Evaluating Health Service Users' Satisfaction with the Quality of Health Care Services in New Zealand: A Qualitative Study of Kurdish Immigrants

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Abstract

Background: The relationship between health care quality and service users' satisfaction has gained considerable attention in many countries, including New Zealand. It is essential to comprehend the concept of quality across all sectors, including health as it plays a significant role in fulfilling the needs of services users. This research evaluated health care users' satisfaction with the quality of health care services in New Zealand by utilising Donabedian's model of Structure, Process and Outcomes. Donabedian's model facilitated a comprehensive analysis aiming to identify distinct aspects of health care quality in New Zealand.

Method: This study utilised a qualitative descriptive methodology to explore the quality of health care services in New Zealand for Kurdish immigrants. To generate new and exploratory data, face-to-face interviews were conducted with 20 Kurdish immigrants who used health care services in New Zealand within the past 10 years. Data collection occurred place between February and April of 2022 and participants were selected from various regions in New Zealand, with ages ranging from 21 to 67 years. Semi-structured interview questions, adapted to reflect Donabedian's model of quality of care, were used to collect data. The collected data were analysed using NVivo Software and Braun and Clarke (2006) thematic analysis.

Results: The results of this study produced four key themes and eight sub-themes that shed light on Kurdish health care users' satisfaction with the quality of health care services in New Zealand. Among the themes, participants emphasised the barriers to accessing health care services, which included both external and internal barriers. External barriers such as COVID-19 protocols, discrimination, the shortage of doctors, and the lack of follow-up health care users' health issues and access were identified as major challenges to accessing health care services in New Zealand. Participants also identified other barriers, including language issues, lack of health education and cultural aspects, that hindered their full access to health care services.

Additionally, participants described the health care settings' structures and procedures as key dimensions that impacted their satisfaction with the quality of health care services. Participants acknowledged that the physical and psychological aspects of

health care provider's environment had an impact on their health and well-being. Furthermore, participants expressed satisfaction with the quality of confidentiality services delivered. Kurdish health care users indicated that health care providers were serious about keeping the health issues of health care users confidential. Participants also highlighted the polite and respectful behaviour of the health care settings staff.

Conclusion: This research represented a novel contribution to the understanding of Kurdish immigrants' perspectives on the New Zealand health care system. The results of the study showed that participants viewed some aspects of health care delivery positively, such as the politeness of staff, ongoing renovation, punctuality of emergency response teams, documentation, confidentiality of health records and attractiveness of children's rooms. However, the study also highlighted areas in need of improvement, particularly the waiting halls, which should focus on the provision of a clean environment, discrimination-free and interpretation services. The findings of this study provided valuable insights that can inform efforts to improve the quality of health care services for other immigrant populations in New Zealand, contributing to the successful integration of immigrants into New Zealand society.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

17/10/2023

Signature   Date

List of Abbreviations

ASQC   American Society for Quality Control

AUDC   Australian Unity Dental Centres

AUTEC   Auckland University of Technology Ethics Committee

EHR   Electronic Health Records

GP   General Practitioner

IOM   Institute of Medicine

KDP   Kurdistan Democratic Party

KRG   Kurdistan Regional Government

NZKC   New Zealand Kurdish Community

PUK   Patriotic Union of Kurdistan

QSCNZ   Quality and Safety Commission of New Zealand

SPO   Structure, Process and Outcomes

UDHR   Universal Declaration of Human Rights

UNHCR   United Nations High Commissioner for Refugees

WHO   World Health Organisation

List of Health Care Glossary

Donabedian's Model A theoretical framework used to analyse health care services and evaluate the standard of health care provided.

Health Quality The level of effectiveness of health services in achieving desired health outcomes for both individuals and populations.

Health Satisfaction It is a measure of how pleased the health care users is with the health services they have received from health care provider.

Health Services Any services given by health care providers that can enhance overall health or aid in the identification, management, and recovery from illness.

HEALTHQUAL An integrated model used to evaluate health care service quality by focusing on care processes and results.

HospitalQual A framework used to measure in-patient service quality in hospitals.

PubHosQual A scale used to measure public hospital service quality.

SERVPERF A model used to measure health service quality-based performance.

SERVQUAL A framework for measuring service quality and health care user satisfaction.

Acknowledgements

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Dedication

I would like to dedicate the completion of this thesis to the loving memory of my dear mother, **Rabi'aa Abdullah Rasul**. Her unwavering support, encouragement and belief in my abilities have been a constant source of inspiration throughout my academic journey. Although she is no longer with us, her memory lives on and continues to guide me in everything I do. This thesis is a tribute to her legacy and the profound impact she has had on my life. Thank you, Mom, for everything you did for me and my siblings.

Mom, your unwavering love and guidance during your time on this earth have left an indelible mark on my heart. Despite the weight of grief I carry, I am also buoyed by the immeasurable love, resilience, and determination that you instilled within me. Your steadfast belief in my capabilities continues to propel me forward, even in the face of formidable challenges. As I navigate the complexities of life, your memory serves as a perpetual reminder to persevere and uphold your legacy by embracing each day with grace, compassion, and unwavering resilience.

Thank you, Mom, for the immeasurable sacrifices you made and the unconditional love you showered upon me and my siblings. Your presence may be absent, but your influence remains eternally alive within me. This thesis stands as a tribute to your extraordinary impact on my academic pursuits and serves as a testament to the profound bond we share. In all that I do, I will strive to honour your memory and make you proud.

