

Transnational marriages and the health and well-being of Thai migrant women living in Norway

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Abstract

Purpose – *The purpose of this paper is to investigate the health and well-being of Thai immigrant women in transnational marriages.*

Design/methodology/approach – *Interviews with 13 Thai women living in Norway who have (had) a Norwegian spouse/partner were conducted and the transcripts were analysed using thematic analysis.*

Findings – *Initial culture shock and a mixture of employment issues, transnational ties, marital relationships and social networks intertwined to influence women's health and well-being over time. Sending financial remittances to family in Thailand could be challenging due to struggles to obtain suitable employment, working in low-paid physical jobs and spouses' lack of understanding of this cultural practice. Over time, these intertwined factors led to chronic stress and deteriorating health for some. Thai networks and friendships were important for emotional and practical support.*

Practical implications – *More organised assistance may be beneficial to facilitate integration, reduce social isolation and improve employment opportunities.*

Originality/value – *Research on Thai women has so far focused on their position as immigrant wives and the vulnerabilities to exploitation and abuse they face. Focusing on only discourses around marital relationships may be limiting when trying to understand factors that influence the health and well-being of Thai immigrant women.*

Keywords *Well-being, Qualitative research, Women's health, Immigrant health, Marriage migration*

Paper type *Research paper*

While Thailand is traditionally a country of immigration, over 1m Thais live abroad and help to support the economy through financial contributions to their families (Huguet and Chamrathirong, 2011). Notably, in several European countries, Thai migration is highly feminised. In Norway, 84 per cent of all registered Thai migrants are women (Statistics Norway, 2017a), and many are marriage migrants, predominately married to Norwegians (Dzamarija and Sandnes, 2016). Despite now constituting the biggest group of migrant women in Norway from outside the European Union, we know very little about their experiences of living in Norway. This study considers the factors that influence the health and well-being of Thai migrant women, who marry Norwegians, from the perspectives of Thai women.

Transnational marriages

Marriages between women from low- and middle-income countries and men from high-income countries are often put under intense scrutiny in the public sphere. In the media, women are often portrayed as exploiting men for money or a visa, or as vulnerable and in need of protection from abusive men (Hedman *et al.*, 2009; Leinonen, 2017). In politics, discussions centre around the concern that such marriages, particularly when partners differ vastly by age and education or do not share a common language, are purely of convenience (Eggebo, 2013). This scrutiny, often disproportionately directed at migrants, is a source of othering that serves to differentiate legitimacy of marriage motivations between nationals and non-nationals. Yet, the increase in

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transnational marriages can be seen as a result of globalisation as well as shaped by receiving countries themselves (Beck-Gernsheim, 2011; Schmidt, 2011). The introduction of the internet, new technologies and cheaper travel has enabled people from different parts of the world to connect, meet and fall in love more easily. Further, there is a demand for unskilled or semi-skilled labour, yet tightened migration policy in high-income countries. A shortage of women in rural areas also leads men in high-income countries to look elsewhere for potential partners (Schmidt, 2011). Several studies suggest economic mobility, autonomy, love and adventure are among the reasons for marriage migration among Thai women (Butratana and Trupp, 2014; Sinsuwan, 2018; Suksomboon, 2009).

Thai women in Norway

There are almost 10,000 Thai migrant women living in Norway (Statistics Norway, 2017a). While some come for work or study, majority who stay long-term are family migrants; either wives of Norwegians, or children of Thai wives. The number of Thai women who marry Norwegians outweighs any other migrant group (Dzamarija and Sandnes, 2016). Because of marriage, Thai women have settlement patterns close to that of Norwegians' (Høydahl, 2013). Thus, Thai migrants are more likely to reside in rural areas than other groups of migrants. Recent figures suggest that 63 per cent of Thai women are employed, compared with an average of 57 per cent for all migrant women (Statistics Norway, 2017b). Further, families with Thai migrants in them are also less likely to experience poverty than many other families with migrants (Omholt, 2016). Only around 15 per cent of Thai migrant women may have higher education, however, compared with almost 37 per cent among Norwegian women (Statistics Norway, 2017c).

