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Chinese and Indian migrant mothers' perceptions and experiences of utilising maternal and early childhood healthcare services in Aotearoa New Zealand: a qualitative descriptive study

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ABSTRACT

Although the health system in Aotearoa New Zealand is based on universalism and equity, disparities exist in the uptake and quality of health care for ethnic-migrant mothers and their children. This qualitative descriptive study explored the perceptions and experiences of Chinese and Indian migrant mothers ($N = 24$) accessing maternal and early childhood healthcare services. Semi-structured interviews and focus groups were conducted and data were analysed using reflexive thematic analysis. Three themes were generated. Migrant mothers displayed limited awareness of services available for themselves and their children, and experienced difficulties navigating the complex and fragmented health system. Transnational ties influenced mothers' expectations of care and health seeking practices for themselves and their children. Mothers shared suggestions for a system that is inclusive of migrants' needs, such as offering orientation sessions to raise awareness and ease navigation challenges, having interpreters available and translated resources to support language challenges, and improve postpartum support as mothers adapt to motherhood. To improve health equity, it is important that national policy supports improvements to the health system to address the challenges faced by ethnic-migrant families when navigating health services.

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Early childhood; maternal; Asian; health services; primary care; access; equity; ethnicity; migrant

Introduction

Migration is a global phenomenon with international migrants currently representing an estimated 3.6% of the global population (United Nations Department of Economic and Social Affairs (UN DESA) 2021; International Organisation for Migration 2024). Although no universal definition exists for migrants, the term 'international migrant' generally refers to 'any person who changes his or her country of usual residence'

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(United Nations Department of Economic and Social Affairs 1998). Migration is a complex process influenced by various socio-economic, demographic, environmental, and geopolitical factors; many migrants relocate for reasons related to employment, family and/or education (International Organisation for Migration 2024).

Almost half of international migrants are female (International Organisation for Migration 2024). The global presence of women in migration reflects an important intersection of migration, ethnicity, gender, and motherhood. Access to quality health care in the pre- and post-natal period is important for both migrant mothers and their children. However, international literature indicates poorer accessibility and quality of maternal care for migrants than the local population, which has been attributed to many factors including language and communication, cultural differences, systemic racism, and structural barriers (Heaman et al. 2013; Keygnaert et al. 2016; Dougherty et al. 2020). Migrant mothers' pregnancy, childbirth, and motherhood experiences are influenced by dynamic societal and cultural values (Benza and Liamputtong 2014). In addition to challenges of raising children in a foreign country (Benza and Liamputtong 2014), migrant mothers can experience various barriers to accessing health services for their children (Huang et al. 2009; Tulli et al. 2020). Reviews have shown lower use of health services, except for emergency and hospital services, by migrant children compared to host populations (Markkula et al. 2018; Charania et al. 2019). The unmet health needs among migrant mothers and children indicates a need to understand and address the possible reasons with a focus on the type of service and region of origin (Keygnaert et al. 2016; Markkula et al. 2018).

Aotearoa New Zealand has experienced net migration over the years with various pathways for migrants to relocate, albeit this trend has been negatively impacted by the COVID-19 pandemic (Stats NZ n.d.-b). Against a backdrop of colonisation and biculturalism, NZ has a long history of gendered and racially driven migration policies pertaining to the Asian population (Badkar et al. 2007). The Asian population is the fastest growing ethnic group currently representing 15% of the total New Zealand population with projections to make up 26% of population by 2043 (Stats NZ 2022, n.d.-a). The Asian population represents much diversity in terms of ethnicity, culture, language, religion, and migration background (Stats NZ 2022, n.d.-a). Chinese and Indian are the two largest Asian ethnic sub-groups (Stats NZ 2019). Of note, over three quarters of Asians in New Zealand are migrants with the majority originating from Asia (Stats NZ n.d.-a). Approximately half of Asian New Zealanders are female and over half of them have children (Stats NZ n.d.-a).

The New Zealand health system is based on principles of universalism and equity, and financed primarily through taxation and includes access to general practitioner, midwifery, well child, immunisation, and hospital services, for those who are eligible (Goodyear-Smith and Ashton 2019; Gauld 2020; Te Whatu Ora Health New Zealand n.d.). A free, women-centred, continuity of care maternity system has been in place for three decades (Sandall et al. 2016). Specifically for children, 'zero-fee' policies attempt to reduce direct financial costs to accessing preventative and acute health services, including free doctor visits, vaccinations, and dental care (Ministry of Health 2019, 2020, 2022b). Despite 'universal' healthcare and various efforts to improve the system (e.g. accessibility, cultural safety, etc.), disparities exist in the uptake and quality of healthcare for ethnic minority migrant mothers and their children. Research points to a health system that is predominantly based on Western/Euro-centric norms thereby failing to address power relations

and appropriately incorporate different cultural beliefs and practices of ethnic minority migrant mothers and their children (DeSouza 2013, 2014; Guo et al. 2014; Akhtar et al. 2022; Sharma et al. 2023).

