

Policy Analysis on the Mental Health Needs of Overseas Filipino Workers: Addressing Gaps through Evidence-based Policy Reform

Ma. Esmeralda C. Silva, MPAf, MSPPM, PhD,^{1,2} Ma-Ann M. Zarsuelo, RND, MSc,^{1,3}
 Zenith D. Zordilla, MD,^{1,3} Leonardo R. Estacio Jr., MCD, MPH, PhD,^{1,4}
 Michael Antonio F. Mendoza, DDM, MA^{1,5} and Carmencita D. Padilla, MD, MAHPS⁶

¹University of the Philippines Manila Health Policy Development Hub

²College of Public Health, University of the Philippines Manila

³Institute of Health Policy and Development Studies, National Institutes of Health, University of the Philippines Manila

⁴College of Arts and Sciences, University of the Philippines Manila

⁵College of Dentistry, University of the Philippines Manila

⁶University of the Philippines Manila

ABSTRACT

Background. There is an increasing number of distressed Overseas Filipino Workers (OFWs) due to adverse working conditions and unresolved post-repatriation issues. The enactment of the Republic Act 11036 (Mental Health Act) in 2018 supports the commitment of the State in promoting and protecting the mental health of every Filipino.

Methods. A systematic review of literature was conducted to generate evidence-based policy tools for the round table discussion conducted by the UP Manila Health Policy Development Hub, engaging all major stakeholders from all sides of the policy issue. Strengths and challenges of the current government initiatives in the phases of pre-deployment, deployment, repatriation, and reintegration were discussed to attain consensus policy recommendations.

Results. Increased migration led to a cascade of distressed OFWs and their subsequent need for trained mental health professionals. In host countries, challenges in on-site services include (i) limited psychiatry practice as prescribed by law of the host countries, (ii) reciprocity of the host country in allowing more welfare officers, and (iii) budget to support more plantilla items of Assistance to Nationals (ATN) staff. The inter-agency collaboration and legal support for all phases of migration should be holistic and set.

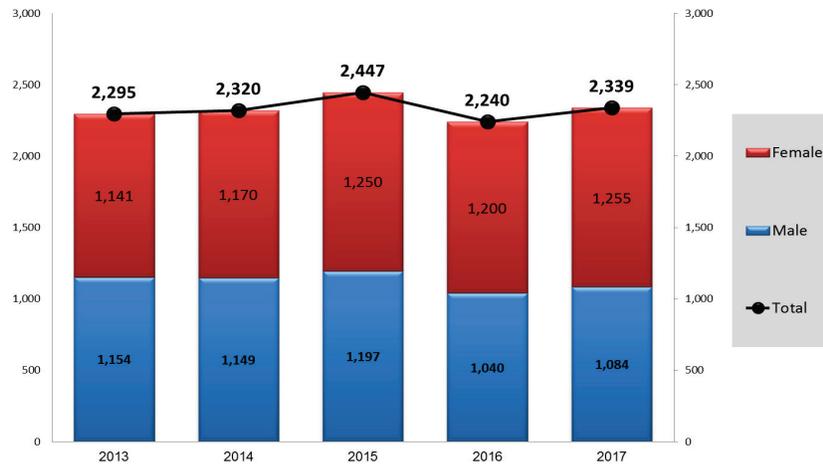
Conclusions and Recommendations. From the literature review and policy discussion, consensus recommendations included strengthening pre-deployment preparation, curbing the trafficking of minors, improving psychiatry practice through the Bilateral Labor Agreement, developing psychosocial counseling competencies among front line host country personnel, enhancing telecounseling services and exploring telemedicine, among others.

Key Words: Mental health, migrant workers, health policies, Philippines

INTRODUCTION

According to the Philippine Statistics Authority (PSA), the number of Overseas Filipino Workers (OFWs) has been steadily rising (Figure 1). However, approximately three percent of these are without contracts. There were approximately 2.3 million OFWs deployed globally in 2017, wherein 54% of the workers were female. The number of Filipinos seeking work overseas is expected to increase. One-third of the workers are in elementary occupations, and one out every five workers is a household service worker (HSW). This sector significantly contributed to the Philippine's

Corresponding author: Ma-Ann M. Zarsuelo, RND, MSc
 UP Manila Health Policy Development Hub
 National Institutes of Health
 University of the Philippines Manila
 623 Pedro Gil St., Ermita, Manila 1000, Philippines
 Email: mmzarsuelo@up.edu.ph



Source: Philippine Statistics Authority, Survey on Overseas Filipinos. 2013- 2017.

Figure 1. Total estimated number of OFWs by sex from 2013 to 2017 (in ‘000).

economic gain, with 28.1 billion USD in 2017. In mapping their destinations across the globe, it was found that the top destinations of OFWs are Kingdom of Saudi Arabia (KSA), United Arab Emirates (UAE), Kuwait, Hong Kong, and Qatar.¹

Much of migration is linked with the search for a better life, including economic opportunities. However, migrant health studies found that adverse mental health outcomes among migrant workers are linked with stress and social isolation,²⁻⁵ marginalization, discrimination, and abuse.⁶⁻⁹ Employed in low-wage occupations with considerable occupational hazards and longer working hours, migrant workers are at increased risk for poor physical and mental health outcomes. Other obstacles compound this during the migration process, such as distance from family and unfamiliar environment, food and housing insecurity, housing, racism, among others.¹⁰ Thus, migrant workers, in general, face mental health risks such as adjustment disorder, mood disorder, psychosis, and even suicide ideation and suicidal acts.¹¹ These factors were found to be true among OFWs as well.¹² Other challenges faced by OFWs in the labor market include the increasing “nationalization” of economies, resulting in increased deployment costs, and increasing vulnerability of migrant women in the Middle East. These prevailing forces in the labor market translate to conditions that can affect the mental health of Filipino workers overseas. These are further compounded by the low Philippine Overseas Labor Office (POLO) worker-to-client ratio in the embassies.¹³

