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# Knowledge, attitudes, and beliefs regarding cervical cancer and screening and perceived barriers to cervical cancer screening programs among Thai immigrant women living in Germany

Unchalee Ice

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**KNOWLEDGE, ATTITUDES, AND BELIEFS REGARDING CERVICAL  
CANCER AND SCREENING AND PERCEIVED BARRIERS TO CERVICAL  
CANCER SCREENING PROGRAMS AMONG THAI IMMIGRANT WOMEN  
LIVING IN GERMANY**

**by**

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DISSERTATION

Submitted in Partial Fulfillment of the  
Requirements for the Degree of  
**Doctor of Philosophy**  
**Nursing**

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Albuquerque, New Mexico

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## **DEDICATION**

I dedicate this professional endeavor to the Thai women participants of this study, for without their willingness to share a cultural piece of their lives, this study would not have been possible.

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**ABSTRACT**

Since the introduction of national cervical cancer screening in the 1960s, the mortality rates for cervical cancer have decreased significantly in most Western European nations. The countries of the European Union (EU) employ both opportunistic and organized screening programs for cervical cancer using Papanicolaou (Pap) smears as the method of screening. However, data from 2000 showed that Germany, an EU member, had a considerably higher incidence of cervical cancer mortality than did the EU. Study findings in the United States, Australia, and Thailand indicated that participation of Thai women was suboptimal. The extent to which those findings apply to Thai women in other countries is not known. The purpose of this focused ethnographic study was to determine the knowledge and attitudes about cervical cancer among Thai women living in Germany, their health beliefs and practices regarding cervical cancer, their cervical cancer screening practices, and the barriers to participation in cervical cancer screening. The Health Belief

Model provided the theoretical guidance for the development of the research questions and the interview guide that was used in the interviews. Data were collected via semistructured interviews with 30 Thai immigrant women and 2 practicing German health care providers. Data were analyzed inductively through the process of immersion and crystallization. Key findings indicated that all participants had heard about cervical cancer screening and described their knowledge of cervical cancer based on personal, traditional, and clinical knowledge. Participants integrated both traditional and modern health beliefs and practices, which influenced their cervical cancer screening practices. Participants offered an array of cervical cancer prevention practices, including having a yearly Pap test. Personal, cultural, and health care system barriers were identified. Age, levels of education, and socioeconomic status did not seem to be factors in participating in screening, whereas having health insurance seemed to increase the likelihood of participation. The findings of this study may assist German health care providers in gaining insight and a more in-depth understanding of the cultural implications and barriers that may prevent Thai women from seeking early screening, thus, having a direct impact on immigrant Thai women's preventative health.



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## **CHAPTER 1**

### **INTRODUCTION**

The components of Chapter 1 are as follows: (a) the background for this research; (b) statement of the problem; (c) purpose of the study; (c) significance of the study; (d) the research questions and definition of terms; and (d) a chapter summary.

#### **Background**

##### **Cervical Cancer**

Cervical cancer remains an important health challenge at the national and global levels. It is the second most commonly diagnosed cancer (Cervical Cancer Action [CCA], 2012; Michels & zur Hausen, 2009) and the leading cause of death from cancer among women in most developing countries (CCA, 2012). According to the CCA, approximately 500,000 new cases of cervical cancer are diagnosed each year, leading to 275,000 deaths from the disease around the world (CCA, 2012). More than 80% of these cases occur among women in developing countries, with the highest incidence rates in Central and South America, the Caribbean, Sub-Saharan Africa, and Southern Asia. It is projected that by 2030, approximately 474,000 women will die from cervical cancer each year and more than 95% of those cancer deaths will be in low- and middle-income countries. In addition, the cervical cancer incidence rates are expected to double in Sub-Saharan Africa by 2030 (CCA, 2012). Cervical cancer comprises approximately 15% of female cancers in the developing world compared with 3.6% in developed countries (Gakidou, Nordhagen, & Obermeyer, 2008). Cervical cancer is the major cause of death among women in developing, countries, including Thailand, Vietnam, and Cambodia, primarily

due to the lack of access to early screening (Kritcharen, Suwan & Jirojwong, 2005).

Despite this fact, current health care efforts have been ineffective in reducing the mortality rates in these settings primarily because of the lack of effective resources and screening (American Cancer Society [ACS], 2008; CCA, 2012; World Health Organization [WHO], 2009a).

### **Cervical Cancer Incidence in the United States**

In the United States, an estimated 12,170 women will be diagnosed with invasive cervical cancer, and 4,220 women are projected to die from the disease in 2012 (ACS, 2012). Among women in the United States, Hispanic women have the highest incidence rate of cervical cancer, followed by African American, White, American Indian/Alaska native, and Asian American/Pacific Islander women. However, African American women have the highest mortality rates. The overall cervical cancer death rate has declined by nearly 70% over the last several decades. The main reason for this change is attributed to prevention and early detection due to the increased use of Papanicolaou (Pap) smear screening (ACS, 2012).

Healthy People 2010 included the objectives that 97% of women aged 18 years and older should have received a Pap test in their lifetime and 90% of eligible women should have received Pap tests within the previous 3 years (U.S. Department of Health and Human Services [USDHHS], 2000). However, researchers with the Centers for Disease Control and Prevention (CDC, 2012) indicated that the percentage of American women receiving recommended screening for cervical cancer did not meet the Healthy People 2010 objectives, with a screening rate of 83.0% (below the Healthy People 2020 target of 93.0%; USDHHS, 2011b). In addition, recommended screening rates for breast

cancer, cervical cancer, and colorectal cancer were markedly lower among Asians than among Whites and African Americans. Hispanics were less likely to undergo screening for cervical and colorectal cancer (CDC, 2012).

Healthy People 2020 was released in December 2010, highlighting objectives for health promotion and disease prevention. One of these areas involves cancer (there are 20 cancer objectives), and the Healthy People goal is to reduce the number of new cancer cases as well as disability and death caused by cancer. The Healthy People 2020 objective for cervical cancer is to reduce the death rate from a 2007 baseline of 2.4 deaths per 100,000 women (age adjusted to the year 2000 standard population) to the target rate of 2.2 deaths per 100,000 women (10% reduction in death rates; USDHHS, 2011b)

According to the ACS (2012) cervical cancer screening guidelines, a woman should start receiving regular Pap tests at the age of 21. If the Pap test results are normal, the Pap tests can be done less often, according to the judgment of the health care provider. Women aged 21 to 29 years should be screened for cervical cancer with a Pap test at least every 3 years, regardless of sexual activity. Women aged 30 to 65 years may choose to have a human papillomavirus (HPV) test in addition to the Pap test (co-testing) every 5 years or the Pap test alone every 3 years. Following adequate negative prior screening, women older than age 65 may not need to have a Pap test, according to the judgment of the health care provider. In the United States, there is no centralized government program for cervical cancer screening; however, numerous government programs and agencies provide funding. Additionally, the U.S. Preventive Services Task Force and health professions societies publish guidelines for screening programs.

In spite of the recognized benefits of Pap smear screening, not all American women participate in this cancer screening. According to the ACS (2008, 2012), slightly more than 80% of women had undergone Pap tests in the previous 3 years. However, Asian American women, women without health insurance, and women with low levels of income and education were less likely to undergo a routine Pap screening than non-Hispanic, White women (ACS, 2008; CDC, 2012; Fang, Ma, & Tan, 2011). Data show that overall cancer incidence and death rates are lower in other racial and ethnic groups than in Whites and African Americans; however, minority and ethnic groups have higher incidence rates for stomach, liver, and cervical cancer than do Whites (ACS, 2008; Jemal et al., 2006). According to data from the 2000 National Health Interview Survey (Alba, Hubbell, McMullin, Sweningson, & Saitz, 2005), women who immigrated to the United States within the previous 10 years were less likely to be screened for breast, cervical, and colorectal cancers than any other population groups, including the uninsured. Moreover, in the same study, only 61% of recent immigrants reported having Pap tests in the previous 3 years compared with 83% of women born in the United States (Alba et al., 2005).

Other countries, such as Canada, reported similar findings, including the importance of foreign birthplace as a barrier to cancer screening. Analysis of population health surveys in Canada indicated that the participation rate of cervical cancer screening among Asian immigrant women remained markedly lower than the native-born Canadian level, even after many years of living in Canada (McDonald & Kennedy, 2007). In addition, both Asian immigrant women who arrived as children (first generation) and second-generation Asian Canadians received significantly lower rates of Pap smear

screening than Canadian-born White women (Lofters, Glazier, Agha, Creatore, & Moineddin, 2007; McDonald & Kennedy, 2007).

According to Ackerson and Gretebeck (2007), sexually active women are at risk for developing abnormal cell changes of the cervix (cervical dysplasia) resulting from skin contact from a partner who is infected with HPV during a sexual encounter. The primary factor in the development of cervical cancer is the persistence of HPV infection (Mittendorf, Petry, Iftner, Greiner, & von der Schulenburg, 2003). Clinical studies indicated that infection with certain types of HPV is the major risk factor for cervical cancer (ACS, 2008; CDC, 2009; Likes & Itano, 2003; Namkoong, 1995; WHO, 2009b). Mittendorf et al. (2003) stated that “WHO officially designated the high-risk HPV types 16 and 18 as carcinogenic agents” (p. 209). In addition, WHO has recognized the significant impact of cervical cancer and other HPV-related diseases on global public health concerns and recommended that the provision of routine HPV vaccination needed to be included in the national immunization programs and policies (WHO, 2009c).

Since 1980, the incidence of both HPV and cervical cancer has been increasing, as HPV infection is one of the most common sexually transmitted diseases (CDC-Division of Sexually Transmitted Disease Prevention, 2007). Other factors associated with an increased risk of women’s exposure to high-risk types of HPV and development of cervical cancer include multiple sexual partners, sexual intercourse at early age, the sexual behaviors of a woman’s partner, immunosuppression, oral contraceptive use, multiple pregnancies, low socioeconomic status, diethylstilbestrol use, smoking, and family history of cervical cancer (ACS, 2008; Gericke & Busse, 2004). Researchers found

that among sexually active female university students, at least 50% had been infected with one or more types of HPV (Winer et al., 2003).

Klug, Hukelmann, and Blettner (2008) performed a systematic review of 39 published studies conducted between 1992 and 2006, with a total sample of 19,986 participants, to ascertain knowledge about HPV infection and HPV as a risk factor for cervical cancer. The authors concluded that the overall knowledge of the general public regarding HPV infection was poor. In this review, nine studies addressed the knowledge of U.S. physicians, nurses, and teachers of health courses in middle and high schools regarding the association between HPV infections and cervical cancer. The findings indicated that physicians had more knowledge about HPV infection (82%-100%) than nurses and teachers. Only 50% of teachers and nurses agreed that HPV was found in the cervixes of most women with cervical cancer, and 33% did not know that most women infected with HPV would develop cervical cancer (Klug et al., 2008).

### **Cervical Cancer Incidence in Thailand**

Cancer is the leading cause of death in Thailand. The most common cancers in Thailand include colon, lung, liver, breast, and cervix (Sriplung, Sontipong, & Martin, 2005; Thai Cancer Base National Cancer Institute, 2008). Although the incidence rates are stable, the number of newly diagnosed cases of cervical cancer is increasing. In 2008, more than 8,000 women were projected to be diagnosed with cervical cancer in Thailand (Sriplung, Wiangnon, Sontipong, Sumitsanan, & Martin, 2006). The overall age-standardized incidence rate of cervical cancer is relatively high in Thailand (19.8 per 100,000) compared with the other developing countries in Southeast Asia (18.7 per 100,000) and world incidence rate (16.2 per 100,000; Thai Gynecologic Cancer Society,

2006; WHO Thailand, 2007). Cervical cancer ranked as the number one cause of death from cancer among Thai women (Kritchairoen et al., 2005; Sindhuphak et al., 2003; Vatanasapt, Sriamporn, & Vatanasapt, 2002), and ranked as the most frequent cancer among all women in Thailand and the most frequent cancer among Thai women between 15 and 44 years of age (WHO Thailand, 2007). In 2002, the Department of Medical Services of the Ministry of Public Health established a cytology-based screening program for the entire population of Thai women aged 35 to 60 years to have Pap tests every 5 years (Sriamporn, Khuhaprema, & Parkin, 2006; Yothasmut, Putchong, Sirisamutr, Teerawattananon, & Tantivess, 2010).

In spite of government campaigns and the high incidence rate of cervical cancer, large numbers of Thai women have never received a Pap smear screening, and a small number had their first Pap screenings at age 35. Data obtained from the Policy and Planning Office of Thailand indicated that only 29% of Thai women aged 35 to 59 years had cervical cancer screening (Boonpongmanee & Jittanoon, 2007). In terms of cervical cancer screening coverage in Thailand, WHO Thailand (2007) indicated that national annual participation in screening covers only approximately 5% of the at-risk population of Thai women.

According to WHO (2009a), two core components of early detection of cancer that are crucial to successful reduction of cancer mortality include education and screening. In a literature review of studies of cervical cancer screening by Pap smear from various settings in Thailand, Wiwanitkit (2005) concluded that health education remains crucial in the success of the screening programs for Thai women. Wiwanitkit suggested that health education needs to be integrated into future cancer screening programs. In



addition, primary prevention of cervical cancer by screening for cervical dysplasia is central to the public health goal.

In general, cervical cancer screening is a routine procedure in gynecology. Pap smear screening is a classic, highly effective public health intervention for the early detection of cervical cancer. Currently, Thailand's cervical cancer screening program uses the Pap smear as a primary method of screening. Recently, implementation of various new screening techniques for precancerous lesions have been proposed for as alternative choices in developing countries, including Thailand, primarily due to cost-effectiveness. These alternative techniques include visual inspection with acetic acid (VIA), HPV DNA testing, and combined Pap smear and VIA (Wiwanitkit, 2009).

In Thailand, the cervical cancer screening program is mostly opportunistic screening, or on an "on-demand" basis (Kritpetcharat et al., 2003; Sriamporn et al., 2006). For example, screenings are provided to women in formal settings while the women are attending services such as prenatal, postpartum (Kritpetcharat et al., 2003), family planning, pregnancy counseling, or sexually transmitted diseases (STDs) clinics (Sriamporn et al., 2006). Additionally, Pap screenings usually involve fee-for-service testing by doctors, with occasional campaigns initiated by local public health departments or charitable organizations (Sriamporn et al., 2006). Presently, Thailand has no established screening programs at provincial health facilities. Thus, data regarding the percentage of cervical cancer screening coverage in Thailand is limited (Kritpetcharat et al., 2003).

## **Cervical Cancer Incidence in Germany**

In most Western European countries, the mortality rates for cervical cancer have decreased significantly since the introduction of the national cervical cancer screening programs in the 1960s and 1970s (International Agency for Research on Cancer, 2008). According to Anttila et al. (2004), the countries of the EU utilize both opportunistic and organized screening programs for cervical cancer using the Pap smear. In addition, reports show that implementation of these screening programs are effective in decreasing the incidence and mortality rates of the disease among the European women (Anttila et al., 2004).

According to Miles, Cockburn, Smith, and Wardle (2004), the distinction between organized screening and opportunistic screening rests mainly on the basis of how invitations to screening are extended. Lyng, Clausen, Guignard, and Poll (2006) explained:

The term ‘an organized screening program’ is used in the following for a set-up with personal invitation to screening of all women in the target age group at regular time intervals and with all services provided free of charge. The term ‘opportunistic screening’ covers use of Pap smears in asymptomatic women outside the schedule of an organized program, for example as part of a consultation for prescription of oral contraceptives. (p. 41)

In Germany, cervical cancer is the seventh most frequently occurring cancer (Seidel, Becker, Rohrmann, Nimptsch, & Linseisen, 2009). The WHO Europe (2007) indicated that approximately 6,500 women are diagnosed with invasive cervical cancer every year in Germany. However, there is a lack of information on the prevalence of HPV

and precancerous lesions. In Germany, the cervical cancer incidence and mortality rates are 13.8 per 100,000 and 3.3 per 100,000 population (all data standardized for age), respectively (Siebert et al., 2006). From this information, approximately 1,485 women are projected to die from the disease each year in Germany.

Prior to the implementation of cancer-specific early detection, cervical cancer was the second most frequent cancer among German women, after breast cancer (Seidel et al., 2009). In terms of the EU incidence rate of cervical cancer, Germany had a 27% higher incidence of cervical cancer mortality rate in 2000, at 3.28 per 100,000 (all data standardized for age) than the EU average of 2.57 per 100,000 population (all data standardized for age; Gericke & Busse, 2004). The lack of an organized screening program and the potential lower screening rate for high-risk women were cited as contributing factors to the increased incidence of cervical cancer among German women (Gericke & Busse, 2004).

According to Sullivan (2008), almost everyone in Germany has access to health care coverage. Only 0.2% of legal German residents are uninsured, compared with approximately 16 % of Americans (49.9 million; USDHHS, 2011a). In terms of cancer screening services, in Germany, the so-called “statutory early detection program,” or the *Krebsfrüherkennungsuntersuchungen* (KFU), is a self-referring screening program without an invitation and registration system. In other words, it is an opportunistic screening program, the success rate of which depends largely on individual compliance. The KFU was initiated in 1971. The program consists of an annual free-of-charge Pap smear to German women ages 20 years and older (Seidel et al., 2009). Despite the free-of-charge screening service, data indicated that only 50% compliance was achieved

among the target population of 34 million German women aged 20 years and older (17 million of 34 million at-risk population of German women; Ackermann et al., 2005; Seidel et al.).

Studies showed that an organized cervical cancer screening program is a more effective method than opportunistic screening in reducing the incidence rate of cervical cancer (Adab, McGhee, Yanova, Wong, & Hedley, 2004; Lynge et al., 2006). In fact, organized screening programs can prevent up to 80% of cervical cancer cases.

Unfortunately, organized screening programs are available only in 11 countries of the EU (WHO Europe, 2007). For example, since Finland adopted an organized screening program in 1964, the incidence and mortality rates for cervical cancer are very low (age standardized of 4.3 and 1.8 per 100,000 women, respectively). This decline is credited to an organized, cytology-based cervical cancer screening program with high coverage and quality control mechanisms (WHO Europe, 2007). Since the introduction of this program, there has been more than an 80% reduction in the incidence and mortality rate from the disease in Finland (WHO Europe, 2007).

Despite the success of the organized screening method, Becker (2003) contends that the German self-referring system (opportunistic screening) resulted in a significant reduction of cervical cancer incidence and mortality rates of about 80% since the 1960s. Seidel et al. (2009) argued that although the self-referring system showed a strong decline in cervical cancer incidence and mortality rates, the program failed to meet the goal of a 90% reduction in rates, even with 3-year screening intervals and a narrower target age group (25-64 years). In addition, Seidel et al. suggested that the screening program's

partial failure is perhaps due to several factors, with one key contributing factor being inadequate personal compliance.

### **Thai People in Germany**

The last few decades have been marked by increased rates of immigration from developing countries to industrialized nations, in particular, the United States, the United Kingdom, Canada, Australia, France, and Germany. Thai people migrated to Western countries for various reasons, such as marriage, employment opportunities, study, and business ventures (Kwanbunjan, Chaikate, & Songmuaeng, 2005). Many Thai women immigrated to Germany by way of marriage to German citizens and other foreigners. Data from the Foreign Ministry of Thailand indicated that Germany was one of the most popular countries in Europe for human trafficking. It is estimated that 14,000 Thai women are living in Germany illegally (Assavanonda, 2003). Presently, there are 54,580 legal Thai immigrants living in Germany. Of those, approximately 86% (47,030) are women (Statistisches Bundesamt Deutschland, 2008). This number does not include illegal residents and people of Thai origin who have changed their nationality. Roongwitoo (2009) indicated that approximately 100,000 Thais are living in Germany compared with 2,000 Thai immigrants in 1975.

### **Cervical Cancer Practices Among Thai Immigrant**

#### **Women Living in Other Developed Countries**

No research was found regarding cervical cancer screening among Thai immigrant women living in Germany. However, studies of cervical cancer screening among Thai immigrant women living in other developed countries such as Australia revealed that only 44% ( $N=145$ ) of participating women had ever had Pap tests in the past 5 years

(Jirojwong, Maclennan, & Manderson, 2001; Jirojwong & Manderson, 2001). This finding of suboptimal use of Pap tests was similar for other Southeast Asian groups (i.e., Vietnamese, Cambodian, and Laotian) living in the United States (Nguyen, McPhee, Lam, & Mock, 2002; Taylor, Hislop, et al., 2002; Tung, Nguyen, & Tran, 2008). Moreover, the results of Jirojwong et al. (2001) and Jirojwong and Manderson (2001) indicated that embarrassment, the perceptions of pain and discomfort during the procedure, not being sexually active, not perceiving benefits of the tests, feeling a sense of wellness, and the lack of choices regarding the health care provider were barriers to having Pap tests among participating Southeast Asian women (Jirojwong & Manderson, 2001).

In the United States, a recent survey study of 322 Thai women living in California regarding factors that influenced cervical cancer screening behaviors (Tsui & Tanjasiri, 2008) showed that 26% of the participating women were never screened for cervical cancer and 39% had not participated in cervical cancer screening within the last 3 years. The results of this study indicated that factors influencing adherence to cervical cancer screening included having a physician's recommendation, health insurance status, language most used, and knowledge about cervical cancer. These findings were similar to the results of the study by Jirojwong and Manderson (2001) in that Thai women participating in the study had lower cervical cancer screening rates than the overall national average (92% ever screened, 82% screened within past 3 years), the screening rates for Asians in California (77% ever screened, 72% screened in the past 3 years), and the target screening rate for Healthy People 2010 (97% women aged  $\geq 18$  ever screened, 90% women aged  $\geq 18$  screened within the past 3 years; USDHHS, 2000). In addition,

the results of the screening rates among participating Thai women in the study of Tsui and Tanjasiri (2008) were lower than the national rates among other Asian American subgroups (i.e., 70% of Korean and 74% of Filipino women).

### **Statement of the Problem**

A systematic review of the literature by Johnson, Mues, Maynes, and Kiblawi, (2008) suggested that participation rates in cervical cancer screening programs among immigrant and ethnic minority women are influenced by different factors, including traditional values and beliefs, concepts of health prevention, social environment, one's beliefs about sexual behaviors, fatalism, acculturation, English language proficiency, previous negative experiences with the health care system, and the knowledge of general and personal risk factors for cervical cancer. In their review of literature, Ackerman et al. (2005) indicated that a number of studies showed that one of the contributing factors associated with screening compliance was information deficits regarding patients' knowledge of the disease. In addition, study findings revealed that knowledge, attitudes, and beliefs about the Pap test may be associated with actual participation in cervical cancer screening (Wong, Wong, Low, Khoo, & Shib, 2009).

Wong et al. (2009) indicated that women's knowledge and beliefs about Pap tests were shown to be the strongest predictors of repeated screening. As already mentioned, study results in the U.S., Australia, and Thailand showed that participation of Thai women was suboptimal, even in the more organized screening programs, such as Australia's cervical cancer screening programs (Fiebig, Hass, Hossain, Street, & Viney, 2009; Mitchell & Hocking, 2001; Trevena, 2009). The German opportunistic screening system, which is based on a self-referring system and individual compliance, may place

Thai women at a greater risk for delaying early cervical cancer detection due to factors such as cultural and language barriers and lack of knowledge of cervical cancer and the benefits of early screening.

### **Purpose of the Study**

The purpose of this study was to describe the knowledge, attitudes, and beliefs of first-generation Thai immigrant women living in Germany regarding cervical cancer, cervical cancer screening and the barriers to participation in cervical cancer screening.

### **Significance of the Study to Nursing**

The efficacy of the Pap smear as a method of cervical cancer prevention has been demonstrated by reduced incidence and mortality. However, in spite of routine screening efforts, a woman's decision to undertake Pap smear screening or not is influenced by various factors, including health beliefs, attitudes, and cultural barriers. Thus, it is a significant challenge for health care providers to explore the traditional health beliefs that may influence a woman's health decision making, the extent of cultural preservation with immigration to a new country, and the effects of acculturation on reproductive health attitudes, knowledge, and practices regarding cervical cancer and prevention.

The current study explored Thai women's health beliefs and attitudes regarding cervical cancer and screening. The findings from this study may assist German health care providers in gaining insight and a deeper understanding of cultural implications and barriers that may prevent Thai women from seeking early screening. Information from the current study may not only have the potential to assist German health care providers, but it may also help all health care providers to tailor preventative programs that are



culturally sensitive and thereby increase cervical cancer screening compliance, resulting in a decrease of morbidity and mortality in Thai women.

### **Research Questions**

According to Fossey, Harvey, McDermott, and Davidson (2002), qualitative research questions mainly focus on three areas, namely “language as a means to explore processes of communication and patterns of interaction within a particular social group; description and interpretation of subject meanings attributed to situations and actions; and theory building through discovering patterns and connections in qualitative data” (p. 723). Thus, the aim of this study was to describe the knowledge, attitudes, and beliefs regarding cervical cancer, screening, and perceived barriers of cervical cancer screening programs among Thai women living in Germany by answering the following research questions.

1. What are the knowledge and attitudes about cervical cancer among Thai women living in Germany?
2. What are the health beliefs and practices regarding cervical cancer among Thai women living in Germany?
3. What are the cervical cancer screening practices among Thai women in Germany?
4. What are the barriers to participation in cervical cancer screening perceived by Thai women living in Germany?

### **Definition of Terms**

Within the context of this study, the following definitions of terms were used:

**Attitude:** The individual's predisposition, manner, position, or tendency to respond positively, negatively, or neutrally regarding certain persons, things, ideas, or situations (*BusinessDictionary.com*, 2010.).

**Barrier:** Any condition or situation (e.g., language, culture, lack of transportation, lack of insurance, lack of physician's recommendation for screening, and lack of social support system) that makes it difficult for Thai immigrant women to access the German health care system ("Barrier," n.d.).

**Cervical cancer screening:** Within the context of this study, "screening" refers to the use of the Pap smear to detect cervical abnormalities in asymptomatic women (*Mayoclinic.com*, 2008), a health promoting behavior. This term will be used interchangeably with "Pap smear screening" or "Pap tests."

**Culture:** A major construct that describes the total body of beliefs, behaviors, sanctions, values, and goals; a social heritage of people; and the ways of acting and doing things that are passed from one generation to another via teaching and demonstration ("Culture," n.d.). Additionally, culture is dynamic and constantly changing and evolving, with no culture being untouched or remaining static (Agar, 1994; Bushy, 2000).

**Euro:** The basic monetary unit of most members of the EU, introduced in 1999. At the time of this research, one Euro equaled 1.60 USD.

**Health beliefs:** Personal feelings that influence health behaviors ("Health Beliefs," 2009). For example, an individual believes that a negative health condition can be avoided (cervical cancer), and by taking a recommended action (undergoing a Pap smear screening), an individual will avoid negative health consequences (early detection for cervical cancer).

**German cervical cancer screening program:** The German statutory early detection program, the KFU, currently uses the Pap smear as a method for early detection of cervical cancer. The target population is women aged 15 years and older, with cervical cancer screening starting at age 20. The current cervical cancer screening program is called an opportunistic program because there is no invitation sent out to the women who undergo the screening program (Klug, Hetzer, & Blettner, 2005).

**Knowledge:** Knowledge is defined as “the range of one’s information or understanding” (“Knowledge,” n.d.).

**Pap smear screening:** An internal examination that includes the use of a speculum by a qualified health care provider to visualize the cervix and vaginal vault and to obtain cervical and vaginal specimens for detection of cervical cancer (MayoClinic.com, 2008). Because it is impossible to have a Pap smear without also performing a pelvic exam, the term “Pap smear” will be used in this dissertation to indicate Pap smears and pelvic exams.

**Perception:** Defined as “a process in which receiving and interpreting information is based upon attributes of knowledge, attitudes, awareness, insight, personal and cultural beliefs, and personal experience” (Ice, 2006).

**Practice:** The individual’s habitual or customary behavioral patterns (“Practice,” 2010), which may be influenced by one’s beliefs, values, social norms, and cultural influences.

## Chapter Summary

Chapter 1 provides an introduction to the dissertation study of the knowledge, attitudes, health beliefs, and practices regarding cervical cancer and screening among

Thai women living in Germany. The incidence of cervical cancer is greater among Thai women in Thailand compared with other groups in developed countries. Studies from the United States, Australia, and Thailand showed suboptimal early screening among this ethnic group. Currently, there is no information regarding the health beliefs and attitudes of cervical cancer screening among Thai immigrant women residing in Germany. This study has the potential to help gain a deeper understanding and insight into the health beliefs, attitudes, cultural implications, and barriers that may prevent Thai women from seeking early screening. Further, information gleaned from this study will potentially assist health care providers to tailor prevention programs that are culturally sensitive to increase cervical cancer screening and thereby decrease morbidity and mortality rates in Thai immigrant women living in Germany and, perhaps, in other countries where the predominant mode of screening is opportunistic.

## **CHAPTER 2**

### **REVIEW OF THE LITERATURE AND THEORETICAL FRAMEWORK**

As mentioned in Chapter 1, no information specific to cervical cancer screening among Thai immigrant women living in Germany was identified. In this chapter, a brief review of the Thai culture's influence on Thai women's general health beliefs and practices regarding cervical cancer screening is described. A review of the literature related to cervical cancer screening in this population from studies conducted in other developed countries, including Australia and the United States, is presented. In addition, the overview of current cervical cancer screening in Germany, as well as the Health Belief Model (HBM), is delineated.

Chapter 2 consists of seven components: (a) cancer incidence among Asian Americans; (b) sociocultural influences on cervical cancer screening among Thai women; (c) a brief overview of Thai history and culture; (d) a review of the literature pertaining to cervical cancer screening among Thai women; (e) a review of current cervical cancer screening program in Germany; (f) a presentation of the HBM, which serves as the theoretical framework for this study; and (g) a chapter summary.

#### **Incidence of Cancer Among Asian Americans**

In the United States, Asian Americans have the highest rate of any racial/ethnic group for cancers that have infectious origins, which include liver, stomach, and cervical cancer (Chen, 2005). Moreover, Chen (2005) stated that Asian Americans' cancer burden is unique because only this ethnic/racial group experiences cancer as the leading cause of

death in the United States. Analysis of the literature showed that the incidence of invasive cervical cancer among Southeast Asian American women is higher than among other ethnic groups, primarily due to a lower use of Pap smear screening (Jackson et al., 2000; Tanjasiri, Kagawa-Singer, Nguyen, & Foo, 2002; Taylor, Jackson et al., 2002, along with unfamiliarity of Western culture and health concepts of prevention (Chilton, Gor, Hajek, & Jones, 2005; Jackson et al., 2000; Taylor, Jackson, et al., 2002).

### **Sociocultural Influences on Cervical Cancer Screening**

Health-related attitudes, beliefs, and perceptions are shaped by culture and passed on from one generation to another. Moreover, Smith, Phillips, and Price (2001) stated, “Cultural values also determined how health and illnesses are perceived, defined, and how health decisions are made” (p. 161). Xu, Ross, Ryan, and Wand (2005) contend that culture is a major determinant that may account for the low usage of Pap smear tests among minority women, as cultural values and beliefs are significant factors in determining health behaviors. In addition, Smith et al. (2001) indicated that an individual’s attitudes, beliefs, and perceptions regarding cervical cancer play a significant role in promoting screening and early detection.

Jirojwong and Manderson (2001) conducted a cross-sectional study that used a survey and ethnographic methods to identify social, cultural, and personal factors influencing the use of cervical cancer screening or Pap smear tests and self-breast examination among Thai immigrant women in Brisbane, Australia. The researchers found that only 44% ( $N = 145$ ) of the participants had biennial Pap smear tests in the past 5 years. The study results indicated low use of cervical cancer screening services, which

was contrary to the researchers' hypothesis that Thai women were more likely to be exposed to cervical cancer screening in Thailand.

Moreover, Jirojwong and Manderson (2001) stated that among Thai women participating in the study, young and unmarried women were unlikely to have Pap smears and perceived "feeling well." This finding is possibly related to cultural beliefs that Thai women are expected to maintain virginity if traditional marriage is desired (Klunklin & Greenwood, 2005). These factors can affect and alter the decision to undergo screening among this group. Furthermore, individuals' attitudes, beliefs, and perceptions regarding cancer may also play a significant role in promoting cervical cancer screening (Jirojwong et al., 2001; Jirojwong & Manderson, 2001).

The other factors in preventing minority women from undergoing routine screening procedures include the lack of financial support and health insurance, lack of regular primary care services, and lack of social support (Smith et al., 2001). According to Smith et al. (2001), socioeconomically disadvantaged groups have a higher incidence and a lower survival rate for specific types of cancer. This is particularly significant in that many racial and ethnic minority populations are disproportionately characterized by socioeconomic disadvantage.

### **Overview of the History and Culture of Thai People**

To assist in understanding the sociocultural influences affecting the health beliefs and practices regarding cervical cancer and screening among this population, a brief historical overview of the Thai people is presented. According to Lundberg (2000), the name Thai means "free." The kingdom of Thailand was established in the mid-14th century. Thailand was formerly known as "Siam" until 1939. This name was changed to

“Thailand” after the successful “bloodless revolution” by a group of civil servants and army officers, with the support of military units in Bangkok areas, transforming the governed system of absolute monarchy to a constitutional monarchy in 1932 (Central Intelligence Agency [CIA], 2009b; Lundberg, 2000). Because of the introduction of the constitutional monarchy, men and women were granted the right to vote in 1932. Despite its tumultuous political history, Thailand is the only country in Southeast Asia that has never been colonized by European powers (CIA, 2009b).

Thailand is located in Southeast Asia and is bordered by Myanmar, Cambodia, Laos, Malaysia, the Andaman Sea, and the Gulf of Thailand (see Figure 1). It has a total area of 513,120 square kilometers. For administrative purposes, Thailand is divided into 76 provinces within four geographical regions: Northern, Northeastern, Southern, and Central (CIA, 2009b). Bangkok is the capital city and the largest population center, with approximately 7 million people. In 2009, Thailand’s total estimated population was 66.9 million. Approximately 50.8% (34 million) of the population is female (National Statistical Office of Thailand, 2009). The ethnic composition of Thailand is 75% Thai, 14% Chinese, and 11% other ethnicities.

In terms of religious affiliations, 95% of Thai are Buddhist, 3.8% are Muslim, 0.5% are Christian, 0.1% are Hindu, and 0.6% are other religions. Thailand’s official language is Thai. The English language is widely taught in schools and considered the secondary language of the privileged. In addition, there are numerous ethnic and regional dialects spoken in Thailand (CIA, 2009b). Approximately 92.6% of the total population aged 15 years and older is able to read and write Thai (CIA, 2009b).





Figure 1. Map of Thailand. (Source: Lonely Planet. [2012]. *Map of Thailand*. Retrieved from <http://www.lonelyplanet/maps/asia/thailand>)

## Gender and Sexuality

For centuries, Buddhism has been deeply rooted in the Thai culture and traditional ways of living. Buddhism has played a vital role in shaping the character of the Thai people and has permeated almost all aspects of daily cultural activities. Buddhist ideology also represents women as inferior to men and negatively values female sexuality (Klunklin & Greenwood, 2005). According to Klunklin and Greenwood (2005), the most obvious sexual differentiation due to Buddhism in Thailand centers around the traditional religious activities, where men perform all the roles of Buddhism. Thai Buddhism only allows men to be ordained as monks, to lead chanting, and to conduct all religious rituals

(Klunklin & Greenwood, 2005). In addition, the Thai people believe in the law of karma as the law of cause and effect. Thais perceive that life is a cycle of events, and they believe in reincarnation (Klunklin & Greenwood, 2005; Picavet, 2005). Picavet (2005) wrote that “some text states women cannot reach Nirvana unless they are first reborn as a man” (p. 31).

Buddhist temples and monks are the center of the community. Thus, Thai community life traditionally revolved around the temple. Buddhist monks serve as community leaders for spiritual guidance and moral support of the community (Sangha Metta Project, 2005). Though modernization and social economic development brought many changes to contemporary Thai society, the role of the Buddhist monks as one of the community’s main support systems has not changed. For example, after the outbreak of the HIV/AIDS epidemic in Thailand in the 1990s, Buddhist monks and nuns adapted their traditional role to respond to the needs of the community by conducting the HIV/AIDS awareness-raising camps for adolescents to prevent the spread of this devastating disease among the Thai adolescent population (Sangha Metta Project, 2005).

In terms of social inequality in Thai culture, Burnard (2006) observed, “One of the keys to understanding Thai culture is an appreciation that no one, in Thai society, is equal. All Thai people are constantly assessing their relationships with others in terms of who is ‘senior’ and who is ‘junior’ (sometimes referred to as big person/little person)” (p. 254). The practice of Theravada Buddhism also differs among social class, ethnic group, and regions; however, religion is an essential key to Thai identity. In addition, religion has a crucial impact on the relationships between men and women in terms of their gender roles (Picavet, 2005). Jongudomkarn and West (2004) conducted qualitative

research in northeast Thailand on low-income Thai women regarding their work life and psychological health. In this study, the women's way of life was complex and involved the care of their children, husband, extended families, work, and themselves. Researchers also found that religion, Buddhism, and the Thai way of life were the major factors influencing women's views on health, living, and well-being.

Recently, despite the traditional view of disparities of social status between genders, Thai women's access to the political arena has been increasing. Nonetheless, men tend to hold more executive administrative positions than women do (CIA, 2009b; Muecke, 2005). Perhaps this is a result of Thai culture, traditions, and living conditions of Thai women.

Tangmunkongvorakul, Kane, and Wellings (2005) stated that Thailand has shifted from an agricultural society to a more urbanized and westernized way of living due to the past few decades of Western influences, massive economic growth leading to greater material purchasing power among Thai people, and drastic changes in social norms across a range of behaviors. Thai youth are easily affected by changes in social norms. The negative side of this globalization is the adoption of unhealthy life styles, such as increased consumption of fast foods, alcohol, and tobacco; recreational drug use; night-time recreational practices; and unsafe sexual behaviors among young people (Tangmunkongvorakul et al., 2005). Studies showed that due to recent changes in societal norms, there is an increased practice of premarital sexual behavior among Thai adolescents and young adults (Allen et al., 2003; Saranrittichai, Sritanyarat, & Ayuwat, 2006; Tangmunkongvorakul et al., 2005; Thato, Jenkins, & Dusitsin, 2008; Thianthai, 2004). According to Domingo et al. (2008), reports from sexual behavior survey studies

among Thai adolescents and young adults, aged 13-25 years, indicated that the median age of participants engaging in premarital sexual behavior was 16 years for males and 18 years for females.

Analysis of the literature also revealed that the negative impact of this shift in sexual practices among Thai adolescents has had a significant effect on unplanned teenage pregnancies and illegal pregnancy termination, in addition to the potential spread of HIV and other STDs, such as HPV, which is one of the precursors to cervical cancer (Kanato & Saranrittichai, 2006; Thato et al., 2008). Formal sex education provided to adolescents is a recent phenomenon in Thailand. Although sex education is taught in public schools, it is limited to anatomical and physiological interpretations, and teachers are hesitant to teach it in the classroom (Liu et al., 2006; Muecke, 2004; Thato, Charron-Prochownik, Dorn, Albrecht, & Stone, 2003).

Researchers also reported a variety of contributing factors in high-risk sexual behavior among Thai youth, including age, gender, economic status, geographic residence (living in the rural or urban area), living with parents (parental residence), parent-young adult communication about sexual matters, HIV knowledge, and negotiation about safer sex with sexual partners (Allen et al., 2003; Liu et al., 2006; Rasamimari, Dancy, Talashek, & Park, 2007; Saranrittichai et al., 2006; Tangmunkongvorakul et al., 2005; Thato et al., 2003). For example, Thato et al. (2003) conducted a study to describe the prevalence of premarital sexual behavior and condom use, and to identify predictors of condom use among 425 Thai students (aged 18 to 22 years) from eight randomly selected private vocational schools in Bangkok, Thailand. Results showed that age was associated with condom use among study participants. Older Thai adolescents demonstrated lower

levels of intention and lower actual condom use. The prevalence of premarital sexual behaviors among the participants was considered high. In addition, participants engaged in unsafe sex. Many reported unplanned pregnancies and contracted STDs.

Another study to determine risky sexual behaviors among young Thai adults conducted by Rasamimari et al. (2007) sought to identify the correlation of sexual behaviors among young adults between 18 and 24 years of age. They found that young Thai men were more likely to have multiple partners than were young women. Urban Thai men were more likely to engage in sexual experiences and were less likely to consistently use condoms. According to Thato et al. (2008), data gleaned from the Thai Ministry of public Health in 2007 indicated that the prevalence of STDs among Thai adolescents and people under the age of 25 was relatively high, and the incidence rates accounted for 70% of all the STD cases.

In spite of recent social changes, Thai society continues to be patriarchal and retains gender inequalities regarding sexual norms and socialization. According to Tangmunkongvorakul et al. (2005), in contemporary Thai society, gender double standards still persist, particularly when dealing with sexual activity among young and unmarried women, which is strongly disapproved of. In addition, Thai social and cultural norms have traditionally discouraged open discussion regarding sexuality, especially for women (Liu et al., 2006; Muecke, 2004; Thato et al., 2008). Premarital sex is still considered unacceptable for a “respectable woman,” and may have negative effects on the reputation of the woman and her family. According to Thianthai (2004), virginity at marriage is, to a large extent, still socially expected. In contrast, Thai society generally permits Thai men greater freedom in expressing sexuality than women, and these norms

tend to be held even by Thai female counterparts (Liu et al., 2006). Thus, the “norm of virginity” expected among young women is not generally expected among young men, perpetrating the double standard (Tangmunkongvorakul et al., 2005).

It is crucial for health care providers to understand their patients’ values, beliefs and knowledge of disease processes. Understanding Thai women’s perception of health, values, and beliefs will lead to more appropriate disease prevention methods and therefore will enhance health care services for this group of people (Jongudomkarn & West, 2004). As discussed earlier, some Thai women believe that a pelvic examination is reserved for married women only. Jirojwong et al. (2001) recommended that health care providers empower Thai women by promoting public awareness, increasing knowledge, and improving health practices through health education. Additionally, dispelling culturally based misconceptions is also a crucial component in the cancer prevention educational process.

### **Traditional Thai Health Beliefs About Body and Cancer**

The Thai world view is rooted in Buddhist philosophy, Brahman philosophies, traditions from the Indian subcontinent, and Chinese Confucianism that advocates the need to maintain equilibrium in one’s life. Health is considered a state of equilibrium, and illness is believed to occur when equilibrium is disturbed. Such disturbances are viewed holistically as affecting the body, mind, and spirit (Klunklin, & Greenwood, 2005; Picavet, 2005). The practice of the traditional Ayurvedic health system aims to maintain and balance the energy and health of the mind and body. In addition, this practice emphasizes avoidance of stress and maintenance of a moderate harmonious, balanced life (Chirawatkul, Patanasri, & Koochaiyasit, 2002).

