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Healthcare-seeking behaviour in relation to sexual and reproductive health among Thai-born women in Sweden: a qualitative study

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ABSTRACT

Thailand is one of the most common countries of origin among immigrants in Sweden and Thai immigrants comprise the immigrant group most frequently diagnosed with HIV. Little is known about their healthcare-seeking behaviour and views on HIV prevention. This study explored Thai women's healthcare-seeking behaviour in relation to sexual and reproductive health and their views on HIV prevention. Nineteen in-depth interviews were conducted with Thai-born women in the Stockholm area. Three themes were identified: (1) poor access to healthcare in Sweden, preferring to seek care in Thailand; (2) partners playing a key role in women's access to healthcare; (3) no perceived risk of HIV, but a positive attitude towards prevention. Despite expressing sexual and reproductive healthcare needs, most women had not sought this type of care, except for the cervical cancer screening programme to which they had been invited. Identified barriers for poor access to healthcare were lack of knowledge about the healthcare system and language difficulties. To achieve 'healthcare on equal terms', programmes and interventions must meet Thai women's healthcare needs and consider what factors influence their care-seeking behaviour. Integrating HIV prevention and contraceptive counselling into the cervical screening programme might be one way to improve access.

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Thai women; migration; healthcare-seeking; sexual and reproductive health; HIV prevention; Sweden

Introduction

Ensuring equitable access to healthcare is a global challenge and one of the most important determinants of a population's health worldwide. While Sweden may have one of the healthiest populations in the world, disparities in health and healthcare use still exist (Agerholm et al. 2013; Molarius et al. 2007). According to Swedish law, the main goal of the healthcare system is good health and healthcare on equal terms for the entire population, meaning that healthcare providers should offer healthcare according to needs (SFS 1982:763). Studies have shown that socioeconomic disadvantage, unemployment and perceived

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discrimination are linked to refraining from seeking healthcare despite having needs (Ahs and Westerling 2006; Wamala et al. 2007). According to Andersen's behavioural model, gender, age, education, ethnicity, religion and marital status are some of the predisposing factors explaining the use of healthcare services (Andersen 1995). Several studies show that non-Western immigrants underutilise and inappropriately use healthcare compared with others (Diaz et al. 2015; Gerritsen et al. 2006; Norredam et al. 2004). This may be explained by language barriers, insufficient healthcare knowledge, cultural background, views on health and previous healthcare experiences (Kreps and Sparks 2008; Norredam et al. 2004; Svenberg, Matsson, and Scott 2009; Zhou, Majumdar, and Vattikonda 2016). Nevertheless, healthcare providers' knowledge, behaviour and attitudes can also contribute to unequal healthcare access (Klassen et al. 2002; Schouten, Meeuwesen, and Harmsen 2009).

Sweden is a multicultural society, and approximately 15% of the total population is foreign-born (Statistiska Centralbyrån 2014). Thailand is one of the most common countries of origin among immigrants in Sweden. Migration from Thailand to Sweden has increased threefold over the last 10 years. In 2014, around 38,100 people born in Thailand were registered in Sweden, of whom approximately 80% are women. Among those in relationships, almost 80% cohabit with/are married to a Swedish partner. Thus, Thai women differ from other women born outside of Europe: many of the latter immigrant women being married to partners from the same country of origin as their own. Women who migrate to marry men from another country comprise a growing international phenomenon, with an over-representation of south-to-north migration flows of women from southeast Asia, eastern Europe and Russia (Niedomysl, Östh, and Van Ham 2010). A recent Swedish study describes Thai women as active agents of their migration process, but despite high rates of labour participation among this group, many still face inequalities in Sweden (Webster and Haandrikman 2014). Moreover, as Thai women are migrating to Sweden as presumptive partners to a Swedish resident, they are not offered the same support from Swedish society as refugees or asylum-seekers. According to Swedish regulations, Thai women who are cohabiting with/married to a Swedish resident receive an initial two-year temporary residence permit, and if they are still cohabiting/married after this period, they may be granted permanent residence. During the first two years, the woman's main source of economic support is her partner, unlike asylum-seekers, who receive support from social services upon arrival.

