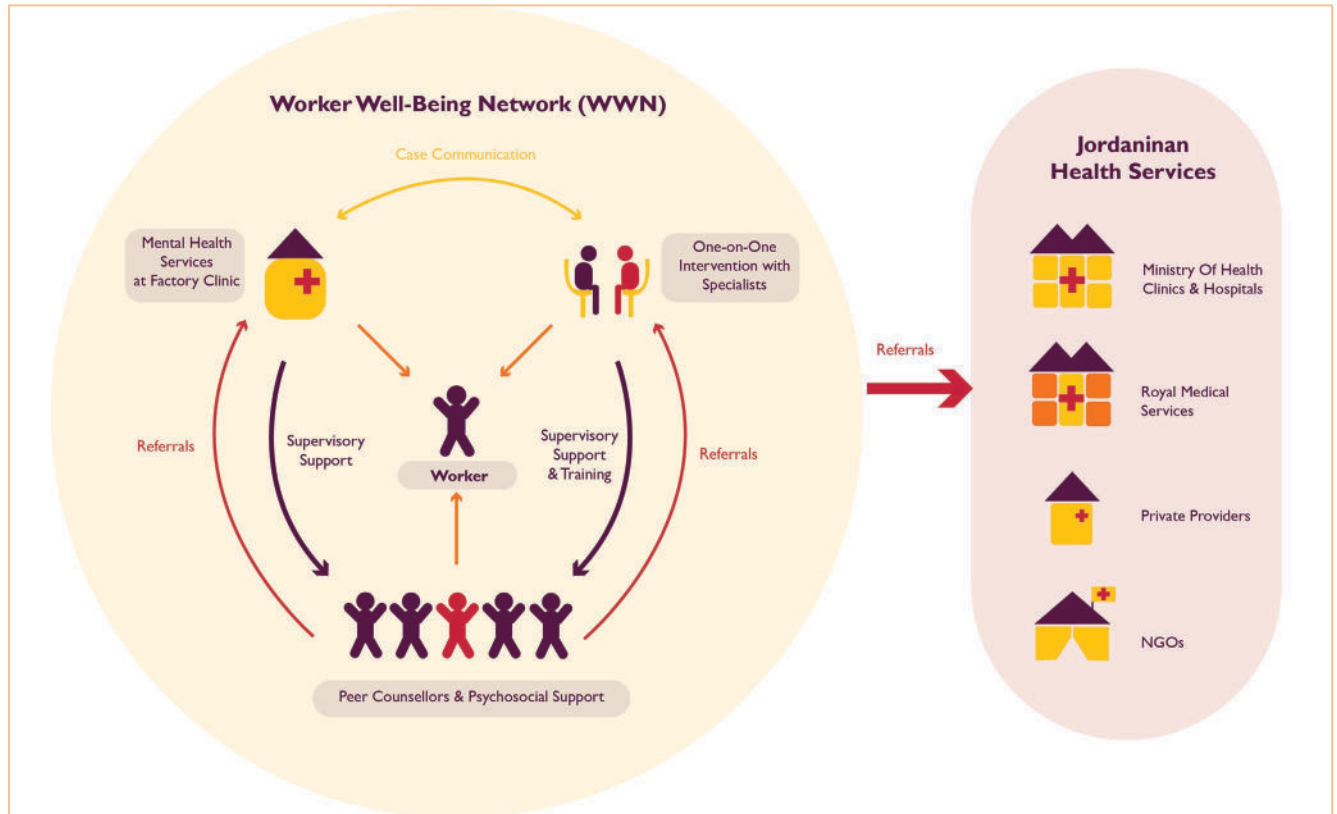


Figure 7: Worker Well-being Network

6.2.1. Worker Well-being Network (WWN)

WWNs are aimed at creating immediate and decentralized mental health services to remote or inaccessible communities. WWNs can be formed across entire industrial zones, within large individual factories, or between clusters of factories. The WWN establishes three levels of care which function in a feedback loop and build on each other for integrated case management. Due to the persistent stigma associated with mental health treatment, it is unlikely that workers will be forthcoming with mental health concerns and seek out treatment independent of outreach. The three prongs of the WWN are designed to reach workers from different angles and to encourage those in need of treatment to seek care. The WWN combined with continuous mental health awareness training through media outreach or formal training sessions will generate an ecosystem of nudges to remind the worker of the importance of mental well-being and promote a gradual shift in mental health norms. The three levels of care are discussed in greater detail below.

