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Access to the healthcare system: Experiences and perspectives of Pakistani immigrant mothers in New Zealand

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ABSTRACT

Worldwide, there is limited literature on Pakistani immigrants' challenges and experiences accessing healthcare services for their children and themselves. In this article, we present a case study of Pakistani immigrant mothers in New Zealand to explore their experiences and perspectives on navigating the healthcare system of a new country. Data was collected from 23 mothers in Wellington through in-depth semi-structured interviews, which each lasted 60 to 80 min. Participants had been living in New Zealand for an average of 3.25 years and were mostly highly educated. They talked about their prior knowledge and experiences regarding the New Zealand healthcare system. Lack of knowledge, different expectations, and experiences of healthcare services inhibited their utilization of healthcare. Most mothers treated their children at home before visiting a general practitioner (GP) due to previous perceived unsatisfactory experiences, such as lack of availability of GP appointments for the same or next day, or long waiting times at emergency departments and after hours medical facilities. Immigrant mothers need to feel they are getting the right services at the right time to ensure and promote better health outcomes. Identifying the barriers and promoting information about the healthcare system can play an essential role in the appropriate use of health services by immigrant mothers.

Introduction

Migration is an important aspect of globalization and involves migrants making cultural and linguistic adaptations and transitioning to a new country (Berry, 1997). Immigrants need to learn to navigate a new healthcare system to obtain healthcare for their children and themselves (Straiton and Myhre, 2017). Inability to navigate the healthcare system in their new country is a significant barrier (Dias et al., 2010). Immigrants' access and navigation of the new healthcare system is affected by their socioeconomic status, culture, beliefs, and pre-migration experience of healthcare services (Horne et al., 2004; Småland Goth and Berg, 2011). An increasing immigrant population also demands a culturally competent and equitable healthcare system capable of addressing different communities' healthcare needs and expectations (Ahmed et al., 2016; Anderson et al., 2003; Kay et al., 2010).

The literature is more limited about the experiences of mothers accessing healthcare for their children. Previous research has identified the importance of continuity of care, healthcare provider and parent communication, preventive care guidance, and accessibility of information rather than clinical meetings (Coker et al., 2009; Radecki et al., 2009). Reasons for delayed care can also be financial, linguistic and cultural (Huang et al., 2009). Immigrant children are often left untreated or miss assessments like immunization, hearing and vision, and dental checkups (Schiariti, 2016). Almost 40% to 50% of young children experience stress and other problems when settling into a new country (Hjern and Bouvier, 2004; Schiariti, 2016). Immigrant parents also felt stress and uncertainty (Karim et al., 2020). They compared experiences of the new country's health services to those in their home country (Karim et al., 2020). Non-European parents had high expectations (Mangrio and Persson, 2017). A systematic review of the use of medicines and healthcare services among Pakistani immigrants in high-income countries has highlighted the complexity and individuality of people's perspectives, practices and experiences (Saleem et al., 2019).

The New Zealand healthcare system was established in 1938 as a universal, tax-funded national health service. Today, fully funded public hospitals operate together with privately owned general practitioners (GP) with partial public funding. Hospitals treat citizens and permanent residents free of charge (Goodyear-Smith and Ashton, 2019). Most GPs do not charge a fee for a regular daytime consultation for eligible children under 14 years. The standard prescription charge also does not apply. New Zealand provides many services for families from conception until the age of six years. These are free for eligible families, but in other cases a fee may be charged. Families usually access these specific services after assessment and referral from a general

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service provider, but hospital emergency departments (ED) can be accessed directly (Ministry of Health, 2012).

Pakistan's healthcare system, however, is different from New Zealand in many ways. Patients can access public-funded as well as private hospitals depending on their income. Waiting times for appointments to see a health practitioner are often minimal and specialists can be accessed without referral. Self-medication is very common because of easy access to all kinds of medicines from pharmacies without a prescription. There is no support system, however, for children with special needs and disabilities.