Chapter 1 : Introduction

1.1   Introduction

Chapter One focuses on positioning the research topic within the current literature. It provides a background to the health service user satisfaction and quality of health services, which is essential for contextualising the research topic. The chapter then proceeds to give a demographic overview of the Kurdish immigrants in New Zealand and discusses the research questions in relation to the research objectives. The research questions are designed to examine Kurdish health care users' satisfaction with the quality of health care services delivered in New Zealand. The chapter also explains the rationale and significance of the research topic and explores the personal context of choosing the research area.

Additionally, the chapter discusses the research design and the contribution of this research to new knowledge. The aim is to provide a clear understanding of the research methodology and its significance in contributing to the field. The chapter concludes with an overview of the organisation of the thesis.

1.2   Background to the research

1.2.1   Health service user satisfaction and quality of health services.

The business field defines quality as a product's performance that leads to customer satisfaction and freedom from product deficiencies (Evans & Lindsay, 2015). The satisfaction of customers not only authenticates the superior quality of a product or service but also serves as a pivotal metric for the success of any manufacturer or service provider (Angelova & Zekiri, 2011). Quality, *concerning products*, is encapsulated by the provision of goods characterised by exceptional design, features, and usability (Brissaud et al., 2022). A pivotal facet in defining product quality is its functionality. If a product fulfils its intended function, it signifies that it possesses the fundamental or minimum quality standards expected by the buyer or user (Lina, 2022).

Another perspective in the realm of quality definition within *manufacturing contexts* revolves around the principle of *'doing it right the first time'* (Psychogios & Priporas,

2007). In the context of manufacturing, the efficiency of processes and operations relies heavily on meticulous design and strict adherence to specific specifications or standards for product fabrication (Claes et al., 2023). In the sphere of *service delivery*, quality can be delineated in terms of the promptness of service provision (Ocampo et al., 2019). Customer perception of service quality often hinges on the expeditiousness with which services are delivered and the extent to which service providers fulfil their commitments regarding delivery speed. This concept is closely tied to the waiting time experienced by customers during the service delivery process (Rao et al., 2014).

From the *customer's standpoint*, quality is contingent upon the extent to which a product or service meets their expectations and requirements (Hawkins et al., 2015). Customer satisfaction serves as a barometer for evaluating whether a product or service has attained the expected and necessary quality standards (Grigoroudis & Siskos, 2004). On another facet, the broader *operational perspective* is crucial to understanding quality. In both manufacturing and service sectors, enhancing quality performance involves minimising costs and eliminating wastages (Hicks, 2007). This concept is intricately linked to operational efficiency. The higher the efficiency level within operations, the greater the quality performance achieved (Gittell, 2009). From a *policy and procedural standpoint*, evaluating the concept of quality involves adherence to established guidelines and standards. Quality performance is achieved when activities align with the specified policies and procedures (Bubolz et al., 2020).

In the health sector, the Institute of Medicine (IOM) has defined the quality of care in the health sector as the extent to which health care services enhance the probability of achieving desired health outcomes and are aligned with the latest professional knowledge (Mitchell, 2008). The increasing demand from health care users to receive the best quality of health services has led to higher service user demands in various countries. Consequently, the correlation between health care quality and health service user satisfaction has gained more attention in many countries (Rad et al., 2010). This attention has been spurred by a desire to meet the increasing demand for high-quality health services (Elleuch, 2008). The importance of knowing the relationship between health care quality and health service user satisfaction cannot be overstated. It is essential to ensure that health care services are delivered to the highest possible standard to meet the expectations of service users. Additionally, understanding this

relationship can lead to the development of strategies that can enhance service user satisfaction and improve the quality of health services (Zuriati & Chiew, 2020).

In the United States, health care providers compete with each other for business, which places a premium on health service user satisfaction (Musalem & Joshi, 2009; Propper, 2018). However, health care services in New Zealand differ from those in the United States, as health care services are largely publicly funded and do not operate in a competitive environment. In New Zealand, the government subsidises the public health system and many of its services, including hospital treatment (with some exceptions), are free for residents (New Zealand Immigration, 2020). This difference in the health care systems of the United States and New Zealand has implications for the way in which health care providers prioritise health service user satisfaction. In a competitive environment such as the United States, providers are more likely to place greater emphasis on user satisfaction as a way of distinguishing themselves from their competitor's satisfaction (Ferreira et al., 2023; Musalem & Joshi, 2009).

The commitment to delivering high-quality health services to populations is shared by both the United States and New Zealand's health care systems, despite significant differences between them (Booth & Mor, 2007). These differences in funding and competition emphasise the unique challenges faced by health care providers in different countries, underscoring the importance of understanding these differences when assessing the quality of health services. It is necessary for the government to comprehend immigrants' perceptions of health services to ensure that health care users receive optimal care (Richard et al., 2019). Therefore, it is important for health care providers to know the health needs of immigrants from different backgrounds and the New Zealand health system subsidises primary health care providers to ensure that health care settings can provide optimal care to immigrants (Ministry of Health, 2021).