The presence of maternal health inequities are notable in New Zealand and found to be associated with socio-economic and health determinants (Dawson et al. 2022). For instance, poorer maternal and perinatal outcomes have been found among Asian women compared to New Zealand European/European women (Dawson et al. 2022). Numerous complex barriers to equitable maternal care in New Zealand have been identified, including difficulties in accessing care, political factors, acceptability, colonialism, the model of maternity care, and factors related to ethnicity, culture and race (Dawson et al. 2019). A recent study found that Asian mothers were more likely than New Zealand European mothers to see a GP while pregnant (Lewycka et al. 2023). However, Asian mothers were less likely than New Zealand European mothers to have their first-choice lead maternity caregiver (LMC); social factors, including discrimination by a health professional, largely explained the ethnic gap (Lewycka et al. 2023). Complex and dynamic factors influence the structural, cultural, and institutional competencies of maternal healthcare professionals, noting the implications of professionals' own personal and cultural positionality on delivering care for ethnic minority and migrant women in New Zealand (Sharma et al. 2023).

Differences in the uptake of child health services within the Asian group (Chiang et al. 2021) and between ethnic groups notes the influence of social determinants and structural racism (Clark et al. 2020; Lewycka et al. 2023). A study with Pakistani migrant mothers noted how lack of knowledge, differences between expectations and reality, and experiences of healthcare services impacted utilisation of healthcare for their children (Akhtar et al. 2022). There is limited evidence available regarding the access to and use of GP and dental services specifically for Asian children. A study using Growing Up in New Zealand (GUINZ) data reported that Asian mothers were less likely to be satisfied with their child's usual general practitioner (GP) compared to New Zealand European mothers (Clark et al. 2020). Moreover, Asian mothers were more likely relative to New Zealand Europeans to access dental care for their child at 2 years of age, but less likely at 4 years of age (Clark et al. 2020). An evaluation of New Zealand's B4 School Check (B4SC), the national child health and development check that includes an oral health component, found high overall engagement rates of 86% (just below the 90% target), but found that Asian children were significantly less likely than European/Other children to complete the B4SC (Premium Research Limited 2014). Inequities in dental caries experience among preschoolers has been shown to vary by ethnicity and socio-economic deprivation (Shackleton et al. 2018). In contrast, Asian children generally have the highest immunisation coverage rates compared to other ethnic groups (Ministry of Health 2022a; Lewycka et al. 2023) even when accounting for migration backgrounds (Charania et al. 2018). Current coverage rates (for the 24-months milestone age, reporting period from Oct-Dec 2023) for Asian children is 91%, higher than the other ethnic groups and the national rate of 81% (Te Whatu Ora Health New Zealand 2023). High immunisation coverage among Asian children has been attributed to positive parental vaccine attitudes and perceiving minimal barriers to accessing immunisation services (Pal et al. 2014).

The health needs of Asians continue to be overlooked in New Zealand's health policies and literature focused on Asian health and wellbeing is limited (Wong 2015; Chiang et al.

2021). Specific research on Asian migrant mothers accessing healthcare for themselves and their children is scant (Chiang et al. 2021). It is important that research reflects the ethnic and cultural diversity within the Asian ethnic group and explores how migration influences mothers' health practices and behaviours for themselves and their children. Quantitative analyses cannot explain all the factors influencing ethnic gaps in the uptake of maternal and child health services; thus, it is important to qualitatively explore reasons for underutilisation to inform improvements to policy and practice (Clark et al. 2020; Lewycka et al. 2023). Thus, the aim of the presented research was to explore the perceptions and lived experiences of Chinese and Indian migrant mothers (as these are the two largest Asian ethnic sub-groups) about navigating and utilising maternal and early childhood healthcare services for their children in New Zealand.

Methodology and methods

A qualitative descriptive study (Sandelowski 2010; Bradshaw et al. 2017), involving semi-structured interviews and focus groups, was conducted to collect rich and in-depth insights. This study was part of a larger multi-methods research programme comprised of quantitative and qualitative studies seeking to examine and explore factors that influence ethnic disparities in accessing early childhood healthcare services (Anguera et al. 2018). Ethical approval was granted by the Auckland University of Technology's Ethics Committee (Reference #: 20/160).

