



Original Paper

Immigrated, interculturally-married women in South Korea: Mental health status, health care utilization, and suggested policy directions

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Abstract. Korea is becoming a multi-cultural society. The Ministry of Justice and the Ministry of Gender Equality and the Family play central roles in creating policies to support marriage-based immigrants. Various services, including Korean language and culture, have been provided through Multi-Cultural Family Support Centres based on the 'Multi-cultural Families Support Act'. However, health care policies for immigrants are relatively scarce. The ever-increasing multi-cultural population in Korea poses a significant challenge to nurses offering individualized care to their clients. The author reviews articles and reports related to marriage-based immigrant women's health status, behaviors, and health care service utilization in Korea, and proposes policy directions as follows: integration of the health care system with language, culture, and health literacy; development of national standards on culturally and linguistically appropriate services; development of an assessment instrument and individualized intervention programs; and vitalizing functions of the Public Health Centers.

Keywords: Mental Health, Women, Immigrant, Health Policy

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INTRODUCTION One of the challenges of the 21st century for South Korea is providing care to an increasingly multicultural society. The number of foreigners living in Korea has increased since the 1990s. As of December 31, 2009, 2.4% (1,268,477 persons) of the total Korean population were foreigners (Ministry of Justice, 2009). The rate of increase every year is important. Korean society is becoming a multicultural society. The rate of international marriage increased in 2005 over 2000, but it has decreased since 2005 (National Statistics Office, NSO, 2009). However, it stands at over 10% of all marriages. Marriage-based immigrants are 3 times more likely to be women than men in inter-ethnic or interracial marriages. Most such immigrants come from China, Vietnam, and the Philippines. The Ministry of Justice and the Ministry of Gender Equality and the Family plays a central role in making policies to support marriage-based immigrants. Various services for marriage-based immigrants, including Korean language and culture, have been delivered through multi-cultural family centres, based on the 'Multicultural Families Support Act'. However, health care policies for these women are relatively scarce. The ever-increasing multicultural population in Korea poses a significant challenge to nurses offering individualized care to their clients. This review examines articles and reports related to marriage-based immigrant women's health status, behaviors, and health care service utilization in Korea and are proposed policy directions. The term of "marriage-based

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immigrant women” is used in this article referring to foreign women who immigrate to South Korea for an arranged marriage to Korean husband. The interethnic marriages take place in South Korea to resolve the problems of a shortage of women for men, mostly farmers, working in rural areas.

NATIONAL POLICIES and health care system as related to marriage-based immigrants

In 2006, the government instituted a plan outlining multicultural policies to facilitate immigrants’ integration into their communities. First, 38 Marriage Immigrant and Family Support Centres were established across the country in 2007 and were increased to 171 centres as of 2010. The name was changed to Multicultural Family Support Centres, according to the ‘Multicultural Families Support Act’ [MFSA], which was enacted on March 21, 2008, by the Ministry of Justice. Maternal and child care are delivered to immigrant women and their children based on the MFSA. Examples are the provision of helpers after delivery, health screenings, and interpreters for health examinations, and medical expense coverage for women who deliver premature babies. These services are supported by the Public Health Centres (PHCs) in 2010 (Ministry of Health and Welfare, 2010).

Cultural competence of nurses The Cultural Competence Scale was used to measure nurses’ cultural competence, including cultural behavior and cultural sensitivity (Ahn *et al.*, 2009). Public Health Nurses at Public Health Centers had lower scores on cultural behavior than care providers at Multicultural Family Centers. However, cultural sensitivity scores did not differ significantly between the two groups. Public Health Nurses have no educational experience regarding culture in terms of caring for multi-cultural families.

Socio-demographic characteristics of marriage-based immigrant women In nation-wide research studies the socio-demographic characteristics of marriage-based immigrant women have been examined (Kim *et al.*, 2010; NSO, 2009; Seol *et al.*, 2005). Immigrant women were on average older at first marriage than Korean women; namely 33.3 years for immigrant women compared to 28.7 years for Korean women. The average age difference between immigrant women and their partner-husbands was 9.9 years (Kim *et al.*, 2010); the Korean husbands are much older than their immigrated wives; while for Korean couples the age difference was 2.7 (NSO, 2009). In terms of nationality, immigrant women in their twenties at first marriage came from Vietnam or Cambodia. The average age difference between them and their partners was 17-18 years. Most immigrant women were high school graduates, but 20-30% of women coming from Vietnam or Cambodia had less than elementary school education. Regarding length of residence, 90% of women coming from Vietnam or Cambodia had less than 5 years’ residency in Korea. Among immigrant women, 21.5% had a household monthly income under 1,000,000 won (about US\$ 1,000) (Kim *et al.*, 2010). Medical aid benefits were received by 7.9% of immigrant women (Kim *et al.*, 2010), which is higher than the 3.7% of Korean people receiving benefits (NSO, 2009).

