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台灣印尼籍居家看護新冠疫情前後心理健康的質性研究

A Qualitative Study on Indonesian In-Home Careworkers' Mental Health in Taiwan Before and After the COVID-19 Pandemic

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摘要

隨著臺灣進入「高齡社會」階段，對外籍看護工的需求大幅增加，主要是擔任居家照護長輩的印尼女性。在 COVID-19 疫情期間，由於與長輩者密切接觸，這些看護工面臨更高的健康風險。本研究探討在臺灣疫情控制成效顯著的背景下，疫情對居家印尼看護工心理健康的影響。現有研究鮮少採取縱向視角，未能比較疫情前後看護工的心理健康經驗。本研究旨在從看護工的觀點出發，定義心理健康的意涵，追蹤其心理狀態隨時間的變化，並辨識影響心理健康的關鍵因素。

研究參與者透過社交媒體、社區公告與口耳相傳的滾雪球抽樣方式於臺北招募。研究進行了八場半結構式訪談，訪談語言為印尼語，並由翻譯協助。訪談內容經轉錄與翻譯為英文後，採用詮釋現象學分析法進行分析。

研究結果歸納出四個主要主題與七個次主題：與雇主的關係位置（疏遠、中距離與親近關係）、來自家鄉的推力與拉力（家庭連結與生產結構）、信仰作為立足點，以及在海外的社交網絡（傾聽的耳朵與學習/充實）。受訪者將心理健康理解為情緒穩定，極易受到外在因素影響，尤其是與雇主的關係。疫情對於與雇主關係不佳者造成負面影響，但對於關係良好者則促進了情感連結與心理福祉。由於臺灣疫情控制得當，多數雇主得以繼續工作，有助於緩解看護工的經濟不穩定。所有受訪者皆展現出韌性，並對在疫情期間展現同理心與關懷的雇主表達感謝。

為了在面對高齡化挑戰時維持競爭力，臺灣應在薪資之外，提供安全、高品質的工作條件與有意義的成長機會，吸引與留住外籍看護工。雇主可透過建立健康且開放的關係，以及善用長照 2.0 所提供的專業服務，來提升外籍看護工的能力並支持其心理健康。

關鍵字：外籍移工、看護工、長輩者、COVID-19、心理健康

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Abstract

As Taiwan enters an “aged society” phase, the demand for migrant caregivers - primarily Indonesian women in in-home eldercare roles - has increased significantly. During the COVID-19 pandemic, these caregivers faced heightened health risks due to their close contact with older adults. This study investigates the mental health impacts of the pandemic on in-home Indonesian caregivers within the context of Taiwan’s highly effective pandemic response. Existing research has rarely adopted a longitudinal perspective, failing to compare caregivers’ mental health experiences before and after the pandemic. This study aims to define mental health from caregivers’ perspectives, trace changes in their mental health status over time, and identify key influencing factors.

Participants were recruited in Taipei using snowball sampling through social media, community postings, and word of mouth. Eight semi-structured interviews were conducted in Indonesian with the assistance of a translator. The interviews were transcribed, translated into English, and analyzed using interpretive phenomenological analysis.

Four major themes and seven subthemes emerged: Position Relative to Employers (distant, mid-distance, and close relationships), Push and Pull from the Homeland (family ties and productive structures), Grounding Faith, and Social Networking Abroad (listening ears and learning/enrichment). Caregivers conceptualized mental health as emotional stability, highly susceptible to external influences, particularly their relationships with employers. The pandemic negatively impacted those with unsupportive employers, while it strengthened bonds and emotional well-being for those with positive relationships. Taiwan’s successful pandemic control allowed employers to continue working, helping alleviate caregivers’ financial instability. All participants demonstrated resilience and gratitude toward employers who showed empathy and commitment to their well-being during this period.

To remain competitive with other aging societies, Taiwan must complement its wage offerings with safe, high-quality employment conditions and meaningful enrichment opportunities for migrant caregivers. Employers can achieve this by fostering a healthy and open relationship with their caregiver, as well as using the services offered by LTC 2.0 healthcare professionals to enhance foreign caregivers’ competence and support their mental health.

Key words: migrant, caregiver, older adults, COVID-19, mental health

doi:10.6342/NTU202501557

Table of Contents

doi:10.6342/NTU202501557

List of Figures

List of Tables

doi:10.6342/NTU202501557

Chapter One: Introduction

An aging society

Taiwan's inverted population pyramid (**Figure 1**) (National Development Council, 2024b) is of national concern. The inversion process started in 1993 when Taiwan became an "aging society" with those 65 years and older comprising 7% of the population (Lin & Huang, 2016; Wang & Tsay, 2012). The status changed to "aged society" (14%) in 2018 (Wu et al. 2022) and is now teetering on the edge of "super-aged" (20%) with seniors making up 19.18% of the population in 2023 (National Development Council, 2024a,c). This high ratio of older adults (OA) is the result of high life expectancies combined with low fertility rates (Chien, 2018).

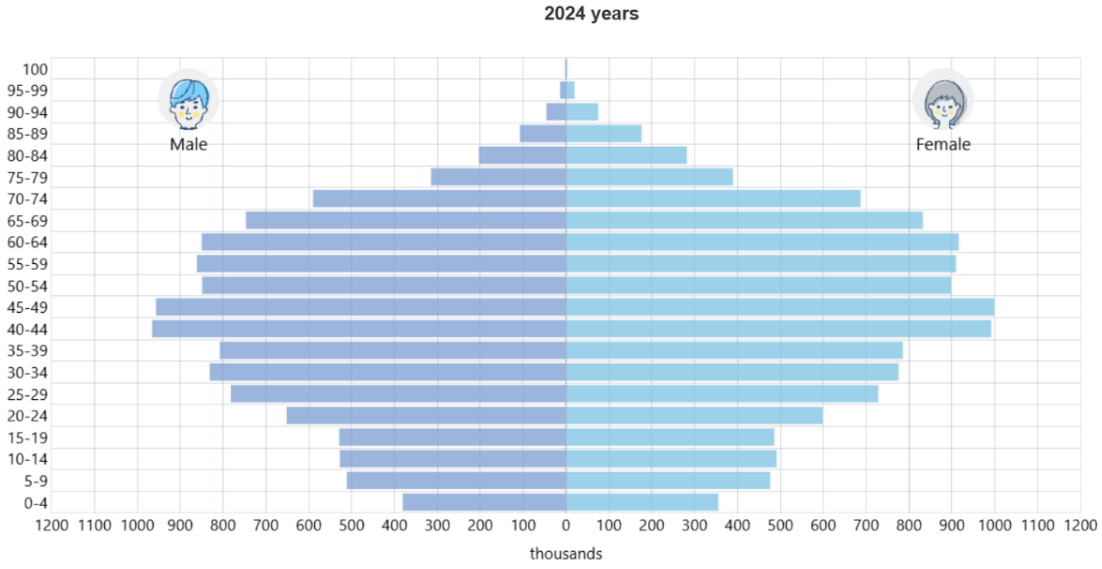

Figure 1. Taiwan population pyramid for 2024 (National Development Council, 2024b)

The average life expectancy has been increasing since the 1950s and is now 80.23 years (Ministry of the Interior, R.O.C. (Taiwan), 2024; Yang, 2019), placing Taiwan in the 79th percentile of countries (Central Intelligence Agency, 2024). The mortality rate of seniors has significantly dropped since the Kuomintang's (KMT) migration to Taiwan in

doi:10.6342/NTU202501557

1949 (Hermalin, et al., 2009). The island underwent a 50-year period of economic expansion known as the Taiwan Miracle: despite drastic political changes, the economy steadily grew (Lin & Wong, 2016). Though growth slowed in the 1990s due to transitioning from labor-intensive exports to electronics, the robust Taiwanese economy fueled the establishment of National Health Insurance (NHI) in 1995 (Sato, 2002) and the Mass Rapid Transit System in 1996 (Metro Taipei, n.d.). These resources increased access to healthcare (Wu et al., 2010). Additionally, the government has supported gerontology research since the 1980s and 1990s via the Ministry of Health and Welfare, the Ministry of Science and Technology, and the Ministry of Education. The departments fund universities and centers like the National Health Research Institute and Academia Sinica (Lin & Huang, 2015). Produced studies like the Healthy Aging Longitudinal Study in Taiwan (HALST) and the Taiwan Longitudinal Study of Aging (TLSA) have found that lifestyle factors such as a healthy diet, regular exercise, continuous learning, and community involvement are common in healthy seniors (Lin & Huang, 2015). The government, along with nongovernmental organizations including The Taiwan Association of Gerontology, the Taiwan Association of Gerontology and Geriatrics, and the Federation for the Welfare of the Elderly, work to promote life-extending healthy habits and advocate for senior wellbeing (Lin & Huang, 2015; Yang, 2019). Considering the increased standard of living, healthcare infrastructure, and investment in geriatric research, Taiwan's life expectancy is staggeringly high.

Looking at the younger demographics, the total fertility rate (TFR) declined to 0.865 in 2023 (Ministry of the Interior, R.O.C. (Taiwan), 2024; Pan & Wu, 2024) which is well-below the established population replacement rate of 2.1 (Craig, 1994For married

doi:10.6342/NTU202501557

couples in Taiwan, the TFR stands slightly higher at 0.917 (Ministry of the Interior, R.O.C. (Taiwan), 2024). Overall, the population is not growing at a sustainable rate.

Importing reinforcements

Given the ever-increasing ratio of older adults, Taiwan's older generations lack economic and practical support (Fuhrman, 2021; Lin & Huang, 2015; WDA, MOL, Taiwan, 2024). The shrinking population decreases future funding for older adult resources like pensions, social security, and long-term care. To bolster the labor force, Taiwan allies with low-middle income Southeast Asian countries, like Indonesia, Vietnam, the Philippines, and Thailand, to import migrant workers (MW)[1] (Chan & Lan, 2022; Chen & Duyen, 2024; Ferry, 2018; WDA, ROC MOL, 2024a). These "guest worker" importation relationships started in 1992 (Chen & Duyen, 2024; Cheng, 2022; Lan, 2003, 2016, 2022; Lin & Bélanger, 2012; Lu et al., 2022; Nursalam et al., 2020; Tseng & Wang, 2011; Wu et al., 2021). Most workers migrate in hopes of higher salaries (Efendi et al., 2016; Ferry, 2018; Lin & Bélanger; Nursalam et al., 2020; Wu et al., 2022a)

As of March 2025, MW made up just over 3.5% of the residing Taiwanese population, with a proportion of 25.94% in the caregiving sphere (WDA, ROC MOL, 2024b; Worldometer, n.d.). Other migrant worker positions exist in the manufacturing, agriculture, construction, fishing, and domestic sectors (Kaur-Gill & Dutta, 2021; Tseng & Wang, 2011; WDA, ROC MOL, 2024a,2024b,2024c). The migrant social welfare industry is female-dominant, with 99.2% of positions occupied by females (WDA, ROC MOL,

[1] Hereafter, "migrant worker" or "MW" refers to blue collar migrants working in productive or social welfare sectors. The white collar, university-educated migrant workforce (e.g. engineers, information technology professionals, and academicians) is excluded.

doi:10.6342/NTU202501557

2024b), the majority of those positions held by Indonesian nationals (80.3%) (Lan, 2016; WDA, ROC MOL,2025c).

Migrant workers are categorized as low-skilled (Kaur-Gill & Dutta, 2021; Tseng & Wang, 2011) or unskilled which initially barred them from applying for permanent residence or naturalization (Lan, 2022b)[2]. Before migrating, care workers are taught basic Chinese and nursing skills for two months in training centers in Indonesia before migrating to Taiwan. During the 1990s and early 2000s, care workers were required to cover their own recruitment fees, which could be up to 160,000ntd, as there was an oversupply of migration-hopefuls. As Taiwan's care needs have increased though, Indonesian brokerages pay prospective care workers a 5,000ntd settlement fee and expect the repayment of an approximately 36,000ntd loan in half a year's time. A Taiwanese employer pays an agency a fee of around 15,000 to 20,000NTD which the agency then pays to an Indonesian brokerage for résumés before the care workers immigrate.

Taiwan introduced the direct hiring system in 2007 to take middlemen out of employment (Faustina, 2015; Lan, 2016; MOL, Taiwan, 2021a). Employers can visit the Associated Services Center of Direct Employment and hire foreign caregivers without the hassle of negotiating with private agencies. This also simplifies visa, insurance, and job-changing processes on top of protecting migrants from financially predatory agency practices (MOL, Taiwan, 2021a).

[2] Lan (2022b) relays that the path to permanent residency was recently opened by the "Long Term Retention of Skilled Foreign Workers Program" (Executive Yuan, 2022; IFINetwork, 2024; WDA, MOL, National Labor Rights Portal, n.d.) which recategorizes migrant workers as "intermediate-skilled" Caregivers must have an A2 level language proficiency, complete a 20-hour online training course, and five years of residence.

doi:10.6342/NTU202501557

Taiwan is not alone with this reliance on migrant labor. Global North countries like Singapore (Ha, 2018; Kaur-Gill & Dutta, 2021; Kaur-Gill et al., 2021; Saw, 2021; Yeoh & Huang, 2010), Japan (Lan, 2016, 2022; Wu et al., 2024), Korea (Chan & Lan, 2022), Persian Gulf countries (e.g. United Arab Emirates, Bahrain, Saudi Arabia, etc.) (Chan & Lan, 2022; Cholewinski, 2023; Johnson, 2011), Israel (Attal et al., 2020), Italy (Dotsey et al., 2023), Spain (de Diego-Cordero et al., 2022), Germany (Kriegsmann-Rabe et al., 2023), Canada (Vahabi et al., 2018), and the United States (Simões, 2012) all import labor from South and Southeast Asia as well as Eastern Europe.

Long-term care in Taiwan

An aged population is inevitably afflicted by different conditions with corresponding health-related needs compared to a younger population. Conditions range from hearing and vision impairment to nerve degeneration, bone density issues, heart disease, and depression (World Health Organization, 2023). To support longevity and maintain quality of life, elders rely on various types of care providers, including physicians, nurses, and other healthcare professionals in acute care settings, but community and institutional caregivers are also necessary. These caregivers assist with *instrumental* activities of daily living and activities of daily living, respectively defined as activities that enable independence in a community (e.g., financial management, cooking, and cleaning) and essential personal care activities (e.g., eating, bathing, and walking) (Edemkong et al., 2023; Guo & Sapra, 2023; Karni-Efrati et al., 2022). Companionship is another large responsibility for caregivers of OAs (Yeoh et al., 2023).

The Taiwanese government formulated the first ten-year National Long-Term Care (LTC) plan in 2007, later developing LTC plan 2.0 in 2017, seeking to offer subsidies and

doi:10.6342/NTU202501557

care options for older adults and disabled peoples (Hsu & Chen, 2019; Lin & Huang, 2015; Wang & Tsay, 2012). Current services exclude care institutions but include "home care, meal programs, and community daycare" (Chen & Fu, 2020; Lan, 2022b, p. 5). This manifests as dementia care, respite care for in-home caregivers, aboriginal community centers, the "ABC network" community-based integration care system (Chen & Fu, 2020). While LTC 1.0 pulled funding from local governments and had limited capacity for care, LTC 2.0 utilizes the increased tobacco and alcohol tax and the estate and gift tax which has greatly expanded care coverage and quality (Chen & Fu, 2020; Henley, 2021; MOHW, 2019; Yang et al., 2020).

Having a caregiver available 24/7 is a common expectation among Chinese OA. Prioritizing filiality, OAs are ideally cared for in-home by a spouse, son, or daughter-in-law (Lan, 2016). The concept of "aging in place" is supported by the government. There are several cultural and practical reasons for aging in place: (1) most people live in apartments and want to retain family ownership, (2) staying at home allows for children to avoid care institutions and have a larger role in care, (3) many seniors are more prone to injury and are safer remaining stationary than transferring to a care home, and (4) the familiar environment is placating for those with cognitive impairment (Lin & Huang, 2016; Lin & Yi, 2019). However, caring for ailing parents on one's own has become progressively difficult over the past two decades as a result of the rising cost of living in Taiwan, the grueling work culture, and the "sandwich generation dilemma." The sandwich generation refers to an adult child who is caught between taking care of their aging parents and their own children (Kao and Pan, 2023).

doi:10.6342/NTU202501557

Filiality is reconciled by hiring a live-in caregiver. Taiwanese live-in caregivers charge premium rates, though, so live-in migrant caregivers (LIMC) are a popular way of "sub-contracting filial piety" for less (Lan, 2016; Liang, 2021). Potential employers must apply and have the OA evaluated at a hospital to ensure that they qualify for a LIMC (Ministry of Labor, 2024). The criteria state that the OA must meet one out of two qualifications : (1) The OA is less than 80 years-old and needs daily care, between 80 to 85 years old with a serious need for care or daily care, or over 85 years and has a mild need for care; (2) The OA has a specific or severe disability such as balance issues, dementia, limb disorders, etc. (WDA, MOL, Taiwan, 2017). LTC 2.0 does not subsidize in-home care provided by migrant workers (Lan, 2022b; Tseng & Wu, 2024), but it does offer services like the "home-based guidance for foreign caregivers' skills service" in New Taipei City. In order to receive the guidance, the employer of an LIMC must call the 1966 Long-term Care Service Hotline (Taiwan Immigrants' Global News Network, 2020). As of 2020, avenues of care ratios were institutional care (11%), LTC 2.0 services (23%), LMIC (26%), and familial care (40%) (Chen & Fu, 2020).

Legal landscape of migrant care workers

Caregivers are protected by numerous legal documents such as the Employment Service Act (MOL, ROC (Taiwan), 2016), the Occupational Disaster Insurance Law (Bureau of Labor Insurance, MOL, 2022), and Regulations on the Permission and Administration of the Employment of Foreign Workers (MOL, 2024). The Employment Service Act outlines fair labor practices regarding the recruitment and management of employees and employer training. Article 57 stipulates that it is illegal for an employer to withhold or confiscate a foreign worker's belongings and official documents such as

doi:10.6342/NTU202501557

passports and alien resident visas (Employment Service Act, Taiwan, 2023). The Occupational Disaster Insurance Law ensures that employers cover any medical care that care workers need if injured on the job (MOL, ROC (Taiwan), 2021a). Articles 33 and 34 of The Regulations on the Permission and Administration of the Employment of Foreign Workers specify that an employer submits and adheres to a Foreign Workers Living Care Service Plan. This plan should outline the clean and safe accommodation, health and safety measures, and information on recreational and cultural facilities and religious activities the employer will provide to their care worker (MOL, 2024). In 2022, the Foreign National Labor Rights Network proposed amendments to the Foreign Workers Living Care Service Plan demanding that employers respect migrant workers' religious food taboos, their accommodation hygiene and safety, their personal safety from sexual misdemeanor, and introduce the 1955 labor advisory line, police reporting line, and women and children protection line (Foreign National Labor Rights Network, WDA, MOL, 2022). The government has not added these specifics into the Regulations, nor can it force employers to comply with the guidelines. The Domestic Workers Protection Act has been in the works for over a decade, but the document, which covers domestic worker time off, wages, and other protections, remains to be enacted (MOL, ROC (Taiwan), 2021). The Labor Standards Act establishes time off and fair minimum wage for Taiwanese nationals and migrant workers, but excludes migrants who work in-home (DHSC, 2018; Labor Standards Act, 2024; Lan, 2022b). The minimum wage for Taiwanese citizens is NT$28,590 per

doi:10.6342/NTU202501557

month (Ministry of Labor, 2025) while the MOL has set the minimum wage for migrant domestic workers at NT$20,000[3] per month as of 2022 (WDA, MOL, Taiwan, 2024).

Migrant care worker mental health

As defined by the World Health Organization, mental health is "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in" (2022). Migrants are often classified as a precarious population with heavy economic vulnerability. Thus, migrant worker mental health is a well-established field of study. Accurate job descriptions, healthy and ideal employment conditions, and labor law coverage are not guaranteed (Li et al., 2023). On top of occupational hazards, sociocultural isolation and immigration policies (Lovelock & Martin, 2015) can negatively impact mental health. Examining migrant caregiver mental health introduces a nuanced perspective.