In regard to Thai women's health perception of cancer screening, health perception is defined within the context of religion and a culturally traditional life. Religion and cultural traditions were the major factors influencing Thai women's perception on living, health, and well-being (Jongudomkarn & West, 2004). According to Saniotis (2007), the Buddhist Thai approach to health is holistic and comprises physical, mental, emotional, and spiritual components. Health is viewed as the harmonious interaction of all these elements (physical, mental, emotional, and spiritual) in accordance with the teachings of Buddhism. The concept of karma contributes to an individual's state of health and/or illness. Health and disease are interpreted as a consequence of negative or positive karma that an individual has accumulated from a previous life (Saniotis, 2007). To maintain harmony of one's health, "Thai Buddhism prescribes that the individual practices morality (*sila*), discipline (*samadhi*), and wisdom (*panna*) to lessen the accrued negative karma and its result on health" (Saniotis, 2007, p. 24).

The practice of Thai traditional medicine, known as the Ayurvedic health system, which originated from India, aims to maintain and balance the energy and health of the mind and body. Disayavanish and Disayavanish (1998) stated that Thai traditional medicine is one of the most valuable practices passed on from generation to generation. Despite the increasing utilization of modern Western medicine, Thai traditional medicine is still widely used in addressing health and illness, particularly in the rural areas. Thai traditional medicine consists of four main categories, which include traditional herbal medicine, psychological treatment, traditional massage and physical therapy, and traditional herbal medicine based on elements or humors theory (Disayavanish & Disayavanish, 1998). Disayavanish and Disayavanish (1998) indicated that of the four

categories of Thai traditional medicine, traditional herbal medicine is the only system accepted by the Thai government or the Ministry of Public Health.

In addition to the hot and cold concept, or imbalance causing illness, the basic principles of Thai traditional medicine are that the body is composed of four elements: earth (solidity), water (fluidity), wind or air (motion), and fire (heat). Most of the theories of the Thai traditional medicine originated from the four elements theory (Disayavanish & Disayavanish, 1998). Additionally, Buddhist teaching also states that “there are 32 body organs and six additional air components and four fire components in the human body” (Jirojwong & Manderson, 2001, p. 55). According to Jirojwong and Manderson (2001), a disease is viewed as the “result of the imbalance of these 32 organs, possibly due to internal and external causes including the changes in food, spirits, climate, effects of karma (previous behaviors), and sorcery” (p. 55). Herbalist, acupuncturist, or cancer specialists who offer diagnostic treatment and services provide treatments when illness occurs.

In their study, Jirojwong and Manderson (2001) found that Thai immigrant women believed cancer to be a complicated and mysterious disease that cannot be explained by a single etiology. Thai women diagnosed with cervical cancer perceived the possible causes to be “abnormality of menstrual blood flow and vaginal discharge, previous trauma to the uterus, previous physically demanding work, consequences of previous behaviors (karma), and astrological influences” (Jirojwong and Manderson, 2001, p. 56).

In a study on Thai women’s sexual and reproductive health in northeastern Thailand, Boonmongkon, Nichter, Pylypa, Sanhajariya, and Saitong (2002) found that



while most of the participants willingly engaged in the cervical cancer screening clinic, they did not fully understand the purpose of the Pap smear and the associated reasons for attending the clinic. The findings did not correspond to the global standard of a Pap smear as a preventive screening procedure for health promotion. In addition, the participating women's use of the Pap smear clinic was primarily associated with gynecological symptoms and concerns that the existing symptoms could turn into cervical cancer.

Boonmongkon et al. indicated that more than a quarter of the participants interviewed ( $N = 1,028$ ) who suffered from chronic or recurrent "uterus or *mot luuk* problems" (p. 66) believed their problems were the result of an inadequate traditional postpartum practice of "lying by the fire" or *yuu fai*, for a period of 3 to 15 days (Kaewsarn, Moyle, & Creedy, 2003a, p. 469) or as long as "30 days of the confinement period" following childbirth (Liamputtong & Naksook, 2003, p. 32). This traditional postpartum practice involves the belief that childbirth causes an imbalance of hot and cold in the mother. Lying by a hot fire is believed to "reheat the mother's body, increase uterus involution, flatten the belly of the new mother, help to removed stretch marks, help to heal the perineal tears, help to increase milk supply, and help the woman to gain strength and avoid permanent ill health due to a cold state" (Kaewsarn et al., 2003b, p. 364).

Additionally, the participating women associated *mot luuk* problems with a wide array of causes, such as physically demanding work or heavy lifting in the rice or sugar cane fields, past bodily injuries, complication during previous pregnancies, or abortion. Various sources of impurities were considered to be the cause of *mot luuk* problems. For instance, the menstrual blood flow was viewed as a monthly cleansing of impurities from the woman's body; if women had irregular menstruation or if their menstrual flow was in

any way blocked, impurities might remain in the body and result in *mot luuk* problems (Boonmongkon et al., 2002; Chirawatkul et al., 2002). The findings of this study indicated that the participants' perceptions of the possible causes of cervical cancer were similar to the study conducted by Jirojwong and Manderson (2001).

### Brief Overview of Germany

The Federal Republic of Germany, or Deutschland, is located in Central Europe, with its borders to the Baltic Sea and the North Sea, between the Netherlands and Poland, and to the south of Denmark (see Figure 2). Germany has a total area of 357,000 square kilometers (137,821 square miles), approximately the size of the State of Montana (U.S. Department of State Diplomacy in Action, 2008). In addition, Germany is considered Europe's largest economy and the fifth largest in the world. Germany is also the second most densely populated nation (82 million people in 2005) in Europe, after the Russian Federation (140 million people; Population Division of the Department of Economic and



Figure 2. Map of Germany. (Source: Lonely Planet. [2012]. *Map of Germany*. Retrieved from <http://www.lonelyplanet.com/maps/europe/germany/>)

Social Affairs of the United Nations Secretariat, 2009). Berlin is the capital city and the largest population center, with 3.4 million people (CIA, 2009a; U.S. Department of State Diplomacy in Action, 2008).

Germany is one of the member countries of the EU. The initial step of the establishment of the so called EU was a regional economic agreement among six neighboring countries, namely Belgium, France, West Germany, Italy, Luxembourg, and the Netherlands, for the integration of the coal and steel industries in Western Europe. Thus, the Treaty of Paris was signed in 1951 (CIA, 2009a) to create the EU. Currently, the EU has expanded and covers more than 27 countries across the European continent, including Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom. The unification has created a political and economic community throughout Europe (CIA, 2009a).

The official language of Germany is German. In 1997, about 99% of the total population aged 15 years and older were able to read and write (CIA, 2009a). For administrative purposes, Germany is divided into 16 states. These 16 states (*Länder*) include Baden-Württemberg, Bayern, Berlin, Brandenburg, Bremen, Hamburg, Hessen, Mecklenburg-Vorpommern, Niedersachsen, Nordrhein-Westfalen, Rheinland-Pfalz, Saarland, Sachsen, Sachsen-Anhalt, Schleswig-Holstein, and Thüringen (CIA, 2009a).

In 2005, 91.5% of the population were German, 2.4% were Turkish, and the other 6.1% were made up largely of Greek, Italian, Polish, Russian, Serbo-Croatians, and

Spanish individuals in 2005 (U.S. Department of State Diplomacy in Action, 2008). The Statistisches Bundesamt Deutschland (2008) indicate that approximately 811,369 Asians are living in Germany. Of those, 412,511 (51%) are women. There are 54,580 registered Thais living in Germany, with the majority being female (47,030). Among those, the majority of Thai women are married to German citizens or other foreign nationals residing in Germany. It is interesting to note the contrast of information obtained from the Thai Ministry of Foreign Affairs (2009) indicating that, to date, an estimated 100,000 Thai men and women live in Germany legally and illegally.

In the state of Rheinland-Pfalz, 45.7% of the population is Catholic, and 35.3% belong to the Evangelical Lutheran Church in Germany. Rheinland-Pfalz is well known for its wine industry and is the only German state to have a cabinet minister for winegrowing, called the Ministry of Economy, Traffic, Agriculture and Winegrowing. Major industries in Rheinland-Pfalz include wine-producing, chemical (BASF is located in Ludwigshafen), pharmaceutical, and auto parts. Distinctive regional industries in this state include gemstone (in Idar-Oberstein), ceramic and glass, and leather (MyGermanCity.com, n.d.).

For administrative purposes Rheinland-Pfalz is divided into 24 rural districts (counties), namely, Ahrweiler, Altenkirchen, Alzey-Worms, Bad-Dürkheim, Bad-Kreuznach, Bernkastel-Wittlich, Birkenfeld, Bitburg-Prüm, Cochem-Zell, Donnersbergkreis, Germersheim, Kaiserslautern, Kusel, Mainz-Bingen, Mayen-Koblenz, Neuwied, Rhein-Pfalz-Kreis, Rhein-Lahn-Kreis, Rhein-Hunsrück-Kreis, Südliche-Weinstrasse, Südwestpfalz, Trier-Saarburg, Vulkaneifel, and Westerwaldkreis. Each rural district is also composed of numerous municipalities, villages, or groups of villages,

known as Verbandsgemeinden. In addition, in Rheinland-Pfalz, there are 12 urban districts, including Frankenthal, Kaiserslautern, Koblenz, Landau, Ludwigshafen, Mainz, Neustadt (Weinstrasse), Pirmasens, Speyer, Trier, Worms, and Zweibrücken (MyGermanCity.com, n.d.).

The Rhine is the major river in Germany. The Rhine Valley is surrounded by mountain chains (the Eifel, the Hunsrück, the Westerwald, and the Taunus) and forms a spectacular landscape, containing some of the most historically significant places in Germany, such as famous castles (e.g., Burg Eltz, in Münstermaifeld), cathedrals, and abbeys. These mountain chains are separated by several tributaries of the Rhine River: the Mosel, the Lahn, and the Nahe. The southernmost region of the state is hilly, and the land is covered by the Palatinate forest and the Palatinate.

### **Cervical Cancer Screening Program in Germany**

Cervical cancer is an increasing public health threat, particularly in low- and middle-income countries, where it is the leading cause of death from cancer in women younger than 65 years of age. In 2005, there were an estimated 493,000 new cases and 274,000 deaths from cervical cancer. In the WHO European Region, the age-standardized mortality rate varies from 0.8 to 12.5 per 100,000 women (WHO Europe, 2007).

Adab et al. (2004) stated that many industrialized countries have adopted organized screening programs. In Europe, there is diversity in how cervical cancer screening programs are organized, and performance varies greatly among the countries. For example, the target age group in Finland is 30 to 60 years, with a 5-year screening interval; in the United Kingdom, the target age group is 25 to 64 years, with screening

intervals of 3 to 5 years, respectively (Rebolj, van Ballegooijen, Berkers, & Habbema, 2006).

Since 1971, all German women aged 20 years and older have been eligible for a yearly gynecological “cancer early detection exam or the *Krebsfrüherkennungsuntersuchungen (KFU)*” (Klug et al., 2005, p. 70). According to Klug et al. (2005), the KFU, which is covered by the statutory health insurance system, includes a Pap smear for early cervical cancer screening and a gynecological examination. Additionally, the KFU is “always performed by medical doctors, mostly performed by office-based gynecologists” (Klug et al., 2005, p.70). The current cervical screening program is not an organized screening program, as there are no invitations sent to the women. A recent study of the current screening programs in the EU showed that only six of the 15 countries adopted nationally organized screening programs (Adab et al., 2004).

Ackermann et al. (2005) conducted a survey study to assess the knowledge of 2,108 healthy German women who attended routine gynecological visits regarding uterine cancer and possible risk factors for cervical and endometrial cancer. They found that the general knowledge of participating women about the risk factors, as well as general facts about the disease, was low (47.4%). Furthermore, Ackermann et al. stated that Germany had a low rate of coverage, approximately a 50% uptake of cervical cancer screening of the female population, which may be due to the existing opportunistic, nonorganized screening program.

Another survey study was conducted by Klug et al. (2005) to assess the attendance for cervical and breast cancer screening, breast self-examination, and knowledge about risk factors for cervical cancer among 532 German women aged 25 to 75 years. The

findings showed that most participating women felt they were insufficiently informed regarding risk factors of cervical cancer (69.9%). Only 3.2% of participating women had the knowledge that HPV is a risk factor for cervical cancer. Klug et al. indicated that the age of the participating women undergoing the first Pap smear exam was older and in the lower socioeconomic group. Researchers concluded that the results of this research support the published literature regarding the association between attendance for cervical cancer screening and social class.

### **Theoretical Framework**

Creswell (2003) stated that qualitative researchers use theory in their research inquiries in a variety of ways. They may employ theory as a broad explanation, an advocacy lens or perspective, or an end point for a study. When using theory as a broad explanation, the “theory provides an explanation for behaviors and attitudes, and it may be complete with variables, constructs, and hypothesis” (Creswell, (2003), p. 131). In this study, the HBM provided theoretical insight for the development of the research questions. In addition, the HBM was used as a theoretical lens to describe the health beliefs, behaviors, and attitudes of Thai women regarding cervical cancer and screening.

The HBM was developed in the early 1950s by a group of social psychologists, Hochbaum, Rosenstock, and Kegels, while working in the U.S Public Health Services (Janz, Champion, & Strecher, 2002). The model was developed in response to the failure of a free tuberculosis health screening program. The HBM helps to explain common failures of people to participate in programs to prevent diseases (Janz et al., 2002; Rawl & Champion, 2004). The HBM maintains that preventive health behavior mainly depends on one’s desire to avoid illness and the belief that certain action will help prevent illness

(Rawl & Champion, 2004). Initially, the HBM had four key concepts: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. Later, the concept of cues for action was added. Finally, the concept of self-efficacy was included to address the challenge of risk behavior, such as smoking, dieting, and condom use (Rawl & Champion, 2004).

Most health behavior theories can be applied to the study of diverse culture and ethnic groups. However, to apply the theories correctly, it is imperative that researchers have a deep understanding of the characteristics of the target population (e.g., ethnicity, socioeconomic status, age, gender, and geographical location; USDHHS, 2005). The HBM is a popular health behavior model for nursing, particularly for dealing with issues of patient compliance and preventive health care practices. The HBM focuses on beliefs and attitudes of the individuals; thus, it is a good fit for prevention-focused programs because health motivation is its central theme (i.e., cervical cancer screening, condom use to prevent HIV, and breast cancer screening programs). In addition, these programs generally promote specific actions, and the HBM helps guide participants to take specific action (USDHHS, 2005).

### **The HBM Theoretical Constructs**

There are six main constructs in the HBM that influence decisions regarding whether to take action to prevent, control, and screen for illness. Theorists argue that people take related action if they:

Believe they are susceptible to the condition (*perceived susceptibility*); believe the condition has serious consequences (*perceived severity*); believe taking action would reduce their susceptibility to the condition or its severity (*perceived*



*benefits*); believe costs of taking action (*perceived barriers*) are outweighed by the benefits; are exposed to factors that prompt action (e.g., a television ad or a reminder from one's physician to get a Pap smear (*cues to action*); are confident in their ability to successfully perform an action (*self-efficacy*). (USDHHS, 2005, p. 13)

The HBM main constructs will be discussed in detail below.

**Perceived susceptibility.** One of the most powerful perceptions or beliefs that assist or drive individuals to change their behaviors or adopt new healthier behaviors is the individual's personal perceived susceptibility to any given disease and the perceived severity of the consequences of the disease on the individual's life; however, this perception of susceptibility may vary widely with each individual (Salazar, 1991). For example, if an individual's mother and grandmother had cervical cancer, then the daughter may have a personal perception that her susceptibility and vulnerability to cervical cancer is high and, therefore, may seek appropriate Pap screening and reduce high-risk behaviors. In contrast, this same individual may perceive little or no susceptibility to the disease, resulting in no or few behavioral changes or actions to prevent the disease. In addition, this belief may be influenced by such factors as demographic variables (age, gender, ethnicity, race,); sociopsychological variables (personality, social class, peer and reference group pressure); and structural variables (individual's knowledge about the disease, experience with the disease; Salazar, 1991).

**Perceived severity.** Although one may recognize a personal susceptibility to the disease, the concept of the seriousness or impact that the disease would have on the individual's life may vary from individual to individual. If an individual believes that

there are possible negative physical, psychological, and social effects that stem from the disease, they are more likely to take preventative actions, as the consequences of the disease may alter relationships, independence, cause suffering and pain, create a disability, or ultimately result in death (Redding, Rossi, Rossi, Velicer, & Prochaska, 2000).

**Perceived benefits.** A perceived benefit involves a person's opinion or belief of the value of a new behavior in reducing the risk or preventing the development of a disease. These perceived benefits play a distinct and important role in changing behavior or adopting new behaviors that are seen as preventative in nature.

**Perceived barriers.** Burak and Meyer (1997) stated, "the HBM posits that the likelihood of taking an action is determined by beliefs that barriers to action are outweighed by the benefits of the action" (p. 253). Individuals must evaluate their own obstacles that they see as preventing them from adopting or making it difficult to adopt new behaviors or change old behaviors that increase the risk of contracting a disease. Barriers may be perceived as internal or external. For example, an internal barrier may consist of the belief that a given action, for example, Pap screening, may cause pain, discomfort, or embarrassment. An external barrier may include the lack of financial resources, transportation difficulties, and lack of health insurance.

**Cues to action.** The HBM suggests that cues to action influence behavior. Cues to action include people, events, or things that influence individuals or prompt health-related behaviors. In addition, cues to action may stem from an internal or external event or source (Burak & Meyer, 1997). Examples include, but are not limited to, experience of a

family member with an illness, news media, government health campaigns, reminders for routine Pap tests, and advice from friends and family.

**Self-efficacy.** Self-efficacy is “defined as the belief in one’s own ability to do something or to perform the behavior of interest” (Salazar, 1991). Unless an individual has the belief or confidence that he or she is capable of performing a given action, that action will not be performed.

Since its conception in the 1950’s, the HBM has served as one of the most widely used theoretical frameworks for examining and explaining health-related behaviors (Janz et al., 2002), especially with regard to screening and prevention. Numerous studies have employed the HBM framework because the HBM has demonstrated some consistency across a variety of studies, including those that sought to understand breast and cervical cancer screening behavior among unscreened or underscreened women (Austin, Ahmad, McNally, & Stewart, 2002), described the beliefs and behaviors regarding Pap tests and breast self-examination among Thai immigrant women living in Australia (Jirojwong & Manderson, 2001), examined the effects of an emotion-cognition focused program on the decision of undergoing Pap tests among Korean women (Park, Chang, & Chung, 2005), predicted Pap test use in working women in Bangkok, Thailand (Boonpongmanee & Jittanoon, 2007), explained barriers and facilitators of cervical cancer screening among Hispanic women (Byrd, Chavez, & Wilson, 2007), and examined beliefs and Pap test use among Chinese American immigrant women (Lee-Lin et al., 2007). Concordant with the HBM, previous data supported barriers to screening, including lack of knowledge, perceptions of cervical cancer, cultural issues (Jirojwong et al., 2001; Jirojwong & Manderson, 2001; McFarland, 2003), embarrassment, virginity issues for unmarried Thai

women, and perceived discomfort (Jirojwong et al., 2001; Jirojwong & Manderson, 2001). Screening rates are influenced by perceived discomfort and screening service satisfaction. In addition, study results (Hsia et al., 2000; Sung, Alema-Mensah, & Blumenthal, 2002) indicated that health care coverage may also play a crucial role in increasing utilization of screening services.

The HBM is a psychosocial model, and despite its usefulness, it has certain limitations. Salazar (1991) did a review of four behavioral theories, namely, the HBM, the Theory of Self Efficacy, the Theory of Reasoned Actions, and the Multiattribute Utility Model. Salazar found that the HBM has a limited ability to account for variation in human behaviors that related to attitudes and beliefs. Salazar (1991) maintained that many other factors can influence health decision making as well. For instance, individuals may choose to join a health club, not for health reasons, but perhaps because they feel they can meet potential dates or partners at the gym.

Another criticism of the HBM, according to Salazar (1991), is that “it defines motivation as a combination of likelihood and severity of belief” (p. 130). Many theorists later identified various dimensions of motivation, including social norms; thus, experts disagreed regarding the use of the HBM to measure motivation. Salazar cited the fact that the model did not address the issue of coping skills as another limitation of the HBM. The main focus of the HBM is on rational, intentional behavior, and it ignores the spontaneity of activities that characterize human behaviors (Salazar, 1991).

Johnson et al. (2008) conducted a systematic literature review of studies examining sociocultural factors influencing cervical cancer screening among immigrants and ethnic minorities in the United States along with the HBM. They found that the HBM

has certain limitations. These include factors that may influence health service access, such as health insurance status, English proficiency, social support, acculturation, and demographic and socioeconomic factors, in addition to previous Western health care experience, which may be crucial in cancer screening practices but are not reflected in the model. Furthermore, there were issues of inconsistencies in the testing and the use of the model, along with the inclusion of the subcomponents of the model among the studies being reviewed.

In their systematic review, Johnson et al. (2008) evaluated all six concepts of the HBM and found that only four—perceived barriers, perceived susceptibility, cues to actions, and perceived benefits—were consistently mirrored across the represented studies. Despite the inconsistency, Johnson et al. believed that the HBM enables researchers to gain a better understanding of cultural-specific attitudes and beliefs that affect the acceptance of cervical cancer screening practices among minority ethnic groups.

It is a great challenge to persuade individuals to change their behaviors in order to improve their health. Utilizing proven theoretical frameworks to guide the development of health education is likely to result in more effective outcomes (Champion, 1985; Salazar, 1991). In addition, the use of theory allows researchers to choose moderating, mediating, and outcome measures that are most appropriate to the phenomenon of interest (Rawl & Champion, 2004). Many theories of behavior propose that beliefs play a crucial role in explaining and determining health behaviors (Burak & Meyer, 1997). Moreover, the HBM is one such theory that informs the selection and development of measures used in screening behavior studies.

In this study, the HBM was used as a theoretical lens to examine the relationship between individuals' health beliefs and their specific health behaviors. The HBM asserts that one would be more likely to take a health-related action if one's perceptions of susceptibility and seriousness were high, barriers were low, benefits to engage in health-related behaviors were high, one had positive expectations, and confidence in the ability to perform the action was high (Champion, 1985). However, no single theory can explain or predict all the complexity of human health behaviors; perhaps the combination of compatible theories of behavior, such as the HBM and the Theory of Planned Behaviors, can help to create a more effective health prevention program.

Although there is a large body of literature on cervical cancer screening, most of the studies employed quantitative approaches to evaluate the development of programs and efficacy of intervention studies regarding cervical cancer screening. Few studies used qualitative methods (Jirojwong & Manderson, 2001; McFarland, 2003; Wong et al., 2009), especially ethnographic design, to describe how knowledge, cultural beliefs, and attitudes influence women's decisions to undergo Pap smear screening. To narrow the gap in the literature, utilization of focused ethnographic perspectives will help researchers to understand the richness of social and cultural implications in Thai women's health preventive behaviors. The HBM was used as a theoretical lens to gain insight from this particular ethnic group with respect to their personal perspectives, cultural behaviors, health beliefs, and attitudes toward cervical cancer and screening.

### **Chapter Summary**

This chapter provides insight into the current age of globalization, in which countries become multiracial. In this world arena, health care providers need a deeper

understanding of the cultural practices and health beliefs of their patients to remove communication obstacles and to provide culturally sensitive care. To facilitate communication and develop a perceived need for cervical cancer screening, the health care provider should consider all influences, including the cultural, religious, and personal values of each individual, and should try to understand the whole person before change in health belief behavior can be effective. Taking individuals “where they are” and understanding what makes up the perceived personhood of the individual will give the health care provider insight and thus the potential to assist each individual to make changes (not necessarily change their beliefs), that will positively alter their health care behavior. In addition, health care providers can facilitate the use of Pap smear screening by discussing with their female patients the behavioral risk and disease process. Cultural values and beliefs should be taken into consideration while communicating the solutions to overcome potential barriers in undertaking cervical cancer screening.

This chapter provides a brief review of Thai culture and its influence on Thai women’s health beliefs and practices regarding cervical cancer screening. The literature review related to cervical cancer screening among this population includes studies conducted in the United States and Australia. An overview of current cervical cancer screening programs in Germany is presented. Because the HBM was used as an advocacy lens in the development of the research questions for this study, the chapter also provides an overview of the HBM, with its established history and position as one of the most popular of all the health behavior models with respect to the utility in behavioral science research for intervening with health screening, illness, sick roles, and preventive behaviors is presented.

## **CHAPTER 3**

### **METHODS**

Chapter 3 provides a description of the methods used in this research. This chapter presents: (a) an overview of ethnography; (b) a discussion of reflexivity; (c) the researcher's perspectives; (d) a description of the sampling and setting; (e) a review of the procedures used to protect human subjects; (f) a description of the study protocol; (g) a description of data collection methods; (h) a description of data analysis; (i) assurance of the trustworthiness; and (j) a chapter summary.

#### **Ethnography**

Speziale and Carpenter (2003) stated that “inductive reasoning is a process that starts with the details of the experience and moves to a more general picture of the phenomenon of interest” (p. 8). Hence, qualitative research methods are inductive. There are two research traditions that inform qualitative research methodologies: critical and interpretive. The major emphasis of these two paradigms is on “seeking understanding of human actions and experiences, and on generating accounts of their meaning from the viewpoints of those involved” (Fossey et al., 2002, p. 718). The critical research tradition includes participatory action research and Marxist, feminist, and psychoanalytic approaches, whereas the interpretive methodologies include ethnography, critical ethnography, phenomenology, and narrative approaches. Each of these approaches addresses the issue of meaning of human actions and experiences from different viewpoints (Fossey et al., 2002).



Ethnography is one type of interpretive methodology that primarily focuses on the meaning of a phenomenon in “its particular societal and cultural context” and explores “the ways in which the phenomenon has been instituted within a community, or collective of members, over time” (Fossey et al., 2002, p. 720). Additionally, in ethnographic research design, the researcher interacts with people within the participants’ environment (Laugharne, 1995; Young, Taylor, & McLaughlin-Renpenning, 2001).

The philosophical foundations governing ethnography are rooted in anthropology (Laugharne, 1995). The most important aspects of the philosophical basis in anthropology include culture, naturalism, and holism. Ethnographic research attempts to describe culture rather than infer or test causal relationships. Thus, the focus on cultures as well as the role of the researcher as a participant observer set ethnography apart from other qualitative methods (Laugharne, 1995). Moreover, ethnography provides the researcher with a means for exploring cultural groups (Richards & Morse, 2007) or what members of a group have in common in a particular setting.

Focused ethnography is a subfield of conventional ethnography that enables the nurse researcher to “focus on a distinct problem within a specific context among a small group of people” (Roper & Shapira, 1999, p. 7). The main differences between conventional and focused ethnographies are their demands on time (Knoblauch, 2005; Muecke, 1994). Conventional ethnographies are experientially intensive and longer ranged, whereas focused ethnographies are of shorter range and do not depend on protracted immersion. Focused ethnographies are characterized by selected, specified, and focused aspects of a field (phenomenon) being studied; therefore, the researcher needs to have knowledge of the field (phenomenon) of which it forms a part (Knoblauch, 2005).

Thus, the focused ethnography was an appropriate method to answer research questions for the current study of Thai immigrant women's knowledge, attitudes, and beliefs regarding cervical cancer and screening and perceived barriers of Germany's current cervical cancer screening services.

### **Reflexivity**

Reflexivity relates to the degrees that the researcher exerts his or her influence intentionally and/or unintentionally on the findings (Jootun, McGhee, & Marland, 2009). In general, reflexivity is a concept vital to qualitative research in terms of adding rigor or credibility to the study (Dowling, 2006; Roberts, 2006; Thompson, 2004). According to Jootun et al. (2009), in order to add credibility to qualitative research inquiry, one must reflect on the process of one's research and try to understand how one's own values and perspectives may subsequently influence findings.

With regard to ethnographic research, according to Pellatt (2003), "It has increasingly been observed that there is no way of removing the observer from research in naturalistic settings" (p. 29). Researchers undertaking the ethnographic research method recognize they cannot entirely suspend their own knowledge of the social world to achieve objectivity due to both the researcher and the studied participants using the same resources to understand meaning (Pellatt, 2003). For this reason, researchers must critically think about the potential impact of their assumptions, values, and actions on the study.

Pellatt (2003) pointed out that, unlike early ethnography studies, contemporary ethnographic researchers are often members of a culture related to or similar to those they study rather than complete outsiders. Such was the case in the current research. In

addition, Pellatt stated that “researching in one’s own culture can cause tension between strangeness and over-identification” (p. 31), which may result in analytical problems. To enhance the rigor of ethnographic study, it is recommended that the researcher add his or her own reflexive account to the ethnographic record. In addition, the relationship and the influence between the researcher and participants need to be made explicit (Pellatt 2003,). The transparency about the conditions by which the reports were created will inform readers about what transpired during the research process and enable them to decide whether the study is credible.

### **My Perspective**

I was born and raised in northeastern Thailand. My initial nursing education in Thailand was in midwifery and public health. I worked for the Thai Ministry of Health at an outpost clinic serving a rural community for 4 years prior to immigrating to the United States to advance my education in nursing. My nursing experience in the United States was mostly spent working in acute care settings. Nevertheless, I have had a great interest in women’s health issues due to the influences of my earlier educational background as a midwife in Thailand.

My specific interest in the area of women’s health, especially in the area of cervical cancer screening, was shaped by my own personal experience. In 1989, at the beginning of my graduate study, I suffered severely from symptoms of hormonal imbalance, and my physician recommended hormonal replacement therapy. In order for my physician to prescribe appropriate treatment, I needed to undergo a pelvic examination to rule out other diseases. Although at that time I was 29 years old, I had never had a pelvic examination or Pap test because I was an unmarried woman. I was

distressed at the prospect of having the procedure done. Initially, I refused the treatment; however, my symptoms worsened. The initial reason I refused the Pap smear was due to my own cultural beliefs. I was brought up in a very traditional household and taught at a very early age that premarital sex and promiscuity were central to the characterization of “bad” women. It was expected that, as a “good” woman, I would uphold my virginity until marriage. This situation caused me great internal conflict. It was an extremely difficult decision for me to submit to the pelvic examination procedure to receive an appropriate diagnosis and treatment, as it was in direct conflict with my cultural values and beliefs. In spite of my physician’s cultural and personal sensitivity and her careful guidance and explanation throughout the procedure, I mourned the loss of what I perceived to be “a special gift” to my future husband at marriage.

Subsequently, after an extensive literature review in preparation for my master’s thesis, entitled, *Health Practices and Knowledge of Laotian Women in Anchorage, Alaska, Regarding the Pap Smear as Cervical Cancer Screening*, I found that the incidence of cervical cancer is relatively high among Southeast Asians, especially among Vietnamese, Cambodian, and Thai women, compared with other ethnic groups in the United States. I also found that the contributing factors for low utilization of cervical cancer screening included cultural and language barriers, lack of resources, and preventive health concepts. My personal experience, combined with the inquisitiveness to learn more about women’s attitudes toward this life-saving screening, further stimulated my interest in delving into this phenomenon. For my master’s thesis requirement, I conducted a small descriptive survey study of the health beliefs, knowledge, and attitudes regarding cervical cancer screening among Laotian women living in Anchorage, Alaska;

however, I was dissatisfied with the way in which the quantitative approach answered the research questions regarding this topic. I chose to pursue this subject to become more aware of and understand other women's personal perspectives and experience regarding cervical cancer and screening. The target population for this study was Thai women, who, like me, were born and raised in the same cultural context of social norms and traditions in terms of gender role and sexuality.

Due to previous experiences regarding this phenomenon of interest, I naturally brought biases to this study. However, being aware of this, I made every effort to ensure that I remained objective throughout the entire research study. These personal biases influenced the way I viewed and understood the data that I collected and potentially colored some of the analysis and interpretation of data. However, I undertook this study with a strong belief that the richness of the findings may give a greater insight and understanding into Thai women's knowledge, health beliefs, and attitudes regarding cervical cancer and screening.

### **Sampling and Setting**

Gibbs et al. (2007) proposed that in qualitative research as much as in quantitative, "sampling and data collection are critical to determining the quality of a study" (p. 540). In ethnography, sampling is ascertained by the number of participants in the group being studied (Higginbottom, 2004). In focused ethnography, a specified number of individuals who meet the specific criteria, possess specific knowledge, or express an interest in the study may be contacted to optimize the chance that data will be robust and informative when time and financial resources are limited (Higginbottom, 2004; Richards & Morse, 2007). Additionally, the sample size in qualitative research

refers to the numbers of participants, but may also refer to the number of interviews and observations conducted. In qualitative research, there are no absolute rules or formulas for estimating needed sample size (Patton, 2002). Factors in determining sample size depend on the scope of the study, nature of the topic, quality of the data, study design, and use of shadowed data (Morse, 2000; Patton, 2002). Morse (2001) described shadowed data as speaking-for-others, or “information that participants give us about the types, characteristics, and dimensions of concepts, perceptions, behaviors, and opinions of others” (p. 291). The most common use of shadowed data occurs when it is necessary to obtain information about others when they are not accessible (Morse, 2001).

In ethnographic studies, when using semistructured single interviews, the researcher obtains a small amount of data per interview, which is considered relatively shallow data. To obtain the richness of data required for qualitative analysis, the researcher needs to obtain a larger sample size than would be needed if multiple interviews were being conducted with each participant; Sandelowski (1995a) and Morse (2000) recommended at least 30 to 60 participants as a minimum sample size in an ethnographic study.

Walker (2012) stated that saturation may be considered as the gold standard by qualitative researchers in determining purposive sample sizes. According to Gillis and Jackson (2002), in qualitative inquiry, saturation refers to “a situation in data collection in which the participants’ descriptions become repetitive and confirm previously collected data” (p.185). The concept of saturation is a crucial methodological concept in the qualitative research inquiry. There are two types of saturation: theoretical saturation and data saturation. Theoretical saturation occurs when no new themes emerge within the

data, and all the existing category structure appears stable; data saturation occurs when the data being collected has become repetitive and no new themes emerge from the analysis (Gibbs et al., 2007; Miller & Crabtree, 1994; Walker, 2012). In qualitative study, data saturation provides the researcher with confidence that the description of the phenomenon has been captured (Gillis & Jackson, 2002).

In the current study, recruitment was guided by the concept of data saturation. After 25 participants were recruited into the study and interviewed, and after reviewing the field notes, it was apparent that data saturation was achieved. I noted repetition and no new patterns, and no new themes were apparent in the preliminary analysis. However, I continued with the recruitment process until the sample size of 30 participants was reached because I followed Sandelowski (1995a) and Morse's (2000) recommendations of minimum of sample size for an ethnographic study.

### **Inclusion Criteria and Recruitment of Primary Participants**

Hereafter, the primary participants will be referred to as “women” or “participants.” Study participants were 30 Thai women, age 22 through 56, living in Rheinland-Pfalz and neighboring regions. The inclusion criteria for all participants were: (a) women aged 20 through 64 and self-identified as Thai; (b) first-generation Thai immigrant women living in Germany; (c) being single, unmarried, or married to a German citizen; (d) being able to speak and comprehend the Thai language adequately to provide informed consent (Appendices A and B); and (e) willingness to participate in a 60 to 90 minute audio-recorded, in-depth interview.

**Exclusion criteria.** Exclusion criteria included women who did not meet the criteria, had a hysterectomy, or had been diagnosed with cervical cancer, as they may

have had different perspectives regarding cervical cancer and screening. However, no participants were excluded from the current study.

The rationale for selecting the target age of participants was as follows: (a) in Germany, starting at age 20, all women are eligible for a yearly, cancer, early-detection gynecological exam (KFU; Klug et al., 2005); (b) information from the analysis of the literature indicated that the cervical cancer screening rates from those, first-generation immigrant women of Asian descent were considerably low (Alba et al., 2005; Jirojwong & Manderson, 2001; Tsui & Tanjasiri, 2008) and remained significantly low, even after many years of living in their host countries (McDonald & Kennedy, 2007); (c) data from Thailand indicated a high incidence of Thai youth engaged in premarital sexual practices (the incidence of unsafe sexual practices, multiple partners at a younger age, and relatively high incidence rates of STDs among Thai adolescents and people under the age of 25 accounted for 70% of all the STD cases [Thato et al., 2008]; these contributing factors may predispose Thai women to a greater risk of developing cervical cancer); and (d) cervical cancer ranked as the most frequently occurring cancer among all women in Thailand and the most frequent cancer among Thai women between 15 and 44 years of age (WHO Thailand, 2007).

Purposeful sampling using the maximum variation method (Patton, 2002) was used to obtain known variables associated with cervical cancer screening rates, such as age, education, marital status, number of children, occupation, insurance status, economic status, and years of residency in Germany. In addition, I employed snowball sampling to maximize the chances of recruiting potential participants. Snowball sampling is a special nonprobability technique used for developing a research sample in which existing study



participants help recruit future participants from among their acquaintances. This sampling technique is often used in recruiting members of populations that are difficult for researchers to access (StatPac.Com, 2008) and was effective in recruiting study participants for this study. The participants recruited by this method were provided with my contact phone numbers for further information regarding the study.

In addition to the snowball strategy, recruitment of the participants occurred through known contacts of Thais living in the federal state of Rheinland-Pfalz, Thai temples, and word of mouth. Written permission was submitted to the Buddhist temples in Mannheim and Frankfurt (see Appendices C and D) to allow the investigator to recruit potential participants while the women were attending the temple. However, only one newly established Buddhist temple, located near my resident community (Bosenbach), responded and gave permission for recruitment. All primary participants received 15 Euros upon completion of their interviews.

### **Inclusion Criteria and Recruitment of Secondary Participants**

The secondary participants included an office-based German gynecologist and a German registered nurse. These providers served as key informants and described their experiences in providing health care to Thai women. Inclusion criteria for secondary participants included (a) age of 20 years and older, (b) able to read and speak English fluently, (c) be a practicing gynecologist or a practicing registered nurse, and (d) willingness to participate in a 60- to 90-minute, audio-recorded, in-depth interview.

The secondary participants were solicited from the practicing physicians and registered nurses in local communities in Kusel, Kaiserslautern, Ramstein, and Landstuhl (nearest towns to my home community); from known contacts through my German

neighbor, who served as a key contact; and through participating Thai women who utilized health care services in their communities. The two German health care providers provided information that complemented and enhanced understanding of the overall German health care system Thai immigrant women utilize and provided their own personal perspectives regarding cervical cancer and screening. Consent forms for the secondary participants are shown in Appendices E and F.

### **Consenting Procedures**

After the study was approved by the Institutional Review Board of the University of New Mexico, I contacted and explained the study to the Buddhist temple boards in Frankfurt and Mannheim, Germany, in writing. Unfortunately, I did not receive a response from either the Frankfurt or Mannheim Buddhist temples. In the spring of 2011, I contacted and explained the study to a newly established Buddhist temple that was located near my home town and obtained written permission for recruitment of Thai women attending the temple.

After approval was obtained, flyers regarding the study were posted at local Thai restaurants and Asian grocery stores (Appendices G and H). Depending on their preference, participants would either contact me directly by phone or in person, or would leave their names and phone numbers with key contact persons listed in the fliers. Once the primary participants were identified and the University of New Mexico Human Research Protections Office approved the information regarding voluntarism in the study, the research procedure and its purposes, the risks, and the anticipated benefits, the consent was read in Thai by the investigator. The participants were also offered the opportunity to ask questions and to read a statement indicating that all participation was voluntary and

that participants could withdraw from the study at any time without negative outcomes. The time and location of the interview were chosen by the participant.

The briefing of the overall purpose of the study was provided to the secondary participants in the same manner as for the primary participants. The interview process with the secondary participants was initiated shortly after they agreed to participate. I scheduled appointments, times, and locations of the meeting with the secondary participants based on their preferences. The interviews with secondary participants took place after approximately half of the primary participants had been interviewed. This method provided insight regarding Thai women's knowledge, attitudes, and beliefs regarding cervical cancer and helped to frame further in-depth questions.

### **The Study Protocol**

At the time of this writing, in Germany, there was no printed cervical cancer educational information available in the Thai language. As a part of the research protocol, at the end of the interview, I provided participants with information in Thai regarding current cervical cancer and screening recommendations in Germany and how to access the screening. The purpose of providing the cervical cancer educational information was to increase awareness of cervical cancer screening and the asymptomatic nature of the disease, prompt preventive health behavior among the participants, stress the benefits of early detection through routine Pap smear screening and provide information about the current cervical cancer screening recommendations and how to access the screening in Germany. In addition, I offered printed brochures regarding cervical cancer screening information in Thai, which I obtained from the National Cancer Institute of Thailand

website to the participants at the end of the interview (National Cancer Institute of Thailand, 2004).

### **Setting**

The site for this study was mainly the investigator's home community, Rheinland-Pfalz, and neighboring regions (see Figure 3). Rheinland-Pfalz, or Rhineland-Palatinate, a German federal state with a population of more than 4 million, is located in the central southwest region of Germany. Rheinland-Pfalz shares international borders with France, Luxembourg, and Belgium. In addition, it borders the German federal states of North Rhine-Westphalia in the north, Hesse in the east, and Baden-Württemberg in the southeast. Rheinland-Pfalz is well known for historical cities and villages and some of the best wine-producing areas in Germany. In addition to the state capital, Mainz, other major cities of Rheinland-Pfalz include Frankenthal, Idar-Oberstein, Kaiserslautern, Koblenz, Landau, Ludwigshafen, Neustadt, Pirmasens, Speyer, Trier, Worms, and Zweibrücken (Nationonline.org, 2009).

As previously stated, there are 54,580 registered Thais living in Germany, with the majority being female (47,030; Statistisches Bundesamt Deutschland, 2008). According to the Royal Thai Consulate General (2008), there were 3,610 Thai immigrant women in the State of Rheinland-Pfalz in 2007.

### **Data Collection Method**

Data sources for this focused ethnographic study were (a) responses from the demographic questionnaire and cervical cancer screening practice questionnaire; (b) interview data from primary and secondary participants gathered during a single interview

with each participant; (c) observational data from the interview sessions recorded as field notes; and (d) diary or notes of the research process.



*Figure 3.* Map of the Federal State of Rheinland-Pfalz, Germany. (Source: GEOATLAS.com (2004). Map of Germany. <http://www.maps-of-germany.co.uk/map-of-rheinland-pfalz.html>).

### **Interview Guide**

The interview guide for both primary and secondary participants included a set of demographic questions (see Appendices I and J). A set of the cervical cancer screening

questions (see Appendix I) were incorporated into the primary participants' interview guide. All questions were administered verbally as part of the interview and were audio-recorded to ensure that any narrative discussion about the demographic and cervical cancer practice questionnaires was captured as data.

**Demographic data.** The demographic questionnaire (see Appendix I) for primary participants included questions about age, number of children, marital status, educational level, other females living in the same household, employment status, occupation, insurance status, years of residency in Germany, and economic status. For the secondary participants, a demographic questionnaire (see Appendix J) contained questions about the following items: age, specialty area of practice, number of years in practice, practice hours per week, number of patients per day, and whether the provider was in solo practice or group practice (for the physician).