The aim of this research was to provide a detailed case study of the perspectives and experiences of Pakistani immigrant mothers in New Zealand accessing healthcare for their children, as no previous research had been undertaken on this topic. Immigration requirements in New Zealand mean that Pakistani immigrants are a relatively homogenous group of highly educated professional individuals and families, almost all of whom are of working age.[1] This study explores their beliefs and practices, the challenges they face and how they learn to navigate the healthcare system of a new country.

Methods

Study design

We used a qualitative research design, using one to one, in-depth, semi-structured interviews to explore Pakistani mothers' experiences and reflections on the New Zealand healthcare system.

Participant recruitment

A purposive sampling technique was used for the recruitment process, where we first identified eligible participants through different Pakistani community groups. These later helped in recruiting their eligible peers. Eligible participants were Pakistani mothers born and educated in Pakistan, at least 18 years of age, with at least one child under 12 years and who had moved to New Zealand within the last five years and were living in the capital city of Wellington. Mothers who had healthcare education or worked in healthcare were excluded as it was thought that their knowledge of healthcare could influence the results. The lead researcher (SA) initially contacted potential participants by telephone, WhatsApp or Facebook and explained the research objectives and the inclusion/exclusion criteria. Those who wanted to be involved were asked for an interview appointment at a place and time convenient to them. All the participants received an information sheet and consent form. Written consent was taken before the interview. SA also took chocolate or cake for participants to thank them for their time and help in the study.

Ethical approval

Ethics approval was granted from the University of Otago Human Ethics Committee (#D17/132).

Data collection and analysis

The lead researcher (SA) developed a schedule of questions based on the literature and discussions with the other researchers (SH and PN). In Pakistan, English and Urdu are official languages. Most of the population understands and speaks Urdu. The "study instrument" (participation information sheet, consent form, and interview schedule) was translated into Urdu by SA. The interview was piloted on three participants before finalizing the interview guide. The interviews allowed participants the opportunity to share detailed information about their experiences and opinions on healthcare access (Brinkman, 2009; Ritchie et al., 2013).

In-depth interviews were conducted in Urdu by the lead researcher (SA) between April and October 2017. Each interview lasted between 60 and 80 min. The interviews were audio-recorded with the consent of the participants. SA also wrote field notes and reflections during the interview. Interviews were continued until no new themes were identified, with saturation (data collection producing no new information contributing to the research aims) reached after 23 interviews (Creswell and Poth, 2016).

Recordings were transcribed verbatim by SA. Identifying information was removed and interviews labelled with specific code numbers. Initial results were discussed within the research team and then coded using NVivo 11 software. Topics and themes related to the research aims were identified. A general inductive approach (GIA) was used for the thematic analysis (Thomas, 2006).

Results

Participant demographics

The sample consisted of 23 married mothers, aged 30–45 (mean: 34.85) years. The majority of the mothers had a master's degree as their highest educational qualification (n = 13). Ninety-one percent (91%) of the mothers had two or more children, and 9% had one child. Most (65%) mothers were housewives, with only 35% involved in casual or full-time work. Participants were asked about their visa status because this determines access to public funding for healthcare. Nine percent of the participants were on a student visa and so were not eligible, while the others were on a resident visa and therefore were eligible.

Mothers' knowledge of the healthcare system

Mothers reported limited knowledge about the healthcare system in New Zealand when they arrived. Subsequently, they mostly learned through their experiences of using it, with most mothers saying that it took them around two years. Some felt that they still did not know much and needed to learn more. Mothers stated that they had easier access to specialists, private clinics, tests, and screening in Pakistan compared to New Zealand, where referral from a GP is required to access specialists. Most of the mothers were also not fully aware of how to navigate the private healthcare system in New Zealand.