Health and well-being

Migration can be associated with a number of stress factors that can affect health and well-being, including language barriers, discrimination, lack of social support and employment opportunities (Delara, 2016). For women in transnational marriages, marital satisfaction also plays a role (Kim *et al.*, 2011) and international research suggests that women in transnational marriages appear to report poorer health and mental health than local married women (Yang and Wang, 2011).

Norwegian studies on maternal health indicate that Thai women are at lower risk of adverse maternity outcomes than many other migrant groups (Naimy *et al.*, 2013, 2015). The researchers suggested that having a native spouse can increase awareness, and use, of maternity services among Thai women, minimising the risk of poor outcomes. Findings from another study, however, indicated that Thai women were less likely to have a primary health care consultation for mental health problems than Norwegian women (Straiton *et al.*, 2016). Further, Thai women who did consult were less likely to purchase psychotropic medicine or have conversational therapy with the doctor. This may indicate greater barriers to health care and treatment.

Despite the growing Thai population in Norway, to our knowledge, there are no other studies on their health and well-being, and none specifically on the perspectives of women in transnational relationships. These women may have different experiences than other migrants. Having a Norwegian spouse may assist with learning the language, understanding the culture, establishing a social network and obtaining employment. Spouses may also be able to orientate their Thai wife about the health care system, increasing access to some types of care (Naimy *et al.*, 2013; Straiton and Myhre, 2017). However, Swedish research indicates that Thai women in transnational marriages still experience considerable barriers to seeking sexual and reproductive health care (Åkerman *et al.*, 2016). Additionally, in many cases, women may not know their spouse well before marrying and some may be at risk of abuse or exploitation, increasing the risk of mental health problems (Fernbrant *et al.*, 2014). Thus, in this study, we ask what are the factors that influence the health and well-being of Thai migrant women who have, or have had, a Norwegian spouse/partner?

Materials and method

Sample

While we conducted interviews with 15 women, we include here only the 13 women who had married or cohabitated with a Norwegian. They were aged between 31 and 55 years (mean = 42). Ten of the women moved to Norway to marry, or shortly following marriage. Three came to Norway for other reasons and subsequently married/cohabited within a year or two of arrival. Except for one informant who had been in Norway for 30 years, they had been living on average 8.2 years in Norway (2.5–15 years). Seven informants were currently married/cohabiting and six were divorced or widowed. Ten were mothers and ten were currently working and/or studying. Five of the women had higher education from Thailand.

Procedure

Using purposive and snowballing (Speziale and Carpenter, 2010) sampling techniques, potential informants were identified and recruited through key personal contacts and organisations in the Thai community. Selection criteria included being over the age of 18 and having lived in Norway for at least one year. Women who met this criterion were contacted via telephone or e-mail, informed about the study and invited to participate. They were sent written information in English, Norwegian and Thai, about the goals of the study, what participation involved, rights and ethical considerations. The principle investigator then arranges a suitable time and place for the interview. Informants could request a Thai interpreter. They were also asked to tell their contacts about the study and those who wished to participate contacted the researcher. Each informant gave consent for voluntary participation. Anonymity and confidentiality were assured.

Informants, first, completed a short questionnaire with background information and the ten-item Hopkins symptoms checklist (HSCL-10), a reliable measure of psychological distress (Strand *et al.*, 2003). Semi-structured interviews were then carried out with open-ended questions related to living in Norway, family background, emotional difficulties, perceptions of health and experiences consulting with general practitioners in Norway.

Data collection continued until data saturation was reached and relatively little new information was obtained. All the informants were interviewed by the first author, a native English speaker, fluent in Norwegian. An interpreter was present in two of the interviews and all others were conducted in Norwegian. Interviews were audio-recorded, lasted on average 70 min (range 37–116 min) and were transcribed verbatim.

Ethical approval was obtained from the Regional Committee for Medical and Health Research Ethics, West Norway (2013/542/REK Vest).