HIV is also more prevalent among Thai immigrants than other migrant nationalities in Sweden (Folkhälsomyndigheten 2012). About 75% of all new HIV cases are immigrants, which is the highest percentage in Europe. More than 60% of all newly diagnosed HIV cases in 2011 were so-called late-presenters, and most of them were immigrants. Consequently, they are diagnosed at a stage when treatment is normally already being applied. Despite Thai people being the largest immigrant group with HIV diagnoses, there is no systematic HIV-prevention programme addressing the Thai population in Sweden. According to the Swedish National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases, HIV infection among asylum-seekers and their newly arrived family members should be identified within two months and within six months for other immigrant groups who have stayed in high endemic areas (Prop. 2005/06:60). This goal has not yet been achieved, and the only systematic strategy to reach it is through a health examination of asylum-seekers, a group to which Thai women do not belong. The intention of the examination is to identify infectious diseases such as HIV and TB or other health problems and to introduce asylum-seekers to the Swedish healthcare system (SOSFS 2011:11). In addition, Swedish

healthcare policy includes several screening programmes for all women, despite nationality and migrant status, such as HIV, Chlamydia and trachomatis testing for all pregnant women, and the cervical cancer screening programme for all women aged 23–60 years. Women are invited to a cervical cancer screening every third year up to the age of 50 and every fifth year thereafter. These screening programmes are provided by maternal healthcare services, which also serve women who want contraceptive counselling.

Despite the increasing number of Thai women residing in Sweden, studies of their experiences with healthcare services and care-seeking behaviour are limited. Our own study, a postal questionnaire based on 804 Thai women, showed that only 25% had been HIV-tested in Sweden and that most had poor knowledge of where to turn if they needed contraceptive counselling or HIV testing (Åkerman et al. 2015). A qualitative study may help us understand the low uptake of HIV testing and how HIV prevention can be made more available to Thai-born women. The aim of this study was therefore to explore Thai women's healthcare-seeking behaviour in relation to sexual and reproductive health and their views on HIV prevention. We define sexual and reproductive healthcare as knowledge, access and use of contraceptive counselling and HIV prevention.

Methods

Study design

A qualitative approach with in-depth interviews was used to capture the depth of participants' understanding and perceptions (Dahlgren et al. 2007). In-depth interviews are particularly useful for exploring potentially sensitive areas regarding behaviour and perceptions.

Study setting and data collection

The study was conducted in Stockholm County, which consists of 26 municipalities with a total population of approximately 2.2 million people, of whom 23% are foreign-born.

Data were collected between May to September 2014. In total, 19 women were interviewed, 17 individually and 2 in a paired interview, as requested by these two women. Data collection continued until saturation was reached, meaning that no new information emerged in the last few interviews (Flick 2009). Purposive sampling was used to recruit newly arrived Thai-born women with various backgrounds regarding age and education and who lived in different parts of the Stockholm area. The inclusion criteria were: (1) over 18 years of age; (2) no older than 50; and (3) having lived in Sweden for less than five years. The women were recruited at different Swedish language schools for immigrants (n = 11), workplaces (n = 7) and one by a key person (i.e., a Thai woman who had lived in Sweden for over 10 years suggested the first author [EÅ] contact a newly arrived Thai woman). The reason for recruiting from Swedish language schools was the possibility of reaching newly arrived Thai women. A letter about the study in Swedish and Thai was sent to teachers and principals at several Swedish language schools located in different parts of the Stockholm area. They were asked to inform their Thai students about the study. Most of the schools invited EÅ to visit the classrooms to inform Thai students about the study.

A time for interviews was subsequently set with each interested participant; a total of 10 participants were recruited through classrooms. In cases where EÅ was not invited to visit the classroom, only one participant contacted EÅ by email to indicate her interest in participating; an interview appointment was then arranged with this participant. However, to include Thai women from various backgrounds, EÅ visited several workplaces that potentially had Thai employees, such as a Thai restaurant and Thai massage centres, located in different parts of Stockholm. When visiting these workplaces, EÅ informed potential participants about the study and asked if they were willing to participate. Those who declined to participate, mostly from the massage centres, said they were not interested or gave lack of time as a reason for not participating. However, most employees at the Thai restaurant did not meet the inclusion criteria, as they had been living in Sweden for more than five years. Recruitment through workplaces resulted in one participant from a Thai restaurant and six participants from four different Thai massage centres. The women did not receive any compensation for participating.