Pharmacy services and use of over-the-counter (OTC) medicines

All the mothers said that they obtained their prescription medicines from a pharmacy but thought that a community pharmacy only provided prescribed medicines and some OTC medicines or creams. None of them knew about other services community pharmacies provide in New Zealand, such as treatment of minor ailments and counselling. They were, however, aware of not being able to get medicines without a prescription in New Zealand, unlike the system in Pakistan. As a result, they did not often go to pharmacies or ask pharmacists questions without having a prescription. Likewise, mothers did not take or ask about their children.

> I do not know that they can give us consultation or any other services. I just thought maybe they gave you medicines when you have prescriptions, so I never went there without prescriptions.
>
> (Interview 16: Full-time working with two children)

Most mothers reported buying OTC medicines from either a pharmacy or a supermarket as they did not see any difference between them. The types of OTC medicines participants mentioned included antiseptics, analgesic creams, and antihistamines. For their children they also

[1] New Zealand statistics also show that Pakistani immigrants overall are more qualified than other Asian immigrants. For example, 21.6% of them have a master's degree compared to 7.4% for other Asian immigrants.

bought antipyretics and cough syrups. Other purchases were multivitamins, Strepsils®, VapoDrops®, VICKS®, and VapoRub®.

Yes, I brought OTC medicine like Nurofen®, ibuprofen, cough syrups, and paracetamol from the supermarket.

(Interview 9: Full-time working with two children)

I take Multivitamins …like Vitamin D and E. I took total multivitamins which I found by searching online.

(Interview 13: Housewife with two children)

Use of GP services

The participants indicated that they visited GPs more often for their children than for themselves. Many reported that they and their husbands avoided going to a GP because of the high consultation fee, so most of their visits were only for their children for whom the service was free. Most families did not have any health insurance and each adult visit to a GP cost $NZ50–70. Often, they came away without a prescription and therefore felt disappointed, feeling that their discomforts and worries were not adequately listened to.

My GP does not take me seriously. I felt like I was being ignored as I told her that I feel tired and fatigued every morning I woke up. She told me to eat meat that is all. Then I went to Pakistan. There I got my blood done, and I was found to be diabetic and hypothyroid. I was very angry at her as she delayed it and I had to wait for the trip to Pakistan.

(Interview 20: Housewife with two children)

My husband is allergic to something. We went thrice to the GP, but he does not give him anything. So now he has stopped going to him, and we brought medicine for allergy from Pakistan or the supermarket.

(Interview 2: Housewife with three children)

Most mothers also reported that they preferred a female GP for themselves.

First response to children's sickness

Most mothers said that they treat their children first at home before taking them to the doctor. The majority, however, also added that it depended on the severity of the illness. For example, in the case of serious injuries, they immediately visited the doctor. Otherwise, they preferred to treat children at home for two to three days if they have a cold, fever or diarrhea. During this time, the mother observed the condition of the child. If symptoms worsened, they immediately took the child to the doctor. They thought that most of the time the initial treatment at home made children start to feel better.

If they (children) have a fever for one or two days, I will not take them to the doctor immediately. I already know that the GP will not give us anything. [laugh]

(Interview 13: Housewife with two children)

I decide, as I understand the condition better, how severe the condition is or how much the child was suffering from pain. Because I know when it is best to take them to the doctor.

(Interview 8: Housewife with two children)

Home remedies and self-medication

Most of the mothers said that they believed in home remedies, but added that they could not rely on them for their children's recovery and so used biomedicine. All the mothers mentioned that they had medicines for their children at home, which they used before visiting the GP. A few said that they used home remedies for minor to moderate symptoms. Some of the common ingredients used were lemon, honey, ginger, tea, mustard oil, fennel, black cardamom, and other herbs.

Just for common colds, honey, and ginger, if there is a sore tummy, mint and yoghurt.

(Interview 16: Full-time working with two children)

Yes, I mix honey and black pepper and give that for colds. For diarrhea, I usually give Isaphagol (psyllium husk) in yoghurt.