The quality of health services is determined by the perceptions and expectations of the recipients of care (Mendes et al., 2018). Thus, health service users' perceptions and expectations are indicators of the quality of health care organisations. To provide high-quality health care, the quality of services delivered to health care users should meet or exceed their expectations and perceptions (Suki et al., 2011). In New Zealand's health system, health service users' perceptions of trust, sensitivity to service quality and

respect are significant factors in assessing the quality of health care (Jansen et al., 2008). Moreover, interaction between health care providers and health service users is a critical predictor of health service user satisfaction. When health service users feel that general practitioners' communication and relationship-building skills are inadequate, health care users may seek an alternative health care provider (Berkowitz, 2016; Jansen et al., 2008; Kitapci et al., 2014).

1.2.2   Demographic overview of the Kurdish immigrants in New Zealand

The Kurdish population in New Zealand is relatively small, with official statistics reporting 921 individuals, including 501 males and 420 females, according to Stats NZ Tatauranga Aotearoa (2018a) (see Figure 1). It is important to acknowledge that the data obtained from the census usually resident population count variable is of very high quality. Furthermore, the data related to the gender of the Kurdish population in New Zealand is classified using a binary system comprising two categories: male and female, as per the 2018 report from Stats NZ. Unlike other demographic classifications, such as ethnicity, Stats NZ does not provide for residual categories such as "not stated" for sex, as their policy is to account for the sex of every person in the census, in line with international practice (Stats NZ Tatauranga Aotearoa, 2018a).

Figure 1

Population of Kurdish People in New Zealand

Population Counts for the Kurds Ethnic Group (2018 Census)

420

501

■ Males

■ Females
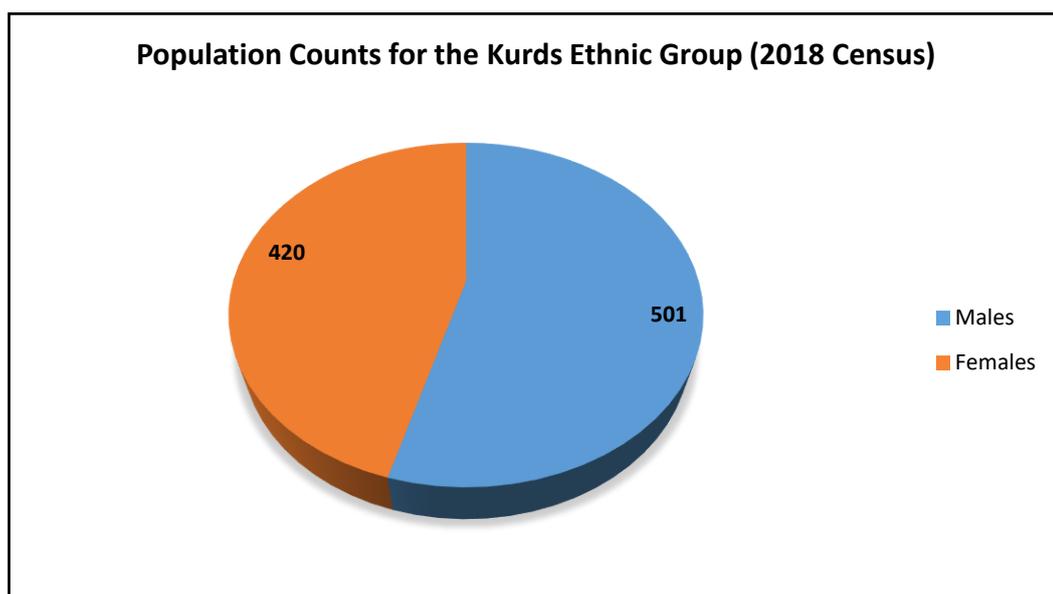
Note. Adapted from (Stats NZ Tatauranga Aotearoa, 2018b)

However, Abdullah Zadeh (20 July 2020) (personal communication with the former head of the New Zealand Kurdish Community- NZKC) suggests that the actual number of Kurds in New Zealand may be higher than 2000, as many have not disclosed their presence to the government. The lack of identification among the Kurdish population is partly due to their small numbers. Nonetheless, in the late 1990s, a noticeable Kurdish migration emerged in New Zealand, with communities of Kurds establishing themselves in Auckland and other regions, as illustrated in Figure 2. These figures are based on data from (Stats NZ Tatauranga Aotearoa, 2018a).

The distribution of the Kurdish population among different regions of New Zealand is presented in Figure 2. The data indicates that the highest percentage of Kurdish people reside in Auckland, comprising 70% of the total population of Kurdish people. On the other hand, Hawke's Bay has the lowest rate, with only 0.3% of the total Kurdish population. The Waikato and Canterbury regions are the second and third highest regions with Kurdish residents, accounting for 12.1% and 8.8%, respectively (see Figure 2).