Analysis

We analysed the data using thematic analysis, a flexible method for identifying and reporting patterns (Braun and Clarke, 2006). Using an inductive approach, the first author read and reread the transcripts to allow familiarity with the data. She took notes about initial impressions for each case and then using NVivo to assist with coding, coded the data line by line, case by case before comparing and contrasting categories across the different cases. Through discussions with the third author, we then grouped the categories into higher ordered descriptive themes.

Findings

During the interviews, a number of respondents mentioned health problems and majority indicated a reduced sense of well-being since moving to Norway. Examples of problems included high blood pressure, respiratory, kidney and gastric problems, headaches, pain, dizziness, stress, sleeping problems, anxiety, poor appetite, exhaustion and low mood. Four of the women also scored above 1.75 on the HSCL-10 scale, indicating clinically significant levels of distress.

Through the analysis, we identified a number of different factors that influenced the informants' health and sense of well-being. We group them here into five main themes: initial culture shock,

employment issues, transnational ties, marital relationships and social network. Through each of these themes, we see that these different factors have a positive or negative influence on health, depending on the women's circumstances and resources. To animate the themes, we use translated anonymised citations in order to protect the women's identities.

Initial culture shock

The first year was [...] incredibly hard and you feel completely exhausted [...] you come here and everything starts again. Even the clothes, what you wear to go outside. Because of the weather [...] it was tough and I was really exhausted. So many times I was ready to give up [...] (Int 5).

Upon moving to Norway, the women described deep culture shock. Everything was new to them; the culture, the language, the food, the people and the climate. The lack of familiarity in their daily lives made them feel isolated, lonely and homesick. Some also experienced temporary bodily reactions to new foods, which increased their worries about settlement in Norway:

At first it was really difficult for me. When I ate bread, my stomach [...] I had cramps all the time. I wanted to throw up [...] was dizzy [...] We eat rice [...] my husband, he eats bread, cheese, butter, jam [...] I thought I can't live here [...] the food is so different. But [...] I just needed time. It is easier now [...] (Int 4).

Through time, the women mostly reported some sense of adjustment as they established new lives, social circles and daily routines. Language acquisition played a key role for many. Although feelings of loneliness and isolation still affected them, most women normalised their feelings "I feel here in Norway there are a lot of people who feel lonely. Especially during the winter, you can't do so much" (Int 6).

Employment challenges

Working reduced financial worries, increased independence and self-esteem and gave a sense of purpose and belonging. However, two main issues also negatively influenced the women's health and well-being: obtaining suitable and stable employment, and the nature of the work.

Obtaining suitable and stable employment. Women with higher education faced downward mobility in the job market and were often underemployed compared to their education level and previous employment in Thailand. The women lacked fulfilment and longed to put their skills to better use. Over time, the lack of suitable job opportunity affected their self-esteem:

I got a job as a cleaning lady. And thought – "oh my god. ME, who worked as a department manager in [a company] in Thailand!" [...] I earned a really good salary and here, I'm like, completely at the bottom [...]. [later] I thought "I will try to get another job" [...] but after I had sent a lot of applications and not gotten a positive response [...] I felt really low (Int 1).

Despite a constant battle of challenges, the women actively sought ways to improve their job prospects; they improved their Norwegian, converted qualifications, engaged in further study and considered different career options. The uphill struggle alongside working and worries about making ends meet, however, influenced both the physical and mental health of the informants:

[...] it is so exhausting [...] it's difficult to get a job here, a permanent job. I thought that if I got authorisation as a health worker, [it would be easier]. But it isn't good enough [...] I want to be a nurse again. So now I just work and work, and go to school so I have almost no free time [...] and I have stomach ulcers from before [...] I think it is because I am stressed (Int 2).

Some informants eventually obtained jobs where they "could use their heads" (Int 1), even if not specifically related to their education. However, the work was often irregular, so they had little job security and were forced to take on other low-paid, unskilled work in order to make ends meet:

How many hours you are offered depends on [the demand]. So [it varies] constantly. And you only get a one year contract [...] the first three years I got an 70-80% position. But this year [...] only about 10 hours [...] So then I needed to apply for a job as an assistant too [...] (Int 1).