(Interview 8: Housewife with two children)

The decision to visit a doctor

Most mothers reported that they decided when to take children to the doctor. A few, however, also stated that they discussed the condition of their children with their spouse, and mutually decided when to visit the GP.

Me, this is not a decision. This is a responsibility. And this is my responsibility.

(Interview 4: Full-time working with two children)

I decide as I am taking care of them, so I do. Whenever they get sick, he asks me that they are getting sick, so should we take them to GP?

(Interview 13: Casual working with two children)

Mothers' expectations and disappointment

Most mothers mentioned that they preferred to treat children at home first because of their experience of not getting a prescription from the doctor. They interpreted this as the doctor not understanding them and were disappointed. Their expectations for "syrups, pills and injection" was due to their past experiences of the Pakistan healthcare system, where children usually get injections for the administration of antibiotics for symptoms similar to those reported by mothers in this study. It is also standard practice to immediately get a prescription if you visit a doctor, even for minor ailments. Therefore, mothers expect a prescription for instant relief for their children, who cannot feed or sleep properly and stresses the mothers.

I know the doctor will not prescribe them any medicine, so better to give them paracetamol at home. However, during the initial days, I used to take them more frequently to the GP.

(Interview 5: Housewife with two children)

All the participants said that being mothers meant they are the parent usually responsible for taking care of their children's welfare and so understand them. Yet, many commented that they felt that the GP did not give due attention to their concerns during appointments. Mothers reported that they were particularly distressed when their observations and recommendations were ignored.

Some participants thought that doctors in Pakistan were more knowledgeable than doctors in New Zealand when the latter used the internet to search for information about symptoms, diagnosis, and medicines.

In New Zealand, whenever you go to a GP, they start using Google in front of you. I really feel disappointed; if you want to see from there, then I can also use the internet to treat my children.

(Interview 9: Full-time working with two children)

Once I took my elder daughter to the GP for her arm as she was unable to move her hand. The GP started using Google; I was annoyed as she looked there how to move her hand.

(Interview 11: Housewife with two children)

Experience of rushed appointments

Mothers indicated that they felt discouraged and disrespected because they perceived the healthcare providers ignored them when they explained their children's symptoms and condition. Mothers expected the GP and nurses to be friendly, sincere, and understanding, to take a good look at the child's condition, to give proper time for an appointment, and not hurry. They wanted healthcare providers to respect them as mothers and relate well with them.

Mothers stated that often the GP was in a rush at the time of the appointment. They expected the GP to listen to all the concerns they had for their children and take time, rather than rushing. Most of the mothers mentioned that they made considerable effort to get to the medical center (often with other children), so they expected that the GP would reciprocate by taking them seriously. They knew that medical centers were busy, but they expected healthcare providers to give importance to their concerns. Mothers felt worried as they were not getting answers to their concerns for their children's health.

> *Like once, my elder daughter had a throat infection and no voice, and she was even unable to feed properly. GP said, I know she is sick, but I am not giving her any medicine. She even didn't give her paracetamol. I even requested antibiotics because previously, she had antibiotics for the same symptoms.*
>
> (Interview 11: Housewife with two children)

> *They gave you medicine when you are on edge, and things are worse. You must make three visits before you are being prescribed with antibiotics, so everyone should prefer to go to the GP at that stage when they immediately prescribed you antibiotics [laugh] after seeing you.*
>
> (Interview 15: Full-time working with two children)

Transportation barriers

Most mothers could not drive or did not have a car, and so must either wait for their spouse to come home after work or otherwise use public transport to access healthcare. Public transport was particularly difficult for mothers who had two or more children.

> *I must change two buses to reach the medical center with two children and when one is already sick as I do not know how to drive and we have one car which my husband uses. After 25 min of the bus ride and all the hurdles, the GP was not interested in listening and didn't give my son anything. I was so upset that I started crying on the bus on the way back home.*
>
> (Interview 19: Housewife with two children)

Most of the mothers said they would prefer to be accompanied by their husbands when visiting healthcare services. It was not easy when you did not have anyone to help you with other children.