Unfortunately, there is a dearth of literature to describe OFW mental health issues. In 2014, Kronfol, Saleh, and Al-Ghafry conducted an extensive literature review of mental health issues among migrant workers in the Gulf Cooperation Council states.¹¹ They found very few published works on psychological and psychiatric issues among migrant workers in these countries, which were also dated and

focused on pre- or post-migration phases. They were mostly descriptive with limited quantitative analysis. One study published in 2007 estimated that the suicide rate in Bahrain was 0.6 per 100,000 for Bahrainis and 12.6 per 100,000 for non-Bahrainis.¹⁴ In 2008, it was reported that one female domestic worker commits suicide every week in Lebanon.¹⁵ European surveys on migrant health are also scant due to inadequate systems of registration.¹⁰ Meanwhile, according to a study by Anjara et al. (2017), female migrant workers (n=182) in Singapore reported symptoms of stress (53%) associated with social isolation (20%).⁴

Seafarers are considered to be a high-risk population due to prolonged isolation at sea compounded by long working days and separation from family.¹⁶ Statistics from 1960 to 2009 on deaths of seafarers (n=17,026) showed that suicide accounted for 5.9%. This figure would be higher if the number of seafarers disappearing at sea was to be included.¹⁷ Over five years, Abaya et al. (2015) found that among seafarers (n=388,963) contracted from the Philippines, 1.7% of these were repatriated.¹⁸ Among those repatriated, 1.8% were referred for psychological or psychiatric reasons. This translates to about 1 in 3,000 of the population studied. A survey of women seafarers (n=595) showed that 43% reported stress, depression, or anxiety, as part of their top three health challenges.¹⁹

There is no official Philippine data on the prevalence of mental health problems of OFWs. As a proxy, the Department of Foreign Affairs provided the number of OFWs in distress that were assisted in 2011-2015 (Figure 2).

Migrant workers have little incentive to interact with the local health system.²⁰ Seeking mental health services may be monetarily prohibitive or may be inaccessible due to the distance or the inflexible appointment system.²¹ Other workers fear that seeking mental health services could prematurely terminate their contracts.⁷ Personal beliefs on

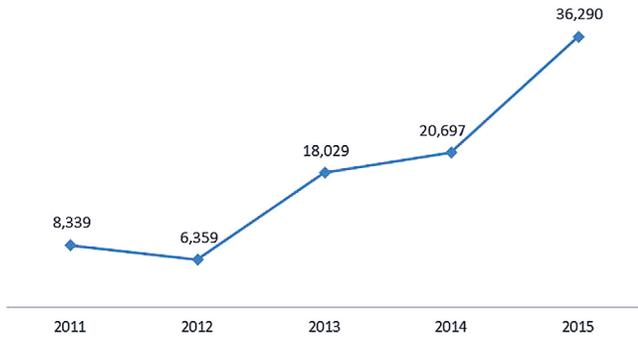


Figure 2. Number of Overseas Filipinos in distress given assistance through Assistance to Nationals Funds (ATNF), 2011-2015.

Source: Department of Foreign Affairs. (n.d.) <https://www.dfa.gov.ph/assistance-to-overseas-filipinos-in-distress> (accessed on 14 August 2018).

the nature of mental illness and the possible stigma from families and friends also constrain workers from seeking mental health services.^{7,22} Figure 3 illustrates the identified barriers from the economic migrants from a meta-synthesis of 28 studies by Agudelo-Suarez et al. (2012). The barriers to seek care among migrants include factors such as previous experience, health condition, and knowledge on the disease, among others. Once immersed in the health system of the host country, identified barriers of migrants extend to the structure of social security, insurance coverage, and communicative abilities of the health personnel, wherein language and culture play critical parts. Further, undocumented migrants were constrained from seeking care due to fear of awaiting sanctions from immigration or unscrupulous employers. All these could lead to low utilization of health services which could lead to the use of alternative medicines, self-medication, and social vulnerability, among others.²³