**Cervical cancer screening practice interview.** Questions regarding cervical cancer screening practices (see Appendix I) were used to ascertain specific practices among Thai women. An example of the screening practice question on the perceived risk of developing cervical cancer was: "Have you ever had a Pap smear? If so, what was the reason for your most recent Pap smear?"

## **Interviews**

Patton (2002) stated that the purpose of interviewing is to "allow us into the other person's perspective" (p. 341). The assumption of a qualitative interview is that, "the perspective of others is meaningful, knowable, and able to be made explicit" (p. 341). The usefulness of a semistructured interview is that it provides the researcher with the organization and comfort of using planned questions and yet offers the challenge of

presenting them to the participants in a manner that encourages detailed and complex responses (Richards & Morse, 2007).

The interview guide for this study was developed using the HBM framework to elicit Thai women's personal perspectives of their knowledge, attitudes, and beliefs about cervical cancer and screening (see Appendix I). The semistructured interview was well suited for this study (Richards & Morse, 2007). Because I am Thai, I carefully framed the interview questions for the participants in a culturally sensitive way and respectfully listened to their responses.

In the qualitative interview process, total or partial linguistic competency is central to cross-cultural studies. Problems occur when the researcher and participants do not share the same language (Meetoo, 2004). All the interview sessions with the primary participants were conducted in Thai. The interview session began with open-ended questions designed to elicit information about each woman's knowledge of cervical cancer and screening, causes of cervical cancer, and the use of Pap smear screening. Richards and Morse (2007) suggested that the researcher's role during the interview session take the form of helping to maintain and facilitate the conversation rather than disrupting the participant's flow of thoughts. Probing and clarifying questions were used as necessary to encourage participants to elaborate. An example of the open-ended question to elicit a response on knowledge of cervical cancer is: "How is it that you learned about Pap smears?"

**Face-to-face interviews with primary participants.** Data collection consisted of one interview session of approximately 60 to 90 minutes at the location of the participant's choosing. Participants were offered their choice of interview locations: my

home, the primary participant's home, or a private office located above a local Thai grocery store. The owner of the grocery store was a Thai national and did not participate in the study; however, she served as an intermediary contact person and kindly offered a private office for the interview sessions.

Of the 30 participants, 20 chose to hold the interview sessions at the private office above the grocery store, where it was more convenient for them because their husbands could drop them off and pick up groceries within the same trip. The majority of the participants in this study did not know how to drive. One interview took place in a traditional Thai massage parlor, where the participant worked part time as a masseuse. Three interviews were held at my home. The remaining six interview sessions took place in the participant's home. Informed consent was obtained prior to the interview and participants were asked to choose a pseudonym, which was used throughout the interview.

Like many Asian cultures, the Thai culture emphasizes modesty and politeness in interpersonal relationships. Addressing an elder by his or her first name is considered socially unacceptable (Suh, Kagan, & Strumpf, 2009). In addition to the use of pseudonyms, I employed another precaution to avoid using the participants' real names, using polite and respectful Thai terms, such as older sister (*Pee-sao*), younger sister, (*Nong-sao*), younger aunt (*Naa*), older aunt (*Paa*), or mother (*Mae*) during the interview. I took all possible precautions to avoid leading the participants during the interview in order to capture genuine subjective responses.

**Face-to-face interviews with secondary participants.** Interviews with secondary participants occurred at the time and place of the participants' choosing and focused on



the context of Germany's health care system. The interview session with the office-based gynecologist took place in a private office after work, whereas the interview session with the registered nurse occurred at her home. Questions were related to broad social and cultural perspectives of the current health care services. In addition, the secondary participants were asked about their personal perspectives and perceptions of providing care to minority groups, including Thais; perceived barriers to cancer screening; and current cancer screening programs in Germany (see Appendix J). The interviews were conducted in English and audio-recorded to ensure accuracy.

### **Observations**

Richards and Morse (2007) stated, "Observation is the most natural of all ways of making data, but observing unobtrusively is extremely difficult" (p. 115). Participant observation is a method employed by an ethnographer in the anthropological tradition. It is used to capture the unspoken, naturally occurring routines, activities, and practices of a particular group of people in their social world to understand their culture (Fossey et al., 2002; Patton, 2002). According to Richards and Morse (2007), in focused ethnography, data gathering may include only some of the strategies of traditional ethnography to elicit information on a special topic.

Because the data collection is technically supported by using an audio recorder during the interview process, researchers have more time to observe. In this study, I used the observational method to gather such information as the characteristics of the participants, verbal communication (e.g., participants' ability to articulate and their demeanor), nonverbal communication (body language), activities (e.g., what method do they use to communicate?), and environmental settings (e.g., participant's home

environment, noise level) during the interview process. Contextual observations of nonverbal behaviors were recorded as field notes after all interviews. I used the observational data to add context to the narratives and to support emerging themes, as well as to develop further in-depth interview questions.

### **Field Notes**

Researchers traditionally record their observation data in addition to their own interpretations of data in the form of field notes (Richards & Morse, 2007). Field notes were kept throughout the entire research process. Observation notes and my thoughts, beliefs, biases, and impressions of details occurring during the interview process were recorded immediately after each interview. I also recorded memos and analytical notes throughout the study process. Additionally, field notes were regularly reviewed as a means of assuring reflexivity.

### **Data Analysis**

In qualitative research, data analysis is an ongoing process involving the researcher's continued reflection about data, asking analysis questions, and writing field notes throughout the research process. In addition, data analysis takes place concurrently with data collection in the qualitative approach (Creswell, 2003; Fossey et al., 2002; Richards & Morse, 2007). Fossey et al. (2002) maintained that qualitative analysis "is a process of reviewing, synthesizing, and interpreting data to describe and explain the phenomena, or social worlds being studied" (p. 728). The analytical procedure can be categorized differently into content, discovery, and meaning-focus approaches. Regardless of which approach is used, as with data collection methods, the rigor of the data analysis process relies mainly on adequacy and transparency (Fossey et al., 2002). In

ethnography, according to Richards and Morse (2007), data analysis consists of first-level descriptions of the setting and individuals, followed by analysis of the data for themes.

The following sections will describe the process of data analysis used in this study.

### **Analysis of the Interview Data**

Miller and Crabtree (1994) identified three main steps of qualitative data analysis strategy, which include: (a) choosing an organizing system for “sifting and prioritizing the information” (p. 292); (b) using the organizing system to segment the data; and (c) making connections by categorizing or grouping segmented data into patterns or themes.

Miller and Crabtree (1994) stated that there are four main types of strategies for qualitative analysis which include editing, template, immersion/crystallization (I/C), and quasistatistical styles. In the editing style, the interpreter (analyst) is the editor. The analyst or the interpreter reads the text and organizes information from the text based on the relevancy from the research question. This style is the most commonly used method of qualitative analysis because of its versatility in different disciplines. These include ethnography (from anthropology), grounded theory (from sociology), and hermeneutics (from psychology; Miller & Crabtree, 1994). The second strategy for qualitative analysis is the I/C style. In this style, the researcher’s intuition and reflexivity is the organizing system and primary source of interpretation of data. The third analysis style, template, uses the template or code book to distinguish relevant information. The fourth style is quasistatistical, in which, like template, “a detailed, rigid code book is applied to the text and used to identify and sort data into categories” (Miller & Crabtree, 1994, p. 293); however, statistics are used to find correlation in data.

In addition, Miller and Crabtree (1994) added that the important factors in deciding which analysis strategy to use for a particular research study is the researcher's prior knowledge of the topic of interest, as well as the purpose of the study. In this study, I used the process of I/C as the analysis strategy to interpret and elicit the findings. The purpose of this study was to describe knowledge, attitudes, and beliefs regarding cervical cancer and screening among Thai immigrant women; thus, "a less structured, more intimate style is preferred, such as immersion and crystallization or editing" (Miller & Crabtree, 1994, p. 295).

In qualitative study, the I/C organizing style provides the researcher with "a means to move from the research question, the generated text and/or field experience, and the raw field data to the interpretations reported in the write-up" (Borkan, 1999, p.180). Borkan (1999) maintained that in the process of I/C, the researcher should be immersed in the data and should rely on intuition or reflexivity in working the iterative steps of the research study. In the process of I/C, as the data analysis is being implemented and as new themes are emerging, the researcher may decide whether to continue with further data collection (data saturation).

The process of I/C (Borkan, 1999; Miller & Crabtree, 1994) was used as a strategy for data analysis in the current study. According to Mendelson (2006), the processes of I/C are crucial in the data analysis of the interview. Through this process, "an intimate knowledge of the data is developed through a disciplined process of multiple readings and reflections on the data" (Mendelson, 2006, p. 987). In this approach, the researcher undergoes a prolonged immersion into the data using iterative and reflexive process to facilitate the emergence of themes and insights (Borkan, 1999). This method of analysis

provides the researchers with the opportunity to involve themselves in the transcribed text and experiences of the participants. After repeated reflections and immersion, interpretations of the data begin to emerge, and themes begin to crystallize.

In the current study, I systematically approached the interview data as follows: (a) identified major topics, content, or story lines (Sandelowski, 1995b); (b) summarized each interview; and (c) created a single narrative for each participant, including the demographic data and observation data obtained during the interview process (Mendelson, 2006). According to Mendelson (2006), this approach “allowed for a contextualized understanding of each woman’s unique story against the findings for the sample” (p. 987).

The process of I/C was followed by a line-by-line review of the transcripts. In this process, the crystallized findings (identified themes) were applied directly to each section of data, which enabled me to compare the more abstract crystallized findings directly with the interview data and major topic originally identified in each transcript, thus ensuring that the final findings remained consistent and true to the language used by the participants (Mendelson, 2006). The follow research analytical procedures were conducted: (a) organizing and preparing the data for analysis; (b) reducing the data; and (c) making connections.

**Organizing and preparing the data for analysis.** This process involved transcribing interviews, typing up field notes, and sorting and organizing the data into different categories. Suh et al. (2009) maintained that, after the interview, culturally appropriate analytical skills are required in data analysis. In addition, interview translations may “significantly influence study findings if not handled appropriately” (p.

196). They stated that there are various techniques available for qualitative interview data, including one-way translation, translation by committee, and back translation to verify the content of narratives or an instrument. They suggested avoiding losing cultural or contextual specific expression or meaning. If a bilingual and bicultural researcher is available, non-English narratives need to be analyzed in the original language. Consequently, data analysis for this study was conducted in the original Thai.

The recorded interview sessions with the primary participants were transcribed verbatim in Thai by a Thai transcriptionist who was not involved with the study. The transcriptionist did not have access to the identifiers (i.e., participants' names, phone numbers, and home addresses). After the transcription was completed, I cleaned the data by comparing the transcripts with audio recordings for accuracy, which not only ensured that the transcripts were accurate but served to reacquaint me with the interviews. All responses were syntactically corrected for ease of reading, with careful attention to retaining correct contextual meaning. The initial coding was accomplished immediately after the interview and then followed by translation into English during analysis. The English translation, with constant contextual comparisons between the meanings of two languages, occurred during coding categorization. This method enables the researcher an opportunity to capture implicit and explicit meanings from the transcript, in addition to culturally specific expressions and concepts (Suh et al., 2009).

In addition, a written summary of each interview was generated. An informal process of member checking occurred with each primary and secondary participant at the end of the interview to validate their responses. The formal portion of member checking

involved the selection of 7 participants with whom I provided a written summary of the interview transcript and reviewed the emergent themes.

For the secondary participants who were interviewed in English, a transcriptionist not involved with the study transcribed the audio-recorded interviews verbatim. I then cleaned the data by comparing the typed transcripts with the audio recordings to ensure accuracy. A written summary of each secondary participant's interview was generated.

**Reducing the data.** Coding is the process of analyzing segments of data, sentences, and paragraphs, and labeling those segments with a term, often based on the actual words of the participants. Creswell (2003) suggested that researchers read and re-read through all the data to obtain a general sense of information and to reflect on the overall meaning, including general ideas, the tone of the ideas, the general impression, and the overall depth, credibility, and usage of the information. As Patton (2002) pointed out, this step allows the researcher to “get a sense of the whole” (p. 441) by checking out the quality of the information collected. During this process, I recorded notes and general thoughts regarding the data in the margins.

**Making connections.** I created descriptions that denoted an in-depth representation of the information about people, places, and events in the setting where the interview took place. Additionally, thick description (Geertz, 1973) was developed by processing field notes including the physical environment, people, actions, settings, and dialogue, along with the interviews, in which informal conversations and observations were reported, and through the theoretical lens developed from this information (Richards & Morse, 2007).

According to DeSantis and Ugarriza (2000), themes are largely abstract and mostly implicit, implied, and tacit; “Themes are used as evidence of their manifestations, existence, and unifying properties” (p. 355). Qualitative researchers agree that themes emerge from the data. The functions of themes include: unifying a large body of data that otherwise may appear unrelated or disparate; capturing the meaning or experience; and directing behavior across multiple situations (DeSantis & Ugarriza, 2000). In this study, themes and subthemes were inductively developed from the interview data.

### **Data Management**

Weitzman (1999) stated that “design of software can have an impact on data analysis because different software works in different ways of presenting the relationships among codes and between codes and texts” (p. 1248). Therefore, software selection all depends on the specifications of the researchers and projects. Data analysis of the interviews was supported and enhanced, in part, by utilizing the qualitative software package called NVivo (Version 9.2; QSR International, 2010). NVivo is a qualitative data analysis and management software developed in 1999 by QSR International and widely used in various fields, including psychology, communications, sociology, forensics, tourism, and marketing. This software facilitates classifying, sorting, and arranging chunks of information and assists with linking, shaping, searching, and modeling concepts. All transcripts were entered in the NVivo software program for coding to assist in locating useful quotes and multiple perspectives on categories and themes, and aiding in the data management, and retrieval.

In addition, IBM (2010) SPSS Statistics (version 19) was used to analyze the demographic data of the participants, including age, marital status, number of children,



other females living in the same household, level of education, employment status, length of residency in Germany, insurance status, and economic status. These descriptive data were used to supplement the interview and observation data. The data were coded into NVivo for cross indexing with thematic codes and added perspective to the final narrative.

### **Assurance of Trustworthiness**

In qualitative inquiry, there is much debate concerning methodological rigor in terms of establishing validity criteria to guard against the investigator invoking concepts and theories that do not accurately represent the phenomenon of interest (Whittemore, Chase, & Mandle, 2001). Standard methods of validity and reliability assessment in quantitative research are not appropriate to qualitative research. Within the interpretive research perspective, numerous terms have been proposed to aid qualitative researchers in the articulation of valid criteria. Some authors have suggested such terms as truth value, credibility (Lincoln & Guba, 1985), authenticity (Guba & Lincoln, 1989), and goodness (Emden & Sandelowski, 1998). Lincoln and Guba's (1985) philosophical and practical contributions to the development of credibility criteria are commonly used to assure trustworthiness in qualitative research inquiry. The concept of trustworthiness clearly established the need for credibility and authenticity to ensure quality in qualitative research if the data and the findings were to be trusted (Lincoln & Guba, 1985). The proposed study used Lincoln and Guba's criteria: (a) credibility; (b) transferability; (c) dependability; and (d) confirmability.

## **Credibility**

According to Lincoln and Guba (1985), credibility of the data can be supported by prolonged engagement, persistent observation, triangulation, and member checking “to make it likely that credible findings and interpretation will be produced” (p. 301). This study used prolonged engagement with the data, persistent observation, triangulation of data sources, and member-checking approaches to support credibility.

**Prolonged engagement.** In ethnographic study, prolonged engagement is the investment of sufficient time to accomplish the purposes of “learning” the cultures, testing for misconception, and building trust with the participants (Lincoln & Guba, 1985). Thus, this method provides scope to the data gathering.

I resided in Germany for 3 years and developed an extensive network within the Thai community in Rheinland-Pfalz, my resident community. Over the past 5 years, I performed an extensive review of the literature regarding this phenomenon. Sufficient time investment was devoted to this study to ensure that data saturation was accomplished in interview data (Bertram & Magnussen, 2008). The length of face-to-face interviews with primary and secondary participants was sufficient to provide time to build a rapport with the participants as well as to provide opportunities for member checking where any misconceptions or misunderstood information could be clarified.

**Persistent observation.** According to Lincoln and Guba (1985), the purpose of persistent observation is “to identify those characteristics and elements in the situation that are most relevant to the problem being pursued and focusing on them in detail” (p. 304). Thus, persistent observation adds depth to data collection. In this research, persistent observation was accomplished by the number of participant interviews that

allowed for a degree of persistent observation by returning to ideas frequently and with different participants.

**Triangulation.** Triangulation refers to a method that enhances the validity by using multiple methods, data sources, theories, and/or investigators (Farmer, Robinson, Elliot, & Eyles, 2006). This study employed triangulation to ensure dependability and credibility. In qualitative research, triangulation enables the researcher to examine data collected by using different sources, different methods, several researchers on a team, or findings resulting from different procedures of analysis (Creswell, 2003). This method may contribute additional information that may be unobtainable from a single method (Speziale & Carpenter, 2007). In this study, triangulation was used in the following areas: (a) data sources, (b) data collection methods, and (c) data analysis procedures.

*Triangulation of data sources.* I used multiple data sources that focused on a similar phenomenon to provide different information (Holcomb & Andrew, 2005). The demographic data and cervical cancer screening practices provided characteristic information about the participants. The interview data provided rich in-depth descriptions of the participants' health beliefs and attitudes regarding cervical cancer and screening practices among Thai women. The field notes allowed me to record my impressions about the study process, environmental observations, and the participant's behaviors during the interview, which were not captured on the transcripts or audio recordings.

*Triangulation of data collection methods.* Triangulation of data collection methods integrates the use of more than one method of data collection within a single study (Holcomb & Andrew, 2005). A combination of two data collection methods, a semistructured interview and observation recorded as field notes, was used in this study.

According to Holcomb and Andrew (2005), the advantage of triangulation of methods is that “the weakness of one method can be compensated for by the strength of the other” (p. 76).

***Triangulation of data analysis procedures.*** This type of triangulation involves using two or more approaches to analyze the same data for validity. Holcomb and Andrew (2005) stated that this method of triangulation has recently been recognized among qualitative researchers; yet, there is no agreement on a universally acceptable definition. I employed the approach to triangulation of the data analysis procedures Mendelson (2006) used in her study entitled *Managing a Medically and Socially Complex Life: Women Living With Lupus* as a method to enhance validity of the analytical process. In this process, the more abstract crystallized findings were applied directly through each section of a line-by-line review of data. This approach ensured that the crystallized findings were not only consistent with the raw data, but also remained consistent when compared with the key concepts of the data and the language used by the participants (Mendelson, 2006).

**Member checking.** Member checking, or respondent validation (Johnson & Waterfield, 2004), involves the participants reviewing the collected data or data analysis and then comparing it with the investigator’s account to confirm or challenge the validity between the two sets (Horsburgh, 2002; Mays & Pope, 2000). The participants’ responses to the analysis are included in the study findings. Lincoln and Guba (1985) viewed this as the strongest available technique on the credibility of a qualitative research study. The member-checking process can be both formal and informal and occurs constantly. The data collected from the participants went through a careful process of analysis,

interpretation, abstraction, and synthesis. It is conceivable that many participants may not have a comprehensive notion of the nature of the study due to their varied backgrounds. Each participant contributes only a part of the study; thus, the member-checking process was accepted as that part of the individual's world that they can recognize (Cutcliff & McKenna, 2002) and is presented by dialogue, explanation, and discussion that transpired during the interview process.

As previously mentioned, the informal process of member checking occurred at the end of the interview, with each primary and secondary participant validating her responses. The formal component of member checking was accomplished by selecting 7 participants as key informants, to whom I provided individual interview transcripts and written summaries of their interviews and the investigator's interpretation of the data. At the end of the interview process, the primary participants were asked if they were willing to participate in the formal member checking by allowing me to call them to validate their transcript responses. All 7 primary participants concurred with the emerging data without dispute or verbalizing a difference of opinion on the data. All participants received 5 Euros on completion of this process.

### **Transferability**

This study did not seek to generalize the findings from a sample to a population but rather to provide in-depth descriptions that aid in understanding and illumination of important cultural behaviors and patterns (Patton, 1999) of this particular subgroup of Thai women. In addition, data were organized and presented to answer each research question in a comprehensive, consistent, and logical portrayal of the phenomenon studied

(Richards & Morse, 2007), thus from the participants' subjective voice or "emic" perspective.

According to Lincoln and Guba (1985), the issue of transferability of results rests in the hands of the consumers who use them regarding their beliefs about the applicability to particular contexts. Transferability in this study was facilitated through thick description of Thai immigrant women's knowledge, attitudes, and beliefs regarding cervical cancer, screening, and the perceived barriers to accessing health care services in Germany. This may enable the readers to transfer the knowledge to other populations or settings, thus, leading to the transferability of knowledge.

### **Dependability**

Dependability deals with the consistency of the research findings. Dependability is one of the steps used to establish credibility through the construction of an audit trail. Qualitative researchers use the audit trail to enhance the study rigor by providing the detailed data analysis and the decisions that led to the study results (Wolf, 2003). I addressed the issue of dependability by using an audit trail that included keeping and reviewing field notes of the research process. These contained the recorded methodological decision and the periodic discussion with the Chair of the faculty research committee, Dr. Cindy Mendelson, regarding the research procedure and its results. In this study, the faculty research committee served as experts or auditors (Lincoln & Guba, 1985) who first examined the process and then examined the records of the process of the study for accuracy (Lincoln & Guba).

## **Confirmability**

Confirmability is the last component to establish trustworthiness in qualitative research. According to Lincoln and Guba (1985), it is the second part of the inquiry audit process and in establishing “its acceptability the auditor attests to the dependability” (p. 319). In this part, the auditor will examine “the data, findings, interpretations, and recommendations” (Lincoln & Guba, 1985, p. 318). To achieve confirmability, I retained all the data, coding, and field notes that were reviewed by Dr. Cindy Mendelson, the dissertation chair. In addition, all questions regarding the decisions made during this inquiry were discussed.

## **Chapter Summary**

In this chapter, the methods for this study are presented. The design of the study is a focused ethnography of Thai immigrant women’s health beliefs and attitudes regarding cervical cancer and screening and the perceived barriers of screening services in Germany. The process used for recruitment of the participants, which included recruitment criteria and protection of human subjects, is presented. The data included interviews with primary and secondary participants. Demographic data were obtained from all participants. In addition, observational data and field notes were collected and maintained. The process of I/C was employed for data analysis. This approach provided a means to move from the research question, the generated transcript, and field experience to the interpretation reported in the study findings (Borkan, 1999). Guba and Lincoln’s (1985) criteria for the assurance of trustworthiness were used to establish validity. Trustworthiness was facilitated through multiple approaches, including credibility through triangulation and member checking. Thick description of the data provided

transferability of the results. Dependability and confirmability were accomplished by the process of audit trails that included keeping and reviewing field notes on the research process.



## **CHAPTER 4**

### **DEMOGRAPHIC DATA AND NARRATIVES**

Chapter 4 presents (a) the context that framed the lives and experiences of participants; (b) the narrative overviews of 9 primary participants (the 21 remaining narratives are presented in Appendix K); and (c) a chapter summary. Throughout this chapter and those that follow, any names used are aliases and not the actual names of the participants.

#### **The Context**

In ethnographic inquiry, context is vital in terms of providing a resource for understanding the human experience within a specific culture. In addition, the context provides the framework that enables researchers to interpret or make sense of human action and experience in a particular setting, place, and time (Patton, 2002). The context of this study arises from documentary research of the community, observation, and patterns in the interviews that provide a foundation for understanding immigrant Thai women's lives, work, social support, and socioeconomic and cultural aspects that may influence their knowledge, attitudes, and health beliefs regarding cervical cancer and screening.

#### **The Women**

Table 1 displays the demographic characteristics of the primary participants. The participants ranged in age from 22 to 56 years, with a mean age of 40.6 years (range = 34;  $SD = 9.110$ ). Twenty-six participants (86.7%) were married, 2 participants (6.7%) were divorced, and two participants (6.7%) were unmarried but living with the fathers of their

Table 1. *Demographic Characteristics of the Primary Participants*

<b>Characteristic</b>	<b>N</b>	<b>%</b>
Age, years		
18-29	4	13.3
30-39	9	30.0
40-49	11	36.7
50-59	6	20.0
Marital status		
Married	26	86.7
Divorced	2	6.7
Never married	2	6.7
Number of children		
0	8	26.7
1	7	23.3
2	10	33.3
3	4	13.3
4	1	3.3
Other females in household		
Yes	9	30.0
No	21	70.0
Education level		
Primary	14	46.7
Junior secondary	6	20.0
Vocational certificate/high school	6	20.0
High vocational certificate/associate degree	2	6.7
Bachelor degree	2	6.7
Employment status		
Yes	19	63.3
No	11	36.7
Types of occupation		
Housekeeping	10	52.6
Cashier	3	15.8
Thai traditional masseuse	2	10.5
Assistant cook	4	21.1
Years of residency		
1-5	4	13.3
6-10	13	43.3
11-15	10	33.3
16-20	3	10.0
Health insurance		
Yes	30	100.0
Economic status		
0-24,999 Euros/year	17	56.7
25,000-49,999 Euros/year	13	43.3

children. Eight participants had no children (26.7%), 8 participants had one child (23.3%), 10 participants had two children (33.3%), 4 participants had three children (3.3%), and 1 participant had four children (3.3%; median = 1, mode = 2).

Fourteen participants (46.7%) completed a compulsory primary education in Thailand. Six participants (20%) completed a secondary-level education, 6 participants (20%) completed high school or received a high school equivalency degree from Thailand, 2 participants (6.7%) held an associate degree from Thailand, and 2 participants (6.7%) held a bachelor's degree from Thailand.

Of those who completed a secondary education level, 2 participants completed a ninth-grade education in a German Hauptschule. In Germany, Hauptschule (secondary general school) is the lowest track in the German education system. It begins with fifth grade and advances through the ninth grade. A Hauptschule is a school in which the students prepare for occupations that require training. After students graduate from Hauptschule, they can go on to a vocational school for about 2 years (Howtogermany.com, n.d.).

Nineteen participants were employed (63.3%), and 11 participants were unemployed (36.7%) at the time of their interviews. Ten of the 19 (33.3%) participants who were employed were housekeepers, 3 (10%) were cashiers, 2 (6.7%) were traditional Thai masseuses, and 4 (13.3%) worked as assistant cooks in local restaurants.

The length of residency for the primary participants ranged from 3 to 18 years, with an average of 10.1 years. The women stated that they all had health insurance. Most of the participants revealed they were highly satisfied with health services in Germany. In terms of economic status, 17 participants stated that their annual family income was

between 0 and 24,999 Euros per year (0-39,998 USD), whereas 13 participants' stated that their annual income was between 25,000 and 49,999 Euros per year (40,000-78,400 USD). Based on the information regarding Germany's average salaries and expenditures, the average gross employment income in 2003 (annual, per worker, including dependent and self-employed) was 30,207 Euros (48,331 USD; [Worldsalaries.org](http://Worldsalaries.org), 2008). Based on these data, the majority ( $n = 17$ ) of the participants' economic status in this study fell below the average national income. Although some participants had an annual household income below the national average, all participants stated that they had health insurance and had full access to health care services. In Germany, citizens are required to have health insurance by law.

Twenty-seven of the participants migrated to Germany by way of marriage to German nationals. The exceptions were 2 participants who migrated to Germany at a very young age; 1 participant moved with her mother, who had married a German national, and 1 participant was a foreign student but decided to marry a German national to gain legal residency in Germany.

According to Ruenkaew (2009), since 1990, the number of inter-marriages between Thai women and German men has increased steadily, with more than 1,000 inter-marriages occurring yearly since 1991. Moreover, in 2007, there were 53,952 (excluding naturalized persons) Thai in Germany, 86% (46,438) of whom were women, and 60% (27,863) of those women were married to German men (Ruenkaew, 2009). Ruenkaew characterized the immigration of Thai women to Germany as "marriage migration: a migration emerging by means of marriage" (p. 23) and cited one of the most

important contributing factors for Thai women to immigrate to Germany as being “economic deprivation” (p. 23).

Ruenkaew (2009) stated that in the beginning of the “marriage migration,” the majority of the women came from the northeastern and northern regions of Thailand and had mainly completed the compulsory education of elementary school. It is commonly known that the northeastern region of Thailand is the most impoverished region of the country. However, in past decades, many women from the central and southern regions of Thailand, especially from the tourist areas such as Phu-ket and Pattaya, who had a higher education at the vocational or the university levels, joined the influx of immigration to Germany (Ruenkaew, 2009).

### **Secondary Participants**

The secondary participants were a 63-year-old practicing female gynecologist and a 52-year-old female registered nurse, who lived and worked in Rheinland-Pfalz. Both were born and raised in Rheinland-Pfalz. The gynecologist provided vital insight regarding the overall German health care system and the current cervical cancer screening program. The registered nurse worked full time at a convalescent home. She was well known to me, and I believed she had valuable insight, both from a nursing perspective and as a consumer, about the cervical cancer screening program and the overall health care system. In addition, she had been married to a member of the U.S. military and had lived in the United States for several years. After divorcing, she returned to her home town in Germany.

## **Husbands and Significant Others**

Twenty-six participants were married to German nationals. Only 2 participants were divorced, and 2 women, though unmarried, were living with their German boyfriends. Many participants described their married lives as “happily married” and stated that they were “treated very well” by their husbands. One participant who was divorced revealed that the cause of the breakup was related to her teenage son from her previous Thai marriage. “We were married for over 10 years and my husband was a nice man. My son was very disrespectful and has some behavioral problems and sometimes he was out of control” (Joom).

In 2007, Germany’s immigration laws imposed new rules that require Thai women (or any foreign nationals) who want to marry a German man to have a basic command of the German language before an entry visa is approved. To help Thai citizens deal with the new regulation, the Thai Foreign Ministry collaborated with Khon Kaen University, in Khon Kaen, Thailand, to launch a training program to help women who desire to marry German men to learn the German culture and language (“Speaking the Lingo,” 2010). The purpose of this regulation was to ensure that a foreign national who wants to live in Germany has basic life skills to function independently, for example, to be able to apply for a job, understand family laws, and gain access to state services for health benefits.

In this study, most of the women were dependent on their husbands for all decision making in the household, including making medical appointments and accompanying them to the doctor’s office. In addition, the husbands were also the interpreter for those women who experienced a language barrier when conversing with

the doctor. At the time of the interviews, only a few participants had a driver's license and were able to drive.

### **Sociocultural Factors**

Most of the participants lived in nuclear families. Only a few of the participants owned a home, and many lived in apartment dwellings or in rental properties. The majority ( $n = 22$ ) of the participants stated that they had children. For those participants with children, 16 stated that their children were Thai-born from a previous marriage or relationships with Thai men. For those who were employed ( $n = 19$ ), most of their earnings were derived from service-oriented jobs.

Regarding the social and cultural aspects of family dynamics (divorce or separation), there is a double standard of social expectations for Thai women with respect to their responsibility to their Thai family, especially in putting their children above all other family commitments. One participant, Nooy, stated that most German husbands do not understand Thai culture and are opposed to sending financial support to families in Thailand. Therefore, it was important that she had part-time employment to be able to send money to support her children, whom she had left in the care of her aging mother in Thailand. However, she was embarrassed to tell her Thai family that she worked as a housekeeper. Prior to migrating to Germany, she "used to work in the rice fields and had never dreamed of 'cleaning the toilets' for a living. However, a job is a job; it brings income to send money home to support my children in Thailand" (Nooy).

According to Humbeck (1996) "the cultural identities and experiences of immigrant Thai women are strongly influenced by the fact that most of them live in isolation from other Thais" (p. 190). For instance, most of the available social contacts of

those immigrant Thai women who live outside the major cities, like Berlin, Frankfurt, Munich, and Hamburg, are individual Germans or German groups and organizations. Humbeck (1996) stated, “This isolation may cause them to lose their identities or deny their Thai cultural identity” (p. 190).

However, from my personal observation of living in the community and from the interview data, I found that Thai women in this study were not socially isolated. In this part of Germany, there were no established Thai community centers for social meetings. However, 1 Thai woman described some of the social activities among Thais; they often met for certain events, such as birthday parties, Oktoberfest (usually held between the months of September to October), or Kerwe (typically a week-long, open-air party held in all small villages in the Rheinland-Pfalz community), or they “just get together for Thai food at someone’s house.” Often, the meeting place was the local Thai grocery store, especially on the days of the week when the new shipments of fresh vegetables and goods arrived. This is where the women would get updates on local news, events, or gossip.

The society of Thai women living in this part of Germany appeared to be close-knit; however, there were some problems existing among Thai women who were married to German nationals. One participant explained that many Thai women liked to compare income or show off their wealth, as evidenced by the amount of gold jewelry that they wear at social gatherings or at the temple. This is one of the issues among Thai women living in this area and causes social rifts and dissention, thereby, fragmenting the small social group cohesiveness. Additional issues identified by participants included “adultery, gossiping, and gambling.”



In Germany, the transportation system is very convenient. Germany's mass transit systems in major cities offer convenient access to travel inside the cities and take less time than conventional travel by car. An exception is for people whose villages are not near the train stations and have to travel by bus between villages and the cities, unless they own their own cars. One participant expressed the problems of lack of public transportation in her own village and the inconvenience for those who do not know how to drive, or for husbands who must take off from work to take their wives to medical appointments due to the limited bus schedules.

Before a new Buddhist temple, or *wat*, was established in the village of Schönborn in Rheinland-Pfalz, Thai people who lived in this region had to travel quite a distance to either Frankfurt or Munich for important religious holidays. One participant revealed that she did not go to the temple often, especially during the winter, due to the treacherous road conditions and additionally, because she did not know how to drive a car. She stated that her husband "was old" and he did not like to attend Thai functions. She stated that she would attend the temple regularly if she could get a ride from her Thai friends.

The German government provides social welfare, including support for rent, utilities, and child care assistance to women who are unemployed. One participant stated, "the German health care services and federal assistance for health insurance and housing are wonderful," as she had received social assistance for housing, unemployment benefits, and child care assistance from the government when she was unemployed.

## **The Participants' Narratives**

Narratives, or stories, are one approach to a complex ethnographic study in which narrative interviews are a key research tool (Mattingly & Lawlor, 2000). Narratives play an important role in helping to shed light on the informants' world by revealing cultural and social patterns through the lens of individual experience (Patton, 2002). In this study, the purpose of the narratives is to provide the readers with a flavor of the participants' lives, condensed from a plethora of data, and may or may not include the themes and examples of the themes discussed in the body of the dissertation. To present the context for analysis of the data that follows, the narrative overviews for 9 Thai women selected arbitrarily from the 30 participants serve as exemplars. The remaining 21 narratives are presented in Appendix K.

### **Naree's Story**

Naree was a 53-year-old Thai woman, married with no children, and had lived in Germany for 18 years. She completed the fourth grade in Thailand, was unemployed, and had health insurance, with a stated household annual income of 49,999 Euros or less. Naree came from central Thailand. She was attentive to her appearance, friendly, talkative, and eager to provide information. The interview took place in a private office at a local Thai grocery store.

Naree's initial experience with cervical cancer was related to her mother-in-law's disease, which resulted in surgical treatment and eventual cure. Despite her mother-in-law's encouraging outcome, Naree still remained fearful of cervical cancer. Her first Pap smear was in Germany at the age of 35 due to fertility issues. Her first exam elicited embarrassment and anxiety; however, she was relieved when the result came back

normal. She intended to have yearly screenings as a preventative measure. Her current gynecologist was female, which she preferred over a male physician. She said that she received a thorough explanation regarding the Pap test procedure from her current gynecologist.

Although she understood what the Pap smear tests were for, Naree had no specific knowledge regarding disease prevention of cervical cancer; however, she believed that yearly exams, exercise, and drinking lots of water improve health and aid in preventing cervical cancer. Her beliefs regarding the causes of cervical cancer were that they stemmed from “friction during intercourse, and a genetic predisposition.”

Naree further explained that she felt that an abnormal test result may mean the possibility of developing cancer, a cyst, or tumor. Her definition of cervical cancer was “the tumor...or sore that developed and it becomes dangerous and it can be popped up anywhere,” and she believed that every woman, including herself, had a 50% chance of developing the disease. Her fear of contracting cervical cancer led her to have an additional Pap exam done when she visited her homeland of Thailand.

Naree believed that she has received excellent health care services in Germany, although the language was a barrier to communication; she felt that the doctor communicated adequately with her husband. Naree’s husband made her appointments and accompanied her because Naree did not know how to drive. Test results were received either by phone or mail, with a follow-up postcard reminder for her next appointment. In addition, long waiting periods to be seen were a drawback for Naree and caused her to change her gynecologist.

## Lin's Story

Lin, a 35-year-old married woman with one child, had lived in Germany for 5 years. She completed the sixth grade in Thailand, was unemployed, and had health insurance, with a stated household annual income of 49,999 Euros or less. Lin was born and raised in northeastern Thailand. Lin was friendly, but quiet. At the time of the interview, she had red eyes, was sneezing and coughing, and continued to apologize throughout the interview because of her allergy symptoms. The interview took place in a private office at a local Thai grocery store.

Lin's first Pap test was a result of viewing an advertisement from the Health Department in Thailand explaining that women aged 30 and older should have a Pap test. Although there was no family history of cervical cancer, she had yearly exams in Germany and received normal results. Prior to her first exam, Lin experienced fear due to the explanation her friends gave her regarding the medical equipment, especially the speculum. However, she did not experience any pain during her first procedure.

Lin preferred a female doctor due to the cultural barrier and her own embarrassment, although she stated that women should not be embarrassed to get the checkup. However, Lin did experience communication difficulties because her female gynecologist was also a foreigner and could not communicate in German very well. To assist with the communication barrier, her gynecologist explained the procedure to Lin's husband, and her husband then explained it to Lin in "husband and wife talk."

Lin believed that women should have a yearly exam, as cervical cancer is preventable and if discovered at an early stage, is also curable, but she also stated that she believed it could be a deadly disease if discovered at an advanced stage. Lin believed that

an abnormal test result meant that a tumor was present, and if not treated, might advance to cancer. When asked what she would do if she had a positive result for cervical cancer, Lin stated that although she would be worried, she would discuss treatment options with her doctor and husband. Staying focused to find ways to treat the disease was important to Lin.

Although Lin did not believe that she had a chance of getting cervical cancer due to having her yearly checkup, she believed that some possible causes of cervical cancer were smoking, eating vegetables that were sprayed with pesticides or chemicals, not exercising, and eating red meat that had been injected with hormones to “make the meat look red or to stimulate growth in pigs.” Furthermore, Lin did not believe that eating certain foods, such as those in food taboos, would cause the disease, even though she believed that eating right, exercising, and taking care of your health would help to prevent cervical cancer. She also stated that stress and worry may increase the chances of cancer. In general, Lin felt that the German health care services were good, with the exception of being rushed and having long waits, especially for specialty care, as Lin suffered from allergies. Despite having an appointment, Lin carried food and water with her because of the long waits. Although her husband made the appointments, went with her, and acted as an interpreter, Lin felt that there was not enough time spent on her examination and thus felt that it may not have been thorough enough.

Lin felt that if a Thai woman did not have a husband with her to help with the communication, the language barrier was a real difficulty, even though the doctor would make an effort to communicate appropriately. Another drawback was that Lin had to pay

an additional 110 Euros for her Pap test and her mammogram, in addition to her regular insurance, and no postcard or phone reminders for appointments were provided.

### **Da's Story**

Da, a 48-year-old married woman with two grown children, had lived in Germany for 15 years. She completed the ninth grade in Thailand, was unemployed, and had health insurance. She stated that her household yearly income was 24,999 Euros or less. Da was friendly and very talkative. During the interview process, she tended to stray from the topic. Da was small in stature, had long salt-and-pepper hair, and was born and raised in the eastern costal area of Thailand. The interview took place in a private office above a local Thai grocery store.

There was no history of cervical cancer in Da's family, even though her mother, who lived in Thailand, had a history of benign uterine tumors. Da's sister, who was a village health volunteer, insisted that Da have the Pap test done. Although all her female relatives in Thailand had undergone Pap tests, she still experienced embarrassment during the procedure.

Since living in Germany, Da has had yearly Pap tests and, starting this year, her gynecologist has advised having a Pap test every 6 months, as Da is older and premenopausal. Da had no history of abnormal Pap tests and planned to continue her recommended screening schedule. Da learned about cervical cancer from watching television, reading, and working as a nursing assistant at a hospital in Thailand.

Although her gynecologist was male, Da preferred a female because of the embarrassment of having the procedure done by a male. However, Da had her current physician for a lengthy period of time and felt it was "ok" now. Da stated that women

must realize that a Pap test is very important, especially during menopause, because she believed that women have a higher chance of developing cancer during menopause.

Da felt that there were a lot of factors that might cause an abnormal Pap test, but may not necessarily be cancer. When asked to define cervical cancer, Da stated, “the changes in the uterus after menopause.” Da believed that every woman has a chance of developing cervical cancer, and it may also depend on a woman’s genetic predisposition. However, she was not sure of the causes and felt that perhaps the chances of developing cervical cancer may increase after child bearing, with older age, as a result of menopause, and from illegal abortions. In addition, Da felt that some other plausible causes of cervical cancer may include chemicals in food, antibiotics, multiple sex partners, and prostitution.

In terms of her health beliefs, Da stated, “an apple is good to prevent cervical cancer, in addition to sesame seeds, which help to absorb all poisons from the body. Products that are made from sesame seeds and sesame oil also help to detoxify bad substances from the human body and helps people with breast and cervical cancer, in addition to balancing hormones among menopausal women.”

Da felt that the health care providers in Germany had prejudiced attitudes toward foreigners, including Thai immigrants living in Germany. In addition, she felt that the type of health insurance policy that one had seemed to influence the amount of time that providers spent with patients.

Da was able to drive and make her own medical appointments. However, she was frustrated with the long waiting periods to obtain an appointment, the long waits (up to 2 hours) to be seen by her provider, and the scant amount of time spent with the provider

(about 5 minutes). She felt that this was not enough time to discuss her problems and concerns.

The communication barrier and long waits were of great concern to Da, especially when her children were involved. For example, despite calling for an urgent appointment for her sick children, she still had to wait over 2 hours to be seen. The language barrier was not only frustrating, but “if you don’t understand the language you may end up paying for services out of your pocket.” Da stated that it is important to verify what services are covered by one’s health insurance policy. Furthermore, she said that despite having health insurance, she still had to pay the government an additional 10 Euros every 3 months.

### **Wee’s Story**

Wee, a 24-year-old Thai woman, unmarried with one child, had lived in Germany for 11 years. She completed the ninth grade at Hauptchule (middle school) in Germany. She was employed and had health insurance. She stated that her household annual income was 24,999 Euros or less. Wee, a very tall young woman with long brown hair, was very shy. She was born and raised in the northeastern part of Thailand and lived there until the age of 13. Even though Wee had spent 11 years in Germany, her fluency in her native language was excellent. The interview session took place in a private office above a local Thai grocery store.