Integrating mental health services into factory health clinics

Every factory is mandated by law to provide an existing health center, with a minimum of one doctor and one nurse for a factory of 50-100 workers, one doctor, two nurses and one medical unit for a factory of 101-500 workers, and three doctors, four nurses, and one medical unit for a factory employing over 1000 workers.¹³¹ Currently, services are limited to the provision of basic physical healthcare, which should be expanded to include mental health services. This presents an opportunity for the existing infrastructure, resources, and capacity of the factory health clinics to be leveraged in the diagnosis and treatment of mental health disorders. General practitioners and nurses within the clinics should be capacitated with the relevant knowledge and skillset to diagnose and treat patients with mental disorders.

All patients visiting the health clinic should undergo a mental health screening as a part of the physical screening. Cases which require more specialized attention (including those who demonstrate suicidal risk) should be referred to the one-on-one specialists for common mental disorders or out of the WWN to a specialist in the Jordanian mental health sector for severe mental disorders. The health practitioners at the clinics will share case management with the one-on-one specialists for those patients using both clinic services and one-on-one treatment. These two legs of the WWN will communicate to provide comprehensive mental health treatment to the worker.

BWJ has partnered with WHO to extend WHO's mhGAP training (aimed at improving mental health knowledge of general practitioners and nurses in non-specialized health settings)¹³² to factory health clinics. It is currently undergoing pilot stage in select factories and plans for scale-up are currently under discussion. Partnerships with existing NGOs who provide mental health services can be developed to further support and accelerate the scale-up of these trainings.

Providing specialized treatment for mental health through one-on-one interventions

WHO recommends for mental health PHC staff to be supervised, monitored, and supported by mental health specialists. It is important to provide direct access to specialized treatment for mental health in the form of psychiatrists and psychologists for specialized diagnosis and treatment of

¹³¹ BWJ 2019 Annual Report.

¹³² WHO (2016).

mental health disorders. They will be more equipped to handle cases which exceed the service capacity of the factory health clinics. It is necessary to provide specialist services at the factory level (onsite within the factories or dormitories) given the geographical and financial barriers and unique working conditions faced by migrant workers. Additionally, the health professionals at the factory clinics and the PCs will need supervision from the recruited mental health specialists. This will provide the doctors, nurses, and PCs with case management support and overall guidance in the delivery of their own services. If licensed mental health specialists, such as psychologists or psychiatrists, are difficult to procure in the short term, social workers or graduate students pursuing higher degrees in psychology or counseling can be trained to conduct the interventions, but will similarly need a supervision structure.

Given the size of the garment migrant labor force (approximately 60,000 workers), and resource constraints in the availability of specialists, it may be feasible to provide one visiting psychiatrist, psychologist, and/or trained non-specialist (depending on the range of mental health issues observed through the focus group study) per factory for one day every week. This intervention will function as a 30 to 45-minute session similar to psychotherapy, or talk therapy, which is used to help individuals with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms and enable a person to function better and improve mental well-being.¹³³

This one-on-one intervention should be conducted near the factories or in the dormitories. Those conducting the intervention can provide scheduled appointments and drop-in services, as well as referred cases from the factory clinic and PCs. It is recommended that services are provided on a one-on-one basis in a confidential setting in the evenings or weekends. This is to accommodate the workers' work schedule and to preserve confidentiality and privacy. Especially in the beginning phase of the intervention, workers missing from the production line during the one-on-one session may feel exposed as needing mental health service, which runs the risk of further stigmatizing the service. Additionally, workers may find it challenging to discuss personal issues

¹³³ Ranna Parekh and Lior Givon (2019).

within the context of the factory work day. As such, it is recommended to offer these interventions outside of the work day.

Language barriers and cultural nuances are important considerations in the provision of specialist services due to the multilingual nature of the population. Language and cultural understanding is essential for specialists to communicate effectively with migrant workers of different nationalities, establish a baseline of trust, and thereby develop a strong therapeutic alliance with the patient. Obtaining specialists from the migrant workers' home countries who possess the language ability and cultural background would be the most ideal solution. However, this may not be feasible in the short term due to Article 12 of Jordanian labor law, which establishes medical professions as a closed occupation to non-Jordanians, in which case translation services should be developed to aid the communication between migrant workers and mental health specialists. The Jordan Ministry of Health could also issue special work visas to mental health professionals in the home countries of the migrant workers to avoid these language and cultural barriers.¹³⁴

It is necessary to develop robust referral systems to link severe mental health cases to appropriate care outside of the WWN structure – to the nearest tertiary level or specialist hospital. One expert interview highlighted that the dealing with past or existing trauma in psychologist sessions or peer-led support groups can stir up reactions that deserve immediate clinical attention.¹³⁵ This referral system can be established with public and private hospital networks, as well as NGO services within close proximity to the factories.

Developing a decentralized peer-counselling (PC) model of care

Psychosocial solutions are required to successfully address many mental disorders. Community and social support beyond the direct treatment from a health professional is necessary for the effective implementation of prevention and rehabilitation strategies.¹³⁶ A peer-counselling system involving a few selected workers from the factories who display high levels of emotional intelligence and empathy, is proposed to be adopted within factories. These individuals will act as

¹³⁴ Article 12 of Jordanian Labor Law.