The interviews were conducted in Thai by the first author and were held in a place that ensured privacy and was convenient for the participants. A semi-structured interview guide with open-ended questions was used, and follow-up questions were asked when needed. Topics included in the interview guide were: social relationships/networks, views and perceptions of health and diseases, experiences with healthcare and reproductive healthcare, thoughts on HIV prevention and sources of health information and healthcare. All interviews were audio-recorded with the participants' permission, lasted between 45 and 60 minutes and were transcribed verbatim. Three participants were interviewed twice to further clarify their answers and deepen the discussion of certain topics. The first author transcribed all the interviews.

All interviews were conducted by EÅ, a female doctoral student with a master's degree in public health. She had been trained in qualitative methods and interviewing techniques as part of her public health studies, and also during previous work as a research assistant. She is a Swedish citizen and has been living in the country since she was 10 years old. She speaks fluent Swedish and Thai; her father is Swedish and her mother is Thai.

Participants

The women were between 24 and 50 years old with a mean age of 34 years. The most common reason for immigration was a relationship with a Swedish partner ($n = 18$ women). Most had lived in Sweden for about three to four years. One woman was illiterate, 5 women had completed primary school, 10 had completed secondary school and 3 had completed higher education. Demographic data are presented in Table 1.

Data analysis

Thematic analysis as described by Braun and Clarke (2006) guided the data analysis. Transcribing and analysis started in the early phase of data collection in order to develop additional questions or probes to be included in subsequent interviews. After data collection, EÅ listened to all recordings repeatedly and read all transcripts several times to obtain an overall picture of the data, and notes were made on the texts for coding ideas. Initially, the entire dataset was manually coded with the notes on the text and then organised into Tables

Table 1. Characteristics of women in the study ($n = 19$).

Factor	
Age (years)	*N*
Range	24–50
Mean (SD)	34
18–29	5
30–39	9
40 or older	5
Education level	
No education/illiterate	1
Primary school (1–9 years)	5
Secondary school (10–12 years)	10
University (more than 12 years)	3
Immigration year	
2012–2013	7
2011–2010	10
2009	2
Marital status	
Married/cohabiting	17
Living apart	1
Divorced/separated	1
Have children?	
No	10
Yes	9
Children living in Sweden	3
Children living in Sweden and Thailand	2
Children living in Thailand	4
Current occupation	
Language studies	9
Language studies and paid employment	3
Paid employment	7
Religion	
Buddhist	18
Christian	1

based on the topics from the interview guide. From this phase, the codes were reviewed and codes with similar meanings were grouped into working themes using mind-maps. To triangulate the analysis and increase the objectivity of the interview interpretations, the last author (EL) independently analysed more than half of the interviews; EÅ and EL compared and discussed their analyses several times until consensus was reached. To enhance the rigour of the analysis, the working themes were also reflected on and discussed with the other co-authors. Throughout the analysis process, codes and themes were constantly reviewed and refined to ensure they reflected the dataset.

Ethics

Ethics approval was obtained from the Regional Ethical Review Board of Uppsala, Sweden (registration number 2014/077). Informed consent was provided by all women before their participation. All participants received information explaining the purpose of the study and were informed that participation was voluntary and they could decline to participate at any time. They were also informed that their answers would remain confidential and that all identifying variables would be deleted. All women agreed to have the interviews audio-recorded.

Theoretical framework

Andersen's behavioural model of health services utilisation provided the theoretical framework for discussion in this study (Andersen 1995). The model has been widely used to predict health services utilisation for the past 40 years. This model views access to healthcare services as a result of decisions made by an individual constrained by their position in society and the availability of healthcare services. According to the model, healthcare utilisation depends on the interaction between individual behaviours, population characteristics and the surrounding environment, including the healthcare system. The model contains three features useful for explaining an individual's use of healthcare services: predisposing characteristics, enabling factors and the need for a healthcare service. Predisposing characteristics are divided into demographic elements and social structure and consist of: age, gender, residence, ethnicity, education, occupation, marital status, religion and attitudes toward health. Enabling factors include: personal, family and community resources, such as income, health insurance, social support and factors affecting the ability to use these resources. Need for healthcare service includes: perceived health status, illness and expected outcome of treatment.

Results

Three themes were identified during the data analysis: poor access to healthcare in Sweden, preferring to seek care in Thailand; partners playing a key role in women's access to healthcare; no perceived risk of HIV, but positive attitude towards HIV prevention. Each of these themes is described below. The names given for each quotation below are pseudonyms to maintain confidentiality.