Figure 2

Kurdish Population by the Regional Council
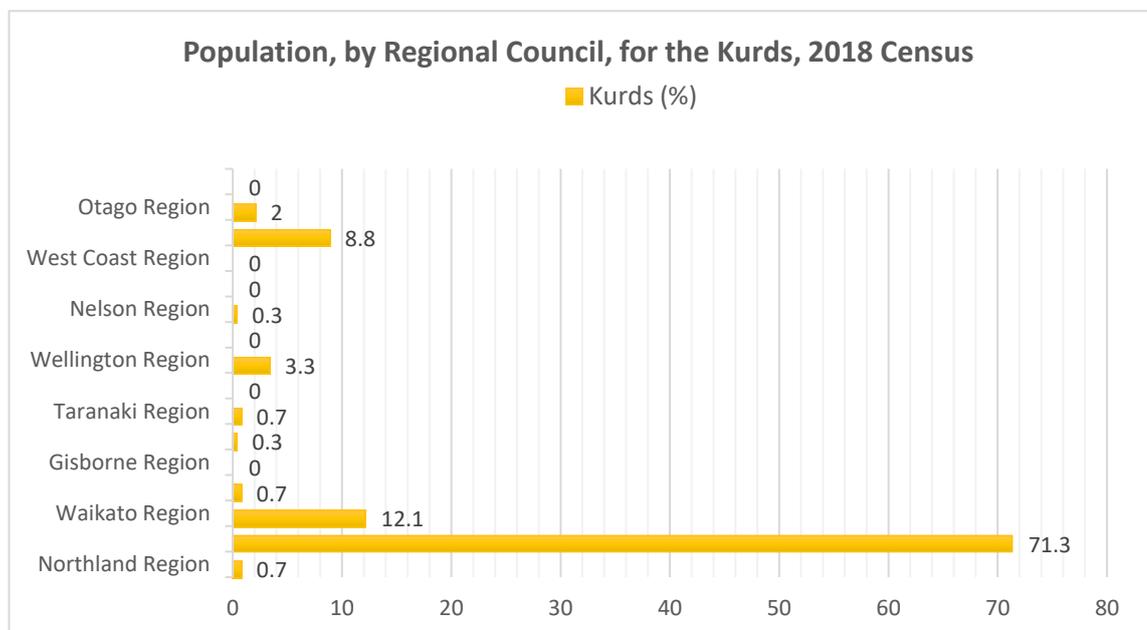
Note. Adapted from (Stats NZ Tatauranga Aotearoa, 2018b)

Figure 3 illustrates the distribution of the Kurdish population in New Zealand based on age and sex. According to Stats NZ Tatauranga Aotearoa (2018a), the largest number of

females in the Kurdish population fall within the 25-29 age group (11.4%), while the lowest rates were found among females aged 65-69 and 75-79 years (0.7%). In contrast, males aged 30-34 years have the highest rate (10.6%), while males aged 65-69, 70-74 and 80-84 years have the lowest rate (0.6%).

Figure 3

Kurdish Population by Age and Sex

Population, by age and sex, for the Kurd ethnic group, 2018 Census

	0–4 years	5–9 years	10–14 years	15–19 years	20–24 years	25–29 years	30–34 years	35–39 years	40–44 years	45–49 years	50–54 years	55–59 years	60–64 years	65–69 years	70–74 years	75–79 years	80–84 years	85 years and over
■ Male (%)	10.2	8.4	9	9	7.8	9.6	10.8	6	6	7.8	6	3	4.8	0.6	0.6	0	0.6	0
■ Female (%)	10	10.7	8.6	7.9	7.1	11.4	10.7	9.3	4.3	6.4	6.4	3.6	1.4	0.7	0	0.7	0	0

■ Male (%)   ■ Female (%)
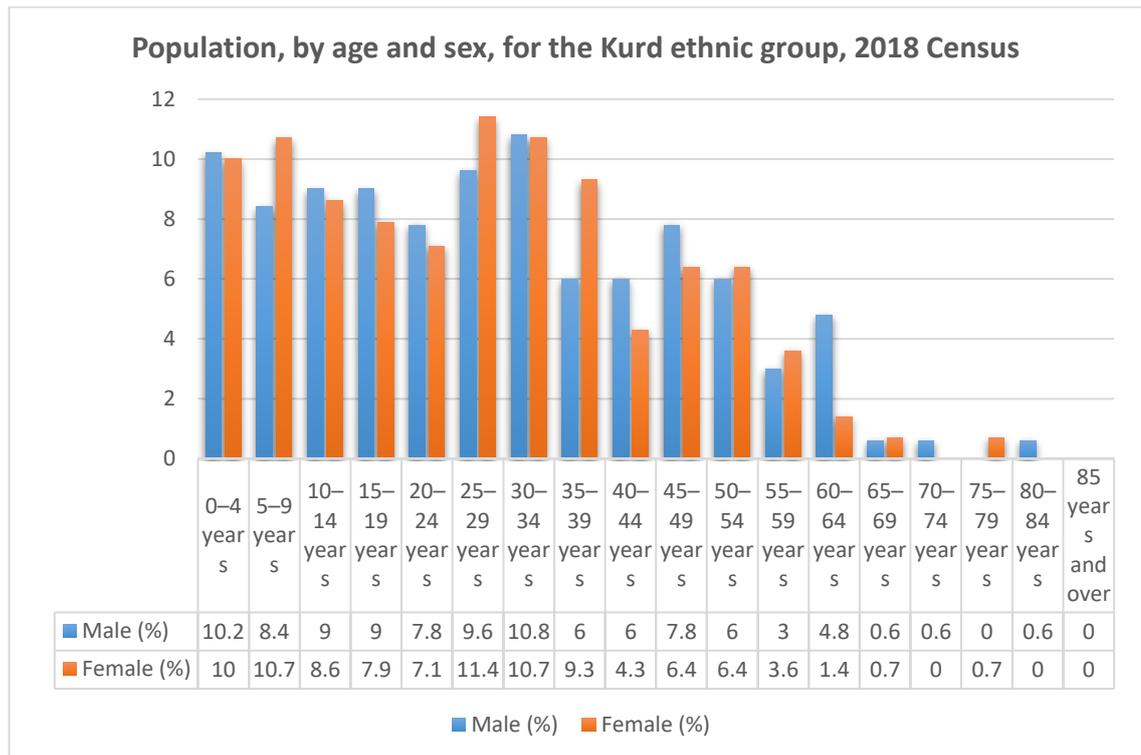
Note. Adapted from (Stats NZ Tatauranga Aotearoa, 2018b)

1.3   Aims and objectives of research.

The objectives of this research were to:

- Explore the perceptions of health service quality among Kurdish immigrants in New Zealand.
- Apply Donabedian's model of quality of health care to assess whether health services in New Zealand meet the expectations of Kurdish immigrants.
- Generate evidence that may contribute to address the existing knowledge gap in the quality of health care services from the perspective of Kurdish health care users.