¹³⁵ Authors' interview with Anindita Dasgupta and Adam M. Brooks, New York, February 2019.

¹³⁶ WHO (2008).

community champions of mental well-being providing peer support in the form of awareness building, mental health education, basic peer counselling, case finding (identifying and reporting high-risk cases), and ongoing follow-up support (informal check-ins).

The PCs can offer psychosocial support groups through which workers can build a sense of community and acceptance. Support groups can provide workers the space, social network, and coping mechanisms they need to deal with stress, anxiety, depression, and other mental well-being issues as they arise over the course of their time in the factory.¹³⁷ Key to the success of support groups is building a culture of trust among workers to share personal concerns. The groups can specifically discuss mental well-being or be conducted around a shared activity, possibly one of mutual cultural significance. These psychosocial support groups ameliorate mental health outcomes through 1) reducing feelings of isolation and 2) giving PCs access to workers. PCs can monitor for risk within their groups and encourage workers to seek out formal mental health service through the one-on-one intervention or at the factory clinic. Ideally, as mental well-being topics become normalized, the psychosocial support groups can function as group therapy forums and/or a core sense of community for workers.

Additionally, a formal peer support system will give access to those workers who find themselves marginalized within the community or cannot rely on informal structures and friendships.¹³⁸ The formal structure also links workers to care in the form of referrals to the factory clinic or the one-on-one specialist. The PC functions as the triage point to convince the worker to seek a higher level of care, ultimately integrating the three tiers of intervention within the WWN. Adequate training and supervision are required to prepare PCs for the comprehensive basket of support services they would provide. As such, the recruited mental health specialists conducting the one-on-one interventions will ideally train PCs on their roles and provide supervisory support to the PCs, consistently meeting with them to discuss case management issues.

Not only is the peer counselling structure efficient in addressing human resource shortages but PCs are more relatable to their peers, particularly when they share the worker's language and

¹³⁷ The Ministry of Health, Labor and Welfare, Japan (2007).

¹³⁸ Authors' interview with the Union, Amman, March 2019.

cultural background. This provides an alternative option to those who perceive a risk of retaliation or loss of employment when seeking help through the more formal channels of the WWN.¹³⁹ PCs are envisioned to be the most accessible connection to the worker and thus likely the first point of access for workers in need of help.

6.2.2. Mental Health Crisis Management Protocol (MHCMP)

In moments of mental health crisis, workers need access to immediate and ongoing support services. It is therefore crucial to take preventative steps to identify workers at risk for mental health problems and/or suicidal behavior. A mental health crisis management protocol (MHCMP) should inform the WWN response to intervene on behalf of workers who may be deemed “high-risk” for mental health emergency. It is also important to prepare staff in position to intervene, “gatekeepers” – such as PCs, factory psychologists, and welfare officers – as identification and recognition are essential to reducing the potential for harm.

As part of the MHCMP, we recommend a two-pronged strategy to provide immediate support services for workers. The first component establishes a strong referral network for high-risk individuals who need more specialized treatment beyond the resources of the WWN. This will entail developing links to care between the WWN and Jordanian health system. Decisions about referrals should be informed by specific criteria, such as the severity of suicidal ideation and irregular or harmful behavior. The second tier underscores the necessity to pre-coordinate crisis response efforts. To use the MHCMP most effectively and efficiently, factories should outline steps to manage sensitive incidences, such as the most extreme case of a suicide death.

Mental Health Crisis Identification

The first step in effective suicide prevention is to identify those at risk of harmful or suicidal behavior. Identification entails immediate action for individuals who have not only previously attempted suicide, but also if he or she has considered suicide, prepared for an attempt, or aborted plans for suicide due to a last-minute intervention. Properly identifying a person’s risk for suicide

¹³⁹ Authors’ interviews with the Workers’ Center and Tamkeen Fields for Aid, Amman, March 2019.

enables the WWN to determine next steps and save lives. As part of a factory protocol, we recommend the following identification and intervention support for workers:

Referral System to Link Severe Mental Health Cases:

An official protocol to identify individuals at “high-risk” of mental health issues should be established by factory management and other WWN staff with the input of an expert psychologist. This criterion can be established based on information the individual discloses, or behaviors that are out of the ordinary. Once individuals are identified as “high-risk”, it is necessary to refer the individual to advanced psychiatric care within the Jordanian mental health system. To make this link effective, relationships between the WWN and nearest Jordanian hospital or specialist should be established in advance. The referral to the external specialist partner should take place immediately, with daily follow-up until the specialist establishes low risk.