This lack of a guaranteed income leaves women with less control over their own lives, finances and in planning their future.

Women with lower levels of education also experienced difficulties in obtaining employment, due to the challenge of entering a labour market that values formal education. Not only was this a hurdle on its own but the way in which potential employers approached this could increase feelings of worthlessness: “she [spoke to me] like I was stupid ‘you don’t understand anything! You need to have a diploma here’ [...] why did she say it like that? I’ve worked in [the occupation] for almost 20 years and she said I don’t know anything! I felt really low [...] crying, felt like I don’t want to live here. Because what she said, it hurts [...]” (Int 4).

Others who were offered work could not get stable, full-time positions, despite having lived and worked in Norway for years. This left them feeling stressed due to financial worries and limited expendable income, especially if they were no longer married. While many of the women regularly worked extra shifts to earn more, this additional income was not guaranteed. Further, lack of recognition from employers increased their sense of worthlessness:

[...] first when you start you are always temporary. And then they tell you afterwards that you should apply for a permanent position, and so I got a 60% permanent position. And then they say, you can do more than 60% and I need to try and take more shifts. Eventually I went up to 80% permanent [...] but those who started after me [...] they got full time [positions]. So sometimes I get a bit sad. I just wonder “am I not good enough?” (Int 12).

Nature of the work. In addition to the uncertainty and instability of many positions, some of the educated women worked alone and felt socially isolated at work. This, coupled with colleagues making assumptions, based on her appearance as a Thai woman, contributed to one woman’s lowered sense of worth and well-being: “Sometimes, you get to work and [...] I have the same position as them but because most of them don’t know me they are like ‘oh are you here to clean?’” (Int 1).

Many of the informants worked, or had worked in cleaning jobs or other positions involving heavy work or long hours on their feet. This affected some women’s physical health. Additionally, because of their relatively low and unstable income, some women took on extra work whenever they had the opportunity. This eventually led to burnout and had long-term consequences for a couple of the informants:

I started working in the first year [...] 2 or 3 jobs everyday. I [...] worked so much. I said yes every time someone offered work [...] I never said no [...] Maybe I had too little time to relax, maybe not enough hours to sleep [...]. Then I got sick after 5 years of working [...] it isn’t good, because maybe I can’t work for the rest of my life now [...] (Int 10).

Transnational lives

Most of the informants described maintaining strong ties with their family members at home, through regular contact and visits and sending financial remittances, while simultaneously building up a future for themselves in Norway. However, there were clear tensions from living in two spaces.

Financial remittances. “[in Thailand] the system doesn’t [...] look after people. It is the family that looks after the family” (Int 1). Thus, almost all of the women sent money home to family members to support aging parents with health care and day-to-day living expenses or other family members with educational fees. For some, sending remittances was relatively unproblematic. For others, the responsibility caused stress, and prevented a couple of women from improving their Norwegian and job prospects. Thus, they remained in low-paid unskilled work: “I went to Norwegian lessons before [...] but I didn’t have time [...] I needed to work [...] cleaning [...] I needed money for the family” (Int 11). This became a cycle of worrying about sending remittances, over-working in order to do so, which in turn led to stress and health problems. Health problems then reduced income as they worked less, which then increased worries about sending remittances. While one woman eventually shared her deteriorating health and financial situation with her family to relieve some responsibility and stress, another wanted to avoid worrying them because “they are also sick” (Int 11).

Living in two spaces. Several of the women were considering moving back to Thailand. Push and pull factors included health problems, stress and financial difficulties. Their role as women and expected responsibilities as carers also made them feel guilty about being away from aging family members “I think I haven’t [done my duty] [...] just money. But I haven’t looked after my mum and dad [...] I can’t look after them and live here” (Int 10). Some also had children in Thailand who needed them:

[...] my child lives alone in Thailand. Doesn’t have family. Because I had siblings who helped but now they are dead. He lives alone [...] I worry so much about him and his loneliness (Int 9).