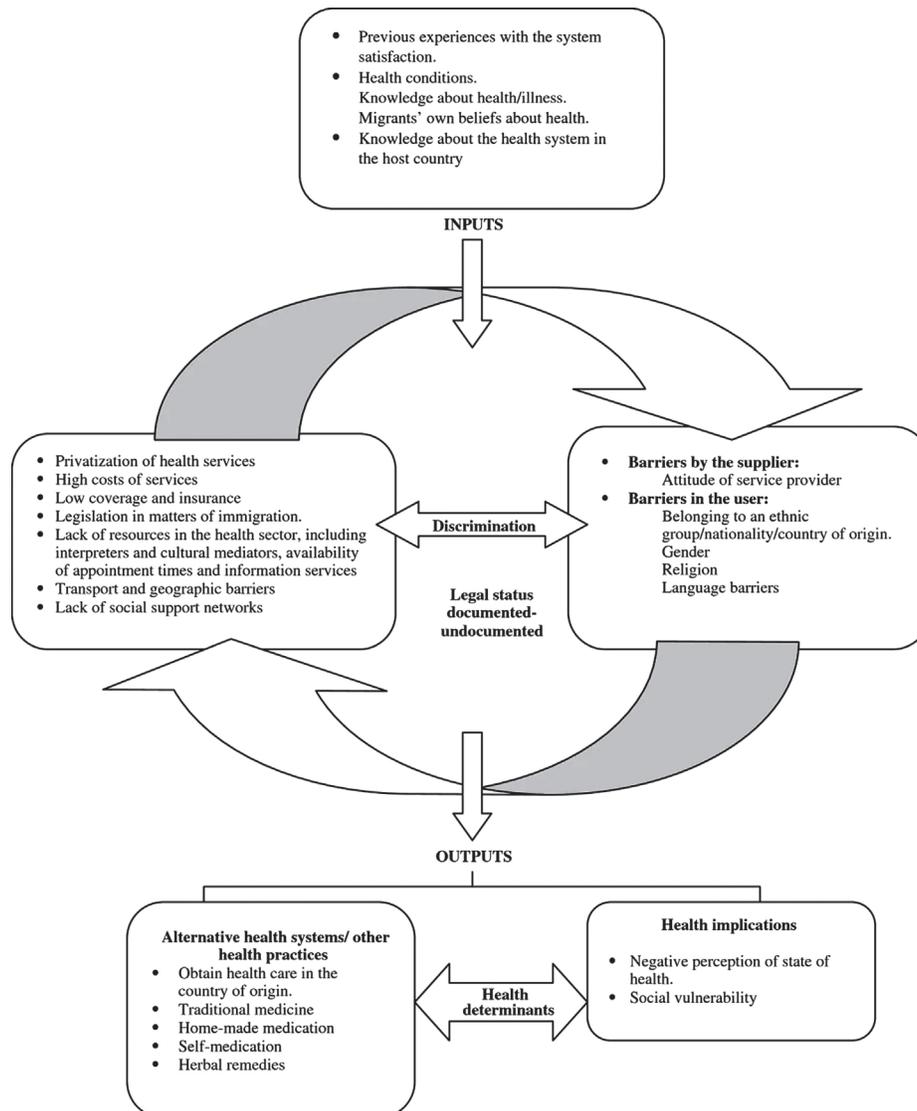


Figure 3. Barriers to seeking health care services of migrants (Agudelo-Suarez et al., 2012).

Current policy framework for labor migration and health

The Philippines' underlying principle which guides the management of migration of Filipinos is the constitutional mandate to afford full protection to labor, local and overseas, organized and unorganized, and promote full employment and equality of employment opportunities for all. Other national policies that support safe labor migration and health interventions for OFWs include:

1. Labor Code of the Philippines, 1974 – Filipinos who wish to work overseas should be secured the best possible terms of employment²⁴
2. Letter of Instruction 537, 1977 – created a Welfare and Training Fund for Overseas workers and provide social and welfare services for the workers²⁵
3. Executive Order 797, 1982 – created the Philippine Overseas Employment Administration (POEA) with the mandate to promote and monitor overseas employment²⁶
4. Migrant Workers and Overseas Filipinos Act of 1995 (RA 8042) – created the Overseas Filipino Resource Center that provides welfare assistance including the procurement of medical and hospitalization services²⁷
5. Amended Migrant Workers Act (RA 10022), 2009 – identified the Department of Health (DOH) to regulate psychological examinations on Filipino migrant workers²⁸
6. Overseas Workers Welfare Act (RA 10801), 2016 – mandates the Overseas Workers Welfare Administration (OWWA) to provide social and welfare programs including psycho-social counseling services²⁹
7. DOH AO No. 2016-0007 – Creation of the Philippine Migrant and Health Network (PMHN) - The AO aims to set the overall policy directions and the national policy framework for addressing the health of migrants and overseas Filipinos³⁰
8. Joint Manual of Operation in Providing Assistance to Migrant Workers and Other Filipinos Overseas, 2015 – includes psycho-social services among the services provided to overseas Filipinos³¹
9. Joint Memorandum Circular No. 2017-0001 - Integrated Policy Guidelines and Procedures in the implementation of Inter-Agency Medical Repatriation Assistance Program (IMRAP) for Overseas Filipinos³²

The recent promulgation of the Mental Health Act of 2018 (RA 11036) supports the commitment of the State in promoting the mental health of the Filipino people. The Act also seeks to protect persons afflicted with mental health conditions “to exercise the full range of their human rights and participate fully in society and at work.”³³ The Act also mandates the creation of the Philippine Council for Mental Health and the DOH Mental Health Division. The DOH takes the lead as the principal implementing agency of RA 11036.³³

The OWWA also has several current and proposed interventions that were focused on providing support to

the mental health issues of OFWs. In April 2019, the Office launched the 24/7 Hotline 1348 that will attend to a request for assistance on various OWWA assistance and OFW-related inquiries.³⁴

METHODS

Research as inputs for the policy roundtable discussion

A review of literature was conducted to generate evidence for the policy tools to be utilized in the stakeholders' discussion. To have a broad pool of literature, a search in PubMed was done using keywords “mental health” AND “seafarers” AND “OFWs” and in Google Scholar search using “mental health” AND “household service workers.” When screened by relevance, year of publication ranged from 2007 to 2019. For official reports of various national government agencies and recognized local and international migrant groups, a search on Google Chrome using keywords “mental health” AND “OFWs” was used, yielding a combination of reports, manuals, short articles, and guidelines. For related mental health and migrant policies, pertinent copies of laws were retrieved from the Official Gazette, which is the public journal and publication of the Government of the Philippines. After screening by relevance, 11 reports and 12 laws were included. Below is the PRISMA diagram for the article search (Figure 4).