24/7 Suicide Prevention Hotline:

Individuals who self-identify as high-risk, but may not be sufficiently connected to the WWN, should have access to a 24/7 suicide prevention hotline in order to receive immediate support during a critical time. The hotline would be operated by trained workers who speak the different languages of the migrant worker population. To ensure impartiality and consistent availability, we recommend such a hotline to be provided by the Jordanian Ministry of Health. In addition, some countries of origin have existing, NGO-run hotlines for suicide prevention or emotional support. For example, both Kaan Pete Roi in Bangladesh and AASRA, a non-governmental crisis intervention center for distress and suicide in India, provide free mental and psychological support lines for the purpose of suicide prevention. Such services are culturally adequate and can be advertised to complement a hotline in Jordan.

Post-Crisis Protocol

Incidents of suicide or attempted suicide can generate trauma for factory employees and workers closest to the victim. It is essential in worst-case episodes that workers have immediate access to ongoing support services. “Postvention” is a term used in the suicide prevention field to describe

an organized response in the aftermath of a suicide which facilitates the healing of individuals from grief, mitigate other negative effects, and prevent additional suicide among people who are at high risk after exposure.¹⁴⁰ Workers can experience elevated rates of new-onset anxiety disorders or post-traumatic stress syndrome (PTSD) as well as a heightened risk of suicide after witnessing a peer's suicide. Based on this vulnerability, suicide clusters could emerge within factories or wider social communities of migrant workers in the industrial zones. Suicide clusters describe a phenomenon where an unusual number of suicides occur within a community after an initial suicide case. The MHCMP response to the crisis will mitigate the increased risk of further harmful activity within the factories. The following postvention strategies are recommended:

Psychological first-aid (PFA):

PFA is a modular approach designed to provide humane, supportive, and practical help to individuals in the immediate aftermath of a disaster or traumatic incident.¹⁴¹ As an immediate response to a traumatic event, workers should have access to mental health staff who should initiate contact in a non-intrusive, compassionate, and helpful manner. Workers should be prioritized if they were part of the victim's immediate social environment, such as roommates and workers of the same production line. Within this group, a particular focus of support lies on the individual(s) who discovered the suicide.¹⁴² The WWN should provide additional psychosocial support following the immediate aftermath of a death, increase case identification measures and provide clear and continuous information about the clinical services available.

Transparent and effective communication:

After a health or police investigation has been completed, factory management should provide workers with a minimum level of information on the incident to dispel any potential rumors and establish messages of support. Interviews with stakeholders revealed a lack of uniform communication following a suicide death or no communication at all, leaving workers to speculate heavily on the death case and further stigmatize suicide.

¹⁴⁰ Survivors of Suicide Loss Task Force (2015).

¹⁴¹ The National Child Traumatic Stress Network (2019).

¹⁴² Andress, V. R., and Corey, D. M. (1978), pp. 759-764.

Instead of ignoring the incident, factory management is encouraged to sensitively and sympathetically engage in dialogue around the specific incident in order to continue the process of building a safe-space for mental health topics. Clear communication post-crisis will help de-stigmatize the shame and fear associated with severe mental distress. The post-crisis communication content should be designed by a mental health specialist, ideally one specialized in suicide and self-harm.

6.3. Establishing a mental health information system (MHIS)

Prior to any implementation of training or programming, data on the incidence and prevalence of mental health issues for the target demographic must be collected. Actual concrete data on the mental health of workers is still needed in order to identify and target the specific aspects of mental well-being that require attention. Adding metrics to the problem area will help crystalize the magnitude and scope of the existing mental health issues and create accountability for stakeholders to address them. Given the methodology of the research conducted (see section 2.1), the immediate next phase of research should include focus groups to gauge current levels of worker well-being, understanding of mental health, degree of stigmatization, and service needs. The input of workers is needed to validate the conducted research and inform the design of the mental health awareness training and WWN services. The establishment and oversight of the MHIS should be in collaboration with the WHO and overall maintenance the responsibility of the WWN.

Ideally, focus groups will be led by a mental health specialist with appropriate translation services and immediate access to mental health care networks within Jordan. It is likely workers already have developed opinions on the well-being services needed and their input for program design is essential. Using a participatory process in the program design will enhance service delivery and uptake and ultimately enable the policy to be more successful in accomplishing improved mental well-being of workers. Further, the composition of the mental health personnel recruited for service delivery will depend on the scope and severity of mental health issues observed in the target demographic. It is suggested Better Work Jordan facilitates the coordination and execution of the focus group studies in collaboration with a recruited mental health specialist or the WHO.