Study site and participants

Participants were recruited from the Tāmaki Makaurau (Auckland) region as it is home to the two largest Asian sub-groups who identify as Chinese and Indian (Auckland Council 2021; New Zealand Government 2022). Participants were eligible if they were 18 years or older, had a preschool aged child (2–8 years old) and identified as being of Chinese or Indian ethnicity. Purposive and snowball sampling guided recruitment, with the aim of ensuring diversity across various characteristics such as age, socio-economic status, and level of engagement with health services. Recruitment was supported by our personal and community networks, in addition to contacting various organisations (e.g. Plunket). We posted flyers in community venues and posted on social media platforms to reach potential participants. Interested participants had their eligibility confirmed and were then provided with the participant information sheet and consent form to review before providing informed written consent. The final sample size was guided by practical considerations and our previous research experience (Braun and Clarke 2021). We also considered the study aim, methods of data collection and analysis, and depth of the produced data when determining the final sample size (Braun and Clarke 2021).

Data generation

A semi-structured question guide was developed and vetted through the Advisory Committee of the wider project who represented various organisations that deliver health services. The questions were slightly modified to improve clarity and flow. The guide was

further modified based on pilot interviews conducted with two Chinese and one Indian mother to ensure the questions were culturally appropriate. The guide focused on exploring Chinese and Indian mothers' perceptions and experiences of assessing healthcare services for themselves and their children, with a focus on factors that influence their decision-making process and suggestions for improvement. Participants also completed a brief demographic form to gain background information.

Focus groups were the primary method of data generation; three focus groups were conducted with Chinese migrant mothers and two focus groups with Indian migrant mothers. For pragmatic reasons, individual interviews were offered to support recruitment efforts among Indian migrant mothers as this method better catered to their availability (Lambert and Loiselle 2008). Mothers who participated in interviews versus focus groups did not vary in relation to the phenomenon of interest. We used the same question guide for all data generation sessions and were cognizant of the contribution of each method when analysing the data (Lambert and Loiselle 2008). Interviews and focus groups were scheduled either in-person or virtually based on participants' preference between January and June 2021. The interview and focus group locations were determined by the participants for their convenience and included their homes, university meeting rooms, and via Zoom. Sessions lasted between one to two hours depending on the method of data collection. All participants were given a voucher (koha) in appreciation for their time and contributions.

Participants were given the choice of Hindi, Mandarin, and English language options as researchers were bilingual. All researchers identify as migrants and are of either Chinese (HQ) or Indian (AB and NC) ethnicity; thus, they are familiar with migration journeys and relevant cultural nuances (e.g. appropriate ways to dress and greet people). This enabled us to create a safe and trusting environment for participants to share their experiences. For Chinese participants, all the focus groups were conducted in Mandarin. For Indian participants, all interviews and focus groups were conducted in English except for one in Hindi.

Data analysis

Interviews and focus groups were audio-recorded with each participant's permission. Data collected in English were transcribed by a third party and checked for accuracy. The focus group that was conducted in Hindi was translated and transcribed verbatim into English by one of the researchers (AB). The focus groups conducted in Mandarin were transcribed and analysed in Mandarin by another researcher (HQ) with only the relevant portions translated for reporting. Translating only relevant portions ensured keeping as close to the data as possible. With this approach, we aimed to maintain the integrity of the original data and ensured that the translated portions do not result in loss of meaning (van Nes et al. 2010).

Reflexivity, which are the ways in which researchers probe into how their background and positioning influence the research process, is paramount to qualitative research given the intersubjective nature of the researcher-participant relationship (Braun and Clarke 2013, 2022). Each researcher kept a reflexive researcher journal and engaged in regular in/formal discussions to meaningfully reflect on our positionality as the study progressed (Kohl and McCutcheon 2015; Folkes 2022). As noted above, all authors are ethnic

minority migrants who have firsthand experience in navigating a health system that is different from the one in their respective countries of origin thereby sharing some similar lived experience to the participants. AB has an educational background in health sciences, social psychology, and mental health, and over six years of qualitative research experience. Due to her research focus on Indian youth and stress, the mental health concerns expressed by mothers, how eligibility criteria can constrain access to services, and how utilisation of services could impact their children's health and wellbeing particularly resonated with her. HQ has a background in tourism and migration studies, with a focus on the experiences of international students during their doctoral studies and the experiences of female Chinese migrants of online harassment. Her background made her particularly aware of financial pressures, cultural nuances, and discrimination expressed by participants. NC has an educational background in health and environmental sciences and public health, and fifteen years of qualitative research experience. She came to this research as a migrant mother, being aware of the experiences of navigating health services as a new mother and the range of emotions expressed by the mothers.