This particular widowed informant had applied for her son to join her in Norway but was denied by authorities. According to migration law, she did not earn enough money to support him.

Yet, moving back was not straightforward; the women were also had responsibilities in Norway. Although some women had children back in Thailand they wanted to be with, they also had children who had joined them in Norway: “I brought my son here earlier, to Norway [...] I need to think about him first [...] When he has a family I can go home” (Int 8). Other informants had children who were born in Norway did not want to make their future more difficult by moving. Although becoming a mother in Norway could heighten loneliness and the absence of family: “at first I was a bit sad, or maybe even depressed [...] If I’d given birth in Thailand, there would be a lot of people around me. But here, it is just you and your husband” (Int 1) in other ways, it gave the women stronger ties to Norway and helped them feel more settled.

Marital relationships

Marital relationships affected our informant’s health and well-being both positively and negatively. Having a spouse aided many women’s adjustment process and helped them cope with other life challenges. They spoke of how their spouses had assisted them with practical and financial support, helped in learning Norwegian or provided emotional support “I only have my husband who helps, he is the only one who understands me [...] he is the one who supports me” (Int 13).

Upon moving in together, the women noted that they had experienced small cultural conflicts in terms of how to run the house or the type of food to make that were usually resolved in time. Disagreements relating to finances were not uncommon. Sending financial remittances to family at home was one issue that was less easily resolved: “some of the men in Norway who marry [...] Thai women [...] don’t understand why Thai girls need to send money to the family [...] It creates problems [...] arguments. A lot of the time it ends in divorce” (Int 8). This could not only affect marriages but also lead to a reduction in autonomy for many women.

Some also expressed that they had little say in financial decision-making: “I’ve never had so much debt. I’m totally shocked [...] I’m so careful with money and how I use it [...] He never thinks about it. Just buys in and buys in. Think about your income! [...] I want to save and he’s like ‘why must you save? You only live once, you can die tomorrow!’” (Int 3). This woman further indicated that early in their relationship, she experienced disempowerment due to her situation as a newly arrived migrant. Not knowing or understanding the society meant her partner had taken control of important decisions about her future:

When I lived in Thailand, I went to school, studied my whole life. Since I was a kid I was typically someone who loved to learn. But he stopped me [studying more] and it made me feel low [...] At first I let him decide but after a while, it was wrong [...] maybe I trusted him [...] [When I moved here] I didn’t understand how things worked (Int 3).

By preventing her from continuing her studies, the cycle of dependency continued, as she was less able to improve her earnings and thus have greater say in financial matters.

Issues of limited control over one’s life, in addition to psychological abuse arose when one woman’s husband found a new Thai woman when they were visiting her family in Thailand. Her husband, who forced her out of their home upon return to Norway, quickly became verbally abusive towards her. At the time, she had few financial resources, was unsure of her rights, spoke little Norwegian and was at a loss of what to do:

[...] he said “you need to move out as quickly as possible” to me. I said “how can I? You are my guarantor [...] that I could come here, don’t you understand, I don’t have family here [...] how can I

leave [...] you won't help me find a house [...] I don't have money, I don't earn, how can I get my own place?" It was a huge problem [...] he was pushing me out, all the time to "get out". I was thinking, yes I need to get out as quickly as possible because I can't listen to this. It's dragging me down in my heart and my head (Int 8).

While the other informants did not indicate having experienced abuse in their relationships, several informants spoke of other Thai women who had. In addition to the powerlessness and hopelessness migrant women in transnational marriages can feel in such situations, they can also experience shame due to a failed marriage. Cultural perceptions in Thailand of "lucky" Thai women living in Europe together with expectations of financial remittances leave many women unable to share their difficulties with family members: "in Thailand people [...] really respect Europe. They think Europeans are kind and good. The Thai girl wouldn't tell her family. She thinks it is her who has the problem, it isn't the family's problem. She needs to be strong" (Int 8).