6.3.1. Setting up the mental health information system (MHIS)

Once focus group data is collected, a MHIS should be created to collect, analyze, and use information about the mental health services delivered through the WWN.¹⁴³ This system will enable factory management and the WWN to ensure effective service delivery and improve quality of care through informed decision making.¹⁴⁴ The MHIS will allow stakeholders to track changes in mental health and identify key trends at the factory level. This will instruct future phases of programming; as mental health needs will invariably evolve over time. The MHIS will also be a useful tool in determining the effect of mental health awareness training and outreach.

6.3.2. Benefits of the MHIS

Several benefits exist to the establishment of an MHIS. As an essential planning tool, the MHIS forms a comprehensive and consistent method of providing accurate information about a mental health service and therefore assists with coherent planning, implementation and evaluation.¹⁴⁵ The MHIS can assist in recording and monitoring the mental health needs of workers, provide a means of reporting services used per individual case, and overall contribute to the ongoing improvement of care. Measurement of indicators will track progress and status of service delivery as well as efficient use of resources. The MHIS enables the WWN program to accomplish its primary goal of providing effective mental health care with limited resources.

6.3.3. MHIS Indicators

Indicators should be well-defined with the intention of summarizing relevant information and can be used to indicate a given situation and ultimately measure change.¹⁴⁶ The indicators will be used to measure the mental health service delivered and the population served. Generally, the indicators should measure needs, inputs, processes, and outcomes of the mental health program. The MHIS should capture the minimum information necessary and be created to be user-friendly. A variety of stakeholders should be consulted in the design and intent of the MHIS in order to capture individual information needs. The MHIS could be linked to the greater information system used by the factory medical clinics and factory management. The foundation of the MHIS should be to

¹⁴³ WHO (2005b).

¹⁴⁴ WHO (2005b).

¹⁴⁵ WHO (2005b).

¹⁴⁶ WHO (2005b).

protect the privacy and confidentiality of the workers serviced and all necessary measures should be taken to ensure that private information is only shared with professional staff required to access that information.¹⁴⁷

The MHIS does not need to be built all during the first phase of programming. The information system should be progressively developed as programming unfolds and successful interventions can be identified. Overall, the big picture design of the MHIS requires an understanding of the comprehensive priorities of the mental health program and the capacity of the stakeholders involved.

6.4. Embedding mental health support across the migration cycle

The problem analysis in Chapters 3 and 4 revealed that mental health stressors not only arise during the factory experience but along various segments of the migration cycle, including the pre-migration and migration phases (see Section 3). Whilst re-integration to the home country is acknowledged to be yet another important aspect of the full migration cycle, it will not be addressed for the purposes of this report. This section sheds light on specific recommendations that follow the migration timeline and address migrants' specific needs during each step of the migration journey.

Starting with the pre-migration phase, the below section addresses workers' access to meaningful pre-departure training and information materials. Upon arrival in Jordan, we recommend in-depth onboarding, a buddy-system, as well as extended on-the-job training opportunities. Internet therapy and mobile wellness applications and be employed as psychosocial support in the post-migration phase. These measures will be complemented by the WWN services, particularly the one-on-one interventions and PC-led psychosocial support groups. The earlier capacity building at the worker-level occurs, the more successful individual coping strategies will be. This will also improve help-seeking behavior during a worker's stay in Jordan.

¹⁴⁷ WHO (2005b).

6.4.1 Improving pre-departure services

Pre-departure training is a key resource for migrants to prepare for life and work in Jordan. As previously discussed, current pre-departure training formats convey limited information on working in Jordan and do not cover the psychological toll of coping with migration. A realistic view of what to expect in Jordan, both in the workplace and beyond, will allow migrants to minimize potential shock and build up individual coping capacity for dealing with subsequent stressors.¹⁴⁸ Two steps should be taken guarantee adequate information access:

Mental health component in pre-departure training

Considering the information gap in mental well-being in pre-departure trainings, a strong effort should be made to integrate and standardize a mental health component across countries. Based on the gaps identified, such trainings could cover matters related to coping with stress, homesickness, and financial management. Trainings should be paired with providing information on resources in the home and host country that will be of support as migrant workers make the transition. Home country recruitment agencies and embassies should work together to incorporate this mental health component in pre-departure trainings.

Video material

In addition to pre-departure training workshops, we encourage the provision of video material that workers can access regardless of their literacy level. As women are currently most drastically affected by withheld information and misinformation, video formats will empower female migrants in particular to form their own view of Jordan regardless of what they learn from labor agents and family members.¹⁴⁹ Ideally, workers will be able to access these videos easily through social media channels such as YouTube. Content should be available in multiple languages and feature impartial information on living and working conditions in Jordan's garment sector, which will minimize migrants' culture shock and build up capacity for their relocation. BWJ can take a lead role in producing such content, potentially in collaboration with BWJ offices in migrants' countries of origin to allow for cultural appropriateness.

¹⁴⁸ Moussaoui, D., & Agoub, M. (2011), p. 98.

