WHITE PAPER

Led by the Community: Building Dignified Mental Health & Psycho-Social Support for MigrantDomestic Workersin Lebanon

2025

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About LCCE

The Lebanese Center for Civic Education (LCCE) is a non-governmental organization established in 2007, working to empower youth, women, and marginalized communities in Lebanon to become active agents of positive change in their societies. Guided by a vision of a society where all individuals are empowered, protected, and able to participate fully and equally in shaping their future, LCCE supports people living in disadvantaged contexts to transform their lives for the better. Through education, capacity building, and community-based support, LCCE equips community members and participants with the knowledge, skills, and tools needed to actively engage in community life, access essential services, exercise their rights, and contribute to building a more just, equitable, and inclusive society.

Building on its broader mandate of social justice and community empowerment, LCCE has strengthened its engagement in supporting dignified, rights-based, and migrant-sensitive mental health and psychosocial support (MHPSS) for migrant worker communities in Lebanon. Through community-based interventions, capacity building, and collaboration with national and international stakeholders, LCCE works to promote culturally and linguistically adapted services, while supporting migrants' safe and respectful access to mental health and psychosocial support. This engagement informs LCCE's advocacy for inclusive MHPSS systems that recognize migrants as rights-holders and essential members of society.

FOREWORD

By the Executive Director of LCCE

This white paper is published on the occasion of International Migrants Day, a moment to recognize the resilience, rights, and voices of migrant communities worldwide, and a reminder that dignity, protection, and mental well-being must be central to how we serve them.

Every day in Lebanon, thousands of migrant domestic workers carry the emotional weight of a system that was never designed to protect them. Many live and work in isolation, far from their families, disconnected from community, and excluded from services that affirm their dignity and well being. Their mental health challenges are not simply personal, they are structural, shaped by inequality, exploitation, and invisibility.

This white paper is not just a publication, it is the result of years of listening, learning, and standing alongside migrant women who, despite extraordinary adversity, continue to organize, support one another, and demand justice. It draws directly from their lived experiences and proposes actionable, community-driven solutions grounded in rights, participation, and care.
As the Lebanese Center for Civic Education (LCCE), we have had the privilege of working closely with migrant-led groups, frontline practitioners, and institutional partners to co-develop a model of psychosocial support that centers dignity. From training community facilitators to adapting services in multiple languages, we have seen firsthand that when services are shaped by those they intend to serve, they become not only more effective, but more just.

This paper comes at a time of deep reflection and transformation in Lebanon's mental health landscape. The National Mental Health Strategy (2024–2030) rightly calls for the inclusion of vulnerable groups. Now it is up to all of us to make that vision real. This includes dismantling the Kafala system, embedding MHPSS into primary care and community centers, and ensuring migrant voices lead the way.

I invite policymakers, donors, and implementing partners to read this white paper as a call to action. Migrant workers deserve more than access. They deserve respect, protection, and the power to shape the systems that affect their lives.

Maroun Mikhael
Executive Director, Lebanese Center for Civic Education (LCCE)
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EXECUTIVE SUMMARY

Led by the Community: Building Dignified Mental Health & Psycho-Social Support for Migrant Workers in Lebanon

Migrant domestic workers (MDWs) in Lebanon, primarily women from African and Asian countries, face compounding mental health challenges shaped by legal exclusion, exploitative working conditions under the Kafala system, discrimination, and limited access to care. Despite their vital contributions to

households and the economy, MDWs remain largely invisible within national mental health responses.

This white paper, launched in alignment with International Migrants Day, calls for the urgent integration of migrant-sensitive, dignity-centered mental health and psychosocial support (MHPSS) into Lebanon's health, protection, and labor systems.