> *One night both my children started vomiting at the same time, and my husband was not in the city. So, I took them to the Kenepuru after hours as I know how to drive, but it was so far from the city … and the place is very quiet and weird. You will never see a person outside. That place makes me scared to go there at night.*
>
> (Interview 4: Full-time working with two children)

After hours and emergency department visits

Mothers reported frequent use of after hours medical centers and hospital emergency departments. The reasons for this included the lack of availability of same day GP appointments, and the transport barriers mentioned above, which meant that they preferred to go with their husbands who were unavailable during working hours. While they often had to wait days or weeks for an appointment with the GP, at an after hours medical center or hospital emergency department the doctor was available on the same day. However, after hours and emergency departments had long waiting times.

> *Ahhhh… one night, my older son got a very high fever. It was very high. I think above 104. So, I immediately cooled him and took him as he was fainting to an emergency department. We went at midnight, and they sat us outside until morning. In the end, they just gave paracetamol. So, they should have told us to go home and give paracetamol.*
>
> (Interview 17: Housewife with two children)

Some mothers commented that there is always a long wait in an emergency department, so why is it known as this? They also compared the emergency department wait time in New Zealand and Pakistan and felt it was much longer in New Zealand.

> *There is a lot of wait in the emergency departments of hospitals in New Zealand. All the procedures are very fast in Pakistan as most doctors are in the emergency department. Like my elder daughter had a hand fracture and needed to wait for 3 to 4 h. If that happened in Pakistan, we don't need to wait.*
>
> (Interview 6: Casual working with two children)

Discussion

Memories of accessing health services at home and unsatisfactory experiences with a new healthcare system, lack of information, dissatisfaction with healthcare professionals, transportation difficulties, and long waiting times can lead to the underutilization of available healthcare services. These are familiar themes in the literature and are not specific to any one immigrant group or any one country. Researchers have provided various reasons for these barriers (Kalich et al., 2016; Mangrio and Persson, 2017; Saleem et al., 2019; Son et al., 2018). This study is different because the participants (Pakistani immigrant mothers in New Zealand) are a highly educated group of migrants, which makes it clear that their problems are not caused by a lack of education or literacy. Although we did not set out to recruit only highly educated Pakistani mothers, we found that most mothers were highly educated.

The study highlights the experiences of Pakistani immigrant women in New Zealand when trying to access and use healthcare services for their children. During the initial years of resettlement, mothers reported having difficulty in understanding and navigating complex systems, saying that it took at least two years to become familiar, and that they are still learning. Coming from a low middle-income country with different healthcare systems, and without any previous knowledge of the New Zealand healthcare system, led mothers to have to learn to navigate the unknown new system through experience. Information about health and the healthcare system, however, is necessary (Sørensen et al., 2012). Previous studies have shown that inadequate healthcare information hinders immigrants from accessing the healthcare system of a new country (Lewis et al., 2018). The literature also suggests that barriers such as language and discrimination can limit access to the healthcare system (Mbanya et al., 2019). During this study, these barriers were not evident. In Canada, Khanlou et al. identified other challenges immigrant mothers experience such as the need to complete a large amount of paperwork and having to reach geographically separate locations across a city for different services (Khanlou et al., 2015). Transportation was a common barrier reported by the mothers in the study. Most preferred to visit the GP with their husbands, as only a few were able to drive. Instead, they had to use public transportation which became even more difficult when they had other children with them. Most of them waited for their spouse to come home. A recent New Zealand study on barriers to accessing healthcare services for children with weight issues concluded that poor access remained a crucial barrier to achieving better health outcomes (Wild et al., 2021).