To achieve the above objectives, this research aimed to answer the following questions:

1. How do Kurdish health care users feel about the quality of health care provided in New Zealand?

   a. What are Kurdish health service users' experiences of New Zealand health care service delivery and do health care services meet health service users' expectations?

   b. How does the quality of health care services impact the satisfaction of Kurdish immigrants with New Zealand's health care system?

   c. What are the enablers and barriers for Kurdish immigrants to engage with health service delivery in New Zealand?

   d. What changes, if any, are required to improve the health care system to meet the needs of Kurdish immigrants in New Zealand?

1.4 Rationale and significance of research

Access to health care services is recognised as a basic human rights, as stated in Article 25-1 of the 1948 Universal Declaration of Human Rights (UDHR), which emphasises that everyone has the right to access medical care for themselves and their family members (Brown, 2016). However, ensuring access to health care services for immigrant populations, including illegal immigrants, irregular migrants and undocumented workers, remains a challenge (Dwyer, 2004). Immigrants may face difficulties accessing health care due to adverse living and working conditions, discrimination and socioeconomic status (Suphanchaimat et al., 2015). Therefore, it is essential to provide good quality health care services to improve the health and well-being of vulnerable populations, including immigrants (Dwyer, 2004). In New Zealand, the health policies aim to use a coordinated approach to improve the health and well-being of diverse population groups, including the aged and those living with long-term conditions (Associate Minister of Health, 2016).

As a diverse population, this research is significant as it focuses on the quality of health care services for Kurdish immigrants in New Zealand. This research will also contribute to building a body of knowledge to assist policy makers when considering health care services from an immigrant population. Various policies and legislation in New Zealand requires health and disability services to be inclusive of service users such as refugees and victims of trafficking offenses including the New Zealand Healthy Ageing Strategy

2016 (Associate Minister of Health, 2016) and the Health and Disability Services Eligibility Direction 2011 (Ministry of Health, 2019).

This research aims to contribute to the body of knowledge related to health care services for immigrant populations in New Zealand. This research will be particularly valuable for policy makers who need evidence-based insights to make informed decisions about health care services for vulnerable people, such as refugees and victims of trafficking offenses. New Zealand has several policies and legislation in place that require health and disability services to be inclusive of all service users. These policies include the New Zealand Healthy Ageing Strategy 2016 (Associate Minister of Health, 2016) and the Health and Disability Services Eligibility Direction 2011 (Ministry of Health, 2019). As such, immigrants, including the Kurdish population, have the right to benefit from subsidised health care services in New Zealand (Ministry of Health, 2018).

It is worth noting that the Kurdish population is a growing minority group in New Zealand. Therefore, understanding their health care experiences is vital to ensure that Kurdish health care users receive equitable and effective health care services. By conducting this research, policy makers can gain a better understanding of the health care needs of the Kurdish and other immigrant populations and design policies and interventions that address their needs. Ultimately, this research can help promote a more inclusive and equitable health care system in New Zealand.

Further, there is a considerable gap in the research on Kurdish immigrants' perceptions and experiences of mainstream health services in New Zealand. Exploring their perceptions is fundamental in identifying any barriers to accessing health care services in the country. Moreover, this study aimed to examine changes in the Kurdish immigrants' perception of the quality of health care services after they have settled in New Zealand. Notably, the researcher has not found any similar research conducted among Kurdish population groups in other countries and societies. Therefore, this study concerned about generating evidence that may contribute to address the knowledge gap in the quality of health care services from the perspective of Kurdish health care users. This study will be the first to use Donabedian's model to evaluate whether health services meet the needs of this population group. The three components of

Donabedian's model - Structure, Process and Outcomes (SPO) (Donabedian, 2002) will be used to assess the quality of health care services provided to Kurdish immigrants.

The study findings will contribute to the existing literature on the quality of health care services in New Zealand and its provision to minority groups. Health service user satisfaction is a key measure of the quality of health services (Bhanu, 2010) and it provides valuable understandings into the effectiveness of care and the level of empathy shown by health care providers (Heath, 2022). Health service user expectations of health care services are increasing and health care providers' primary goal is to meet these growing health requirements (Gostin, 2019; Heath, 2022).

The findings of this study will have wider implications beyond improving the quality of health care services for Kurdish immigrants in New Zealand. The results will also be relevant to other immigrant population groups, helping health care providers to better understand their needs and improve the overall quality of health services (Fang et al., 2019; Franz et al., 2016). By identifying the barriers to accessing health care services, this study can help inform policies and interventions that aim to address health care inequities experienced by immigrant communities in New Zealand and other similar contexts. Ultimately, this research can contribute to the goal of achieving equitable and culturally responsive health care services for all populations, regardless of their background or status.