The Gaps

Current MHPSS services are often:

Fragmented, lacking coordination or continuity

Inaccessible due to language, legal status, and cost

Inappropriate, failing to reflect migrant women's lived experiences

Detached from related sectors like protection, GBV response, and SRH

The Model: LCCE's Community-Led Approach

The Lebanese Center for Civic Education (LCCE) is piloting a scalable, community-driven MHPSS model that:

Engages migrant leaders in design and delivery of services

Offers culturally and linguistically adapted group PSS sessions

Trains migrant facilitators and CSO staff

Uses hybrid methodologies (e.g. podcasts, digital outreach) to reach isolated live-in workers

Builds partnerships across PHCs, community centers, embassies, and NGOs **5**

Key Recommendations

1. Governance & Policy

Develop a dedicated migrant-sensitive MHPSS strategy aligned with the National Mental Health Strategy (2024–2030)

Advance efforts to dismantle the Kafala system and recognize

domestic work under labor law
Include migrant-led organizations in national coordination platforms
Provide translated information at points of entry (e.g., airports) in collaboration with ISF

2. Service Delivery
Expand community-based and peer-led MHPSS services
Embed support in PHCCs and centers already serving migrants
Promote preventive, group-based MHPSS approaches

3. Medical Coverage & Referral
Strengthen referral systems between MHPSS, protection, and health services
Ensure access to care regardless of legal or residency status

4. Capacity Building
Train frontline staff and community facilitators on migrant-sensitive, trauma-informed MHPSS

5. Cross-Cutting
Use inclusive media and hybrid tools to reach isolated workers
Promote anti-racism, anti-discrimination, and mental health literacy
Link MHPSS to SRH, GBV, and legal protection services
Support action-oriented research to inform sustainable solutions

Call to Action

Policymakers, donors, and implementing partners must act now to mainstream dignity, inclusion, and community leadership in Lebanon's MHPSS landscape. The tools and models exist—what's needed is the commitment to scale them, support them, and sustain them.

Mental health care must not be a privilege. For migrant workers, it must be

a right.

Background & Context

Towards Equity in Mental Health for Migrant Workers

As the world marks International Migrants Day, Lebanon stands at a critical juncture in how it treats and supports one of its most essential yet invisible populations: migrant domestic workers (MDWs). The urgency of this paper stems from a deepening crisis, where tens of thousands of women live and work under a system that denies them basic rights, dignity, and mental health care.

The Kafala (sponsorship) system, still in force across Lebanon, creates a structurally violent environment that enables abuse, silences victims, and blocks pathways to justice. Described by rights organizations as a form of modern slavery, the system legally binds domestic workers to their employers, stripping them of mobility, agency, and access to support—even when facing psychological or physical harm.

This paper advocates for dignified, migrant-sensitive, and culturally appropriate mental health and psychosocial support (MHPSS) for MDWs in Lebanon — services that center their humanity, recognize their resilience, and respond to the trauma of systemic exploitation.

The Migrant Domestic Worker Context in Lebanon

According to the International Organization for Migration (IOM), over 176,000 migrant workers currently reside in Lebanon — a country of under seven million people. Among them, women make up 70%, with the vast majority employed as domestic workers. These women, largely from Ethiopia, the Philippines, Bangladesh, Sri Lanka, Kenya, and other African and South Asian countries, form the backbone of caregiving and household labor in Lebanon, yet are among the most marginalized and least protected.

Roughly half of MDWs live in the homes of their employers ("live-in"), often isolated from the outside world. The other half are "live-out" workers who may have slightly more autonomy but still face exploitation and insecurity. Whether live-in or live-out, MDWs operate under conditions shaped by race, gender, and class hierarchies, all of which heighten their vulnerability to mental health stress.

A Hidden Crisis: Mental Health and Access Gaps

The mental health and psychosocial wellbeing of migrant domestic workers in Lebanon is shaped by a daily reality of isolation, exploitation, and systemic discrimination. This community faces a high and growing burden of mental health conditions. Findings suggest that more than 80% of chronic illnesses reported by around half of MDWs in Lebanon are related to mental health [1] conditions. Estimates retreived suggest that migrant domestic workers in Lebanon die at an alarming rate of one to two per week from escape attempts, suicide, and unexplained causes linked to abuse and psychological [2,3] suffering.