All the mothers in this study preferred to visit a GP or an emergency department/after hours medical facility for their children's health issues rather than visiting a pharmacy. They were unaware of the services provided by pharmacies in high income countries including New Zealand (Aziz et al., 2021; Houle et al., 2014; Naik Panvelkar, Saini, and Armour, 2009). This could also be due to their previous practice in Pakistan where pharmacies are only visited to buy medicines (Aziz et al., 2018. Migrants are thought to excessively use emergency departments for general health issues that a GP could treat. The principal finding of a systematic review of migrants' use of emergency departments in Europe was that migrants used these more than the host population (Credé et al., 2018). One study attributed this to an overwhelming feeling of needing urgent healthcare services among immigrants (Ruud et al., 2017). One of the most known barriers is the long waiting time at healthcare facilities (Flores et al., 1998; Gregory et al., 2013). Participants in this study revealed a more complex picture. Their use could also be due to the unavailability of an appointment with the GP on the same day or not having information about emergency appointments with a GP. The mothers first treated their children at home and then preferred to visit after hours medical facilities rather than a GP for their children because of transport issues and more timely availability of doctors.

A key issue for mothers in this study was their frustration at the lack of prescriptions from GPs (Akhtar et al., 2021). Very high levels of antibiotic use and easy availability of antibiotics in Pakistan is likely to have led to high expectations for antibiotic prescriptions. In contrast, in New Zealand antibiotics are not available over the counter and many initiatives have attempted to reduce antibiotic prescribing for infections that are likely to be viral in origin.

Participants also highlighted the need for good parent and provider relationships. This finding is consistent with previous literature which found that parents value the provider/parent relationship, appreciate providers who were caring, spend time with the child and knew the child's name, (Gregory et al., 2013; Zanchetta and Poureslami, 2006). The medical center's environment can give a sense of respect and dignity for the mother and her child.

New Zealand has established national health policies and procedures to attain specific healthcare goals. However, policy initiatives often focus more on educating healthcare practitioners on topics such as treating culturally and linguistically diverse patients. However, information, access and use of healthcare services by many of its citizens and residents remains challenging. Other practical policies and interventions are also required. These could include workshops for new immigrants about the New Zealand healthcare system which could provide parents with a forum to ask about children's healthcare services. In addition, interventions to improve mother's health literacy and improve parent–provider relationships could help increase satisfaction and communication. They could also assist healthcare providers with insight into mothers' past healthcare experiences and expectations for their children.

Strengths and limitations

This is the first study that provides in-depth insights into Pakistani immigrant mothers' access to and barriers in navigation of a new country's complex healthcare system for their children. It contributes to the limited international literature on immigrant mothers' experiences.

For practical reasons, the participants were recruited from one city. While specific details may vary around New Zealand, it is unlikely that the overall findings are affected. Indeed, Wellington as the capital city may be expected to have better services.

Conclusion

Despite being eligible for funded health care for children in New Zealand, and being highly educated, immigrant mothers in this study experienced a range of challenges and barriers that eventually often led them to avoid using appropriate healthcare services. Studies have concluded that parents experiencing stress and confusion while trying to access healthcare services for their children in a new country can have a negative outcome (Mangrio and Persson, 2017; Sime, 2014). This may have significant implications for the long-term health of immigrants' children.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Ahmed, S., Shommu, N.S., Rumana, N., Barron, G.R., Wicklum, S., Turin, T.C., 2016. Barriers to access of primary healthcare by immigrant populations in Canada: a literature review. J. Immigrant Minority health 18 (6), 1522–1540.

Akhtar, S.S., Heydon, S., Norris, P., 2021. Bringing medicine from pakistan and self-medication among Pakistani mothers in New Zealand. J. Immigrant Minority Health 1–7.

Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J., 2003. Culturally competent healthcare systems: a systematic review. Am. J. Prev. Med. 24 (3), 68–79.