1.5   Why quality of health care services (the personal context)

When I was working as a university lecturer in Kurdistan-Iraq, I planned to pursue a PhD in the field of management. While considering research areas for my PhD, I visited hospitals in Kurdistan-Iraq several times to receive treatment. During my visits, I observed that health professionals' behaviours and treatment towards health care users were not positive. I witnessed many professionals did not respect health care users and ignored them while they were waiting for treatments. This experience led me to research how health professionals should treat health care users in the right manner. I began browsing and searching for topics related to public health and health management, which allowed me to gain valuable knowledge about evaluating the quality of health care services from health care users' perspectives. As I examine topics related to public health and health care management, I realised that evaluating the

Kurdish peoples' satisfaction with the quality of health care services could provide valuable insights.

However, my personal journey in health care management took on a new meaning after my mother contracted COVID-19 and was admitted to the hospital. Unfortunately, during her three-week stay, she said she was mistreated and felt ignored by the health care professionals. The quality of services provided to her was not up to her expectations and she passed away in the hospital. This personal tragedy further motivated me to gain a deeper understanding of the attitudes and values of health care professionals that influence the satisfaction of health care users with the quality of health care services. I am committed to completing this study as a tribute to my mother and to contribute to improving the quality of health care services for all users, including immigrant communities in New Zealand.

1.6   Summary of research design

This study employs a qualitative research design using face-to-face interviews to gather the perceptions of Kurdish health care users on the quality of health care services in New Zealand. The research focuses on evaluating the satisfaction level of health care users and identifying areas that require improvement by utilizing thematic analysis. Donabedian's model, which examines three domains of health care providers, namely Structure, Process and Outcomes (SPO), was used to evaluate the quality of health services. The study collected data from twenty participants, including eleven males and nine females of varying ages and regions in New Zealand. Data analysis was conducted using NVivo software to generate themes and provide insights. The results of the research were combined to present a comprehensive evaluation of the quality of health care services available to Kurdish health care users in New Zealand.

1.7   Contribution of this research to new knowledge

This research made a significant addition to the knowledge base by providing a broad analysis of the quality of health care services as perceived by Kurdish health care users in New Zealand. The study investigates differences in satisfaction with health care services among the Kurdish population across health care centres in New Zealand. The findings of the study have the attainable to inform health policy and practice by

identifying key areas where developments can be made to better meet the needs of immigrant communities, including Kurdish communities, in New Zealand. Therefore, this research is expected to add to the existing knowledge and bridge the knowledge gap in the quality of health care services from the perspective of Kurdish health care users.

1.8   The organisation of the thesis

The structure of this research is as follows:

Chapter one provides the background of the study, including health service user satisfaction and quality of health services. It also presented a demographic overview of Kurdish immigrants in New Zealand, the objectives of the research, the rationale and significance of the research and the contribution of this research to new knowledge.

Chapter two presents an extensive literature review of both academic and grey literature relevant to the issue addressed by this research. Specifically, it covered the quality of health care services, health care users' satisfaction and models for assessing the quality of health care services in Europe, America and Asian countries.

Chapter three discusses the research methodology and methods used in this qualitative research, which examined the satisfaction of Kurdish health care users with the quality of health care services in New Zealand.

Chapter four examines the research findings and analysis, which were obtained by administering face-to-face interviews with Kurdish immigrants residing in New Zealand. This chapter outlined the results of the evaluation of Kurdish health care users' satisfaction with the quality of health care services provided in New Zealand, followed by a discussion of the findings.

Chapter five summarises the discussion of the findings of the research in relation to the existing literature.

The final chapter provides the conclusion of the research, including the strengths, limitations and major implications of the research, as well as future recommendations.

Chapter 2 : Review of Literature

2.1 Introduction

This chapter provides a comprehensive review of relevant literature on health care service quality, health care user satisfaction and measurement tools for evaluating the quality of health care services. The literature review provides identifies gaps in the existing knowledge on this research. In this research, the scoping review method was used to identify and produce the literature review chapter. The structure of this chapter is as follows: Firstly, the chapter provides an explanation about the method to scoping background literature review and then definitions related to quality, including different types of quality, such as clinical and health care services and forms of quality in health care services. Next, it discusses the importance of health care user satisfaction and how health professionals value it. The chapter also examines health service satisfaction among migrants overseas and methods for measuring quality. Finally, the chapter concludes with a discussion on Donabedian's evaluation model for the quality of health care services.

2.2 Literature search process

This study employed a scoping review as a method to comprehensively cover the existing body of literature concerning the evaluation of the quality of health care services in New Zealand from immigrants' perspectives. The chosen method offers a broad overview of New Zealand's health care quality addressing general inquiries. This scoping review is designed to provide a comprehensive understanding of the existing literature rather than specifically addressing narrow research questions within this thesis (Munn et al., 2018; Pham et al., 2014).

The primary objective of this literature review was to identify the most appropriate measurement tool for evaluating the quality of health care services in New Zealand from the perspective of Kurdish immigrants. By utilising a scoping review, the researcher aimed to explore a wide range of evidence derived from immigrants' experiences with health care services. In conducting the scoping review, this research adopted the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extensions for Scoping Reviews (PRISMA-ScR) approach (Tricco et al., 2018). This methodology was not

only chosen but also refined collaboratively by the research team, including both supervisors and the student, at the Auckland University of Technology (AUT), New Zealand. The PRISMA-ScR approach encompasses a checklist comprising 20 essential reporting items, alongside two optional items. The use of PRISMA-ScR aimed to enhance audience understanding of health care terminologies, theories, and quality measurement models (Tricco et al., 2018).