These outcomes are traced to a pervasive environment of systemic exploitation, where the Kafala system functions as a "trap" that subjects workers to abuse, forced labor, and the deliberate denial of basic human necessities. These burdens, exacerbated by the structural violence of the Kafala system and institutional racism, have been intensified by Lebanon's [4,5] recent trajectory of compounded crises, and ongoing political instability. These shocks have severely strained public services, deepened poverty, and eroded community support systems, pushing many MDWs further into precarity. For those already marginalized by displacement, racial hierarchies, and legal exclusion, the mental health toll has become heavier and more invisible. Yet despite this growing need, access to appropriate, safe, and culturally sensitive MHPSS remains scarce, hindered by legal, linguistic, [5,6] financial, and social barriers. Without targeted interventions, thousands of MDWs continue to carry these burdens in silence unsupported, unseen, and underserved.

A Global Responsibility: Dignity and Care as a Human Right

This white paper echoes both global and national commitments that affirm mental health care as a universal right — regardless of nationality, gender, or legal status. At the international level:

- The WHO's Mental Health Action Plan (2013–2030) calls for integrated, people-centered services, especially for marginalized communities.[7] The Inter-Agency Standing Committee (IASC) guidelines emphasize inclusive MHPSS in humanitarian settings, adapted to local cultures and languages.[8]
- The Sustainable Development Goals (SDGs) urge countries to "leave no one behind"— especially in SDG 3 (Good Health & Well-being) and SDG 5 (Gender Equality).[9]
- The Global Compact for Migration commits to promoting migrant responsive health systems and protecting the well-being of all migrants, including women in domestic labor.[10]**9**

Lebanon is also bound by numerous international legal instruments, including the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) — both of which, in principle, offer protections against the types of abuses and systemic neglect faced by migrant domestic workers.

In practice, however, these protections often fail to reach migrant women in Lebanon. Domestic workers are explicitly excluded from Lebanon's labour law, which otherwise guarantees minimum standards for working conditions. As a result, MDWs operate in a legal void — denied the protections afforded to other workers and left with minimal access to justice, redress, or psychosocial support.[11,12]

Even as the National Mental Health Strategy (2022–2030) acknowledges the need to extend mental health services to vulnerable groups, including migrants, this vision remains unrealized on the ground. The structural barriers created by the Kafala system, coupled with policy inaction, continue to undermine both Lebanon's international obligations and its stated national priorities.

What is needed now is not just reform, but a rights-based transformation — one that brings practice in line with principle, and restores dignity, care, and protection to the migrant women who form an essential but invisible part of Lebanon's society.

Gap in Migrant-Sensitive MHPSS

Invisible Needs, Inadequate Responses

Despite growing recognition of the mental health needs of migrant populations, current MHPSS approaches in Lebanon remain fragmented, exclusionary, and poorly aligned with the lived realities of migrant domestic workers. Services are dispersed across humanitarian, governmental, and non governmental actors, with limited coordination or shared standards, resulting in inconsistent care and poor referral pathways. Most importantly, these services often lack a migrant-sensitive design—rarely accounting for the linguistic, legal, gendered, and cultural dynamics that shape migrant workers' access to and trust in mental health care. For women living under the Kafala

system, whose daily lives are marked by isolation, dependency, and fear of retaliation, existing services are not only hard to reach, but frequently unresponsive to their specific psychosocial realities. There is also insufficient investment in preventive and community-based approaches that could offer early support and build resilience, especially among live-in workers with limited mobility. Migrant workers continue to face barriers to affordable care, including limited health coverage and few accessible pathways for legal, psychological, or protection-related support. The core challenge is not just access — it is the appropriateness, dignity, and continuity of the care being offered. Mental health support that fails to recognize the structural, cultural, and relational contexts of migrant women's lives ultimately reinforces their exclusion rather than addressing it.

Findings & Case Study:

Evidence for a Community-Led MHPSS Approach

Case Study: LCCE's Migrant-Sensitive MHPSS Approach

Context and Rationale

In a country where migrant domestic workers remain one of the most underserved and marginalized populations, Lebanese Center for Civic Education (LCCE) has been pioneering a migrant-sensitive mental health and psychosocial support (MHPSS) model grounded in participation, cultural adaptation, and community ownership. Recognizing that standard service models often fail to reflect the lived realities of migrant workers, especially

women living under the Kafala system, LCCE's approach is built on the belief that care must begin with dignity, relevance, and inclusion.