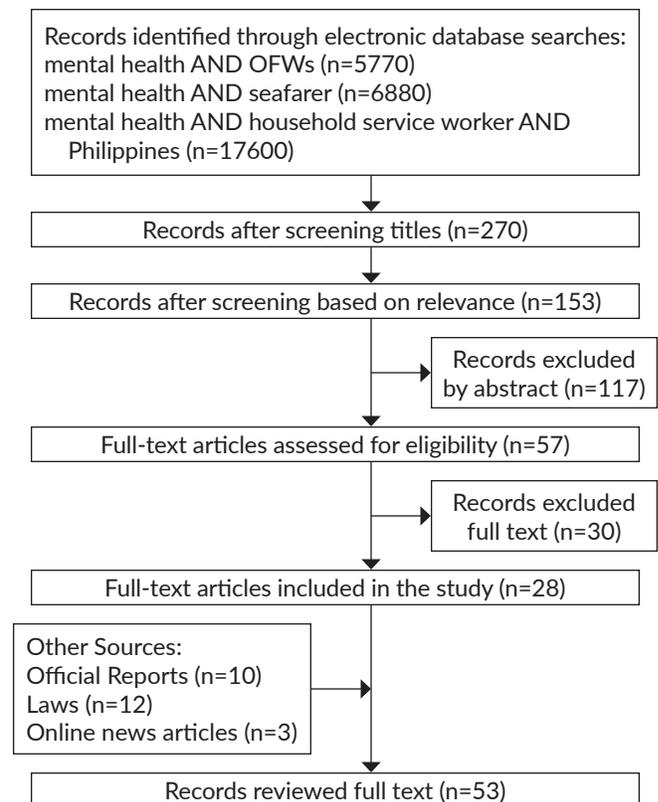


Figure 4. PRISMA diagram of article search.

Results of the literature review served as the basis in crafting the policy brief presented in the roundtable discussion. International and local evidence showed that mental health issues and policy gaps were present in any phase of migration, from pre-deployment to reintegration. The review article on Philippine policies on the mental health of OFWs demonstrated the stressors and interventions in each phase of migration succinctly (Figure 5).^{2-4,6-20,22-23,35} It underscored the need to have multi-sectorial implementation and monitoring to attain synchronized efforts of involved agencies to timely arrest potential stressors at any point in the migration process.

Several good practices in the provision of mental health services to overseas workers in different phases of migration were reported.

Before deployment, pre-departure psychosocial counseling through face-to-face counseling and hotline services by a non-government organization in Nepal was reportedly well-received by the outgoing migrants. Similarly, discussion on mental and psychological issues are included in the pre-departure briefings in Placement and Protection of Indonesian Overseas Workers of the Indonesian Agency for Service.³⁶

In the Philippines, the Department of Labor and Employment issued Department Order No. 95-09, series of 2009, implementing the Comprehensive Pre-Departure Orientation Education Program for overseas household service workers (HSWs) to include a stress management course. In 2010, a review of the compliance of pre-departure orientation seminar providers found a wide variation on how these seminars were implemented.³⁷

A published white paper by Ujano-Batangan (2011) on the mental health of Filipino women migrant domestic

workers during the phases of migration recommended the following: (1) integration of mental health on programs of the Department of Education and Department of Social Welfare and Development, among others; (2) incorporation of mental health topics on the PDOS; (3) integration of psychosocial intervention in the training of foreign service personnel; and (4) placement of mechanisms to identify mental health needs of aspiring and returning OFWs and how they will be managed should they fail psychiatric tests and deemed “unfit to work.”³⁶

For protection on financial health risk, Zimmerman et al. (2011) highlighted the need for countries with a large population of migrant workers to implement multilateral employment and social insurance schemes with recruitment agencies and destination countries. An example is the Migrant Workers and Overseas Filipinos Act that mandates compulsory insurance for departing OFWs to be paid by licensed recruitment agencies and foreign employers (i.e., accidental or natural death, permanent disability, repatriation costs, subsistence allowance, settlement claims, compassionate visit, medical evacuation, and medical repatriation) at no cost to the worker. However, the article also noted that resource centers that coordinate availing of these services were only available in countries with substantial OFW population.³⁸ In a meta-synthesis of the perceived barriers in health care access, most migrants identified the lack of coverage in health and social security insurance, and even of private insurance, due to lack of access and prohibitive costs.²³ Middle Eastern countries use the visa sponsor system, or the *Kafala system*, where the employer will shoulder the health insurance of the foreign workers they employ.³⁹ However, this *Kafala system* has also been reported to be onerous to the migrant worker if abused by the employer.^{40,41}