Poor access to healthcare in Sweden, preferring to seek care in Thailand

Almost half of the women had no experience of seeking healthcare in Sweden, with the exception of a cervical cancer screening to which they had been invited via a letter. The majority of the women had undergone the cervical cancer screening, and all appreciated it feeling that they had been treated well by the medical staff:

> As soon as I arrived in Sweden, I received an invitation letter. They are so friendly. It is a very good offer. (Dao, 44 years old)

Many of the women were only vaguely aware of the existence of Swedish maternal healthcare and its purpose, even though the majority had attended the cervical cancer screening. Only those who had given birth in Sweden (two women) had any idea that they had been in contact with maternal healthcare.

Among the women who had sought healthcare in Sweden, the reasons were mainly for acute ailments via primary healthcare centres or emergency departments. The main reason for seeking acute care was for symptoms related to coughs, fever, stomach upsets and so on. Several women had refrained from seeking care in Sweden despite articulating healthcare needs. Lack of knowledge about the Swedish healthcare system and insufficient knowledge of the Swedish language, which complicated communication with medical staff, were the major reasons for refraining from seeking care. Despite insufficient knowledge of the Swedish language, most of the women had never been offered an interpreter during contact with

healthcare services and consequently did not always understand what happened during the consultation.

The women said that as a consequence of not being able to benefit from healthcare services in Sweden, those who visited Thailand sought care during their visit or planned to visit a doctor when they were there for vacation:

> Since I do not know the language it is much more difficult for me to make an appointment. It is much easier for me in Thailand. … It is not that I am shy of the doctor, but I know that I do not understand everything they say. But with the doctor in Thailand, I am not limited in any way when expressing myself and I can ask any questions I want. (Wimon, 35 years old)

Some women did not feel they had any special healthcare needs, but took the opportunity to undergo or planned for a health examination in Thailand while they were there anyway. Undergoing a health examination was said to be on preventive grounds: in case any disease was discovered, there would be time to prevent and treat it. One woman sought healthcare in Thailand in order to get a second opinion, because she was unsure whether she had understood the Swedish doctor's advice.

Another type of healthcare contact in Thailand among the women was to obtain medicines such as contraceptives. Most women brought with them contraceptives from Thailand and when they ran out, some continued to buy contraceptives from Thailand instead of establishing contact with Swedish healthcare services. Others stopped using them when they ran out, despite not wanting to become pregnant. Most women were unsure about where to turn if they needed to use contraceptives. Only a few women had been in contact with Swedish healthcare services to obtain contraceptives and they thought that access to contraceptives was more complicated in Sweden than in Thailand. Some women had also bought contraceptives for Thai-born friends in Sweden while visiting Thailand:

> … my friend says that it takes almost an entire day to see a doctor, so she prefers to work instead and earn SEK 700–900. This is a waste of time. When you are in Thailand, you can buy pills lasting for a whole year … (Wimon, 35 years old)

Partners playing a key role in women's access to healthcare

It was clear that the women's partners play a prominent and key role in the women's access to healthcare services in Sweden. When in need of help for various health problems, most of the women consulted their partner first. Also, many women who had been in contact with healthcare services had been assisted by their partner, who booked an appointment or accompanied the woman to the clinic:

> He arranges everything. The first time, it was a call for the gynaecological examination [cervical screening] and the person who examined me asked me if I was using a contraceptive. And we, me and my partner, discussed it, and then he booked a time for me. He drove me there too. My Swedish language is not too good yet. (Mae, 34 years old)

For some women, the partner had also acted as interpreter, despite the fact that the partner was not able to speak Thai. One woman described how she could not really explain what type of contraceptive she wanted and was therefore recommended to use contraceptive pills even though she preferred injections instead. Another woman was particularly frustrated with Thai women's dependence on their partners and the lack of interpreter when visiting healthcare services:

> Thai women usually get help from their men to find their way around. Women whose partners have retired may perhaps get help a little more often, but it does not need to be so. What if my partner dies one day, what will I do? How would it be for me, since I am not very good at speaking or writing in Swedish? It is a big problem when visiting the healthcare service because you do not get an interpreter. (Noi, 42 years old)

Several women reported cases where they had refrained from or delayed seeking care while waiting for their partner's assistance. This was the reason why two women refrained from participating in cervical cancer screening: one because her partner was unable to accompany her, and the other because she did not understand the invitation letter and, according to her partner, it was a call for a general health examination and if she was not ready to do it, it did not matter.

