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Health Empowerment Among Immigrant Women in Transnational Marriages in Taiwan

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Abstract

Purpose: The aim of this study was to develop, implement, and evaluate a theory-based intervention designed to promote increased health empowerment for marriage migrant women in Taiwan. The rapid increase of international marriage immigration through matchmaking agencies has received great attention recently because of its impact on social and public health issues in the receiving countries.

Design and Methods: A participatory action research (PAR) and in-depth interviews were adopted. Sixty-eight women participated in this study. Eight workshops of the health empowerment project were completed.

Findings: Through a PAR-based project, participants received positive outcomes. Four outcome themes were identified: (a) increasing health literacy, (b) facilitating capacity to build social networks, (c) enhancing sense of self-worth, and (d) building psychological resilience.

Conclusions: PAR was a helpful strategy that enabled disadvantaged migrant women to increase their health literacy, psychological and social health, and well-being.

Clinical Relevance: The findings can be referenced by the government in making health-promoting policies for Southeast Asian immigrant women to increase their well-being. Community health nurses can apply PAR strategies to plan and design health promotion intervention for disadvantaged migrant women.

The rapid increase of international marriage immigration through matchmaking agencies has received great attention recently because of its impact on social (e.g., demographic structure and culture) and public health (e.g., healthcare services) issues in the receiving countries. The U.S. Citizenship and Immigration Services (2013) reported that the "mail-order bride" business results in 4,000 to 6,000 marriages between U.S. men and foreign women each year. In Asian countries, an increasing number of women from Mainland China, Vietnam, Indonesia, the Philippines, Thailand, Malaysia, and Cambodia have migrated through international marriage to Taiwan, Singapore, Japan, South Korea, and Hong Kong (Hsia, 2010). In Taiwan, the immigration of Southeast Asian brides started in 1987 in rural areas of Taiwan (Yang & Wang, 2012). However, the number of undocumented international marriage immigrant women is often underestimated. According to Taiwan's Ministry of the Interior (2012), there has been an influx of 410,000 foreign spouses in Taiwan, including 140,000 from Southeast Asia and approximately 260,000 from Mainland China. The Ministry of the Interior (2012) reported that the overall immigrant population in Taiwan has grown dramatically, especially immigrants from Mainland China

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(318,390; 67.45%), Vietnam (87,274; 18.49%), Indonesia (27,648; 5.86%), Thailand (8,333; 1.77%), and the Philippines (7,468; 1.58%), making the influx of racial or ethnic immigrant minorities an increasingly challenging social and public health issue.

For many women in developing countries, international marriage immigration has emerged as a way to escape poverty and achieve a better life by marrying men from more financially developed countries. For men in East Asia who experience difficulties finding a wife, matchmaking agencies can arrange a trip to allow men to locate a partner in a few days and return to their homeland with a new bride. The bridal candidates, however, are called by many derogatory terms, such as "mail-order brides" or "foreign brides," and are often treated with disrespect and derision in the receiving country (Choe, 2005).

Health Care Among Immigrant Women in Transnational Marriages

The growing number of immigrant women has become a significant global concern in the social and public health sectors. According to the United Nations' Committee on the Elimination of Discrimination Against Women (2009), immigrant women may not only be subject to sex discrimination in their receiving country but also face specific health challenges. Indeed, one of the primary goals outlined in Healthy People 2020 is to eliminate health disparities among different segments of vulnerable populations, such as immigrants (U.S. Department of Health and Human Services, 2013). Studies showed that immigrant women in Taiwan not only tended to be more vulnerable to illness but also experienced more barriers to their health care than nonimmigrants. A cross-cultural comparison indicated that Vietnamese immigrant women in Taiwan had a generally lower health-related quality of life than native Taiwanese women (Yang & Wang, 2011a). Lin and Wang (2008) investigated Southeast Asian pregnant immigrant women and found they had irregular prenatal examination behavior.