[3]Live-in care workers who qualify for the long-term retention program for migrant workers are eligible for NT$24,000 per month (WDA, MOL, Taiwan, 2024).

doi:10.6342/NTU202501557

Caregiver burden can impact quality of care delivered[4] (Willemse et al., 2016; Alves et al. 2019; Karni-Efrati et al., 2022; Wu et al., 2022), and mental health status is an integral contributor to the level of caregiver burden (Chang et al., 2010; Ha et al., 2018). Caring for a senior with dementia (SWD) is very demanding and increases stress levels (Ha et al., 2018; Kriegsmann-Rabe et al., 2023; Tam et al., 2018). Tam et al. (2018) studied LIMC in Singapore and developed two models of caregiving dynamics: foreign domestic worker (FDW)-centered and team-based (**Figure 2.**). SWD care is unsustainable for individual familial caregivers, so completely transferring the OA to a foreign caregiver fails to resolve the care burden issues. Distributing care responsibilities between parties and having an open communication network is best for OA care and LIMC mental health. The study also found that LIMC need culturally appropriate dementia care training. Other studies have established the stress caused by language barriers (Efendi et al., 2016; Ha et al., 2018; Nursalam et al., 2020)

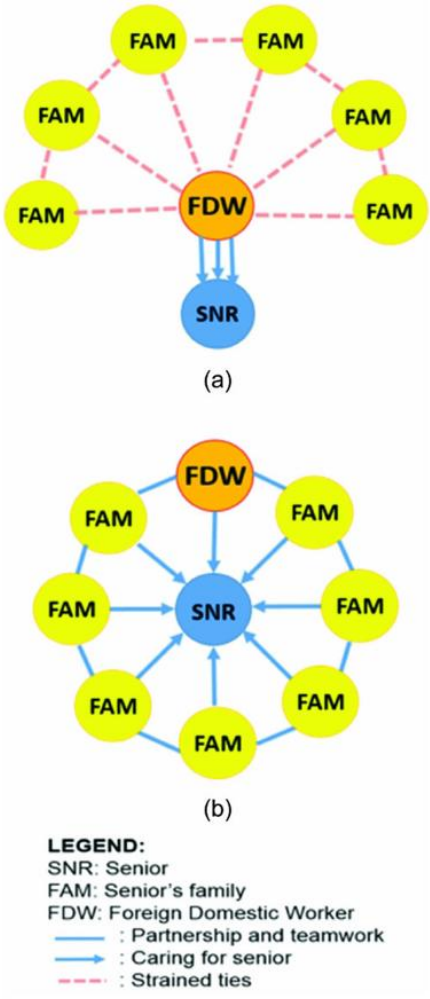

Figure 2. Tam et al.'s (2018) two family models of care (a) foreign domestic worker-centered (b) team-based

As homesickness afflicts many migrant care workers (Kriegsmann-Rabe et al., 2023), it is important to build a social network abroad (Tam et al., 2018). "Enacted, perceived, received, and desired

[4] Most of the participants in caregiver well-being studies are female. This statement is in *no way* insinuating that *sex* has anything to do with professionalism or the capacity to perform well under a heavy burden.

doi:10.6342/NTU202501557

support" from ones' network can have both positive and negative effects (Liao et al., 2024, p. 2). Peers can offer emotional comfort and bolster resilience (Kriegsmann-Rabe et al., 2023) but may also transfer their feelings in a process called emotional contagion (Ho et al., 2022b). Religious beliefs, practices, and communities stand as a pillar of support and help care workers traverse their roles (Baig & Chang, 2020; Ho et al., 2022a; Reyes-Espiritu, 2022). Overall, adequate social time and rest ensure migrant care workers can manage their mental health.

Due to the dejuridified[5] nature of in-home work, employers are caregivers' closest allies but can also be their main stressors when too demanding and unempathetic (Ho et al., 2022a; Kriegsmann-Rabe et al., 2023; Nursalam et al., 2020). "Kinned" caregivers, or those existing in a quasi-familial dynamic within the home, are typically emotionally bonded to their OA and the extended family which provides another layer of support (Baldassar et al., 2017; Lin & Bélanger, 2012). Care is mutual in the relationship and nurtured by domestic space. Close kinship is more likely to occur when the OA has a higher degree of agency and the extended family is not intricately involved in care (Baldassar et al., 2017). This allows space for the OA to form a stronger emotional bond where their relationship is not constrained by purely physical assistance. The intimacy of the relationship makes it so the workers are indispensable but also vulnerable to exploitation (Lin & Bélanger, 2012).

COVID-19 in Taiwan

In 2003, Taiwan and China were afflicted with severe acute respiratory syndrome (SARS, SARS-CoV-1) (Hsieh et al., 2024; Jamil & Dutta, 2024). This experience shaped

[5] Dejuridification: "the 'space of exception' within the home in which labor regulations do not apply" (Dotsey et al., 2023, p. 13).

doi:10.6342/NTU202501557

their pandemic mitigation strategies for Coronavirus Disease 2019 (COVID-19, SARS-CoV-2). Taiwan never went into lockdown while countries like Italy, Singapore, the United States, Australia, New Zealand, and many more did (Bliźniewska-Kowalska et al., 2021; Chen & Fang, 2024; Reuters, 2021). Instead, the government established the Taiwan Central Epidemic Command Center, secured Taiwan's borders in March of 2020, and managed to stave off the virus until May 2021 when the island experienced its first wave of infections (Lai et al., 2023; Lan, 2022a). Infections peaked twice more in May and October of 2022 from the Omicron variant (Hsieh et al., 2023).

Promoting prevention measures like masking, social distancing, hand washing, contact tracing, quarantining the infected and new arrivals, and prioritizing vaccine rollout to high-risk groups (frontline workers, government employees, the elderly, respiratory-compromised patients) helped Taiwan accomplish one of the most globally successful pandemic mitigation efforts (Chen et al., 2021). Bliźniewska-Kowalska et al. (2021) posits Taiwan's that success is due to its experience with SARS, the government's swift action, and the population's trust in the government. This was aided by daily press briefings demonstrating the administration's commitment to transparency and populace awareness.

Pandemic mental health trends

The world saw an uptick in the prevalence of mental health issues such as depression, anxiety, panic attacks, and sleep disorders following the start of the pandemic, with terms like "coronaphobia" coined to describe the paranoia and fear of the disease (Aknin et al., 2022; Dubey et al., 2020; WHO, 2022). Mental health was poor especially for those with prolonged exposure to an infected population (Takahashi et al., 2022) and marginalized groups like migrants and prisoners (Li et al., 2023). Meanwhile, suicide rates,

doi:10.6342/NTU202501557

life satisfaction, and loneliness remained largely stable throughout the first year of the pandemic (Aknin et al., 2022; Chen et al., 2022). Bliźniewska-Kowalska et al.'s (2021) review states that social isolation and lockdowns had immense psychological repercussions because of the resulting loneliness and economic insecurity. Those who were already financially stable and free of mental illness faired better than those with pre-existing mental conditions. As such, young people were the most prone to developing anxiety and mood disorders during the pandemic period. The prevalence of poor mental health was less Taiwan compared to other countries though because of the country's effective mitigation policies (Chen et al., 2021).

doi:10.6342/NTU202501557

Chapter Two: Literature Review

To narrow the conversation, this literature review includes studies from the PubMed and ProQuest databases on migrant worker lived experience and mental health (MH) during and after the pandemic. The global nature of the pandemic necessitates a global perspective, so study populations encompass various types of care workers and industry workers from Southeast and South Asia, Latin America, and Eastern Europe working in aged, Global North countries (e.g. Taiwan, Singapore, Canada, etc.) whose economies rely on supplementary migrant labor.

Palpable borders

Migrant work and the sociopolitical concept of "borders," whether geopolitically or personally established, are inseparable (Lan, 2022a). With the advent of COVID-19, borders became a tool for protection and vector control while simultaneously destabilizing the lives of millions of migrant workers.

Firstly, it is necessary to examine scale. National borders significantly reduced travel and initiated feelings of entrapment, homesickness and health-related anxiety in migrant workers (Jamil & Dutta, 2021; Kaur-Gill et al., 2021; Lee et al., 2022; Sanfelici, 2021; Wu et al., 2022a). Most migrants had scarce opportunities to visit home or leave their work posts during the COVID period (International Organization for Migration, 2024; Li et al., 2023) which stretched from March 11th, 2020 until May 5th, 2023 (Sarker et al, 2023). Facebook page qualitative analyses by Jamil & Dutta (2021) revealed that Bangladeshi workers in Southeast Asia and the Middle East, especially those abroad when borders closed, felt anxious about losing their jobs as production halted and migrant workers were laid off (Li et al., 2023). In Japan (Wu et al., 2022b) and Taiwan (Wu et al., 2022a),

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Vietnamese and Indonesian institutional care workers respectively struggled with increased care loads because of migrant shortages. Fear of liability and mistakes, handling OA extended families' requests and accusations, and finding effective stress relief were also difficult (Wu et al, 2022a), but introducing rewards increased sense of personal coherence which boosts MH (Wu et al., 2022b).

Domestic borders included shelter in place and mandatory physical distancing orders. They were rendered useless by laborers living in packed dormitories in Italy and Taiwan (Asri et al., 2025; Li et al., 2023; Sanfelici, 2021) and isolated live-in care workers in Spain (Diego-Cordero et al., 2022). Migrant domestic workers (MDW) in Hong Kong experienced a sort of paradoxical social distancing as their employers and families spent more time at home. MDW privacy and social interaction decreased while workloads increased (May, 2021). Singapore is regarded as an exemplar of pandemic prevention, though the travel restrictions and quarantines mostly targeting migrant manual laborers resulted in loneliness and stress (Li et al., 2023; Saw et al., 2021). Restrictions aimed at marginalized groups are a type of sanitization politics where the citizens are seen as safer when the foreign “carriers of disease” are cloistered away from them (Lan, 2022a).

Boundaries between care workers, employers, and OAs were erased. Live-in caregivers, robbed of their regular micromovements[6], worked longer hours and took on more domestic labor like cooking and sanitizing the household (Jamil & Dutta, 2021; Karni-Efrati, et al., 2022; Kaur-Gill et al., 2021). Karni-Efrati et al. (2022) surveyed in-home caregivers of OAs in Israel and found that confinement increased care burden which

[6] Care worker micromovements, as explained by Lan (2022a), are small actions like taking out the trash, buying groceries, and chatting with nearby friends.

doi:10.6342/NTU202501557

mediated anxiety and depression. Migrants made up just 20% of participants though. Dejuridification, exacerbated by confinement, made it harder for live-in caregivers to advocate for adequate rest and wages and escape harmful employment (Dotsey et al., 2023; Kaur-Gill et al., 2021). Keeping in mind that Taiwan, unlike Italy, Spain, Israel, and Singapore, never instituted lockdown measures, it is important to investigate the impact of the country's nuanced borders on live-in care workers.

Cultural and structural precarity potentiation

Precarity is defined as a state of uncertainty, risk, and vulnerability (Lan, 2022a). For care workers, their pre-pandemic circumstances dictated how well or poorly they faired during COVID-19. Kaur-Gill et al. (2021) focused on domestic migrant workers in Singapore and their mental health definitions under cultural and structural conditions of labor. Meanings were mainly constructed by their working conditions like wage cuts, long hours, and restricted mobility which harmed social support networks and self-advocacy efforts. Poor conditions made it hard to maintain good mental health.

Similarly, migrants in Italy and Spain suffered hyper precarious conditions because of preexisting cultural and structural barriers (Diego-Cordero et al., 2022; Sanfelici, 2021). Sanfelici (2021) interviewed migrant-dedicated social workers and asserted that the labor market continued to prioritize migrant labor flexibility over societal integration which maintained the illegal gang master system ("Caporalato") as the most popular hiring avenue. Contracts were seasonal and exploitative, stipulating long hours and substandard housing for agricultural workers. In Spain, labor contracts were an achievement rather than a prerequisite as denoted by Diego-Cordero et al.'s (2022) interviews with Latina live-in OA care workers.

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The regionally managed Italian National Health Service failed to adequately train health professionals, accommodate language differences[7], and disseminate accurate information on top of limiting migrant care options (Sanfelici, 2021). Workers living in over-crowded buildings were not able to physical distance or take advantage of in-home care for mild to moderate illness, and regular healthcare centers were reserved for serious COVID cases. Live-in caregivers fortunate enough to keep their jobs felt comforted by the luxury of staying inside while the less fortunate lost their income and housing if their OA succumbed to the high senior mortality rate (Diego-Cordero et al., 2022; Sanfelici, 2021). The financial support package provided by the government's "Care for Italy" decree excluded live-in domestic workers and those without long-term resident status (Dotsey et al., 2023; Giammarinaro & Palumbo, 2020; Sanfelici, 2021). It was not uncommon for pandemic welfare schemes to leave out migrant workers (Li et al., 2023). According to the Italian social workers, emotional responses of the migrants included anxiety, frustration, anger, sadness, while the social workers themselves felt bewildered or powerless to better the situation. Live-in care workers paralleled these sentiments with added stress and fatigue (Diego-Cordero et al., 2022).

Unlike Italy, Taiwan covers healthcare costs of legally-contracted migrant workers under the National Health Insurance system. Because of the harsh work environment and emotional labor caregiving requires, lots of care givers requested industry transfer during the pandemic and created a shortage in the care sector. If a caregiver lost their job or

[7] Medical communication also hindered care for migrants in Taiwan and South Korea (Kang et al., 2022; Lee et al., 2022).

doi:10.6342/NTU202501557

wanted a transfer, they could quickly find a position thereby increasing their bargaining power because of their scarcity (Lan, 2022a).

Acharya et al.'s (2024) mid- and post-COVID MH surveys found that migrants in South Korea had higher depression and anxiety during the pandemic compared to after. Depression was most affected by living situation and employment status, and anxiety was affected by relief funding and employment status. The study included high- and low-income migrants but did not specify occupations. Uekusa (2025) investigated Global North-to-North Japanese migrant institutional care worker experiences during COVID in Aotearoa (New Zealand). Their diligence and commitment as collectivist Japanese women made them desirable employees to compensate for staff shortages leading to high workloads. They were subjected to increased linguicism because of their accents while speaking English, and medical masking exacerbated this challenge, stressing the care workers. Uekusa mentioned the care workers used "a higher reference point" (p. 56), or a comparative mindset, between their situations in Japan versus Aotearoa. They tolerated seemingly poor working conditions because they differed from the hardships they escaped in Japan. Though the care workers acknowledge how their lives could improve, they do not feel their MH is affected.

Cholewinski (2023) and Johnson (2011) explain how the exploitative *kafala* (sponsorship) visa system legally binds migrant workers to employers in Persian Gulf countries. This encourages employers to confiscate residence and identification documents as a way of protecting their "investments". Migrants also pay hefty recruitment fees to private agencies in their country of origin. In late 2020, Qatar offered greater autonomy to migrant by enacting reforms that allowed all workers to change employers or leave the

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country without previous employer's permission. Thus, the pandemic did prompt some positive systemic change, but other countries like Saudi Arabia and Bahrain exclude domestic workers from similar reform.

The threat of disease

COVID-19 penetrated migrant workers' minds before entering their bodies due to the population's intimidating high risk of exposure (Li et al., 2023). In Singapore, the proportion of migrant manual laborers who suffered from poor MH from a dormitory outbreak was similar to the proportion of the general populace with poor MH (Saw et al., 2021); however, live-in migrant care workers in Israel had a high prevalence of anxiety and depression compared to the general populace. Study participants from the Philippines, India, and Sri Lanka cited limited access to personal protective equipment, food insecurity, and lack of self-efficacy to care for their OA and themselves (Attal et al., 2020). Interestingly, Singapore and Israel were applauded for their timely COVID responses, both of which involved lockdowns (Asthana et al., 2024; Muhsen et al., 2024). Live-in care workers suffered psychological distress and anxiety from the uncertainty of the pandemic (Diego-Cordero et al., 2022). With new information on the virus emerging daily, delivering the best care for their OA and their own safety was stressful and non-linear. Institutional care workers in South Africa and Aotearoa shared these feelings and feared occupational exposure within the high-risk OA cluster atmosphere (North et al., 2020; Uekusa, 2025).

Migrant manufacturing workers feared infection in Taiwan (Lee et al., 2022) but eventually normalized it as just another illness (Asri et al., 2025). Conversely, an actual COVID diagnosis brought on anxiety symptoms in male migrants (Saw et al., 2021). The vaccine helped mitigate general worry and anxiety about personal health and the well-being

doi:10.6342/NTU202501557

of loved ones (Asri et al., 2025). Studies like Saw et al. (2021) were limited by their cross-sectional survey design which failed to inquire about migrant mental health context, and the studies done post-COVID, like Asri et al. (2025) centered around male migrants' COVID perceptions and practices. Based on Attal (2020) and de Diego-Cordero et al. (2022), female live-in caregivers had a more dramatic response to COVID because of their higher infection risk and the vulnerability of their OAs.

Benefits and coping mechanisms

Kotera et al. (2023) points out that most literature solely focuses on the pandemic's negative mental health effects on migrants and counters with a general review screening for papers that study the positive mental health effects in the United Kingdom. The result was a mere two papers. Saleem et al. (2021) interviewed Pakistani physicians while Yen et al. (2021) documented the thoughts and feelings of high-skill Chinese, Italian, and Iranian professionals. The white-collar participants used religious beliefs, learning opportunities, exercise, and small social gatherings to support MH pillars like inner peace and confidence (Saleem et al., 2021; Yen et al., 2021). Adhering to a desperate and somber tone when specifically discussing low-skill migrant workers may attract policy makers' attentions, such as with Vahabi et al. (2018) and Vahabi & Wong (2017), but ignoring healthier participants erases the opportunity to learn the reasoning behind their narratives.

Despite the inherent risks of being an in-home care worker, there was a sense of relief and security in staying inside the home (Diego-Codero, 2022; Sanfelici, 2021). In-home care workers did not have to risk constant viral exposure while commuting to a job site or live in crowded dormitories. They also avoided government-prompted eviction anxiety. Mental health management was supported by open communication between the

doi:10.6342/NTU202501557

caregiver and OA, OA and family, and surrounding social networks (Kaur-Gill et al., 2021). Sumerlin et al.'s (2024) mid-COVID survey study even failed to inquire about the potential impact of the pandemic on MDW MH in Hong Kong. The authors state that because Hong Kong maintained social distance and kept case counts low, the pandemic should not have been a confounding factor. Their study found that the relationship between job conditions and levels of anxiety and depression were mediated by stress and job satisfaction.

For male migrants working in Taiwan's industrial sectors, the pandemic offered an excuse to prioritize health since they believed a healthy body was less susceptible to infection (Asri et al., 2025). Workers continued to maintain mental health via social and religious congregation until a COVID outbreak in a Miaoli electronics factory forced a three-week pseudo-isolation (Lan, 2022a; Lee et al., 2022). Migrant workers were strictly shuttled to and from their dorms and place of work while their Taiwanese counterparts continued business as usual (Lee et al., 2022). This precautionary "lockdorm" was labelled by researchers as sanitization politics (Chan & Lan, 2022; Cheng, 2022) while anxious Filipino electronics workers soon accepted it as protective action (Antonio & Lee, 2024).

Fortunately, some federal and private pandemic interventions directly benefited migrants. Taiwan adjusted its residence permit rules to extend soon-expiring migrant worker permits an extra three months to decrease border crossing which increased earning potentials (Asri et al., 2025). Organizations offering free medical advice, reduced cost testing, and Islamic holiday gifts were formed to support workers in Singapore (Jamil & Dutta, 2021). Italy, utterly ravaged by COVID, introduced several government acts in an effort to heal the nation and "Build back better" (Sanfelici, 2021). The Relaunch Decree

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was introduced to regularize undocumented migrants in the agricultural, fishing, domestic, and care work spheres (European Commission, 2020; Sanfelici, 2021). In doing so, workers would be eligible for higher wages and better living conditions which would secure the labor force and strengthen infection control (European Commission, 2020). This decree was met with hostility from right-wing politicians looking to maintain profit margins.

Pulling from migrant studies in Europe and Singapore, there are limited findings on positive mental health influences of in-home caregivers during COVID. The Taiwanese landscape specifically lacks any literature on the coping mechanisms of female migrants.

Research Gap

There are no post-pandemic studies that examine the specific mental health of in-home caregivers of OAs in Taiwan. Those carried out mid- or post-pandemic did not focus on Indonesian live-in caregivers or mental health (Antonio & Lee, 2024; Asri, 2025; Lan, 2022a; Lee, 2022; Wu et al., 2022). Mid-pandemic studies outside of Taiwan prioritized swiftness, sending out online surveys and capturing cross-sectional data relegated to categorial symptoms of mental illness like anxiety and depression (Acharya, 2025; Attal et al., 2020; Karni-Efrati, 2022; Saw, 2021). Qualitative studies adopted pessimistic angles usually used when discussing migrants which dampens the nuanced voices of participants (Diego-Cordero et al., 2022; Dotsey et al., 2023; Jamil & Dutta, 2021; Kaur-Gill et al., 2021; Kriegsmann-Rabe et al., 2023; Sanfelici, 2021). Using a temporal lens, I am curious to explore how migrant caregivers have processed and how they reflect on the COVID period now that pandemic mitigation policy implementation is over.

doi:10.6342/NTU202501557

Study significance

Mental health is a significant factor for caregiver burden and quality of life (Chang et al., 2010; Ha et al., 2018). Focusing on an extreme time period like COVID-19 can help illuminate true protective factors, coping mechanisms, and harmful forces that affect migrant caregivers. Actively exploring and exhibiting interest in caregiver mental health dignifies the marginalized population, encourages readers to critically examine their worldview, and has the potential to strengthen the caregiver supply for the future (Chen & Duyen, 2024; Uekusa, 2025). Equally important is documenting their lived experiences which can be used to inform caregiver mental health action during similar future crises and influence policy and behavior directed towards migrant workers.

Research question and aims

My research question is "Do Indonesian in-home caregivers in Taiwan have mental health effects caused by the COVID-19 pandemic? If so, why and how did they develop?"