As the focus was on mothers' perceptions and experiences, we drew from an interpretivist research paradigm and employed an experiential orientation to data analysis following Braun and Clarke's six phases of reflexive thematic analysis (Braun and Clarke 2013, 2022; Braun et al. 2018; Terry and Hayfield 2021). Data management and analysis was supported by using QSR NVivo® computer software (QSR International Pty Ltd., Doncaster, Victoria, Australia). Within each ethnic group (dataset), familiarisation involved re-reading transcripts and making notes. For each dataset, initial codes were inductively developed and focused on both the semantic and latent aspects (Terry and Hayfield 2021; Braun and Clarke 2022). Codes were then clustered to construct prototype themes across both ethnic groups (data corpus). Throughout the coding and prototype theme generation process, we met regularly as a research team to discuss ideas. Thematic maps were used to help visualise relationships between themes and encompassing codes (Braun and Clarke 2022). Care was taken as a team when iteratively refining and naming the themes and drafting the findings to ensure that all important meanings within the raw data were appropriately presented. Our analysis was guided by published tools for demonstrating quality reflexive thematic analysis (Braun and Clarke 2020; Braun and Clarke 2023).

Results

The participants were 24 mothers of Asian descent (12 Chinese and 12 Indian). [Table 1](#) outlines the collected demographic information. Notably, most mothers were between 30 and 39 years old and held a Bachelors or higher degree. All the mothers were born overseas in China or India, and migrated to New Zealand. Nearly three quarters (71%) of participants had been in New Zealand for 5 years or longer. All the mothers, except for two who returned to India to give birth, delivered their children in New Zealand. The following section presents the generated themes supported by participants' quotes to demonstrate the quality of the presented analysis (Finlay 2006); pseudonyms were used to protect participants' privacy.

Table 1. Demographic characteristics of study participants ($N = 24$).

Characteristic	Indian mothers $n = 12$ (%)	Chinese mothers $n = 12$ (%)
Age (years)		
18–29	1 (8)	–
30–39	8 (67)	8 (67)
40–49	3 (25)	4 (33)
Duration of residence in New Zealand (years)		
1–4	2 (17)	5 (43)
5–9	5 (42)	3 (25)
10+	5 (42)	4 (33)
Highest level of education		
High school	–	4 (33)
Bachelor	5 (42)	5 (42)
Post-graduate/Masters/PhD	7 (58)	3 (25)
Occupation		
Self/employed	12 (100)	4 (33)
Unemployed	–	–
Caregiver	–	8 (67)
Annual household income (NZD)		
<\$25,000	–	9 (75)
\$26,000–\$50,000	2 (17)	1 (8)
\$51,000–\$75,000	2 (17)	–
\$76,000–\$100,000	3 (25)	–
More than \$100,000	5 (42)	1 (8)
Enrolled with a general practitioner		
Yes	12 (100)	12 (100)
No	–	–
Enrolled with a dental clinic		
Yes	10 (83)	9 (75)
No	2 (17)	3 (25)
Immunisation status		
Fully	12 (100)	4 (33)
Partially	–	8 (67)

Awareness and complexity of the health system

Most participants expressed that they were not aware of the available health services during pregnancy and for their children, and they also mentioned the difficulties they faced when trying to navigate the complex health system. As all the participants were migrant mothers, they lacked familiarity with how the health system functioned in New Zealand and the role of certain health professionals, especially midwives. Most of the mothers were also not fully aware of how to navigate the private healthcare system in New Zealand. Navigating the health system was particularly challenging as they had limited to no support available to them:

... [I had] a pretty hard time to find a good midwife because when I was pregnant for the first time, I didn't know anything, and New Zealand is a new country. And I didn't have anyone, didn't know anyone, and had no family and no friends. (Indian mother #9)

The mothers mentioned that once they established their 'informal channel' in New Zealand, it became easier for them to learn about and navigate the health services available to them. Participants expressed that they received information about various services available to them through their networks of family, friends, and colleagues:

They [family and friends] provide more information sometimes than the midwife. Like experienced moms, moms who already have kids who have been through that stage ... (Indian mother #2)

Mothers also discussed various barriers to accessing health services for their children. Having to manage the language barrier was one of the key barriers to accessing health services among Chinese migrant mothers regardless of their duration of residence, which further added to the system's complexity. A mother talked about how she factored in needing help from others to interpret during appointments in her decision to seek medical care for her child:

For any kind of appointment including GP and doctor, the first thing is to make an appointment. No matter how much time it takes, I have to use translation. And I need to ask others to help make the call every time ... sometimes I don't want to bother others, so I would rather not see the doctor. (Chinese mother #10)

Mothers reported long wait times to get GP appointments and dental visits, which acted as a barrier to accessing timely care. Participants perceived health services to be slow, which was particularly problematic when their child was acutely sick:

The main problem is the long wait. When the kids are small, for example, they get fever. We cannot get the appointment three days later and by then they've already recovered. (Chinese mother #2)

Moreover, mothers perceived that the health system was overwhelmed and overworked, particularly Plunket (the national health and wellbeing service for young children), which resulted in delays in accessing services and feeling unsupported during the post-partum period:

They're [Plunket] very, very good but I think there is just not enough of them to come back to you frequently or to just be available for you more than what you need. Those initial few months you really need a lot of support. (Indian mother #4)