Immigration is a stressful, unexpected life event in which immigrants experience a complicated process of re-adaptation in the host society (Meleis & Lipson, 2004). To cope with the challenges of living in a new country, marriage migrant women in Taiwan are also vulnerable to psychological distress, which can negatively impact their health and well-being (Yang, Wang, & Anderson, 2010). Moreover, greater acculturative stress increases the risk for developing psychological problems, particularly in the initial months of immigrating to the new host society (Berry, 1997). The lack of true friendships, personal relationships, and social support in their host country intensifies their loneliness and social isolation (Yang & Wang, 2011b).

Marriage migrant women's marginalized status and difficulties in accessing adequate health care indicate a lack of empowerment to effectively seek the resources they need to improve their health and well-being. Shearer (2007) asserted that health empowerment may increase one's awareness in health and one's own healthcare decisions. Ensuring health empowerment among marriage migrant women may improve their ability to access health care, achieve better health, and overcome their marginalized status in their receiving country. The aim of this study was to develop, implement, and evaluate a theory-based intervention designed to promote increased health empowerment for marriage migrant women in Taiwan.

Methods

Design and Theoretical Framework

Action research is an interactive research process that equalizes problem-solving actions implemented in a collaborative framework with data-driven analysis or an inquiry to understand underlying causes enabling future expectations about personal and organizational change (McNiff, 2013). Participatory action research (PAR) is based on critical social theory; it is conducted to realize and transform the world, collaboratively and reflectively (Reason & Bradbury, 2008).

PAR was used to develop the intervention of this health empowerment project (HEP). The bottom-up approach of PAR was chosen as the most appropriate method to develop and evaluate an intervention program designed to empower an especially marginalized and oppressed population (Minkler & Wallerstein, 2010). Previous researchers have documented PAR as an empowerment-based inquiry methodology that bridges the gaps between knowledge and daily lives and equalizes the power between researcher and participants (Tapp & Dulin, 2010). It promotes the research participants' ability to identify their own problems, make their own priorities, handle their own solutions, and control their own progress. In addition, Etowa, Bernard, Oyinsan, and Chow (2007) considered PAR a user-friendly framework for community-based inquiry and provided the model for researchers and community members to work together to identify problems, take action, and achieve the goal. The essential elements of PAR are collaboration, participation, and reflection, which take place during multiple cycles of planning, acting, and reviewing (Koshy, 2005).

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Intervention

Planning cycles. During the planning phases of our PAR-based HEP, the specific health concerns of the participants had been identified based on the previous literature (Lee, Wang, Yang, & Tsai, 2013; Tsai, Cheng, Chang, Yang, & Wang, 2014; Yang & Wang, 2011b), including social isolation, acculturative stress, lack of health information, and lack of health literacy. Investigators established a collaborative relationship with community partners, and integrated community resources. The research team met with community partners several times to discuss the appropriateness and effectiveness of the health promotion strategies presented in the workshops. Investigators established a preliminary curriculum.

To recruit participants, the research team established community partnerships such as the local neighborhood managers (the heads of the subdivisions of the districts), the local Christian church, the primary healthcare center, and the Management of Assistance Center for Foreign Spouses. The community of interest was considered and the appropriate consent procedures were implemented for participants who were involved in the design of the curriculum. We formalized an arrangement with community leaders to establish contacts with community partners, to build a trusting relationship between participants and our research team, and to agree on a time frame for the HEP.

Acting cycles. The goal of the various acting cycles of our PAR project was to develop an HEP, implemented as a series of eight workshops, in order to generate positive psychological and social changes among the participants. A major component of the HEP's curriculum was a holistic health concept, which included physical, psychological, and social well-being. The curriculum addressed the following six topics: reproductive health (maternal health and family planning); disease prevention (human immunodeficiency virus, sexually transmitted illnesses, cancer screening); healthcare system utilization (health information and health insurance); cultural competence (social support and acculturation); mental health (interpersonal relationships and stress management); and the special issue (domestic violence prevention and management). The study's principal investigator designed and developed the preliminary curriculum based on previous studies (Lee et al., 2013; Wang & Yang, 2002) and discussion with community leaders, and two instructors presented the health information by means of various activities conducted in the workshops, such as lectures, demonstrations, drama, role-play exercises, group discussions, and group presentations.