My study aims to conceptualize how Indonesian in-home elder caregivers define mental health (Kaur-Gill and Dutta, 2021), inquire on how mentally healthy participants express themselves to be, and identify the influences for participants' mental health status by eliciting their lived experiences from the pre-COVID-19 period up to the present.

doi:10.6342/NTU202501557

Chapter Three: Methods

Positionality and Reflexivity Statements

For the sake of transparency and credibility of the qualitative study, the translators and I provide positionality and reflexivity statements preceding the methodology. These statements aid in revealing internal biases, thereby explaining study design, interview translation, and data analysis decisions. They also help us, the research team, establish deeper rapport and appreciation for each other. The introspection necessary for writing these passages can recontextualize the labor for the translators and potentially readers as well, opening a new avenue of critique. I created a literature-based guide on how to write a positionality and reflexivity statement for my translators and me (Appendix I).

Principle researcher: Juliet

As I was looking over interview #5's transcript, I came across this exchange between my translator, Virly, and the participant, Susi, which summarizes my positionality. They were discussing how to deliver study compensation vouchers because Susi opted for an online interview:

> Susi: I mean, if you want to go to Taoyuan, you'll be with her later, right?
>
> Virly: Are you afraid of only Juliet? {laughs}
>
> Susi: {Susi laughs} I'm afraid. I'm afraid I won't understand what she says. My English is not that good.
>
> Virly: Yeah, I'll be with her. Okay. Okay. (Susi [(2) 66])

I am an American female from a high SES family living in Taiwan. Just like the caregivers, I temporarily immigrated, but we are here for very different reasons: work vs. higher

doi:10.6342/NTU202501557

education. One caregiver even had to give up her dream of going to university in order to work in Taiwan and support her family (Ayu [109]). We are both subject to culture shock, but my lens does not focus on the same features as theirs nor is it exposed to the same settings. Before starting this research, I knew little about Indonesia, apart from Bali, which was an unexpected benefit as I had no conscious biases about people from the country. Regarding Islam though, I am aware of how the wide-spread Islamophobia in America, my personal Western feminism, and Middle Eastern background could affect my perception of the faith and kept that in mind when interviewing.

Before deciding to study Indonesian caregivers, I was slowly and unconsciously enculturating myself. I had made some Indonesian friends on campus, met Indonesian global health students at seminars, and coincidentally joined a host family program where my five "siblings" all happen to be Indonesian. After cementing my study concept, I made a concerted effort to involve myself in the Indonesian community Taiwan by going to local Indonesian-owned restaurants, visiting the Taipei Grand Mosque, and attending cultural events hosted by the NTU Indonesian student association. I also tried to expose myself to the long-term care sphere more than just passing by caregivers with their OAs on the street. I spent time at parks amongst caregivers with and without their OAs and visited care facilities which I later delivered recruitment flyers to. These acts were not in vain. I increased my social network and absorbed cultural customs and norms, but there was still an insurmountable obstacle preventing me from connecting with participants during interviews: the language barrier.

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I am not powerless without my translator. The caregivers' and I's common language is Chinese. After ten years of classes, I speak well, and they learned Mandarin to work in Taiwan, but using both the researcher's and the participants' non-native language to conduct qualitative research is a poor decision. Talking about mental health is challenging in and of itself let alone with a limited vocabulary. Virly opened up my participants' worlds to me. Without her, I would not even have the opportunity to read about Susi's anxiety towards me, but while sitting quietly and hearing them converse during interviews, it was like observing them from outside a window. There was intimacy that I was excluded from. I came to terms with this and made sure to note caregivers' demeanors and body language and have Virly and my other transcript translator, Nicho, highlight any culturally significant diction in the transcripts. The caregivers trust in me is directly related to their trust in Virly. I am very grateful that our energies had a comforting effect on participants so much so that all of them asked to a take a picture with us after the interview.

While asking probing questions and later analyzing transcripts, I steered away from prescribing overly strong negative emotions to caregivers' experiences. I had a tough time during Covid and got depressed at my undergraduate university. Completing an assignment was like ripping out a fingernail, and my self-image plummeted. This was not a universally shared experience though. The caregivers' main landscapes were their households, and they were in Taiwan, not America. They had different responsibilities, and listening to their pandemic sentiments with a clear mind took practice which I got via my pilot interviews with Indonesian college students. COVID was actually a time of transformation for them. Some started college, and others changed careers because of the down time COVID

doi:10.6342/NTU202501557

provided them to introspect. This helped reframe my perspective of pandemic before starting the formal interview process and avoid leading questions.

Primary translator: Virly

My name is Virly, and I am a 30-year-old Indonesian female currently pursuing a doctoral degree in the Global Health Program at National Taiwan University. I participated in this study as a translator after Juliet, a junior in the program and the study's main researcher, invited me to join. Although my research field differs from Juliet's and I had no prior experience with qualitative research, I was eager to learn something new, especially regarding topics related to my home country. At the time, I wasn't particularly close to Juliet, as she belonged to a previous cohort, but I believe that learning can come from anyone, at any time, and in any circumstance. Additionally, since I was still in my first year and had not yet begun my own research, I had more time to contribute to this study.

I must admit that I felt excited yet apprehensive about accepting the offer. As an Indonesian student who has lived in Taiwan for several years, I have seen many Indonesian migrant workers employed as caregivers and industrial workers throughout the country. I often wondered about their motivations for coming to Taiwan, the challenges they faced, and how they coped with leaving their families behind in Indonesia. Even as a foreign student, being unable to see my family face-to-face for a long time often gave me a sense of homesickness, especially when I had to face challenges on my own. During that time, I trained myself to cope by relying on my religious beliefs and learning a bit about psychology to maintain my mental health and develop positive ways of solving my problems. This experience made me curious about whether living and working abroad also placed a heavy

doi:10.6342/NTU202501557

emotional burden on caregivers and affected their mental health, particularly during the COVID-19 pandemic, when caregivers could not return home and were simultaneously worried about their families in Indonesia. This study, therefore, became a way for me to learn more about other people's life experiences and how they found strength in facing similar challenges.

However, I was also nervous about taking on this role. Growing up in Tangerang, a city adjacent to the capital city of Indonesia as a person of Chinese descent, I have a painful history of discrimination by native people, particularly those who are Muslim. Chinese descendants are a minority in Indonesia and have often been targets of violence, especially during times of social unrest. One example is the monetary crisis in 1998. I vividly remember that I had to evacuate to a relative's house due to widespread demonstrations. The protests, directed at the government, unfortunately, led to many people venting their anger and intolerance through looting and even taking the lives of ethnically Chinese Indonesians. That experience shaped my perspective, making me wary of interacting with native Muslim Indonesians unless necessary to avoid potential conflicts. Although the situation has improved over the past 20 years, and many of the native Muslim Indonesians I have encountered have been kind, discrimination still exists in certain areas, particularly among those with less education and economic opportunity. Knowing that many Indonesian migrant workers in Taiwan, especially those working as caregivers, often come from underprivileged educational and economic backgrounds made me feel anxious about interacting with them. Furthermore, my lack of knowledge about the skills required to care for older adults led me to question migrant caregivers' abilities. Despite my personal experiences and concerns, I

doi:10.6342/NTU202501557

consciously tried to maintain a neutral and positive mindset during data collection, ensuring I did not allow bias to influence the interview process or my interactions with participants.

My perspective shifted after starting the interview process. Despite my previous unpleasant experiences, meeting and speaking with the caregivers, most of whom were native Indonesians, felt like conversing with old friends in a foreign land. They did not display any intolerance towards me. In fact, they openly expressed their grievances to Juliet and me during the interviews. Initially, there was some awkwardness as we were unfamiliar, and the caregivers and I tended to speak formally. However, as the interviews progressed, the conversations flowed more smoothly, and the caregivers became comfortable to the point of using more informal language. I also realized that my role involved more than simply translating questions and answers. There were instances where I had to improvise the questions to elicit detailed responses and accurately translate them from English to Indonesian. I tried to use analogies and examples to explain complex terms like mental health, mental illness, physical health, and mental status. Literary translations were sometimes challenging, so I had to find ways to convey the meanings to Juliet during the interview and provide detailed explanations during the transcription process.

Apart from connecting with the caregivers, I found that as the research progressed, Juliet and I developed better communication and made efforts to improve our teamwork. In the first few interviews, we would end the meetings without further discussing the interview results or identifying areas for improvement for future sessions. However, over time, our teamwork noticeably improved. This became evident as we started having more frequent conversations and reflections about our interview performance and the caregivers' responses

doi:10.6342/NTU202501557

after each session. As a result, we were able to generate ideas to enhance the quality of the subsequent interviews.

Ultimately, this study taught me many valuable lessons, not just about conducting qualitative research, but also about working with and adapting to new people. I learned to set aside my past experiences and approach the interviews as a neutral party, ensuring unbiased interactions and accurate interpretations of the caregivers' responses. Additionally, each new interview session sparked greater curiosity, making me eager to listen to more stories from different caregivers, rather than feeling nervous or bored by the repetitive nature of the process. Finally, although time-consuming, the transcription process became an opportunity for me to reflect on and learn from the diverse life experiences of others.

Secondary translator: Nicho

I'm a second-generation Chinese Indonesian (hereinafter Chindo), versed in Indonesian, English, Mandarin, and Hokkien (Chinese dialect). I was born and raised in Indonesia, but I'm ethnically Chinese. I'm 20 years old, and I am currently doing my bachelor's degree in political science at National Taiwan University (NTU). My relationship with Juliet is that we're friends and used to be university ultimate frisbee teammates. Juliet asked me to assist with interview transcript translation and proofreading because I am of a similar cultural background as most of the participants, and I speak both Indonesian and English fluently. Knowing that this research would potentially help inform the local government to craft better policies addressing issues such as mistreatment from employers within the caregiver community—especially Indonesian caregivers—in Taiwan, I felt obligated to help. This obligation not only stemmed from ethnic ties but also because I

doi:10.6342/NTU202501557

have heard about cases of mistreatments of female migrant workers in Taiwan through courses I have taken at NTU and through the news.

However, I believe that I belong to a different social class in Indonesia in comparison with most of the participants though this did not affect my work on the project. Most Chindos, especially where I am from in Medan, belong to the middle-income social class and often neglect or cast negative opinions on people who belong to the participants' social class. Common negative views cast by Chindos are that this population is financially irresponsible, poorly educated, crass, etc. I grew up with these negative opinions floating around dinner conversations, but I have fought to combat these prejudices long before Juliet requested my participation in her research. For instance, ever since I left home for Taiwan, I have tried to see these prejudices from a social and cultural point of view. If one family is poorly educated, instead of judging, I tend to ask, "why are these kids poorly educated? Is it because their parents are also poorly educated and set a bad example for their kids? Is it because they do not have the financial capacity for school? Is it because they grew up in an impoverished environment where less emphasis is put on education?" Judgments are pointless because they can only plant seeds for mutual hatred, but asking the right questions can lead to helpful solutions. I hope that everybody, including my family, will learn to understand this.

Moreover, I fostered curiosity for Indonesian migrant workers, and through listening to the audio recordings of the interviews of the participants, I have also learned to appreciate the contributions that this community has made in Taiwan.

Design and theoretical framework

doi:10.6342/NTU202501557

This study was approved by the National Taiwan University Research Ethics Committee (IRB approval number 202312HS021, Appendix II). This qualitative study required roughly one-hour interviews. Heidegger's hermeneutic phenomenology (van Manen approach) was useful for framing questions around the caregivers' lived experiences, probing, and interpreting answers (van Manen, 1997). Questions were meant to elicit stories from respondents that answer the original research questions while giving them space to think about other topics relating to their identity like migration motivation, potent memories, and opinions on caregiving.

Hermeneutic phenomenology is a cyclical process where a researcher is constantly revising their understanding of a phenomenon (the whole) through the lens of their participants (the parts) (Figueiredo, 2023). Meaning is revealed by story and interpreted by the researcher taking into consideration their own lived experiences, and a sort of "interactive exchange" takes place through repeated contact with participants to ensure accurate interpretation (Johnson, 2000; Lauterbach, 2018; Vandermause, 2008; Vandermause & Fleming, 2011). I was unable to have repeated interactions with participants because of language and time constraints, so I cannot label this study as pure "phenomenology".

Sampling and recruitment

I used convenience and snowball sampling as they are viable methods for gathering participants for a qualitative study (Asa et al., 2023; Attal et al., 2020; Efendi et al., 2016; Karni-Efrati et al., 2022; Lovelock & Martin, 2015; Maksum et al., 2021; Mehta et al., 2017; Nursalam et al., 2019; Vindrola-Padros et al., 2020). To control for potential bias, multiple sources were sampled from including 財團法人天下為公社會福利慈善事業基金

doi:10.6342/NTU202501557

會 總部 (Headquarters of Tianxiawei Social Welfare and Charity Foundation), 財團法人恆安社會福利慈善事業基金會 (Hengan Social Welfare and Charity Foundation), Taipei Grand Mosque, Indonesians working in Taiwan (ROC) Friendship Societies Facebook page, National Taiwan University International Students Information Service events, an Indonesian influencer's social network in Taipei, Taipei international student WhatsApp, International Student Information Service events, Diaspora RI, One-Forty, Taiwan International Worker's Association, Shelter SPA, Harmony Home, National Domestic Worker's Union, Domestic Caretaker's Union, Ikatan Pekerja Indonesia di Taiwan, and Indonesian Street restaurants next to Taipei Main Station. Recruitment materials included online posts, emails, and paper flyers included in Appendices III and IV. The final sample size was eight participants which is in accordance with phenomenological study guidelines (Moser & Korstjens, 2018). The recruitment snowball ended up rolling only after posting at restaurants where masses of migrant workers casually congregate in the evenings. The recruitment process is further explained under the **Discussion**: *Limitations and challenges* subheading.

Inclusion and exclusion criteria

Inclusion criteria were that a participant must be an Indonesian female, she must work full-time as an in-home caregiver in Taiwan for an adult who is 65+ years old, she must be comfortable communicating in Bahasa Indonesia or English, and she must have worked continuously in Taiwan at least since December 2019 until April 2023 (Taiwan Centers for Disease Control, 2023). I specific female simply because the sex ratio of caregivers in Taiwan dramatically skews towards females with males occupying just 0.8% of social welfare positions (WDA, ROC MOL, 2024b). Exclusion criteria are if the

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caregiver cannot comfortably communicate in English or Bahasa Indonesia, is working here illegally, lives outside of the elder's home, if she left Taiwan anytime during the pandemic (December 2019 until April 2023), if the caregiver has transferred to any other type of industry, or if the caregiver is/has been pregnant within the last 4 years. Pregnancy and labor introduce a myriad of hormonal changes which can cause abnormal mood swings and post-partum depression. Coupled with navigating the pandemic as a vulnerable population, pregnant and recently migrant caregivers deserve their own study.

Pilot interviews

Before conducting interviews with recruited participants, I conducted four pilot interviews with Indonesian nationals and my translator Virly[8]. These pilot interviews were not connected to the recruited population, but they gave me an idea for the flow of probing questions and helped to form a working rapport between my translator and me. We used the interview question outline (Appendix VI). The participants are as follows: 20 year-old male bachelor's student, 35 year-old male master's student, 22 year-old female bachelor's student, 23 year-old female working full-time holding a bachelor's degree.

All were born in Indonesia, one living in Singapore since he was 11 years old, but all immigrated to Taiwan during COVID and underwent personal growth spurts. They had the time to since the world slowed down. The male bachelor's student felt like he became more mature during COVID, having to socially isolate and start college overseas in a more competitive academic climate. The master's student was prompted to start his degree and leave a career in architecture. The employed female participant also noticed in this down

[8] Virly is a native Indonesian speaker and has experience in public health research, specifically food science and safety. She holds a TOEFL IBT score of 99/120. Her reading, listening, and writing scores advanced, and her speaking is high-intermediate. She is currently pursuing a PhD in global health.

doi:10.6342/NTU202501557

time that her diagnosed clinical depression worsens during menstruation. The other female participant is diagnosed with a mental disorder as well: attention deficit hyperactivity disorder. Both are queer and come from religious families. Poor relationships with their parents and introversion were associated with a positive view of COVID because they could isolate and take better care of their mental health.

The most useful insight from the interviews is that Indonesia is governed by local village hierarchies, and mental health awareness is low. The concept is widely stigmatized and equated to mental illness in most cases. I entered interviews with this information in mind but was open to contrasting narratives.

Data collection

I posted and sent recruitment materials to the heads of the participant sources, and interviews were scheduled directly with those who filled out the recruitment survey and met the inclusion criteria. The recruitment survey asked participants to specify the contact method (LINE ID, email, or phone number). Timing and location were set by the interviewees as caregiving is a time-intensive occupation. Location-dependent power dynamics were also addressed by this measure.

Virly reminded the participants of the time and place of the scheduled interview 24 hours beforehand via the specified contact method. Caregivers were allowed to bring their client if the client would not understand the interview or impact their answers. Before the interview started, two copies of the informed consent form (Appendix V) were signed by the participant and me. I asked for consent to audio record, and then verbal informed consent was audio recorded on a secure app on my cell phone. Notes were taken on my laptop. The interview questions outline is located in Appendix VI. It was used as a guide to

doi:10.6342/NTU202501557

probe into mental health. After the interview was over, 200ntd in Family Mart vouchers was gifted to the participant, and a receipt was signed for their own proof of compensation.

I addressed environmental and positional concerns in every interview to control data quality. In theory, this allowed my translator and I to elicit the most authentic accounts from participants but also maintain speech volume and clarity to streamline transcription. The inherent hierarchy between the interviewer and interviewee dictated where my translator, Virly, and I sat. I always made sure Virly was sitting on the same side of the table as the caregiver, like an advocate, or in between us, like a conduit, if we were on a bench. Before and during the interviews, I would confirm that the caregivers were secure and ready to talk about their experiences freely.

I debated on conducting the interviews in Chinese since that is the caregivers' and I's common language. The study would require less money and less time but severely lack depth. For the highest quality and most valuable accounts, I used Indonesian. This meant that for a large portion of the interview, I was listening intently while the participant and Virly went back and forth, waiting for Virly to relay what had been said. She worked hard to keep interviews on track, and she was able to because of the time spent briefing her on my questions and research goals in addition to having short post-interview debriefing sessions on themes. While commuting to sites and gathering data, we grew closer and slowly developed trust. This aided accurate translation and increased communication fluidity over time. Nicho stepped in for transcription and translation (TT) checking and followed a guide (Appendix VII) I made for verbatim translation. He was less familiar with the participants, but the content was approachable since he was one of my pilot interviewees. Edits were minimal and efficient going from Virly to Nicho and vice versa.

doi:10.6342/NTU202501557

Step by step, the main project was completed after five months. Including ethics proposal preparation and data analysis, this thesis is the product of 16 months of work, with TT being the most time-consuming task.

Transcription and Translation

Interviews with participants were audio-recorded with a wireless microphone and saved on password-protected phone. A post-interview debrief with my translator was also audio-recorded on password-protected phone. Both recordings were downloaded onto a password-protected computer for processing. Interviews were put into revoldiv (a multi-lingual translation & transcription website) to get time-stamped English and Indonesian transcripts (two total). I then sent the interview audio recordings and both transcripts to my translators as google docs for simultaneous work. I listened to the audio recordings of the interviews, labeled the speakers, and corrected the original English speech in the auto-translated English transcript. One of my translators edited the original Indonesian speech in the auto-translated English transcript by cross-referencing with the interview audio recording and the auto-translated Indonesian transcript (guide located in Appendix VII). The first all-English draft of the interview transcript would then be sent to my other translator for cross-checking with the interview audio recording and the auto-translated Indonesian transcript. The track changes-edited draft would then sent back to me for final review and analysis.

Analysis procedures and Interpretive Phenomenological Analysis

I listened to audio recordings of the interviews and followed along with the finished transcripts while highlighting pertinent pieces of information and writing down participant sentiments in my research notebook (first round of analysis). I noted themes from an

doi:10.6342/NTU202501557

interview and recontextualized them after reading subsequent transcripts. After all eight were preliminarily themed, I met with my professor to discuss the themes and their feasibility for real-world implications. I typed up the first round of analyses while cross-referencing with transcripts and adding any extra notes to the write-up. I started the theming process over again after input from another professor by extracting questions and corresponding quotes from the interview for a total of 255 quotes. I then went through and added motifs to each quote via the comment function on excel. Those motifs were then organized into their own excel and themed in a separate word document by cross-referencing with participant quotes for accuracy.

IPA prioritizes searching for multiple truths constructed by multiple actors and seeing where they converge and diverge. As opposed to narrative or ethnography, a phenomenological approach allows for more interpretation of data and is more succinct i.e. data collection can be more brief and less raw data is presented (Chapman et al., 2015). IPA is also an inductive process, so no hypothesis or established theory is used to interpret interviews. It is ideal for exploring emotional experiences because of how open it is (Smith & Osborn, 2015).

IPA uses hermeneutics as a tenet which just means it is guided by researcher interpretation and not restricted to certain avenues of thought (Delve & Limpaecher, 2023). The role of the researcher's analysis is to identify the characteristics of the communicated lived experiences that are essential to the phenomenon (van Manen, 1990). The phenomenon in this case is mental health through the lens of COVID-19. Efendi et al. (2016) and Nursalam et al. (2020) are great influences for this study because of their focus on the lived experiences of a population very similar to Indonesian in-home caregivers.

doi:10.6342/NTU202501557

Through listening to caregivers, I can more naturally craft an image of their mental health and why it is at its current state rather than try to piece one together form survey questions or assign a hard theory to their dialogue.