Five of the women wanted to become pregnant, and each of them had tried for more than a year. Despite their wish to become pregnant, none of them had sought care, and they had delayed seeking care while waiting for their partner's support:

> I am 42 years old and soon turning 43. I would at least like to have one child that I can have as a friend. I have talked about this with my partner and he said to me, 'Let's get back from Thailand first'. But I do not know if it's possible for me to have children. If I do not get pregnant, I want to see a doctor and get counselling. (Vipada, 42 years old)

When asked where they had sought or where they would seek health information and information about Swedish healthcare, most women said that they would ask their partner to look for this information. A few women reported trying to find health information on the Internet:

> I will then have to ask my partner and then he will search on the Internet. … If I have a stomach ache and do not know why, he will check on the Internet and read it for me and explain it to me. (Anchali, 24 years old)

The women were also asked where they would go if they wished to be tested for HIV or other infectious diseases. Even here, most women said they would turn to their partner first. Although the majority turned to their partner concerning health information and contact with healthcare services, some women said that their partner did not always have the necessary knowledge about health and healthcare services. Some women said that they preferred to turn to their Thai friends in Sweden when seeking information about contraceptives and other issues related to women's health:

> When it comes to contraceptives, my partner knows nothing about that. He has no knowledge of issues related to women's health. (Choi, 24 years old)

In addition to their partner, the partner's family, such as the mother-in-law or a sister, was important for some women in accessing contraceptives in Sweden. In cases (two women) where there was no partner, the women reported consulting with Thai relatives in Sweden.

No perceived risk of HIV, but positive attitude towards prevention

When discussing general concerns about health, cancer was the disease that worried most of the women. Few women were concerned about becoming infected with HIV or other infectious diseases. The women did not perceive themselves as at risk of HIV because they had knowledge about the infection and how to protect themselves from it. Their perceptions of HIV-related risks were linked to drinking alcohol and partying; several women said that

they were in a stable relationship and did not go out partying, and that they were therefore not at risk:

> No, nowadays I am not afraid of HIV because the friends I choose to hang out with are not 'sleeping around' with other men. The friends I choose to socialise with have a stable relationship with a partner and children. (Lek, 25 years old)

Living in Sweden was another reason for not being at risk of HIV. Women perceived HIV as uncommon in Sweden, and the women explained that since Swedish people in general have more knowledge of how to protect themselves compared to people in Thailand, this was not an issue:

> HIV is a disease which is widespread and extensive, and Sweden is a country with 'free sex', but mostly people in Sweden use condoms and therefore the threat feels remote as one can protect oneself from the disease. I do not think many people care so much about HIV and contraceptives because Swedes use condoms. Therefore, the disease is not so relevant to me. These kinds of issues need to be addressed more in Thailand. (Malee, 25 years old)

However, not all women shared the view that HIV was not something to worry about. Some women saw a possible increased risk of HIV due to the partner's risk of becoming infected by others and then infecting her. One woman was primarily concerned about her partner becoming infected by others as a possible consequence of her not wanting to have sexual intercourse with him. Several women mentioned that it is possible today to live with HIV because of effective HIV medicines:

> Nowadays, one is not so concerned about HIV because there are effective medicines that stop the development of the infection. Many people live with HIV today, but the disease is not as scary as cancer. If you get cancer you cannot expect to live much longer. If you ask me what disease I am most concerned about, HIV or cancer, I am much more worried about getting cancer because there are medicines for HIV. (Malee, 25 years old)

Except for two women who had been pregnant in Sweden, none had been offered HIV testing or undergone an HIV test in Sweden. However, the two women were not sure which samples had been taken from them during their pregnancy. Several women had been HIV-tested when they lived in Thailand. Only a few women knew where to go if they wished to be HIV-tested in Sweden. Some women said that they would like to have an HIV test in Sweden and that they would ask their partner to schedule an appointment for one. HIV testing was irrelevant for some of them and, as one said:

> AIDS, they have never checked for that. I have never worried about it, or do you have to get tested for it? (Sirirat, 44 years old)