The organization identified a critical gap: MHPSS services were not only inaccessible but misaligned with the cultural, linguistic, and structural realities of migrant domestic workers. In response, LCCE began engaging migrant community leaders, grassroots civil society organizations (CSOs), and frontline workers to co-design interventions that center the voices and needs of the very communities they aim to serve. Informed by prior experience with MWs, LCCE integrates migrant-sensitive adaptation strategies throughout its interventions:

Adaptation Strategies

1. Participatory Design with Migrant Communities

At the heart of LCCE's approach is a deeply participatory methodology: Community consultations are the core of decision-making and adaptation, as community members are consistently involved throughout the entire project cycle, including design, implementation, and monitoring and evaluation. This is achieved through: (1) close engagement with active community leaders who play a key role in shaping activities, guiding ongoing adaptations, and supporting outreach; and (2) targeted focus group discussions through which LCCE consults migrant worker leaders and community members from diverse national and linguistic backgrounds to assess, adapt, and strengthen mental health interventions. This included:

A focus group assessing gaps in national MHPSS services, which directly informed the adaptation of Lebanon's national mental health sensitization campaign to be inclusive of migrant realities and languages.

A consultation with CSOs and frontline workers supporting migrant workers, to map out the core mental health needs and barriers and design capacity-building modules rooted in dignity, equity, and trauma sensitivity.

Several focus groups explored the cultural relevance of psychosocial support programs, providing critical insight into how community-based group interventions can be adapted for different migrant communities and sustained from within.

These participatory processes are structural, shaping how information is disseminated, who delivers support, and how trust is built.

Focus Group Discussion Snapshots

"Reply and Stand"

Filipino migrant workers in Lebanon face many acute stressors, ranging from the daily household chores and parenting to the trauma of verbal abuse and racism in public spaces. For many, the pressure of "adjusting to Lebanon" is compounded by a lack of security, yet participants shared stories on how they have shifted from silence to assertiveness, learning to "reply and stand" in the face of harassment.

Grounding interventions in everyday realities

During an FGD aiming to adapt material for an MHPSS intervention, findings showed the importance of humor and friendship in coping. By validating existing coping strategies such as humor and social connection, the material content was designed to be relatable and grounded in participants' everyday realities, while building on their resilience and recognizing them as active agents in their own wellbeing through a culturally adapted approach.

2. Language and Cultural Mediation

Language remains a major barrier to mental health access. To address this, LCCE ensures all materials, including information, education, and communication (IEC) tools, digital content, and training materials are translated and culturally adapted into key migrant languages such as Amharic, Tagalog, Bengali, and Sinhala. Migrants are engaged throughout the project cycle to translate and culturally adapt all content to ensure that services are well understood, and resonate with community values and experiences. This includes the adaptation of consent, complaint, and similar forms to respect the principles of informed participation, inclusion, and accessibility, and strengthen trust and a sense of safety for community members.

3. Empowering Migrant Facilitators

Rather than relying solely on external service providers, LCCE invests in training facilitators from within migrant communities to lead group-based psychosocial interventions. These facilitators are equipped with tools, knowledge, and supervisory support, building on peer-to-peer trust and ensuring long-term sustainability. The model shifts power to the community, recognizing their capacity to care, lead, and recover.

4. Safe Spaces and Trust-Building

Recognizing the stigma and risks many migrant workers face, especially live-in domestic workers, LCCE emphasizes the creation of safe, non-institutional, community-rooted spaces where psychosocial dialogue and healing can take place. This includes working with community centers, embassies, CSOs, and faith-based spaces to identify safe hubs for gathering, support, and referral. For those confined to employers' homes, LCCE is developing digitally enabled interventions, such as adapted podcast series and online support tools, to reach the most isolated.