Phenomenology also allows participants beneficial reflective space (Picton et al., 2017). There is no right answer and no rigidity. The application of the methodology is meant to naturally elicit the world view of those living the target phenomenon, and in this case, how it relates to mental health. The study results do not adequately represent the larger Indonesian elder caregiver population in Taiwan, and they are not meant to. This work is meant to dig deeper into the minds of participants, not be generalizable, so the challenge was maintaining trustworthiness (Moules et al. 2015; Volstad et. al, 2020).

Rigor

Rigor was maintained throughout the study design, data collection, and data analysis phases. The four metrics for qualitative studies are credibility, transferability, dependability, and confirmability (Mabuza et al., 2014). Credibility was supported by briefing all parties (professors, translators, and participants) on study subject matter and goals. Response understanding was checked at the end of each interview to ensure that I could accurately interpret participants' lived experiences. Data transferability was considered by collecting demographic information and providing detailed descriptions of interview content. Dependability was maintained via compensation receipts and dated activity tracking in an excel spreadsheet to easily look back at progress. Confirmability is ensured by reflexive statements noted in the spreadsheet and formally written out by the researchers.

doi:10.6342/NTU202501557

The concept of data saturation was not strongly considered as per the van Manen approach to phenomenology (van Manen et al., 2016; Saunders et al., 2018). Phenomenological approaches focus more on the richness of current accounts than exhausting an area of inquiry. Even in a thorough interview, van Manen posits that it is impossible to elicit a fully "saturated" answer because of the temporal nature of lived experience. The more time that passes, the more a participant will add to their reflection and feelings.

doi:10.6342/NTU202501557

Chapter Four Results

This study used IPA to generate four main relation-informed themes and seven subthemes: Position Relative to Employers (Distant Relationship, Mid-Distance Relationship, & Close relationship), Push and Pull from the Homeland (Family Ties & Productive Structures), Grounding Faith, and Social Networking Abroad (Listening Ears & Learning and Enrichment). The isolation of in-home care contrasted with the interconnectedness of the migrant caregiver collective. Given the dense intersectionality of the population (e.g. Indonesian, migrant, caregiver, student, mother, wife), themes emerged qualifying caregiver mental health with the impact and complexity of their relationships. Relationships that persisted through the pandemic were not just human to human, but human to institution, human to knowledge, and human to spirit.

Out of the 33 caregivers who filled out the online recruitment survey, 13 were qualified. The most common reasons for study exclusion were failure to care for an older adult 65 years or older (4) and pregnancy within the last four years (6). Out of the 13 qualified caregivers, eight ended up scheduling an interview. Interviews spanned from 45 minutes to 2 hours as seen in **Table 1.** with 75% of interviews lasting over the anticipated one hour. This variation depended on the fluidity of communication between my translator and I as well as how much the participants shared. Translation slowed the pace of interviews, but they are meant to be relaxed especially when discussing mental health. **Table 2.** includes basic demographic information of the eight caregivers. Most are Javanese, married, senior high

Table 1. Interview Duration

Participant Pseudonym	Interview Duration (minutes)
Dewi	64
Irma	87
Tuti	103
Asih	70
Susi	84
Ajeng	43
Ayu	54
Mita	105

doi:10.6342/NTU202501557

school-educated, Muslim, and work in the greater Taipei area. The average time spent working in Taiwan is 9.5 years, and none are diagnosed with a mental illness.

Table 2. Participant demographics

Participant Pseudonym	Age (years)	Ethnicity	Marriage	Children	Religion	Education	Mental Illness	Time in Tw (years)	Number of Employers	Current Location	Recruitment
Dewi	39	Javanese	Yes	1	Islam	Senior High School	No	12	7	Banqiao	DayDayJamu Facebook
Irma	45	Sundanese	Divorced	2	Islam	Senior High School	No	15	6	Songshan	DayDayJamu Facebook
Tuti	35	Central Javanese	Yes	0	Islam	Senior High School*	No	12	2	Taichung	Facebook friend
Asih	38	Western Javanese	Yes	1	Islam	Junior High School	No	10	5	Yilan	DayDayJamu Facebook
Susi	35	Javanese	Yes	1	Islam	Vocational High School	No	8	7	Taoyuan	DayDayJamu Facebook; Ministry of Labor Taichung Line
Ajeng	42	Javanese Chinese	Divorced	2	Catholic	Senior High School*	No	4	4	Zhonghe	Friend
Ayu	25	Javanese	No	0	Islam	Senior High School	No	5	1	Yonghe	Friend
Mita	37	Javanese Sundanese	Yes	1	Islam	Senior High School	No	10	3	Yonghe	DayDayJamu Facebook

*enrolled in an online university

Interviewee and transcript passage numbers are denoted as [(name) #].

Position relative to employers

Asih has worked in Taiwan for the last 10 years and defines her mental health as environmentally dependent:

> So, if we're Indonesian, or Muslim, we have a term of “sincere”. If we're happy, happy, the heart feels happy, happy, or something like that, our work becomes easy and we sincerely do it, even though it's heavy. But when we get an employer who is not understanding and always complains, ultimately, we are not happy. So it’s not

doi:10.6342/NTU202501557

> about the money but the [mental] health during work. If we are comfortable during work, it also affects our mental health. (Asih [82-83])

Asih's use of her Islamically-rooted sincerity directs the conversation towards employers to examine mental health, for a paycheck cannot make up for an unempathetic boss in such an intimate work environment. Irma, having been in Taiwan longer than all other participants, adds that,

> If someone in the family doesn't like me or is not kind to me and my employer doesn't protect me, they will treat me badly. It is impossible for the government to directly intervene. That's why I said to them, I don't mind if they don't give me a day off as long as you (the employer) protect me. (Irma [180-181])

which exemplifies the direct effect employers have on their caregivers and motivated this theme. The following three sub-themes categorize employer-employee relationships distant, mid-distance, or close.

Distant relationships

I categorize distant relationships as employer-employee dynamics where the employer is either absent or overbearing. The OA lacks a cohesive care team, and the employer exhibits little to no empathy towards the caregiver in attitude and household policies. Caregivers often mentioned the stress incurred from a willfully uninformed and distant familial employer such as Dewi's:

> And in the past (pre-COVID), if the elderly with dementia were in an error condition, [they would] hit me. There were also those employers who did not want

doi:10.6342/NTU202501557

> to know about their grandmother...Everything is handed over to us. So we are like, like depressed. Work becomes something stressful, you know...The problem is that the children don't want to know anything about their grandmother, they don't want to know. Then in the afternoon I also, like, being told to do housework...They're like...you (the caregiver) are already here, why are we still taking care of grandma, like that. All of this is imposed on us. Because they feel they have paid us. (Dewi [30-31, 33])

The thrusting of an OA with dementia onto solely Dewi emphasizes the consequence of an entitled employer. With the bonus responsibility of household chores came an increase in stress. Asih echoes this sentiment when her employer made her perform domestic work when caring for a dementia patient:

> During COVID, I cooked for all of them. For grandpa, grandma, employer...Those three years were really tough. It's hard. {giggles}...Because I did everything...That one was like being a PRT (Pekerja Rumah Tangga: housekeeper). So, it's not caregiver. (Asih [50])

Coupled with COVID confinement, Asih's mental health declined so much that she did not renew her contract though the OA was still alive (Asih [35, 50]). The OA's Alzheimer's was a health risk during COVID because she was constantly trying to leave the house, forcing Asih to usher her back inside and calm her down. Comparing Asih's concepts of physical and mental health, she perceives internal and external loci of control respectively, leading her to label her mental health as "colonized" when subjected to poor circumstances as she was during COVID (Asih [90]). She can prevent illness and injury by living cautiously, but

doi:10.6342/NTU202501557

occupational exposure to unpredictable OAs and demanding family members is unavoidable and mentally taxing.

During Ajeng's interview, her OA was sitting by her side watching a movie, occasionally signaling for juice or a tissue. Pre-COVID, Ajeng was limited to OA responsibilities, but she was poked in the eye by an OA in the early stages of dementia who, having no close family, was ruthlessly demanding. It was only Ajeng and the OA in the house: "So, my employer was in Shanghai. I reported to my employer, but she/he didn't believe me" (Ajeng [63]). The mistrust from her employer not only exposed Ajeng to physical harm but made her more susceptible to mental harm as well:

> Usually, for me, if the patient is hard to control, yes, it makes me stressed. The patient is hard to control, and the employer doesn't want to understand our situation, doesn't want to understand the patient's condition. The employer doesn't really know the patient's condition which makes me down {laughs}. (Ajeng [51-52])

The lack of employee advocacy from the employer especially while taking care of an OA with dementia saddened Ajeng. It meant that neither her work nor her own condition mattered to who she was serving.

Mita, the most jovial of the participants, struggled in tandem with adhering to employer care standards while her OA with dementia challenged the rules. She rested less and was regularly told to perform well:

> Oh maybe when she's (the OA) sick. Yeah, it's really really stressful. Because, she has to be properly taken care of, and the employer has his/her own regulation...I also have less rest, right?...The rules are like, you have to take care of it properly, so the

doi:10.6342/NTU202501557

person can heal quickly. The rules are only like that. Yeah [they] remind us to. (Mita [99-100, 102-106])

An ill OA during the pandemic was a major stressor on the caregivers. Mita's OA did not grasp the concept of pandemic prevention measures:

> Other than that, if I ask her to wear a mask, and she don't know about COVID right, she keeps taking off the mask. And then when someone, she heard, uh, "Amma you need to be wearing the mask." And then Amma say "For what?"...Another example was the sanitizer. They think it's, it's the drinking water {laughing}. But that's all. There's nothing like that, it's just to me, it's funny. {laughing}. (Mita [51-52, 55-56])

Mita's relaxed attitude made her see the humor in her situation despite her OA putting herself at higher risk for falling ill. This protected her mental health from harm.

Continuing, Irma has been working for her current employer for less than a year and describes an incident where her 97 year-old OA sustained injury at a haircut appointment:

> So yesterday, after he was taken by my employer to have a haircut, my employer didn't ask me to go with them. The employer asked the grandpa to wait alone. But the grandpa can't stand up by himself. At the end, he fell down. (Irma [25])

The OA ended up needing stitches, and Irma noted her responsibility to keep an eye on him since he is a "hothead" and has a tendency to pull at the stitches (Irma [26]). Irma is intimately familiar with her OA's demeanor. This gives her authority in his care, and the

doi:10.6342/NTU202501557

employer's decision to keep her at home undermined her expertise at the cost of the OA's health. Irma explained what affects her and why employers behave in such a manner:

> In fact, what makes us depressed are the people at home, the family. Sometimes, they don't trust [me]. So, in their imagination, Indonesians are uneducated and stupid. In fact, before coming to Taiwan to become a caregiver, we have to undergo various caregiving training. So, maybe it's almost the same as a nurse in a hospital. Only, we are not medical nurses. They just think we can only clean the house. (Irma [45])

To Irma, her employers' preconceived notions limit how they perceive her professional potential. This is exacerbated in a distant employer-employee dynamic. One negative feature of her current employment is her weekly day off which sounds quite generous compared to the normal one day off per month for caregivers, but to Irma, she is losing money (Irma [67]). Being forced to purchase her own meals during workdays is also a stressor with the rising cost of food and unstable Indonesian economy (Irma [21]). Later in the interview, she summarized her sentiment: "Basically, all patients, older adults are the same. They are difficult to control, difficult to make obey, and emotional. But the one that becomes the stress factor is the employers' attitude" (Irma [120]). Irma was with her previous employer for a decade before her OA passed away and she found herself in a new household (Irma [120]). This transition has been extremely hard on her. With the employer to blame for causing her poor mental health, Irma copes by assuring he/she is the one who is aware of her stress:

doi:10.6342/NTU202501557

> Sometimes, when I am very angry, I show my scary, sullen, sad face to my employer. But in front of the patient, I will still smile. Because, actually, the healing of sick people is not with medicine but with feeling happy...we must keep our feeling in good condition, don't show sadness to the patient because it will make the patient sad. If the patient is sad, he/she will be more susceptible to disease. We are also the ones who are in trouble. (Irma [156-157])

By shielding her face from the OA, she attempts to ensure their health while engaging in healthy emotional expression. Another way she releases stress in a distant employer relationship is via writing:

> Sometimes, I also write a diary. Maybe others say I'm just exaggerating. But, rather than keeping it in my mind and it eventually becoming a disease, it's better for me to express my emotions…People who like to paint will paint, something like that, or maybe people whose hobby is singing will sing. I'm just writing, sometimes grumbling {laughing} (Irma [164-165])

Irma's religiosity is discussed later in the chapter as a mainstay of her well-being and mental health.

Furthermore, over video call, Susi revealed that her pre-pandemic, early caregiving career was fraught with sexual harassment by a male OA: "He always wanted to touch my breasts and bottom, all sensitive parts for a woman. If I didn't allow him to do so, he would get angry even for a week or a month" (Susi [(1) 45]). She reported the abuse to her agent but received a dismissive and apathetic response:

doi:10.6342/NTU202501557

> The agent, like usual, only said that I should be patient. I also talked to my employer, and he/she only asked me to talk to the agent. My employer once also said that the grandpa was just like that. We couldn't do anything. (Susi [(1) 46]

Having been mistreated and her pleas for help ignored, Susi contemplated running away, but the risk was too great in her mind. She remained with that employer and the OA, living in a village and tilling the OA's land (Susi [49-50]). The most formidable task was with the OA's animals though:

> I once was asked to look for pigs' manure for up to 15 baskets...That's why, I didn't want to take care of him from then on...{Susi laughs} That is the thing that I cannot forget until now...Actually, they wanted me to extend my work there. But, I didn't want it to happen. Also, I was not comfortable with the grandpa and the agent anymore. So, I returned to Indonesia, stayed there for half a year, and returned to Taiwan again. (Susi [(1) 49-50, 58-59])

This abhorrent contract scared Susi and is her most memorable moment while working in Taiwan. The abuse from the OA was harmful on its own, but the damage was potentiated by her negligent superiors. Posing as careless bystanders, their psychological distance from Susi shone through, for they were complacent with the harm the OA was inflicting on Susi. They were enabling it. The physical demands were not just harmful to her body, but her doctrine, as pigs are impure animals in Islam (Alrahawan, 2023). The effect of the abuse was so great that Susi could not seek further employment after the three years concluded and had to take time to heal back home in Indonesia

doi:10.6342/NTU202501557

Ajeng was not so much purposefully abused but traumatized by her employer when they jumped to their death from the apartment building:

> My employer was found to have liver cancer...It was the child [of the older adult]. My employer...then he/she committed suicide. Well, that's very memorable...So, I was traumatized. Sometimes, it makes me…but then, I can still handle it. It doesn't make me scared…He/she committed suicide at home, on the top floor of the apartment. He/she fell down by herself. I held his/her hand. I was like, saying, "Don't, don't"...Yes, that happened when the first time I came [to Taiwan]. {laughs}. I was afraid...I was brought to the police...Also to the court...I was afraid that I was suspected as the one who pushed (Ajeng [24-29])

Ajeng did not disclose any attachment to this employer or whether she missed them after they were gone, classifying this relationship as distant. The main impact was witnessing the act of suicide and the aftermath that ensued. Ajeng's fear of being accused is unsurprising because a murder charge in Taiwan can result in foreigner deportation or the death penalty (Human Rights Watch, 2024; Ministry of the Interior, Taiwan; 2024). The emotion is still fresh in her mind, but it thankfully no longer affects her. When distant employers make caregivers feel alone in their position, othered, and unsupported, caregivers may become aware of their mental for the first time or feel their mental health decline. This was especially true during the pandemic and even overshadowed pandemic effects in some cases.

Mid-distance relationship

doi:10.6342/NTU202501557

I categorize mid-distance relationships as employer-employee dynamics where the employer limits their caregiver's duties to the OA and attempts to eliminate precarity but fails to develop a "fictive kinship" with their caregiver (Karner, 1998; Sussman, 1976). Ajeng's main pandemic stressor was her OA: "I've been through it all. I was also stressed because of dementia, dementia patients. The employers were also nice at that time. So, it was not a big problem. My meals were also provided. I could sleep and go anywhere freely" (Ajeng [61]). Aside from Dewi's mid-COVID employers minded her position yet failed to treat her with familial warmth. Despite their prohibiting Dewi from leaving the house during the pandemic in an effort to protect her and the OA, their own freedom ended up jeopardizing the health of the whole family including Dewi and the OA's:

> With us not being able to take holidays, not being able to go out, it can make us stressed. Normally we can go out, from normal days we go out shopping, to the market, we can take grandma for a walk, during the pandemic we couldn't do it all for several months…I also caught COVID with the employers and the whole family members. Because the employers were afraid of anything bad happening to the elderly, so the elderly and I were hospitalized for two weeks…Although I had a fever, I still had to work. That's my job...A lot, headache. I was sick for a long time and didn't get better. (Dewi [47, 51-52, 86, 89])

The boredom and stress of confinement were interrupted by prolonged illness; however, the seemingly nonchalant exclamation "I still had to work. That's my job" implies a level of sincerity towards work as seen in Asih. Her mental health may be affected, but considering the extenuating circumstances, she remained devoted to her post.

doi:10.6342/NTU202501557

Dewi now works for a new employer who similarly lacks explicit warmth but restricts her responsibilty to the OA:

> I just look after grandma, there's one Filipino who cleans, and there's also one person who cooks. The thing is, they... the current employers are really good...because they know we rarely get rest. So... not everything is handed over to us. In the past, right...even if I could or couldn't sleep...They didn't care. The important thing is that the house is clean and the grandma is taken care of. Now, no. Now, I just look after the grandma. The thing is, the current employer probably knows the regulations because the regulations are now also clear—different from before[9]. (Dewi [37-38])

Susi's COVID experience parallels Dewi's post-COVID conditions in that her employers were understanding of her duties which limited her stressors to her OA:

> I was not stressed [because of COVID]. Maybe, if I felt tired, it was more from the patient because the one I took care of couldn't do any activities anymore, the patient only laid on the bed for most of the time. Maybe I got tired only because of the patient's condition. And I don't think I was stressed at that time because I only focused on taking care of the grandma. (Susi [(2) 28-28.1])

[9] There is currently no policy that explicitly states the responsibilities of in-home caregivers. The vague description of the family nursing position as written by the Workforce Development Agency is "Take care of daily affairs for people with disabilities or diseases" (2017, July 4).

doi:10.6342/NTU202501557

Susi's employers observed her energy levels and let her play on her phone, rest, or even visit a 7-Eleven after finishing with the OA (Susi [(2) 28-28.3]). They were also very accommodating of her when she fell ill with COVID:

> There was a time when I got sick in Hsinchu. Alhamdulillah, my employer didn't ask me to do this and that. In fact, my employer was quite responsive. She/he immediately contacted a doctor, although it was only for an online consultation via video call from the mobile phone. I was prescribed some medicines, and I ate them right away. So it's not like, in Javanese, we called it "dirasani" (Eng: someone talking about you behind your back). My employer didn't do that to me. (Susi [(2) 11-12])

Susi was very lucky to have empathetic and honest employers who wanted the best for her though she did not indicate any deeper bond thereby categorizing this relationship as mid-distance. Her comment on "dirasani" alludes to how her peers are subjected to gossip and judgement by their employers. She did become cognizant of her migrant status, "However, as a foreigner in this country, I knew myself, and I tried to obey the rules of the government and my employer as much as possible," which involved following extra hygiene protocols (Susi [(2) 2-4]). She exclaims that she is grateful for this increased health awareness though (Susi (2) [10]). Dewi's current state of mental health is no longer a product of poor employer treatment but of the difficulties of dementia care:

> Mental health is, how do I put it? We rarely sleep, that can be. Then when the…grandma is in an "error" state…The previous ones could still be handled and weren't too talkative, so I could rest a little. Right now, it's really, five minutes

doi:10.6342/NTU202501557

> asking for this, five minutes asking for that, basically talking all the time and not stopping. So my head felt like it was going to explode. Listening to the grandmother is like, how is that…It's wrong for me to be silent, it's also wrong to speak. I was silent, she said I didn't respond to what she was saying, I didn't have any manners. {chuckles} But when I said something later, she got angry again. Basically everything is wrong with the current grandmother. (Dewi [68-69, 115, 117])

Dewi's employers let her take time for herself everyday with brief walks and have a vacation day once or twice a month because they know the behavior of the OA is not easy to manage (Dewi [107]). Tuti's employers were kind and took good care of her during COVID. Tuti and her friends shared fears about job precarity because of their OA's comorbidities and a lack of a vaccine (Tuti [(2) 7-8]), but her fears were quelled though by her loyal employers:

> It was not bad in terms of work, because, at that time, I asked my boss for reassurance. Even if my patient died. It's like, we were talking about the worst case if I lost my job there before my contract ended. Would they immediately send me home amid the COVID-19? And they gave me a good answer, "We will still employ you." So it's not bad. (Tuti [(2) 30-31])

After Tuti was stabilized by her employer, she recognized the opportunities pandemic confinement offered: "In fact, it brought a lot of blessings. So, at that time, there were many online classes. I could join online classes, online competitions, and radio competitions. I am also grateful to be the winner of the competition" (Tuti [(2) 35-36]). She is doing quite well now as her employer pays her 32,000ntd per month. This high salary makes her tread

doi:10.6342/NTU202501557

lightly and prioritize her quality of care because she does not know if this generous of an employer will present themselves again (Tuti [(2) 82, 87-87.1]). Ultimately, employers at a mid-distance from caregivers are mindful of boundaries and care for them. They quelled precarity via salary guarantees and treatment for illness during the pandemic, but their caregivers were still cognizant of their migrant status.