All women were asked whether Thai-born women in Sweden should be offered an HIV test or other testing to identify infectious diseases. They all had a positive attitude toward HIV testing if they were offered the opportunity. None of the women expressed any stigma attached to HIV testing. Some claimed that it was unfair that Thai immigrants are not offered the health examination that asylum-seekers receive. The women stated that a health examination including testing for HIV or other sexually transmitted infections is a good strategy for identifying infectious diseases and stopping their spread:

> I think it's good. It may help one become better at protecting oneself and some may never have been tested for infectious diseases. I also think it's good because it can stop the spread of infectious diseases. (Dok, 33 years old)

Moreover, the women were positive toward receiving information about where to go to be HIV-tested in Sweden, as well as where to get contraceptive counselling. A common view

among the women was that the information should come from healthcare providers and that information should be communicated by regular mail and/or Facebook.

Discussion

This study explored the healthcare seeking behaviour in relation to sexual and reproductive health of Thai-born women who have recently arrived in Sweden, and their views on HIV prevention. Despite the fact that the women expressed sexual and reproductive healthcare needs, most had not sought this kind of care in Sweden. However, most women had attended the cervical cancer screening programme to which they had been invited. None of the women, except those who had been pregnant in Sweden, had undergone HIV testing in Sweden. The women did not perceive themselves as at risk of HIV or in need of HIV testing, but they expressed positive attitudes towards taking part in HIV-prevention interventions if provided. Barriers to accessing healthcare services in Sweden were identified as: communication difficulties and insufficient knowledge about the healthcare system, which in turn contributed to the respondents' dependence on their partners when seeking healthcare in Sweden and the decision to seek care in Thailand instead.

Study findings highlight the complex interrelation between individual, societal and environmental factors that influence the participants' care seeking behaviour and whether to use healthcare or not. The theme 'Poor access to healthcare in Sweden, preferring to seek care in Thailand' exemplified the importance of the external environment for accessing healthcare, as described in Andersen's behaviour model (Andersen 1995). This theme describes very different healthcare seeking behaviour of Thai migrant women in a Swedish versus a Thai context. Furthermore, the strategic action to seek care in Thailand illustrates Thai women's shift in agency when moving from Thailand to Sweden. The phenomenon of immigrants seeking healthcare in other countries as a consequence of not being able to benefit from the healthcare services in the country in which they live has been found among Somali immigrants in Sweden (Svenberg 2011).

Furthermore, this study reveals the importance of family support for Thai women's access to healthcare in Sweden. The theme 'Partners playing a key role in women's access to healthcare' highlights the importance of enabling factors (e.g., family and community resources) as described by Andersen (1995). Women describe how their partners often facilitated contact with healthcare services in Sweden by providing health information, booking appointments, acting as interpreter and providing transportation. This finding further confirms some of the mechanisms that explain the association between social capital and health outcomes: namely, that social relationships provide channels for the distribution of knowledge and information (Kawachi and Berkman 2000), and thus heterogeneous relationships enhance access to external resources (Putnam 2000). However, the results of our study also showed the opposite: while waiting for a partner's support and assistance, several women refrained from or delayed seeking healthcare in Sweden. For example, despite the fact that the women spoke about reproductive healthcare needs, such as issues concerning infertility, they had not sought this kind of care in Sweden.

In line with this finding, previous research has shown that women of non-Swedish origin in Sweden are more likely to refrain from seeking care than Swedish-born citizens, despite the perceived need to do so (Westin et al. 2004). Andersen (1995) also identifies gender and ethnicity as predisposing characteristics of healthcare use. Furthermore, being dependent

on one's partner when seeking healthcare, combined with the fact that men generally seek healthcare later than women (Socialstyrelsen 2004), may mean that Thai women wait even longer before receiving healthcare. The partners' prominent role in women's access to healthcare points to a power imbalance between the women and their partners. This could be problematic for women in destructive relationships in combination with the fact that newly arrived Thai women receive less support from Swedish society, as revealed in our literature review.

An important finding related to women's perceived communication difficulties with healthcare professionals was that most of the women had never been offered an interpreter in their contact with healthcare services, even though one should always be provided for patients who do not speak Swedish (SFS 1986:223). One example of communication problems was that even though most of the women had experienced maternal healthcare through the cervical cancer screening programme, they had only a vague understanding of the existence of maternal healthcare and its purpose. Previous research has pointed to the issue of communication difficulties between immigrant patients and healthcare professionals (Wearn et al. 2007; Wiking et al. 2009).