¹⁴⁹ Open Society Foundations (2014), pp. 12-19.

6.4.2 Improving in-country services

During the migration phase, gaps persist in the orientation support workers receive at the factory-level as they arrive in Jordan. In particular, not all factories offer orientation sessions and, if so, they are often too short to meet migrants' needs.¹⁵⁰ Similarly, on-the-job training needs to be extended. Workers need to be able to learn how to cope with their workload and tasks (see section 5.1). Our stakeholder interviews have shown that the first weeks and months in Jordan need special attention for workers' mental well-being. Migrants face the loss of familial, societal, and cultural support structures for the first time and do not yet have a network in Jordan (see Section 5.3). To address this, we recommend the following services that workers can access after their arrival:

Creating a Buddy System

Our research has identified the creation of a buddy system as an effective practice. Currently implemented by only one of the interviewed factories, NGOs stated a need for stronger one-on-one peer support upon arrival.¹⁵¹ Teaming newly arrived migrant workers with a "buddy" from their own country, or someone who understands their culture language, has proven to be extremely successful in supporting a worker's transition. A buddy can help the newly arrived to address early questions in Jordan, such as getting a SIM card, finding ingredients and spices from home, or contacting family and friends through relevant media applications.¹⁵² Tamkeen or similar NGOs may be effective partners in instituting this system within the factories.

Extending the length of migrant worker orientation

Orientation should allow time for workers to transition to their new environment, without expectations to begin work immediately upon arrival. An extended orientation, lasting approximately 3-5 days, will provide more time for re-adjustment and acclimation. Beyond addressing immediate mental health needs during the arrival phase, the initial orientation should provide workers with an overview of mental health services for the length of their stay. Throughout the process, we specifically recommend involving well-being officers from migrants' own nationalities in the orientation sessions, and designing communications and training materials in

¹⁵⁰ Authors' interview with Tamkeen Fields for Aid, Amman, March 2019.

¹⁵¹ Authors' interview with Tamkeen Fields for Aid, Amman, March 2019.

¹⁵² Authors' interviews with factory management, Amman, March 2019.

cooperation with professional mental health specialists. We recommend Better Work Jordan require a uniform length of orientation for all factories, ideally between 3-5 days in duration.

On-the-job Training

The problem analysis demonstrates that many workers have not worked abroad or in the garment sector before moving to Jordan (see section 5.3). Being confronted with a new task on a tight production schedule can burden newly arrived workers mentally in addition to the demanding cultural transition. On-the-job training is currently not formalized at the assessed factories.¹⁵³ While some factories have informal on-the-job training in place, these periods appear to be brief and may not allow for workers to take on full responsibility with confidence.¹⁵⁴ We recommend introducing workers slowly to the production processes by assigning them to a more senior co-worker for at least a full week before they are expected to meet quotas. Workers who have never worked in the garment sector need to be provided with additional resources, such as a separate, multi-day training on technical skills and processes in the production line. Even if those new to the sector start in support positions such as packaging,¹⁵⁵ adequate training will empower them to feel more confident about their tasks and experience less stress.

6.4.3 Potential tools to improve worker's post-migration experience

Beyond formalized mental health services in the WWN, the following interventions would support migrant workers during the post-migration phase throughout their stay in Jordan:

Social Media

Social media has been shown to hold enormous potential for suicide prevention. Social media platforms can access particularly isolated individuals. They also provide an anonymous and non-judgmental forum to share emotions and experiences and prompt intervention should users express suicidal ideations online.¹⁵⁶ In conversations with factory management, we have identified factory-

¹⁵³ Authors' interviews with factory management and Tamkeen Fields for Aid, Amman, March 2019.

¹⁵⁴ Authors' interview with Tamkeen Fields for Aid, Amman, March 2019.

¹⁵⁵ Authors' interviews with factory management, Amman, March 2019.

¹⁵⁶ Robinson, J., et al. (2016), pp. 2.

level applications as a best practice to engage with workers, especially in case of limited literacy.¹⁵⁷ However, more research is needed in social media-based suicide intervention on how to control user behavior and accurately assess risk.¹⁵⁸ Given persisting knowledge gaps on online case support as well as capacity constraints at the factory-level, we therefore recommend an app-design that is only focused on engaging marginalized workers at each factory. Apps are already starting to be used as a complaint channel, and could include video messages on psychosocial capacity building, as well as message boards. An app could be designed in collaboration between factories with the help of mental health professionals and be customized slightly to match the number of workers and specific communication needs.¹⁵⁹

E-Mental Health

Beyond social media, mobile application-based mental health psychoeducation, therapy, and even training can provide workers with cost-effective and unlimited access to mental health information and online support. Existing applications such as WHO's digital mental health intervention for depression *Step-by-Step* provides psychoeducation and training through an illustrated narrative with additional therapeutic techniques such as stress management, identifying strengths, positive self-talk, increasing social support, and relapse prevention.¹⁶⁰ This tool is easily adapted across different cultural and gendered contexts, with recent successful adaptations for overseas Filipino¹⁶¹ workers and Syrian refugees in Europe.¹⁶² The ease of adaptability can help address the language and cultural barrier concerns mentioned in section 6.2.1. However, the accessibility (such as mobile phone and internet access) should be thoroughly assessed before adopting as an intervention.