Social network

Norwegian social networks were not common amongst the women. Thai networks in Norway were important for the women's well-being and helped against feelings of loneliness. They were also a source of advice, practical help and emotional support. The Thai Buddhist temple was an important social arena for those who lived near one as it provided a sense of belonging; "I thought about going back home [...] [when] my husband died. I thought I was alone, without a husband. Not now I have the temple here. Have friends, loads of people come and we talk and eat together. I live here, like I live in Thailand" (Int 9).

However, many informants still felt lonely as contact with Thai friends was infrequent in comparison to in Thailand. Several informants related lack of socialising to the climate: due to it being colder, people stayed inside more in Norway.

A few women had also had negative experiences and found networks to be a source of gossip, making it difficult to trust others "I don't have friends [...] well some Thais [...] they are not real friends. There are big problems so I can't trust them. We can chat, but can't really [open up]" (Int 13). Women on the receiving end of gossip tended to distance themselves from Thai networks, which increased feelings of social isolation.

Women with higher education tended to have both a close network and a large extended network of acquaintances, often through formalised associations for Thai women. They would provide information, advice about available services, inform them of their rights, act as translators or give moral support for a variety of different problems. While the women wanted to help others, the support was often one way and at times, could be overwhelming: "I got really stressed for a period where I heard so much, took on far too much from the others. It affected me [...]" (Int 5).

Discussion

Our study aimed to investigate the factors that influence the health and well-being of Thai migrant women who are in, or have been in transnational relationships in Norway. The study moves beyond discourses focusing only on Thai women's vulnerable positions as wives and shows there are a multitude of factors that intertwine with each other. Despite marked differences in our informants' life circumstances, marital status, education levels and Norwegian proficiency, they share a number of common factors that influence their health and well-being, either negatively or positively. We see that Thai networks and friendships are important for emotional and practical support, but some still suffer from loneliness. Despite having (had) a Norwegian partner, many Thai women living in Norway, particularly those with lower education levels, appear to remain socially and economically marginalised.

Like many migrants, the women had transnational lives and remained firmly rooted in two different spaces (Schiller *et al.*, 1992). Their lives, socially, culturally and economically take place across borders. As Levitt (2001) indicates, both the migrant and their non-migrant families' lives are

transformed. Since economic and social mobility of families is an important motivation for some Thai women migrating to Europe (Sinsuwan, 2018), the practice of sending regular financial remittances to family is common. This not only benefits the family economically but also raises the family's social standing within the community as well as increases the power and influence the woman herself has within her family (Suksomboon, 2008). However, we see that in our study the struggle to juggle the demands of their life in Norway and their roles as breadwinners, mothers or children in Thailand can have a negative effect on health and well-being. It has been argued that a migrant's life should be understood not only by through their lives in the receiving country but also the continuation of their lives in the country of origin (Levitt and Jaworsky, 2007). Our study shows that this is also important in relation to health.

Moreover, our findings also suggest that Thai migrant women often refrain from disclosing migration difficulties, health, financial or marital problems, to their family. This may be because of these enduring transnational ties and women not wanting to worry their family members in Thailand. Prioritising family's well-being over one's own may also be important in Thai culture (Angeles and Sunanta, 2009). Regardless of the reasons, the lack of public discussion in Thailand about failed foreign marriages, together with sending financial remittances can serve to maintain myths and unrealistic expectations about life and wealth in Europe among local Thai people (Suksomboon, 2008). Suksomboon suggests that this maintains the attractiveness of migration, particularly for women from rural areas with low education. Thus, many Thai women arrive completely unprepared for the challenges they will face in the new country, or without the knowledge and information to help deal with them.