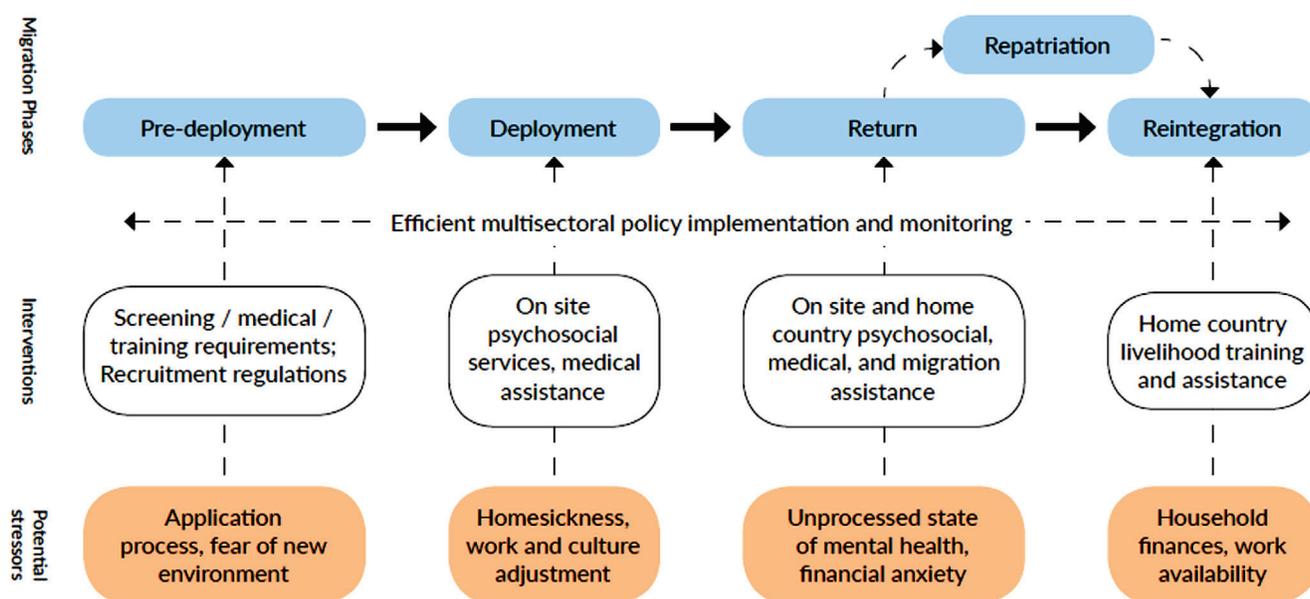


Figure 5. Conceptual framework on the migration process of distressed migrant workers (Zarsuelo, 2018).

One concern among migrant workers is that they might lose the benefits they have once they return to their countries of origin. A World Bank white paper (2005) explored the possibility of portability of insurance benefits for migrant workers from the host countries.⁴² It stated that the Philippines has bilateral social security agreements with Austria, Belgium, Canada, France, Spain, Switzerland, and the United Kingdom. However, these cover exportability of pensions but not health coverage. These non-health benefits include:

- Mutual assistance between the Philippines and the host country in the field of social security, as both covered members or beneficiaries may file their claims with the designated liaison agencies in the Philippines or the host country, which will extend assistance to facilitate the processing of claims
- Equality of treatment – a Filipino covered by social security, including his/her dependents and survivors, shall be eligible to benefits under the same conditions as the nationals of the other host country.
- Totalization – Creditable membership periods in both the host country and the Philippines (excluding overlaps) shall be added to determine the qualification benefits and transfers between public health care authorities. This guarantees the continuity of the pension of migrants in both countries.
- Prorated payment of benefits – both the host country and the Philippines shall pay a fraction of the benefit due from their respective systems, in proportion to the actual contributions or creditable periods.⁴²

During the deployment phase, one of the government interventions to be explored is the utilization of an electronic mental health intervention app as an alternative to face-to-face treatment. A survey among 1,365 Filipino domestic workers in Macau showed that 62.8% would likely utilize the eMental Health.⁴³ Using electronic platform may mitigate the physical inaccessibility to mental health services experienced by OFWs.

A review of the challenges encountered by health care providers when migrants seek treatment discussed how specific laws can deter access to health by migrant patients. Physicians in the host country may be compelled by law to inform government authorities and report the presence of illegal migrants. Some providers utilize informal networks such as non-government organizations (NGOs) to circumvent administrative barriers in managing services for illegal migrants.⁴⁴

Conduct of policy roundtable discussion

In line with the commitment of the University of the Philippines Manila Health Policy Development Hub (UPM HPDH) to be in the forefront of generating evidence-informed and inclusive health policies, a round table discussion (RTD) on the current state of mental health

policies and programs for OFWs was conducted on 2018 August 16. A total of 18 participants, including program managers / coordinators from critical national government agencies, mental health academicians, professional societies, and migrant-related NGOs, were invited to the policy RTD to share insights and understanding of the policy issues.

The ultimate goal of the RTD was to craft consensus policy recommendations to address gaps in mental health programs and policies in each phase of migration—deployment, employment, repatriation, and integration. The first half of the RTD was devoted to generating the various perspectives from selected presenters to provide scientific, legislative, and background evidence which was from (i) UPM HPDH, (ii) Department of Health– Essential Non-Communicable Diseases Division (DOH-ENCDD), (iii) Policy and Program Development Office of the Overseas Workers Welfare Administration (PPO-OWWA), and Blas Ople Training Policy Center and Training Institute.

To attain the objectives, the policy RTD was guided by the following discussion questions:

1. What are the strengths of and challenges to the current government action to address the mental health needs of OFWs during the following phases:
 - a. pre-deployment
 - b. during deployment
 - c. post-deployment
 - d. reintegration?
2. Among these challenges, what should be prioritized?
3. What are the recommended strategies to address these?