Radio Station

Depending on factories' capacity, one activity that provides the dual effect of support and activity is the creation of a worker-run radio station that will service the industrial zones. The concept of a

¹⁵⁷ Authors' interviews with factory management, Amman, March 2019.

¹⁵⁸ Robinson et al. (2016), pp. 2.

¹⁵⁹ Authors' interviews with factory management, Amman, March 2019.

¹⁶⁰ Carswell et al. (2018).

¹⁶¹ Garbiles et al. (2019).

¹⁶² Burchert et al. (2019).

community radio station utilizes the agency of local actors, while also providing technical skills.¹⁶³ Participants can form friendships, and enable workers to overcome the sense of invisibility they may feel. This model is a medium of cultural expression for the people of the industrial zones, and gives workers a platform to broadcast their voice. Alternatively, factories can implement a less resource-intensive way for workers to choose and play their own music at the factory. Playing music on the production floor has already been perceived as a successful instrument to keep workers in good spirits.¹⁶⁴ The positive effect of music on mental health outcomes has been documented for decades. More exposure to music can help garment workers overcome feelings of anxiety and stress.¹⁶⁵ Music has even been shown to improve performance outcomes, and can help production lines meet their quotas in a more relaxed manner.¹⁶⁶

Providing resources and additional support to workers from embassies

The government of India recently introduced a Resource Service for workers in the United Arab Emirates (UAE) to assist Indian workers in the country. In 2016, this service received nearly 25,000 calls from workers regarding grievances.¹⁶⁷ Establishing a Workers' Resource Center in Jordan by the Bangladeshi, Sri Lankan, Indian, and other relevant embassies could provide their workers with a crucial third-party contact in case of personal crises. A nationally-run Resource Service will guarantee that migrant workers have a point of contact that can consider their cultural background in problem-solving approaches.

6.5 Building capacity at and beyond the factory-level towards an integrated mental health policy in Jordan

Building mental health capacity at the factory level is pertinent to meeting the immediate needs of migrant workers' mental wellbeing. However, integration of this with mental health capacity beyond the factory level is required to ensure long-term sustainability and expansion of mental health programs for migrant workers. This section identifies various opportunities for sustained

¹⁶³ Castells-Talens A (2010).

¹⁶⁴ Authors' interviews with factory management, Amman, March 2019.

¹⁶⁵ Lin, S. T., et al. (2011), pp.34-46.

¹⁶⁶ Schellenberg, G. E. (2012), Chapter 23 (*Music, Health, and Wellbeing*).

¹⁶⁷ Nagaraj, A (2017).

capacity and synergy creation. These include establishing embassy support networks, developing partnerships with global brands, and ultimately, integrating factory-level activities into national mental health policy. The establishment of a factory-based task force is required to effectively lead the discussion, approval, and management of these initiatives.

6.5.1 Factory-Based Task Force on Mental Health Sustainability (FTF)

A mental health task force should be established to manage and coordinate mental health interventions at the factory-level. This task force would ideally be led by a coalition of factory management and comprise of representatives from key stakeholders including BWJ, WHO, affiliated global brands (buyers), the union, factory clinics, and migrant workers themselves. Overtime, as partnerships develop outside the factory level, it could include stakeholders such as the Ministry of Health and the Ministry of Labor, as well as the private-sector and NGOs. We recommend BWJ and WHO to co-chair this task force. The role of the task force would be to define the short- and long-term goals and oversee the project lifecycle of all mental health-related programs at the factory level, similar to the key functions of the National Technical Committee at the Ministry of Health and the Mental Health and Psychosocial Support Working group at the inter-agency level. Given this function, it would be integral to include a third-party mental health specialist in the task force to help with intervention design.

The benefits of establishing an overarching governing body allows factories to standardize implementation of the various interventions described under sections 6.1 – 6.4. This in turn brings about cross-pollination of ideas, shared best practices, and synergetic collaborations. The majority of stakeholders interviewed, recognized the need for mental health interventions at the factory-level, but also indicated the importance of having someone take the lead. This way the ownership and responsibility lie within all interested parties and the task force will hold these parties accountable. A well-coordinated system to provide these services will not only better serve the beneficiaries, but will also limit any existing redundancies in the system.