Close relationship

I categorize close relationships as employer-employee dynamics where employers protect their caregivers from precarity and take steps to develop "fictive kinship". Asih's first employer in Taiwan was her best. She had to care for her bed-ridden OA, but the employer gave her personal time in the afternoons where she could ride her bike around town or go meet friends. She was just expected to return home when she was done with her outing. She reflects that,

> Every time I change my employer, it is uncertain that we'll get employers like that in different places...You can relax, you can go everywhere. You feel happy...My employer. I take care of her husband. But I can't call them grandma and grandpa...She said I must call them mama and papa...So, because they don't have a daughter, I'm like their child...The first one was really kind. (Asih [43-44])

This closeness fostered trust between Asih and her employer which loosened her restrictions. At this point in time, she was unaware of "mental health" because she was in a protective employment dynamic. She only became aware of her mental health when she felt stressed in her distant COVID employment. Irma's relationship with her pre- and mid-

doi:10.6342/NTU202501557

COVID employer and OA was highly influential for her own mental health as well as mental health knowledge and awareness:

> I also got a lot from my previous employer, who was a doctor…Because of being a doctor, whatever the problem at home, he must remain calm when dealing with patients. Sometimes, he had a lot of problems, for example, arguing with his wife, but he always remained calm when facing me. So, I also felt helped. That's also what keeps me mentally healthy while working there. There's no stress. I felt comfortable working there. (Irma [95])

This employer served as a model for Irma and increased her personal valuation of optimism, resilience, and emotional control:

> My mental health is how we can control our emotions. Our psychological comfort. It should always be comfortable. So, in any condition, we should be able to control our emotions to always be happy and also to make others happy. If we are happy, that happy aura will automatically be transmitted to other people. Remain positive thinking. So, in my opinion, mental health is a person who is able to overcome any situation. It doesn't mean we don't cry. We can still cry but don't express our emotions brutally. (Irma [85-89])

Irma's revere of the doctor was helped by the empathy she felt towards him and the learning opportunities he and his wife provided:

> So, I feel that my work is connected [to the employer]. So, the conversation was also smooth. So, there was not much conflict. There were also many things that I could learn. Because, if the employer is an ordinary person, usually it's more

doi:10.6342/NTU202501557

> difficult… And his wife was a professor, making me learn a lot at home. If other people look for courses out there, my employer taught me at home. Sometimes, she invited a knitting teacher to the house… Then, I could also learn languages online. Not all employers in Taiwan like us to study, even if it is online…No matter how difficult it is to look after the elderly, I can still handle it. (Irma [44-45, 75, 83])

The enrichment provided was paired protection from serving family members when they visited. She did not have to assume the role of host though she was compelled to because of her culture. (Irma [67]). Her previous employers positioned themselves as equals to Irma and conversed with her, so she preferred to converse with her employers even over friends because she could learn from her employers insight (Irma [75]). When the pandemic arrived in Taiwan, this close relationship and the subsequent secure mindset established protected Irma from feeling oppressed by strict COVID policies. She was no longer allowed to go on holiday or go to the market,

> But I think, Alhamdulillah, it should be like that. Because if we had to go outside with the grandmother, it would be very dangerous. Sometimes, there were employers who still asked the caregivers to go outside or to the market. It actually could harm us. But Alhamdulillah, my employer didn't treat me like that. If we go out, while grandmother is at home vulnerable. Then, for example, if we get COVID but have no symptoms because our immune system is strong, we can still infect the grandmother. So, it's not protective. (Irma [62-64])

doi:10.6342/NTU202501557

In fact, Irma interpreted her COVID confinement as “free at home” which was helped by her introversion (Irma [106]). She did exercises with the OA, sunbathed, watched Netflix, and played on her phone:

> The important thing was that I looked after the grandmother well. So, my employer tried his best to provide comfort so that I felt at home. I was also free to pray, no problem. I was also free to eat whatever I wanted. Because, many [workers] go on holiday because they are frustrated at home, so they look for happiness outside. Sometimes there are employers who are very stingy, and very sparing with food. (Irma [67])

Irma’s COVID experience was akin to a child being kept inside during a storm. She avoided sickness, ate well, and remained entertained. As long as she provided high-quality care to her OA, she was allowed privileges which also benefitted her OA. When asked to confirm her closeness with her OA, Irma replied,

> Yeah, soul bond. Sometimes I think, I have never slept together, and have never been that close to my mother, eaten together, or slept in the same room. But when I was with the grandma, I was always with her 24 hours a day. In the past, when I was on holiday, the grandmother cried. She didn't want to be left. Then, she didn't want to eat, so there was no one to feed her. That's why I didn't want to take a day off. Because of that (Irma [56-58])

Early on in the interview, Irma divulged a need to care for others, to be depended on. That’s why she pursued caregiving. While with this OA, her efforts were highly valued, making

doi:10.6342/NTU202501557

the position extremely fulfilling emotionally as well as financially as she was paid 30,000 NTD every month. Her salary was kept “intact,” and she could spend the money on herself or the grandmother if she chose. She was worry-free during the pandemic while her peers were stressing on social media about job precarity:

> In fact, with the pandemic, I was more grateful to see all the good things, such as getting protection and good treatment. When people were in financial trouble, I still got a salary. That's what makes me even more grateful. So, the pandemic is not a stress trigger. But everyone’s condition is different. When we're not in a pandemic now, and I am at my lowest point, so, the stress is not due to the pandemic, right? (Irma [116-117])

The hardship and anxiety experienced by others stood in stark contrast to Irma’s gratitude, and her current mental status proved to her that mental health is dictated by her employment circumstances.

Ayu has been with the same older adult since she arrived in Taiwan five years ago. He has generalized anxiety disorder which prompted her to research the condition and familiarize herself with mental health: “Yeah, so I gained a deeper understanding. Oh, he had mental illness. I am interested in this topic…Mental health means...Thoughts within yourself...How one controls oneself...How to manage your own emotions” (Ayu [38-39]). With the physical and emotional care she provides for him, self-control and stability is essential:

doi:10.6342/NTU202501557

> So, if his disease recurs, he's afraid to die. He will cold sweat during winter, when it's cold, his body is stiff…I'll be by his side to massage him so he won't be afraid…I'm also afraid. But, I must not look afraid in front of him. If he's like, "I'm afraid of dying," and I respond, "What would happen if you die? {panicked}" But I can't be like that. I'm like, "Just stay calm." After you take the medicine and wait for half an hour, you'll be alright. (Ayu [64-66, 84-85])

Knowing her brave face and nurturing actions will soothe her OA, she masks her own stress which is caused by his poor health (Ayu [64-66]). In fact, when she took a month off in 2023, her OA was sent to a nursing home where he got a lung infection and spent three weeks in the hospital intensive care unit (Ayu [20-23]). This demonstrates how much her quality of care impacts her OA's quality of life. Ayu is in Taiwan to support her family, but she takes her work to heart: "I mean, I'm genuine. I hope that he recovers. If the person I'm taking care of is kind, I'm also kind" (Ayu [90]). Of course, Ayu will provide care to any type of OA, but, like Irma's last care contract, she has a deep bond in her current position:

> Because my employer and my laoban (boss) see me as their own child. They have one son and no daughter. They view me as their own daughter. So that's what's memorable. They never ask me to do things. So all I do is based on my initiative. And I also like to take this initiative...So when my patient got sick, I was like, "How do I deal with this" {panicking}?...I'm also hurt. (Ayu [33-35])

This problem solving initiative extends to doing household chores which she has no issue with contrary to distant employer dynamics in which extra housework is a major stressor

doi:10.6342/NTU202501557

(Ayu [81]). During COVID, Ayu stayed at home like other caregivers and upheld sanitary conditions. This kept the patient healthy and her mental health stable:

> If the patient was infected, it would be more dangerous. So the patient had to be taken care of first, only then it would be my turn...So for me, the important thing is to maintain sanitation. In terms of mental health, more or less, I wasn't affected. (Ayu [59-60])

The confinement also had little effect on her because she is an introvert and revels in the comfort of solitude (Ayu [62]). Regarding explicitly positive mental health influences, Ayu appreciates when her employer and OA give her verbal affirmations: "If he's calm, he's all good, he will say thank you. Even though he's just saying thank you, I'm happy...In my work environment, they respect me. I'm happy because of that" (Ayu [68-69]). Apart from praise and acknowledgement, Ayu's employers take it upon themselves to defend her work ethic and integrity against family members' judgement:

> If they (the siblings) come, they will ask, "Do you help this or that?" But my employer and my patient answer the question before I answer. "She, Yuyu…," my employers call me Yuyu, "Yuyu has done it." They answer the question before me...They (the siblings) are like, "You're so comfortable here." My employer never commands me to do anything. I don't have to mop the floor. So they are like, "How are you paid by doing so little?" But my employer would never treat me that way. (Ayu [70-71, 73])

doi:10.6342/NTU202501557

This advocacy is a protective mechanism which preserves the household as a safe, non-violent work environment thereby encouraging Ayu's stable mental health.

Employers in close range of their caregivers demonstrate a close bond by using informal titles, emphasizing caregiver autonomy in and out of the home, and providing novel learning opportunities. This comfortable and safe environment even reframed the pandemic for caregivers, eliciting gratitude and contentedness.

Push and pull from the homeland

The majority of migrant caregivers leave their homes in search of economic opportunity with the plan to support their families back home and return after having made enough money for their children's tuition and a sound retirement fund: "{I came here} because choosing the highest salary compared to other countries: Singapore, Hong Kong, Malaysia. Taiwan is higher...Yes, sending child to school, building a house, and savings for retirement" (Dewi [9, 63]). Some flee from unsafe or traumatic family situations with no plans of returning: "At first, it was not a good thing. Because I had a job in Indonesia, not a jobless person. Because there was a problem at home. So I went here" (Irma [8]). The former captures the narratives of six out of eight of the caregivers interviewed whose mental health was impacted by Indonesian tethers.

Family Ties

Whether connected by blood or by marriage, family back in Indonesia occupies space in the caregivers' minds and affects their moods. Ajeng underwent a particularly tumultuous divorce before she came to Taiwan. The conflict was not only between her and

doi:10.6342/NTU202501557

her ex-husband but also between her and both of their families (Ajeng [35]). This low point now serves as a metric for her mental health:

> The definition is…How do you say it? {giggles} There are too many pressures and problems. So we can't express…our feelings, and no one around us cares for us. There's no one who cares for you, even worse, you are pressured by them. That's what I know. This is how I evaluate myself (my mental health). (Ajeng [33-34])

Tuti was, for the most part, stable during the pandemic, but her own health and her family's health worried her:

> Oh, during COVID, many of my family members in Indonesia caught COVID because some of them were poor in health. There are also nurses and doctors. So, there are so many of them who had COVID, and it made me scared. Because we're far away...I was also afraid of catching the virus here. And the worst case was I died here, and my body couldn't be returned to Indonesia because the bodies of people who died due to COVID will not be returned. Those are what made me scared about COVID. (Tuti [(2) 79-81])

In parallel, Mita worried about the health of her parents and child (Mita [113-115]). This anxiety is initiated by familial closeness, but this bond also protects Tuti from everyday work stressors:

> I'm grateful to have my spouse. We understand each other, and neither is forced to make time or phone calls every day. We don't have to. We do it when we have time. And from the family, my parents never asked me to send money, because I am

doi:10.6342/NTU202501557

> already used to handling my siblings for a long time, so my parents understand, and I know my responsibility. (Tuti [(2) 53-54])

When convenient and necessary, Tuti can reach out and find solace in her husband while avoiding monetary requests from other members. Asih and Susi share this coping mechanism and often enjoy confiding in their husbands to restabilize their mental health (Asih [144]; Susi [(2) 35]). Similarly, Dewi shares a commitment to her family, but their monthly remittance reminders burden Dewi:

> Here the pressure is working, never sleeping, feeling tired, the grandmother keeps screaming, I can't get a full rest. Family from home (Indonesia) also asked for money. Here I feel very depressed. So it's like, how can I... I can’t scream, I must endure everything myself. Sometimes my brain feels full, I can't get it out. (Dewi [74-75])

Compounded with her other stressors, family expectations and anxieties add to her mental load. Family back home can either add stress, with caregivers worrying about monthly remittance and health risks during the pandemic, or subtract stress, with spouses acting as sounding boards for their wives abroad.

Productive Structures

doi:10.6342/NTU202501557

Structures refers to organizations or organized events that are Indonesia-based which the caregivers are able to engage with while abroad. During the pandemic, Tuti [10]started participating in online competitions as mentioned earlier:

> There was a writing competition organized by one of the radio stations in East Java, and Alhamdulillah, I won first place. And then there were poetry competitions and cooking competitions. I often joined online cooking competitions, Alhamdulillah, held by the Indomie platform from the beginning of the pandemic to now. (Tuti [(2) 41-42])

Tuti also mentioned Cookpad cooking competitions which she is enthusiastic about because of the "many sponsors from many great Indonesian brands" (Tuti [(2) 45]). These activities still keep her entertained but sparked gratitude while confined to the home. They also provide a sense of achievement during her slower-paced workdays. Post-COVID, Tuti enrolled in an Indonesian online university and is studying for her bachelor's degree in psychology. The education has opened up her concept of mental health and mental illness and lessened the stigma associated with poor mental status:

> Previously, we only knew mental health was associated with "crazy people". But we know now, there's this, there's that, there's this, so judge people, and we can't underestimate people. If there's a friend telling you that his or her mental health is hit, then you can't just say, "Why do you act this way?" We can't arbitrarily judge

[10] Tuti is the only participant who talked about her involvement with Indonesian structures. This strand is specific to her (Saunders et al., 2018). She parallels other participants who engage with Taiwan-based enrichment. I hypothesize that her location in Taichung affects her ability to connect with Taipei-based Indonesian activities, which guides her more towards familiar online platforms.

doi:10.6342/NTU202501557

people's mental health. So, I have more respect for the person who tells the story (Tuti [(2) 19-20])

Caregivers value Indonesian institutions for the entertainment and mental enrichment they provide. Cooking, writing, and higher education classes offer a sense of accomplishment amidst the slow and routine-based days of a caregiver in and out of pandemic times.

Grounding faith

All of the caregivers follow an organized religion, Islam being the most popular. Mita iterates Asih's faith-based work philosophy: "As a believer of a religion, this is my responsibility because this is my work. I believe in Islam, duty is mandatory, like, the caregiving job, if this is your job, you must take care of it" (Mita [43]). Mita worked with children in Hong Kong, and she sees little differences between OAs with dementia and kids. The work is "Normal, normal, normal" to her, and her patience and ability to enjoy the process of caregiving for "mother and fathers" are her most valuable assets (Mita [40-41, 43-44]).

Religion recenters believers and placates their spirits. When Susi was in a harmful caregiving position, she often prayed that the contract would end soon, and Mita "forgets about the stress" when she does salat (prayer) (Susi [(2) 34]; Mita [60]). Regardless of the pandemic, when Irma's mental health starts to dip and she loses her empathy, her faith provides strength and reliability that people do not. She may become temporarily apathetic towards a difficult OA,

But then, again, we have God; we introspect ourselves. I always think like this, people do bad things to me, maybe because I made mistakes myself or to God. Or,

doi:10.6342/NTU202501557

> maybe my prayer is still lacking. So, I go back to God to seek help...Sometimes if we confide in friends, as humans, they don't necessarily give good feedback. We don't always ask for solutions when telling stories because sometimes we just want to be heard. But sometimes they like to make comments that make you feel hurt. If it's like that, we become more emotional and down. If we communicate with God, we will not be judged and receive energy that, as if suddenly calming down, we think of a solution. (Irma [142-143, 160-161])

As she is a Muslim woman who observes the five prayers per day, she is quick to recompose herself, remarkable discontent usually only lasting 24 hours (Irma [148]). The reliability on God as an omnipotent listener positions prayer as a superior coping mechanism to conversation for Irma. When entering a new employment contract, as she did at the end of COVID, religious freedom is the first item on her list:

> The first thing I negotiated [with the employer] was salat. If I wasn't allowed to salat, things wouldn't go well. I'm alone here. If God doesn't help me, then who will? I can lose anything, but if I lose God, everything is gone. (Irma [149-150])

She reflected that reciting the Qur'an and listening to Murotal (slow Qur'an recitations) during COVID helped maintain her mental health (Irma [75]). Faith is a constant for Irma and the main source of her strength. It empowers her to persevere through trying circumstances, but her stability, maintained by religious practice, is at the mercy of employer empathy. Based on caregiver accounts, carrying out Islamic doctrine, such as salat, fasting, and a halal diet, is dictated by employers and OAs. Some are afraid of the mukena (Indonesian prayer robe), find it difficult to understand pork avoidance, or are

doi:10.6342/NTU202501557

devoted to their own beliefs, prohibiting religious coexistence under their roof (Dewi [22-23]; Susi [(1) 22-24]. Tuti was even reported to the police for praying (Tuti [89]). Irma's current employer does not take her beliefs seriously, which causes a lot of turmoil inside of her:

> I prioritize halal and haram. So, I have mentioned several things at first, like I can't eat certain foods, I can't touch certain things…So, the idea is like, you're a servant ("babu:" negative connotation of slave) here. "Whatever food I give, you have to eat." Yeah, like that. So, my previous employers were not like that, from Tainan to the one in Taichung. Even the one in Kao Hsiung, the one who was really bad, for the food issue, they were still considerate, because like this, we must work in healthy conditions, we have to get enough vitamins. And then, my employer in Taichung once said, not only the grandmother who has to be healthy, you have to be healthy too. (Irma [122-126])

According to Irma, her current employer disregarding her faith is a serious offense because she framed him/her as worse than earlier employers in Kao Hsiung and Tainan who forced her to process raw chickens, survive off of 500 NTD per month, and take care of dogs. She was not allowed to use her phone, leave the property, and would work long hours, sometimes 24-hour shifts, which landed her in the hospital from over-exhaustion (Irma [37-40]). Even with grueling, illegal expectations, those employers respected her religious food rules. Ayu's employers reside on the other side of the tolerance spectrum though:

> As a Muslim, I will practice "wudu" and "solat" (prayer). I will pray...If I'm afraid and anxious because of work, I will ask my family to pray for me...Even if when I

doi:10.6342/NTU202501557

> pray, my patient needs my company, he'll tell me to pray first before keeping him company...My female employer is understanding. She's like, "You haven't prayed. I will cover you for 5 minutes, 7 minutes." Then I'll do my prayer...Alhamdulillah, my employer allows me to wear a hijab. (Ayu [98, 100-102])

Ayu's relationship with her faith is respected by her employer, which inspires significant gratitude. She needs to feed her OA nutrition formula every three hours through his NG tube, which leaves little freedom for leisure activities. When she has time, she will indulge in Islamically-framed discussions online:

> As a Muslim, sometimes if there's a study meeting through zoom, we will talk about this and that. For instance, during Ramadan, we talked about things during the Ramadan month...{laughs} Sermons. If you attend online classes, it's like, for example, like discussing. Even earlier there was something like this...Like the mental health given by the...also the Muslims. (Ayu [119])

Faith is an avenue for comfort, hope, and education for Ayu. We even met her outside of her mosque before the interview, ensuring that she felt safe and enthusiastic about participating.

Ajeng is the only Catholic participant and offered the brief statement, "Religion might influence, prayer, and you sharing with friends. But we are the ones who can help ourselves recover from depression. From within oneself" (Ajeng [30-31]). This places religion to the side and focuses Ajeng's mental health on her internal locus of control. With the exception of Ajeng, a relationship with faith provides a basis of duty, an impartial listener, and a way to destress and regain strength for caregivers. It can also pose as an

doi:10.6342/NTU202501557

additional barrier for an ignorant or intolerant employer, preventing them from forming a bond with their caregiver while the caregiver endures their disrespect.

Social networking abroad

The caregivers interviewed repeatedly emphasized the impact of their social networks in Taiwan, primarily composed of other Indonesians. The networks could be comprised of friendships on and offline, and virtual communities used for discussion or competitive purposes. The following two subthemes specify how migrant social networks influence mental health.

Listening ears

Most caregivers talked about the importance of having a friend to share their thoughts and frustrations with to help relieve stress and maintain composure. This could be in person, over the phone, on social media, or in structured classes or discussion groups. Ajeng fended off quarantine boredom by hearing and relaying daily happenings: “I only played with my cell phone...Talking to my friends. Watching movies. {laughs}...Chit-chat. I ask them how they spend their days” (Ajeng [58, 58.2-58.3]). Post-pandemic, Ajeng meets her friends when she needs to raise her mental health, but if they are busy, she just watches TV (Ajeng [60]). However, a distraction does not resolve negative emotions, and her approach is as follows: “If there is a problem, don’t overthink about it...And find a friend who truly, uh, who can truly understand us...So, find a friend who really knows your flaws and how you behave when you are angry. Someone who can handle you” (Ajeng [59]). Given her life in Indonesia where she altercated with kin, there is no replacement for genuine companionship to Ajeng. Mita also relishes social life, sharing that, “If we’re more

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more lonely, my mental health is even more affected" (Mita [72-73]). COVID posed an obstacle to socializing, and, like Susi, Mita recognized her migrant status and very intentionally limited her interactions (Mita [88]).