Wee’s mother had a yearly screening done, and there was no family history of cervical cancer. Wee had her first experience with cervical cancer screening at the age of 23, when she sought medical intervention for a urinary tract infection (UTI) and went to a local gynecologic clinic. Her doctor talked to her about having a Pap screening done at



the same time, and she agreed to the procedure. She stated that she “felt embarrassed, anxious, and scared” during her first exam. Since becoming pregnant, she had so many visits to the gynecologist that she did not feel embarrassed anymore and just wished that the process would end quickly; she had a sense of relief when the exam was completed.

Wee knew it was important to have a yearly screening, but this year, she did not pay attention to it. When asked whether she intended to have a Pap smear done this year, she stated that the year had already passed, but if the doctor sent a reminder for next year, she would go. Her physician was female, which she preferred. In addition to the conversation with her doctor about having a Pap screening done, she has since seen brochures regarding cervical cancer, but because she had never had any problem, she did not feel the need to learn more about it at the time. However, she thought it was important that women have the screening done for prevention. She felt that by being a woman, she might have a chance of getting the disease, and if told that she did have cervical cancer, she would be fearful and would consult the doctor about the causes, the severity of her condition, the stages of the disease, and how to treat it. Wee felt that cervical cancer was very deadly but had not thought of any practices that may help prevent it, even though she had been told to have the screening and had heard discussions about cervical cancer.

According to Wee, the German health care services and federal assistance for health insurance and housing were wonderful, as she had received social assistance for housing, unemployment benefits, and child care assistance from the government. She made and attended her appointments by herself, and because she lived close to the clinic, transportation was not a problem because she could walk to the clinic.

Although Wee did not have a perceived difficulty with the language barrier, as she spoke German fluently, her physician was not a German national; however, the doctor was culturally sensitive and respectful, and made every attempt to communicate. Additionally, Wee felt that her doctor was very thorough and spent quality time with her.

Some of the perceived drawbacks were the long waits for appointments and the long wait at the clinic due to a high volume of patients. Waits could be as long as 2 to 3 hours before Wee could see the doctor. She felt that other Thai women have major problems with the language barrier, cultural barriers, and perceived prejudice by the German health care providers.

### **Wannisa's Story**

Wannisa was a short, stocky, 34-year-old Thai woman who was married with one child, whom she left in the care of her mother in Thailand. She was born and raised in the northeastern part of Thailand, where she completed the sixth grade in school. She had lived in Germany for 9 years and was unemployed, but had health insurance. She stated that her household annual income was 24,999 Euros or less. Wannisa giggled frequently during the interview.

The interview was conducted at my home. Wannisa said she had no family history of cervical cancer, and she had her initial Pap exam at the age of 29 in Germany. She stated that while living in Thailand, she did not have time for a checkup because she was employed full time. Wannisa had never had an abnormal Pap test result and usually had her screening done during her yearly checkup, although she missed last year when she went to Thailand for a visit.

Wannisa's gynecologist was female, which she preferred because of embarrassment and anxiety. However, for nongynecologic or reproductive health concerns, she did not care whether the doctor was male or female. Wannisa stated that she was afraid the doctor would find cervical cancer during the Pap screening procedure and was relieved when told that everything was normal. She further stated that she was not advised or informed by the German physician about cervical cancer screening and the importance of cervical cancer screening, and prevention was not stressed. However, the doctor did walk her through the Pap test procedure.

Wannisa did not know exactly what cervical cancer meant; however, she did know that it was a "deadly disease and that you need to have checkups for." In addition, she felt that an abnormal Pap test meant that something was wrong, and she would be scared and worried if she had such a test result. If told she had cervical cancer, she would be shocked, then inquire how much time she had, and wonder how her family would survive without her. She also felt that every woman had a chance to get cervical cancer because "no one can foresee the future."

Wannisa had never thought about adherence to any general health care practices that prevent cervical cancer and had not been informed of such by others; she thought that "taking a daily bath is very important, not having sexual relations with someone you do not know and making sure your husband is clean." She stated, "If he is not taking a bath, I can't sleep with him. In other words, if I don't take care of myself and my husband, we can't have sex." In addition, Wannisa thought that some plausible causes of cancer were lack of good hygiene, especially during menstrual periods and after sexual intercourse,

contracting germs or disease from public restrooms, and eating food prepared in unsanitary conditions.

Although Wannisa did not know the exact reason women have Pap tests, she believed the screening was a good thing for women to have as a preventive checkup. She stated:

You have to look after the people around you and you have family to take care of. If something happens to you, how are you going to care for your family? It is important that you take care of your own health and body so that you can be healthy to look after your husband, your children, and your parents. Without you around, who will take care of them?

Wannisa described a “bad experience” with German health care providers, in which her abdominal pain was misdiagnosed; she felt that the health care providers had an uncaring attitude. She was bounced back and forth between the hospital and the clinic, and then was referred to a gynecologist, with whom it took 14 days to get an appointment. She went through some of her own medicines that she had brought from Thailand and treated herself with “some kind of antibiotic.” However, her symptoms had subsided by the time she saw the gynecologist.

Other than this bad experience, Wannisa felt satisfied most of the time with the thoroughness of the doctor and felt that quality time was spent with her during her office visit. Her husband made appointments for her and accompanied her, as she did not drive, although it was often difficult for him to take off from work.

Wannisa felt that the language barrier made it difficult for her to present her complaints and to ask any follow-up questions regarding her health. The long waiting

periods for setting up an appointment and the long wait at the clinic were further frustrating barriers. In addition to these difficulties, Wannisa did not understand why she had to pay an extra 10 Euros every 3 months, even though she had insurance that covered cervical cancer screening and mammograms.

### **Pare-wa's Story**

Pare-wa, a 30-year-old married Thai woman, with three young children, had lived in Germany for 7 years. She received a High School Equivalency diploma, was unemployed, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Pare-wa was born and raised in the northeastern part of Thailand. The interview took place at Pare-wa's modest home. She was dressed casually and was friendly, but reserved. Her husband took care of the children during the interview.

Pare-wa had a family history of cervical cancer; a relative, who was 18 when she was first diagnosed with an advanced stage of cervical cancer, died as a result of the disease. Pare-wa stated that her first Pap exam was at the age of 23 due to heavy vaginal discharge, vaginal itching, and infection. Her gynecologist at the time did not provide any education prior to her Pap test. Cervical cancer screening was done during that visit, with normal results.

Pare-wa had yearly Pap exams, and her last screening results were abnormal. Pare-wa felt at that time that the abnormal results meant she had cervical cancer. However, her gynecologist explained that the abnormal result was not cervical cancer. Pare-wa had irregular menses, and the gynecologist adjusted her birth control prescription.

Pare-wa said she preferred a male doctor. Her previous gynecologist was female, but Pare-wa felt that she rushed through the exam, and Pare-wa was dissatisfied with the care she received. Pare-wa switched to a male physician, with whom she was satisfied. She said he was very knowledgeable and thorough. Pare-wa had delivered all three of her children in Germany and felt that the health care services they received was of high quality. Although she had difficulty understanding the German doctor and still felt rushed with the exam, she stated that he was very caring, culturally sensitive, and tried “very hard to communicate with me.” She also stated that in addition to feeling rushed, she had observed that the doctor seemed to take more time in the exam room with the German patients than with her.

Pare-wa learned about cervical cancer from reading newspapers and searching the Internet. She stated that she did not receive information regarding cervical cancer from her doctors, either in Thailand or Germany. Although she was afraid of cervical cancer when she was having “female problems,” she stated that she did not know the specific reason for having a Pap exam and did not ask for any information regarding cervical cancer; she just wanted to know if everything was normal.

She believed that every woman had a chance of getting cervical cancer, depending on that individual’s hormones, and was fearful that the doctor would find cancer every time she was tested. She stated that cervical cancer was cancer in the uterus and was possibly due to a genetic predisposition, eating burnt food from baking, and eating food cooked in a microwave. Pare-wa stated that she thought ways to prevent cervical cancer included good nutrition, taking good care of your health, and avoiding carcinogenic substances. Furthermore, she stated that she was told that one way to prevent cervical

cancer was through good hygiene of the genital area. If told that she had cervical cancer, she would try to re-group and would seek treatment options from her doctor.

Pare-wa made her own appointments, although her husband drove her and waited outside the exam room in case there was need for interpretation, as the language was difficult for her to understand. Obtaining appointments took between 1 to 2 weeks, and there was a 30-minute to 1½-hour wait to be seen. Pare-wa had been informed that she needed to have Pap screening every 6 months because she was on birth control pills, and her doctor sent reminders via postcard every 6 months.

### **Linda's Story**

Linda, a 53-year-old Thai woman, married with two children, had lived in Germany for 15 years. She completed the fourth grade, was employed as an assistant chef at a restaurant, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Linda was a small woman with long hair. She was friendly and at ease during the interview, which took place in a private office over a local Thai grocery store. Linda was born and raised in the central part of Thailand.

Linda had no family history of cervical cancer and had her first Pap exam at the age of 35 in Thailand. Her rationale for having Pap exams was to take care of her own health, it was required for her work, and her doctor advised it. She had yearly exams in Germany and learned about cervical cancer and screening from television and her own doctor.

Linda's gynecologist was female, which she preferred. Due to her culture, Linda still felt embarrassed during her gynecological exams, even with a female doctor. She stated that "cervical cancer screening is prevention, and to help find the causes of the

disease at the beginning” and was relieved when the procedure was finished and her results were normal.

Linda stated that women should have Pap screening because women have uteruses, and it was good to have the screening when you get older. If told that she had an abnormal Pap result, she “would feel really frightened.” She further stated that an abnormal Pap smear could be the early stages of cervical cancer, tumors, or infection. Linda had an experience with an infection of the uterus in the past and felt that the cause of inflammation was from sexual intercourse with her husband.

Linda’s understanding of cervical cancer was explained as “we have cells in our body, and our bad cells may turn into cancer cells, which we do not know when it may happen.” Linda stated that some possible causes of cancer are “cells in our body turning into cancer cells, infection with STDs, HPV, or gonorrhea.”

Linda believed that she might have a chance of getting cervical cancer because “you don’t know when you are going to get it, and the best way to prevent it is to have Pap smear screening.” If told that she had cervical cancer, Linda stated that after the initial shock, she would regroup or focus by doing meditation, and if it were found in the early stages, it could then be treated.

Linda stated that she had not been informed by other people about health care practices that prevent cervical cancer because no one wanted to discuss the subject, as it was so personal. However, she did receive a call from her son in Thailand with the news that a neighbor had died from cervical cancer. This news frightened and worried Linda, as she had missed her last appointment for screening. She planned to make a new appointment for a Pap test.



With regard to the health care system in Germany, Linda felt the services that she had received (she had a bilateral knee replacement) were average. Although Linda was going through menopause and was told by a German doctor that there was no medicine to help alleviate her hot flashes, Linda believed that the herbal medication she got from Thailand helped.

Linda felt that the health care services at the clinic catered to German citizens, in her opinion, probably “because I am not fluent in German.” She observed that German patients seemed to receive more attention and were given more information. She thought perhaps the preferential treatment by the health care providers was due to her being a foreigner and her language barrier, which to her, was a major factor in accessing health care in Germany.

In terms of other prejudices, she felt that it depended on the individual and that she had a good doctor who overlooked that she was a foreigner and treated her equally. Although there were long waits to be seen, Linda was satisfied with the quality of care and time spent during office visits with her current gynecologist, whom she felt was attentive to her needs.

### **Nalita’s Story**

Nalita, a 38-year-old Thai woman who was married with two children, had lived in Germany for 4 years. She completed the sixth grade, was unemployed, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Nalita, a well-mannered woman, pregnant with her third child, was born and raised in the northeastern part of Thailand. Nalita’s interview took place in a private office above a local Thai grocery store.

Nalita had no family history of cervical cancer and had her first Pap exam in Thailand at the age of 25, after the birth of her first child. The doctor told her at that time that she should have cervical cancer screening done. Prior to her marriage and pregnancy, Nalita did not feel that she needed screening, as she was not married.

Although Nalita had learned through health promotions related to cervical cancer screening in her village in Thailand, she did not have a yearly exam. She stated that if she were back in the village, she would go for a screening when the chief of the village sent a list of women that needed screening done.

Nalita stated that she was interested in her own health, and if the doctor told her to have the exam, she would go as advised, in spite of being shy and embarrassed during the test. In addition, she planned to have a Pap test right after she delivered her next child. She was under the care of a female gynecologist, whom she preferred. However, she did occasionally see a male gynecologist for prenatal visits and stated that she felt self-conscious and vulnerable when she was naked on the exam table, especially during the trans-vaginal ultrasound, “when the doctor inserted a metal rod into my vagina.”

Nalita asserted that she would be worried if she were ever told that she had an abnormal Pap exam and would consult the doctor for details of treatment. In addition, she added that an abnormal Pap smear could also be a misdiagnosis. As an example, she said that after having irregular menses after the birth of her first child, she went to have a checkup at the local public health clinic in her Thai village. The nurse at the clinic performed the exam, told her she had a tumor, and referred her to the main hospital in town. The doctor who performed her next exam told her that she did not have uterine tumors. She had been very worried, as her mother had been diagnosed with uterine

tumors when Nalita first moved to Germany. In Nalita's opinion, an abnormal Pap smear does not necessarily mean cancer but it is important to follow up with the doctor. She stated, "If something is wrong, I have to find solutions, but I would be worried."

Nalita stated that she did not know exactly what cervical cancer meant, but she used to read celebrity magazines, which included columns on health, with questions and answers about the signs and symptoms of cervical cancer, and she had been trying to practice what she had learned from the magazines. She had not received any information from other people, including family, friends, or health care providers, concerning health care practices to prevent cervical cancer.

After her first baby was born, Nalita felt that her uterus was a little enlarged, perhaps because she was unable to follow the traditional postpartum care practice of *yuu fai*, or "lying by the fire." She often wondered if an enlarged uterus could be the cause of cervical cancer.

Nalita believed that she had a chance of getting cervical cancer, but did not know when. "It can happen to any woman; that is why you should have a screening done every year." If told that she had cervical cancer, Nalita stated that she would be very sad and would not be able to eat or sleep because of the fear of dying. "The time that the nurse informed me that I had uterine tumors was bad enough, tumors...I could live with, but having cancer would be really bad."

With regard to health beliefs, Nalita stated that she did not follow the traditional postpartum health practice of *yuu fai* with her first child because she believed that if she drank a traditional herb medicine, *ya-dong*, it could help to prevent an enlarged uterus and get rid of bad blood from childbirth. However, after her second child was born, she

observed the traditional postpartum practice of *yuu fai* because she wanted to breastfeed her baby, and she said lying by the fire helps to stimulate breast milk and uterus involution. With her brother assisting her, she stayed by the fire for 3 to 4 days, but could not tolerate the practice any longer because “it was too hot.” However, Nalita stated that she did not feel any different in terms of recovery time from childbirth by following the traditional practice of *yuu fai*.

Nalita felt that the health care services, including the prenatal care that she received in Germany were of high quality. She felt that the doctors were more competent and thorough in providing care compared with her experience in accessing health care services in Thailand. In addition, she felt that she was given the same quality of care as her German counterparts, even though the language was a major barrier for her. Her husband made her appointments for her and accompanied her on prenatal visits to act as an interpreter, and the length of time she must wait to be seen was, in Nalita’s opinion, tolerable.

### **Nid’s Story**

Nid, a 42-year-old Thai divorced woman with three children, had lived in Germany for 10 years. She completed high school, was employed as a housekeeper, and had health insurance. Nid stated that her household annual income was 24,999 Euros or less. A small woman with short brown hair, Nid presented with a flat affect and initially required encouragement and probing to tell her story. She was born and raised in the northeastern part of Thailand. The interview took place in a private office of a local grocery store.

Nid had no family history of cervical cancer and stated that she had never had cervical cancer screening to her knowledge, even though she had breast and pelvic exams done yearly, with her first pelvic exam occurring at the age of 30. She explained that every year during the pelvic exam, the doctor would use a swab inserted into her vagina and then wipe the swab on a glass slide, which was followed by an ultrasound. Nid was not sure what the doctor was doing. The doctor did not tell her what the tests were and she did not ask, although the test results were normal. Nid experienced pain during her pelvic exams, and she did not understand when the doctor tried to explain the procedure and results to her.

Nid stated that she was apprehensive about carrying on a conversation with her doctor because she was afraid of not being able to understand. “German is a very difficult language, especially medical terms.” She was, however, able to understand the breast cancer exam, but the cervical cancer information was difficult for her to understand. “If the exam is normal, I just have to be satisfied with that.”

Nid’s gynecologist was male. She stated that she was used to having both male and female doctors and did not see any gender differences in providing care, as she felt both genders were competent. She intended to have another exam done that year and planned to ask her doctor about the Pap smear screening because she was older now, even though she had not had sexual relations in more than a year. Nid stated that she might be foolish to think that cervical cancer screening was not an important exam for her at the moment because she had not had any problems with her uterus or vagina; however, Nid believed that every woman, including herself, had a chance of getting cervical cancer “if you do not take care of your body.”

Nid stated that an abnormal Pap smear meant a “yeast infection and has to be treated.” With regard to cervical cancer, Nid stated that it was caused by “inflammation which turns into nodules and yeast infection; it will cause itchiness, and if not treated, the spreading of yeast infection will cause pain at the cervix or vagina.”

According to Nid, some possible causes of cervical cancer were not cleaning the vagina properly, too much sexual intercourse, and too much force during sexual intercourse. She further stated that she had been in Germany for more than 10 years and had never heard other people talk about health care practices to prevent cancer.

If told that she had cervical cancer, she stated that she really did not know what she would do, as it had never occurred to her that she would have cervical cancer. However, she said that she knew she had to take care of her health, and she goes for a ½- to 1-hour walk daily “regardless of rain or snow; walking helps me to get fresh air and helps me to feel good and healthy.”

Nid felt that some food could possibly cause problems with the uterus. She stated that she felt burning and itchiness in her vagina after eating fermented fish, pickled bamboo shoots, or any pickled food products. She tried to avoid these foods, but because she liked to use them in Thai cooking, she was not doing very well in avoiding these foods.

With regard to her experience with the health care services in Germany, she explained, “it depends on the doctor.” Nid had a history of thyroiditis and needed surgery the previous year. She felt that she did not receive much attention postoperatively from her general practitioner. Although she was not satisfied with the services, she did not want to switch physicians too often. She stated that her gynecologist was very thorough

and attentive to her needs, but she felt she had less time for the visit due to high patient loads.

Nid described how impressed and satisfied she was with the health care services that were provided to her older daughter, who had Down syndrome and required a lot of medical intervention. She stated that if her daughter had remained in Thailand, she would have been dead a long time ago, as there was no money for medical expenses. Her daughter was now able to function at her optimal level, performing daily activities with little assistance.

Her former husband used to make her medical appointments for her and acted as interpreter during office visits. Nid perceived barriers to health care services as the language, long waits during office visits, and not enough time spent with the doctor.

### **Chapter Summary**

Chapter 4 surveys demographic characteristics of the primary and secondary participants and the context in which the immigrant Thai women's life and work influences their knowledge, health beliefs, and attitudes regarding cervical cancer and screening. In addition, the narratives of 9 women are presented in detail as examples.

## **CHAPTER 5**

### **FINDINGS AND INTERPRETATIONS**

In Chapter 5, the study findings are presented by research question and organized into themes and subthemes that resulted from the analysis and interpretations of the ethnographic data. This study was guided by four research questions: (a) What are the knowledge and attitudes about cervical cancer among Thai women living in Germany?; (b) What are the health beliefs and practices regarding cervical cancer among Thai women living in Germany?; (c) What are the cervical cancer screening practices among Thai women living in Germany?; and (d) What are the barriers to participation in cervical cancer screening perceived by Thai women living in Germany?

The HBM was used to frame the interviews about Thai women's knowledge, attitudes, and beliefs regarding cervical cancer, screening, and their perceptions of barriers to accessing cervical cancer screening programs in Germany. After obtaining demographic characteristics and cervical cancer screening practice information, I opened the interviews with broad questions on participants' thoughts and ideas about Pap smear screening, including its purpose and importance. I then focused on how and where the participants learned about Pap smears, their perceptions regarding abnormal Pap smear results, and their perception of the meaning of "cervical cancer."

#### **Research Question 1**

Research Question 1 was: What are the knowledge and attitudes about cervical cancer among Thai women living in Germany? Published studies reported that Thai women had a knowledge deficit regarding cervical cancer and the screening procedure



(Boonpongmanee & Jittanoon, 2007; Jirojwong & Manderson, 2001; Tsui & Tanjasiri, 2008), and described their knowledge of cancer based on traditional beliefs and clinical knowledge (Jirojwong & Manderson, 2001). In the context of this study, traditional beliefs are defined as a tradition or practice accepted from the past, having been passed down from generation to generation, for example, the postpartum practice of lying by the fire (*yuu fai*). However, personal beliefs may stem from, or be embedded in, traditional beliefs but may take on additional or expanded aspects, such as the concept of eating certain types of foods, for example, “burnt food which may be carcinogenic, red meat, or food cooked in a microwave” may trigger the development of the disease. The core belief is built on personal beliefs regarding certain food avoidance; however, the examples given are an assimilation of modern information applied to personal beliefs. In other words, the basis for a personal belief may originally be a traditional belief, but the individual may not recognize or be cognizant of separating the two and, therefore, accepts it and expresses it as one’s own personal belief. As discussed in Chapter 1, “practice” is defined as “the individual’s habitual or customary behavioral patterns which are influenced by one’s beliefs, values, social norms, and cultural influences.” In addition, “health beliefs” are defined as “personal feelings that influence health behaviors.”

The data that informed the themes for this research question included the participants’ descriptions of their knowledge of cervical cancer, screening procedures, perceived risks/susceptibility, and attitudes of cervical cancer that influence their screening practices. Four themes emerged from the analysis of the data for Research Question 1: (a) *Knowledge and explanations of cervical cancer*; (b) *Sources of knowledge and information about Pap screening*; (c) *Perceived risk/susceptibility to cervical cancer*;

and (d) *Fear of the disease/the unknown*. The themes and subthemes are presented in Table 2 and are described in detail in the following section.

Table 2. *Themes and Subthemes for Research Question 1*

<b>Research Question 1</b>	<b>Themes</b>	<b>Subthemes</b>
What are knowledge and attitudes about cervical cancer among Thai women living in Germany?	Knowledge and explanations of cervical cancer	Clinical knowledge of cervical cancer  Knowledge from traditional and personal beliefs
	Sources of knowledge and information about Pap screening	
	Perceived risks/susceptibility to cervical cancer	
	Fear of the disease/the unknown	

### **Theme 1: Knowledge and Explanations of Cervical Cancer**

The theme, *Knowledge and explanations of cervical cancer*, describes the participants' knowledge of cervical cancer and possible causes. The participants used medically accurate knowledge and traditional and personal beliefs to describe the causes of cervical cancer. This theme is divided into two subthemes: (a) *Clinical knowledge of cervical cancer*, and (b) *Knowledge from traditional and personal beliefs*.

**Subtheme 1: Clinical knowledge of cervical cancer.** The participants' most frequently identified, medically accurate knowledge about the causes of cervical cancer included having a genetic predisposition, a family history of cervical cancer, multiple sexual partners, and sexually transmitted diseases, such as HPV and HIV. An additional factor identified by some participants as causes of cervical cancer included smoking,

infection of the cervix, and inflammation. The combined use of both medically accurate knowledge and personal beliefs is exemplified by the following statements:

Personally, I think that it may be...genetic predisposition, multiple sex partners, or prostitution. (Linda, lines 132-134)

I guess the causes of cervical cancer are due to the lack of genital hygiene after sexual intercourse, promiscuity, and lack of screening for cervical cancer. (Noot, lines 176-178)

When asked to explain or describe what cervical cancer, or *mareng paak mot luuk*, meant to them, participants responded by describing it, as being something to get rid of, deadly, incurable, as causing pain and suffering:

*Mareng* [sic; cancer], no matter where it happens, at the cervix or anywhere else in our body, it is very scary. We know that there is no treatment to completely cure cancer. However, if it's detected at an early stage and with the doctor's advice, we can get appropriate treatment right away. (Tien-yot, lines 140-143)

Cervical cancer is something in our body that we must get rid of because it can cause suffering, pain, and death if left untreated. (Koop, lines 98-99)

Many participants perceived cervical cancer as a “deadly disease and is incurable.” Some participants described where cervical cancer may originate; one participant stated, “cervical cancer means something related to internal organs.” Other participants knew that cervical cancer is cancer of the reproductive organs, the uterus, or *mot luuk*. Participants used the following phrases: “cervical cancer is cancer related to the

vagina or tumor in the vagina,” “cervical cancer is cancer in the uterus,” and “cervical cancer is related to the uterus.” Toy-ting stated that the term “cervical cancer” gave her a clue:

I guess that cervical cancer is cancer of the cervix. I never asked the doctor where it is located exactly, and my doctor never explained it to me. After the exam, he said everything was okay, then I would go home. (Toy-ting, lines 82-85)

Several women described cervical cancer in terms of its progression and development:

We have cells in our body, and our bad cells may turn into cancer cells, we don't know when it may happen. (Linda, lines 129-131)

Cervical cancer is developed from a tumor and becomes dangerous, cancer may pop up anywhere in our body...cervical cancer may develop as a sore, and if we're too stressed about it, it may spread rapidly. (Naree, lines 115-120)

**Subtheme 2: Knowledge from traditional and personal beliefs.** Many participants offered personal explanations and beliefs for the causes of cervical cancer, which included failure to maintain proper personal and genital hygiene, especially after sexual intercourse or during menstrual periods. Some participants offered other causes, including eating unsuitable foods that may cause heavy vaginal discharge, or *maat khaaw/tok khaaw*; childbirth; an individual's hormones that are related to the menstrual cycle and menopause; bad karma; an anomaly of one's body, especially the uterus and ovaries; heavy lifting, which may cause uterine prolapse; being older; illegal abortions; contracting germs or bacteria from using dirty public restrooms; and lack of exercise.

Moon responded, “It may happen when the genital area is dirty; the genital area didn’t get cleaned very well, after sexual intercourse” (lines 132-133). Other participants gave examples of possible causes related to sexual activity, such as friction and too much force during sexual intercourse, too much sexual intercourse, and an accumulation of germs in the foreskin of a man’s penis during sexual intercourse, as the ejaculation of the semen may force these germs into the uterus, which may cause cervical cancer later on in life.

Timm, described her worry that she may get infected from her husband’s germs, which then may turn into cervical cancer, as he did not bathe very often:

I used to compare my husband’s lack of personal hygiene with some of my foreign friends who are taking the same German language class. I asked them if their husbands bathe often, especially after sex. My friends told me that their husbands do not like to bathe either. They were all worried that someday they may get cervical cancer from their husbands; everyone was so afraid. (Timm, lines 146-149)

Some participants believed that eating certain types of food may trigger the development of the disease, such as burnt food, which may be carcinogenic; food cooked in the microwave; vegetables sprayed with pesticides or chemicals in food; red meat; or food prepared in unsanitary conditions.

Namm believed that childbirth could be one of the causes of cervical cancer. Another participant believed that a lack of adherence to the traditional postpartum practice of staying by the fire may be a possible cause of cervical cancer:

After my first baby was born, I felt that my uterus was a little enlarged, perhaps because I was unable to follow the traditional postpartum health practice, *yuu fai*. I often wondered if an enlarged uterus could be associated with cervical cancer. (Nalita, lines 155-158)

## **Theme 2: Sources of Knowledge and Information About Pap Screening**

Theme 2 describes sources the participants used to obtain knowledge about Pap screening. All of the participants had heard about cervical cancer screening. The majority of participants stated that screening should be done every year, with the exception of those who were told by their gynecologist to have the Pap test done “every six months” due to “menopause or being older.” One participant recalled:

When I had a problem with heavy vaginal discharge or *maat khaaw/tok khaaw*, I was afraid of having cervical cancer. However, I didn’t know the specific reason for Pap screening. I went for the exam because I wanted to know if everything was normal with my body. It never occurred to me to ask the doctor why I needed to have an exam other than for a checkup. (Pare-wa, lines 100-101)

A secondary participant, a practicing German gynecologist, confirmed the screening practice guidelines that she used in her practice and added that eligible women can receive an annual cervical examination starting at 20 years of age until “the end of life, if they want.” She gave as an example a patient who was 92 years old and came in every year for a Pap test and breast cancer exam until her death.

In addition, the doctor stated that there were no invitations sent out to eligible women for Pap smear screening; however, invitations were sent to those women who were eligible for “mammograms every 2 years, starting at the age of 50 through 70 years

old.” When asked why some participants in this study reported that they had to have Pap tests every 6 months, the gynecologist clarified that in her practice, she asked women to come in every 3 to 6 months on an individual basis and “when something is not good” or when the patients needed to be seen for follow-up with hormones or birth control pills. However, for a routine cervical cancer screening, she stated, “It is once a year.”

Many participants associated Pap tests with the detection of cervical cancer; however, some participants thought that the test “helps to detect something abnormal in our body,” “the test must be related to hormones and female reproductive organs,” or “to check if there is any sores in the vagina.” Although these participants had a general knowledge that the Pap test had something to do with checking for abnormalities with their bodies, specific knowledge was vague or lacking altogether.

One participant, who was divorced, stated that since she had not had any sexual relations for more than a year, she did not feel the need to go for Pap smear screening:

I may be foolish to think that cervical cancer screening is not an important exam for me right now, but I never had any problems with my uterus or vagina. (Nid, lines 75-76)

In addition, two participants, who were unmarried before migrating to Germany, stated that the reason for not having the screening done at that time was that she was single and therefore did not need the screening.

Although all participants believed that Pap smear screening was an important test for women to have, saying “it is disease prevention,” and expressed their desire and intention for future Pap tests, one participant was adamantly negative when asked whether she had any intention to undergo future Pap test screening:

I do not intend to have another Pap smear in the future. My thinking may be irrational or foolish for refusing to have a checkup. I am not afraid of dying.

(Naam, lines 84-88)

Participants in this study had learned about Pap screening through a variety of sources, including reading, television, the Internet, word of mouth from friends, through family experience, government-sanctioned advertisement campaigns, and overheard conversations. Only 6 participants stated that they were advised by their gynecologist to have the Pap test. Nut explained:

I learned about cervical cancer and screening from my gynecologist. In addition, the doctor taught me how to do self-breast examination. She was very thorough in explaining how to check my breasts for lumps. (Nut, lines 70-71)

Many participants learned about this disease from reading, watching television, and surfing the Internet. A 22-year-old participant who was raised in Germany since she was 11 years old explained how she learned about cervical cancer:

I had never learned from any one in my household any information regarding this disease. However, I had heard from the news that beginning at 20 years of age, a woman should have a yearly cervical cancer screening. I said to myself, “that’s not important because I’ve never had a problem,” even though all my German friends went and had the screening done. (Aar, lines 62-64)

Another participant recalled her own attitude toward the subject of cervical cancer and echoed Aar’s sentiment:



I saw a German brochure about the disease. However, I never paid any attention to this subject and did not open the brochure to read. I think my lack of interest was because I never had any problems. (Wee, lines 83-84)

Many participants learned about cervical cancer through friends, family members, and village health volunteers who advised them to have a screening done or learned about the danger of cervical cancer from witnessing their relatives die from the disease. Two participants learned about the disease from the Thai government's cervical cancer prevention campaign encouraging Thai women to undergo cervical cancer screening. Koop explained how she learned about cervical cancer:

I was listening not so much for knowledge, but overheard people talk about the pain and suffering of someone who had cervical cancer and a subsequent hysterectomy. (Koop, lines 86-88)

Some participants could not recall if anyone ever told them about the disease, including their gynecologists during their yearly physical exams. One of these participants explained her lack of knowledge regarding cervical cancer:

I never learned specifically about the disease of cervical cancer....But I had heard about the checkup. There are no Thai magazines available in Germany, and I hardly have time to watch TV since I've been working. When I saw the advertisement for the study, I decided to participate. (Timm, lines 111-112).

### **Theme 3: Perceived Risks/Susceptibility to Cervical Cancer**

The theme, *Perceived risks/susceptibility to cervical cancer*, described the participants' perceptions of their chances of getting cervical cancer. Most participants

recognized their susceptibility to this disease and believed they were at risk for developing cervical cancer. For example, a participant stated:

Every woman is at risk of getting cervical cancer. I also heard the news from Thailand last year that they had a cervical cancer advertising campaign encouraging women 18 years of age to get the HPV vaccination. They also advertised in TV that the vaccines were free. (Jaa, lines 81-82)

They acknowledged their chances of getting cervical cancer with statements such as, “I am a woman and have a uterus” or “I’m still sexually active with my husband.” These perceived risks prompted them to take action to undergo cervical cancer screening. In contrast, one participant believed that she had a chance of developing cervical cancer, but “Not everybody has a chance of getting the disease, as it depends on one’s health, the immune system, and sexual activity” (Moon, lines 140-141).

In addition, participants offered their beliefs of conditions that may predispose women to cervical cancer, which included environmental factors, one’s state of health and immune system, being a woman and having a uterus, and not taking care of one’s health. The following participants’ statements describe their perceptions of the risk of developing cervical cancer:

I believe that I have a chance of getting cervical cancer because when a woman becomes menopausal, happens to have vaginal discharge, *maat khaaw/tok khaaw*, and gets an infection without having a checkup or treatment, this may turn into cervical cancer later. (Plaa, lines 149-150)

I know that I am possibly at high risk of developing cervical cancer because I have vaginal discharge off and on. I'm worried about this all the time because I don't have any knowledge about the disease... and I don't have that many Thai friends or know anyone in the medical field that I may confide in. (Timm, lines 172-175)

In addition, 2 participants stated that it was inconceivable that they might get cervical cancer: "I don't believe that I have a chance of getting cervical cancer because I have my uterus checked very often" (Da-wan, line 101); and "I believe that my chances of getting cervical cancer are zero because I have a yearly checkup" (Lee, line 108).

Some participants also believed that their risk of the disease was low to none because they have taken preventive measures by going for a yearly Pap test. In addition, one participant offered other preventive measures to reduce the chance of having cervical cancer:

Personally, I believe if you have a yearly Pap test, are eating right, exercising, and taking care of your health, you will not get cervical cancer. However, you may have a chance to develop the disease if you're stressed out and worried too much. (Lin, lines 91-92)

#### **Theme 4: Fear of the Disease/the Unknown**

The majority of the participants in this study expressed fear of the unknown, in particular, whether the doctor would find cervical cancer or not during a Pap screening. In addition, they expressed fear of cervical cancer and the resulting consequences of being diagnosed with the disease. This theme describes participants' beliefs that cervical cancer has a multiplicity of consequences, may lead to a hysterectomy and the resulting stigma associated with it, and is an incurable and deadly disease. Some participants reported that

the reason for undergoing their first Pap test was because of the fear of being diagnosed with cervical cancer and the consequences. This fear stemmed from being involved with family members who had cervical cancer and the resulting experience of tremendous stress and emotional and physical suffering to both the patient and their families:

Fifteen years ago, before I came to Germany, my first cousin was diagnosed with advanced cervical cancer after giving birth to her youngest child. She died two years later in spite of cancer treatment....After she died, we were very afraid of cervical cancer so my mom and I went to the hospital and had Pap test done for the first time. (Naang, lines 52-63)

Naree, whose mother-in-law had cervical cancer, was very fearful about the disease and went for another Pap test while visiting Thailand to make sure that she did not have the disease.

A few participants believed that abnormal Pap results carry a social stigma. Having an abnormal Pap test may be associated with sexually transmitted diseases as a result of being promiscuous or involved in prostitution:

This is my personal opinion, I don't know much about women who are hired for sex. Perhaps there are too many sexual activities going on...too many sexual partners. I heard that many prostitutes have cervical cancer. If I had cervical cancer, I would die from "shame." (Phaa, lines 132-134, 143-147)

When I was still working...in Thailand, I went for a female checkup because I heard that someone had *ngon kai* [sic; HPV]...I was so afraid...if you have this disease, it may turn into cervical cancer later. After I started working, I went

immediately for a checkup. I had some pus coming out...I was very scared.

Initially, I did not want to go to the public health clinic for a checkup...I didn't have the courage and besides the public health clinic was so dirty, so I chose a private medical clinic because it's so much cleaner. (Linda, lines 139-144, 148-154)

One participant, Koop, recalled a Thai friend who was diagnosed with cervical cancer and had a hysterectomy; she was reluctant to bring up the subject or ask about that individual's well-being. She stated that her indifference may have seemed like a lack of sympathy toward that woman's unfortunate circumstances; however, she understood the stigma associated with removal of the uterus, and she did not want to keep reminding her of this misfortune.

Many participants also reported that they felt more apprehensive than modest or embarrassed that the doctor would find cervical cancer during the Pap test procedure. One participant expressed her feeling about the Pap test:

I think the anticipation of the Pap test made me feel so anxious that I could hear my heart pounding. I felt so shy and embarrassed when I made an appointment; however, those feelings completely disappeared when I got on the exam table; and then I became more concerned and afraid of the unknown. What if the doctor found something abnormal and what if I have cervical cancer? I felt so relieved when the doctor told me that everything looked normal. (Wannisa, lines 197-201)

Another concern described by some of the participants was "fear of the unknown during the procedure" (Nooy, line 90). One participant described her fear prior to her first Pap test:

The first time, I heard about the Pap test was from my coworkers' discussion at work in Thailand. They talked about how unlucky they were to have male doctors perform the Pap tests; it was an embarrassing and painful experience for them. However, my doctor walked me through each step of the procedure. It was so scary at first but I tried to be less tense and it seemed to help with my first Pap test. It was not as painful as I thought it would be. (Lin, lines 95-100)

Ump spoke of her first experience:

I was shocked when I saw the equipment on the exam table, especially the long metal rod for ultrasound...I had never had a pelvic examination before. It was painful and uncomfortable. (Ump, lines 110-118)

### **Summary**

Research Question 1 was: What are knowledge and attitudes about cervical cancer among Thai women living in Germany? It was answered with four themes: (a) *Knowledge and explanations of cervical cancer*, (b) *Sources of knowledge and information about Pap screening*, (c) *Perceived risk/susceptibility to cervical cancer*, and (d) *Fear of the disease/the unknown*.

The findings discussed in response to Research Question 1 suggested that the participants' knowledge of cervical cancer was influenced by their attitudes and health beliefs. However, it is important to consider and be aware of the potential change in attitudes, beliefs, and knowledge as a result of direct exposure to continued yearly checkups as a result of health insurance recommendations.

All participants had heard about cervical cancer screening and described their knowledge of cervical cancer based on personal, traditional, and clinical knowledge. The

majority of participants believed that screening is for early cervical cancer detection, and Pap screening should be done every year with the exception of those who were told otherwise by the doctor. In terms of the participants' attitudes regarding cervical cancer and screening, most participants perceived they were at risk for developing cervical cancer because they were women and had a uterus. The participants offered various conditions that were most likely to predispose them to cervical cancer. In addition, some participants had their first Pap test because of fear of cervical cancer and its consequences, and other health-related problems such as UTIs, birth control pills, and vaginal discharge. Most participants expressed a desire to have cervical cancer screening in the future and to seek medical advice and treatment if diagnosed with cervical cancer.

### **Research Question 2**

Research Question 2 was: What are the health beliefs and practices regarding cervical cancer among Thai women in Germany? When trying to understand the participants' health beliefs and practices of cervical cancer and screening practices, it is important to be aware of the influence of location, for example, immigration to Germany, and the potential influence of being exposed to the dominant culture's health belief systems.

Health beliefs and practices may not always be congruent culturally or personally, and one may not act on or practice a given belief, for example, one may believe that the Pap test is beneficial, but does not have the screening done. It is difficult to tease out how cultural influences affect the implementation or practice of a given belief, as one may be influenced by the other. In addition, the mixture of contemporary and traditional cultural beliefs may become amalgamated in such a way that the person may accept or adopt the

common threads or attributes as their own beliefs. For example, one participant stated that food cooked in a microwave may be a potential cause of cancer; however, the microwave was only recently available to contemporary Thai households and was basically a luxury item. This is a good example of how the combination of contemporary and traditional cultural beliefs is portrayed as a personal belief, exemplifying the influence of the dominant culture.

The participants were asked about their knowledge or awareness of specific health practices that they believed prevent cervical cancer. They were also asked to share their traditional and personal health belief perspectives that may influence their daily activities and general health practices in cervical cancer prevention. Analysis of the data resulted in one theme: *Traditional and modern health beliefs and practices of cervical cancer prevention*.

**Theme: Traditional and Modern Health Beliefs  
and Practices of Cervical Cancer Prevention**

According to several participants, in the Thai culture, the subject of cervical cancer was too personal to talk about openly; therefore, information and practices of cervical cancer prevention, if any, may not have been passed on from one generation to another. Preventative health practices, such as mammograms and cervical cancer screenings, are a new concept in contemporary Thai culture. Most of the participants had not heard of or been informed by other people about specific health practices to prevent cervical cancer. One participant explained, “I don’t know how to answer about my health beliefs or practices to prevent cervical cancer because I don’t know what causes cervical cancer” (Koop, lines 139-140). A 22-year-old participant explained that no one talks



about cervical cancer because of “bad karma,” for example, “if we talk about it, it may happen.” Another participant confirms the sensitive and personal nature of the topic:

The subject of a yearly pelvic exam is so personal; no one would want to discuss this subject, especially among Thai ladies. When we get together we only talk about food. (Moon, lines 175-179)

Many participants believed that adhering to the traditional health beliefs of food taboos, *sa-laeng* or *pid-ka-boon*, prevents vaginal discharge, as vaginal discharge is believed to possibly cause cervical cancer. Some participants feared that heavy vaginal discharge or abdominal pain from menstruation may be related to cervical cancer. The most concerning symptom that participants reported was recurrent “heavy vaginal discharge, or *maat khaaw/tok khaaw*, especially if it was combined with odor and itchiness, which they believed could turn into cervical cancer. Many participants stated that they should avoid eating certain foods in order to prevent “vaginal discharge, *maat khaaw/tok khaaw*,” which they believed was a sign and symptom of “*mot luuk mai dii* or uterus problems.” Some participants maintained that eating pickled food or fermented fish (*plaa-raa*) may also cause heavy vaginal discharge. Foods to avoid included fermented fish (*plaa-raa*), fermented shrimp paste (*ka-pi*), pickles, and seafood. Many participants believed that this type of food was “unsuitable” (*sa-laeng* or *pid-ka-boon*) for a woman’s body, especially the uterus. Plaa added “sun flower seeds” to the list of foods that could be potentially unsuitable for a woman’s uterus and cause vaginal discharge:

I noticed that a week after eating sun flower seeds, I would have heavy vaginal discharge. In my opinion, having heavy vaginal discharge means my uterus is not good, *mot luuk mai dii*; it’s impure. (Plaa, lines 179-182)

Another participant made a similar remark regarding certain foods that she believed may be unsuitable for a woman's reproductive organs:

I try to avoid our Northeastern food such as *plaa-raa* or fermented fish or any pickled food like bamboo shoots. I noticed that if I eat these foods, I would experience itchiness and burning in my vagina right away. However, it's hard to avoid, because I like them so much in my cooking. (Nid, lines 122-125).