Policy Analysis

Thematic analysis of the roundtable discussion was conducted with the migration phases as sub-themes. Diversity of the participants and variability of the shared insights and experience brought up policy issues that were cross-examined to determine the possible gaps and trace its influencing factors.

Both the systematic review of literature and policy discussion were utilized as inputs for the policy analysis, with the balance of scientific and expert evidence. The draft policy paper was circulated to all RTD participants for inputs and/ or approval. This guarantees that the policy paper is impartial and reflects consensus recommendations of all participants. After finalizing the consolidated comments of the participants, the paper was reviewed by the UPM HPDH members, then to the Chancellor for approval and endorsement to the DOH and other relevant agencies.

Scope and Limitations

Results of policy RTD were limited to available evidence at the time of conduct of the event and framed by the discussion questions only.

With the anticipated changes in the health care system brought about by the recent enactment of the Universal Health Care (UHC) Act, provision of comprehensive and

accessible quality health care services while protecting every Filipino from financial risk is expected to impact significantly individual- and population-based health outcomes, including mental health. To entrench the relevance of the migrant health policy discussion, related provisions of the UHC Act were discussed.

RESULTS AND DISCUSSION

The identified policy gaps, opportunities for mental health assessments, and interventions are presented across the four phases of deployment.

Pre-deployment

Strengthening the pre-qualification process

Aspiring OFWs should undergo the Pre-employment Orientation Seminar (PEOS) and the Pre-deployment Orientation Seminar (PDOS) before they leave for their destination countries. During the PEOS, they learn about job application procedures, requirements, and costs, as well as the safeguards against illegal recruitment. On the other hand, PDOS focuses on their adjustment concerns in their destination country.⁴⁵ This program is supplemented by the Comprehensive Pre-departure Education Program (CPDEP), which provides specialized courses on language, culture, and stress management.⁴⁶

Further, prospective OFWs undergo a Pre-employment Medical Examination (PEME) to ensure their fitness to work. Ideally, this should include a psychometric exam.²⁴ Under RA 10022, “all DOH regional and/or provincial hospitals shall establish and operate clinics that can serve the health examination requirements of Filipino migrant workers to provide them easy access to such clinics all over the country and lessen their transportation and lodging expense.” At present, the PEOS has a module on how OFWs may keep healthy and safe. This is further complemented by the DOH’s module on healthy lifestyles and other prevention measures.⁴⁵

However, participants discussed the various issues related to mental health screening among OFW applicants. They shared anecdotes that showcased the lack of sensitivity of mental health exams in diagnosing mental health issues nor to predict mental health risks of the applicants. It was stressed that through the course of migrants’ work experience, many would develop physical, emotional, and mental sickness.

Participants emphasized the need to strengthen the mental preparation of OFW applicants, particularly on the challenges that they will be facing once they are deployed. These include but are not limited to homesickness, acculturation, and social isolation, among others.

Competencies of welfare desk officers of recruitment agencies

It was stressed during the discussion that competencies of welfare desks officers of local recruitment agencies

should be expanded to enable them to handle the broad array of mental health challenges that OFWs face. This includes their capability to prepare departing OFWs to the challenges they will face during their deployment as well as to handle psychosocial cases that crop up. Current efforts are being made to address this. OWWA has started to put together a training module to address this while POEA’s Workers Education Division and the recently re-established Welfare Division have been tasked to handle the OFW pre-deployment requirements and the requests of their OFWs family, respectively.

Strengthening civil registry processes

There is increasing evidence that there are a significant number of OFWs who are minors, which is a clear violation of the provisions of Section 7 of RA 8042. Participants attributed this to the weak civil registry processes. One participant from the government sector shared that majority of the underage migrant workers came from Mindanao, particularly from the Autonomous Region of Muslim Mindanao (ARMM). This was attributed to the high rate of late birth registrations. Recruiters and applicants can game this system and generate falsified birth certificates.

It is imperative to fix the birth registration process with strict compliance and monitoring as a new control measure. The passport review by POEA needs to be strengthened in terms of its validation methods for possible frauds. Participants proposed bone age determination using wrist radiographs or dental records at the airport departure areas to prevent unlawful exits of minors as OFWs. With the current resources, comprehensive research is needed to determine its accuracy and applicability in the Philippine setting.

Deployment

Creating and sustaining supportive mechanisms for deployed OFWs

There is a need to create a supportive, decent, and humane working and living environment for deployed OFWs. Adjusting to a different culture and way of life is a significant challenge for them. An example of this is the *Kafala* or sponsorship system of employers among the Gulf Cooperation Council (GCC) countries.⁴⁷ According to Human Rights Watch, “the combination of the high recruitment fees paid by Saudi employers and the power granted to them by the *kafala* system to control whether a worker can change employers or exit the country made some employers feel entitled to exert ‘ownership’ over a domestic worker,” and that “sense of ownership... creates slave-like conditions.”⁷⁴⁸

Participants shared that this practice increases the vulnerability of HSWs since employers control the terms of employment, residence visa, and, subsequently, immigration status.⁴⁹ In the light of a drastic increase (300%) in the processing fee of PEME and visa per worker, participants

divulged that this has led to a “greater sense of bondage” of HSWs to employers.

Participants emphasized the need for the different government agencies working on issues related to labor migration to come up with a holistic approach to ensure that OFWs have access to supportive services that they need, including psychosocial counseling and health care services. This can be as simple as ensuring that the OFWs can communicate with their family in the Philippines as well as with embassy officials. This is seen as a simple intervention that can address their prolonged social isolation while being employed. Reports have shown that HSWs have limited to no access to mobile phones. This restrains them from communicating with their family and further hinders them from seeking assistance from the foreign recruitment agency (FRA) or any government agencies in the event of abuse.