Another barrier that was highlighted among some Indian mothers was that their child's eligibility to access health services was dependent on their visa status. Indian mothers spoke of having to pay out-of-pocket for services and delays in receiving treatment for their child because they needed to first fill out paperwork. The financial costs associated with accessing healthcare was particularly problematic for Indian mothers given other financial pressures. Due to the high cost of early childhood care, one mother decided to send her child to stay with family back home in India:

... we were spending a lot of money for her daycare because she [daughter] was under three years, so she wasn't getting any free hours for daycare. So, we were spending more than \$60 per day for her daycare, so it was quite expensive for us. So that's why me and my husband decided to leave her with my mom and dad [in India]. (Indian mother #9)

She [daughter] was not covered on Plunket for one year because we were on work visas, and they don't cover you. (Indian mother #5)

To summarise, the lack of awareness and perceived complexity of the New Zealand health system stemmed from Chinese and Indian mothers' different health practices and health system expectations owing to their upbringing in their home countries. The following theme emphasises how these transnational expectations and practices influenced migrant mothers' health seeking behaviours for their children.

Transnational expectations and practices

All the mothers in this study compared New Zealand's health services and healthcare professionals to that of their home countries. Although some mothers mentioned that healthcare professionals were friendly, there was a general lack of trust in doctors in New Zealand among the participating mothers. Some mothers believed that doctors in China and India were more competent and knowledgeable than doctors in New Zealand owing to some of their practices. For instance, a mother spoke of how a New Zealand doctor used the internet to search for information regarding their symptoms which undermined her trust and confidence in the doctor.

I saw the GP searched on Google before saying anything about my problems. It is unbelievable ... (Chinese mother #3)

Furthermore, most of the mothers were disappointed that basic diagnostic tests were not conducted by doctors in New Zealand when their children were sick. Mothers felt that requesting basic diagnostic tests was a reasonable request and felt dismissed when doctors did not concur and comply. Not undertaking these 'basic checks' led to some mothers perceiving doctors in New Zealand to be unreliable regarding their diagnosis and proposed treatment plan. Because of the aforementioned factors, some mothers mentioned that they prefer to travel back to their home country to receive care because of their trust in the doctors, and it is easier and faster to access care:

My kid had an extra teeth [sic] when she was 3 years old and we have been waiting for the dentist. Now two years have gone, and we are still in the line ... When we went back to China, we paid ourselves and extracted the tooth. (Chinese mother #4)

Migrant mothers compared the process and wait time to consult a specialist in New Zealand to that in China and India. Mothers stated that they had easier and faster access to specialists and private clinics in China and India compared to New Zealand, where a referral from a GP is first required and then there is a substantial waiting period to access specialists.

Most of the mothers in this study stated that they treat their children at home before taking them to the doctor since they knew doctors would only recommend paracetamol for everything. Moreover, there would be long waiting times and 'you never know when can we see the doctor, maybe a few hours, maybe the whole day' (Indian mother #2). However, they said that their use of home remedies was dependent on the severity of their child's sickness. For instance, if their child was seriously injured or had a high fever, they went to the doctor immediately. Otherwise, if their child had a mild cold or fever, they preferred to first treat them at home. They believed that most of the time, home remedies made their children feel better:

The doctors here usually don't give you any medicine. Whenever I go back [to China], I take a lot the traditional Chinese medicine. It is mild and not that strong. The children can take them. (Chinese mother #7)

Only when he got fever, the high one, I would take him to GP. Otherwise, I usually give him some medicine if he coughs or has loose bowels at home, the few common medicine. (Chinese mother #8)

In addition, Indian mothers' narratives underpinned the importance of caring for the mother's mental health and wellbeing following childbirth. Culturally, it is customary for new mothers and their child to be cared for by their family members in India. That support structure, however, does not exist in New Zealand for many of the Indian migrant mothers. Furthermore, after childbirth, all the attention shifts to focus on the newborn's health and wellbeing, while the mother's needs are often overlooked by health-care professionals:

... when I got home, I was on borderline depression, so postpartum depression, and when I asked my midwife, 'Hey, I've got these feelings.' And so on and so forth, I really didn't receive any like, 'Oh, you've got this, you can ask your GP to assess you, and then we can give you some mental wellbeing support.' It just seemed very difficult to ask for help in terms of postpartum. It wasn't like, 'Oh, you feel really low, let me get a counsellor and you can speak to them, I'll give the counsellor your number.' (Indian mother #4)

Therefore, there is a need for the health system to account for migrant mothers' needs and transnational influences. This is expanded upon in the next theme.