Nooy stated that she still adhered to all the food taboos that her grandmother and mother taught her. She elaborated:

After my baby was born, I was told that eating Muscovy duck during postpartum will harm your body. Eating fermented fish, pickled bamboo shoots, and pickled food products will cause heavy vaginal discharge which may in turn cause uterus problems or *mot luuk mai dii*. (Nooy, lines 155-156)

Participants believed that certain types of foods may have the power to reduce the risk of cervical and other cancers as well. One participant explained her beliefs:

Apples are good to prevent cervical cancer, in addition to sesame seeds which might help absorb all poisons from the body. Products that are made from sesame seeds and sesame oil may also help to detoxify bad substances from the body. It also helps people with breast or cervical cancer and helps to balance hormones among menopausal women. (Da, lines 154-161)

Regardless of the length of residency in Germany, all participants continued cooking and eating their traditional foods.

The traditional Thai post-partum practice of lying by the fire involves the belief that childbirth causes an imbalance of hot and cold in the mother and, therefore, she

needs to lie by a hot fire to dry out her insides or uterus. In addition, it is traditionally believed that this postpartum ritual will help the uterus return to normal faster. It is also believed that the mother must restrict her activities and observe food restrictions for a period normally lasting from 3 to 15 days or as long as 30 days of confinement. These restrictions are in place to protect the mother's body after childbirth. Although this traditional practice is still a part of the contemporary Thai culture, it has become an optional practice for reasons such as convenience; availability of time and support, which is usually provided by female family members; and the modern medical practices and recommendations that surround modern-day childbirth.

One participant believed that her uterus was enlarged because she did not observe the traditional postpartum practice of lying by the fire, or *yuu fai*, after her first child was born. She often wondered whether an enlarged uterus might be related to cervical cancer. She further stated:

Traditionally, if a woman is unable to practice *yuu fai*, she would have to drink the herb medicine *yaa-dong* to help prevent an enlarged uterus. The herb medicine helps get rid of "bad blood" and also helps prevent a prolapsed uterus. I was not able to drink this herb medicine either; and I could feel the difference. Sometimes I felt stabbing pain in my uterus when I lifted heavy stuff or when I squatted down. (Nalita, lines 161-168)

Another participant also expressed her belief in the postpartum practice and a personal conflict between her belief and the instruction given to her by her German doctor:

A few days after I gave birth, the doctor wanted me to exercise. I was stunned because a woman's body after child birth is weak and in bad shape. He wanted me to go for a walk and exercise? I had to do what I was told by the doctor and my husband. I didn't really understand the purpose because I didn't understand German. It is difficult to observe the postpartum practice, *yuu fai*, because there is no wood charcoal in Germany. So I just took hot showers to substitute for the heat from the fire instead. It felt good to take really hot showers. (Timm, lines 232-239)

In addition, many participants stated that having a yearly checkup, as well as an additional array of personal and modern health practices, may help prevent cervical cancer. Similar to the practices discussed in the Research Question 1 section, many participants maintained that good personal hygiene, especially bathing and cleaning the genital area, is of utmost importance, especially after sexual intercourse. One participant explained:

I usually take very good care of myself. But I've never specifically or consciously thought about what I have to do to prevent cervical cancer. However, I think bathing is very important and no sexual contact with strangers, only with your husband...I also have to make sure that he is clean. If he is not taking a bath, I can't sleep with him. Am I being too straightforward?...In other words, if I don't take care of myself and my husband, we can't have sex. (Wannisa, lines 234-239)

Naang also explained:

Cervical cancer may be caused by poor personal hygiene, being dirty. Thai people bathe daily but the Germans don't bathe very often; however, it seems that the

Germans don't get this disease more often than Thai people. I think, perhaps, German people see the doctor more often. I really don't know for sure if the cause of cervical cancer is related to cleanliness. (Naang, lines 145-148)

Modern health practices and beliefs expressed by the participants included maintaining one's health; good nutrition; stress reduction; wearing a condom; not smoking; moderate alcohol consumption; not reusing cooking oil; not eating fatty foods, red meat, or foods that contain hormones and added chemicals; having a Pap test every 6 months; and exercising. Da, a former nursing assistant in Thailand, presented a singularly unique perspective by explaining her belief that the improper use of antibiotics, for example, not understanding the need to finish the whole course of treatment and not understanding the possible side effects, as well as the long-term accumulation of antibiotic chemicals, could "cause cancer" (Da, line 171).

### **Summary**

Researches Question 2 was: What are the health beliefs and practices regarding cervical cancer among Thai women in Germany? It was answered with one theme: *Traditional and modern health beliefs and practices of cervical cancer prevention.* Participants' health beliefs and practices of cervical cancer prevention and examples of both traditional and modern beliefs expressed as the participant's own belief were presented. In terms of personal and modern health beliefs and practices to prevent cervical cancer, many participants offered an array of health practices that they believed may help prevent cervical cancer, including a yearly Pap test.

### Research Question 3

Research Question 3 was: What are the cervical cancer screening practices among Thai women in Germany? The single theme, *Factors influencing screening practices*, emerged from the analysis of data.

#### **Theme: Factors Influencing Screening Practices**

In this theme, participants' cervical cancer screening practices were described. As previously discussed, the majority of participants perceived that they were at risk for cervical cancer and consistently expressed that cervical cancer screening was an early detection measure, even though they may have expressed it as a "preventative measure."

The majority of participants had cervical cancer screening done as part of their yearly physical exam. Some participants stated they had a yearly pelvic examination, but had no knowledge as to the purpose and were not informed by their gynecologists that the purpose of the pelvic exam was cervical cancer screening. One participant recalled:

Yes, I have a pelvic examination once a year to check for any changes in my uterus. My last pelvic exam was last year...everything was normal. My doctor told me that after the age of 35, I need to have a test to check for cervical cancer. So I think this year, I'm 35 years old now, I'm going to have the Pap smear done.

(Jaew, lines 30-39)

Other participants offered various reasons for their most recent Pap test, including taking birth control pills, abdominal pain, UTI, ruling out pregnancy, and giving birth. Most of the participants perceived the Pap test as beneficial and important for women as an early detection test for cervical cancer.

Three participants who reported no knowledge of having the “Pap test” performed, although they “had yearly pelvic exams,” agreed with the majority of the participants about the importance of cervical cancer screening for early detection. All of the participants, except one, voiced their intentions to undergo future Pap tests. Namm had an ambivalent attitude about her intention for future Pap test. Her last Pap test was approximately 6 years ago, and she expressed a lack of interest in having future Pap tests. However, Naam’s responses were somewhat incongruent because she also said she wanted to have a complete checkup, as she had started having her period again, after not having had it for about 4 years, which worried her.

Most of the participants also believed that in order to prevent any type of illness, including cervical cancer, they must maintain their health. Analysis of the data showed that the majority of the participants utilized preventive health services that included Pap smears and mammograms. Some participants visit Thailand every 1 to 2 years, which enabled them to use health services in both Thailand and Germany. One participant said, “If I had a chance to go to Thailand, I would go for another Pap test just to make sure. Because I have a hard time with Deutsche [the German language]” (Sand, lines 62-66). Because of the language barrier and fear of the disease, Naree sought another Pap smear screening and physical checkup while visiting Thailand:

My doctor did not tell me how often I should go for a Pap test, and if he did I could not remember or understand. I think at my age, I need to have it checked every 6 months. For my own peace of mind I want to make sure that I don’t have the disease, I had another Pap test done in Thailand during my last visit. (Naree, lines 149-157)

Another participant complained that she was “fed up” with the long wait of at least 2 weeks or more to obtain a gynecological appointment; she was experiencing changes with her reproductive system and expressed a desire to see a specialist in women’s health when she goes for a visit to Thailand:

I’m going to Thailand this May. I am thinking about having a thorough physical exam while visiting. I have been menopausal for 3-4 years now. However, two months ago I had a back ache so I went for a two-hour total body massage. Four days after that, my breasts felt heavy like I used to experience before my menstrual periods started, and not very long after that I started my period....It lasted 3-4 days and it was not just spotting, it was a period. I’m just a little concerned after three years without menses. I am not sure if this is considered normal or not. (Namm, lines 94-106)

In addition, participants recalled their first Pap test, which occurred between the ages of 20 and 40 years of age. The participants offered various reasons for undergoing their first Pap test, including preventing cervical cancer, following the advice of Thailand’s Health Department cervical cancer campaign, receiving prenatal care, undergoing a postpartum checkup, taking birth control pills, having fertility issues, having irregular menses, having health insurance, having a UTI, being encouraged by a spouse and family members, having an abnormal vaginal discharge, being fearful of cervical cancer, contracting STDs, and having uterine cysts. Three participants stated they had a history of abnormal Pap smears, but the subsequent tests were negative for cervical cancer. Nineteen participants stated that their most recent Pap smear, in contrast to the reason for their first Pap smear, was part of their yearly physical exam. The remainder of



the participants went for Pap screenings because of other related problems, such as abdominal pain, UTI, pregnancy, postpartum checkup, and birth control pills.

Analysis of the data about the participants' stated reasons for their initial Pap test and their current practices revealed a shift in the rationale for screening from the reasons described above to a more proactive or at least an increased inclination to adhere to insurance mandates and yearly checkups, which involved Pap screenings. There was also a subtle shift in the emotional response; although modesty and embarrassment were still present in the participants' responses, the overtones were not filled with the same degree of expressed emotions as were evident in the original screening. Tien-yot said:

Initially, with my first Pap, I was feeling anxious and afraid of the unknown, now I am feeling okay with it, because I receive a yearly checkup for my health. (Tien-yot, lines 126-128)

If diagnosed with cervical cancer, participants indicated that they would be "devastated," "shocked," "horrified," "distressed," "scared," "frightened," or "sad," but would seek medical advice and treatment. One participant felt that her response to a hypothetical scenario, a cervical cancer diagnosis, would be different depending on where she was living at the time:

If I was told that I had cervical cancer, I think initially I would be very scared and afraid of dying from the disease. I would seek treatment from the doctor.

However, I believe that I wouldn't have any problems or worry about the cost of treatment in Germany. I have good health insurance coverage. This scenario would be different if I were to get sick with cancer in Thailand due to the high cost of treatment and as I had no health insurance there. (Tien-yot, lines 162-168)

One participant expressed her sense of responsibility to take care of her own health in order to care for her husband, parents, and child:

I have to look after my family and my husband. If anything happens to me how would they survive without me? If I don't take care of my health I won't be able to take care of my family... If I am healthy and strong, I will be able to care for my husband, my child, and my parents. (Wannisa, lines 82-85).

In addition to a strong sense of responsibility for maintaining one's health in order to support family, several participants also expressed a sense of social duty to comply with the insurance mandate so as not to burden the host country. This is illustrated by the following participant's statements:

Since I have been living in Germany, I have heard that other women had to go for Pap smears. I think perhaps, because the health insurance tells them that they have to go for a yearly checkup. Besides, the premiums have already been paid. Each year the insurance company tells us what kind of tests and specialties will be part of our benefits. You have to go for a checkup even though you are not ill; otherwise it would be a waste of money. (Jaew, lines 92-95)

Phaa concurred and explained:

I think the cervical cancer screening program here is very good. Unlike Thailand, they seem to be stricter here in terms of screening. The German government takes good care of us here. Thai women are foreigners, and like when living in someone else's house, if we get sick, it will be difficult for the host and in this case the host country. That's why, it's important to take care of our health in the beginning. (Phaa, lines 77-78)

One participant expressed her rationale for continued cervical cancer screening: Here, in Germany, according to the rules of the health insurance company, when you are getting older you have to go for Pap smears. They told me if I don't get a Pap test, and I happen to get cervical cancer, the insurance company can refuse coverage for cancer treatment. (Moon, lines 63-64)

### **Summary**

Research Question 3 was: What are the cervical cancer screening practices among Thai women in Germany? It was answered by one theme, *Factors influencing screening practices*. Findings suggest that the majority of the participants had cervical cancer screening done as part of their yearly physical exam. Other reasons participants underwent their most current Pap test included taking birth control pills, having abdominal pain, having a UTI, ruling out pregnancy, and after giving birth. Participants recalled various factors influencing their first Pap test, such as cervical cancer screening campaigns, prenatal care, birth control pills, fertility issues, irregular menses, STDs, and having insurance. All participants, except one, expressed their intent to undergo future Pap tests. Most of the participants had a strong sense of personal responsibility to care of one's own health and have yearly checkups in order to be "strong and healthy" to enable them to take care of their families. In addition, the participants also possessed a strong sense of social obligation to comply with the health insurance mandate and a desire not to burden the host country through illness.

### **Research Question 4**

Research Question 4 was: What are the perceived barriers of the German cervical cancer program among Thai women living in Germany? Data supporting this research

question came from the primary and secondary participants. Analysis of the data resulted in three themes: (a) *The German health care system barriers*, (b) *Personal barriers*, and (c) *Cultural barriers*. The themes and subthemes are presented in Table 3 and are described in detail in the following section.

Table 3. *Themes and Subthemes for Research Question 4*

<b>Research Question 4</b>	<b>Theme</b>	<b>Subthemes</b>
What are the perceived barriers of the German cervical cancer program among Thai women living in Germany?	The German health care system barriers	
	Personal barriers	Language barrier Feelings of prejudice Lack of support system
	Cultural barriers	Shyness, embarrassment, and gender preferences for providers Health care provider as authority figure

### **Theme 1: The German Health Care System Barriers**

This theme describes the primary and secondary participants' perceptions and experiences of barriers encountered within the German health care system. In general, the majority of participants stated they were satisfied with the quality of health care services they received. One participant said:

I am very impressed with Germany's health care services. I received such great service when I was hospitalized. The way I was taken care of in the hospital here made me feel like I was a very important customer, compared to the service that I

received in Thailand....I also felt that I was being treated equally compared to German patients. (Jaa, lines 130-144)

Another participant stated that she was very appreciative of the German health care services, which helped to improve the quality of life of her special needs child:

My oldest child, who was born in Thailand, has a congenital problem. Thankfully, her German pediatrician was wonderful and was very thorough with the examinations....Although she has a mild form of Down's syndrome and required a lot of medical intervention....She was under this doctor's care since we migrated here. He was very good with quick referrals if she had any problems, for instance, she had problem with her eyes, and he sent her to see the eye doctor....If my daughter had remained in Thailand, she would have died a long time ago as there was no money for medical expenses....Now, my daughter is able to function at her optimal level with daily activities with little assistance....She also had heart surgery when she was four years old here in Germany...10 days after the surgery she was able to walk and talk, prior to that, at four years old, she was not even able to crawl, she just sat there, looking tired and jaundiced. Her legs were so thin and wasted away. (Nid, lines 226-248)

In contrast, although many participants were satisfied with the health care services they received, some participants expressed their dissatisfaction with the health care system in Germany; they identified issues that were perceived as a hindrance to accessing health care services, included long waits for obtaining appointments, long waits to be seen during visits, lack of quality time spent with health care providers, no reminders sent

for the next appointment, and lack of communication with health care providers.

Participants expressed their feelings of frustration:

I feel really annoyed with the long waits to obtain an appointment...it may take about 3 months to get one, especially an appointment for the clinic which is well-known for “good” gynecologists. We have a gynecological clinic closer to my house but I never went there, even though my friend told me it only took her about two weeks to get an appointment to see the *frauenartz* [gynecologist] at this clinic. (Namm, lines 109-112)

Personally, I think health care services here are good, if you have private insurance, you will get faster service including almost an instant appointment and a very thorough physical exam. However, for those of us who have a regular health insurance, we have to wait....Despite having an appointment, sometimes I had to wait to be seen, the longest was about 2 hours....I had no choice but to sit and wait; I always take food and water with me when I have an appointment. When I finally saw the doctor, I felt that the exam was very short and quick, taking only about 5 minutes. (Lin, lines 180-193)

Some participants expressed concerns regarding a perceived lack of communication from the doctor. One participant explained:

In terms of health education, I think Thai health care providers are doing a much better job. Thai doctors go into more detail to help me understand. However, here, most of the time the doctors would send information by mail. If I could read German fluently, it wouldn't be a problem....My husband tries his best to explain

the content of the letter to me. It's useless when you don't understand the language. (Naang, lines 257-259)

Also a consumer of health care services, one of the secondary participants, the nurse, expressed a similar sentiment with the issues of long waits for appointment availability. When asked about her perception of personal barriers in accessing health care services, she related the following:

The doctors get very little money from the regular health insurance policy holders. They get more money from people who have private insurance, that's why they get appointments faster. That's why they love privately insured patients....It takes me much longer to get an appointment. (Nurse, lines 1376-1385).

With regard to the women's complaint of long waits, the nurse concurred: Nowadays, depending on what type of doctor you want to see, it may take up to 3-4 months to get an appointment....Oh, yes, long waits on the day of your appointment, at least two hours or more....Even though the doctors are not allowed to do that, you could actually call the insurance company or tell the doctor, look I am not willing and I don't have to wait more than three quarters of an hour...because if you don't show up and don't call in to tell them you're not coming, they can charge you for it. But if you call and go in there and have an appointment at 9 o'clock and you are still sitting there at 12, nobody will give you any money or not even a "sorry."...They say that's tough luck that you have to wait. (Nurse, lines 1520-1613)

The secondary participants described their perceptions of the German health care system and the types of health insurance as being "good" (Doctor, line 277) and "it is

better than the U.S. health care system” (Nurse, lines 288-289) because “in Germany, by law, almost everybody has health insurance” (Doctor, line 113). The doctor acknowledged that there are people without health insurance living in this country, but she “seldom had patients come in without any health insurance. We have them but very seldom” (Doctor, lines 285-286). The nurse commented, “Even for those without any health insurance, if they need medical treatment, they will receive ‘basic treatment’ from the health care services” (Nurse, lines 299-300).

In addition, the nurse offered a brief description of the types of health insurance in Germany. “There are two types of health insurance, private or *privat*, and regular insurance.” Those that have an income greater than 5,000 Euros (8,000 USD) a month have private insurance and the benefits that go with it, for example, choosing their own primary physician, quicker appointments, and preferential treatment in type of service and by whom. Those individuals that have regular or social insurance may choose to have private insurance, which is completely paid out of pocket. However, for regular or social insurance, one half of the premiums are paid by the insured and the other half is paid by the employer.

In terms of their work schedules, the doctor and the nurse worked full time. The doctor worked approximately 30 to 35 hours per week. The nurse’s schedule was 5 days on and 5 days off, working 10½- hour days. The doctor explained her patient load: “I see about 30 patients a day.” She is in a partnership with a male gynecologist, and stated:

We have about 4-5 ladies working as medical technicians... we have no nurses working in the office. Nurses only work in the hospitals... We have a midwife, who is my partner’s wife, and she sees patients for prenatal care at the clinic and



postpartum care when the mother and baby are at home for breast feeding.

(Doctor, lines, 1572-1605)

The doctor stated that most of the time, in spite of a heavy patient load; she believed that she had adequate time to spend with her patients. She explained:

I have about 15 minutes with each patient...if they have a lot of problems...and I need more time I would ask them to make another appointment...If my patients have problems, we make sure that we discuss it and sometimes for this reason the other patients have to wait...But they also know that when they have problems, I would spend as much time with them as well. So, it is understood that long waits are common. (Doctor, lines 424-486)

With regard to her work conditions, the nurse explained that the convalescent home where works has 108 residents, about 80 of whom are unable to turn themselves; two nurses work at night, with 48 and 60 patients assigned, respectively. The coworker, or “work maid,” also has her own work to do, and most of the work is done alone. It is difficult to find time to take a break or eat, even though she says she tries “to find time to talk to the patients...they need warmth, somebody there to listen to them, and they need somebody to caress them sometimes” (Nurse, lines 966-968).

The nurse also perceived that her counterpart, acute care nurses experienced similar types of difficult working conditions:

Here, in Germany, we are facing the same problem as the U.S. with a shortage of nurses...The hospitals will hire anyone if they can get them, and qualified people are hard to find. (Nurse, lines 779-786)

In terms of job satisfaction, the nurse stated that low pay and undesirable working conditions, were the primary causes of the nurse shortage in Germany:

It's not the job that we don't like; it's just the conditions that we don't like....I think that's the reason a lot of people don't want to go into the job and the statistics say that every fifth nurse is leaving the job after 4 or 5 years. (Nurse, lines 862-867)

The nurse agreed with the doctor's comment that most nurses work in the hospital and not in the clinics. In addition, she stated that she has never sent patients from her facility for cervical cancer screening.

Regarding the current German guidelines for cervical cancer screening and effectiveness, the nurse responded, "I have a Pap test every year, the health insurance companies encourage you to do it at least once a year...because the sooner you can find cancer, the better you can treat it" (Nurse, lines 993-1004). The nurse believed that the current opportunistic method for Pap screening, with no invitations to remind patients, herself included, may miss a target population of German women who have never been seen by the doctor or who perceive that they are healthy. The nurse also stated there are a lot of German women who do not go for cervical cancer screening, including her aunt, "because they think they are healthy...or just being embarrassed" (Nurse, lines 1098-1100). However, she believed that one should take responsibility for one's own health, "Everybody should know and I think everybody in Germany does know that you can have the Pap test every year" (Nurse, lines 1201-1202).

The doctor acknowledged that among western European countries, Germany has one of the highest incidence and mortality rates of cervical cancer, "although, the problem

here, is not as bad as in some other countries.” She was optimistic that the HPV vaccines would have a significant impact on improving the incidence and mortality rates of cervical cancer in Germany in the near future, “I believe that we will see fewer problems in terms of bad Pap results in the next 10 years, but only if we can do vaccinations for a lot of young women” (Doctor, lines 984-986).

Although, the HPV vaccination has been available in Germany since 2006, with the recommendation to vaccinate girls 12 to 17 years of age, there is currently no organized vaccination program. The doctor stated that in her practice, “there are many health insurance companies that will pay for HPV vaccination until the woman is 26 years of age” (Doctor, lines 1014-1015). However, she stated that the HPV vaccine would not be as effective in preventing cervical cancer if given to women at that age: “I think it would be better if you give 3 consecutive doses to younger women starting at age 11 or 12 years up to 18 years old” (Doctor, lines 1016-1018). She stated that “the cost of three dosages of HPV vaccine is around 500 Euros [800 USD]” (Doctor, line 1072).

The doctor explained her method of reminding the patient about their next exam: I tell them, we are finished now and the result of the Pap smear will be available in 10 days. I tell them that they can phone and ask for the results. If there is something wrong, I will call them... When something is wrong, I, or the ladies at the desk will call the women, if it is an infection, we tell them, they should have therapy. If the Pap result is not good, I tell them they should come back in 3 months for another control Pap smear. But if everything is okay, we do not speak to the women. I tell them when everything is okay, and to come again next year. (Doctor, lines 700-728)

The doctor believed that this verbal method of communication is an effective reminder method for her patients to come for their future Pap tests. When asked how long it takes to obtain an annual Pap test appointment at her office, she stated, “we can schedule about 3 weeks in advance, no longer than that” (Doctor, lines 1533-1534).

## **Theme 2: Personal Barriers**

As previously described, most of the participants were satisfied with their health care services; however, some had experienced inconveniences in accessing them. Three barriers were identified as subthemes affecting the use of health care services: (a) *Language barrier*, (b) *Feelings of prejudice*; and (c) *Lack of support system*.

**Subtheme 1: Language barrier.** Analysis of the data revealed that the lack of German language proficiency was consistently identified as one of the major barriers to health care services and effective communication between the participants and their health care providers. Jaew stated, “The first few years of living in Germany, I was not fluent in the language, I had problems with communication, I used a lot of hand gestures to tell my symptoms to the doctor” (lines 199-320). Another participant expressed feeling hesitant to carry on a conversation with her physician:

I think my doctor did what he’s supposed to do. When the examination is over, it’s the end. If I didn’t ask questions, he didn’t offer any information. I really don’t know how to ask what else needs to be discussed because my language is not that good. I do understand some German but when I replied he didn’t seem to understand what I tried to say, perhaps, it was my accent. (Toy-ting, lines 125-128)

One participant relayed a story about how language is very important because the patients can become victims of health care fraud because of language barrier:

I heard about a woman who did not understand the German language very well; after she had cervical cancer screening done she was advised by the doctor to undergo some tests that she did not understand in full detail. This woman agreed to have the tests done and ended up having to pay from her own pocket because the tests were not covered by her insurance policy. The government needs to tighten their regulations....It happens so often that the doctors try to persuade the patients to have some unnecessary tests done that are not covered by the insurance policy. (Da, lines 277-281)

Many participants stated that their husbands made their appointments for them, and because many participants did not have a driver's license, their husbands usually accompanied them. In addition, the husbands often acted as interpreters during office visits. Two participants explained:

The doctor would explain the findings to my husband and then my husband would translate German to German in ways that I could understand. Most of the time, the doctor spoke the local dialect, then my husband translates the local dialect to High German [Hochdeutsche] for me. (Lin, lines 103-111)

I am sure that my doctor tried to give me health information, but I don't understand. The doctor would converse with my husband then my husband would tell me that the doctor said "everything is good." That's why I always ask my

husband to go with me because I am not very good with the German language.  
(Phaa, lines 66-67)

The participants explained that their spouses translated German to German in ways that help to facilitate communication between the women and their doctors and by using “husband and wife talk” for a better understanding of the medical findings:

I can speak some German; my husband would relay the information from the doctor to me. I can understand my husband’s German better than the doctor’s. She was not a German national and her accent was different and she spoke really fast. Some of the German vocabulary is difficult to understand, however, the way my husband speaks to me, *husband and wife talk* [italics added], it is easier to understand. (Sand, lines 201-213)

Some participants became more resourceful when their husbands were unavailable to accompany them to the appointment; they asked the doctor to write a note describing the findings to give to their husbands: “If I don’t understand what the doctor was telling me, she would write it down for me. However, most of the time, I do understand the information that was given” (Nut, line 125).

When asked about perceived barriers in providing care to minority populations, the doctor did not perceive any barriers; however, she stated:

Most of the women from Asia, they speak horrible English sometimes...but most of the time we understand...often the husband comes to speak for the wife....I can’t understand how they live together without speaking the same language.  
(Doctor, lines 783-844)

In addition, she stated that she “seldom used a translator” when dealing with patients who had problems with the language barrier; she uses gestures in communication; “most of the time we try it with hand and feet” (Doctor, line 1429).

**Subtheme 2: Feelings of prejudice.** A few participants reported that they had negative experiences with the health care system, including prejudice. One participant, who reported differential treatment when receiving health care services, believed it was based on being an “immigrant, foreigner [*ausländer*], or Thai.” She explained:

I think the quality of health services here is both good and bad. For instance, when I tried to call for an appointment, I frequently sensed animosity from the other end of the line. I am not sure, maybe because I am a foreigner. In this part of Germany, people have anti-foreigner attitudes. I think Thais are at the top of the chart. I don't feel they like to take care of foreigners very much. (Da, lines 194-203)

Namm offered an additional example of her experience of perceived prejudice and a lack of caring attitude by the health care providers:

Not all the doctors that I have seen had prejudiced attitudes towards foreigners. Some were really good doctors and took good care of me. However, most of the time, they acted like they didn't have time for you because there are many patients waiting to be seen....After the exam, I still had something that I wanted to discuss with him, but he told me point blank that “your time is over.”...I never went back to see this doctor again...he didn't have time for me...but I was one of his patients, even though I am an *ausländer* [foreigner]. (Namm, lines 279-295)

One participant believed the health care services at the clinic cater to German nationals, probably “because I am not fluent in German” (Linda, lines 192-193).

Furthermore, this participant felt that if she could have spoken German well, she would have been able to express her needs better:

When I went to the rehab clinic after my knee surgery...I felt that the physical therapists did not explain about the service to me in full detail...however, I noticed that the German patients seemed to receive more attention and they were given more information...I think perhaps...the preferential treatment was because I am a foreigner and my German is not perfect...I felt kind of deprived. (Linda, lines 192-193)

In contrast, the doctor explained her position in providing care to minority women, by stating:

We have a lot of women from Asia...but which country I don't know...I treat them equally...It doesn't matter where they come from when they need help...I'll do it. Nobody will say "no" and I think I am not the only one, but of all the gynecologists, most would say "yes" to helping. (Doctor, lines 1343-1357)

The nurse also believed "equal treatment" was provided to all minority populations: "I think Germans try to treat all people the same no matter what country they're from" (lines 1391-1403). In addition, the nurse stated that the barriers were a patient's perception, "The barriers are not from the doctors or nurses." She gave as an example one possible reason for perceived barriers as stemming from the patient's religion: "I don't think that a lot of Germans, especially doctors or nurses should care what kind of person they have in front of them; they are just a person no matter where they are from" (lines 1395-1441).



**Subtheme 3: Lack of a support system.** This subtheme described the participants' concerns over their lack of a support system as it relates to meeting their health care needs, for example, having a means of transportation, having a confidante or some form of emotional support, and the lack of language-appropriate educational material. Most of the participants did not have extended families to provide convalescent care, assist in the household, care for children, or provide advice and emotional support. Therefore, having a support system becomes very important at the time of illness, recovery, or dealing with medical issues:

One of my personal barriers is transportation; I usually drive myself for medical appointments. However, after major abdominal surgery, I was not allowed to drive. I either had to wait for my husband to come home from work, take a taxi or ask my neighbor to take me if she was available. (Tien-yot, lines 248-251)

Transportation is also a barrier, as I cannot drive a car. I have to wait for my husband's day off for an appointment otherwise he has to hurry home from work to take me. If he is out of town, I have to ask my in-laws to take me. Unlike living in Thailand, I don't have my immediate family or good neighbors to help me. (Wannisa, lines 446-451)

In terms of emotional support, one participant, Timm, explained that even after living in Germany for 10 years, she still lacked the necessary language skills to relay her medical concerns to her husband. She further explained that she did not have close friends who would advise and encourage her to seek necessary medical attention, in spite

of her embarrassment or shyness. Another participant also emphasized the importance of emotional and physical support during her convalescent period from major surgery:

Life here is so different from living in Thailand. Asking someone for a favor or help is not that easy. Not all Thai women who live here have good husbands...everything, including culture and communication is so vastly different from Thailand, having someone that you can depend on in time of need is so important. (Tien-yot, lines 252-254)

Many participants expressed the lack of any written material in the Thai language as a lack of support. Furthermore, without being able to read German, any information given to them from the doctor was “useless” unless translated by their husbands. Even though husbands would attempt to translate, the finer nuances of the communication could be lost due to the language barrier.

### **Theme 3: Cultural Barriers**

This theme describes the cultural implications of barriers to cervical cancer screening. Data analysis resulted in two subthemes: (a) *Shyness, embarrassment, and gender preferences for providers*; and (b) *Health care provider as authority figure*.

#### **Subtheme 1: Shyness, embarrassment, and gender preference for providers.**

In the Thai culture, sexual health education at home was identified as a restricted subject among parents who wanted to encourage modesty, especially among daughters. Thus, Thai women were socialized and taught at a very young age the virtue of being modest. Although many of the participants stated that Pap smear screening is the primary screening method for cervical cancer, the majority of participants described feelings of modesty, shyness, and embarrassment when undergoing the Pap test:

I never had a Pap test done in Thailand because I didn't have enough courage to go for the exam. In our culture, it was difficult for me to take my clothes off and expose my body. It's a disgusting and embarrassing thought. (Moon, lines 84-85)

All participants stated that they received the Pap test at a local gynecology clinic by the gynecologists, or *frauenartz*. The majority of participants stated that their "current" gynecologists were female, and all but 3 preferred a female provider. Most of the participants revealed feelings of embarrassment, modesty, and discomfort when examined by male gynecologists. For this reason, many participants changed gynecologists: "I used to have a male gynecologist, he was a very good doctor but I switched to a female doctor because it is so embarrassing to have a male doing the pelvic exam" (Nut, lines 53-57). Only 1 participant preferred a male gynecologist. She stated that her former female doctor rushed through the exam and seemed to have too much confidence and lacked sensitivity. Her reason for switching doctors was explained:

I think a male doctor is more thorough with the examination....It seemed that when I had a female doctor, she was rushing through the exam...not so much explaining done...just opened the drape. (Pare-wa, lines 87-88, 113)

When asked why they preferred a female gynecologist, most participants gave the reason as modesty or embarrassment with a male physician; they felt that female doctors had a better understanding of female problems and, in general, were believed to be more thorough with the exams:

One of the participants, who did not have a gender preference, elaborated, In Thailand, the health clinic in my village used to send an invitation for cervical cancer screening to me. But I never went because I knew everybody who worked

at the health clinic. I just couldn't bear the thought of having someone whom I knew doing the pelvic exam even though the screening is free....I think it's because of our culture regarding modesty. Being seen by a German doctor does not bother me that much as long as they are a complete stranger. (Koop, lines 66-73)

Although participants may have expressed a gender preference for their health care provider, giving reasons such as modesty, shyness, and embarrassment, most participants did not see gender as a barrier to obtaining a Pap screening; instead, it was a preference related to the cultural issues of modesty, shyness, and embarrassment.

**Subtheme 2: Health care provider as authority figure.** This subtheme described the role of health care providers in accordance with Thai culture. In Thailand, in general, equal status is very rare, especially in the health care setting hierarchy; doctors are highly respected and revered. As a rule of Thai interpersonal communication patterns, confrontation and conflicts are to be avoided by not challenging or questioning the authority figures, especially teachers and doctors. As a result, doctor and patient communication is likely to suffer.

Nid's statement is an example of such patient-doctor relationship:

I never had a Pap test that I was aware of....I used to ask the doctor about it...he did check my breast for cancer. He said it was okay, no cancer, just fatty tissues...My vagina...I had a pelvic examination done yearly. He never told me what the test was for and I never had the courage to ask. He just told me if everything was okay. (Nid, lines 27-31)

Even though many participants did not fully understand the purpose of Pap smear screening, all of them complied with the doctors' instructions when told to have cervical cancer screening. One participant stated that she had her first exam done because "the doctor told me to have an exam, and I agreed. I was pregnant at that time" (Toy-ting, line 38). Another participant recalled her first experience of a Pap test in Thailand:

I remember that I was so afraid of the doctor and felt so embarrassed to have the cervical cancer screening done....At that time, I was very young, I was still a teenager but I already had a family and a baby. The doctor told me to come in for a follow up and I went without knowing the real purpose of the exam. I had complete trust in my doctor....I really didn't know anything about this disease until I came to live in Germany. (Da-wan, lines 128-135)

### **Summary**

Research Question 4 was What are the perceived barriers of cervical cancer screening program among Thai women living in Germany? It was answered with three themes: (a) *German health care system barriers*; (b) *Personal barriers*; and (c) *Cultural barriers*.

The findings suggest that the majority of the participants were satisfied with the health care services they received in Germany. The participants' perspectives about the barriers in the health care system and issues with health care services that significantly influenced accessing cervical cancer screening were identified.

In addition, the secondary participants described their perceptions of the overall German health care system, which they believed was "good" and "better than the U.S. in terms of health insurance." In terms of minority populations, they stated that they tried to

treat their patients equally, regardless of the nationality or countries of origin. Participants were usually accompanied by their husbands, who would act as the “voice” or the interpreter. Participants stated that “husband and wife talk” facilitated understanding of the communication to and from the health care provider, and even though this is beneficial, the finer nuances may be lost, therefore limiting the actual intended communication. In addition, the women’s perceived personal and cultural barriers were described.

In terms of personal barriers, the participants identified the language as one of the major barriers to accessing health care services and effective communication with the health care providers. Additional barriers included the feelings of prejudice within the health care system and the lack of a personal support system, which included confidantes or close friends. Additional barriers identified were transportation difficulties and a lack of language-appropriate educational materials.

Although participants may have expressed a gender preference for their health care provider, giving reasons such as modesty, shyness, and embarrassment, gender was not seen or expressed as a barrier to obtaining a Pap screening by most participants; rather, it was a preference related to cultural issues such as modesty, shyness, and embarrassment. Health care providers, particularly doctors, are seen as authority figures and, as such, may represent an inherent barrier for the patient. Generally, in the Thai culture, patients are expected to comply with the doctor’s recommendations without question; therefore, to ask questions is to subtly challenge the doctor, even though the intent is to seek additional information or clarification. Although this type of conflict is

not expressed directly to the health care provider, it is nevertheless inherent within the culture's hierarchical relationships.

### **Chapter Summary**

In summary, this focused ethnography study was guided by four research questions: (1) What are the knowledge and attitudes about cervical cancer among Thai women living in Germany?; (2) What are the health beliefs and practices regarding cervical cancer among Thai women living in Germany?; (3) What are the cervical screening practices among Thai women in Germany?; and (4) What are the barriers to participation in cervical cancer screening perceived by Thai women living in Germany? The findings from the data and analysis were presented. All research questions were answered, and the findings were presented by themes and subthemes, in response to each research question.

## **CHAPTER 6**

### **DISCUSSION**

This chapter consists of six parts: (a) a summary of study findings; (b) comparison of study findings to relevant literature; (c) discussion of the findings in relation to the HBM; (d) the strengths and limitations of the study; (e) the significance of the study, and recommendations to the German health care system; and (f) the study conclusion.

#### **Summary of Study Findings**

The purpose of this study was to describe the knowledge, attitudes, and beliefs of Thai immigrant women living in Germany regarding cervical cancer and cervical cancer screening, and the barriers to participation in cervical cancer screening they encountered. Analysis of the data provided answers to the four research questions presented in Chapter 1.

In summary, the key findings of the current research study indicated that all participants had heard about cervical cancer screening and described their knowledge of cervical cancer based on personal, traditional, and clinical knowledge. The majority of the participants stated they had received information regarding cervical cancer from a variety of sources. Only 6 participants received cervical cancer information from their gynecologists. The majority of participants perceived the Pap test as an early detection method for cervical cancer. Most of the participants believed they were at risk for developing the disease by the very nature of being a woman. Lastly, if diagnosed with the disease, each participant stated they would seek medical advice and treatment.



In the current study, the participants integrated both traditional and modern health beliefs and practices that influenced their cervical cancer screening practices. Many of the participants stated they were not aware of any specific traditional health practices to prevent cervical cancer. However, some believed that observing the traditional health postpartum practice, “lying by the fire,” or *yuu fai*, may help prevent cervical cancer, as well as avoiding certain types of unsuitable food, which may cause “uterus or *mot luuk* problems.” In terms of personal and modern health beliefs and practices of cervical cancer prevention, participants offered an array of health practices, including having a yearly Pap test.

The majority of the participants had cervical cancer screening done as part of their yearly physical exam. In addition, the participants also expressed a strong sense of personal and social responsibility in taking care of one’s health. All but 1 participant verbalized their intention to have future Pap tests. All participants had health insurance. In general, most of the participants were satisfied with the quality of health care services they received. System, personal, and cultural barriers were identified within the health care system. Age, levels of education, and socioeconomic status did not seem to be factors in participating in cervical cancer screening among the participants; however, having health insurance seemed to increase the likelihood of participation.

### **Comparison of the Findings to Relevant Literature**

To my knowledge, this study is the first to explore and describe the knowledge, attitudes, and beliefs regarding cervical cancer, screening procedures, and perceived barriers to cervical cancer screening programs among first-generation immigrant Thai women living in Germany. The findings of this focused ethnographic study unveiled

opportunities and challenges for improving health and health care services among the immigrant Thai women population residing in Germany.

The findings of this study highlighted the significance related to first-generation immigrant Thai women's knowledge, attitudes, and beliefs about cervical cancer and the screening procedure, and perceived barriers to accessing Germany's health care services. They are summarized and compared with the relevant literature in the following sections: (a) knowledge of and attitudes about cervical cancer and the screening procedure; (b) health beliefs and practices regarding cervical cancer and the screening procedure; and (c) identified barriers to cervical cancer screening participation.

### **Knowledge of and Attitudes About Cervical Cancer and Screening Procedure**

Cervical cancer is a disease of increased focus in developing countries. Early detection by Pap screening has been shown to be lifesaving by decreasing the morbidity and mortality rates of cervical cancer. Several studies of cervical cancer and screening procedures among Thai immigrant women were conducted in the United States and Australia (Dang, Lee, & Tran, 2010; Jirojwong & Manderson, 2001; Jirojwong et al., 2001; Tanjasiri et al., 2002; Tsui & Tanjasiri, 2008). However, no previous study concerning this phenomenon among this ethnic group in Germany was found. Previous research among Asian American Pacific Islander women in the United States indicated that knowledge, attitudes, and beliefs toward the disease were contributing factors influencing breast and cervical cancer screening (Dang et al., 2010; Ho, et al., 2005).

The participants in the current study described their knowledge of cervical cancer in relation to clinical knowledge and traditional and personal beliefs. Most participants gained knowledge of cervical cancer from a variety of sources. Some participants were

able to identify possible causes of cervical cancer, such as genetic predisposition, a family history of cervical cancer, multiple sexual partners, sexually transmitted disease, HPV, HIV, smoking, illegal abortion, inflammation, and infection of the cervix. Similar findings of causes, such as previous history of STDs, family history of cervical cancer, history of abortion, and history of using birth control methods, were identified in the studies by Jirojwong and Manderson (2001) and Tanjasiri et al. (2002). In addition, a risk factor regarding genetic predisposition was also identified by Wong et al. (2009) and Liang, Yuan, Mandelblatt, and Pasick (2004), supporting that part of the current study findings.

Participants in the current study described a variety of beliefs, both traditional and personal; however, “personal hygiene,” especially of the genital area, was a belief consistently expressed by the majority of participants as a possible contributing cause of cervical cancer. These explanations include failure to maintain proper hygiene, including bathing and genital hygiene “after sexual intercourse” or “during menstrual periods.” These findings concur with Jirojwong and Manderson (2001), Wong et al. (2009), Liang et al. (2004), Do et al. (2007), Donnelly (2006), and Tanjasiri et al. (2002), who also found that their study participants emphasized the lack of personal cleanliness and hygiene as a potential cause of cervical cancer.

In the current study, many participants believed that eating certain types of food may trigger the development of cancer, such as burnt food, food cooked in the microwave, vegetables sprayed with pesticides, red meat, and food prepared in unsanitary conditions. Jirojwong and Manderson (2001) stated that perceived causes of cervical cancer included “wrong food item intake”; however, they did not elucidate further on the

subject. Although, Wong et al.'s (2009) study findings listed several types of food believed to cause cervical cancer, the concept of food as a potential cause of cervical cancer is similar. In addition, the study by Lee, Tripp-Reimer, Miller, Sadler, and Lee (2007) on breast and cervical cancer among Korean American women revealed the participants' belief that chemicals in food and preservatives may cause cancer, including cervical cancer, thus, supporting the current study findings. The concept or belief that food may act as a causative factor in the development of cancer seems to permeate Asian cultures.