Reviewing cycles. During the multiple reviewing cycles of the PAR project, the research team worked with community partners to evaluate and reassess the HEP during intermittent periods and at the final stage of the program. Participatory observations and group discussions during the workshops, as well as in-depth individual interviews with each participant at the conclusion of the program, provided the participants' points of view and reflections during the PAR process. Feedback from the participants was ongoing. For example, many participants complained their husbands beat them after quarrels, so the special session on domestic violence in the curriculum was in response to participants' feedback in the reviewing cycles.

Data generation and analysis occurred concurrently and began in the early stages of the HEP, which enabled the use of emerging themes and issues to guide group discussions in the workshops. The researchers' role throughout the reviewing cycles was to explore and stimulate the participants' reflections on their experience during the HEP.

Participants and Setting

Among the 87 women who were invited to participate in this study, 68 completed the eight workshops of the HEP. The reasons of those who did not complete the study included transportation problems, being forbidden to go outside by their mother-in-law, taking care of young children, or moving out of the community. Eligible participants were women who fit the following criteria: (a) were marriage migrants from Vietnam, Indonesia, the Philippines, Thailand, or Cambodia; (b) were married to a Taiwanese man; (c) had a basic conversation ability in Taiwanese or Mandarin; and (d) were willing to participate in the study. Although immigrants from Mainland China comprise the majority of the marriage migrants, they were not included as part of the inclusion criteria. This is because Mainland China migrants share the same culture and speak the same language (Mandarin) with Taiwanese. They can access more information by themselves with no language barrier and have better acculturation in Taiwan. The women from Vietnam, Indonesia, the Philippines, Thailand, or Cambodia who were included have all learned a new language since immigrating. They need to learn Mandarin or Taiwanese dialect to communicate with their husband and in-laws. From June 2009 to February 2010, eight workshops with 1-month intervals were held in a local church located in Pingtung County, southern Taiwan. Each workshop lasted approximately 3 hr, for a total of 24 hr of contact time with study participants throughout the intervention

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program. The participants were grouped into five groups by ethnicity. Taiwanese dialect and Mandarin were the languages used while conducting the workshops.

Data Collection

Two qualitative methods were used to collect data: participatory observation and in-depth individual interviews. Participatory observation involved a member of the research team taking field notes to record the interactions and activities in each of the eight workshops throughout the entire health empowerment program. The content of these field notes included observations on the setting arrangement, the participants, group dynamics, and interactions between participants, group presentations, and the premeeting with community partners. At the conclusion of the program, another member of the research team conducted in-depth individual interviews to gain a deeper understanding of the personal experience of each study participant. We developed a semistructured interview guide to elicit responses from each participant. The individual interviews were conducted for 60 to 90 min and were tape recorded and transcribed.

Ethical Considerations

The institutional review board of Kaohsiung Medical University, Taiwan, approved the research and procedures before the study began. The participants in the study did not experience any physical harm, discomfort, or psychological distress. They were fully aware of participating in a study, and they understood the purpose of the research by giving their informed consent. The study procedures were fully described in advance to each participant, the participants had an opportunity to decline to participate, and appropriate consent procedures were implemented.

Data Analysis

Following guidelines recommended by Miles and Huberman (2013) for qualitative data analysis, three members of the research team used the transcribed data for a thematic analysis to examine the qualitative data, which were categorized based on prominent theme patterns expressed in the text of the individual interviews with participants. First, the researchers applied categories to each transcript code. They read and analyzed all the transcripts in a three-stage process of data analysis and synthesis, as recommended by Rice and Ezzy (2001). The verbatim transcripts of the 68 interviews in our study generated a codebook of 36 units. In the next stage, the same three researchers used the focused coding method for the second coding cycle. They met together and, through peer discussion and agreement, recategorized the 36 coding units. Finally, on the basis of the coding, the principal investigator of our research team identified themes that integrated substantial sets of the coding units. Data were collected by two trained, bilingual research assistants who were proficient in Taiwanese dialect and Mandarin and had each obtained a bachelor's degree in nursing.