A system inclusive of migrants' needs

Mothers highlighted the need for the health care system to be inclusive of migrants' needs. To address the language barrier, it is crucial to offer interpretation services and translated resources at each health encounter. This would help provide reassurance to mothers that they could appropriately express themselves during health appointments and be able to understand the healthcare professionals:

I think no matter how much English you can speak, no matter how long you have lived in NZ. As long as English is your second language, you'll always find it difficult to understand some parts of the conversation with doctors, especially when you are worried [sic] about your children ... you cannot fully understand them, so the hospital would consider to offer the translation services to migrants. (Chinese mother #6)

While all mothers stated that healthcare services were 'quite accessible' (Indian mother #3) and that they had no difficulty with transportation to reach those services, they did face challenges of awareness and navigation. To raise awareness of services available to them and how to navigate services, mothers suggested providing an orientation to the health system for migrants. For example, a Chinese mother shared her experience of working in Japan where she was provided with an orientation, which she believed would be valuable for New Zealand to offer:

In the first week when we arrived in Japan, they provided a whole week training including the national system, rubbish recycling, and medical system ... Some basic trainings, for example, how and where to register GP, the process for seeing a doctor when you are sick, the emergency number, etc. These would be valuable for people that are new to New Zealand, especially those that cannot speak English. (Chinese mother #11)

All the mothers in this study emphasised the importance of immunisation for their children. They placed a high value on GP advice, particularly regarding vaccinations. 'For the vaccine ... I would definitely turn to ask the doctor. They are the experts and I trust their judgment' (Chinese mother #G2). However, there were inconsistencies with receiving vaccination reminders from their child's GP office. Chinese migrant

mothers stated that they did not receive reminders and had to proactively book vaccine appointments for their children, whereas Indian migrant mothers were satisfied with the promptness of vaccination reminders from their child's GP office:

GP will send the reminders. So, we get our vaccination done. For my one [child], especially, I get the reminder from the GP. If you're enrolled in a particular medical center, then they do the reminder. (Indian mother #6)

In addition, some Indian migrant mothers stated that telehealth services, such as PlunketLine and Healthline, were particularly beneficial because they could contact a healthcare professional at any given point if their child felt sick and they needed to seek assistance. For instance, a phone call to Healthline enabled them to understand the severity of their child's illness and assess if urgent doctor's care was required:

Over the phone only, they'd ask you several questions just to assess if things are ... Then they would analyse to see what's going on. And if it's really bad, then they'd guide you or wait and see for 24 hours, or just go straight over to a GP or a doctor or whatever. (Indian mother #6)

On the contrary, Chinese migrant mothers were opposed to seeking telehealth services for their children because they believed that unless the doctor saw the patient in person, they would not be able to provide an accurate diagnosis or treatment. Moreover, language barriers would be more pronounced over the phone, making it more challenging to communicate their concerns:

Due to the language barrier, I have a feeling of uncertainty. I am concerned that what if I cannot understand what the doctor says. (Chinese mother #1)

There was a disconnect between migrant mothers' expectations of care and what was done in practice. For example, some migrant mothers expected that medical tests would be undertaken to support a diagnosis of their child's health condition (s) and the treatment plan rather than simply observing the child. Some migrant mothers suggested that doctors in New Zealand need to be more attuned to their expectations and requests as this may aid in building their trust in doctors' competence and skills:

I think they need to do some check for the children that are quite sick, for example blood test, which is necessary for the doctors to check the potential reasons. (Chinese mother #3)

Migrant mothers were aware of ongoing shortages of medical personnel, stating that the issue of long wait times for health care for their children was caused by a 'limited number of GPs, doctors and hospitals' (Chinese mothers #2, #6, #10). Migrant mothers suggested that healthcare resources need to be allocated more fairly to make the healthcare system more inclusive and accessible. Noting the variances between different public health facilities and between private and public health facilities, a mother suggested:

... more doctors in the emergency department, a better balance of doctors/nurses between public and private hospitals, hospitals & ShoreCare [urgent medical services]. (Chinese mother #7)

Discussion

Reducing inequities in maternal and child health is a global health priority (United Nations *n.d.*). Research among Asians and ethnic minorities in New Zealand demonstrate that the relationship between ethnicity, culture and cultural practices, migration, and the healthcare system are important health determinants (Chiang et al. 2021). This study contributes to our understanding of how these interrelated factors influence utilisation of early childhood health services among Chinese and Indian migrant mothers. This study noted several challenges they encountered while accessing healthcare services for themselves and their children, many of which stemmed from their transnational ties and different expectations of postpartum and early childhood care.

Similar to a study with Pakistani migrant mothers, mothers in our study had limited knowledge about services available for their children and found it difficult to navigate health services, particularly during the initial years following relocation (Akhtar et al. 2022). Health care systems in many countries have become more complex and confusing with increasing fragmentation of specialties, which can be particularly difficult for migrants to navigate (Rechel 2011). The health system was perceived by Chinese and Indian migrant mothers to be complex and fragmented, and lacking social support in a new country compounded their limited awareness and navigation challenges. It was only once migrant mothers developed their networks and had to engage with the system that they gained an awareness of the various services available for themselves and their children.