Dewi expressed deep sentiment regarding being heard by others: "If we have mental pressure, pouring out our feelings to other people makes our hearts relieved. It feels like someone is there to listen to us" (Dewi [73]). Without being able to spend time outside of the house during the pandemic, Dewi sought verbal escape. In her current caregiving situation, though her employer is kind and gives her time to rest from the "fussy" OA, she cannot unload her grievances onto them. No matter how intimate the relationship is, an employer is seldom the right audience for exercising fully free speech when stressed, so exiting the isolated professional setting and expressing one's mind to an empathetic audience is a valuable outlet. The resulting feeling of worth and acknowledgement is a comforting and necessary part of maintaining stable mental health transcending crisis times.

Susi chooses to define mental health via her social coping mechanisms. Mental health means,

> Well, maybe, not to get stressed. There are some methods or therapies to help you relieve stress and be more relaxed...I often join the sharing sessions until now. There was also this kind of event held by Diaspora RI in January...Sometimes, when I am on my day off, the class is a week after or before. The schedule didn't match my day off, so I joined the online session. (Susi [(1) 65-67])

doi:10.6342/NTU202501557

Diaspora RI (Republik Indonesia) is formally known as the Indonesian Diaspora Network. The organization has a Taiwanese branch that regularly puts on events to bring Indonesian migrants together.

The live discussion sessions suit Susi, but Irma enjoys personal social media by "posting WA (WhatsApp) stories because friends on Facebook are too broad, whereas, on WA, it's only certain and the closest people" (Irma [168]). Impacted by past negativity, Irma has adapted her social media habits to best suit her needs and initiate healthy virtual expression. Tuti takes a different approach to ensure positivity by staying offline: "Mm, I am private now. It's just for my inner joy. I feel that I don't need recognition from others" (Tuti [(2) 74.3]). Similar to Irma, Tuti's mental health was previously harmed by sharing her thoughts and accomplishments online, but she decided to withdraw altogether for self-preservation. In order to validate feelings and combat boredom during COVID-19, caregivers vented to friends, ideally trustworthy and empathetic confidants. Avoiding over-analyzing stressors buffers further stress, and caregivers encourage mindful social media usage to evaluate its effects on thoughts.

Learning and Enrichment

To cope with pandemic confinement stress, Dewi immersed herself in online learning provided by Indonesian-targeted sources in Taiwan:

> Just playing with my cell phone...There are a lot of online webinars...Sometimes by the university of cyber online...The one that's in the U-Taiwan...Sometimes, also from Diaspora RI...Learning English, Mandarin, sometimes [the webinar] teaches us how to make a business in Indonesia. A lot of useful topics. (Dewi [102-105])

doi:10.6342/NTU202501557

Dewi's participation in these opportunities highlights her commitment to a growth mindset when physically confined, working to preserve her peace in Taiwan by maintaining her language skills while preparing for her eventual return home.

Asih's current employer allows her time to engage in selfcare activities such as in-house yoga and aerobics, YouTube, Chinese dramas, and online learning opportunities: "I learn from OneForty, learn Mandarin. Like that. And now, there are many online trainings, through Zoom things like that, I always keep up with it" (Asih [137, 139-140]). During COVID, Susi found fulfillment by entering a poetry competition hosted by Ming Chi University of Technology. She also served on the event committee of a local Muslim migrant worker association (Susi [(1) 50-52]). Post-COVID, Susi participated in the Mila Boutique and Radio Taiwan International Kartini Day[11] Batik and Songket fashion show where she and other Indonesian migrant workers walked on the runway and learned makeup techniques. The activities and formal learning opportunities that Taiwan's large Indonesian diaspora has established serve the caregivers in and out of the pandemic, boosting mental health and stability by presenting transferable skills and recreation.

[11] Kartini Day is in honor of late 19th-century Javanese noblewoman and feminist activist Raden Adjeng Kartini, who is credited with founding Indonesia's first school for girls (Hocking, 2024).

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Chapter Five: Discussion

This study investigated Indonesian in-home caregivers' mental health in Taiwan in the context of COVID-19 pandemic. Using interpretive phenomenological analysis, four major themes emerged from participant narratives, including Position relative to employers (Distant relationships, Mid-distance relationship, & Close relationship), Push and pull from the homeland (Family ties & Productive structures), Grounding faith, and Social networking abroad (Listening ears & Learning and enrichment).

Participants largely define mental health as their capacity for emotional control as opposed to using clinical, biomedical descriptors. Emotional control is indicative of being mentally healthy and does not mean repressing emotions but rather expressing them in appropriate ways. Crying is allowed, whereas screaming is not (Dewi and Irma). Writing in a journal, talking to friends and family, and praying are all acceptable outlets. While an employer may receive genuine frowns if they damage their care worker's mental health, OAs should never feel the consequences of a carer's sadness, anger, or fear. That would harm their health, reflect poorly on the caregiver, and demonstrate subpar mental health.

If not learned in a class or because of personal interest, emotional low points can introduce care workers to the concept of mental health, for good health only exists in the context of illness. Otherwise, it is taken for granted. In Ajeng's case, her divorce in Indonesia serves as her low point, and everything that happens after *will* be better than that time in her life. This concept parallels Uekusa's (2025) "higher reference point" where poor treatment in Australia is tolerated because it is different than the hardships back home for

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Japanese institutional and home-visit caregivers. These scarring experiences are pivotal for establishing mental health awareness.

Low points are often prompted by a caregiver's loss of control due to employer behavior (Ho et al., 2022a) and OA illness. This is similar to Kaur-Gill's (2021) finding that work conditions contributed to domestic workers' mental health meaning making in Singapore. When discussing pre-COVID times, my study's participants cited gross traumas caused by apathetic employers who made light of OA sexual and physical misconduct, disrespected and feared Muslim doctrine, or exploited their caregiver as a manual laborer. Unlike caregivers in the gulf countries though, documents were never confiscated by employers (Johnson, 2011). Mid-COVID, employers confined care workers inside the house and stressed those with no care team. Those burdened with excess housework, confined with a person with dementia (PWD) (Kriegsmann-Rabe et al., 2023; Tam et al., 2018), and subjected to ethnically rooted stigma saw their mental health fall (Ha et al., 2018). The COVID-19 virus specifically incited stress and fear in care workers regarding their own health, the health of their families back home, and their OAs' health (Lan, 2022a). Existing in constant close contact with the vulnerable OA population weighed heavily on their psyches, for if their client passed away, they would suffer unemployment. In turn, caregivers were also anxious about losing income and not fulfilling familial remittance requests. These symptoms were present in both in live-in and institutional migrant care workers in countries such as Israel (Attal et al., 2020), Spain (de Diego-Cordero et al., 2022; Dotsey et al., 2023), South Africa (North et al., 2020), and Australia (Uekusa, 2025). Industrial migrants in Taiwan mimicked these fears as they lived in crowded dorms prone to rapid disease spread (Asri et al, 2025; Lee et al., 2022). Notably,

doi:10.6342/NTU202501557

no caregivers attributed their low points or poor mental health to COVID-specific restrictions. The pandemic simply emphasized the consequences of a de-juridified work environment (Kaur-Gill et al., 2021).

The concept of dejuridification typically implies fewer labor regulations and more dangerous working conditions for employees (Dotsey et al. 2023; Lovelock & Martin, 2015; Lu et al., 2022; Tam et al., 2018). Where Filipino, Indonesian, and Vietnamese migrants working in Taiwan's institutional care and productive industries are subject to protective laws, national regulations, and more strict sanitization politics (Chan & Lan, 2022; Cheng, 2022; Lan, 2022; Lee et al., 2022), live-in caregivers' conditions are theoretically more variable. Employers of in-home care workers overpowered symptoms of the pandemic, though, because the government's mitigation policies allowed for greater populace stability compared to other countries. Cases like Singapore's Circuit Breaker and Italy's extended lockdown pushed citizens home for remote work, and MDW could not take rest outside of the home, causing extreme stress on top of the threat of disease and increased precarity (Dotsey et al., 2023; Kaur-Gill et al., 2021). A caregiver's fear of COVID infection, unemployment, and extreme isolation could all be managed by an employer in Taiwan because they were still able to conduct business as usual and receive a paycheck to then compensate their caregiver. Even when caregivers were confined to the home, Taiwan's failure to lockdown meant they had better socialization, income, and overall MH.

Mental health varies based on a caregiver's relationship with their employer. Lu et al.'s (2022) survey on Indonesian caregivers substantiates this claim as older caregivers working in-home were more subject to bullying and had lower MH scores than those

doi:10.6342/NTU202501557

working in facilities. Distant relationships are apathetic and neglectful, sometimes at the expense of the OA's health and always to the detriment of the caregiver's MH. This reflects Parreñas' (2014) theorization of in-home caregivers as unappreciated, quasi-family members subject to the devaluation of their work as legitimate labor, thereby curbing labor rights in their maternal economy. A distant employer may exercise excessive control or maintain unrealistic care demands, ignoring their caregivers' needs. This is consistent with Kaur-Gill et al.'s (2021) finding that a "dysfunctional" employment structure disrupts a caregiver's ability to sustain positive MH identities, whereas respectful treatment within the household "enables and empowers" well-being.

Mid-distance relationships can indicate an effective care team, enough downtime to sleep or consume recreational media, secure finances, religious freedom, and enrichment activities. There are no inherent issues in a mid-distance dynamic, but it lacks the emotional component of kinning present in a close relationship that can fend off emotional fatigue. Regardless of the pandemic, MH is best maintained by caregivers involved in close relationships with their employers and OA. Contrary to Lin & Belanger (2012), kinning was not associated with exploitation or exaggerated care standards. In fact, kinned caregivers felt the most supported by their households because they operated within a care team (Tam et al., 2018). Close relationships distribute responsibility between multiple parties with open communication, ensuring secure employment, autonomy, and adequate personal time. Caregivers like Irma and Ayu experienced the positive manifestation of pandemic domestic dejuridification, I call "free at home." Rather than carry out daily duties like the rest of the populace, caregivers were protected in the home and encouraged to devote all their attention to the well-being of their clients and themselves. They were cared

doi:10.6342/NTU202501557

for just as they cared for their OAs (Baldassar et al., 2017; Lin & Belanger, 2012). Once an OA dies and a caregiver is transferred out of the kinned environment, she loses a layer of protection and is vulnerable to the outside environment.

Care worker security during COVID was aided by salary guarantees, effectively quelling financial precarity. Caregivers in Japan and Taiwan had more leverage during the pandemic because of the border-induced labor shortage (Chen & Duyen, 2024; Lan, 2022b), and Tuti's employers assured they would continue to pay her even if the OA passed away. In general, this is an ideal circumstance, but her abnormally high salary incited financial precarity. She knew the generosity of her employer was rare and felt pressured to maintain an unspoken high standard of care. This state of low-level anxiety transcended the end of the pandemic.

Irma's account highlights the importance of employer socioeconomic class and occupation. The employers, wife a professor and husband a physician, not only provided in-home enrichment classes and shared trade knowledge with Irma but also exercised healthy emotional boundaries with her. This had an enormous effect on their employer-employee dynamic and Irma's relationship with the OA. The couple maintained professionalism by sheltering Irma from their marital quarrels, and she focused on serving the OA, further deepening their affection and dependence on one another. Her employers acted as emotional role models for her, and Irma learned to manage her own mental health for subsequent, less ideal caregiving contracts.

Employers often dictate access to coping mechanisms to maintain good mental health or deal with poor mental health. These can include rest, phone calls to family overseas, a full day off to see friends, educational enrichment, and prayer.

doi:10.6342/NTU202501557

Caregivers' relationships to their transnational familial networks are multi-faceted. Some escaped unstable marriages and started anew, never looking back. Others were comforted by routine calls with their husband during COVID. The risk of infection and pressure to send remittance to Indonesia stressed caregivers (Kaur-Gill & Dutta, 2021; Kaur-Gill et al., 2021). Most work in Taiwan for financial reasons, either funding children's educations or building up a nest egg for when they retire and return home. When COVID threatened their stream of income, similar to Baldassar et al.'s (2014) findings, their role as providers was destabilized.

Social relationships buffer stressful events and improve health outcomes (Cohen and Wills, 1985; Ho et al., 2022b; Lakey & Cohen, 2000), and they can encourage thriving via opportunities like higher education (Feeney & Collins, 2015). Video chats, online classes, and media consumption became important avenues of decompression for isolated caregivers during the pandemic. Their connections to caregiving communities in Taiwan and participation in Indonesia-based virtual competitions provided much-needed mental stimulation and support. Post-pandemic, the gratification they received from participating in said activities gives them a sense of accomplishment and pride.

Similar to Reyes-Espiritu's (2022) work on Filipino domestic migrants, participants cited a belief in God as instrumental in managing their roles as caregivers and maintaining MH. In most studies, religion, Christianity and Islam provide support (Baig & Chang, 2020; Ho et al., 2022a) and increase resilience (Garabiles et al., 2022; Johnson et al., 2011). Baig & Chang (2020) assert that work-related issues necessitate formal religious institution consultation, while emotional issues draw caregivers to confide in informal networks. I

doi:10.6342/NTU202501557

observed no pattern between outreach motivation and source of support. None of the caregivers can regularly visit a place of worship, so all participants rely on personal orthopraxy to uphold religiosity. If they cannot pray or dress according to their doctrine, they lose a coping mechanism, and their quality of life decreases.

Limitations and challenges

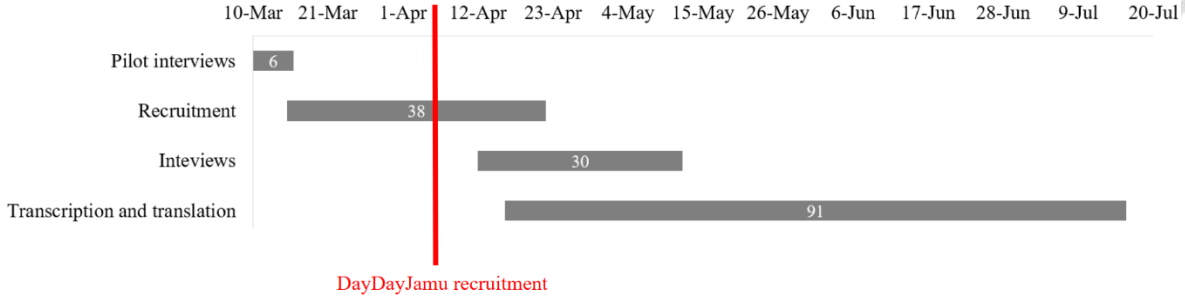
Because my criteria excluded currently or recently pregnant women and those who were not continuously in Taiwan during the pandemic period, I generally selected for older caregivers. This potentially biases my work towards more adapted migrant care workers and neglects those who are more concerned with processes of enculturation, communication issues, and social belonging during COVID. Similarly, I required my participants to have a legal labor contract with their employer. Runaway or illegal migrant care workers' accounts would differ regarding the level of daily precarity they are subject to as undocumented foreign bodies. Translation is thorough because of Virly and Nicho's diligence, but the language and culture barriers remain an obstacle to my interpretation of the transcripts. I did my best to empathize and pay attention to body language as well as heed the cultural observations Virly made during our post-interview debriefs.

Lastly, I would have liked to do another round of interviews with a few participants, but funding did not justify the labor that another round would have required. Conducting this research was a long and involved process, from designing recruitment flyers to translating the informed consent form, distributing the recruitment flyers, interviewing, and processing data. Pictured in **Figure 3.** are the durations of post-IRB approval general tasks: the pilot interviews (5 days: March 10-15), recruitment (38 days: March 15-April 22), interviewing (30 days: April 12-May 12), and transcription and translation (TT) (91 days:

doi:10.6342/NTU202501557

April 16-July 16). The recruitment snowball only started rolling after café DayDayJamu's Facebook post of my flyer (discussed on the next page), and then my translation team was

Figure 3. General research task timing and duration



on the job for another three months. Virly especially had to keep her calendar open to accommodate the caregivers' limited time off, and in the end, she was actively involved in the study for one year. I was able to pay Virly and Nicho a total value of 12,800NTD and 5500NTD, respectively[12]. Comparing the time each translator invested and my payment with the rate of translation services in Taipei, it would have been exploitative to require more work from them without more compensation.

Regarding challenges, participant recruitment and interview locations posed issues. Recruitment was difficult because I was publicizing in suboptimal places at suboptimal times. I failed to visit hospitals for recruitment, and NGOs were the least helpful source, with no qualification surveys submitted post-NGO outreach, and no caregivers ever mentioning an NGO as their recruitment source. The well-known migrant caregiver advocacy nonprofit One-Forty even declined to publicize the study flyer.

Timewise, I was recruiting (March 15th to April 22nd) during Ramadan (March 10th to April 9th, 2024). An important aspect of Indonesian culture is Islam, with around 87% of

[12] Other expenses included the IRB application fee, recruitment flyer color printing, and Family Mart vouchers for participants.

doi:10.6342/NTU202501557

Indonesians identifying as Muslim (Statista, 2024). Ramadan is a one-month period where Muslims do a strict food and water fast from sunrise to sunset, pray, and live with faithful intention (Britannica, 2024). Believers are often exhausted in weeks three and four, with fatigue and headaches being common effects of the prolonged fasting (Lauche et al. 2024). Coupled with caregivers spending most of their time in the home, they were unlikely to see the poster anywhere but online where their convenient social networks exist. The end of Ramadan coincided with increased recruitment, though no causal relationship can be established. Flyers at the Taipei Grand Mosque yielded one unqualified candidate, and I do not have an explanation for this low number.

Figure 4. Timeline of qualification survey responses

I only went to restaurants after three weeks of zero responses to the qualification check survey. The catalyst was DayDayJamu café posting the recruitment flyer on their Facebook page. Immediately after the post, three caregivers filled out the survey, and it received a steady flow of responses over the next month with a spike after interview number six with Ajeng (**Figure 4**). When asking participants how they heard of the study,

doi:10.6342/NTU202501557

over half of them cited the DayDayJamu Facebook post, and the others heard about it from friends who had seen the post and sent it to them.

Deciding on locations and carrying out a smooth interview were low-grade struggles. Virly and I would go wherever the participants decided, despite potentially subpar conditions for us. Even with a clip-on microphone, speech quality suffered during Irma's coffee shop interview, and it took three weeks to translate and fully transcribe. Virly and I were too far away from our microphone (participants were provided their own), and the café's coffee grinder was deafeningly loud which the microphone picked up. With Dewi, I awkwardly sat on the ground while she sat next to Virly on a bench. We were in a small park, and the singular table at the park was occupied.

We ended up conducting Asih's and Mita's interviews at Taipei Main Station (TMS), which was a conflicting setting. Asih and Mita lacked familiarity with Taipei, so TMS was the only place they were comfortable navigating. Because it is a hub for Indonesian caregivers, Virly and I had to walk around with Mita and Asih respectively to find private spots devoid of curious ears. There was also quite a lot of background noise in the recordings. This was not an issue with Ajeng because we were in her quiet apartment lounge with her OA, and Ayu chose a large park to talk in with few Indonesians around. Tuti and Susi's online interviews were flawless, even with occasional tending to OAs and a small earthquake. The difficulties encountered from in-person interviews were still manageable, and the interactions fostered more closeness between participants, Virly, and me.

doi:10.6342/NTU202501557

Chapter Six: Conclusion

This study aimed to conceptualize how in-home Indonesian caregivers define mental health, their mental health status from before to after the COVID-19 pandemic, and the reasons behind the status. I use a nuanced relationship framework to relay the findings, which includes non-social bonds to religion and enrichment activities. The caregivers' definitions of mental health revolve around emotional control and how they react to the forces in and around them. Regardless of the pandemic, employers overwhelmingly affect their mental well-being and access to coping mechanisms like rest and faith. Off time can be used to recharge with enrichment activities, classes, connecting with loved ones, or resting. COVID-19 incited fear of infection and financial precarity, but Taiwanese employers could ultimately mitigate the symptoms of the pandemic since they were still able to go to work and compensate their caregivers. Some caregivers' MH even worsened *after* the pandemic ended because they changed employers. Below are three categories of recommendations based on my findings.

Research

Future studies on migrant caregiver mental health should investigate the impact of employer socioeconomic status and occupation on kinning, caregiver educational enrichment, and well-being. Irma's data inspires this avenue of research because of her memorable experience with her professor-physician employers. The association between utilization of in-home care education offered by LTC plan 2.0, migrant caregiver mental health, and policy awareness is also worth examining. All participants have been in Taiwan for over five years, yet none of them mentioned using LTC 2.0 services to enrich their caregiving knowledge. Inquiring with employers is essential to this potential study because

doi:10.6342/NTU202501557

their caregivers' awareness of Taiwanese LTC policies and laws may be at their (the employers') discretion.