Acculturation, employment, discrimination, social isolation, financial problems and language difficulties are commonly discussed factors in migration literature that affect migrant women's health and well-being (Delara, 2016). This study highlights that Thai migrant women, who have (had) transnational relationships, struggle with many of the same difficulties as migrants without a native spouse. Yet, these women receive less organised assistance compared with other immigrant groups such as refugees and their family members. These groups receive an income while attending an introduction programme for up to two years in Norway (VelkommenOslo, 2016), as well as assistance from an advisor about education, career choices, integration and various social activities. Family migration policy, to reduce the burden on the social welfare system, expects marriage migrants to be supported by their spouse until they can support themselves (Eggebo, 2010). This arrangement, however, places the native spouse as the knowledgeable provider and the migrant spouse in a subservient, dependent position (Merali, 2008). While many of the women in our study reported receiving practical, emotional and financial support from their spouses, there was also indication that some men exploited this power imbalance. Other reports indicate that a migrant spouse's precarious status as a dependent can enable exploitation or abuse (Fernbrant *et al.*, 2014; Tyldum and Tveit, 2008; Vatcharavongvan *et al.*, 2014). More organised assistance may be beneficial to facilitate integration, reduce social isolation and improve employment opportunities.

Yet, women are not passive receivers of information but actively seek it from other sources. Religious meeting places, voluntary organisations and other informal community networks commonly serve as important social arenas not only for friendships but for information exchange within migrant communities (Hynie *et al.*, 2011; Straiton and Myhre, 2017). Thai women with higher education, in particular, were often a source of knowledge and advice about rights and available services, for women with lower education and limited language proficiency. Women active in such organisations, however, have competing demands in their home and working lives so providing help and support can be overwhelming at times. Further, one's knowledge may be based on individual experiences or needs and there may be other appropriate sources of help that the women are unaware of. Given the importance of community networks for migrants as a source of information, formalised training courses for voluntary organisations and/or paid positions in migrant networks could be beneficial to ensure migrants get access to timely information or support in times of stress. Indeed, research suggests that community mediator programmes are beneficial in improving migrants' access to appropriate health care (Abrahamsson *et al.*, 2009; Nguyen *et al.*, 2011).

Although our informants were entitled to free Norwegian language classes and Norwegian social studies upon arrival, we found that not all women attended classes. Many Thai women make the decision to migrate in part to provide themselves and their family left behind with a better future

(Plambech, 2008). As dutiful mothers or daughters (Suksomboon, 2008), women with families who rely on them for financial support may favour working and earning at the first opportunity, rather than attending Norwegian classes. The importance of language proficiency has been increasingly recognised not only for integration in the job market but also in order to learn about their rights and obligations. To encourage completion of language, family reunification migrants arriving after September 2013 are obliged to complete a minimum of 600 h in order to obtain permanent residency (UDI, 2017). However, the right to free lessons falls away after the first three years, and thus, migrants have less opportunity to improve their language skills at a later stage. Removing, or extending the three year limit may encourage more women to return to language classes, which could aid both social and economic empowerment.

While statistics show that Thai women are less likely to be in households of poverty and more likely to be employed than other migrant women (Omholt, 2016; Statistics Norway, 2017b), this study indicates that many still experience financial difficulties. Additionally, in line with other migrant studies, our informants had low job security (Vrålstad and Wiggen, 2017), often working on short-term contracts or with a low number of contracted hours. Thus, most women were unable to fully utilise their skills. For some, education is not recognised and further study or conversion courses are required in order to work in similar professions in Norway as in Thailand. Underemployment is not only “brain waste” at the societal level but deprives immigrants of economic empowerment and also affects their self-identity and their health and well-being (Mutuku, 2017). Other women in our study had skills and years of experience but no formal education. Thus, in a job market that requires formal qualifications (Brochmann and Hagelund, 2011), women with low education have difficulties in competing for jobs. This is likely to reflect a common difficulty among many Thai women in Norway, given the relatively low levels of education compared with the general population. While most education in Norway is free, also for migrants, the reduction in income associated with studying instead of working may make this a less feasible option for women with families to support in Thailand or spouses with low incomes.

Marital dissatisfaction has been linked to poorer mental health in migrant women (Kim *et al.*, 2011). In our study, we see that the practice of sending financial remittances is an issue that can place strain on marital relationships. As Suksomboon (2009) discusses, sending remittances is often accepted by husbands if the woman earns her own income and is also able to contribute to household bills. This may push women to take on more work in order to provide for their families without affecting their financial situation in Norway. Migrants tend to work in less optimal physical environments than the rest of the population and are more likely to be on their feet for longer periods of time (Revol, 2017). Poor working conditions can lead to long-term health problems. We see that this also applies to some of our informants. Some women become trapped in a cycle of cumulative stress; working extra to send remittances home but over time, increases in stress and health effects of physical work leads to sick leave and eventually reduced income, which increases worries about providing for family.