5. Hybrid Methodology and Digital Outreach

To overcome barriers faced by MDWs confined to employers' homes, LCCE leverages a hybrid methodology that integrates digital tools into MHPSS programming. This includes:

- Social media campaigns and audio-visual content developed in migrant languages to raise awareness and reduce stigma around mental health.
- Culturally adapted podcasts designed for low-bandwidth, private listening, allowing isolated MDWs to access psychosocial support discreetly.

6. Stakeholder Engagement and System Synergy

LCCE works closely with the National Mental Health Programme (NMHP), migrant embassies, protection actors, and other NGOs and CSOs and continuously participates in national and sectoral coordination mechanisms to

ensure alignment, avoid duplication, and embed migrant-sensitive approaches into broader systems. This includes incorporating anti discrimination, GBV, and protection modules into MHPSS training packages recognizing that migrant mental health cannot be separated from the structural violence many face.

7. Mapping, Information Sharing, and Protection

To enhance protection and access, LCCE has initiated the mapping and dissemination of migrant-sensitive MHPSS services, helping workers, facilitators, and CSOs navigate a fragmented system more effectively. Clear referral pathways and information-sharing protocols are built into this process, improving not only access but also continuity of care.

Emerging Impact

While challenges persist, early outcomes are promising. Migrant community leaders trained by LCCE are beginning to take ownership of psychosocial activities, leveraging adapted tools, multilingual materials, and stronger linkages to services. Community trust has grown as culturally relevant support becomes more visible and accessible.

The participatory methodology is proving essential—not only for designing appropriate interventions but for restoring a sense of agency and dignity among migrant workers too often left out of the conversation. LCCE's model offers a compelling example of what migrant-sensitive MHPSS can look like in practice: grounded in participation, scaled through partnership, and sustained by the very communities it aims to support.[15]

Case Snapshot:

Bridging Language Barriers Through Peer-Led Support

An Ethiopian migrant domestic worker in her early 30s had been struggling with emotional exhaustion, social isolation, and anxiety after months of unstable employment and repeated verbal abuse in different households. Her limited Arabic and English skills prevented her from accessing support services or understanding her legal rights. She had never participated in any psychosocial support program before and believed that such services were only available to Lebanese or Arabic-speaking communities.

Through community outreach led by a trained Ethiopian facilitator supported by LCCE, she was identified and invited to join a stress management and emotional wellbeing session delivered entirely in Amharic. The session

provided a culturally sensitive, supportive environment where she could share her experiences with peers and learn simple, practical tools to manage stress. For the first time, she received referral information and awareness materials in her native language, including contacts for protection services.

This case demonstrates the power of peer-led, language-accessible psychosocial interventions in reaching live-out MDWs who often remain disconnected from mainstream support systems. It also highlights how empowered facilitators can serve as trusted bridges between vulnerable individuals and critical services, restoring a sense of agency, safety, and belonging.

Recommendations: From Evidence to Action

The evidence in this paper reveals a simple truth: mental health care for migrant domestic workers in Lebanon will remain incomplete until it is made inclusive, culturally relevant, and rights-based. While initiatives like those led by LCCE demonstrate what's possible, systemic change is still needed to ensure that dignity, not dependency, defines care. Below are actionable, cross-sectoral recommendations for government actors, NGOs, donors, and community leaders.

Coordination & Governance

Advance efforts to dismantle the Kafala system, a root cause of exploitation and psychological harm. Despite sustained advocacy, reform remains stalled. Structural change is needed—starting with legal recognition of domestic work and equal access to labor protections, justice, and mental health care for all migrant workers.

Develop a dedicated migrant-sensitive MHPSS strategy to complement the National Mental Health Strategy (2024–2030), with clear implementation pathways, inclusion standards, and co-design by migrant-led organizations and key stakeholders. This would move the response from fragmented projects to systemic, rights-based inclusion.

Strengthen inter-sectoral coordination between the Ministry of Public Health (MOPH), the National Mental Health Programme (NMHP), the Ministry of Labor, migrant embassies, CSOs, and community groups, to ensure MHPSS is embedded across health, labor, and protection sectors.