Lastly, the line between quality of OA care and caregiver quality of life in the context of the de-juridified homecare environment is thin. The dearth of publications on Muslim caregiver MH in non-Muslim majority countries intrigues me because of caregivers like Tuti and Susi, whose experiences infringed on their Muslim identities (e.g. caring for pigs and having law enforcement called on her for praying). Baig and Chang (2020) focus on religious support networks (Christianity and Islam) but fail to question live-in care circumstances.

Practical

Kindness and empathy in an intimate work setting cannot be enforced. Based on my participants accounts, the government should establish a caregiver advocate program to ensure healthy employment conditions where experienced caregivers are assigned to make visits and phone calls to new caregivers or those in new contracts. The advocate could then provide the appropriate resources for the caregivers if need be regarding language learning, legal counsel, social groups, dementia care training, etcetera. This would help them acclimate to a new work setting given the different employer and new working conditions.

Employers themselves should prioritize fostering a healthy relationship with their LIMC. This is helped by maintaining open communication, respecting their LIMC's faith, acknowledging their mental health, and providing support when necessary.

Policy

LTC 2.0 expanded care coverage of Taiwan's OA population, but it is still underused by employers of LIMC. I encourage more collaboration with LTC 2.0 healthcare

doi:10.6342/NTU202501557

professionals to stimulate connection with LIMC via care workshops and classes. This will enhance caregivers' competence and support their mental health.

Based on my participants' pre-COVID traumas, the government should create a blacklist of employers who have been reported by caregivers via the 1955 hotline or who have had caregivers runaway. The Workforce Development Agency should also revise the responsibilities of foreign live-in caregivers from "Take care of daily affairs for people with disabilities or diseases" (2017, July 4) to a more specific description like "Take care of the daily affairs for people with disabilities or diseases that they are no longer able to perform excluding extended family care". This will mitigate care burdens. The Domestic Workers Protection Act needs to be enacted, as well as foreign workers integrated into The Labor Standards Act to raise their wages and ensure time off.

Moreover, the Ministry of Labor should consider instituting the Foreign National Labor Rights Network's 2022 proposed amendments to the Foreign Workers Living Care Service Plan (required to be submitted by employers as outlined by The Regulations on the Permission and Administration of the Employment of Foreign Workers). Similar to my practical suggestions, they demand that employers respect migrant workers' religious food taboos, their accommodation hygiene and safety, their personal safety from sexual misdemeanor, and introduce the 1955 labor advisory line, police reporting line, and women and children protection line.

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Appendix I

Positionality & reflexivity statement guide

A positionality statement is a description of your identity, and reflexivity is acknowledging how your identity and assumptions can impact a research project (Wilson & Williams, 2022): "**[It] should address who you are, how you see the world (your paradigm), and your relationship with the participant and research project**" (Holmes, 2014), for "how do we study the other without studying ourselves?" (Koch and Harrington, 1998). You should also examine your relationship with fellow researchers because this dynamic could impact how you operated in the study and your interpretation of the data (Hsiung, 2010). The final paper is a product of interactive meaning-making.

Your impact on the paper will depend on your role in the research study. You should ask yourself "How did my interaction with or *lack* of interaction with participants affect my thoughts on the study, perception of the data, and work?"

Including a positionality statement in qualitative research validates the study by exposing researchers' potential biases. Since a phenomenological study does not use statistics, it is necessary to demonstrate that researchers are aware of their beliefs/preconceived notions and therefore able to have a neutral study design and useful, "true" analysis. The purpose, methods, and interpretation of findings can all be swayed in one direction or another depending on a "researcher's motives, background, perspectives, and preliminary hypotheses [which should be] presented" (Malterud, 2001) as well as **what is going on in the researcher's life during different stages of research** (Koch & Harrington, 1998).

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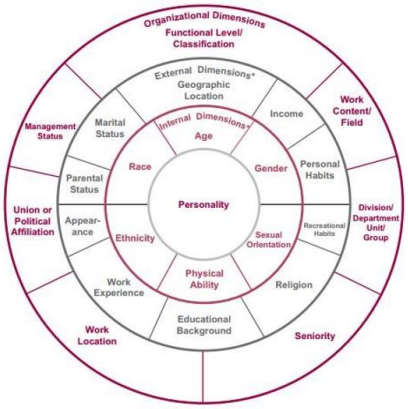
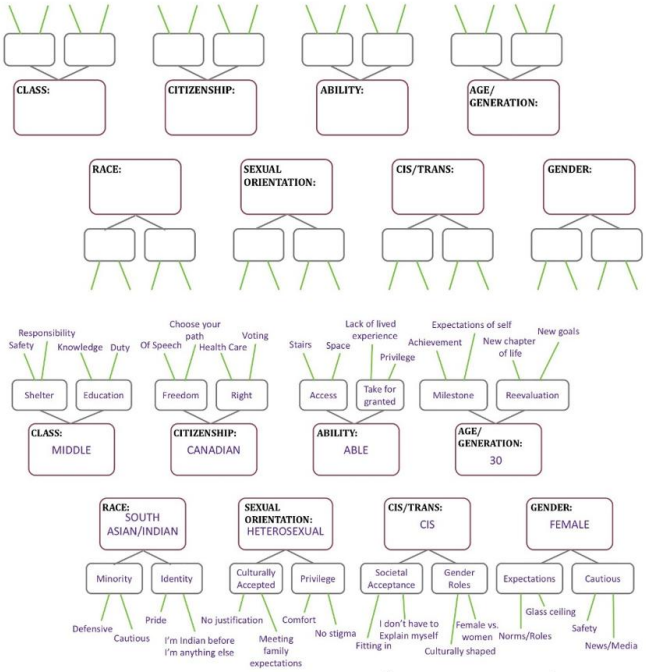
This type of writing is **reflexive** as opposed to **reflective**: "Reflection might lead to insight about something not noticed in time, pinpointing perhaps when the detail was missed. Reflexivity is finding strategies to question our own attitudes, thought processes, values, assumptions, prejudices and habitual actions, to **strive to understand our complex roles in relation to others**" (Bolton, 2010). Past experiences either enable or hinder empathy, and the pertinent experiences should be stated because they will influence research team cohesion, interview quality, and data analysis (Barry et al., 1999).

Below are some models you can use to start your self-analysis and writing process.



Gardenswartz & Rowe, 2003



Jacobson & Mustafa, 2019

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Appendix II

IRB approval form

國立臺灣大學
行為與社會科學研究倫理委員會

Research Ethics Committee
National Taiwan University
No. 1, Sec. 4, Roosevelt Rd., Taipei, Taiwan 10617, R.O.C
Phone: 3366-9956 Fax: 2362-9082

審查核可證明

核可日期：2024 年 3 月 4 日

倫委會案號： 202312HS021
核可證明有效期限： 2024 年 3 月 4 日 起至 2024 年 6 月 30 日
計畫名稱： 台灣印尼籍居家看護的現象學研究：針對看護新冠疫情前以及疫情後心理健康的觀察
校/院/系/計畫主持人： 國立臺灣大學/公共衛生學院/全球公共衛生學位學程/朱麗 Juliet Balkian 碩士生
計畫文件版本日期： 【研究計畫書，2024 年 2 月 26 日】、【知情同意書，2024 年 2 月 26 日】、【問卷，2023 年 12 月 15 日】、【招募文宣，2024 年 2 月 26 日】

上述計畫業經 2024 年 3 月 4 日 國立臺灣大學行為與社會科學研究倫理委員會同意，符合研究倫理規範。本委員會的運作符合本校行為與社會科學研究倫理準則與規範及政府相關法律規章。

本案需經研究經費補助單位核准同意後，該計畫始得執行。

計畫主持人最遲應於本核可證明到期前的 6 週，提出持續審查申請表，本案需經持續審查，方可繼續執行。 在計畫執行期間，若有計畫變更或嚴重不良反應事件，計畫主持人須依國內及本校相關法令規定通報本委員會。

行為與社會科學研究倫理委員會主任委員 洪貞玲 洪貞玲

Ethical Review Approval
National Taiwan University

Date of approval: March 04, 2024

NTU-REC No.: 202312HS021
Validity of this approval: from March 04, 2024 to June 30, 2024
Title of protocol: A Phenomenological Study on Indonesian In-Home Elder Caregiver Mental Health in Taiwan: Pre- and Post-COVID-19 Perspective
University/ College/ Department/ Principal Investigator： National Taiwan University, College of Public Health, Global Health Program/ Master's Student Juliet Balkian
Version date of documents： 【Research Protocol, February 26, 2024】，【Informed Consent Form, February 26, 2024】，【Interview outline, December 15, 2023】，【Recruitment Advertising, February 26, 2024】

The protocol has been approved by Research Ethics Committee of National Taiwan University and has been classified as expedited on March 04, 2024 . The committee is organized under, and operates in accordance with, Social and Behavioral Research Ethical Principles and Regulations of National Taiwan University and governmental laws and regulations.

Approval by funding agency is mandatory before project implementation.

Continuing Review Application should be submitted to Research Ethics Committee no later than six weeks before current approval expired. The investigator is required to report protocol amendment and Serious Adverse Events in accordance with the National Taiwan University and governmental laws and regulations.

Chairperson Chen-Ling Hung
Research Ethics Committee Chen-Ling Hung

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Appendix III

Recruitment text – email

Dear (insert name),

My name is Juliet Balkian, and I am a second year master's student in the National Taiwan University College of Public Health Global Health Program. I am currently recruiting participants for my thesis research project which focuses on examining the mental health of Indonesian in-home caregivers of older adults in Taiwan. The purpose of this research is to allow caregivers the space to reflect and have their experiences, opinions, and mental health impact future policies on migrant caregiver health and work environment. Focusing on mental health during an extreme time period like COVID-19 can help illuminate true protective factors, coping mechanisms, and harmful forces that affect migrant caregivers and their care burdens. Because Taiwan's infection prevention was uniquely effective, the data could be useful for cross-country comparison of caregiver experiences and to gauge mental health awareness.

Research aims include documenting how these caregivers define mental health, their current mental health status, and the main influences on their mental health via an interpretive phenomenological study

The study involves qualitative interviews which ask questions about caregiver experiences during the COVID-19 pandemic. I would like to recruit 10 to 30 participants, and each interview will last one hour. After completing the interview, participants will receive convenience store gift cards as compensation and appreciation for their time.

All information collected will be anonymous and confidential. No identifying information of any of the participants will be included in the study, and no information will be shared with anyone outside of the study. Written and informed consent is required, and participants can withdraw at any time with no consequences.

I have attached publicity flyers in both Bahasa Indonesia and English for your reference (participants need to be comfortable speaking either English or Bahasa Indonesia). Please let me know if you are interested in publicizing this research, and I will send you copies of the flyers with QR codes so potential participants can scan them and see if they qualify to participate.

Best,
Juliet

Email: r11853006@ntu.edu.tw
Phone: +886 09 6643 0147

doi:10.6342/NTU202501557

Recruitment text – social media

ENGLISH

Come and share your story! If you are an Indonesian caregiver who worked in-home during the COVID-19 period, please consider joining this interview study which centers around mental health. Caregivers of older adults are essential to Taiwanese society. The pandemic changed everyone's daily lives, and hearing about the lived experiences and mental health of caregivers who work with vulnerable populations, like older adults, is important to help maintain their quality of life.

Interviews will be 1 hour and held at a location most convenient for the participant. Convenience store gift cards will be given as appreciation for participants' time.

If interested, please click the link and fill out the form to see if you qualify: https://forms.gle/94iMiBPY4yth1gda6

This study is conducted by the National Taiwan University College of Public Health Global Health Program. Contact Juliet Balkian at r11853006@ntu.edu.tw with any questions!

INDONESIAN

Ceritakan pengalamanmu! Apabila Anda adalah seorang WNI yang berprofesi sebagai perawat lansia di Taiwan, tinggal serumah bersama lansia tersebut, dan telah bekerja sejak masa pandemi COVID-19, maka Anda adalah orang yang tepat untuk terlibat dalam penelitian kami mengenai kesehatan mental. Perawat lansia memiliki peran penting dalam kehidupan masyarakat di Taiwan. Pandemi mengubah keseharian semua orang, dan kami ingin mendengarkan pengalaman hidup para perawat lansia pada masa tersebut. Cerita Anda akan sangat bermanfaat bagi kami untuk mengetahui keadaan mental para perawat lansia dan membantu menjaga kualitas hidup mereka.
Wawancara akan berlangsung selama ± 1 jam. Lokasi wawancara dapat ditentukan oleh peserta.
Hadiah berupa *kupon belanja minimarket* akan diberikan kepada peserta setelah mengikuti wawancara!
Bagi yang berminat, silakan klik link di bawah ini untuk mengisi formulir pendaftaran:
https://forms.gle/CRABpm2hC62egEvW7
Peserta yang lolos seleksi akan kami hubungi lebih lanjut.

Penelitian ini diselenggarakan oleh National Taiwan University, College of Public Health, Global Health Program.

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Appendix IV

Recruitment flyers – social media versions

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Recruitment flyers – hard copy versions

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SHARE YOUR STORY

Volunteers needed for a research study on Indonesian caregiver mental health

Qualified participants are welcome to join an interview study that examines the mental health of Indonesian caregivers during the COVID-19 period in Taiwan

Participant Qualifications

- Indonesian female
- Caregiver for someone 65+ years old
- Works and lives in the home of their client
- Worked in Taiwan since December 2019
- Must be comfortable speaking and reading English **or** Bahasa Indonesian

Time, Location, and Compensation

- The interview will last around 1 hour at a location of the participant's choosing
- Each participant will be given **convenience store gift cards** as appreciation for their time contribution

Contact Information and Signing Up

- If you have any questions, please contact Juliet Balkian at r11853006@ntu.edu.tw
- **Please scan the QR code to sign up**

This study is conducted by National Taiwan University College of Public Health Global Health Program

國立臺灣大學 National Taiwan University

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Appendix V

Informed consent form – Indonesian

August 30, 2013 Passed by the 21st meeting of the Social and Behavioral Research Ethics Committee, National Taiwan University

NATIONAL TAIWAN UNIVERSITY

Komisi Etika Penelitian Sosial dan Perilaku

Persetujuan Setelah Penjelasan sebagai Peserta Penelitian

Terima kasih atas partisipasi Anda dalam penelitian ini. *Persetujuan Setelah Penjelasan sebagai Peserta Penelitian* ini berisi informasi mengenai penelitian dan hak Anda sebagai peserta penelitian. Sebelum memulai proyek penelitian, peneliti utama atau peneliti akan menjelaskan isi penelitian kepada Anda dan menjawab segala pertanyaan yang mungkin Anda miliki sebelum Anda menandatangani formulir persetujuan ini.

Judul penelitian

Chinese: 新冠疫情前後在台印尼籍居家看護之心理健康現象學研究

English: A Phenomenological Study on Indonesian In-Home Elder Caregiver Mental Health in Taiwan: Pre- and Post-COVID-19 Perspective

Indonesia: Studi Fenomenologis Kesehatan Mental Perawat Berkewarganegaraan Indonesia yang Merawat Lansia di Taiwan: Perspektif Pra- dan Pasca-COVID-19

Nama Institusi Penelitian: National Taiwan University
Sumber Pendanaan: National Taiwan University College of Public Health Global Health Program

Peneliti Utama: Juliet Balkian **Posisi**: Mahasiswa magister tahun ke-2

Peneliti Pendukung: **Posisi:**

(Apabila proyek melibatkan beberapa peneliti utama atau sub-peneliti, harap berikan informasi secara lengkap)

※**Narahubung**: Juliet Balkian **Telepon**: +886-09-6643-0147

1. Tujuan penelitian: (Jelaskan isi penelitian dengan bahasa yang dapat dipahami oleh peserta penelitian.)

Penelitian ini bertujuan untuk mempelajari kehidupan dan kesehatan mental perawat berkewarganegaraan Indonesia yang merawat lansia berkewarganegaraan Taiwan selama periode pra- hingga pasca-pandemi. Penelitian ini mendokumentasikan bagaimana perawat mendefinisikan kesehatan mental, status kesehatan mental mereka saat ini, dan pengaruh utama terhadap kesehatan mental mereka.

2. Kriteria dan batasan dalam penelitian: (Kriteria inklusi dan eksklusi untuk peserta.)

Peserta harus merupakan seorang wanita berkewarganegaraan Indonesia, bekerja penuh waktu sebagai perawat di Taiwan untuk seorang lansia yang berusia 65 tahun ke atas, dapat berkomunikasi dalam Bahasa Indonesia atau Bahasa Inggris, dan telah bekerja terus-menerus di Taiwan setidaknya sejak Desember 2019 hingga April 2023.

Kriteria pengecualian adalah apabila peserta tidak dapat berkomunikasi dalam Bahasa Inggris atau Bahasa Indonesia, bekerja di Taiwan secara ilegal, tinggal di luar rumah lansia, pernah meninggalkan Taiwan kapan pun selama pandemi (Desember 2019 hingga April 2023), beralih ke

Consent form version: 2024/01/28/Version02

doi:10.6342/NTU202501557

bidang pekerjaan lain, atau apabila peserta sedang/telah hamil dalam 4 tahun terakhir.

3. Metode dan prosedur penelitian: (Hal ini mencakup metode dan prosedur penelitian, jumlah peserta yang akan direkrut, dan jumlah waktu yang dibutuhkan dari setiap peserta penelitian.)

Penelitian ini merupakan studi fenomenologi kualitatif, dimana peserta akan diwawancara dan diberikan pertanyaan tentang pengalaman hidup mereka. Penelitian ini akan melibatkan 10 hingga 30 peserta, dan setiap wawancara akan berlangsung selama 1 jam.

Prosedur penelitian yang digunakan adalah sebagai berikut: teknik pengambilan sampel dengan metode *snowball sampling* dilakukan dengan membagikan brosur iklan dan email promosi ke Masjid Agung Taipei, One-Forty, kantor pusat Yayasan Kesejahteraan Masyarakat dan Amal Tianxiawei, dan dua panti jompo di Kabupaten Changhua (tentatif). Postingan akan dilakukan di berbagai halaman grup Facebook Indonesia dan Instagram Perhimpunan Mahasiswa Indonesia National Taiwan University. Setiap postingan dan pamflet akan ditautkan ke link GoogleForm yang menanyakan tentang kriteria keikutsertaan studi dan informasi kontak. Apabila seluruh kriteria terpenuhi, peserta akan dihubungi melalui metode kontak yang ditentukan: LINE ID, nomor ponsel, atau alamat email. Peserta akan memilih waktu dan tempat wawancara. Peneliti utama akan mengingatkan peserta mengenai waktu dan tempat wawancara yang telah terjadwal 24 jam sebelumnya melalui metode kontak yang ditentukan. Sebelum wawancara dimulai, dua salinan formulir *Persetujuan Setelah Penjelasan sebagai Peserta Penelitian* harus ditandatangani secara sukarela oleh peserta. Peneliti akan meminta persetujuan dari peserta untuk direkam dalam bentuk audio, dan persetujuan lisan peserta akan direkam secara audio. Wawancara akan melibatkan peneliti utama, peserta penelitian, dan penerjemah apabila diperlukan. Apabila pihak lain harus hadir, kehadirannya tidak dapat memengaruhi kemampuan peserta untuk memberikan jawaban yang tulus dan jujur. Idealnya, pihak lain tersebut tidak dapat memahami bahasa yang digunakan oleh peserta.

Apabila peserta lebih nyaman berkomunikasi dalam Bahasa Indonesia daripada Bahasa Inggris, seorang penerjemah akan dihadirkan selama proses wawancara. Wawancara akan direkam audio menggunakan aplikasi perekam ponsel yang aman dan kemudian akan ditranskripsi ke dalam Bahasa Inggris. Semua informasi pribadi yang dikumpulkan dan direkam akan bersifat pribadi dan rahasia. Informasi yang direkam tidak akan digunakan untuk tujuan penelitian lain. Wawancara lanjutan akan dijadwalkan apabila diperlukan. Apabila peserta ditemukan mengalami kendala dengan kesehatan mentalnya, maka peserta akan disarankan untuk mencari pertolongan pertama melalui sumber daya yang tersedia. Sumber daya tersebut antara lain berkonsultasi dengan seorang psikolog atau psikiater, menghubungi hotline konseling dan perlindungan bagi perawat asing (1955), menghubungi hotline pencegahan bunuh diri (1925), atau berbicara dengan keluarga, teman, atau pemuka agama apabila peserta merasa nyaman. Perlu dicatat bahwa peneliti tidak memiliki sertifikasi untuk memberikan konseling atau menyarankan perawatan khusus apa pun kepada peserta.

Kompensasi berupa kupon belanja senilai 200 NTD akan diberikan kepada peserta setelah setiap wawancara selesai bersamaan dengan tanda terima sebagai bukti pembayaran. Jika peserta tidak menyelesaikan wawancara, maka kompensasi tidak akan diberikan. Semua informasi pribadi peserta akan di-de-identifikasi dan dikodekan oleh peneliti utama sebelum analisis bersama dengan penerjemah. Hanya peneliti utama yang akan memiliki daftar nama dan kode yang sesuai, yang nantinya akan diubah menjadi pseudonim dalam naskah akhir. Analisis transkrip akan bersifat hermeneutik (interpretatif) dan dikelompokkan berdasarkan pemikiran dan pengalaman bersama.