6.5.2 Enhancing the role of embassies to support migrant workers' well-being

Foreign embassies function as the official point of contact between migrants' native country and the government of Jordan. The role of the embassy serves as a mediator between migrant and host country should any issues arise. However, in Jordan, cooperation between authorities at both origin and destination ends of the garment sector has been limited.¹⁶⁸ The ILO Multilateral Framework on Labor Migration outlines the important role of the embassy to provide legal assistance and monitoring the working conditions of migrant workers in the host country.¹⁶⁹ Labor attachés, a role that already exists in many embassies across the world, are uniquely trained to deal with the challenges migrant workers face in the host country. There is an opportunity to involve embassies, and capacitate labor attachés, to provide additional mental health support to migrant workers who are nationals of their country.

The role of the labor attaché is well developed and integrated into the migrant network. The establishment of an official network between embassies, through the labor attachés can strengthen collaboration on important issues, including the mental well-being of migrant workers. Similar integrated networks have been implemented in Southeast Asia through the Greater Mekong Subregion (the GMS TRIANGLE project).¹⁷⁰ Following this model, collaboration across attachés in Jordan permits knowledge sharing on case management and other mental well-being issues as they arise. It also links the efforts of various embassies operating in Jordan to synthesize support for workers.

6.5.3 Integrating factory-level programs into national mental health policy

The creation of mental health policies is central to devising a common vision and plan for all programs and services related to these objectives. They help to establish benchmarks for mental health services and organize resources towards this common vision, without which programs and

¹⁶⁸ Authors' interviews with BWJ stakeholders and factory management, Amman, March 2019.

¹⁶⁹ ILO (n.d.).

¹⁷⁰ ILO (n.d.).

services are likely to be inefficient and fragmented¹⁷¹. Since 2011, Jordan's National Mental Health Policy and The National Mental Health and Substance Use Action Plan was developed to guide the reform of mental health services within the country. This is in line with WHO's Global Action Plan for Mental Health 2013-2020¹⁷² which speaks to "the essential role of mental health in achieving health for all people."¹⁷³ In light of these developments, the migrant workers' mental well-being should form an integral part of the National Policy and Action Plan.

This requires the buy-in of national-level stakeholders for migrant workers to be included in the national agenda on mental health reform. The role of the FTF would be suited to lead this initiative. Making a business case for the inclusion of migrant workers and continued participation should take place with key national stakeholders through the National Technical Committee and the Mental Health and Psychosocial Support Working group. This integration would not only result in the representation of migrant workers in national strategic plans and access to additional capacity, but also identify opportunities for synergies and lessons learnt.

6.5.4 Quality Improvement and Mental Health Certification from WHO

Jordan was selected as the first country to implement the WHO's mental health action programme (mhGAP), with the goal of scaling up mental health services and integrating mental health into primary health care.¹⁷⁴ The WHO's expertise on the issue, as well as its established programmatic activity in Jordan, make it a key partner in building cooperation and capacity. We recommend that building off the mhGAP program, the WHO create a "Mental Health Certification" for factories. While the WHO would inform and award certification levels, the assessment could be incorporated into BWJ's annual assessment of factories for ease of coordination. The certification would serve as an additional incentive for factories to work towards excellent working standards and take pride in creating a culture of mental well-being and mental health awareness in the workplace.

¹⁷¹ WHO (n.d.).

¹⁷² The Hashemite Kingdom of Jordan (2011).

¹⁷³ WHO (2013).

¹⁷⁴ WHO (n.d.).

Before designing the metrics for certification, it is important to collect more statistical mental health and stress level data for this particular population.¹⁷⁵ The data will describe how well current programs are working, the outcomes when improvements are implemented, and metrics for successful performance. The assessments that will precede WHO certification will reveal the landscape and general trends of mental well-being. Once this is established, experts will have greater insight into quality improvement benchmarks and minimum standards. The WHO's 2007 Framework for Action identified quality as one of the key drivers of improved health outcomes and greater efficiency in health service delivery.¹⁷⁶

The certification process will engage stakeholders in data collection around mental health, as well as incentivize their implementation of best practices. Utilizing a quality improvement health systems model shifts the focus from risk mitigation to health. It also encourages ongoing training for service providers. While the WHO Certification will not be mandatory, it will communicate to the workers, buyers, and international community that mental well-being is a critical component of overall worker welfare.

The mental health assessment would be conducted as part of the BWJ assessment on an annual basis in participating factories. The results of the audit would be reported back to the Jordanian Ministry of Health. If the factory is shown to have gaps or shortages in service delivery, there should be resources in place to build capacity and incorporate any improvements that will improve future assessment outcomes. Again, as this is voluntary, factories will not be required to follow through with recommendations.

¹⁷⁵ Authors' interviews with mental health expert, April 2019

¹⁷⁶ WHO Western Pacific. (n.d.).

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