Social isolation and prolonged maltreatment push these OFWs to take on desperate measures to escape their abusive employers. According to POLO-Kuwait, an estimated 300 to 400 OFWs seek refuge in their office each day. This calls for strict and monitored compliance with the contract terms. Experience of OFWs with recruitment agencies must also be fair and ethical so that workers will not be at risk for fixed or forced labor conditions or debt bondage.

Providing psychosocial support to embassy staff

A sub-population-group that is often overlooked is the embassy staff, especially those in the front-line who are directly dealing with OFWs. Participants who experienced being stationed in a Philippine Embassy (PE) or Consulate General (CG) shared the difficulties that they and their colleagues faced as they tried to respond to the needs of OFWs who seek help in their embassy. A particular difficulty was that the Assistance to Nationals (ATN) of the PE/CG had to deal with the challenges of the OFWs, including emotional problems. However, the embassy personnel did not have access to counseling services that would help them decompress. The participants agreed that there is a need to provide a supportive environment to the PE/CG staff as well.

Repatriation

On-site services: Psychosocial assistance

Repatriation of acutely ill mental health patients is challenging since the practice of psychiatry is usually limited by law in the host countries. The National Center for Mental Health (NCMH) attested to the challenge of escorting OFWs suffering from psychosis through the immigration phases – events that ATN officers are generally not trained to handle, especially since mentally-ill OFWs are not allowed self-representation during immigration interviews, thus, further requiring ATN staff assistance. With the weight of the responsibilities, the ATN should be further capacitated to handle these cases and be granted more plantilla positions. An alternative measure to address

the challenges that ATNs deal with to deploy more trained health professionals to on-site government partner agencies. However, there are two barriers to implementing this: (i) the reciprocity of the host country in allowing more welfare officers and (ii) budget to support more plantilla items.

At present, there are several interventions that have been implemented or are in the pipeline. The Department of Labor and Employment (DOLE), through the International Labor Affairs Bureau (ILAB) and OWWA, are sending augmentation teams to countries with a high volume of reported welfare violation cases. However, the issue of bringing psychiatric drugs to the host countries remains unresolved. Hence, the Bilateral Labor Agreement (BLA) with the host countries must reflect this need. To compensate for the lack of trained counselors and labor attachés in the host country, OWWA launched an online counseling service program that referred distressed OFWs to NCMH psychiatrists. However, the critical issue emerged in procuring the prescribed medication because the host countries do not recognize Filipino psychiatrists.

In addition to POLO, Migrant Workers and Overseas Filipino Resource Centers (MWOFRFC) are established in countries with a high volume of workers under the jurisdiction of the Embassy.⁵⁰ However, according to one participant from the government sector, the MWOFRFC can only provide temporary shelter for distressed female workers. This complicates the situation for males and for child cases, where the PE/CG ATN staff and officials are compelled to refer clients to counterpart agencies of the Host Government, if any.

There is also an urgent need for health experts in the host country, given that severely ill patients require medical attention. In response to this, NCMH offered the idea of providing training to PE/CG staff and officers on Psychological First Aid (PFA). Strengthening tele-counseling staffed by NCMH and exploring telemedicine, if allowed under Host Government's cybersecurity laws and regulations, may be considered.

In-country services

Psychosocial Assistance

Currently, only the OWWA Central Office has a Halfway House that provides temporary shelter where repatriated OFWs can stay for a maximum period of two weeks.⁵¹ For the repatriated migrants who need referrals, NCMH is the partner agency in providing free psychiatric services. An estimated 10 to 15 migrant workers are referred by OWWA monthly, mostly (90%) from GCC countries. The increasing demand for psychosocial services for OFWs places a heavy burden on the current network of OWWA and NCMH facilities. Additional space is urgently needed to accommodate all those in need. Moreover, the scarcity of chronic psychiatric care services outside of Metro Manila hampers the continuity of care.

Referral System

At present, the triaging of mentally ill repatriated Overseas Filipinos (OFs) falls under the auspices of the Philippine Embassy in the host country. “Manageable” cases are referred to as OWWA, while “severe” cases are referred to NCMH. According to the representatives from NCMH, only symptomatic cases are referred to regional hospitals, placing the asymptomatic distressed OFWs in the peripheries of care.

This also poses a threat to those with late-onset of mental illness symptoms. Trauma debriefing and counseling are provided to some repatriated OFWs at the OWWA Halfway House. However, they are only counseled during the time that they are in these facilities. The possibility of the late onset of mental illness symptoms is not captured, especially if this happens when they move back home. It is, therefore, critical to distinguish who is “mentally ill” and who are those “in crisis” for continuous monitoring after family reintegration.

There is a need for a transparent referral system that shows the forward cascading and back referral processes from the host country down to the OFWs re-integration in their community. Tasks of multi-sector agencies from all phases of migration must be delineated for efficient and timely intervention. The participants recommended that all health facilities with residency programs in psychiatry be receiving facilities in the proposed referral system. An essential ingredient to this referral system is the need for regional welfare desk officers to be given training on psychosocial counseling and advanced case management. The Philippine Mental Health Association (PMHA) can be tapped to complement these efforts since it takes part in promoting mental health awareness and providing clinical and diagnostic services for the repatriated OFWs and their families.