Rigor

Rigor was guided by the process of trustworthiness (Lincoln & Guba, 1985). Prolonged engagement and peer debriefing were used to assess the credibility of the themes. To ensure dependability, the principal investigator conducted an 8-hr training session for the research assistants, advising them on the inclusion and exclusion criteria of the study and instructing them in the use of interviewing techniques, participatory observation skills, and field-study knowledge to ensure reliability. In addition, thick description of text and field notes enhanced research transferability.

Results

Sixty-eight marriage migrant women in Taiwan participated in and completed this study. Participants ranged in age from 20 to 42 years, with a mean age of 32.4 years ($SD = 4.6$). Their spouses' ages ranged from 27 to 72 years, with a mean age of 42.5 years ($SD = 4.34$). The participants' original nationalities were Vietnamese ($n = 42$, 61.8%), Thai ($n = 12$, 17.6%), Indonesian ($n = 8$, 11.8%), Filipino ($n = 5$, 7.3%), or Cambodian ($n = 1$, 1.5%). The women's length of residency in Taiwan ranged from 2 to 12 years, with a mean length of stay of 8.3 years ($SD = 2.6$). The levels of education for most of the participants before immigrating to Taiwan were elementary school and junior high school ($n = 62$, 91.2%). The highest level of education for most of the women's spouses was junior high school or high school ($n = 60$, 88.2%). Among the participants, 53 (77.9%) were housewives.

Through an inductive thematic analysis, the following four outcome themes emerged from the data: (a) increasing health literacy; (b) facilitating capacity to build social networks; (c) enhancing sense of self-worth; and (d) building psychological resilience.

Increasing Health Literacy

Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and

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understand basic health information and services (Speros, 2005). The immigrant women in our study had poor health literacy and, consequently, experienced many barriers to accessing and using healthcare services. For instance, one woman said she didn't know "what is Pap smear or cervical cancer screening and how much it cost." Participants were not aware that the Taiwan's National Health Insurance (NHI) program in Taiwan offers a free annual cervical screening to women 30 years of age and older. They not only lacked awareness about NHI and affordable medical care resources but also experienced language difficulties that prevented them from learning about illness prevention and health promotion. One woman shared her experience about feeding her baby: "I chose wrong baby milk formula because I cannot read the instruction on milk bottle." After attending the workshops for our HEP, the participants reported that they felt more informed about healthcare information and resources. For example, one of the participants said:

> When I arrived here [in Taiwan], I very quickly became pregnant. Because I am not a citizen, I thought I am not covered by the National Health Insurance. My husband and I didn't know that we can have free prenatal examinations and obstetrical services provided by primary healthcare centers. We spent a lot of money to visit a private clinic. Now, through this workshop, I know where I can get medical care to help me.

The participants' increased health literacy and knowledge about illness prevention and health promotion prompted them to change their behavior in favor of more healthy choices. For example, one of the participants decided to change her use of an oral pill to the use of condoms for contraception and safer sex. The increased exchange of health-related information and resources provided in the workshops improved the immigrant women's decision-making skills and their ability to apply these skills in health-related situations. For example, one of the participants who experienced domestic violence stated:

> From the special issue workshop on domestic violence prevention and management, I learned that nobody has the right to hurt another's body. My husband beat me and the kids. Now, I will call 113 for help and will have free-of-charge medical treatment.

Facilitating Capacity to Build Social Networks

Many of the participants experienced extreme loneliness and isolation in their community. They missed their friends and family and the familiar culture of their homeland. Moreover, their husbands and in-laws often forbid them to leave the house, preventing them from developing new friendships with others. The women reported that attending these workshops helped alleviate their sense of loneliness and facilitate their capacity to build social networks in the community. By the end of program, participants had developed small, informal groups that would arrive early to the workshops in order to chat with each other and enjoy the company of other participants. These advantages of attending the program's workshops are described in the following statements from participants:

> To get in touch with other immigrant friends is the happiest thing I have. I look forward to the workshops because this is a chance I can go out and meet friends from the same country. My family is afraid that the "bad friends" might influence me.