Acculturation, mental health status, and health care utilization by marriage-based immigrant women Regarding acculturation, these women’s greatest difficulty was the language difference (Kim *et al.*, 2010). The overall level of acculturation stress was moderate, and culture shock was most severe (Noh, 2007). About half of these women perceived their general health status as good, which is higher than the proportion of Korean women over 19 years of age who perceive their health as good (Yang *et al.*, 2009; Kim *et al.*, 2010; KCDC, 2008). However, the immigrant women’s depression prevalence rate was 26.5-40.6% (Yang *et al.*, 2009; Yang & Kim, 2007), higher than the 18.9% depression prevalence rate among Korean women of the same age (KCDC, 2008). The immigrants’ rates of alcohol consumption and smoking were lower than those for Korean women of the same age (Yang *et al.*, 2009; KCDC, 2008). The immigrant women’s rate of visits to Public Health Centres when they felt ill was 3.3-8.7% (Yang *et al.*, 2009; Kim *et al.*, 2010; Seol *et al.*, 2005).

POLICY DIRECTIONS These data show that 1) health policies regarding immigrant women are scarce; 2) nurses needed greater cultural competencies; and 3) immigrant women have been exposed to mental health risks. Therefore, the author proposed 4 policy directions based on literature reviews.

Integration of the health care system with language, culture, and health literacy ‘Language’ is a body of words, and a system of meaning for the use of these words, that is common to a people of the same cultural tradition or nation. To have a limited Korean proficiency is to be restricted in one’s ability to read, speak, write, or understand Korean, such that the language difference causes difficulties in interrelationships among people. The language differences themselves are barriers to effective communication. The inability to communicate with a health care provider not only limits access to health care but also affects the quality of medical care received and the appropriateness of follow-up. ‘Culture’ refers to the learned, shared, and transmitted knowledge of values, beliefs, and ways of life of a particular ethnic group, which are generally transmitted inter-generationally and influence thinking, decisions, and actions in patterns or in certain ways (Leininger & MarFarland, 1991). This pattern of beliefs influences recognition and interpretation of symptoms and affects how and when one seeks health services. The level of acculturation results in differences in the use of health care services. One’s culture affects one’s understanding of a word or sentence and even one’s perception of the world. Cultural differences, which are often associated with language differences, are barriers to communication with health care providers. ‘Health literacy’ is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions (Singleton & Kraus, 2009). Language and culture provide the experiential context for comprehending health information. The culturally-bound beliefs, values, and preferences a person holds influence how that person interprets health care information. Knowing something about a client’s language and culture is a key to assessing the client’s health literacy in any given situation. Reducing unnecessary diagnostic testing or inappropriate use of services, by providing culturally and linguistically appropriate care through improvements in health literacy, leads to efficient care. Therefore, a health care system integrating culture and linguistics and considering health literacy is necessary for quality care, and improvement in the health, of immigrant women.

Development of national standards regarding culturally and linguistically appropriate services and in-service education on culturally competent health care for Public Health Nurses (PHNs) Cultural competence is important, considering PHNs’ diverse cultural backgrounds. PHNs often serve as advocates for multicultural families through health promotion interventions and community-based disease control and prevention activities. Being culturally competent allows PHNs to more effectively engage in their practices and advocacy activities and to decrease client health disparities. Nurses are accountable for considering cultural differences when developing care approaches specific to these multicultural individuals and families. Cultural awareness reflects knowledge of the differences among individuals and families. Cultural sensitivity includes one’s attitudes towards others and one’s openness to acquiring knowledge within multiple cultural dimensions. Cultural competence includes actions taken in response to cultural awareness and sensitivity and involves the ability to providing individualized health care for women from other cultures. Therefore, local and national public health care systems have to be mandated to provide culturally and linguistically appropriate services through the development of national standards. PHNs and other hospital nurses need to be offered in-service education programs on cultural competency skills. Furthermore, nursing education needs to include trans-cultural nursing in its curriculum. Such a curriculum should teach the knowledge and skills needed to provide culturally competent nursing care.

Development of an assessment instrument for high-risk immigrant women and provision of individualized intervention programs The development of an accurate assessment instrument for immigrant women within the community is essential to culturally competent care. Such an assessment instrument needs to discriminate primarily what constitutes high-risk from what does not. The instrument should cover language, culture, and health literacy and should be valid and reliable. Based on the literature review, immigrant women's health and health behaviour differs across demographic characteristics, nations of origin, length of stay in Korea, Korean language proficiency, and acculturation levels. Therefore, individualized care is needed.

Vitalizing functions of the Public Health Centres (PHCs) PHCs provide primary health care. This care is very important for immigrant women. Resolution of the three policies above must precede in order to provide culturally and linguistically competent care, with health literacy, at the PHCs. PHCs need to provide health care for marriage-based immigrant women, including care from their time of entry into Korea, appropriate to their stage of life, and according to level of acculturation. PHCs need to play a key role within the network of multi-cultural family centres and other community resources in order to enhance the health of these women.

FINAL COMMENTS In an increasingly multilingual, multicultural society, providing high-quality health care requires overcoming barriers such as language, culture, and low health literacy. The implementation of high-quality health care practices requires a redesign in the health care delivery system. The government should also support an integrated health care system that is effective, reliable, and sustainable.

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