Formally include migrant-led organizations and trusted community representatives in national MHPSS planning and humanitarian coordination platforms.

Collaborate with the Internal Security Forces (ISF) to ensure that newly arriving migrant workers at airports receive translated, accessible information on rights, protection, and mental health resources—setting the tone for prevention and early support.

Service Delivery

Scale up community-based, peer-led, and culturally adapted MHPSS services, ensuring access through safe spaces, community centers, and trusted civil society actors.

Embed migrant-sensitive MHPSS in spaces migrants already access, such as community hubs, shelters, and embassy-linked services

Integrate migrant-sensitive MHPSS into Primary Healthcare Centers (PHCCs)—beginning with those whose staff have already been trained on MHPSS—to ensure that inclusive care is mainstreamed into national health systems, not left to the margins.

Invest in preventive psychosocial interventions and emotional wellbeing activities in migrant languages, particularly those that reduce isolation and build resilience before crisis.

Medical Coverage & Referral Systems

Improve referral mechanisms between MHPSS, health, legal aid, and protection services, ensuring pathways are trauma-informed, multilingual, and survivor-centered.

Ensure migrants can access basic mental health services regardless of legal

status, by expanding subsidized care options and NGO-MOH coordination.

Produce and distribute multilingual IEC materials, including hotline numbers, protection contacts, and wellbeing tools, in locations migrants frequent (e.g. airports, embassies, shelters).

Capacity Building & Workforce Development

Train frontline service providers and CSO staff on culturally sensitive, gender-responsive, and trauma-informed MHPSS approaches tailored to migrant realities.

Institutionalize and support the role of trained migrant community facilitators, recognizing their role in sustaining psychosocial care at the grassroots level.

Incorporate migrant mental health into GBV, protection, and labor training curricula, especially for police, social workers, and health professionals.

Cross-Cutting Priorities

Launch inclusive public awareness campaigns to reduce stigma, combat racism, and normalize help-seeking among migrant populations.

Use hybrid methodologies, such as adapted podcasts, voice notes, and online support, to reach isolated workers confined to employers' homes.

Invest in action-oriented research and evaluation to document what works, inform national policy, and strengthen advocacy—while ensuring linkages between MHPSS and related sectors such as sexual and reproductive health (SRH), GBV, and labor protection. Encourage multi sectoral pilot programs that reflect the complex realities migrant workers

face.

Conclusion: Towards a Replicable, Dignified MHPSS Model

As this paper has shown, migrant domestic workers in Lebanon continue to face profound mental health and psychosocial burdens—rooted not only in individual experiences of trauma and isolation, but in structural systems of exclusion, legal precarity, and social invisibility. While these challenges are urgent, they are not insurmountable. Dignified, migrant sensitive mental health care is both possible and essential; and Lebanon has the tools, knowledge, and community leadership needed to build it.

The experience of the Lebanese Center for Civic Education (LCCE) offers a compelling blueprint for what that care can look like: participatory, culturally adapted, peer-led, and community-driven. From language accessible psychosocial programs to the training of migrant facilitators and the use of hybrid digital outreach, LCCE's model is scalable, replicable, and rooted in dignity. It does not wait for change from above, it builds solutions from the ground up, led by the very communities too often left behind.

But for this model to reach its full potential, policy and systems-level action must follow. Migrant-sensitive MHPSS must be mainstreamed across health, protection, and labor systems. The Kafala system must be dismantled. National strategies must go beyond rhetoric to include clear, funded pathways for migrant inclusion. And most importantly, migrant workers themselves must be at the center of this transformation—as leaders, not just beneficiaries.

This is a call to action.

To policymakers: integrate migrant-sensitive MHPSS into national frameworks and legal reform.
To donors: fund sustainable, community-led models that prioritize dignity and inclusion.
To implementing partners and health actors: embed MHPSS in all services reaching migrants, from shelters to primary healthcare.

Dignity cannot be an afterthought. It must be the foundation of any mental health system that seeks to be just, inclusive, and effective. The time to act is not tomorrow, but now.

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