All participants in the current study heard of cervical cancer screening from sources that included reading, television, the Internet, friends, family members, village health volunteers, government cervical cancer prevention campaigns, and, for a small number, directly from their gynecologists. Oranratanaphan, Amatyakul, Iramaneerat, and Srithipayawan (2010) conducted a survey in a university hospital in Thailand to evaluate the knowledge, attitudes, and practices of 78 medical workers. The major source of knowledge of the participants came from doctors, educational pamphlets, and the mass media, such as television and radio. In the current study, the majority of the participants' knowledge was similarly obtained from sources such as reading, watching television, surfing the Internet, and family and friends. However, only a small number were educated by their gynecologists (Ackermann et al., 2005; Dang et al., 2010; Dreir, Borutta, Töppich, Bitzer, & Walter, 2011; Klug et al., 2005). An interesting finding from the current study was that all participants had knowledge relating to the recommended frequency of Pap screening, whereas none of the participants in Wong et al.'s (2009) study could answer with any certainty when asked about the frequency of screening. This

phenomenon could be directly related to the fact that all the participants in the current study had health insurance and therefore received direct recommendations from their doctors regarding screening frequency.

Perceptions of susceptibility to cervical cancer may affect screening behaviors (Wong et al., 2009). This concurs with the study findings by Thanappapasr, Deesamer, Sujintawong, Udomsubpayakul, and Wilailak (2012), who conducted a cross-sectional survey of 2,112 hospital health care providers in Bangkok, Thailand. Researchers found that 848 (62.1%) of the respondents had never had a Pap test, and the reasons given included no perceived risk, believing it was unnecessary, and shyness. The findings of Thanappapasr et al. coincided with Lee-Lin et al.'s (2007) findings regarding cervical cancer beliefs and Pap test screening practices among Chinese American immigrants, which showed that participants believed there was no need for screening if they were asymptomatic, menopausal, and not sexually active. In addition, the perception of no risk of cervical cancer was also found among Thai women in a study by Boonpongmanee and Jittanoon (2007).

In contrast, in the current study, most of the participants perceived they were at risk of developing cervical cancer, and even though some participants believed they had little or no risk of developing the disease, the majority of participants had yearly Pap screening. A list of factors and beliefs that would likely predispose or cause them to develop cervical cancer were identified, including environmental and stress factors, the individual's hormones, menopause, vaginal discharge, one's state of health and immune system, engaging in sexual intercourse, being sexually active, being a woman and having a uterus, and not taking care of one's health. Some participants believed that because they

had yearly cervical cancer screening, this precluded them from having any risk of getting the disease. One participant stated, “I believe that my chances of getting cervical cancer are zero because I have a yearly checkup.” This belief lends insight into the misconception that Pap screening is a preventive measure rather than a detection method.

The consequences of cervical cancer are vast and individually complex, and the participants in this study believed in the multiplicity of those consequences, which may then lead to a fear of the disease and the unknown. Many participants believed that cervical cancer is deadly and incurable, consistent with Wong et al.’s (2009) findings, whereas others understood that if the disease were detected early, it could be treated. Some participants stated that the reason for their very first Pap test was due to the experience of a family member with the disease and the resulting fear of being diagnosed with cervical cancer and the consequences. Additional fears of participants related to an abnormal Pap test or cervical cancer included the social stigma associated with a hysterectomy and STDs as a result of being promiscuous or involved in prostitution. In addition, because of the personal nature of Pap screening, the fear of “medical gossip” added to the restrictive nature of talking about such personal issues, also exemplified in the study by Wong et al. (2009). Some of the participants in the current study relayed types of symptoms that caused fear and resulted in seeking medical intervention through Pap screening, including vaginal discharge, pus, itchiness, odor, and abdominal pain. Of note was the fear of finding out through screening that one does have a disease or cervical cancer, and thus by not going for screening, the fear is abated (Lee, 2000; Wong et al., 2009).

### **Health Beliefs and Practices Regarding Cervical Cancer and Screening**

In a culture where the modesty and chastity of women are valued, it is difficult to discuss issues as personal as pelvic exams and problems relating to a woman's private parts. Thus, if this value is maintained or practiced, it is difficult to pass on information in the areas of women's health issues from generation to generation. Without this generational foundation of knowledge, women assimilate knowledge from a variety of sources, which may be traditional and/or contemporary. Therefore, classifying "knowledge" as traditional, personal, or modern must be applied to the person as a whole and the resulting impact that it has on preventative practices. One area that is consistently based on the traditional foundation or belief is the postpartum practice of staying by the fire. Many of the participants in the current study expressed their belief in the necessity of this practice as a preventative measure of cervical cancer, as did participants in the study by Boonmongkon et al. (2002), who believed they had chronic or recurrent uterine problems, or *mot luuk mai dii*, as a result of inadequate postpartum practice. In addition, Jirojwong and Manderson (2001) found that participants believed the practice of lying by the fire may reduce the risks of having cervical or breast cancer. Do et al. (2007) found that among Vietnamese American women, 71% ( $N= 352$ ) believed that not observing the "sitting month" properly after childbirth is one of the risk factors for developing cervical cancer. In accordance with the results of these studies, it is important for health care providers to realize the extent of this traditional belief and discern the relative significance to the patient if she is not able to adhere to this practice.

Furthermore, in the current study, many participants believed that adhering to the traditional health beliefs of food taboos, *sa-laeng* or *pid-ka-boon*, prevented vaginal

discharge, or *maat khaaw/tok khaaw*, that in turn may cause cervical cancer. Some participants feared that heavy vaginal discharge or abdominal pain from menstruation may be related to cervical cancer, although participants believed that vaginal discharge could be prevented by adhering to food taboos. In their study of *mot luuk mai dii*, or uterus problems, of women in northeast Thailand, Boonmongkon et al. (2002) found that participants were fearful of heavy vaginal discharge, as it was believed by many to lead directly to cervical cancer, not from food taboos but rather from a lack of genital hygiene and sexual impropriety.

All of the participants in the current study had heard about cervical cancer screening, and many agreed that the Pap smear is an important test for women: “It is disease prevention.” The majority of the participants had cervical cancer screening done as part of their yearly physical exam. Most of the participants valued their own health and viewed it as a personal and social responsibility in order to take care of one’s family and not be a burden to the host country. These findings are consistent with Donnelly’s (2006) study of Vietnamese-Canadian women’s cultural influences on breast and cervical cancer screening, in which participants explained the importance of personal health as it relates to taking care of one’s own family, including financial stability, when illness is not present.

In the current study, the personal and social responsibility expressed by the participants may be a result of several conditions. First, in Thailand, many participants were without health insurance and experienced a lack of organized governmental mandates for cervical cancer screening; therefore, perhaps this situation did not instill a sense of personal and social obligation, as would be experienced through immigration to



a country with universal health coverage. Second, immigration to a new country with socialized medicine or universal health coverage may possibly bring with it a particularly strong sense of obligation due to the insurance premiums paid for health insurance. Additionally, with the insurance mandates for the yearly health checkups, perhaps a new sense of obligatory adherence could emerge. Lastly, the potential of increased exposure to health care and the concept of health promotion and disease prevention may result in an increase in knowledge in such a way that the participants become aware of the physical and financial ramifications of cancer-related illness, thus increasing a sense of personal and social obligation.

The current study, which was conducted with immigrant Thai women who indicated that personal health was a primary concern, was in direct contrast to the Wong et al. (2009) qualitative study of cervical cancer screening attitudes and beliefs among 20 Malaysian women who had never had a Pap smear screening (aged 21 to 56 years) in their native country. Participants included 6 Malays, 9 Chinese, 4 Indians, and 1 of other ethnicity. Researchers found that one-third of the participating Malaysian women valued their family and social responsibilities over activities related to personal health and illness prevention, such as undergoing Pap smear screening.

### **Identified Barriers to Cervical Cancer Screening Participation**

In the current study, barriers associated with cervical cancer screening practices were identified as system, personal, and cultural. System barriers included long waits in obtaining appointments, long waits to be seen during visits, lack of quality time spent with the gynecologists, no reminders sent for the next appointment, and a lack of communication with the gynecologists. The participants identified personal barriers as a

lack of German language proficiency; feelings of prejudice from health care providers; lack of a support system, such as transportation and confidantes who provided support; and a lack of language-appropriate educational materials. Cultural barriers were identified as shyness, embarrassment, gender preferences for providers, and the perception of health care providers as authority figures.

Barriers to participation in cervical cancer screening were consistently found in other studies. The findings of these studies may have delineated barriers into categories different from those in the current study. However major consistencies were found that concur with the current study, including language difficulties and fear of the disease (Lee, 2000); modesty and embarrassment, and fear of the diagnosis (Jirojwong & Manderson, 2001); language and communication, gender preference for provider, lack of transportation, long waits at the doctor's office, and modesty (Tanasiri et al., 2002); lack of knowledge about cervical cancer, language, and inconvenience in accessing the health care system (Liang et al., 2004); language proficiency, knowledge deficit (Tsui & Tanasiri, 2008); knowledge deficit (Kietpeerakool, Phianmomgkhol, Jitvacharanun., Siriratwatakul, & Srisomboon, 2009); knowledge, fear of the exam, and embarrassment (Oranratanaphan et al., 2010); and shyness (Thanappapasr et al., 2012).

In the current study, all participants had health insurance, in direct contrast to the many participants in other studies (Lee, 2000; Lee-Lin et al., 2007; Liang et al., 2004; Kietpeerakool et al., 2009; Tanasiri et al., 2002). Having health insurance is significant in the potential impact that it may have on knowledge, screening practices, increased participation rates, ease of accessibility to health care services, and doctors' recommendations for Pap screening. Generally, participants in the current study were not

deterred from Pap screening, in spite of the many barriers identified, and they had a high rate of adherence to Pap screening. In contrast, in the United States, the rate of Pap screening among Asian women is significantly lower than the national average, except among Filipinas, and women without access to health care were less likely to receive testing, including cervical cancer screening (CDC, 2012).

### **The Health Belief Model**

In this study, the HBM was used as a theoretical lens to examine the relationship between immigrant Thai women's health beliefs and their health behaviors, and cervical cancer screening participation. The HBM explains and predicts an individual's health behaviors using the attitudes and beliefs toward disease, especially perceived barriers, perceived benefits, and perceived susceptibility. The HBM stipulates that one's health-related behavior depends on one's perception of six important areas: the severity of a potential illness (cervical cancer); one's susceptibility to that illness (perceived risk of developing the disease); the benefits of taking a preventive action (taking care of one's health and family responsibility by participating in Pap screening); the barriers to taking that action (i.e., language barriers, modesty, shyness, gender preferences for health care provider); cues to action that motivate one to take action; and self-efficacy.

#### **Perceived Severity**

The participants' health behaviors identified in this study were consistent with the theoretical framework of the HBM. The majority of the participants believed that cervical cancer is a deadly disease, and some stated that it was incurable. Participants had personal experiences that influenced and affirmed their belief of the fatal nature of the disease due to experiences with family or friends who suffered with the disease and succumbed to it.

These experiences directly lead to fear of the disease and its consequences for the family system or structure. This overall fear of the disease and the strong sense of family responsibility often directed the participants' adherence to Pap screening. In addition, some participants reported that the reason for undergoing their first Pap screening was due to the fear of being diagnosed with cervical cancer and the consequences.

### **Perceived Susceptibility**

As previously discussed in Chapter 2, according to Salazar (1991), the individual's personal perceived susceptibility to any given disease and the perceived severity of the consequences of the disease on the individual's life is one of the most powerful perceptions or beliefs that drive individuals to change their behaviors or adopt new healthier behaviors. However, this perception of susceptibility may vary widely with each individual.

Most of the participants perceived they were at risk for developing cervical cancer just because they were women and had a uterus. One participant expressed her perceived susceptibility as being 100% because she had a uterus. In contrast, a few participants were at the other end of the spectrum, believing that they had no chance of getting the disease because they faithfully had yearly checkups. In addition, the findings suggested that the participants' understanding of cervical cancer was influenced by their knowledge, attitudes, and health beliefs. However, it is important to consider the potential change in knowledge, attitudes, and beliefs that may have been directly influenced by exposure to sources that included, but were not limited to, reading, watching television, the Internet, family and friends, village health volunteer's recommendations, government cervical cancer prevention campaigns, and their gynecologists. In addition, living in a country

with socialized medicine or universal health care coverage may promote a strong sense of obligation due to the insurance mandates for yearly checkups. Finally, the potential of increased exposure to the concept of health promotion and illness prevention may result in an increased awareness of the physical and financial burdens of cancer-related illness, thus increasing a sense of personal and social responsibility and providing motivation for continued yearly Pap screening and checkups.

### **Perceived Benefits**

Most of the participants also believed that to prevent any type of illness, including cervical cancer, one must maintain one's health. In addition to a strong sense of responsibility for maintaining one's health to support family, several participants also expressed a sense of social duty to adhere to the insurance mandate for a yearly health checkup and Pap screening so as not to become a burden to the host country. The majority of the participants had cervical cancer screening done as part of their yearly physical exam and consistently indicated that cervical cancer screening was an important early detection measure.

### **Perceived Barriers**

As discussed previously, barriers associated with cervical cancer screening practices were identified as related to the system, the culture, and personal beliefs. The HBM stipulates that one's health-related behavior depends on one's perceptions. Although the participants' perceived barriers, such as long waits, language difficulties, modesty, shyness, embarrassment, and gender preference of the health care provider, were expressed as obstacles, they did not cause a marked change in Pap screening behavior, but rather were seen as inconveniences and added to the overall dissatisfaction

with the health care experience and perception of service. Most of the participants continued with their Pap screening behaviors in spite of the expressed barriers.

### **Cues to Action**

Cues to action are factors or events that motivate one to take action. This motivation can take the form of a physical or emotional response to an event that triggers one's action in a given circumstance. In the realm of cervical cancer screening, triggers may include, but are not limited to, such events as family and friends having a difficult experience with cervical cancer; a personal crisis or symptoms that are worrisome, such as heavy vaginal discharge and abdominal pain; exposure to media advertisements or government health campaigns; a sense of responsibility to one's health and to the host nation; and advice and recommendations given by health care providers and friends.

### **Self-Efficacy**

Self-efficacy is defined as the confidence in one's ability to successfully perform an action (USDHHS, 2005). In the current study, examples of the lack of self-efficacy were identified as some of the participants' inability to ask questions of the health care provider, understand the health care providers' explanations, and explain the results to others. However, participants in the current study exemplified the desired outcomes of self-efficacy by continuing yearly checkups.

In conclusion, the expanded HBM is a useful framework to explore the participants' perceived severity and susceptibility to cervical cancer, the benefits of Pap screening, and the barriers to their use of health care services. The majority of the participants perceived they were susceptible or at risk to cervical cancer and believed that cervical cancer has serious consequences, which led many to undergo regular Pap testing.

Most of the current study findings were consistent with the HBM. However, one inconsistency was the fact that the identified barriers did not prevent the participants from undergoing Pap smear screening.

### **Strengths and Limitations of the Study**

This study has both limitations and strengths. One limitation was that the secondary participants were limited to two health care providers. A larger number of gynecologists, especially male gynecologists, may have provided different perspectives and additional insight on providing gynecological care to Thai women in Germany.

This study was also limited by the fact that the primary participants were recruited from mostly rural areas and, if employed, participants held service-oriented jobs, such as housekeeper, cashier, and kitchen help. As the majority of study participants were recruited by the snowball sampling method, it stands to reason that this method would draw from the same social strata; if participants had been recruited from academia, professional arenas (i.e., doctors, nurses, lawyers), and highly trained skilled workers from urban settings, the differences in the socioeconomics and degree of acculturation may have provided different perspectives in this study.

Another limitation of this study was my status as a novice researcher, in addition to being an “insider,” or a member of the group being studied. However, this position may also be viewed as one of the strengths of this study. During the entire research process, I found that it was difficult not to influence or be influenced by the study participants. Through the process of reflexivity, I acknowledged that the study findings are the product of my interpretations. However, while striving to understand the participants’ knowledge, attitudes, and beliefs regarding cervical cancer within their

health beliefs and cultural context, I was able to connect culturally, thus enabling me to construct meaning and to develop insight and understanding, which would not otherwise be apparent to an outsider. In addition, I made every effort to withhold my personal clinical knowledge, not to influence the participants' knowledge, and to clarify and separate the possible assumption of knowledge that in actuality may not have been there, thus allowing free expression of the participants' subjective voice of cervical cancer knowledge until the appropriate time after the interview process was completed, per study protocol.

The strengths of this study included prolonged engagement in the communities of interest, single observations during the interview process, triangulation of data sources, member checking, dependability, confirmability of the data, and support of the theoretical framework. I resided in Germany for 3 years, and over the past 5 years, I performed an extensive review of the literature. Thus, a sufficient time investment was devoted to this study to ensure data saturation. The length of face-to-face interviews with the primary and secondary participants was sufficient to build rapport and to permit adequate member checking, in which any misconceptions were clarified. The methods of triangulation of data sources included interviews with primary and secondary participants, observations, and demographic information and field notes, which provided different views of the phenomenon being studied. Credibility was accomplished through member checking by summarizing and validating data with primary and secondary participants throughout the data collection periods. Formal member checking was accomplished by asking the selected 7 primary participants to validate and clarify emerging data from the interview



descriptive summaries. Thick description of data provided transferability of results. Dependability and confirmability were accomplished by the process of audit trails.

### **The Significance of the Study**

This study focused on first-generation immigrant Thai women living in Germany. The study described the women's knowledge, attitudes, and beliefs regarding cervical cancer, the screening procedure, and the perceived barriers of the German cervical cancer screening program. The findings from this study contribute to the knowledge base related to immigrant Thai women and their knowledge, attitudes, and health beliefs regarding cervical cancer, the screening procedure, and perceived barriers to cervical cancer screening participation, and may be useful in future nursing and health research.

### **Recommendations**

Results of this study offer implications for nursing research, education, and practice.

### **Implications for Nursing Research**

Recommendations for nursing research include further exploration of immigrant Thai women's knowledge, health beliefs, and attitudes about cervical cancer and screening procedure in different EU countries, such as the United Kingdom, Sweden, Finland, France, the Netherlands, and Belgium, that use organized screening programs (International Agency for Research on Cancer, 2008). According to the literature review, there was no published research available among this population in these particular European countries. Research in countries that use organized programs would enable a comparison with countries using the opportunistic screening programs and, thus, may increase the body of knowledge and understanding in this phenomenon.

In Chapter 1, I suggested that the German opportunistic cervical cancer screening system, which is based on a self-referring system and individual compliance, may place Thai women at greater risk for delaying early cervical cancer detection due to factors such as cultural and language barriers, lack of knowledge of cervical cancer, and the benefits of early screening. The study participants all had health insurance and were all aware of cervical cancer screening. The majority had cervical cancer screening done as part of their yearly physical exam. Consistent with the qualitative approach, the findings of this study only pertained to the studied sample population, and it is up to the reader to determine whether the findings are applicable to other populations. Because the participants were recruited from a rural area and a single community, they may have had unique characteristics and provided different perspectives than if the sample had been recruited from a more urban setting, from across the country, from academia, or from a population of professionals (i.e., doctors, nurses, lawyers, etc.) and/or highly trained skilled workers that had greater variation in socioeconomic characteristics and degree of acculturation and diversity.

Although the study findings suggest that this sample of Thai women overcame a variety of barriers and received adequate screening, a question remains about access and participation in health care services of the many Thai women who are living in Germany illegally and whose legal status creates a unique barrier to accessing health care services. Therefore, this group of Thai women may still be at risk for delaying early cervical cancer detection due to factors such as cultural and language barriers, lack of knowledge of cervical cancer and the benefits of early screening, lack of health care access due to their illegal status, and possible fear or lack of knowledge about the system. It is recommended

that future research among this vulnerable and possibly underserved population be conducted.

### **Implications for Nursing Education**

If cervical cancer screening in Germany remains opportunistic, public health education needs to be enhanced in several areas, including disseminating educational information to women through peer groups and through the media; providing cervical cancer education brochures translated into the Thai language; and perhaps utilizing mid-level practitioners, such as nurse-midwives, for cervical cancer screening and patient education. In addition, to assist in bridging the communication gap between health care providers and patients with language differences, a trained translator could be utilized.

Although the majority of the participants in this study expressed satisfaction with the quality of health care services received in Germany, some participants expressed dissatisfaction and personal barriers, such as language, feelings of prejudice, lack of knowledge, and long waits, which may have influenced their perceptions of the care received. This may be partially explained by health literacy. Health literacy has been defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Osborn, 2004, para. 2). Without the ability to understand, due to language skills or barriers, complex medical information, and cultural differences, participants may not be able to assimilate the information given and therefore may be unable to ask appropriate questions or seek clarification to be more proactive and maintain good health.

In addition, by way of promoting health literacy among Thai women, further research recommendations may include conducting a survey among Thai students in

German Universities to ascertain their perception of immigrant Thai women health literacy needs and how they perceive those needs could be met. Further research and implementations could be initiated based upon those recommendations.

To address the health care needs of this vulnerable population, the counseling services of Ban Ying (Thai word meaning house of women; Humbeck, 1996), could be utilized to provide educational materials in the Thai language. Ban Ying was founded in 1988 as a shelter for women from Southeast Asia and a counseling and coordination center against human trafficking. This organization is funded by the Department of Women of the Berlin City Parliament.

In addition, to increase the opportunity for Thai women to have a more community-based source of information regarding cervical cancer and other health-related issues, the Thai Buddhist temple, or *wat*, could be utilized to facilitate the dissemination of printed Thai materials. The *wat* is one of the few central cultural social gathering places available to Thai women in Germany and therefore could lend itself to creating a community hub for health care related sources of education. Two additional possible sources for distributing printed Thai materials could be the Thai grocery store and the Thai restaurant.

### **Implications for Health Care Practice**

When cultural differences are poorly understood, several adverse clinical outcomes may occur, such as reduced participation in Pap screening, use of harmful remedies (some participants medicated themselves by taking antibiotics, hormone replacement therapy for menopausal symptoms, or birth control pills without doctor's advice), noncompliance, and decreased satisfaction with care. According to Nees (2000),

“only when you understand the central cultural themes of any given culture can you accurately interpret and understand its inhabitants’ behavior, communication, and way of life. If you don’t understand their cultural themes you will necessarily project your own values, norms and beliefs onto them, and this projection is one of the principal causes of intercultural misunderstandings” (p. 35).

The perception of the secondary participants was that they were meeting the needs of the patients and that any barriers stemmed from the patients viewpoint or perceptions and not from the health care system or health care providers. I suggest that this barrier within a barrier (communication) is more than just language; it is the perception of the need to be met, based on the diversity of the two cultures. The patient’s goals and needs may encompass the perception of individualized care, which may include the amount of time spent. When, or if, time spent equates to care or caring, individuals may be more susceptible to the feelings that their needs are not being met. Additionally, when time is limited or does not allow for a more in-depth discourse, that need may then be perceived by the patient as not being met in addition to “feeling deprived” or a sense of “prejudice.”

The secondary participants’ goal was to provide the best care possible in the allotted time, in a professional manner, which may have involved “professional neutrality” (Beagan & Kumas-Tan, 2009). The perception of prejudice must be viewed from both cultural positions to understand the behaviors that are considered to be prejudicial. One of the secondary participants (the nurse) stated that equal treatment was provided to all minority populations: “I think Germans try to treat all people the same no matter what country they come from.” Additionally, the act of treating everyone the same may be viewed in light of professional neutrality, which takes place when health care

professionals are concerned that if they notice a patient's race, culture, or class, they are "inherently enacting prejudice" (Beagan & Kumas-Tan, 2009, p. e25), and respond accordingly by retreating into professionalism, or professional neutrality. This means "trying to put feelings and values aside, aiming to be color-blind or nonjudgmental, and attempting to provide the best care possible regardless of personal responses" (Beagan & Kumas-Tan, 2009, p. e25). Therefore, the very act of trying to prevent prejudice may be seen by other cultures as cold, blunt, impersonal, and prejudicial.

Because of the inherent "barriers within the barriers," a concerted effort by patients and health care providers alike needs to be made and put into practice to break them down or at least to understand and address them. This may be addressed by expanding the scope of education for this target population with educational materials in their native language, possibly with the German equivalent underneath. This type of "menu" is common in German restaurants, which list the dish in German with the explanation in English underneath. This would enhance the patient's knowledge and allow the doctor to direct additional educational materials to areas of interest. A pamphlet could be devised in which there was a list of questions regarding Pap screening, cervical cancer, and other health-related issues, written in Thai, with the German equivalent underneath and the answer in German and Thai; the physician would know the specific questions that were being asked, and because the answer would also be in German, the husband then could understand what was being asked and answered. This would result in a "triad" of education: the doctor learning about patient, the patient learning about the disease, and the husband learning about the disease and his wife's health concerns.

The burden of providing educational material in the Thai language should not be solely the responsibility of the German health care system, but rather a coordinated effort among the German health care system, the Thai communities, and the educational system, and other interested groups. To accomplish such an undertaking, I propose that some possible resources, including the Thai Student Association in Germany, which was established in 1957 under the patronage of His Majesty, King Bhumibol Adulyadej, possibly provide health-related information as mentioned above or provide written health information in their magazine *Puan-Thai*. Additionally, efforts to develop community-based support groups (e.g., a Thai Women's Association) for Thai immigrant women in Germany, may be spearheaded by the local Thai community leaders to provide women with a support group that may assist in areas related to promoting health, health concerns, and acculturation to the German health care system.

An additional opportunity for education is during the long waits that patients have during their visits to the clinic. During my time spent waiting for an interview with the gynecologist, I did not notice any educational material available to the patients in the waiting room. If a variety of educational materials, such as recorded information in the form of a DVD or video in the Thai language (Love, Mouttapa, & Tanjasiri, 2009), could be provided to the waiting patients, a void could be filled. In conjunction with the question-and-answer-type pamphlets, each visit to the gynecologist could build on a foundation of growing knowledge and communication, thus facilitating a greater depth of understanding of the needs of the patients and increasing the possibility of meeting those needs.

Possible resources that are underutilized for patient care and education are in the arena of human resources or, more specifically, the mid-level practitioners or nurse-midwife. As previously discussed, in Germany, 90% of Pap tests are performed by gynecologists, and the remaining 10% are performed by general practitioners (Klug et al, 2005; WHO, 2012), whereas other EU countries, such as the United Kingdom, Finland, Italy, and Sweden, utilize general practice nurses, nurse-midwives, or public health nurses to perform the Pap tests (WHO, 2012). According to Rosemann et al. (2006), practice nurses in Germany are currently only rarely involved in diagnosis and treatment, and are mainly occupied with administrative tasks, such as arranging appointments, answering telephone calls, and preparing and providing patient files. In contrast, in the United States, the nurse is often the most immediate provider of health information that patients have access to and therefore have more opportunity for patient teaching than any other member of the health care team. However, such is not the case in Germany's health care delivery system; thus, a valuable resource is not utilized to its fullest extent.

In addition, Rosemann et al. (2006) stated that there is the new development of more general practitioners leaving their practices in Germany for better working conditions elsewhere, such as the in United Kingdom or Scandinavian countries. It is getting more difficult to find young practitioners who are willing to work, especially in the eastern part of Germany. Because of this new trend, "these developments force physicians and policy makers to consider new models of nurses' involvement" (Rosemann et al., 2006, p. 2). To increase the utilization of the practice nurse or mid-level practitioner, greater involvement, autonomy, and increased scope of practice is needed, either through the educational institutions encouraging this type of involvement and



autonomy in patient education or practice, or the physicians themselves need to see this as a potential area for increasing the education and overall health benefit to the patients, while liberating themselves for more complex care.

In conclusion, the transferable implications for this study are universal, as cultural sensitivity is a challenge for health care providers worldwide. In today's world, very few health care providers deal singularly with a mono-culture, including their own, such as in a multicultural society like the United States. Cultural sensitivity and cultural competence are buzz words in today's world, and much attention has been paid to these areas, resulting in an abundance of cross-cultural studies. According to Campinha-Bacote (2003), cultural knowledge is "the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups" (Cultural Knowledge section, para. 1). In addition, "In obtaining cultural knowledge, it is critical to remember the concept of intra-cultural variation, there is more variation within cultural groups than across cultural groups" (Campinha-Bacote, Cultural Knowledge section, para. 4). Each individual is a unique blend of his or her own cultural diversity.

However, what each cross-cultural study can bring to all health care providers is to emphasize that one must never make assumptions regarding their own cultural sensitivity or cultural competence. Take, for example, the German health care providers in this study; making every effort not to exemplify prejudice in their own cultural way, they brought about the exact opposite response in some of the Thai participants. Both primary and secondary participants may have misunderstood the needs and behaviors of each other, not so much because of the language barrier, but perhaps because each party did not know enough about the deeper nuances of exemplified cultural behaviors and

expectations of each of the involved cultures (German and Thai). Obtaining cultural knowledge is necessary for both cultures in order to become more aware of the nuances and expectations surrounding cultural behaviors, based on perceptions and lack of knowledge. Therefore, if true cultural sensitivity is to be achieved, cultural knowledge needs to be actively sought, which then will enhance, expand, and evolve, and thus may assist in meeting the true objective of cultural sensitivity.

### **Chapter Summary**

In this chapter, the four research questions are discussed. The summary of the study findings, comparison of study findings with relevant research and theories, strengths and limitations of the study, significance of the study to the German health care system, and recommendations are presented.

## Appendix A Consent Form for Primary Participants

### The University of New Mexico Health Sciences Center Consent to Participate in Research

#### Knowledge, Attitudes, and Beliefs regarding Cervical Cancer and Screening and Perceived Barriers of Cervical Cancer Screening Programs among Thai Immigrant Women Living in Germany

##### **Purpose and General Information**

You are being asked to participate in a research study that is being done by Dr. Cindy Mendelson, RN, PhD, who is the Principal Investigator, and Unchalee Vatanasook Ice, RN, MS, co-investigator, a doctoral candidate at the University of New Mexico College of Nursing, the State of New Mexico, the United States. This research is being done to help us to learn more about your cervical cancer knowledge, health beliefs, practices and attitudes regarding cervical cancer screening and the perceived barriers to participation in cervical cancer screening by the Thai immigrant women living in Germany. . You are being asked to participate because you are a Thai woman. Approximately 30 Thai women; and two German health care providers, a gynecologist and a registered nurse will take part in this study in the state of Rheinland-Pfalz, Germany.

This form will explain the study to you, including the possible risks as well as the possible benefits of participating. This is so you can make an informed choice about whether or not to participate in this study. Please read this Consent Form carefully. Ask the investigators or study staff to explain any words or information that you do not clearly understand.

##### **What will happen if I participate?**

If you agree to be in this study, you will be asked to read and sign this Consent Form. After you sign the Consent Form, the following things will happen: You will be asked a series of questions about your general knowledge, health beliefs, and attitudes of cervical cancer and screening. The interview will be audiotape recorded. At the completion of the interview process, you will be provided with the information sheet about cervical cancer in Thai language and how to receive the screening in Germany.

Participation in this study will take a total of 60-90 minutes interview over a period of a one time interview in one day.

At the end of the interview process, you will be asked if you are willing to participate in the second part of this study by allowing the investigator to call you to validate the discussion that transpire during the interview process with your written transcripts. In the written transcript, you will be identified by false names or nick names and the transcriptionist who transcribes the interview audio tapes will not know your identity. Participation in this part of the study will take approximately 20-30 minutes. Any personal identifying information and any record linking that information to study false names or nick names will be destroyed when the study is completed.

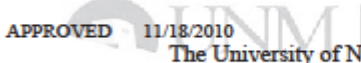
##### **What are the possible risks or discomforts of being in this study?**

Every effort will be made to protect the information you give us. However, there is a small risk of loss of confidentiality, loss of privacy, and emotional distress. The result of this study may be incorporated into further research studies, may be included in future presentations or publications. Your identity or name will not be identified in any publications. Some of the questions I will ask you as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions, and you may take a break at any time during the study. You may stop your participation in the study at any time.

\_\_\_\_ Initials

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HRRC#: 10-543  
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APPROVED 11/18/2010	The University of New Mexico Human Research Review Committee	

**How will my information be kept confidential?**

Your name and other identifying information will be maintained in locked files, available only to authorized members of the research team, for the duration of the study. At the beginning of the interview, you will be asked to choose a false name or nick name, and the false name or nickname will be used during the interview. Because you will be identified by false name or nickname, the transcriptionist who transcribes the interview audiotape will not know your identity. The interview audiotapes will be kept in locked files of the investigator's office. The audiotapes will be destroyed at the completion of the study. For any information entered into a computer, the only identifier will be a false name or nick name. Any personal identifying information and any record linking that information to study false names or nick names will be destroyed at the completion of the study. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name in any publications.

Information from your participation in this study may be reviewed by federal and state regulatory agencies, and by the UNM Human Research Review Committee (HRRRC) which provides regulatory and ethical oversight of human research.

**What are the benefits to being in this study?**

There may or may not be direct benefit to you from being in this study. However, your participation may help others in the future as a result of knowledge gained from the research. This study results will assist health care providers to gain an insight and a deeper understanding of cultural implications and barriers that may prevent Thai women from seeking early screening. In addition, information will directly assist German health care providers to tailor prevention programs that are culturally sensitive to increase cervical cancer screening, and thereby, decrease morbidity and mortality rates in Thai women.

**What other choices do I have if I don't participate?**

Taking part in this study is voluntary so you can choose not to participate.

**Will I be paid for taking part in this study?**

As a result of your participation in this study you will receive a cash value of 15 Euros at the end of the interview session.

If you agree to participate and are selected for the second part of the study by allowing the investigator to contact you to validate the discussion that transpires during the interview process with your written transcripts, you will receive a cash value of 5 Euros at the end of the session.

**Can I stop being in the study once I begin?**

Yes. You can withdraw from this study at any time without affecting your relationship with the investigator or the contact person who introduced you to the investigator for the interview.

The investigators have the right to end your participation in this study if they determine that you no longer qualify to take part, if you do not follow study procedures, or if it is in your best interest or the study's best interest to stop your participation.

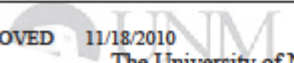
**What if I have questions or complaints about this study?**

If you have any questions, concerns or complaints at any time about the research study, Dr Cindy Mendelson at 011-505-272-8241, or Unchalee Ice, her associates will be glad to answer them at 001-49-6385415820 at any times about the study. If you would like to speak with someone other than the research

\_\_\_\_ Initials

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	<b>OFFICIAL USE ONLY</b> APPROVED 11/18/2010 The University of New Mexico Human Research Review Committee	HUMAN RESEARCH PROTECT EXPIRES 11/17/2011
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team, you may call the Human Research Review Committee (HRRC) at (505) 272-1129. The HRRC is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human subjects.

**What are my rights as a research subject?**

If you have questions regarding your rights as a research subject, you may call the HRRC at (505) 272-1129 or visit the HRRC website at <http://hsc.unm.edu/som/research/hrrc/>.

**Consent and Authorization**

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided (or the information was read to you). By signing this Consent Form, you are not waiving any of your legal rights as a research subject.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this Consent Form, I agree to participate in this study and give permission for my health information to be used or disclosed as described in this Consent Form. A copy of this Consent Form will be provided to me.

\_\_\_\_\_  
Name of Adult Participant (print)

\_\_\_\_\_/\_\_\_\_\_  
Signature of Adult Participant / Date

I have explained the research to the subject and answered all of his/her questions. I believe that he/she understands the information in this consent form and freely consents to participate.

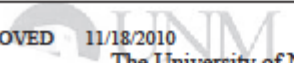
\_\_\_\_\_  
Name of Research Team Member

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Signature of Research Team Member/Date

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## Appendix B Consent Form for Primary Participants (Thai Version)

ศูนย์วิทยาศาสตร์สุขภาพ มหาวิทยาลัยนิวเม็กซิโก  
(The University of New Mexico Health Sciences Center)

### ใบยินยอมในการเข้าร่วมงานวิจัย

ความรู้ ทักษะ และความเชื่อเกี่ยวกับมะเร็งปากมดลูก และการตรวจคัดกรอง และ  
การรับรู้อุปสรรคเกี่ยวกับโปรแกรมการตรวจคัดกรองมะเร็งปากมดลูกในสตรีไทยที่อพยพมาอยู่ในประเทศเยอรมัน

#### วัตถุประสงค์ และข้อมูลทั่วไป

ท่านได้รับการขอให้เข้าร่วมในงานวิจัยนี้ โดยมี คอกเตอร์ชินดี เมนเดลสัน พยาบาลวิชาชีพ เป็นประธาน โครงการวิจัย และนางอัญชลี วัฒนสุข ไรซ์ พยาบาลวิชาชีพ วิทยาศาสตร์มหาบัณฑิต นักศึกษาปริญญาเอกจากมหาวิทยาลัยนิวเม็กซิโก คณะพยาบาลศาสตร์ รัฐนิวเม็กซิโก สหรัฐอเมริกา เป็นผู้ร่วมวิจัย การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อช่วยให้เราเรียนรู้มากขึ้นเกี่ยวกับความรู้ของท่านในเรื่องมะเร็งปากมดลูก ความเชื่อทางสุขภาพ การปฏิบัติ และทัศนคติเกี่ยวกับการตรวจคัดกรองมะเร็งปากมดลูก และการรับรู้อุปสรรคในการเข้าร่วมการตรวจคัดกรองมะเร็งปากมดลูกในสตรีไทยที่อพยพมาอยู่ในประเทศเยอรมัน ท่านได้รับการขอให้เข้าร่วมในงานวิจัยครั้งนี้เพราะท่านเป็นสตรีไทย ผู้เข้าร่วมวิจัยทั้งหมดประกอบด้วย สตรีไทยประมาณ 30 คน ผู้ให้การดูแลสุขภาพชาวเยอรมัน 2 คน สูตินรีแพทย์ 1 คน และพยาบาลวิชาชีพ 1 คน โดยทำการวิจัยที่รัฐโรนัลด์-ฟิลล์ ประเทศเยอรมัน

แบบฟอร์มนี้จะอธิบายการวิจัยนี้ให้ท่านทราบ รวมทั้งความเสี่ยง และประโยชน์ที่อาจเกิดขึ้นในการเข้าร่วมการวิจัย ทั้งนี้เพื่อให้ท่านตัดสินใจได้ว่าจะเข้าร่วมโครงการวิจัยนี้หรือไม่ กรุณาอ่านใบยินยอมนี้อย่างละเอียด ถ้าท่านไม่เข้าใจความหมายหรือข้อมูลต่างๆ ท่านสามารถขอคำอธิบายจากผู้วิจัยหรือเจ้าหน้าที่ในโครงการวิจัยได้

ถ้าเข้าร่วมแล้วจะต้องทำอะไรบ้าง

ถ้าท่านยินดีเข้าร่วมการวิจัย กรุณาอ่านข้อความทั้งหมด และเซ็นใบยินยอมการเข้าร่วมการวิจัย หลังจากท่านเซ็นใบยินยอมแล้ว ท่านจะถูกถามเกี่ยวกับความรู้ทั่วไป ความเชื่อเกี่ยวกับสุขภาพ และทัศนคติเกี่ยวกับมะเร็งปากมดลูก และการตรวจคัดกรอง การสัมภาษณ์จะถูกบันทึกในเครื่องบันทึกเสียง เมื่อการสัมภาษณ์เสร็จสิ้นลง ท่านจะได้รับข้อมูลเอกสารเป็นภาษาไทยเกี่ยวกับมะเร็งปากมดลูกและท่านจะได้รับการคัดกรองมะเร็งปากมดลูกในเยอรมันได้อย่างไร

การเข้าร่วมการวิจัยครั้งนี้จะใช้เวลาในการสัมภาษณ์ทั้งหมดประมาณ 60-90 นาที โดยสัมภาษณ์ครั้งเดียวในหนึ่งวัน

\_\_\_\_\_ อักษรย่อ

หน้า 1 จาก 4

เลขอาร์อาร์ซี#: 10-543

ฉบับ: 11/15/2010

	สำหรับเจ้าหน้าที่เท่านั้น	
อนุมัติ	วันหมดอายุ	
มหาวิทยาลัยนิวเม็กซิโก คณะกรรมการตรวจสอบการวิจัยที่เกี่ยวข้องกับมนุษย์		

เมื่อการสัมภาษณ์เสร็จสิ้นลง ท่านจะถูกถามว่าท่านยินดีที่จะเข้าร่วมในส่วนที่สองของการวิจัยนี้หรือไม่ โดยท่านจะยินยอมให้ผู้วิจัยโทรศัพท์ถึงท่านเพื่อตรวจสอบความถูกต้องของข้อมูลที่ท่านให้ในคอนสัมภาษณ์โดยเปรียบเทียบกับข้อความที่ถูกถอดจากการสัมภาษณ์ ในการลดความมั่นใจ ชื่อของท่านจะเป็นชื่อสมมุติ หรือชื่อเล่น ทั้งนี้เพื่อไม่ให้ผู้ถอดคำสัมภาษณ์รู้ว่าท่านคือใคร การเข้าร่วมในส่วนที่สองนี้จะใช้เวลาประมาณ 20-30 นาที ข้อมูลต่างๆที่เป็นข้อมูลส่วนตัวของท่านหรือการบันทึกต่างๆของข้อมูลนั้นๆเกี่ยวกับการวิจัย ไม่ว่าจะเป็นชื่อสมมุติหรือชื่อเล่นจะถูกทำลายเมื่อการวิจัยนี้เสร็จสมบูรณ์

#### ความเสี่ยงหรือความไม่สะดวกในการเข้าร่วมการวิจัยนี้มีอะไรบ้าง

เราจะพยายามทำทุกอย่างที่จะปกป้องข้อมูลที่ท่านบอกเรา อย่างไรก็ตามอาจเป็นไปได้ที่ข้อมูลของท่านจะถูกเปิดเผย ท่านอาจสูญเสียความเป็นส่วนตัว และมีอารมณ์เศร้าโศก ผลของการวิจัยนี้อาจถูกนำไปใช้กับการศึกษาในอนาคต การเสนองานหรือการตีพิมพ์ แต่ชื่อของท่านและหลักฐานที่จะชี้ว่าท่านเป็นใครจะไม่ปรากฏในงานตีพิมพ์ทุกชนิด คำถามบางคำถามที่จะถามท่านอาจทำให้ท่านรู้สึกอึดอัด ท่านสามารถปฏิเสธที่จะไม่ตอบคำถามนั้นๆได้ และท่านอาจจะขอพักการสัมภาษณ์ในเวลาใดของการสัมภาษณ์ก็ได้ ท่านอาจจะหยุดการเข้าร่วมการวิจัยครั้งนี้เมื่อใดก็ได้