These changes are anticipated in the implementation of the Universal Health Care Act that underscored improved accessibility and affordability of health services. In Section 6 of the Act under Service Coverage, “every Filipino shall be granted immediate eligibility and access to preventive, curative, rehabilitative, palliative care for medical . . . mental . . . services delivered as population-based or individual-based services.” Part of its operationalization is stipulated in Section 30 under Health Promotion, wherein addressing mental health issues is explicitly stated in the scope of health services that the Local Government Units must strengthen and to broaden existing policies through enacting stricter ordinances.⁵² This rationalizes that mental health is indeed an integral part of holistic medical care among Filipinos.

Further, Section 4 of the Act also secures continued enjoyment of benefits despite failure to pay premiums provided that migrant workers will pay all missed contributions with 1.5% interest.⁵² This then insulates repatriated distressed migrants from financial risks of availing mental health services at all levels of health facilities. To timely detect mental disorders, especially late-onset and asymptomatic

conditions, increased financial and geographical accessibility not only for severe mental illnesses but also for consultations and other psychotherapy services, is needed.

For securing adequate and sustainable pool of mental health professionals, the return service agreement of the Act applied to recipients of government-funded scholarship programs for allied and health-related courses, will be required to serve three years in priority areas in the public sector. This can alleviate the scarcity of psychologists and psychiatrists in the country.

Reintegration

Socio-economic Reintegration

DOLE has a three-part-activity to assist returning OFWs: business start-up, loan assistance, and financial literacy.³⁰ Concurrently, the National Reintegration Center for OFWs (NRCO) is mandated under RA 10022 to provide reintegration program even in undocumented OFWs.²⁸ The NGOs may be tapped to increase the pool of local job opportunities for women, particularly in rural and disadvantaged areas, to promote local employment and, thus, be spared from having to go back to high-risk employment abroad.

Reporting system of cases

Foreign recruitment agencies are required to submit a quarterly report to POEA on any significant incidence on the status or condition of its hired Filipino workers.⁵³ However, it was reiterated during the discussion that the actual figures are under-reported since there are FRAs that do not report cases due to fear of being penalized by POEA. To address this gap, there is a need to identify which government agency is tasked to monitor all FRAs and be capacitated to search for unreported cases actively.

Meanwhile, suicide cases are directly handled by PE/CG ATN staff. Being a grave indicator of distress, its increasing number is alarming, particularly among seafarers, since they are far from facility-based psychosocial care for proper diagnosis and treatment. Further, it was shared by a discussion from a national labor agency that suicide cases for seafarers commonly involved jumping off the ship; hence, bodies cannot be retrieved.

One identified measure to keep the communication line accessible to OFWs efficiently, and their families are the use of social networking sites. Participants from the labor and welfare offices shared that this channel is one of the most accessible communication platforms used in reporting and request for help.

CONCLUSION AND RECOMMENDATIONS

In each phase of OFW migration, there were recognized policy gaps, generally rooting from the interplay of the employment system, provision of welfare services, and socio-

cultural factors. With the increasing volume of distressed migrants severed by the lack of human and financial resources and political interference, concrete and synchronized efforts of multi-sector collaboration will ensure continuity of care from pre-deployment to reintegration. Further, the focus of care should be inclusive not only to OFWs but expand to all Filipino migrants who are also vulnerable to socio-cultural and environmental stressors. With the gaps above, there is a need to harmonize the reporting system regulations of both the local setting and its foreign counterpart.

Based on the review of literature and policy discussion, the following are recommended:

1. Expand the mental health preparation workshop on pre-deployment requirements by utilizing the IMRAP alongside other available services from relevant government agencies. All family members must be engaged in the decision to migrate due to the high social cost for families of the OFWs.
2. Curb trafficking of minors by improving the late civil registry process.
3. Research on bone age assessment through wrist bone radiographs or dental records at the airports, which may mitigate unlawful exits of minors as OFWs.
4. Increase the pool of mental health professionals who are engaged in the psychosocial and psychiatric services of overseas Filipinos by collaborating with academic institutions that offer psychology programs and psychiatry residency programs.
5. Set a clear inter-agency referral system in repatriating distressed overseas Filipinos, from the host country to the family reintegration phase. All psychiatric institutions, including private hospitals, must be engaged to meet the demands.
6. Propose a Bilateral Labor Agreement with the host country on allowing more welfare officer posts and on authorizing entry of prescribed drugs for the use of OFWs.
7. Enhance the current tele-counselling system for round-the-clock accessible psychosocial support. Consider expanding to telemedicine for cases in need of immediate medical attention.
8. Develop psychosocial counseling competencies for the PG/CG front line personnel, POLO, OWWA-WELO (Welfare Officers Assigned Abroad), and other migrant serving agencies based in the Philippines (i.e., OWWA regional welfare officers and CFO) to augment the shortage of mental health professionals.
9. Monitor the mental health of distressed returning Filipino workers through OWWA regional offices or other migrant-related NGOs even after the family reintegration.
10. Shift the focus of mental health service package not only to Overseas Filipino Workers, but also to include marriage migrants and the families left behind as they are vulnerable to the same mental health risks.
11. Strengthen accessibility and availability of mental health services at the community level to sustain continuity of care during the reintegration phase, which is in alignment with the aim of universal health care.

Statement of Authorship

All authors participated in data collection and analysis, and approved the final version submitted.

Author Disclosure

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