Aziz, M.M., Masood, I., Yousaf, M., Saleem, H., Ye, D., Fang, Y., 2018. Pattern of medication selling and self-medication practices: a study from Punjab, Pakistan. PLoS ONE 13 (3), e0194240.

Aziz, Y.H.A., Heydon, S.J., Duffull, S.B., Marra, C.A., 2021. What free services do pharmacists offer? Investigating the provision of unfunded pharmacy services in community pharmacies. Res. Soc. Administrat. Pharmacy 17 (3), 588–594.

Berry, J.W., 1997. Immigration, acculturation, and adaptation. Appl. Psychol. 46 (1), 5–34.

Brinkman, W.-.P., 2009. Design of a questionnaire instrument. In: Love, S. (Ed.), Handbook of Mobile Technology Research Methods. Nova Science, New York (NY), pp. 31–57.

Coker, T.R., Chung, P.J., Cowgill, B.O., Chen, L., Rodriguez, M.A., 2009. Low-income parents' views on the redesign of well-child care. Pediatrics 124 (1), 194–204.

Credé, S.H., Such, E., Mason, S., 2018. International migrants' use of emergency departments in Europe compared with non-migrants' use: a systematic review. Eur. J. Public Health 28 (1), 61–73. doi:10.1093/eurpub/ckx057.

Creswell, J.W., Poth, C.N., 2016. Qualitative Inquiry and Research design: Choosing among Five Approaches. Sage publications, London.

Dias, S., Gama, A., Rocha, C., 2010. Immigrant women's perceptions and experiences of health care services: insights from a focus group study. J. Public Health (Bangkok) 18 (5), 489–496.

Flores, G., Abreu, M., Olivar, M.A., Kastner, B., 1998. Access barriers to health care for Latino children. Arch. Pediatr. Adolesc. Med. 152 (11), 1119–1125.

Goodyear-Smith, F., Ashton, T., 2019. New Zealand health system: universalism struggles with persisting inequities. The Lancet 394 (10196), 432–442.

Gregory, D.M., Newhook, J.T., Twells, L.K., 2013. Patients' perceptions of waiting for bariatric surgery: a qualitative study. Int J Equity Health 12 (1), 86.

Hjern, A., Bouvier, P., 2004. Migrant children—A challenge for European paediatricians. Acta Paediatr. 93 (11), 1535–1539.

Horne, R., Graupner, L., Frost, S., Weinman, J., Wright, S.M., Hankins, M., 2004. Medicine in a multi-cultural society: the effect of cultural background on beliefs about medications. Soc. Sci. Med. 59 (6), 1307–1313.

Houle, S.K.D., Grindrod, K.A., Chatterley, T., Tsuyuki, R.T., 2014. Paying pharmacists for patient care: a systematic review of remunerated pharmacy clinical care services. Can. Pharmacists J. /Revue des Pharmaciens du Canada 147 (4), 209–232. doi:10.1177/1715163514536678.

Huang, Z.J., Stella, M.Y., Liu, X.W., Young, D., Wong, F.Y., 2009. Beyond medical insurance: delayed or forgone care among children in Chinese immigrant families. J. Health Care Poor Underserved 20 (2), 364–377.

Kalich, A., Heinemann, L., Ghahari, S., 2016. A scoping review of immigrant experience of health care access barriers in Canada. J. Immigr. Minority Health 18 (3), 697–709.

Karim, N., Boyle, B., Lohan, M., Kerr, C., 2020. Immigrant parents' experiences of accessing child healthcare services in a host country: a qualitative thematic synthesis. J. Adv. Nurs. 76 (7), 1509–1519.

Kay, M., Jackson, C., Nicholson, C., 2010. Refugee health: a new model for delivering primary health care. Aust. J. Prim. Health 16 (1), 98–103.

Khanlou, N., Haque, N., Sheehan, S., Jones, G., 2015. It is an issue of not knowing where to go": service providers' perspectives on challenges in accessing social support and services by immigrant mothers of children with disabilities. J. Immigrant Minority Health 17 (6), 1840–1847.