Our study also highlighted that visa status was an important barrier as some Indian mothers mentioned that their child was not eligible for publicly funded healthcare as it was determined by their visa status. An Indian mother in our study elaborated on how the additional costs to access health care for her child compounded other financial burdens, such as early childhood education, and thus she had to make the difficult decision to send her child to stay with grandparents back home. Children are only eligible if their caregiver meets the eligibility criteria; of relevance to this study, a child's caregiver must be a citizen or permanent resident of New Zealand or Australia, have a valid interim, be on a work visa that entitles them to live in the country for two year or more, or have refugee or protected persons status (Te Whatu Ora Health New Zealand *n.d.*). In contrast to our findings, Akhtar et al. (2022) did not note visa status as a barrier to Pakistani migrant mothers accessing care for their children; this is likely due to majority of their participants being residents and thus eligible to access public funding for healthcare for themselves and their children. Our finding raises an important issue of how national policies of child health care eligibility can create inequities among migrant children. For instance, while immunisations are free no matter a child's citizenship or immigration status, access to other child health services, including GP appointments and hospitals, are not, thereby compounding financial burdens among migrant families.

Furthermore, literature notes that factors such as language proficiency, transportation, long wait times, and discrimination can create hurdles for migrant mothers when accessing the healthcare system for their children (Akhtar et al. 2022). Language barriers were evident in our study, particularly among Chinese migrant mothers as they were concerned about being able to express their concerns and understand information from the GP. Literature supports the use of interpreters, bi/multilingual health providers,

and translated materials to help overcome language barriers (Merry et al. 2020). Transportation issues were not evident in our study as getting to and from health facilities was not a challenge mothers experienced. Mothers in our study did report challenges with long wait times to see healthcare professionals. Mothers stated that they could not book same-day appointments to see a GP for their sick child, and there was a lengthy process to consult specialists. Thus, mothers preferred to treat their children at home rather than going to the doctor and in the case of Indian mothers, consult telehealth services (i.e. health phone lines). Chinese and Indian migrant mothers also experienced discrimination from healthcare professionals as they were perceived to always give medicine to their children. Previous research noted that nurses stereotype ethnic minority and migrant mothers based on their cultural group (DeSouza 2013; Sharma et al. 2023). Nurses' discourses reflected that individuals (in this case non-white migrant mothers) and their culture were to blame for health disparities rather than health system (DeSouza 2013).

A meta-synthesis about the lived experiences of migrant women during pregnancy, childbirth and motherhood noted how their expectations of services and practices in their host country was influenced by the experiences from their country of origin (Benza and Liamputtong 2014). Similarly, our study found that Chinese and Indian migrant mothers' experiences engaging with the health system in their country of origin influenced their health behaviours and their expectations of New Zealand's health system and healthcare professionals. Research among Asian migrant mothers indicates that it is common practice in their countries of origin to undergo various maternal medical procedures and tests (e.g. ultrasound scans and tests), and these results provide reassurance for expecting mothers that everything is all right (DeSouza 2014; Guo et al. 2014). Indeed, a review noted unmet expectations in prenatal care among migrants due to different experiences in their home countries (Merry et al. 2020). In our study, these notions were also apparent with the care Chinese and Indian migrant mothers expected to receive for their children. They felt disappointed and dismissed when providers did not undertake medical tests for their children during health appointments, and this eroded their trust in New Zealand doctors' skills and competence. Our study reflects that Chinese and Indian migrant mothers struggle with transitioning to the New Zealand health system that was perceived to be less medicalised compared to the health system in their respective country of origin. This finding indicates that health services for migrant mothers and their children are not sufficiently responsive to their transnational ties and expectations of care, which supports findings from a recent integrative review (Merry et al. 2020).

Transnationalism generally refers to the socio-economic, cultural, and/or political ties and interactions that migrants maintain with their place(s) of origin (Tedeschi et al. 2020). Migrant mothers in our study displayed transnational health seeking practices as some chose to travel back home to deliver their child, for their child's care, and/or sourced medicines from their home country. To overcome challenges to accessing health services in New Zealand, particularly related to long wait times, language barriers, and perceptions of quality of care, some mothers travelled to their home country to seek health care for their children. This is consistent with the findings of a systematic review highlighting migrants' transnational health seeking practices across borders to receive more accessible, appropriate, and timely care (Villa-Torres et al. 2017). Moreover,

mothers in our study mentioned that they brought medicines from their home country to treat their children. This is consistent with the findings from Babar et al. (2013) which stated that Asian migrants bring traditional medicines when they return to New Zealand from their country of origin. This practice among Asian migrants reflected limited information about medicine use in New Zealand, different expectations of medicine access compared to their home countries, language and cultural influences, perceptions of traditional versus modern medicines, and financial burdens (Babar et al. 2013). Collectively, these findings indicate migrant mothers' parallel use of health care systems and medicines available in their countries of origin and residence to optimise care for their children.