4. Aturan yang harus diikuti oleh peserta serta pembatasan dan kontraindikasi terkait penelitian: (Hal ini termasuk pembatasan yang dikenakan pada peserta penelitian dan segala biaya yang mungkin perlu ditanggung oleh peserta penelitian. Mohon tandai N/A jika

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tidak berlaku.)

N/A

5. Potensi risiko dan tingkat isidensi serta langkah-langkah pencegahan:
(Mohon nyatakan hal-hal berikut: 1. Potensi risiko terhadap kesejahteraan fisik atau psikologis, privasi pribadi peserta penelitian, atau ketidaknyamanan apa pun yang mungkin terjadi; 2. Tingkat isidensi risiko tersebut; 3. Metode mitigasi risiko dan perlindungan peserta; 4. Tindakan pencegahan terhadap risiko)

Tidak ada risiko terhadap kesejahteraan fisik peserta dan risiko minimal terhadap kesejahteraan psikologis peserta. Jika peserta mengalami stres saat wawancara, maka wawancara akan dijeda hingga peserta merasa nyaman untuk melanjutkan wawancara. Wawancara tidak akan dilanjutkan dengan pertanyaan yang secara aktif menimbulkan stres bagi peserta.

6. Manfaat penelitian dan manfaat bagi peserta penelitian: (1. Manfaat ilmiah dari penelitian; 2. Manfaat bagi peserta penelitian, termasuk penggantian biaya perjalanan atau hadiah, serta cara penghitungan penggantian biaya atau hadiah bagi peserta yang mengundurkan diri lebih awal. Mohon tandai N/A jika tidak berlaku.)

Segera setelah setiap wawancara, setiap peserta akan diberikan kupon belanja senilai 200 NTD sebagai kompensasi atas kontribusi waktu dan untuk menutupi biaya transportasi peserta. Studi ini juga memberikan kesempatan kepada peserta untuk merefleksikan pengalaman mereka dalam suasana formal dan memungkinkan pengalaman, pendapat, dan kesehatan mental mereka berdampak pada kebijakan kesehatan dan lingkungan kerja perawat migran di masa depan.

7. Manfaat komersial yang dapat diperoleh dari penelitian dan kesepakatan mengenai cara penggunaannya: (Mohon tandai N/A jika tidak berlaku.)

N/A

8. Periode retensi, rencana pemanfaatan, dan kerahasiaan data penelitian: (Hal ini termasuk: 1. Periode retensi, metode retensi, dan rencana dalam memanfaatkan data penelitian; 2. Kerahasiaan informasi identitas pribadi, seperti catatan identifikasi dan informasi pribadi, dan bagaimana informasi tersebut dilindungi dan ditangani.)

Sesuai dengan hukum, peneliti utama akan menjaga kerahasiaan semua catatan identitas pribadi dan informasi pribadi peserta serta melindunginya dari pengungkapan publik. Identitas peserta akan terlindungi sepenuhnya jika hasil penelitian dipublikasikan di kemudian hari. Dengan menandatangani formulir *Persetujuan Setelah Penjelasan sebagai Peserta Penelitian* ini, peserta menyetujui apabila hasil wawancaranya dilihat oleh pemantau, auditor, anggota komisi etika penelitian, dan pihak yang berwenang, untuk memastikan bahwa prosedur penelitian dan pengelolaan data mematuhi hukum dan peraturan yang berlaku. Personel tersebut di atas berjanji untuk menjaga kerahasiaan data pribadi peserta yang akan disimpan selama lima (5) tahun setelah makalah penelitian akhir diterbitkan. Setelah kurun waktu tersebut, data penelitian akan dihapus secara permanen.

9. Kompensasi kecelakaan atau asuransi: (Hal ini termasuk pertanggungjawaban kompensasi kepada peserta penelitian yang hak hukumnya dilanggar. Mohon tandai N/A jika tidak berlaku.)

(1) Proyek penelitian ini akan dilaksanakan sesuai dengan protokol penelitian. Kecuali untuk kejadian merugikan yang dapat diperkirakan, termasuk cedera fisik saat melakukan penelitian, peneliti utama Juliet Balkian akan memberikan kompensasi atas kejadian yang merugikan atau kerusakan apa pun yang timbul dari partisipasi dalam penelitian ini.

(2) Menandatangani formulir *Persetujuan Setelah Penjelasan sebagai Peserta Penelitian* ini tidak akan memengaruhi hak hukum peserta dengan cara apa pun.

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10. Pengunduran diri dari partisipasi:

Peserta mempunyai hak untuk memutuskan apakah peserta ingin berpartisipasi dalam penelitian atau tidak, dan peserta dapat menarik diri dari penelitian dan/atau mencabut persetujuan peserta kapan saja dengan alasan apa pun tanpa konsekuensi. Penarikan diri dari penelitian tidak akan mengakibatkan timbulnya hubungan yang tidak baik antara peneliti utama dan peserta, bias dari pihak peneliti utama terhadap peserta di kemudian hari, atau hak-hak peserta dikompromikan. Jika peserta memutuskan untuk mencabut persetujuan atau menarik diri dari partisipasi dalam proyek penelitian ini, peserta dapat memberi tahu peneliti utama Juliet Balkian tentang keputusan tersebut. Peneliti utama tidak akan menganalisis data peserta (jika dikumpulkan) dan menghapus secara permanen semua informasi terkait. Apabila dipandang perlu, peneliti utama atau unit sponsor/pengawas proyek penelitian dapat menghentikan sementara proyek penelitian.

11. Hak peserta penelitian:

(1) Proyek penelitian ini telah ditinjau dan disetujui oleh National Taiwan University dan Komisi Etika Penelitian Sosial dan Perilaku, yang melakukan penilaian risiko-manfaat serta peninjauan terhadap perawatan dan perlindungan privasi peserta penelitian. Komisi beroperasi sesuai dengan peraturan yang berlaku dan merupakan organisasi peninjau yang diaudit dan disertifikasi oleh otoritas kompeten pusat. Jika peserta memiliki pertanyaan selama proses penelitian atau yakin bahwa hak-haknya mungkin telah dilanggar, peserta dapat langsung menghubungi Komisi Etika Penelitian National Taiwan University melalui telepon di (02)3366-9956 atau (02)3366-9980.

(2) Peneliti utama atau peneliti harus menjelaskan dengan jelas isi proyek penelitian ini dan informasi relevan lainnya kepada peserta dan memberi tahu peserta semua informasi yang mungkin memengaruhi kesediaan peserta untuk berpartisipasi dalam proyek penelitian ini. Jika peserta memiliki pertanyaan, jangan ragu untuk bertanya kepada peneliti, yang akan menjawab pertanyaan peserta dengan jujur.

(3) Salah satu dari dua salinan asli formulir *Persetujuan Setelah Penjelasan sebagai Peserta Penelitian* yang peserta tandatangani akan diberikan oleh peneliti utama kepada peserta untuk disimpan.

12. Tanda tangan peneliti utama atau peneliti

Peneliti utama atau peneliti telah menjelaskan secara rinci sifat dan tujuan metode penelitian yang digunakan dalam proyek penelitian ini, serta potensi risiko dan manfaat yang mungkin timbul.

Tanda tangan peneliti: _____

Tanggal: ____/____/_____ (mm/dd/yyyy)

13. Tanda tangan persetujuan dari peserta penelitian

Saya sepenuhnya memahami metode penelitian yang dijelaskan di atas serta potensi manfaat dan risikonya. Pertanyaan saya mengenai proyek penelitian ini telah terjawab dan dijelaskan secara detail. Saya setuju untuk menjadi peserta sukarela dalam proyek penelitian ini.

Tanda tangan peserta penelitian: _____

Tanggal: ____/____/_____ (mm/dd/yyyy)

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Informed consent form – English

August 30, 2013 Passed by the 21st meeting of the Social and Behavioral Research Ethics Committee, National Taiwan University

NATIONAL TAIWAN UNIVERSITY

Social and Behavioral Research Ethics Committee
Informed Consent Form for Research Participants

Thank you for participating in this study! This *Informed Consent Form for Research Participants* provides detailed information on this study and your rights. Prior to beginning the research project, the principal investigator or researchers will explain the research contents to you and answer any questions you may have before you sign this consent form.

Research project title

Chinese: 新冠疫情前後在台印尼籍居家看護之心理健康現象學研究

English: A Phenomenological Study on Indonesian In-Home Elder Caregiver Mental Health in Taiwan: Pre- and Post-COVID-19 Perspective

Name of Research Institute: National Taiwan University
Source of Funds: National Taiwan University College of Public Health Global Health Program

Principal Investigator: Juliet Balkian **Title**: Second year master's student

Sub-Investigator: **Title:**

(If the project has multiple co-principal investigators or sub-investigators, please provide their information in full.)

※**Project Contact Person**: Juliet Balkian **Tel**: +886-09-6643-0147

1. **Research objectives:** (Please explain the research contents in terms that the research participants can understand.)

The goal of this study is to investigate the lives and mental health of Indonesian in-home caregivers for Taiwanese older adults during the pre- to post-pandemic period. The study aims to document how the caregivers define mental health, their current mental health status, and the main influences on their mental health.

2. **Research participation criteria and restrictions:** (Inclusion and exclusion criteria for participants)

A participant must be an Indonesian female, she must work full-time as an in-home caregiver in Taiwan for an adult who is 65+ years old, she must be comfortable communicating in Bahasa Indonesia or English, and she must have worked continuously in Taiwan at least since December 2019 until April 2023.

Exclusion criteria are if the caregiver is not comfortable communicating in English or Bahasa Indonesia, is working here illegally, lives outside of the older adult's home, if she left Taiwan anytime during the pandemic (December 2019 until April 2023), if the caregiver has transferred to any other type of industry, or if the caregiver is/has been pregnant within the last 4 years.

Consent form version: 2024/01/29/Version02

doi:10.6342/NTU202501557

3. Research methods and procedures: (This includes research methods and procedures, the number of participants to be recruited, and the amount of time required from each research participant.)

This is a qualitative phenomenological study which means that participants will be interviewed and asked specific questions about their life experiences. This study will include 10 to 30 participants, and each interview will last for 1 hour.

The research procedure is as follows: Snowball sampling of participants will be done by distributing advertising flyers and a promotional email to Taipei Grand Mosque, One-Forty, the headquarters of the Tianxiawei Public Welfare and Charity Foundation, and possibly two Changhua County nursing homes. Posts will be made on various Indonesian Facebook group pages and the National Taiwan University Indonesian Student Association Instagram. Each post and flyer will link to a google form that asks about study inclusion criteria and contact information. If all criteria is met, contact will be made via the specified contact method: LINE ID, cellphone number, or email address. The participant will choose the time and place for the interview. The principal investigator will remind the participant of the time and place of the scheduled interview 24 hour beforehand via the specified contact method. Before the interview starts, two copies of the informed consent must be voluntarily signed by the participant. The researcher will ask for consent to audio record, and then verbal informed consent will be audio recorded. The interview will consist of the principal investigator, the participant, and the translator if needed. If another party must be present, their presence cannot affect the participant's ability to give genuine and truthful response to questions. Ideally, they should not be able to understand the language the participant responds in.

If the participant is more comfortable communicating in Bahasa Indonesia as opposed to English, a translator will be present. The interview will be audio recorded on a secure cell phone recording app and later transcribed into English. All personal information collected and recorded will be private and confidential. Recorded information will not be used for any other research purposes. If needed, follow-up interviews will be scheduled. If it is discovered that a participant is struggling with her mental health, resources will be suggested. Resources include seeing a psychologist or psychiatrist, calling the 1955 counseling and protection foreign caregiver hotline, calling the 1925 suicide prevention hotline, or talking to family, friends, or religious leaders if comfortable. It should be noted that I am not certified to provide any counseling or suggest any specific treatments myself as a researcher.

Financial compensation of a 200ntd gift card will be given after each completed interview along with a receipt for proof of payment. If a participant does not complete an interview, no financial compensation will be provided. All participant personal information will be de-identified and coded by the principal investigator before analysis with translators. Only the principal investigator will have the list of names and matching codes which will later be changed into pseudonyms in the final paper. Analysis of transcripts will be hermeneutic (interpretive) and themed by identified shared sentiments and experiences.

4. Rules that participants should follow as well as restrictions and contraindications related to the research: (This includes restrictions imposed on research participants and any costs that may need to be borne by the research participants. Please indicate N/A if not applicable.)

N/A

5. Potential risks and their incidence rate and countermeasures: (Please state the following: 1. The potential risks to research participants' physiological or psychological well-being or personal privacy or any discomfort that may be incurred; 2. The incidence rate of such risks; 3. Risk mitigation and participant protection methods; 4. Countermeasures against risks)

doi:10.6342/NTU202501557

There is no risk to participant physical wellbeing and minimal risk to participant psychological wellbeing. If a participant becomes stressed during the interview, we will take a break, and I will ask if the participant feels comfortable continuing. I will not continue to ask questions on topics that actively stress participants.

6. Research benefits and benefits for research participants: (1. Scientific benefits of the research; 2. Benefits for the research participants, including travel expense reimbursement or gifts, as well as how benefits are calculated for participants who withdraw early. Please indicate N/A if not applicable.)

Immediately after each interview, each participant will be given 200ntd gift card as compensation for their time contribution and to cover transportation costs. This study also gives participants the opportunity to reflect of their experiences in a formal setting and have their experiences, opinions, and mental health impact future policies on migrant caregiver health and work environment.

7. Commercial benefits that may be realized from the research and agreement on how they will be used: (Please indicate N/A if not applicable.)

N/A

8. Retention period, utilization plan, and confidentiality of research data: (This includes the following: 1. Retention period, retention method, and plan for utilizing research data; 2. Confidentiality of personally identifiable information such as identification records and private information and how such information is protected and handled.)

In accordance with the law, the principal investigator will maintain the confidentiality of all your personally identifiable records and private information and protect them from public disclosure. Your identity will be fully protected if the research results are published in the future. By signing this informed consent form, you are consenting to the viewing of your original records by the monitors, auditors, research ethics committee members, and the competent authorities, so as to ensure that the research procedures and data management comply with applicable laws and regulations. The aforementioned personnel pledge to maintain the confidentiality of your personal data which will be retained for 5 years after the final research paper is published. It will be permanently deleted afterwards.

9. Damage compensation or insurance: (This includes liability for compensation to research participants whose legal rights are violated. Please indicate N/A if not applicable.)

(1) This research project will be carried out in accordance with the research protocol. Except for foreseeable adverse events including sustaining physical injury while conducting research, principal investigator Juliet Balkian will provide compensation for any adverse events or damages arising from participation in this research.

(2) Signing this informed consent form will not affect your legal rights in any way.

10. Withdrawal from Participation:

You have the right to decide whether or not you wish to participate in the research, and you may withdraw from the research and/or revoke your informed consent at any time for any reason without consequences. Withdrawal from the research will not result in animosity between the principal investigator and the participant, bias on the part of the principal investigator against the participant in the future, or the rights of the participant being compromised. If you decide to revoke your consent or withdraw from participation in this research project, you may contact

doi:10.6342/NTU202501557

principal investigator Juliet Balkian and inform her of your decision. The principal investigator will not analyze your data (if collected) and permanently delete all associated information. If deemed necessary, the principal investigator or sponsoring/supervisory unit of the research project may suspend the research project.

11. Participants' rights:

(1) This research project has been reviewed and approved by the National Taiwan University Social and Behavioral Research Ethics Committee, which conducted a risk-benefit assessment as well as a review of research participant care and privacy protection. The Committee operates in accordance with the applicable regulations and is a review organization audited and certified by the central competent authority. If you have any questions during the research process or believe that your rights may have been violated or infringed upon, you may directly contact the Research Ethics Center of National Taiwan University via telephone at (02)3366-9956 or (02)3366-9980.

(2) The principal investigator or a researcher must clearly explain the contents of this research project and other relevant information to you and inform you of all information that may affect your willingness to participate. If you have any questions, please feel free to ask any of the researchers, who will answer your questions truthfully.

(3) One of the two original copies of the Consent Form that you sign will be given to you by the principal investigator for retention.

12. Signature of principal investigator or researcher

The principal investigator or a researcher has explained in detail the nature and purpose of the research methods employed in this research project, as well as the potential risks and benefits that may arise.

Signature of researcher: _____
Date: ____/____/_____ (mm/dd/yyyy)

13. Signed consent from the research participant

I fully understand the research methods described above and the potential benefits and risks involved. My questions regarding this research project have been answered and explained in detail. I agree to become a voluntary participant in this research project.

Signature of research participant: _____
Date: ____/____/_____ (mm/dd/yyyy)

doi:10.6342/NTU202501557

Appendix VI

Interview question outline

1. Demographics
    a. How old are you right now?
    b. What is your ethnicity?
    c. Are you married?
    d. Do you have children?
    e. Do you follow any religion?
    f. What is the highest level of education you have received?
    g. How long have you lived and worked in Taiwan?
    h. How many employers have you had in Taiwan?
    i. Are you currently diagnosed with any mental illnesses?
    j. How did you hear about this study?
2. Caregiver lived experience in Taiwan and COVID-19
    a. Why did you choose to come to Taiwan? Why did you choose caregiving?
    b. Is the culture in Taiwan different from Indonesia? How is it alike or different?
    c. Over the past (x) years, what has being a caregiver been like?
        i. What do you think about your job?
        ii. What are your responsibilities?
        iii. Did the pandemic change how you thought about your job?
    d. What kinds of memorable moments do you have relating to your job?
3. Discussion on mental health and COVID-19

doi:10.6342/NTU202501557

a. Have you heard the term mental health before? What does it mean to you?
    i. Does it differ from physical health?
    ii. Is there a difference between MH and MI?
b. Do you remember when you first heard it?
    i. Did you hear it mentioned during the pandemic?
    ii. Has COVID changed how you thought about MH and how you define it?
c. What affects your mental health? Positively? Negatively?
    i. Did this differ before, during, and after the pandemic?
d. Has your mental health status changed throughout COVID to now?
    i. What caused that?
e. How do you maintain your MH? How do you improve your MH when it is poor?
    i. Did COVID change these mechanisms?
f. How did you feel before the interview, and how do you feel now?
g. Do you have any questions for me or any last thing you would like to say?

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Appendix VII

Transcription and translation guide

1. There are two versions of the transcript: English and Indonesian. I will provide both to you for your own reference, though you only need to edit the English one. Both versions have time stamps, but the text is just a big wall that we need to dissect.
2. There will be a speaker key at the top of the English transcript so you know how to assign speakers: J: Juliet, V: Virly (translator), and A#: the participant (ex: A1, A6)
3. Listen to the interview audio and create speaker labels when you hear each person speaking. Correct the transcript's translated Indonesian (I will do the English). Since it was done by software, there are a ton of mistakes, and sometimes they are funny. Corrections include deleting, adding, or changing words to accurately reflect what is being said in the interview. If you cannot understand what is being said, note it like this: [unclear] . Virly will check it over.
4. If the same speaker is talking over a change in timestamping, please add a speaker label under the new timestamp. In this example, it's J

```
J: Okay. So,

39

00:19:29,240 --> 00:19:58,060

J: when she was taking care of this patient, the poor health
quality was really affecting her emotionally, yeah?
```


doi:10.6342/NTU202501557

5. Please transcribe verbatim. This means adding in stutters and filler words like “uh” or “Mmm”

```
V: and so on. So, this kind of like mislead or sometimes not uh
quite uh quite um a good understanding about Islam makes her
feel like it's not, it’s kind of like a big gap between culture
in Taiwan.
```

6. If there is a short pause, insert it with ellipses (the three dots): …

```
V: also had like blood dialysis. And...Hm And in the NTU
hospital, the situation was very bad. Like, the patient always
secreted bloods from their... um some organs, vital organs. Even
```

7. Please put in laughs or long pauses (more than 2 seconds) like this: {A4 laughs} {pause}

```
A3: I'm come back. {laughs}

J: No problem. Okay, so how many employers have you had in
Taiwan?
```

a. If someone is speaking and then laughs, just put the {laugh} in the same line.

```
V: Huh?

A3: {laughs} Oh, yes. Yes.

V: Is it true?
```


doi:10.6342/NTU202501557

b. If someone is speaking, and then someone else laughs, put the {laugh} in its own line

```
V: actually, you can eat pork here because your God is
Indonesian, not in Taiwan.

{J laughs}

V: So, it's kind of like, you know, yeah right because, but then
you have to explain to - to all the people in Taiwan that
actually, this is not true. I mean, the concept is not - is not
that bad. Yeah, and then, even sometimes, you also
```

8. If there is a longer passage of text that is multiple lines, please take out the extra spaces between lines by backspacing at the beginning of a line and then pressing the space bar. This needs to be done because the software creates individual lines of text like pressing "enter" between each one. I formatted the text as single-spaced with added space before and after paragraphs.
    a. This example shows the spacing of individual lines and then the more compact-looking spacing of the longer ones.

```
V: Do you have any older brother/sister? Or are you the only
child?

A3: I have three siblings, three younger brothers.

V: So, you are the first child?

A3: Yes, and they are all my responsibility.

V: Hmm.

A3: So, I work to support and help their education. So, I
couldn't just hang out every weekend, so as much as possible, I
saved my money for the family at
```

9. If there is abrupt choppiness in the speech, put a hyphen

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V: remember that you know as bag - as being a caregiver, she can save a lot of money and also because she is the first child. And she has like three uh younger brothers that she has to

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