Lewis, A.K., Harding, K.E., Snowdon, D.A., Taylor, N.F., 2018. Reducing wait time from referral to first visit for community outpatient services may contribute to better health outcomes: a systematic review. BMC Health Serv Res 18 (1), 869.

Mangrio, E., Persson, K., 2017. Immigrant parents' experience with the Swedish child health care system: a qualitative study. BMC Fam. Pract. 18 (1), 32–39.

Mbanya, V.N., Terragni, L., Gele, A.A., Diaz, E., Kumar, B.N., 2019. Access to Norwegian healthcare system–challenges for sub-Saharan African immigrants. Int. J. Equity Health 18 (1), 1–13.

Ministry of Health, 2012. New Zealand's Maternity and Child Health Services: preconception to 6 years [Internet]. Wellington: Ministry of Health. https://www.health.govt.nz/our-work/life-stages/child-health/new-zealands-maternity-and-child-health-services-preconception-6-years?.

Naik Panvelkar, P., Saini, B., Armour, C., 2009. Measurement of patient satisfaction with community pharmacy services: a review. Pharm. World Sci. 31 (5), 525–537. doi:10.1007/s11096-009-9311-2.

Radecki, L., Olson, L.M., Frintner, M.P., Tanner, J.L., Stein, M.T., 2009. What do families want from well-child care? Including parents in the rethinking discussion. Pediatrics 124 (3), 858–865.

Ritchie, J., Lewis, J., Nicholls, C., Ormston, R, 2013. Qualitative Research practice: a Guide For Social Science Students and Researchers. Saga, Los Angeles.

Ruud, S.E., Hjortdahl, P., Natvig, B., 2017. Reasons for attending a general emergency outpatient clinic versus a regular general practitioner–a survey among immigrant and native walk-in patients in Oslo, Norway. Scand. J. Prim. Health Care 35 (1), 35–45.

Saleem, A., Steadman, K.J., Fejzic, J., 2019. Utilisation of healthcare services and medicines by Pakistani migrants residing in high income countries: a systematic review and thematic synthesis. J. Immigr. Minor Health 21 (5), 1157–1180. doi:10.1007/s10903-018-0840-4.

Schiariti, V., 2016. The moral needs of migrant children: a call for global action. Acta Paediatr. 105 (5), 445–446.

Sime, D., 2014. 'I think that Polish doctors are better': newly arrived migrant children and their parents' experiences and views of health services in Scotland. Health Place 30 (2014), 86–93.

Småland Goth, U.G., Berg, J.E., 2011. Migrant participation in Norwegian health care. A qualitative study using key informants. Eur. J. Gen. Pract. 17 (1), 28–33.

Son, E., Moring, N.S., Igdalsky, L., Parish, S.L., 2018. Navigating the health-care system in community: perspectives from Asian immigrant parents of children with special health-care needs. J. Child Health Care 22 (2), 251–268.

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H., 2012. Health literacy and public health: a systematic review and integration of definitions and models. BMC Public Health 12 (1), 80.

Straiton, M.L., Myhre, S., 2017. Learning to navigate the healthcare system in a new country: a qualitative study. Scand. J. Prim Health Care 35 (4), 352–359.

Thomas, D.R., 2006. A general inductive approach for analyzing qualitative evaluation data. Am. J. Eval. 27 (2), 237–246.

Wild, C.E., Rawiri, N., Willing, E.J., Hofman, P.L., Anderson, Y.C., 2021. Health system barriers to accessing care for children with weight issues in New Zealand: an interview-based study. J. Health Serv. Res. Policy 26 (4), 234–241.

Zanchetta, M.S., Poureslami, I.M., 2006. Health literacy within the reality of immigrants' culture and language. Can. J. Public Health. Revue Canadienne de Santé Publique 97 26-S30.