#### ข้อมูลของท่านจะได้รับการเก็บเป็นความลับได้อย่างไร

ตลอดเวลาของการวิจัย ชื่อ และข้อมูลเกี่ยวกับตัวท่านจะถูกจัดเก็บไว้ในตู้เก็บเอกสารที่ถูกเก็บไว้อย่างมิดชิด ซึ่งเจ้าหน้าที่ของทีมนักวิจัยเท่านั้นที่จะเปิดเอกสารนี้ได้ในช่วงเวลาของการวิจัย ในช่วงต้นของการสัมภาษณ์ผู้วิจัยจะขอให้ท่านเลือกใช้นามสมมุติ และนามสมมุตินี้จะใช้เรียกท่านตลอดเวลาของการสัมภาษณ์ เนื่องจากท่านจะมีนามสมมุติในช่วงการสัมภาษณ์ ผู้ถอดคำบันทึกเทปจึงจะไม่ทราบว่าคุณคือใคร การสัมภาษณ์ที่ถูกบันทึกไว้จะถูกรวบรวมไว้ที่ตู้เอกสารที่มีกุญแจปิดในที่ทำงานของผู้วิจัย และเทปการสัมภาษณ์นี้จะถูกทำลายเมื่อการวิจัยนี้เสร็จสมบูรณ์ สำหรับข้อมูลที่ถูกเก็บไว้ในเครื่องคอมพิวเตอร์ ชื่อที่ใช้เพื่อระบุว่าเป็นใครจะเป็นชื่อสมมุติ ข้อมูลส่วนตัวของท่าน และข้อมูลต่างๆที่ถูกบันทึก โดยใช้นามสมมุตินี้จะถูกทำลายเมื่อการวิจัยนี้จบสมบูรณ์ ผลการวิจัยจะถูกนำไปใช้ตามวัตถุประสงค์ของการวิจัย และอาจจะถูกนำไปตีพิมพ์ อย่างไรก็ตามชื่อของท่านจะไม่ปรากฏในงานวิจัยที่ตีพิมพ์

ข้อมูลที่ท่านเปิดเผยกับเราในการเข้าร่วมการวิจัยครั้งนี้อาจจะถูกทบทวนจากหน่วยงานรัฐบาลกลาง และหน่วยงานของรัฐ และ โดยคณะกรรมการตรวจสอบการวิจัยที่เกี่ยวกับมนุษย์ของยูเอ็นเอ็ม (เอ็ชอาร์อาร์ซี) ซึ่งเป็นผู้ออกกฎ และควบคุมจริยธรรมการวิจัยที่เกี่ยวกับมนุษย์

\_\_\_\_ อักษรย่อ

หน้า 2 จาก 4

เซอร์อาร์ซี#: 10-543

ฉบับ: 11/15/2010

สำหรับเจ้าหน้าที่เท่านั้น	
อนุมัติ	วันหมดอายุ
มหาวิทยาลัยนิวยอร์ก คณะกรรมการตรวจสอบการวิจัยที่เกี่ยวกับมนุษย์	

### ประโยชน์ของการเข้าร่วมการวิจัยมีอะไรบ้าง

ท่านอาจได้รับประโยชน์โดยตรง และไม่ได้รับประโยชน์โดยตรงจากการวิจัยนี้ อย่างไรก็ตาม การมีส่วนร่วมในงานวิจัยของท่านอาจจะช่วยผู้อื่นได้ในอนาคตเพราะได้รับความรู้ที่เพิ่มขึ้นจากการวิจัยนี้ การวิจัยนี้ยังจะช่วยให้ผู้ให้การดูแลสุขภาพมีความรู้ความเข้าใจอย่างลึกซึ้งเกี่ยวกับสิ่งที่เกี่ยวข้องกับวัฒนธรรม และอุปสรรคซึ่งอาจทำให้สตรีไทยไม่เข้ารับการตรวจคัดกรองมะเร็งในระยะเริ่มต้น นอกจากนี้ข้อมูลเหล่านี้ยังจะช่วยให้การดูแลสุขภาพชาวเยอรมันออกแบบ โปรแกรมการป้องกันที่มีความละเอียดอ่อนในเรื่องวัฒนธรรมเพื่อเพิ่มจำนวนผู้มาตรวจคัดกรองมะเร็งปากมดลูก และส่งผลให้ลดอัตราการเจ็บป่วย และอัตราการตายในสตรีไทย

### มีแนวทางอื่นอีกหรือไม่ ถ้าไม่เข้าร่วมในการทำการวิจัยครั้งนี้

การจะเข้าร่วมในการวิจัยนี้เป็นความสมัครใจของท่าน ฉะนั้นท่านจะปฏิเสธที่จะ ไม่เข้าร่วมก็ได้

### ท่านจะได้รับค่าตอบแทนเป็นเงินหรือไม่ในการเข้าร่วมการวิจัย

เมื่อท่านเข้าร่วมการวิจัยครั้งนี้ ท่านจะได้รับเงินสดเป็นเงินยูโรมูลค่า 15 ยูโร เมื่อการสัมภาษณ์เสร็จสิ้นลง

ถ้าท่านยินยอมและได้รับการคัดเลือกให้เข้าร่วมในส่วนที่สองของการวิจัย โดยท่านจะยินยอมให้ผู้วิจัยโทรศัพท์ถึงท่านเพื่อตรวจสอบความถูกต้องของข้อมูลที่ท่านให้ในตอนสัมภาษณ์โดยเปรียบเทียบกับคำที่ถอดความแล้ว ท่านจะได้รับเงินสด 5 ยูโร เมื่อเสร็จสิ้นส่วนที่สองนี้

### ท่านสามารถหยุดการเข้าร่วมการวิจัยได้หรือไม่ แม้ว่าท่านได้เริ่มเข้าร่วมแล้ว

ได้ ท่านสามารถถอนตัวได้ตลอดเวลา และการถอนตัวนี้จะไม่ผลต่อความสัมพันธ์ของท่านกับผู้วิจัย หรือคนที่ติดต่อให้ท่าน ได้รู้จักกับผู้วิจัยเพื่อทำการสัมภาษณ์ท่าน

ผู้วิจัยขอสงวนสิทธิ์ในการที่จะไม่ให้ท่านเข้าร่วมการวิจัยนี้ถ้าผู้วิจัยพิจารณาแล้วว่าท่านมีคุณสมบัติที่ไม่เหมาะสม หรือถ้าท่านไม่ทำตามแผนการวิจัย หรือถ้าท่านต้องการถอนตัวจากการเข้าร่วม หรือเพื่อความเหมาะสมของงานวิจัย

\_\_\_\_\_ อักษรย่อ

หน้า 3 จาก 4

เลขอาร์อาร์ซี#: 10-543

ฉบับ: 11/15/2010

สำหรับเจ้าหน้าที่เท่านั้น
อนุมัติ <span style="float: right;">วันหมดอายุ</span>
มหาวิทยาลัยนิวเม็กซิโก คณะกรรมการตรวจสอบการวิจัยที่เกี่ยวกับมนุษย์



ถ้าท่านมีคำถามหรือข้อข้องใจเกี่ยวกับการวิจัยนี้ ท่านต้องทอย่างไร

ถ้าท่านมีคำถาม มีความวิตกกังวลหรือมีความไม่พอใจในเวลาใดก็ตามเกี่ยวกับการวิจัยนี้ คอกเตอร์ซินดี เมนเคลชัน หมายเลข 011-505-272-8241 หรือนางอัญชติ วัฒนสุข โอษฐ์ ผู้ช่วยของคอกเตอร์ซินดี หมายเลข 001-49-6385415820 อินดีช่วยตอบคำถามท่านในเวลาใดก็ได้ตลอดการวิจัย หากท่านประสงค์จะพบกับคนอื่นที่ไม่ใช่คณะผู้วิจัย ท่านสามารถติดต่อคณะกรรมการตรวจสอบการวิจัยเกี่ยวกับมนุษย์ (เอชอาร์อาร์ซี) หมายเลข (505)272-1129 คณะกรรมการเอชอาร์อาร์ซีเป็นกลุ่มทำงานจากยูเอ็นเอ็ม และจากชุมชนผู้ให้การดูแลที่เป็นอิสระที่ดูแลในเรื่องความปลอดภัย ประเด็นต่างๆเกี่ยวกับจริยธรรมที่เกี่ยวข้องกับการวิจัยที่ต้องใช้คนเป็นกลุ่มตัวอย่าง

ท่านมีสิทธิอะไรบ้างในฐานะที่ท่านเป็นกลุ่มตัวอย่าง

ถ้าท่านมีคำถามเกี่ยวกับสิทธิของท่านที่เกี่ยวข้องกับการวิจัยนี้ ท่านสามารถโทรไปที่ เอชอาร์อาร์ซี หมายเลข (505)272-1129 หรือเข้าไปดูเว็บไซต์ <http://hsc.unm.edu/som/research/hrcc/>.

การยินยอม และการอนุญาต

ท่านกำลังตัดสินใจว่าท่านควรจะเข้าร่วมการวิจัยนี้หรือไม่ การลงลายมือชื่อของท่านข้างล่างนี้ หมายความว่าท่านได้อ่านข้อมูลแล้ว (หรือข้อมูลนั้นมีผู้อ่านให้ท่านฟัง) การลงลายมือชื่อของท่านในใบยินยอม หมายความว่าท่านสละสิทธิ์ทางกฎหมายใดๆที่ท่านมีในฐานะที่เป็นกลุ่มตัวอย่างในการวิจัย

ข้าพเจ้าได้มีโอกาสถามคำถาม และข้าพเจ้าได้รับคำตอบจนเป็นที่พอใจแล้ว การลงลายมือชื่อของข้าพเจ้าในใบยินยอมนี้ คือ การแสดงว่าข้าพเจ้ามีความยินดีที่จะเข้าร่วมในการวิจัยนี้ และอนุญาตให้มีการใช้หรือเปิดเผยข้อมูลเกี่ยวกับสุขภาพของข้าพเจ้าตามรายละเอียดที่ระบุไว้ในแบบฟอร์มนี้ ข้าพเจ้าจะได้รับสำเนาใบยินยอมนี้ด้วย

ชื่อของผู้เข้าร่วมวิจัย (เขียนตัวบรรจง)

ลายเซ็นผู้เข้าร่วมวิจัย/วันที่

ข้าพเจ้าได้อธิบายการวิจัยนี้ให้กับผู้เข้าร่วมวิจัยหรือกลุ่มตัวอย่าง และได้ตอบคำถามของเขาทั้งหมด ข้าพเจ้าเชื่อว่าเขาเข้าใจข้อมูลในใบยินยอมนี้ และมีความสมัครใจในการยินยอมที่จะเข้าร่วมการวิจัย

ชื่อสมาชิกคณะวิจัย

ลายเซ็นสมาชิกคณะวิจัย/วันที่

อักษรย่อ

หน้า 4 จาก 4

เลขอาร์อาร์ซี#: 10-543

ฉบับ: 11/15/2010

อนุมัติ	สำหรับเจ้าหน้าที่เท่านั้น	วันหมดอายุ
มหาวิทยาลัยนิวเม็กซิโก คณะกรรมการตรวจสอบการวิจัยเกี่ยวกับมนุษย์		

## Appendix C Permission Cover Letter

University of New Mexico Health Sciences Center

### Permission Cover Letter

#### Knowledge Attitudes and Beliefs Regarding Cervical Cancer and Screening and Perceived Barriers in Cervical Cancer Screening Program among Thai Women Living in German

To Whom It May Concern,

Dr. Cindy Mendelson, RN, PhD, and Unchalee Vatanasook Ice, RN, MS, PhD candidate from the college of Nursing, University of New Mexico, Albuquerque, the State of New Mexico, the United States of America, are conducting a research study. The purpose of this study is to provide us with a greater understanding about Thai women's knowledge, health beliefs, and attitudes about cervical cancer and Pap smear screening.

The results of this study may be a great assistance for health care providers to understand the health beliefs and attitudes about cervical cancer and screening programs in Thai immigrant women living in Germany.

Thank you for your assistance in furthering nursing research in this area.

I, (we), understand the purpose of this study and the potential for helping health care providers better serve the health needs of Thai women living in Germany. I, (we), hereby give consent to allow the researcher to advertise to, contact or speak directly with Thai women who are attending the temple, in order to procure participants for this study.

Signature of Responsible Person for the Buddhist Temple

\_\_\_\_\_ Date \_\_\_\_\_

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## Appendix D Permission Cover Letter (Thai Version)

ศูนย์วิทยาศาสตร์สุขภาพมหาวิทยาลัยนิวเม็กซิโก  
จดหมายขออนุญาต  
ความรู้ ทัศนคติ และความเชื่อเกี่ยวกับมะเร็งปากมดลูก และการตรวจคัดกรอง  
และการรับรู้อุปสรรคเกี่ยวกับโปรแกรมการตรวจคัดกรองมะเร็งปากมดลูก  
ในสตรีไทยที่อพยพมาอยู่ในประเทศเยอรมัน

เรียนท่านผู้เกี่ยวข้อง

คอกเคอร์จินดี เมนเดลสัน พยาบาลวิชาชีพ และอัญชลี วัฒนสุข ใจซ์ พยาบาลวิชาชีพ  
วิทยาศาสตร์มหบัณฑิต นักศึกษาปริญญาเอกจากคณะพยาบาลศาสตร์ มหาวิทยาลัยนิวเม็กซิโก อัลเบอร์เคอร์ที่  
รัฐนิวเม็กซิโก สหรัฐอเมริกา กำลังทำวิจัย  
โดยมีวัตถุประสงค์เพื่อทำให้เราเข้าใจมากขึ้นเกี่ยวกับความรู้ของสตรีไทย ความเชื่อเกี่ยวกับสุขภาพ  
และทัศนคติเกี่ยวกับมะเร็งปากมดลูก และการตรวจคัดกรองมะเร็งปากมดลูก  
ผลของการวิจัยอาจเป็นสิ่งที่ช่วยให้ผู้ให้การดูแลสุขภาพเข้าใจความเชื่อเกี่ยวกับสุขภาพ  
และทัศนคติเกี่ยวกับมะเร็งปากมดลูก  
และการตรวจคัดกรองมะเร็งปากมดลูกในสตรีไทยที่อพยพมาอยู่ในประเทศเยอรมัน

ขอขอบคุณในความช่วยเหลือของท่านในการมีส่วนให้การวิจัยทางการแพทย์ด้านนี้มีการพัฒนาก้าวหน้า

ข้าพเจ้า (เรา) เข้าใจวัตถุประสงค์ของการศึกษา  
นี้ และศักยภาพในการช่วยผู้ให้การดูแลสุขภาพได้ให้บริการที่ดีขึ้นแก่สตรีไทยที่อาศัยอยู่ในเยอรมัน ข้าพเจ้า  
(เรา) จึงได้อินยอมที่จะให้ผู้วิจัยประชาสัมพันธ์ ติดต่อหรือพูดคุยกับสตรีไทยที่ไปวัดเพื่อให้เข้าร่วมงานวิจัยนี้

ลายมือชื่อบุคคลที่รับผิดชอบวัดชาวพุทธ

วันที่ \_\_\_\_\_

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## Appendix E Consent Form for Secondary Participants

**University of New Mexico Health Sciences Center  
Informed Consent Cover Letter (Secondary Participant)**

### STUDY TITLE

#### **Knowledge Attitudes and Beliefs Regarding Cervical Cancer and Screening and Perceived Barriers in Cervical Cancer Screening Program among Thai Women Living in Germany**

Dr. Cindy Mendelson and Unchalee Vatanasook Ice, from the college of Nursing, are conducting a research study. The purpose of this study is to provide us with a greater understanding about Thai women's knowledge, health beliefs, and attitudes about cervical cancer and Pap smear screening. You are being asked to participate in this study because as a health care provider, your perspectives and insights about the current German cervical cancer screening program may provide us useful information in understanding the current health care system in Germany in which Thai immigrant women utilize.

Your participation will involve answering questions and providing information during an interview session. The interview session should take about 60-90 minutes to complete. Your involvement in the study is voluntary, and you may choose not to participate at any time. Your name will not be used in on any reports as you will be asked to select a pseudonym for use during the interview. The interview may include questions, for example, "Please tell me about the current guidelines about cervical cancer screening in Germany?"

There are no known risks in this study, but some questions are very personal and some individuals may experience discomfort when answering questions. You may choose to not answer any of the questions at any time. As you are a volunteer for this study, you have the right to quit the interview at any time. All records are confidential and will be kept until the study is complete in a locked cabinet in Ms. Ice's office.

The results from this study will provide an understanding about the health beliefs and attitudes about cervical cancer in Thai women and the perceived barriers regarding current cervical cancer screening in Germany. If this study is published, the findings will be presented in a summary format only.

If you have any concerns or questions regarding this study, please feel free to call Ms. Ice at 0638-541-5820. If you have questions concerning your legal rights as a research participant, you may call the UNMHSC Office of Human Research Protections at 001-505-272-1129.

Thank you for your consideration.  
Sincerely,

Cindy Mendelson, Ph.D., RN  
Associate Professor

Unchalee Vatanasook Ice, MS, RN  
Doctoral Candidate

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I understand the purpose of this study and my rights as a volunteer. I consent to participate in this study. I have been able to ask questions about the study, and have been told that I can ask questions and receive answers at any time during and after the interview.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

I certify that I have explained to above individual the nature and purpose, potential benefits and possible risks associated with participation in this study. I have answered all questions asked and have witnessed the above signature.

Signature of Researcher \_\_\_\_\_ Date \_\_\_\_\_

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## Appendix F Consent Form for Secondary Participants (German Version)

Wissenschaftliches Gesundheitszentrum der Universität von New Mexico  
Begleitschreiben zur Aufklärungsbogen (Sekundärteilnehmer)

### TITEL DER STUDIE

**Kenntnisse, Einstellungen und Überzeugungen zum Gebärmutterhalskrebs sowie Vorsorgeuntersuchungen und beobachtete Hemmnisse bei thailändischen, in Deutschland ansässigen Frauen im Rahmen des Programms zur Vorsorge gegen Gebärmutterhalskrebs**

Dr. Cindy Mendelson und Unchalee Vatanasook Ice vom College of Nursing führen eine wissenschaftliche Studie durch. Zweck dieser Studie ist es, zu einem besseren Verständnis der Kenntnisse, Gesundheitsüberzeugungen und -Einstellungen thailändischer Frauen zum Gebärmutterhalskrebs und den entsprechenden Vorsorgeuntersuchungen mittels Pap-Abstrichen zu gelangen. Sie sind dazu eingeladen worden, an dieser Studie teilzunehmen, weil Ihre Perspektiven und Erkenntnisse, als Leistungserbringer im Gesundheitswesen, zum derzeit in Deutschland laufenden Programm zur Vorsorge gegen Gebärmutterhalskrebs uns hilfreiche Informationen liefern können, die unser Verständnis des derzeitigen, auch von thailändischen Immigrantinnen in Anspruch genommenen, Gesundheitsversorgungssystems in Deutschland weiterbringen können.

Ihre Teilnahme wird u.a. darin bestehen, bei einer Befragungssitzung Fragen zu beantworten und Auskünfte zu erteilen. Die Befragungssitzung wird voraussichtlich zwischen 60-90 Minuten dauern. Ihre Beteiligung an der Studie ist freiwillig, und Sie können sich frei dazu entscheiden, zu keiner Zeit daran teilzunehmen. Ihr Name wird in bzw. auf keinem der Berichte erscheinen, denn Sie werden dazu aufgefordert, ein Pseudonym zur Verwendung bei der Befragungssitzung zu wählen. Die Befragung kann z.B. Fragen der folgenden Art enthalten: „Was bedeutet das Wort „Gebärmutterhalskrebs“ für Sie?“ Es sind keine mit dieser Studie verbundenen Risiken bekannt; jedoch können einige der Fragen sehr persönlicher Natur sein, sodass manche Personen sich beim Beantworten der Fragen unwohl fühlen können. Sie können sich frei dazu entscheiden, jegliche Fragen zu keinem Zeitpunkt zu beantworten. Da Sie ein(e) freiwillige(r) Teilnehmer(in) an dieser Studie sind, können Sie die Befragung jederzeit abbrechen. Sämtliche Unterlagen sind vertraulich und werden bis zur Beendigung der Studie in einem verschlossenen Schrank in Frau Ices Büro aufbewahrt.

Die Ergebnisse dieser Studie können sehr dabei behilflich sein, Leistungserbringern im Gesundheitswesen zu einem besseren Verständnis der Überzeugungen und Einstellungen zu verhelfen, die bei thailändischen Frauen im Hinblick auf den Gebärmutterhalskrebs vorherrschen. Bei der Veröffentlichung der Studie werden die Ergebnisse lediglich in Form einer Zusammenfassung vorgestellt werden.

Falls Sie noch Bedenken oder weitere Fragen zu dieser Studie haben, wenden Sie sich bitte telefonisch an Frau Ice unter der Rufnummer 0638-541-5820. Falls Sie Fragen bezüglich Ihrer Rechte als Teilnehmer(in) an einer wissenschaftlichen Studie haben, wenden Sie sich bitte an das Büro für Schutzbestimmungen für die Forschung am Menschen am Wissenschaftlichen Gesundheitszentrum der Universität von New Mexico unter der Rufnummer 001-505-272-1129.

Vielen Dank für Ihre Aufmerksamkeit.  
Hochachtungsvoll,

Cindy Mendelson, Ph.D., RN  
Associate Professor

Unchalee Vatanasook Ice, MS, RN  
Doktorandin

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Ich habe den Zweck dieser Studie sowie meine Rechte als freiwillige Teilnehmer(in) verstanden. Ich gebe mein Einverständnis, an dieser Studie teilzunehmen. Es wurde mir ermöglicht, Fragen zu dieser Studie zu stellen, und mir wurde mitgeteilt, dass ich jederzeit während und nach dem Interview weitere Fragen stellen kann und Antworten erhalten werde.

Unterschrift des Teilnehmers/  
der Teilnehmerin \_\_\_\_\_ Datum \_\_\_\_\_

Ich bestätige hiermit, dass ich der vorstehend genannten Person die Natur und den Zweck dieser Studie, ihren potentiellen Gewinn sowie die möglichen Risiken der Teilnahme an dieser Studie erklärt habe. Ich habe sämtliche Fragen beantwortet, die mir gestellt wurden, und war persönlich anwesend, als die vorstehende Unterschrift geleistet wurde.

Investigator Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **Appendix G Advertisement Flyer**

Knowledge, Attitudes, and Beliefs Regarding Cervical Cancer and Screening and Perceived Barriers of Cervical Cancer Screening Programs among Thai Immigrant Women Living in Germany

### **Volunteer Wanted for a Research Study**

If you are a Thai woman between the ages of 20 and 64 years old, and live in the State of Rheinland-Pfalz and the surrounding communities, you are invited to voluntarily participate in this study. Your involvement in this study will include participation in a single audio taped interview with Ms. Unchalee Ice. The interview will be conducted in Thai. You will receive €15 for participating in the audio taped interview which is the first part of the study. At the end of the first interview Ms. Ice will ask if you are willing to meet again to validate your interview a response with the written transcript as which is the second part of the study. If you agree and are selected for the second part of the study you will receive an additional €5. The interview will last approximately 60 minutes. The second part of the study in which the investigator will validate your interview responses with written transcripts will take approximately 20-30 minutes. The interview will take place at your preference. The purpose of the study is to learn about the knowledge, attitudes, and beliefs of Thai immigrant women living in Germany, regarding cervical cancer and screening and the barriers to participation in cervical cancer screening that they encounter. This study is being conducted under the guidance of Dr. Cindy Mendelson, RN, PhD, the PhD committee advisor of Ms. Unchalee Ice.

If interested please contact Unchalee Ice at 06385415820 for more information.



## Appendix H Advertisement Flyer (Thai Version)

มหาวิทยาลัยนิวยอร์ก คณะพยาบาลศาสตร์  
ความรู้ ทักษะ และความเชื่อเกี่ยวกับมะเร็งปากมดลูก และการตรวจคัดกรอง  
และการรับรู้อุปสรรคเกี่ยวกับโปรแกรมการตรวจคัดกรองมะเร็งปากมดลูก  
ในสตรีไทยที่อพยพมาอยู่ในประเทศเยอรมัน

### ต้องการอาสาสมัครสำหรับงานวิจัย

ถ้าท่านเป็นสตรีไทยอายุระหว่าง 20 ถึง 64 ปี และอาศัยอยู่ในรัฐโรนัลด์-ฟิลซ์ และชุมชนรอบๆรัฐนี้ ท่านได้รับเชิญให้เข้าร่วมงานวิจัยนี้ด้วยความสมัครใจ

เมื่อท่านเข้าร่วมงานวิจัยนี้ท่านจะได้รับการสัมภาษณ์ครั้งเดียวซึ่งมีการบันทึกเสียงสนทนากับคุณอัญชลี ไช้ การสัมภาษณ์จะใช้ภาษาไทย เมื่อท่านได้รับการสัมภาษณ์ซึ่งเป็นส่วนแรกของงานวิจัยนี้ ท่านจะได้รับค่าตอบแทนเป็นเงินยูโรจำนวน 15 ยูโร เมื่อการสัมภาษณ์เสร็จสิ้นลง

คุณอัญชลีจะถามความสมัครใจของท่านว่าท่านยินดีที่จะพบเธอ ในครั้งต่อไปหรือไม่ ทั้งนี้การพบครั้งที่สองนี้เพื่อตรวจสอบความถูกต้องของคำตอบที่ท่านตอบตอนสัมภาษณ์ ซึ่งคำตอบของท่านจะมีการถอดความตามคำสัมภาษณ์ของท่าน และส่วนนี้จัดเป็นส่วนที่สองของงานวิจัย

ถ้าท่านยินยอมและได้รับการคัดเลือกให้เข้าร่วมในส่วนที่สองนี้ ท่านจะได้รับเงินเพิ่มอีก 5 ยูโร การสัมภาษณ์จะใช้เวลาประมาณ 60 นาที

สำหรับส่วนที่สองของงานวิจัยนี้ผู้วิจัยจะตรวจสอบความถูกต้องของคำตอบของท่านโดยตรวจกับการถอดความจากการอัดเสียงท่านในตอนสัมภาษณ์ ซึ่งในส่วนที่สองนี้จะใช้เวลาประมาณ 20-30 นาที

ท่านสามารถเลือกสถานที่สัมภาษณ์ที่ท่านพอใจได้ จุดประสงค์ของการทำวิจัยนี้คือการศึกษาความรู้ ทักษะ และความเชื่อของสตรีไทยที่อพยพมาอยู่เยอรมันเกี่ยวกับมะเร็งปากมดลูกและการตรวจคัดกรองมะเร็งปากมดลูกที่พวกเขาเผชิญอยู่ การวิจัยนี้อยู่ภายใต้การดูแลของดอกเตอร์ซินดี้ เมนเดลสัน พยาบาลวิชาชีพ และเป็นคณะกรรมการที่ปรึกษาการศึกษาปริญญาเอกของคุณอัญชลี ไช้

ถ้าท่านสนใจ กรุณาติดต่อ อัญชลี ไช้ ที่หมายเลข 06385415820 เพื่อสอบถามรายละเอียดอื่นๆ

## Appendix I

### Semistructured Interview Guide for Primary Participants

#### *Demographic questions:*

- A. Please tell me your age.
- B. What is your marital status?
- C. Please tell me how many children you have.
- D. Are there other females in your household besides you? If so, what are their ages?
- E. How many years of formal education have you had?
- F. Are you presently employed? If so, what is your current occupation?
- G. How long have you been living in Germany?
- H. Do you have health insurance?
- I. Please select your economic status from the following:  
€ 0-24,999; €25,000-49,999; €50,000-74,999; €75,000 and above

#### *Cervical cancer screening practice interview guide:*

1. Has anyone in your family ever had cervical cancer? If so, please explain who they are and what was the outcome?
2. Do any of the other females in your household have annual Pap smears?
3. Have you ever had a Pap smear? If so, what was the reason for your most recent Pap smear? How old were you when you had your first Pap smear? Why did you have a Pap smear the first time? How often do you have a Pap smear? Have you ever had an abnormal Pap smear? If so, what was the outcome?
4. Where do you go for your Pap smear?
5. Do any of the other females in your household have annual Pap smears?
6. Do you intend to have the Pap smear in the future?
7. Is your current physician a male or a female?
8. What is your preference in terms of the gender of your physicians? Please explain why.

#### *Interview questions:*

1. I am interested in learning about your thoughts and ideas about the Pap smear; what are your thoughts about what a Pap smear is and why a woman would get one?
2. How did you learn about Pap smears?
3. What are your thoughts about an abnormal Pap smear? What do you think it means?
4. Please tell me in your own words, what does the word “cervical cancer” mean to you?
5. Please explain what you believe to be some of the plausible causes of cervical cancer?
6. What do you believe your chances of getting cervical cancer are? Please explain.
7. Can you share with me your experience during a pelvic examination for a Pap smear?
8. If you were told that you had cervical cancer, what would you do?

9. Please explain what you believe to be health practices that prevent cervical cancer.
10. Please tell me what you have heard or been told by other people concerning health practices that prevent cervical cancer.
11. Can you share with me your experience or impression regarding the health care services in Germany?
12. When you need to see a doctor, who makes an appointment for you? How do you go to an office visit: by yourself or with your spouse?
13. Do you believe that your doctor communicates with you adequately during the office visit? If not, please give specific examples (Probe...if the doctor explained procedures and treatment thoroughly, quality time spent with patient, health education, health prevention, appointment for next annual Pap smear, etc.).
14. Do you believe there are any barriers to utilizing the German health care system? If so what are the types of barriers? Please give specific examples.
15. Please allow me to summarize our conversation so far, so that I have understood everything correctly. If not, please explain. Is there anything that I have left out or anything that you would like to add? (Clarification and member checking).

## **Appendix J**

### **Interview Guide for Secondary Participants**

#### *Demographic questions:*

1. Please tell me your age.
2. What is your specialty area of practice?
3. How many years have you been practicing?
4. Number of practice hours per week.
5. Number of patients per day
6. Type of practice: single practice or a group practice.
7. Any experience providing care to Thai immigrant women?

#### *Interview questions:*

- A. Could you start by telling me about the overall health care system in Germany?
- B. What are your general feelings (your own perspectives) about the current health care system in Germany?
- C. Please tell me, about your regular day at the office. How many patients do you see each day?
- D. In regard to your patient load, how much time do you spend on communication and patient education? Do you believe it is adequate time for each patient? Why or why not?
- E. Can you tell me about the current guidelines for cervical cancer screening in Germany?
- F. Please share with me the methods you use to remind your patients about their annual Pap smears? Are they effective?
- G. Germany is a multiracial society; do you believe there are barriers to providing care to minority populations? If so, what are the barriers?
- H. Do you believe that current cervical cancer screening is effective in reducing cervical cancer mortality? Why or why not? Please give examples. Does it differ for minority women?
- I. In your opinion, as a health care provider, how can you bridge the gap of health disparity among minority groups, especially in the uptake of cervical cancer screening, as research showed that minority women received low uptake of Pap smear screening?
- J. Please explain what methods of communication you use when dealing with patients who have language barriers?
- K. Please allow me to summarize our conversation so far, so that I have understood everything correctly. If not, please explain. Is there anything that I have left out, or anything that you would like to add? (Clarification and member checking).

## **Appendix K**

### **Thai Women's Stories**

#### **Toy-ting's Story**

Toy-ting, a 49-year-old married woman with two children, had lived in Germany for 12 years. She had a bachelor's degree in Accounting from Thailand, was unemployed, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Toy-ting was a small, well-groomed woman, with extremely long salt-and-pepper hair and a very friendly nature. She was born and raised in the central part of Thailand. The interview took place in a private office at a local grocery store.

There was no family history of cervical cancer, and Toy-ting received her first Pap test at the age of 27 because of a pregnancy. She stated that she did not think about having the exam when she was unmarried. She had never had an abnormal Pap test. Although she preferred a female care provider, her current provider is male. Toy-ting experienced embarrassment, pain, and anxiety during her Pap tests. However, after having the exam, she felt reassured that she did not have cervical cancer. She had a Pap test every 6 months because of her gynecologist's recommendation.

Toy-ting had gained her knowledge of cervical cancer from reading; however, no one ever discussed cervical cancer with her but she had overheard people talking about abdominal and colon cancer. She stated that Pap smear screening was to check the vagina for sores and that one should have a Pap test after having sexual relations. An abnormal Pap test may mean you have "tissue inflammation or sores, not necessarily cancer cells."

Furthermore, she stated, “as women, we need to have the exam because it is inside our body and we need to know, it is prevention.” Other preventative health practices were having a yearly physical exam and good personal hygiene.

Even though she had never asked the doctor where the cervix was located and the doctor never explained, she guessed that cervical cancer was “cancer of the cervix.” Toy-ting did not believe that she had any chances of getting the disease because she had a yearly checkup. She stated that some causes of cervical cancer may include HIV and contracted diseases from sexual partners.

Although Toy-ting felt that the health care services in Germany were good, there were some barriers, including waiting too long to be seen, too little time spent with the patients, and the long waiting period to obtain an appointment. Additionally, she stated that the long wait was not unusual in the German health care system. Her husband made the doctor appointments and accompanied her to interpret and to clarify if she did not understand. She often did not know what to ask or discuss with the doctor, and without being able to ask questions, there was no discussion with the doctor after the exam. There were no postcards or reminders sent from the health care provider for the next appointment.

### **Noot’s Story**

Noot, a 41-year-old married woman with two children (ages 18 and 20) had lived in Germany for 18 years. She completed the sixth grade in Thailand, was unemployed, and had health insurance. Noot stated that her household annual income was 49,999 Euros or less. Noot was a small-framed woman with a pleasant talkative nature. She was born and raised in the central part of Thailand. Noot walked with a limp and had a history

of rheumatoid arthritis. The interview took place in a private office in a local grocery store.

Although Noot had no family history of cervical cancer, she did have a history of uterine cysts, which caused an abnormal Pap test and subsequent cyst removal. Her first Pap test was performed when she was 35 years old because she needed to be on birth control pills for her acne. No one explained or gave her advice regarding the reason for Pap testing other than it was performed prior to being given birth control pills and her physician stated that it was time to have it checked. Her gynecologist was male, although she preferred a female due to embarrassment and cultural barriers.

Noot had heard from the news and read about the high prevalence of cervical cancer among Thai women and felt that women need to have cervical cancer screening done “because the uterus is inside and there may be germs that can get inside or it gets infected.” Although Noot was afraid of this disease she felt that cancer screening was a “prevention, because if you have a checkup every year to make sure that everything is okay, and if you have the disease you can get help before it is too late.”

If told that she had an abnormal Pap test, Noot stated that it could mean many things. It could be a cyst or anything else, not necessarily cervical cancer. She further stated that some possible cause of cervical cancer may include lack of genital hygiene after sexual intercourse, promiscuity with multiple sexual partners, and lack of screening for cervical cancer. In addition, Noot felt that she had a chance of getting cervical cancer “because you don’t know when you will get it, it is just like colon cancer and nonsmokers having lung cancer, so we all have a chance of getting cervical cancer.” To prevent cervical cancer, Noot stated that there should be no promiscuity and a yearly Pap test.

Noot suffered from chronic rheumatoid arthritis and had been on Remicade, which is very expensive, for the last 10 years; she felt that the German health care system had excellent services, and the doctors were very attentive and caring and understood her disease problems.

The long waiting periods for appointments, sometimes as long as 6-8 weeks, was one of the barriers she experienced. Although her doctor was very thorough in his examination, she felt he was too busy and had too many patients. Because of the lengthy wait time, she was contemplating changing gynecologists. In addition, there were no reminders sent from the provider's office for the next Pap test appointment.

### **Lee's Story**

Lee, a 33-year-old married woman with two children, had lived in Germany for 13 years. She completed the ninth grade in Thailand. She was employed as a cashier at the local bakery shop and had health insurance. She stated that her household annual income was 24,999 Euros or less. Lee was a petite woman with shoulder-length hair, well groomed, reserved in her manner, and succinct in her speech. Lee was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Lee had no family history of cervical cancer and had her last Pap screening 1 year earlier, which followed her current practice of yearly screening. She stated that she had never had an abnormal Pap exam. Her initial screening was at the age of 20 in Germany, in response to being advised by someone to have yearly screenings. Although she stated that she was afraid of having a disease, she wanted to have a checkup. Although her first Pap exam was painful, she was relieved to know that she did not have cervical cancer.



Lee's gynecologist was female, which she preferred and had confidence in because "I feel better, I am not so afraid or embarrassed." Although Lee was not sure what Pap smear meant or why women had to have the screening, she was very interested in taking care of her own health and believed that women should have the yearly screening "because it could mean life and death if you get the disease."

Lee stated that the term cervical cancer meant something related to internal organs, and some possible causes included not cleaning the genital area very well and sexual intercourse. Although Lee believed her chances of getting cervical cancer were zero, if she were told that she did have the disease, she would try to find the best treatment options.

Lee believed that cleaning of the genital area was essential, especially during menstrual periods. She had not heard anyone discussing health practices to prevent cervical cancer, "perhaps it is a very personal and embarrassing subject to discuss among friends."

Lee felt that the health care services in Germany were of high quality, and she did not feel that she had any barriers to accessing health care services; however, the long wait to see the doctor was one drawback. Her husband usually made the appointment for her, but she went to the doctor alone, stating that she had "no problems communicating with her doctor," and felt that adequate time was spent with each patient. There were no postcards, telephone calls, or any reminders for the next exam.

### **Nut's Story**

Nut, a 40-year-old Thai woman, married with one child, had lived in Germany for 12 years. She completed the ninth grade, was employed in housekeeping, and had health

insurance. She stated that her household annual income was 49,999 Euros or less. Nut was a vibrant woman with long brown hair, of medium build, well groomed, and pleasant. She was born and raised in the northeastern part of Thailand. The interview took place in a private office of my home.

Nut had no family history of cervical cancer and had her initial Pap exam performed in Thailand at the age of 20. The reason for the first exam was related to fertility issues; she wanted to get pregnant and wanted to make sure everything was okay. However, the doctor did not explain the test or that the reason for the exam was to screen for cervical cancer.

Nut's most recent Pap test was 2 years earlier and was related to abdominal pain, although the results were normal. Nut had never had an abnormal Pap test and planned to have one within the year. Having a male gynecologist was embarrassing for Nut, who switched to a female doctor, which she preferred.

She learned about cervical cancer from her physician and was also taught to do breast self-exams and how to examine her whole body. She believed that cervical cancer screening referred to the method of finding the causes of cervical cancer and further believed that the screening was good for women, as it is a very dangerous disease. "The screening helps detect any abnormality of your body in advance, so that you get appropriate treatment if cancer occurs."

Nut felt that she had learned a lot about cervical cancer since her first screening and believed that every woman has a chance of getting the disease. She stated that some possible causes of cervical cancer were that "something is wrong with your body, menstruation, and sexual intercourse."

Although Nut did not have any specific health care practices to prevent cervical cancer, if she noticed something was not right with her body or was experiencing a lot of abdominal pain from her menstrual periods, she would go to see her doctor. If she was told that she had cervical cancer, Nut said that she would follow the doctor's advice and keep all the appointments.

Nut felt that the German health care system provided excellent service. Although she felt that she was being well cared for, the long waiting period for an appointment (about 1 month), the long wait to see the doctor, and the difficulty of finding a female gynecologist were all difficulties that she experienced.

Nut made her own appointments and attended her appointments alone. Although she felt the doctor spent quality time with her and attempted to communicate treatment plans and findings with her adequately during the office visit, the language barrier presented difficulties for her. Her doctor used to write his findings on paper and send them home with her to have her husband explain the results to her in ways that she would understand. There were no postcards or reminders sent from the doctor regarding the next exam.

Nut believed that other Thai women in Germany face difficulties or barriers with the language, transportation, lack of knowledge of health prevention, and no health insurance. She stated that "some women, if they have no insurance, they usually do not go for checkups."

### **Tien-yot's Story**

Tien-yot, a 39-year-old Thai woman, married with no children, had lived in Germany for 9 years. She completed the 10<sup>th</sup> grade, was employed, and had health

insurance. She stated that her household annual income was 24,999 Euros or less. Tien-yot was a tall woman with robust features; she appeared younger than her stated age. She was born and raised in the northeastern part of Thailand. The interview took place in a private office of my home.

Tien-yot's first Pap test was done in Thailand due to abdominal pain and menstrual irregularities when she was 29 years old. She experienced anxiety and fear, and was very happy to know that her results were normal. Her gynecologist was female, which she preferred, because she felt that a woman understands a woman's problems and because she felt more comfortable without the embarrassment and cultural barriers that were present with a male doctor.

Since living in Germany and learning about cervical cancer from reading Thai health magazines, Tien-yot had yearly Pap tests and believed that yearly screening was important for cancer detection and to make sure everything was normal. She further stated that if screening was delayed and the disease was discovered in the advanced stages, it could be too late to treat.

If told that she had an abnormal Pap test, Tien-yot would seek her doctor's advice and clarify treatment options. She stated that "the word cancer, no matter where it happens, at the cervix or anywhere in our body, is very scary. We know that there is no treatment to completely eradicate the disease. However, if it is detected at an early stage and with the doctor's advice we can get appropriate treatment right away."

Tien-yot felt that we all have a chance of getting cervical cancer, and some of the possible causes include one's current health status, food, especially burnt food that could be carcinogenic, or a genetic predisposition. Although Tien-yot did not have any specific

health care practices to prevent cervical cancer, she felt that people “probably do their best to prevent from some forms of cancer; however, if it is going to happen, it will happen.”

If told that she had cervical cancer, she would be very scared and afraid of dying from the disease. She would seek treatment from her doctor, as she would not have to worry about the cost of treatment in Germany as opposed to the same scenario in Thailand, which would be costly and, for her, especially without health insurance.

Tien-yot felt that Germany had excellent health care services and that the health care providers were culturally sensitive and tried to bridge the language and cultural barriers in order to provide culturally sensitive care to immigrant Thai women. Additionally, she felt that during a hospital stay for removal of benign uterine tumors, she received excellent care.

Tien-yot made her own appointments and went to see the doctor by herself. Even though she was pleased with the care she received, the long waiting period for an available appointment and the long hours waiting to be seen at the clinic were indeed barriers to accessing health care. In addition, transportation may also be a problem because of the health of the patient or the patient’s husband, as was the case in her situation (i.e., she had recently had surgery and her husband was ill), making it difficult to find transportation to the clinic.

Although Tien-yot felt that language and cultural barriers were a major issue for her and many of her Thai friends, she stated that the German doctors clearly explained and discussed treatments plans with patients and did not try to hide the facts from them,

as is often done in Thailand. Follow-up appointments were her responsibility, and no postcards or reminders were sent from the doctors' office.

### **Sorn's Story**

Sorn, a 40-year-old Thai woman, married with no children, had lived in Germany for 3 years. She completed the sixth grade, was unemployed, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Sorn was a tall woman of medium build, was friendly, and dressed warmly due to the inclement weather. She was born and raised in the northeastern part of Thailand. The interview took place in a private office in a local grocery store.