The women's shared ethnicities and personal interactions with other participants at the workshops provided them the opportunity to develop friendships that offered strong emotional support, which reduced their feelings of loneliness and social isolation. Attending the workshops helped them facilitate their capacity to build social networks and communicate with their husbands and in-laws to decrease social isolation. One participant stated that "After the teaching, I have learned to use better way to talk with my husband and mother-in-law, not just always keep silent. They have more patience to communicate with me."

Enhancing Sense of Self-Worth

The participants in our study reported that they suffered discrimination and oppression from their new family. The women's original culture was ignored, suppressed, and even discriminated against by their Taiwanese in-laws. Moreover, because most of the women spoke Mandarin, they could easily be identified as foreigners by their accent in the eyes of the Taiwanese public. Consequently, the women remained silent and were submissive to their in-laws.

The workshops used role-play activities, team presentations, and group discussions designed to increase the women's confidence in their ability to speak out for themselves. After attending the workshops, the participants described feeling more confident in problem-solving and seeking better health care for themselves and their family members. As one participant noted, "I had a better understanding of taking care of myself and my family." Another participant said:

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My mother-in-law won't let my children get close with me. They [in-laws and husband] say I am a foreigner. They try to persuade the kids their mother is an ignorant person, don't ask me questions because I know nothing. Now, I have learned lots of things. I have more knowledge to manage my life. I can teach my children.

Some of the participants experienced physical abuse by their husbands and, in some cases, their in-laws. In the special section workshop on domestic violence prevention and management, participants learned about rescue resources, their legal rights, and the hidden health problems related to abuse. After attending the workshop, the women described feeling more self-empowered and more confident in dealing with and overcoming domestic violence. For example, one participant mentioned:

Now I know my human rights, that nobody can beat me. I can call the 113 protection hotline for help. They [mother-in-law and husband] have no right to beat me. Before attending the workshops, I thought I was stupid. If I do something wrong, my mother-in-law will slap me, and my husband will kick me when he is drunk.

Building Psychological Resilience

The participants felt burdened with the stress of acculturation and its psychological effects, such as emotional distress. This form of distress was reflected in the following statement from one of the women:

I can't sleep very well, and I often cry in the middle of the night. I miss my home town. Immigration marriage in Taiwan is a challenge and a bet. Our lives are filled with hardships, such as no money in my pocket most of the time. If I fight with my husband, I have nowhere to go.

Attending the HEP, however, helped the participants transform their life distress into a more positive outlook. They resolved to make a greater effort to successfully adapt to their new home in Taiwan. During the workshops, they discussed the need to increase their ability to endure the difficulties in life by accepting the challenges as their destiny and focusing on their children's future. Successfully caring for and raising their children became the women's main purpose in life. For example, one participant stated:

I have learned this for my children. I can bear the hardships in life. Sisters, we must stay in Taiwan, because this is our home, now we are mothers and daughters-in-law. In the future, we will be other women's mother-in-law. So we keep going and take care of our kids; they are our roots in Taiwan.

Discussion

The findings from our study not only confirm the disadvantaged status of marriage immigrant women in Taiwan and their vulnerability to health risks, but also demonstrate the effectiveness of PAR as a useful strategy to empower these women to make sustainable and beneficial changes in their health and well-being.

The study participants had poor health literacy and limited knowledge about medical care resources. This finding is consistent with previous studies that found immigrant women tend to have low levels of health literacy, which acts as a barrier to seek out and access appropriate health care (Kreps & Sparks, 2008; Lee et al., 2013; Tsai et al., 2014). The women in our study were unaware of such helpful resources as Taiwan's NHI, migrant welfare program, free services and medical checkups provided by the local health centers, and the telephone hotline number for domestic violence protection. Findings from previous studies showed that health literacy is vital for promoting health and health-promoting behaviors (Speros, 2005; Von, Knight, Steptoe, & Wardle, 2007). However, the health literacy of the marriage immigrant women in our study was poor. Therefore, we recommend that health promotion strategies and interventions for migrant women focus on improving their health literacy. Strategies can include the development of comprehensive, translated health information media for distribution to the women.