Furthermore, communication difficulties can complicate correct diagnosing and lead to an underestimation of the severity of health problems. For patients, this may mean unmet healthcare needs and general dissatisfaction, which can in turn result in refraining from seeking care despite having needs (Wamala et al. 2007; Westin et al. 2004) and consequently going undiagnosed and untreated. In the worst cases, previous research has shown an association between miscommunication, delay in seeking healthcare and perinatal and maternal deaths in Sweden among immigrant mothers from the Horn of Africa (Esscher et al. 2014; Essén et al. 2002). Thai women are perhaps expected by Swedish society to have high social capital because most of them live with a Swedish partner. This may also explain why most women in our study were not offered an interpreter during contact with the healthcare service. Research has shown that factors such as knowledge and attitudes, cultural competence and prejudice on the part of healthcare providers influence ethnic disparities in healthcare (Burgess, Fu, and van Ryn 2004). Training in cultural competence has been identified as a key target for improving patient trust and reducing health disparities (Braveman 2003). More research is needed on healthcare professionals' knowledge of and attitudes toward Thai women in order to understand their reasoning when they meet Thai patients.

The women in this study did not perceive themselves as at risk of HIV or in need of HIV testing, as they identify themselves as not having high-risk behaviour. This perception may explain the result from our quantitative study in which only one quarter of Thai women have been tested for HIV (Åkerman et al. 2015). According to Andersen's model, perceived need factors play a significant role in an individual's decision to use healthcare. Thus, to increase HIV testing among Thai women, they must first feel the need to be tested. Previous research has shown that the low uptake of HIV testing is linked to perceived low risk of HIV infection (Musheke et al. 2013). The women in this study did not appear to be afraid of being infected with HIV; instead, they stated cancer as being the most life-threatening illness. This finding may differ from earlier research where negative attitudes and fear of stigma were identified as barriers to accessing HIV-related services (Zhou, Majumdar, and Vattikonda 2016). However, since many of the respondents had attended the cervical cancer screening programme, integrating HIV testing and contraceptive counselling into this programme might be one possible strategy to reach Thai women with HIV testing. On the other hand, this strategy

would exclude women who do not attend the screening. To improve the availability of HIV testing to all Thai immigrants in Sweden, like asylum-seekers, they could be offered a free health examination. By excluding Thai immigrants, there is a risk of hidden cases of HIV and therefore the risk that women are unable to access treatment at an early stage. Nevertheless, to achieve the goal of 'healthcare on equal terms', future interventions must also meet Thai women's actual healthcare needs, and the various factors that influence their healthcare-seeking behaviours must be taken into account.

Strengths and limitations

The main strength of this study was that we did not use an interpreter, either to communicate with the respondents or for the transcription process. Since the first author spoke the same language as the respondents, she interviewed the women herself and prepared all the transcripts. Therefore, there was a reduced risk of any misunderstanding of the context or of information being lost in the interview and transcription process (Pitchforth and van Teijlingen 2005; Temple 2002), which in turn increases reliability. On the other hand, having the knowledge of language and culture might also affect the first author's interpretation of the data. However, this risk may be reduced by the fact that the author has lived in Sweden for 25 years and grew up in a Swedish context. Another strength was that the interviewer was female, since the women may have been reluctant to discuss subjects related to sexual and reproductive rights with a male interviewer. A further strength of the study was that repeated interviews were conducted when needed in order to clarify issues and gain a better understanding of certain topics. The high agreement in women's perceptions and experiences points to the validity of our data.

As this is a qualitative study based on in-depth interviews with newly arrived Thai women living in the Stockholm area, the results should not be taken as representative of all Thai women in Sweden. One possible limitation of the study concerns the predominance of highly educated women in the sample. The women in our study had a higher level of education than average Thai people in Sweden (Stockholms universitet 2013), and this must be taken into account in interpreting the findings. It is important to note also that the findings of this study apply to newly arrived Thai women. Thai women living longer than five years in Sweden may have greater access to healthcare since they probably have better language skills and are more familiar with the health system compared to newly arrived Thai women. Furthermore, women living in rural areas, such as northern Sweden, may have even less access than others to healthcare services due to the challenge of there being longer distances to travel in order to access these services.

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