Sorn was living in Thailand when she had her first Pap exam at the age of 28. She felt that she had neglected her health in Thailand; even though she was employed full time and had health insurance, she did not go for screening due to embarrassment. She had no family history of cervical cancer and stated that her mother had never had a Pap exam because of embarrassment.

Since living in Germany, Sorn had yearly Pap screening done during her yearly checkup. All her Pap results were normal. Her gynecologist was female, which she preferred due to embarrassment; yet, she still felt quite anxious and fearful when undergoing her first cervical cancer screening in Germany. However, she stated that her German gynecologist did explain it to her and walked her through the procedure.

Sorn learned about cervical cancer from her own doctor and stated that cervical cancer screening was a good thing especially for older women, because "if a woman gets the disease, she could die." Sorn was aware of the high prevalence of cervical cancer among Thai women and felt some causes may be an individual's hormones, bad

contaminants accumulated from sexual intercourse, and from infection. Sorn stated that among her close friends, she had never heard anyone discussing cervical cancer. She stated that most of her friends had little knowledge regarding the disease.

Sorn stated that an abnormal Pap exam did not necessarily mean cervical cancer or it could mean the early stages of cervical cancer. She would try not to be alarmed and would need to discuss prevention and treatment in further detail with her doctor. Sorn believed that every woman, including herself, had a chance of developing cervical cancer because of the environment and stress, and that cervical cancer was deadly. “Stress can affect one’s health and can probably cause cervical cancer.” In terms of health care beliefs to prevent cervical cancer, Sorn believed in good nutrition, taking good care of your health, controlling the environment such as pollution, and stress reduction.

Sorn believed that cervical cancer was related to the vagina or tumors in the vagina. If informed that she had cervical cancer, she would try to focus and try not to be anxious with the diagnosis. She further stated that if she were more relaxed mentally, the disease might not spread and therefore, she might be able to find solutions to battle the disease. “Being strong mentally is important.”

Sorn felt that the German health care system was caring, provided good services, and was more efficient and less complicated than the health care system in Thailand; however, she felt that not enough time was spent during the visit. She felt that she was treated the same as German nationals. Sorn made her own appointments and went to her appointments alone.

The lengthy waits for appointments and the long waits to be seen at the clinic were a definite drawback for Sorn. She believed that if the doctor found something

abnormal, from an ethical standpoint, he would try to communicate the results to her, and she did not worry that he would withhold information from her. No reminders were sent from the doctor's office for the next cervical cancer screening appointment.

Although Sorn did not feel that the language was a major barrier for her in terms of communicating with her physician, she believed that it was for many Thai women, in spite of long residency. Sorn also cited other barriers for Thai women, including a lack of confidence, a feeling of intimidation, and difficulties in accessing health care services because of a lack of transportation.

### **Aar's Story**

Aar, a 22-year-old Thai woman, single with no children, had lived in Germany for 11 years. She completed the ninth grade at Huaptchule in Germany, was employed as a cashier, and had health insurance. Aar stated that her household annual income was 24,999 Euros or less. Aar was a young, shy, pregnant woman, who laughed a lot during the interview. She was born in the northeastern part of Thailand and lived there until the age of 11, when she immigrated to Germany with her mother and her older sister. The interview took place in a private office at a local grocery store.

Aar's sister took her to receive the HPV vaccine, and Aar had her first Pap exam at this time. Embarrassed to go to a German gynecologist for a prescription of birth control pills and the necessary Pap exam, Aar asked family members going to Thailand to purchase birth control pills over the counter for her. She underwent a second exam because she was suspicious of being pregnant (she had a boyfriend), and because she was afraid to go by herself, she had her older sister accompany her.



Aar stated that unless she was pregnant, she would never intentionally have the screening done, although she felt it was important to go to follow the doctor's advice. Aar's gynecologist was female, which she preferred. Even though she had basically grown up in Germany and was used to Western customs, she still felt embarrassed during the exam. She had no family history of cervical cancer, and her results were normal.

Although Aar stated that she had not received information regarding cervical cancer from any household member, she heard on the news that beginning at the age of 20, women should have yearly cervical cancer screening: "I thought to myself that is not important, even though all my German friends went and had the screening done." Additionally, she had seen television advertisements on the subject and had seen articles in women's magazines, but "I would just skim the subject heading and didn't read all the small prints, but the subject did not really stick in my mind." Aar stated that she had not asked anyone for information on cervical cancer.

Aar did not have any idea what the term cervical cancer meant and why women have to have the screening done. She stated that perhaps she had a chance of getting cervical cancer, but did not know when she would get the disease. If told that she had cervical cancer, Aar would be very frightened and understood that it would be serious. She did not know whether it would be a life-and-death situation or whether the disease was treatable. Aar believed that using a condom was a safe method of preventing cervical cancer and birth control pills were not a safe method to prevent the disease.

Aar stated that she had received great services and caring attitudes from the German health care providers. She also felt that she had received quality prenatal care and adequate time during the office visit. She made her own appointments, which usually

took only 1 week, and went by herself, although her boyfriend accompanied her to view ultrasounds. Aar did not perceive any barriers to accessing health care services in Germany, other than the long wait to be seen at the clinic (1-2 hours).

### **Sand's Story**

Sand, a 55-year-old Thai woman, married with three children, had lived in Germany for 7 years. She completed the fourth grade, was employed part time, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Sand was a tall woman with short curly hair, was matronly, and was heavily dressed due to the inclement weather. She was born and raised in the northeastern part of Thailand. The interview took place in a private room at her workplace, where she was employed as a masseuse.

Sand had her first Pap screening at the age of 40 and her second one at the age of 49, when she married her German husband. She stated that her first exam was painful, and she was relieved when it was over and everything was normal. She had no family history of cervical cancer and had yearly physical checkups, including Pap screening and mammograms. Although she was current with her Pap exam, she planned to have her next Pap in Thailand due to having problems with the language barrier. Her gynecologist was female, which Sand preferred due to embarrassment. Sand had gained knowledge about cervical cancer from her friends and watching television, although she had not had discussions or been informed regarding health practices to prevent cervical cancer. She said, "It is a very personal subject."

Sand stated that the reason for a Pap exam was "for your own health and to...detect cancer for an early treatment." She believed that cervical cancer is "dirty

bacteria” and that it can possibly be caused from sexual intercourse and prevented by keeping the genital area cleaned after intercourse. Sand did not believe that she had a chance of getting cervical cancer. If she were informed she had cervical cancer, she would seek medical advice and treatment.

Sand felt that the German health care system was one of the best and that she had received the best care when she was hospitalized for food poisoning. Her husband made all her appointments and took off from work to accompany her unless her daughter was able to do so. Her husband interpreted for her, using “husband and wife talk” to assist her in communicating, especially because her gynecologist was not a German national. Sand had not told her gynecologist that she was taking hormones from Thailand for her menopausal hot flashes.

Sand stated that getting an appointment usually took only 1 to 2 days, but waiting to be seen at the office could take up to 3 to 4 hours. She did not feel that the doctor spent quality time with her during her visit. She did, however, receive reminders from her doctor for her next appointment.

### **Koop’s Story**

Koop, a 29-year-old Thai woman, married with no children, had lived in Germany for 6 years. She completed high school in Thailand, was unemployed and had health insurance. She stated that her household annual income was 49,999 Euros or less. Koop was a slender woman with long dark hair and was casually dressed. The interview took place at her home. She was born and raised in the eastern part of Thailand.

Koop’s husband took her to see a gynecologist for her first Pap screening. Her husband’s sister had a history of cervical cancer, resulting in a hysterectomy, and Koop

was told by her husband's family and close friends that there was a high prevalence of cervical cancer among Thai women and that it was deadly. She had Pap screening yearly since living in Germany and planned to continue having yearly exams. All Pap test results were normal.

Koop stated that because she knew the health care provider in her Thai village, she did not have the screening done due to embarrassment. Her gynecologist in Germany was female, and she had no preference for male or female, except that "they have to be complete strangers." She stated that she felt less embarrassment with the German doctor because she did not know her personally. Her doctor was caring and sensitive, was aware of her anxiety, and coached her through the procedure.

Koop believed that women should go for cervical cancer screening because it helps to "detect something abnormal in our body and it is good for your health." She believed that cervical cancer is something in our bodies that we must get rid of because it can cause pain, suffering, and death if left untreated. She had learned about cervical cancer mostly from hearing people talk about it and having a friend with the disease who talked about the pain and suffering from the disease. Koop stated that possible causes of cervical cancer are health problems or something wrong with the ovaries and uterus.

If told that she had an abnormal Pap test, Koop stated that she would be afraid that she already had cervical cancer; if not cancer, perhaps something else could be wrong, and she would have to consult with the doctor on how to care for the problem. Koop believed that she had a chance of getting cervical cancer and chose yearly exams to help prevent getting the disease. If told that she did have cervical cancer she would be very

frightened and would get more information regarding its severity and what treatment options were available.

Aside from taking good care of one's body and good nutrition, Koop was not aware of any health care practices that help to prevent cervical cancer because she did not know what caused the disease. In addition, she stated that she had never been told or heard of any practices to prevent cervical cancer. She felt that the subject was very personal, and it would be intrusive to ask questions of someone who had the disease.

Koop's only experience accessing health care services in Germany were the two Pap smear screenings she had since moving to Germany. She felt that the doctor spent adequate time with her during her office visits but the language and the technical jargon were difficult for her to understand. She had a German friend accompany her on both of her appointments and requested a written note of the findings so that she might give it to her husband on returning home. Koop did not see transportation or waiting for an appointment as a problem. There were no reminders for the next Pap exam; however, the doctor did remind her verbally to continue with yearly checkups.

### **Plaa's Story**

Plaa, a 43-year-old Thai woman, married with one child, had lived in Germany for 4 years. She completed high school in Thailand, was employed as a housekeeper, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Plaa was of medium build, with long dark hair and a friendly nature. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Plaa's first Pap exam was at the age of 27, after her child was born. Desiring a method of family planning, she decided to have a hormone injection. Before the doctor could prescribe the hormone injection, the Pap exam was required. Additionally, there was a policy in Thailand at the time to encourage women to have cervical cancer screening, although her doctor did not fully explain cervical cancer and the screening to her. Plaa was anxious, tense, embarrassed, and scared during her first exam, especially when she was told that the doctor took a tissue sample. At that time, she was worried and thought something bad had happened, as she did not understand why the tissue sample was taken.

She had no family history of cervical cancer, and her last exam was 2 years earlier, with normal results. Plaa had never had abnormal results from her screenings and planned to make an appointment for a Pap screening as soon as she was allowed vacation time. Plaa stated that an abnormal Pap test could mean an "abnormal growth of tissues, a complication or abnormal cells, a cyst, or tumor in the uterus [her cousin had benign tumors in the uterus]."

Plaa's gynecologist was female, although Plaa did not have a preference in terms of gender; she believed that all doctors should adhere to their code of ethics and, thus, she was confident in their care. Plaa stated that she learned about cervical cancer and prevention from reading. With regard to cervical cancer screening, Plaa stated that it was "the examination of the vagina and taking tissue samples to see if there are any dangerous cells." She believed that a plausible cause of cervical cancer was hormones, which were related to the menstrual cycle and infection of the cervix.

She explained that the meaning of the term cervical cancer was related to the way that the reproductive organs function, but she did not know how to explain the exact meaning. She further stated that perhaps cervical cancer “is the process of excreting waste product from the uterus, which can become toxic if your body cannot get rid of it.”

Plaa believed that she had a chance of getting cervical cancer because she felt that when if a woman is menopausal, happens to have a vaginal discharge, and has infection without having a checkup, it may later turn into cervical cancer. If told that she had cervical cancer, she would be “astounded and ask ‘why me?’ I take good care of my health.” Furthermore, she would ask the doctor what caused the disease and focus on finding treatment.

Plaa believed that one should avoid seafood and fermented food, like pickles, because “eating lots of fermented food could result in deposits in the uterus.” Plaa also stated that one should avoid eating sunflower seeds. She explained that for about a week after eating sunflower seeds, she experienced heavy vaginal discharge. In her opinion, having a heavy vaginal discharge means the uterus is “not good, it is impure.” Lastly, she believed that one must take care of genital hygiene. “You have to wash your vagina every day, especially during menstrual periods, and change sanitary pads every two hours as the moisture and wetness may cause a yeast infection.”

With regard to the German health care system, Plaa stated, “It is okay.” She felt that the services provided were good and very thorough, with a lot of follow-up for different tests, for example, having cervical cancer screening and then a mammogram for breast cancer screening, although she may have to pay extra above what her insurance covered.

Plaa's husband made her medical appointments and accompanied her as her interpreter, as she had difficulty understanding the doctor completely. Plaa felt very impatient and was tired of the long waits to get an appointment and the long office waits (more than 2 hours), even though she felt that the doctor spent quality time on her exam.

### **Moon's story**

Moon, a 46-year-old married Thai woman with no children, had lived in Germany for 16 years. She held an associate degree, was employed as a housekeeper, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Moon was a very outgoing woman with an effervescent personality. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Prior to Moon's first Pap exam at the age of 30, she had no information regarding cervical cancer. However, she stated that according to her German health insurance policy, if she (at her age) did not have yearly cervical cancer screening and contracted the disease, her insurance could refuse to pay medical coverage. Moon had a difficult time taking her clothes off for the examination; she stated that was the reason she did not have Pap test done in Thailand. During the procedure, she felt embarrassment and pain and was worried that the doctor might find cancer.

Moon had no family history of cervical cancer and now had yearly cervical cancer screening, always with normal results. Her gynecologist was female, which she preferred because she felt it was embarrassing to have a male doctor perform the gynecological exam. She felt that cervical cancer screening was good for health and served as



prevention for cervical cancer. She understood that this disease was prevalent among Thai women and that it was deadly.

In Moon's opinion, an abnormal Pap smear was not always cervical cancer. "The doctor may have to send you to see a specialist for further evaluation or for a re-check." If told that she had cervical cancer, Moon would be very sad and then would consult the doctor about how to treat the disease.

Moon stated that not everybody has a chance of getting cervical cancer. It depends on one's health, immunity, and sexual behaviors. She also believed that she did have a chance of getting cervical cancer, but "is not 100% sure." With regard to the causes of cervical cancer, Moon stated that when the genital area is dirty and does not get cleaned well, coupled with sexual intercourse, the disease could develop. In addition, Moon stated that she had never been informed by other people about preventative health care practices and that the subject was so personal that no one wanted to discuss it, especially among Thai women. "We only talk about food."

In Moon's opinion, the German health care services were very good and had specializations. "Compared to Thailand, the German system is much better." However, language difficulties were a major barrier to accessing the health care system. Her husband made her medical appointments and accompanied her to act as interpreter; then he would converse with her in the way she could understand in German (husband to wife talk).

Moon believed that the long wait for office visits was normal for the German health care system and did not see it as a problem. She believed that the long wait was due to the magnitude of the patients' problems; she felt that it took time for the doctor to

listen and to examine each patient thoroughly. If the doctor rushed through the exam, he or she might miss significant findings or even misdiagnose the problem.

### **Naang's Story**

Naang, a 47-year-old Thai woman, married with three children, had lived in Germany for 15 years. She completed the seventh grade, was employed as a housekeeper, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Naang was of medium build, with long dark hair, and was friendly but shy. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Although Naang had no immediate family members with a history of cervical cancer, she did have a cousin in Thailand who died from the disease at a very young age. This incident prompted Naang to have her first Pap test done in Thailand. In addition, Naang said that her female relatives, including her mother, also went for Pap screening at that time due to the fear of having cervical cancer.

Naang's first Pap exam in Germany was at the age of 32. Her gynecologist was male, although she preferred a female due to embarrassment. Even though Naang had already delivered two children at that time, she was embarrassed to have the Pap screening done. Naang had only gone for Pap screening four times in the 15 years she had lived in Germany. She stated that mostly she was annoyed with long waits for available appointments. She had a history of recurrent vaginal bacterial infection, which she felt was caused by "not cleaning the vaginal area very well." She had attempted self-medication, but with no success, and finally went back to her doctor for treatment with a successful resolution.

Although Naang learned about the danger of cervical cancer from the death of her cousin, and she herself has gone for screening because she was afraid of having the disease, she felt that other women had the screening done because of fear also. She did not know exactly what cervical cancer was but understood the term.

She felt that some possible causes of cervical cancer were “poor personal hygiene, being dirty. Thai people bathe every day; the Germans don’t bathe very often, but the Germans do not get this disease more often than Thai people.” She concluded that she did not know for sure whether the cause of cervical cancer was related to cleanliness. She further felt that not cleaning the genital area after sexual intercourse or multiple sexual partners could be a cause of cervical cancer. In addition, Naang believed that eating fermented food, such as fish or shrimp, or pickled bamboo shoots could cause odorous vaginal discharge. She stated that when she ate chicken, her urine had a strong odor. For other preventative measures, Naang stated that she would go to see the doctor for a checkup and follow the doctors’ advice on how to prevent cervical cancer.

Naang stated that if told she had an abnormal Pap exam, she would not know whether that meant she had cervical cancer or not, as she had never had an abnormal Pap test. She believed that she might have a chance of getting cervical cancer; however, she could not foresee the future, even though she was aware of the disease. If she were told that she had cervical cancer, she did not know how she would react. She said, “Perhaps I would be frightened with the news.”

Naang stated that she had received great service in the German health care system, and had caring, competent doctors. However, she once switched her gynecologist because

she felt that the equipment used during her exam looked old and dirty, and she was not confident that the doctor used up-to-date technology.

Some of the drawbacks or barriers that Naang had experienced were feeling rushed during the office visit, not enough quality time spent during her appointment, and the long waits to be seen, which prompted her to change her gynecologist three times. In addition, she felt that there was not enough health care information given during the office visit, although information would be sent by mail, which her husband would read to her; however, she felt that, basically, “it is useless if you cannot read German.”

She felt that the health care providers in Thailand spent more time explaining in detail to provide better understanding than did the German health care providers, although she did not believe that the language was a problem. Naang made her own appointments and went alone to her office visits. No reminders were sent with regard to the next appointment.

### **Phaa’s Story**

Phaa, a 51-year-old Thai woman, married with four children, had lived in Germany for 10 years. She completed the fourth grade, was employed as “kitchen help,” and had health insurance. She stated that her household annual income was 49,999 Euros or less. Phaa was a large-framed woman, with long, dark hair, and was reserved. She was born and raised in the northeastern part of Thailand. The interview took place at Phaa’s house.

Phaa had no family history of cervical cancer, and her first Pap exam was at the age of 35, following the birth of her son in Thailand. Before her first exam, Phaa stated that she had never been told or learned about cervical cancer screening. The doctor

informed her that she needed the procedure, and she did not ask why, but agreed to the exam, with normal results. Phaa stated that she felt neither embarrassed nor anxious during the exam.

Phaa's gynecologist was female; she had no preferences in terms of gender. She had cervical cancer screening every 6 months and intended to continue with this due to her doctor's advice. She stated that perhaps the exam was recommended every 6 months because she was getting older. Furthermore, she stated that having cervical cancer screen was a "good thing for women." She felt that Thailand's health care policy was not as strict as in Germany in terms of health mandates for cancer screening. "Thai women are foreigners living in this country and if they do not go for screening and end up getting sick from cancer, it would be a burden for the host country."

If told that she had an abnormal Pap smear, she would think that it meant that she had cervical cancer or a tumor. She stated that when she took a shower, she often used her finger to check her vagina for a tumor, as she had heard that some Thai women who lived in Germany had a tumor of the cervix and was worried that it might happen to her. Although she stated that she had never been told about or heard any discussions regarding cervical cancer, she had frequently watched programs on television on cancer prevention.

Phaa believed that she had a chance of getting cervical cancer because she was still sexually active with her husband. She believed that cervical cancer might be caused by sexual intercourse, as it may cause friction and inflammation of the uterus, and by not washing the genital area very well after intercourse. Consequently, to prevent cancer, one must clean the genitalia very well after intercourse. She added, some additional causes, including genetic predisposition, multiple sexual partners, or prostitution. If told that she

had cervical cancer, Phaa stated that she would be very embarrassed, “it is very scary and shameful to have the disease.” However, she would seek treatment before it was too late.

Phaa stated that she had received good care from the German health care system and was treated with the same respect that German nationals received; she felt that her doctors spent enough time with her and communicated appropriately, although her husband would be with her to interpret because of her language barrier. Additionally, Phaa did not feel that transportation was a problem; appointments were made by her husband, and reminders were sent out every 6 months; she said, “I am always in good health.”

### **Ump’s Story**

Ump, a 28-year-old Thai woman, married with no children, had lived in Germany for 7 years. She completed high school, was employed as a waitress, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Ump was a young, petite, talkative woman with short hair. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Ump had no family history of cervical cancer and had never had a cervical cancer screening done, to her knowledge, although she had a pelvic exam at the age of 26 in Germany. Her gynecologist was male, and she preferred a female due to embarrassment. The reason for her pelvic exam was because of painful intercourse with her husband. Ump expressed shock when the doctor inserted a long metal tube into her vagina to check her uterus. She was informed that it was an ultrasound and would help to find the cause of

her pain and bleeding during intercourse. During her visit, the doctor did tell her to have cervical cancer screening done before she turned 30.

Ump could not recall where she had learned about cervical cancer and stated that she had never heard or been told by other people about health practices that prevent cervical cancer, although she believed that cervical cancer screening was very important for women to have.

Ump stated that if she had an abnormal Pap smear, she would request to have it checked again. She believed that cervical cancer was related to the uterus and sexual intercourse, stating that “the male partner may have the disease and the woman may get infected from her partner.” In addition, Ump felt that a plausible cause of cervical cancer might be related to heavy lifting, which may cause the uterus to prolapse.

If told that she had cervical cancer, Ump stated that she would seek appropriate treatment. Additionally, Ump stated that in order to prevent cervical cancer, she eats fresh vegetables and makes sure that she washes them very well, blotting them dry with a paper towel, because she is afraid of the chemicals.

Ump felt that the health care services that she had received in Germany were good and very thorough, and she felt that she was treated the same as German patients. She stated that she understood that the long wait to be seen was normal in Germany. Her husband made her appointments and, most of the time, would accompany her on her office visits. Although she did not perceive any barriers to accessing health care services, she stated that “the German language is very difficult.”

### **Naam's Story**

Naam, a 56-year-old Thai woman, married with two grown children, had lived in Germany for 8 years. She had a bachelor degree from Thailand, was unemployed, and had health insurance. She stated that her household annual income was 49,000 Euros or less. Naam was a short woman with long braided hair. She was warmly dressed and suffering from a cold. She was born and raised in the eastern part of Thailand. The interview took place in a private office at a local grocery store.

Naam had a family history of cervical cancer. Her first Pap exam was at the age of 28 in Thailand. The reason for her exam at the time was due to burning on urination. She was diagnosed with a sexually transmitted disease that she had contracted from her former husband. The results of the Pap test were negative for cervical cancer. Even though she was examined by a female gynecologist, which she prefers, she was still embarrassed during the exam. Naam added that she had a very progressive daughter in Thailand who was not shy or embarrassed to have the exam done and “takes great care of her health.”

Naam had another Pap screening in 2002 before moving to Germany and then again in 2004, both with normal results. Although she stated that Pap smear screening was disease prevention and was the type of screening to check for cervical cancer, comparing the screening to a “wall you build to protect your house from flooding,” she did not intend to have another Pap smear screening done in the future. She stated that “my thinking may be irrational or foolish for refusing to have this checkup, but I am not afraid of dying.” Furthermore, she stated that “no one will escape death.” She said that until then, she's ready for whatever is going to happen.



Naam learned about cervical cancer screening from watching television and reading magazines. In addition, before migrating to Germany, a health promotion campaign by the Thai Public Health Department encouraged Thai women to undergo cervical cancer screening. She and many of her colleagues had the screening done as a result of the campaign, which recommended yearly exams.

If told she had an abnormal Pap test, Naam stated that “it could mean the findings of abnormal cells, cancer, or tumors.” She believed that some possible causes of cervical cancer could be from sexual intercourse, not cleaning the genital area, eating certain foods, and childbirth. In addition, she stated that all women, not just women who had a sexual relationship or were married, had a chance of getting the disease: “every woman, including myself, has a chance of getting cervical cancer.” She then exemplified this with the story of a friend who had never married and had never been with a man but had been diagnosed with cervical cancer.

Naam experienced food poisoning from eating barbeque chicken, and her brother fixed her a concoction of basil leaves and uncooked rice, which did make her feel better. She stated that “rice is a wonderful substance to help absorb poisons”; in addition, she concluded that eating chicken could cause illness during the postpartum period, *yuu fai*.

Naam’s practices to prevent cervical cancer included bathing, cleaning the genital area, changing underwear daily, good nutrition, and not eating red meat. She had not heard of or been told by other people about any practices that prevent cervical cancer.

Naam stated that she was not very satisfied with the health care services that she received from the German clinics and perceived that there was a “sense of prejudiced attitudes towards foreigners among health care providers.” Naam related her experience

of having anaphylactic shock during allergy testing she was having done. Her care provider went out for a cigarette, and during this time, Name could not breathe and felt her throat closing up. Calling for help, a different nurse came in and scolded her for being overly reactive. However, she was given epinephrine by her doctor to alleviate her symptoms.

In addition, the long wait of 3 months to get an appointment, not enough time spent during the office visit, and the lack of opportunities to ask questions were all problematic for her. For example, she was told “point blank” that her office visit was over before she could ask questions about her health concerns; that was the last time she saw this doctor due to the lack of a caring attitude. Naam concluded that the quality of care she received was not worth the time she spent waiting to be seen.

### **Jaew’s Story**

Jaew, a 35-year-old Thai woman, married with one child, had lived in Germany for 13 years. She completed the sixth grade, was employed as a housekeeper, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Jaew was a tall, thin woman who was very friendly and talkative, and needed frequent re-focusing. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Jaew had no family history of cervical cancer, and her first pelvic exam was at the age of 22 due to fertility issues. “I was very shy, so my husband took me to the clinic and encouraged me to have the exam done.” Jaew had yearly pelvic exams, although her doctor had never told her whether cervical cancer screening was a part of her exam. Jaew stated that the doctor used a swab inserted into her vagina, applied the sample to a slide,

and sent it to the lab. Her doctor did, however, tell her that she should have the screening done after the age of 35.

Jaew's gynecologist was female. She stated that she preferred female doctors because they would understand their female patients' needs. Furthermore, she would feel embarrassed to have a male doctor perform the pelvic exam. She said, "just the thought of it makes me shudder and gives me goose pimples."

With regard to learning about cervical cancer, Jaew stated that she learned from watching television and reading magazines. Furthermore, she had heard that a lot of Thai women living in Germany went to have cervical cancer screening done. "Perhaps it is related to having health insurance, and taking care of one's health by having a yearly exam; otherwise, it would be a waste of money because the health insurance premium had already been paid."

If told that she had an abnormal Pap exam, Jaew would assume that there was a chance that she would have cervical cancer or that there was a foreign body in the uterus. Furthermore, she stated that cervical cancer was "bad tissues that could cause changes in the uterus, and is an incurable disease." Jaew felt that she had a chance of getting cervical cancer, "because I have a uterus."

Jaew stated that some plausible causes of cervical cancer are abnormal cells, not taking care of personal hygiene especially in the genital area, and genetic predisposition. She further stated that "if you take good care of your personal hygiene and do not have a genetic predisposition to this disease, the risk of getting this disease is probably less." If told that she had cervical cancer, Jaew would be terrified, and then she would seek treatment.

Although Jaew has never been told or heard about practices to prevent cervical cancer, she had gotten some information from reading a book. She stated that some health care practices to prevent cervical cancer included taking good care of your health, not being promiscuous, no sexual contact with people who have the disease, good hygiene, and good nutrition, which includes avoiding a fatty diet or red meat, which may cause many diseases, including cancer. In addition, Jaew stated that you can drink alcohol, but in moderation.

Jaew's impressions regarding the health care services in Germany were that they were superb. She stated that she felt she was treated as if she were very special, like a V.I.P. guest in a very nice hotel, by health care providers in Germany, whereas in Thailand, she was not treated nicely. In her opinion, if you had money and good health insurance, you would be treated nicely in Thailand. In addition, she had less confidence in and felt prejudice from the health care providers in Thailand, whereas, she felt that in Germany, she was treated fairly and had received quality health care in spite of being a foreigner.

Initially, Jaew had difficulty with the German language, so her husband or mother-in-law would make her appointments and accompany her to appointments. Even though Jaew attempted to communicate her symptoms through the use of hand gestures, she felt her doctor was very patient and tried to understand her needs.

Jaew stated that although there were long waits to get an appointment, about 2 months, the German health care providers were very organized and had good communications between doctors for referrals. Jaew stated that she did not have any

barriers with regard to accessing health care, as she was now able to communicate her needs to her doctor and was able to drive herself to her appointments.

Jaew stated that her Thai friends have good support from husbands and relatives who take them to their appointments and assist in communication. She further felt that due to “husband and wife talk,” there were no problems with communicating the findings, recommendations, and treatments from the doctors. No reminders were sent for future exams, Jaew had to write the appointment on the calendar, and if she was late for the appointment, she had to make a new one.

### **Jaa’s Story**

Jaa, a 42-year old-Thai woman, married with no children, had lived in Germany for 7 years. She completed high school, was unemployed, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Jaa was of medium build, had long hair, and well groomed and friendly. She was born and raised in the central part of Thailand. The interview took place in her home.

Jaa had no family history of cervical cancer and was 24 years old when she had her first Pap exam in Thailand due to abdominal pain. Although her Pap exam results were negative for cervical cancer, she was diagnosed with uterine tumors, which caused her to be very upset. The waiting period for the result was almost unbearable. Jaa stated that during this time, she had made up her mind to focus and, regardless of the outcome, she would seek treatment. She was very relieved that she did not have cancer and that her condition was treatable with surgery.

Jaa’s current doctor was female, which she preferred, although she had been assigned a male doctor in Thailand and was very uncomfortable and embarrassed, despite

the doctor's encouraging her to be more relaxed. Jaa learned about cervical cancer from reading magazines, watching television, and the Thai government's cervical cancer prevention campaign. She stated that cervical cancer screening is the exam to detect cervical cancer and that every woman has a chance of getting the disease. She also stated that she is in a high-risk group because of a history of benign uterine tumors.

With regard to an abnormal Pap smear, Jaa stated that perhaps there was a possibility of having cervical cancer; in addition, she stated that cervical cancer is a cancer that may cause death. Although Jaa asked her doctor what causes cervical cancer and was told that there are no real causative factors, she felt that it may possibly be caused from eating "certain foods."

Jaa's health practice to prevent cervical cancer is through good nutrition, avoiding barbequed meat, especially burnt meat; discarding old cooking oil; washing vegetables and fruits thoroughly to remove chemicals; and avoiding air pollution. Jaa stated that even though doctors are still unable to find the true causes of cervical cancer, we really need to be careful with our health practices.

Although Jaa had never heard of or been told by other people how to prevent cervical cancer, other than being advised to go for yearly screenings, her own practice involved making sure that she changed her sanitary pads often during her menstrual period and taking care of personal hygiene, especially in the genital area.

Jaa stated that she visited the doctor more frequently in Germany because she had health insurance. She stated that the health care services provided in Germany are excellent and believed that German health care providers have better human relations and more caring attitudes than those she had known in Thailand. She added that the German

health care personnel made her feel that she was an important customer and treated her with respect.

Jaa did not perceive any barriers to accessing health care services in Germany other than the month-long wait and the more than 1-hour wait to be seen. However, she sometimes asked her husband to accompany her to medical appointments just in case she did not fully understand the information given to her by her doctor. In addition, if she noticed that something was not right, she would ask her husband to make a checkup appointment for her.

### **Da-wan's Story**

Da-wan, a 34-year-old Thai woman, married with one child, had lived in Germany for 9 years. She had an Associate Degree, was employed as “kitchen staff” in a local restaurant, and had health insurance. She stated that her household annual income was 49,999 Euros or less. Da-wan was small in stature and was very friendly and outgoing. She was born and raised in the northeastern part of Thailand. The interview took place at her home.

Da-wan had no family history of cervical cancer, and her first Pap exam was at the age of 22 in Thailand, after the birth of her son, with normal results. She stated that even though she was married, she was “clueless” about cervical cancer and just went along with the checkup because trusted her doctor, who told her that she should have a Pap smear screening.

Da-wan's gynecologist was female, which she preferred because she was more comfortable asking a female doctor questions and was less embarrassed during the procedure. Her most recent Pap exam was 3 months earlier, again with normal results.

She stated that she had never had an abnormal result from her exams, and intended to have Pap exams in the future.

Da-wan learned about cervical cancer from surfing the Internet and watching television. She believed that every woman had a chance of getting the disease because “no one knows when one is going to get the disease.” She stated that a Pap smear screening “is a health examination. Men don’t have the same problems that women have, and women should have the screening done because they have uteruses and menstrual periods.” If told that she had an abnormal Pap result, Da-wan would be horrified, although she would not believe that she had cervical cancer because she had it checked so often.

Da-wan stated that cervical cancer might be caused by an infection or an accumulation of germs “from who knows when,” and it becomes chronic. In addition, she stated that cervical cancer may be caused by using dirty public restrooms, especially during the menstrual period, as the cervix is open and women can get an infection. Furthermore, she stated that she had heard that the foreskin of a man’s penis has an accumulation of germs, and during sexual intercourse, the ejaculation of semen may force these germs into the uterus and may cause cervical cancer later on, although she admitted that she did not know if this was true. In addition, she was also worried that heavy vaginal discharge might cause cervical cancer. If told that she had cervical cancer, Da-wan stated that she would ask the doctor the stage of the disease. If it was at an early stage, she would ask the doctor’s advice on how to treat it and the prognosis.

Da-wan’s specific preventative health care recommendations were “always take good care of her health and cleaning her genital area after intercourse.” Furthermore, she



was told by a nurse friend that doing Kegel exercises may help to strengthen the vaginal canal, and she is doing the exercise faithfully. She hoped that this exercise would strengthen her uterus and prevent a prolapse, like her mother-in-law experienced. She was not certain if this exercise would help to enhance pleasure during sexual relations because she “hardly has any sexual intercourse with her husband.”

Da-wan felt that the health care services that she received in Germany were great, and she believed that she was treated equally as well as the German nationals. She felt that the doctor was very thorough and understanding of her needs during her office visits, spent quality time with her, and addressed her questions and concerns during her visits.

Da-wan stated that she still had problems communicating in German. Her husband made her appointments and accompanied her to the appointments in case she needed interpretation. Da-wan would have her husband relay her questions to the doctor, and her husband would relay the information from the doctor in simple German that she could understand. She called this procedure “husband and wife talk.”

### **Timm’s Story**

Timm, a 43-year-old Thai woman, married with two children, had lived in Germany for 10 years. She completed the sixth grade, was employed as a housekeeper, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Timm was a tall slender woman, was very shy, and was occasionally teary when discussing her own personal recurrent vaginal discharge. She was born and raised in the northeastern part of Thailand. The interview took place in a private office at a local grocery store.

Timm stated that she had no family history of cervical cancer. She had been under a doctor's care only once, at the age of 33, while pregnant with her son. She stated that she had a problem with low blood counts and was under the doctor's care throughout her pregnancy. During her pregnancy, she did not want to see the doctor for prenatal care and said that she would never have stepped into the doctor's office except that she was concerned about her unborn child's health; she was tense during the entire office visit. Her gynecologist at the time was male, and that is why she was afraid to go for checkups. She would prefer a female doctor.

Although Timm would have liked to have cervical cancer screening done, she was too shy and embarrassed to undergo the gynecological exam. In addition, she was afraid that she would not be able to communicate with the doctor, as the German language was very difficult for her, and she still had a difficult time communicating with her own husband in German. Timm admitted that she had difficulty with reading and writing, even in her own native language.

Timm stated that she had never learned about cervical cancer until she saw the advertisement for this study and decided to participate. She added that there were no Thai magazines available in Germany and because of her work, she did not have the time to watch television.

When asked what she thought cervical cancer screening meant, she "guessed it is good for health and to catch the disease early." Timm also stated that she would be more embarrassed of the exam than afraid of the disease itself. When asked what cervical cancer meant, she replied, "Something is rotten inside the body," but she did not know where. Furthermore, she stated that she had been having problems with vaginal discharge

and described it as an “odorous abnormal smell, but no itchiness.” She was worried but was afraid to see the doctor. Additionally, she stated that she had no one to talk to, did not have many Thai friends, and did not know anyone who was in the medical field that she could confide in.

When asked about possible causes of cervical cancer, Timm felt that perhaps not cleaning or bathing after sexual intercourse, promiscuity, and the lack of her husband’s personal hygiene might be causes. Timm stated that she was worried that she might get infected from her husband’s germs, which might lead to cervical cancer, because her husband did not bathe very often. In addition, she used to compare her husband’s behaviors with some of her German friends and found out that their husbands do not like to bathe either. She stated that “they all got worried that some day they may get cervical cancer from their husbands, due to the lack of good personal hygiene and cleanliness.”

Timms’ health care practices that might prevent cervical cancer included exercise, bathing after sexual intercourse, and good nutrition. She avoided eating fermented fish because she felt it might cause vaginal discharge. Timm stated that she had never heard any discussion regarding cervical cancer among her friends, but had been told to “go get cervical cancer screening.”

Timms had more than 10 years of experience with the German health care system, which was limited to prenatal and postpartum care. She stated that she received excellent postpartum care, in spite of the language barrier and her own personal embarrassment. She further stated that she felt that the health care providers treated her fairly and were respectful of her culture.

### **Joom's Story**

Joom, a 50-year-old Thai woman, was divorced with two children. She had lived in Germany for 13 years and had health insurance. She stated that her household annual income was 24,999 Euros or less. Joom was a small woman with flat affect. She was born and raised in the northeastern part of Thailand. The interview took place in a private office of a local grocery store.

Joom had no family history of cervical cancer and received her first Pap exam in Germany at the age of 40. The reason for her first Pap screening was because she was experiencing irregular menses, and she was worried about having cervical cancer; she was scared and embarrassed at the time. However, her gynecologist informed her that she was having side effects from the birth control implant in her upper arm. He told her it was too strong and was causing her uterus to swell, in addition to causing frequent menstrual periods. Following her doctor's advice, she had it removed and had no further problems.

Joom had cervical cancer screening done every 6 months, as advised by her doctor, and had never had an abnormal finding. Her gynecologist was male, and she had no preferences for male or female. She stated that she could not pick and choose her doctors, was always assigned a male, and did not think it was necessary to have a female doctor.

Joom stated that she learned about cervical cancer from her gynecologist, and in her opinion, cervical cancer was a "deadly disease for women, if a woman has it, it is incurable. It is a death sentence." She explained that one of her German coworkers who had never had cervical cancer screening finally went to the doctor because of irregular

menses and found out that she had advanced cervical cancer. She then had to have a hysterectomy and was receiving chemotherapy.

With regard to having an abnormal Pap smear, Joom stated that “something would be wrong,” although she felt that positive test results were not always conclusive for cervical cancer. Joom felt that she had a 100% chance of getting cervical cancer because she had a uterus, and if she were told that she had cervical cancer, she would seek treatment and follow the doctor’s advice closely.

Joom stated that she had no real knowledge of the causes of cervical cancer and had not been exposed to the subject through reading or television, but felt that perhaps it might be caused by inflammation or contracting the disease from a spouse. With regard to preventing cervical cancer, Joom believed that cleaning the genital area and good nutrition were important. In addition, she had never been told by others about health care practices that would prevent cervical cancer. She further stated that she had not adhered to any traditional Thai beliefs regarding food taboos, especially those following the postpartum period. She said that she ate everything that she thought was healthy for her and her baby.

Joom felt that the German health care system was “great” and that she had received great care in Germany. She had no difficulty with transportation, as Germany had a great transportation system. She took the train and walked a short distance to the gynecology clinic. Joom made her own appointments, but stated that she did have some difficulty with the language, resulting in her not fully understanding her doctor. Joom also stated that for exams other than her cervical cancer screening and mammogram, she would have to pay out of pocket if the insurance did not cover them. There were no

telephone reminders for the next appointment, but if she missed a screening, her doctor would then send her a reminder.

### **Nooy's Story**

Nooy, a 39-year-old Thai woman, married with two children, had lived in Germany for 6 years. She completed the sixth grade, was employed as a housekeeper in a nursing home, and had health insurance. She stated that her household annual income was 24,999 Euros or less. Nooy was a very slender woman with long black hair and was extremely shy. She was born and raised in the northeastern part of Thailand. The interview took place at her home.

Nooy had no family history of cervical cancer and had her first Pap screening in Thailand when she was 22 years old, 1 year after giving birth. Nooy stated that her first Pap exam was very embarrassing and frightening. She was scared of the unknown, scared of the doctor, and scared of what the doctor would find during the exam. She also felt that she was not given adequate information and education from the Thai nurse who performed the procedure.

Nooy learned about cervical cancer screening from the health volunteer personnel who were promoting a cervical cancer screening campaign in her village in Thailand, encouraging all eligible women to have the screening done. Nooy stated that she did not continue with yearly screening while living in Thailand; however, she was going to Thailand for a visit and planned to have a checkup while she was there.

Nooy's gynecologist was male, although if she had a choice, Nooy would prefer a female doctor, saying that she would be more comfortable and less embarrassed. Since living in Germany, she had yearly cervical cancer screenings, all with normal results.

Nooy stated that she was told that cervical cancer screening was good for women to have for early detection of cervical cancer.

Nooy stated that an abnormal Pap smear “doesn’t always mean that it is cervical cancer, it may be related to the uterus or other factors that causes an abnormal exam.”

Nooy defined cervical cancer as abnormal tissues, but was not sure if cervical cancer was curable after surgery. She thought that some plausible causes of cervical cancer were “tumors, contracting the disease from sexual intercourse, or contracting germs or bacteria from using dirty public restrooms.”

Nooy felt that she had a chance of getting cervical cancer because she was a woman and had a uterus. If told that she had cervical cancer, she would be shocked and would make an appointment to see the doctor for advice and treatment options.

Nooy believed that she was doing her best to take care of her health by having yearly physical checkups and maintaining good personal hygiene “so that you don’t get the disease.” With regard to food taboos, Nooy stated that she had adhered to all the food taboos that were told to her by her grandmother and mother, such as avoiding eating Muscovy duck during the postpartum period because it would harm her body. In addition, she was told that eating fermented fish, pickled bamboo shoots, and pickled food products would cause heavy vaginal discharge. If a woman was experiencing heavy vaginal discharge, Nooy said it might be related to “having a bad uterus.” She stated that she especially avoids fermented fish if she was having vaginal discharge, as it caused itchiness at the uterus (she pointed her finger to the vaginal area).

Nooy stated that although she feels the German health care services were very good and the doctors were competent, she would still prefer the health system in

Thailand. She was not proficient in the German language and viewed this as her main barrier to accessing the health care system. Her husband made her appointments for her but she was able to drive to her appointments by herself. She felt that her doctor treated her well with respect to her culture and the same as he treated the German patients. She did not view waiting as a problem because “everyone is doing the same.”



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