The scoping review explored various facets integral to the assessment of health care quality. It examined the definitions of quality and health care services, examining the fundamental nature and value of these services. Furthermore, the scoping review investigated health care user satisfaction and explored the different dimensions that constitute satisfaction with health care services. An essential focus of this review was on health care service satisfaction among overseas immigrants and their challenges of accessing health services. Additionally, the review examined the scope of health care measurement tools, a critical examination of the methodologies employed to evaluate health care quality.

In this scoping review, a targeted approach was undertaken, concentrating on the key academic literature pertinent to the quality of health care services. To compile this review, a systematic search process was initiated utilising reputable online databases, including Google Scholar, the AUT library website, Science Direct and PubMed. These searches, conducted between the years 2001-2023, were designed to identify peer-reviewed papers written in English. The search criteria encompassed a range of topics such as healthcare quality assessments, systematic and scoping reviews, patient satisfaction, health care services and measurement tools. 290 records were identified with 84 excluded once the inclusion and exclusion criteria were applied and 206 records were evaluated for eligibility (see Table 1).

Table 1

Inclusions and Exclusion Criteria.

Criterion	Inclusion	Exclusion
Time period	January 2001- October 2023	Studies outside of these dates
Language	English	Non-English studies
Type of Search	Primary research, secondary research, academic and non-academic institutions, and government and non-government websites.	Opinion and editorial articles, presentations, abstracts, drafts or work-in-progress documents, and study protocols.
Population and Concept	Patients, health service users, customer satisfaction, health care providers, immigrants, service users who were included in literature related to quality of health care delivered.	People that were not included in both population and concept.
Context	New Zealand, United Kingdom, USA, Australia, European Union, Asian and African countries.	Countries that did not produce literature in the English language.

Note: Adapted from (Wepa et al., 2023)

In this study, the EndNote Software tool was employed to organise search results, with duplicates removed by the researcher to maintain data integrity. The limitations of this process were the scarcity of information about Kurdish immigrants and their experiences with health care quality across the global landscape. Despite limitations, the scoping review offers a comprehensive collection of literature, providing valuable insights into health care quality assessments, especially for immigrants. This exploration enriches understanding and forms the foundation for future research in this area.

2.3   Definition of quality

Quality is a concept that is critical to various sectors, including health, education, food, tourism and technology (Sharma & Talwar, 2007). Different researchers have defined and conceptualised quality to achieve a better understanding of the term. For instance, Sahney et al. (2004) asserted that the word of quality is obtained from the Latin *Qualis*, which refers to *what kind of*. Additionally, Murphy (2007) added that quality is the degree of excellence of a product and/or service compared to similar products and/or services. Bellows (2004) defined quality as *conformance to requirements* and *zero defects*. Conformance to requirements means that a product or service is considered

high-quality if it meets all the specified requirements or standards and has no defects. In other words, quality is achieved by ensuring that the product or service is made according to the desired specifications and without any errors or defects. On the other hand, Juran's definition of quality, as cited in Neyestani (2017), is *fitness for use*. Juran's definition focuses on the ability of a product or service to fulfil its intended purpose or function effectively. In other words, a product or service is considered high-quality if it can perform the function for which it was designed and meet the needs of the user.

The American Society for Quality Control (ASQC) definition of quality states that it is the comprehensive set of attributes and characteristics of a product or service that directly impact its ability to meet the assured or implied needs of the customer (Griffin, 2021, p. 460). Furthermore, quality is a significant preference and value that consumers seek from organisations (Wherry & Schor, 2015). The increasing number of values associated with products and services reflects their quality. Therefore, quality has a direct link with the value of the offer, which may evoke satisfaction or dissatisfaction in the customer or user (Janicijevic et al., 2013).

While Keleman (2003) defines quality as excellence, for the purposes of this study, Mallen and Adams (2008) focus on conformance to design or specifications is more appropriate. This is because health care users can evaluate whether the quality of health care services satisfies their preferences and expectations. By focusing on conformance to design or specifications, this study explored the degree to which health care services align with the preferences and expectations of users. This can help identify areas where improvements can be made to make sure that health care services are more responsive to the needs of recipients. Ultimately, this can contribute to the delivery of higher quality health care services that better meet the needs of users.

Garvin's (1984) framework is one of the most renowned approaches to defining and determining quality, identifying five complementary approaches: transcendent, product-based, user-based, manufacturing-based and value-based (Van Kemenade et al., 2008). Garvin asserted that employing all five approaches together is necessary to obtain a comprehensive view of quality (Fields et al., 2014). The following descriptions will discuss each of Garvin's approaches in detail. It discusses different approaches to

defining quality, which can vary depending on the perspective and criteria used to evaluate products and services.

- *The transcendent view of quality* considers quality as an objective standard of excellence that is universally recognisable. This view suggests that customers and users of quality can recognize quality through repeated exposure to the product or service.

- *The product-based approach* defines quality based on measurable attributes, such as the number of knots per square inch in a rug or the tightness of a weave. The higher number of knots and tighter weaves refers to the higher quality of the rug. This approach is objective and focuses on the product itself, rather than subjective perceptions of quality.