We also see that immigration policy can have an effect on the well-being of mothers in particular. Since policy stipulates that a sponsor needs to earn a certain amount to have a family member join them in Norway, women with low household incomes are denied the right to family life. The rights are therefore different for Norwegian-born and Thai migrant mothers and can be perceived as discriminatory. Although migration is often construed as a personal choice, leaving children is rarely a choice but rather a result of their socioeconomic circumstances and the global economy (Hochschild, 2004). Thus, this policy contributes to, and maintains, power imbalances, resulting in the marginalisation of migrant women (O'Mahony and Donnelly, 2007).

Finally, a couple of women in our study also spoke of discrimination in the workplace. This is prohibited in all aspects of employment including job advertisement, appointment, training, pay and working conditions (Arbeidstilsynet, 2017). Yet, a recent survey suggests that around 16 per cent of migrants experience discrimination in the workplace (Hamre, 2017). Studies show that workers' perceptions of discrimination are associated with increased stress, decreased satisfaction and intentions to seek new employment (Regmi *et al.*, 2009). It is important that discrimination is tackled, at both management and employee level, not only for the well-being of individual employees but also to better utilise migrants' skills and reduce staff turnover.

Strength and limitations

To enhance the transparency of the findings, we have described all stages of data collection and analysis, including a clear description of the informants. We recruited a variety of women with different experiences and circumstances, and had informants who were living in urban cities and rural communities, some were married/cohabiting and some were divorced. We estimate that women with higher education were over-represented in our sample compared with Thai migrant women in Norway in general. Most of our participants were also fluent in Norwegian. Language acquisition and education is associated with successful integration and better well-being (Kim *et al.*, 2012). As such, the informants in this study are not the most marginalised group of Thai women and our findings may not represent the full extent of the challenges others face. Reports indicate that, among migrants, Thai women are among the top overnight users of women's shelters in Norway (Smaadahl *et al.*, 2002). However, data on intimate partner violence for Thai women are not available and could be a subject for future research (REFs).

The first author, who interviewed the informants, is from the UK, living in Norway. With some shared experiences of being a migrant woman, she was able to establish some common ground with most informants. This may have made women more comfortable in discussions related to difficulties in Norway. Although the first author had the main responsibility for data analysis, the third author was also involved in developing the main themes. The third author is from Canada but has studied, lived, worked and conducted research in Thailand and is thus familiar with Thai culture. Additionally, as part of a masters project, the second author analysed the data set separately and identified similar themes. This triangulation of the analyses adds credibility to the findings.

Conclusion

Research on health of Thai women in transnational relationships tends to focus on their position as migrant wives and the vulnerabilities to exploitation and abuse they face as a result. While, due to their position as women, as migrants and (often) of low socioeconomic status, these vulnerabilities do exist, focusing on only discourses around marital relationships are limiting when trying to understand factors that influence their health and well-being. This study gives a more nuanced description of the factors that play a role.

We found that while most of the identified factors occur throughout their time in Norway, we hypothesise that Thai migrant women may experience higher periods of stress when they first move to Norway due to initial culture shock and challenges in finding employment. However, chronic stress associated with the competing demands of living in two spaces together with working in labour jobs, such as cleaning can lead to some Thai women's health status and well-being deteriorating over time. Our study also suggests that structural issues including discrimination in the workplace and migration policy contributes to reduced health and well-being. At the same time, Thai women make up a heterogeneous group of women with diverse circumstances and different resources. They are not passive receptors of their situations in Norway but actively seek solutions and ways of coping. Social networks may be of particular importance and many try to help empower other Thai women who experience greater marginalisation. More formalised ways of supporting marriage migrants could be beneficial and should be considered.

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Further reading

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