Similar to a previous study, Chinese and Indian migrant mothers in our study struggled postpartum with limited (or no) support and increased childcare responsibilities (Rao et al. 2020). The postpartum phase is characterised by a variety of psychological, emotional, and physical stressors on women. Moreover, being a mother in a new country brings many challenges, particularly the loss of supportive networks during a critical time period, which can lead to new mothers feeling lonely and isolated (DeSouza 2006). Research has also shown that the mother's mental health is negatively affected by experiencing racial discrimination (Becares and Atatoa-Carr 2016). Expectations of support can impact ethnic mothers' ability to mobilise support among their social networks (Negrón et al. 2013). The attentiveness and support that Asian migrant mothers socially and culturally expect to receive from their extended families in their home countries is lost through the migration journey (DeSouza 2006; Qureshi and Pacquiao 2013). For instance, in India, postpartum care involves social, emotional, and practical support for new mothers; special care is provided including restricting strenuous activity and getting plenty of rest (George et al. 2022). It has been demonstrated that social support is instrumental in assisting women with coping with these challenges postpartum (Negrón et al. 2013); however, mothers in our study reported that they experienced much distress postpartum that stemmed from lack of family support as they had to manage everything on their own.

Implications for policy and practice

Our study has important implications and suggested improvements to the health system to better support Chinese and Indian migrant mothers accessing health services for their children. First, to support knowledge and navigation of the health system, mothers suggested that workshops would help educate and orient migrants to the New Zealand healthcare system. This would provide a forum to raise awareness among migrant mothers about the healthcare services available for their children and how to navigate them, and discuss their expectations of care. Newly introduced initiatives, such as the Healthy Mother Healthy Future (HMHF) programme to improve Asian perinatal and infant outcomes, will hopefully help address this need. Second, eligibility to access publicly funded child health services should not be based on visa status as this compounds challenges faced by migrant families and creates inequities in accessing care. Considering the New Zealand health care system is based on the principle of equity, children of migrant backgrounds should have equitable access to child health services no matter their citizenship or immigration status. Third, supporting calls from previous research,

accessible and appropriate interpreters and translated resources are required to support migrant mothers from culturally- and linguistically diverse backgrounds. Fourth, health services and professionals need to be more responsive to the needs of migrant families and account for their transnational ties and provide culturally safe care (Merry et al. 2020). For example, this can be achieved by demonstrating willingness to embrace religious, cultural, and linguistic diversities and by actively supporting migrants in maintaining their cultural and religious traditions, thus fostering their transnational sense of self (Kaihlanen et al. 2019). Lastly, motherhood and migration represent two major life events, and migrant mothers experience unique pressures and challenges during pregnancy, birth, and postpartum (DeSouza 2006; Rao et al. 2020). Thus, more support is needed for migrant mothers postpartum as they adapt to their new country and new role as a mother.

Strengths and limitations

There is limited literature focusing on ethnic minority migrant mothers accessing health services for themselves and their children. While this study gave useful insights into Chinese and Indian migrant mothers' perceptions and experiences accessing healthcare for children in New Zealand, the results are not generalisable on a statistical basis due to the nature of it being a small qualitative study. We have provided a detailed discussion of our study process, and some of our findings may be applicable to other ethnic minority groups and health-care settings. Furthermore, despite our efforts to recruit participants with diverse levels of interaction with health services, all the mothers in our study reported that their children were enrolled in a GP office and were vaccinated thereby demonstrating a level of engagement with the health system. Further research is warranted to explore the views of migrant mothers who have limited engagement with New Zealand's health care system as they may have additional unique challenges. Moreover, research that explores how experiences may vary by duration of residence is recommended. Future research is also needed as the Asian ethnic group has considerable diversity, and it is pertinent that this heterogeneity is not overlooked.

Conclusion

Despite universalism and equity underpinning the New Zealand health care system, our study points to substantial challenges faced by Chinese and Indian migrant mothers when accessing care for themselves and their children. The health system reflects structural barriers to accessing care among migrant families related to awareness, navigation, language, and quality of care. Moreover, the health system is not sufficiently responsive to the transnational ties and different expectations of care of migrant families. It is vital to better support ethnic minority migrant mothers and their children with accessing health care to improve health outcomes.

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Data availability statement

The datasets generated and analysed during the current study are not publicly available due to privacy and ethical reasons. The collected data is of a sensitive and personal nature, and was collected from participants on the basis that strict confidentiality would be maintained. Data can be available from the corresponding author on reasonable request and will require completion of relevant confidentiality agreements.

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