The study participants' difficulties with language and communication created another barrier to their ability to effectively seek out and use Taiwan's healthcare services and resources. This finding supports similar results from other studies that examined the health concerns of marriage immigrant women (Hsia, 2010; Hung, Wang, Chang, Jian, & Yang, 2012). Having difficulties in learning to speak and understand a new language often prohibited the women from effectively communicating with healthcare providers.

The study participants were further isolated by the actions of their husbands and in-laws who intentionally prevented the women from going out alone and making social contacts for fear the women might try to run away and return to their homeland. This form of marginalization and oppression is evident in other studies that focus on health and social issues of marriage migrant women in Taiwan (Yang & Wang, 2003). Our results are consistent with previous studies in which PAR was found to be a valuable strategy for developing a model of health

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empowerment that promotes positive health behaviors, improves access to community health services, and enhances healthcare policies that support the rights of individuals (Meyer, Torres, Cermeño, MacLean, & Monzón, 2003; Minkler & Wallerstein, 2010).

We also found that healthcare professionals can play an important role in advocating for disadvantaged women by participating in community advocacy organizations and serving as spokespersons for the needs of immigrant women within the community and the healthcare system. During the research process, we collaborated with the local media to call attention to the challenges that marriage migrant women face and to arouse community concern. The local newspaper published an article on the workshop activities, and a reporter from a television program interviewed the research team members who described the problems and needs of migrant women in Taiwan.

Study Limitations

The study has some limitations. First, in our study, convenience and snowball sampling was used to recruit participants. The methods could have led to a homogeneous sample, resulting in findings that are not representative of the entire population. Second, the inclusion criteria of the participants were limited to those who had basic conversation ability in Taiwanese and Mandarin. This would exclude those who could not speak Taiwanese and Mandarin. A third limitation is that the average length of residency in Taiwan was 8.3 years. However, our participants live in a very remote area. The social isolation is very severe, and health resources and culturally appropriate education are limited. Even though they have stayed in Taiwan for several years, these women are still facing immigrant distress. And because recruiting was done in a remote area, transferability of our findings may be limited to women who immigrate into a remote area, and our findings may not reflect the experiences of immigrant women in urban areas.

Conclusions

The study provides an example of a successful health empowerment model for disadvantaged immigrant women and offers a framework for using the PAR approach to advance the efforts of community agencies and healthcare professionals. The present study can inform government agencies in making appropriate healthcare policies and in shaping a comprehensive, health-promoting program that improves marriage migrant women's well-being. It is also recommended that primary care centers offer counseling and support groups for migrant women. Increasing the women's social participation through women-to-women discussion groups, conducted in an atmosphere of confidence and trust, can reduce their isolation. Also, providing immigrant women with the opportunity to meet and share experiences with other migrant women, especially those from the same native country, can improve their social support. The findings of this study can be used not only to understand the current situation of health empowerment among marriage migrant women in Taiwan but also to advocate for the health rights of all disadvantaged immigrant women and their families. Health professionals are encouraged to continuously emphasize the importance of identifying and addressing immigrant women's health needs in practice, theory, research, and health policy.

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Clinical Resources

- Bureau of Consular Affairs, Ministry of Foreign Affairs, Republic of China (Taiwan): http://www.boca.gov.tw/mp?mp=2
- Committee on the Elimination of Discrimination Against Women: http://www.un.org/womenwatch/daw/cedaw/
- National Health Insurance Administration Ministry of Health and Welfare: http://www.nhi.gov.tw
- National Immigration Agency: http://www.immigrat-ion.gov.tw
- Lite-on Cultural foundation: http://liteoncf.org.tw/wealth/a2.htm

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