- *The manufacturing-based approach* views quality as conformance to specific requirements, such as specifications and standards. This approach emphasises consistency and conformity in the production process.

- *The user-based approach* defines quality based on how well a product or service satisfies or exceeds customer needs and requirements. This approach acknowledges that different customers have different needs and that quality is subjective, based on individual perceptions. Under this approach, any deviation from the intended user's requirements reduces quality. For example, if a customer believed that BMW vehicles satisfy his or her needs more than Toyota cars, then BMW would be the higher-quality vehicle for him or her.

- *The value-based approach* to evaluating quality considers both the cost and the perceived value of a product or service. By striking a balance between quality and cost-effectiveness, this approach aims to ensure that customers receive good value for their money (Fields et al., 2014).

The concept of quality is widely acknowledged but can be challenging to define since individuals have different understandings of what constitutes quality (Soares et al., 2017). Moreover, quality is a complex and multifaceted concept that can be defined in different ways. Regardless of the approach taken, however, quality is ultimately related to the perceptions and experiences of customers and users. In the context of health care services, quality can be evaluated based on the degree to which health care services

users are satisfied with the services provided. Therefore, when assessing the quality of health care services, it is important to consider the perceptions and experiences of the health care users. This includes evaluating their perceptions of the accessibility, effectiveness, safety and responsiveness of the services they receive. Incorporating the user perspective into the evaluation of health care services can identify areas where improvements can be made to ensure that services better meet the needs of users.

2.4   The concept of quality in health care services

Health care service quality has been defined by researchers and professionals in the health care industry, but the perspectives of patients and service users are also essential in shaping these definitions (Vahdat et al., 2014). This section presents a range of definitions of health care service quality from various perspectives, as provided by experts in the field from 1980 to 2022. As shown in Table 2, the concept of health care quality began with Donabedian's definition in 1980 and has evolved to include the Ministry of Health of New Zealand's description (see Table 2).

Table 2

Definitions of Health Care Quality by Different Authors and Institutions

Authors	Definitions
Avedis Donabedian (1980).	Avedis Donabedian in 1980 defines the quality of health care as the degree to which health care services meet the needs and expectations of users and providers, using legitimate means to achieve desirable outcomes (Büyüközkan et al., 2011).
Institute of Medicine (1990).	According to the Institute of Medicine (IOM) in 1990, quality of care refers to the extent to which health care services provided to individuals and populations enhance the probability of achieving desired health outcomes while being in accordance with the latest professional knowledge (Nylenna et al., 2015).
Council of Europe (1997).	According to the Council of Europe in 1997, quality of health care refers to the extent to which the treatment and care provided by health care professionals enhances the probability of achieving the desired outcomes and reduces the likelihood of adverse effects, taking into account the latest advancements in medical knowledge and technology (Mamalelala, 2022).
World Health Organisation (WHO) (2019).	Quality health services are those that are effective, safe and people centred. − *Effective:* health services are based on evidence and meet the needs of those who require them. − *Safe:* health services do not cause harm to the individuals for whom they are intended. − *People-centred*: health services are responsive to the preferences, needs and values of each user. To achieve the benefits of quality health services should also be timely, equitable, integrated and efficient (World Health Organization, 2019a).
Ministry of Health of New Zealand (2003).	Quality refers to the extent to which health services improve the probability of desired health outcomes for individuals or populations and enhance the participation and independence of people with disabilities, while adhering to current professional knowledge and standards (Minister of Health, 2003a).

Donabedian's definition of quality of care emphasises the importance of gaining desirable health outcomes through legitimate means. This implies that health care providers need to deliver high-quality services to maximise health outcomes for patients (Arah et al., 2003). Donabedian's definition is not limited to the health care sector, as it can also be applied to other industries such as food and cars. Donabedian's definition of the quality of health care emphasises that it should aim to maximise the overall welfare of health care users by considering the balance between expected improvements and potential losses throughout the care process. Donabedian's definition implies that the

quality of care is not solely measured by the attainment of a particular outcome, but by the process involved in delivering care. To achieve a better quality of care, it is essential to consider the preferences of health care users. By understanding what users want and need, providers can improve the quality of care they deliver. Donabedian also recognises the limitations of quality of care, acknowledging that there may be gains and losses in the care process (Busse et al., 2019; Green et al., 2016). To add, Donabedian's definition of quality of care serves as a framework for evaluating and improving the quality of health care services. The framework highlights the importance of maximising patient welfare and satisfaction through legitimate means while recognising the inherent limitations of quality (Busse et al., 2019).

The concept of quality of care has been defined and discussed by various organisations, including the Institute of Medicine (IOM) in the United States and the Council of Europe (Al-Jabri et al., 2021). In 1990, the IOM defined quality of care as a goal of the health care system, with a focus on increasing the health outcomes of health care users (Kc et al., 2020). The IOM emphasised the importance of health care users' perspectives in evaluating the quality of care, particularly in terms of their experiences and satisfaction with health care services (Nylenna et al., 2015). Similarly, in 1997, the Council of Europe recommended the improvement and application of quality development systems in member states' health care systems, with a focus on increasing the possibility of desired health outcomes and reducing the chances of undesirable outcomes for health care users. Notably, the Council of Europe's definition also emphasised health care users' safety as a critical consideration in evaluating the quality of care (Busse et al., 2019; Drosos et al., 2018).

The World Health Organisation (WHO)'s definition focuses on three key dimensions: effectiveness, safety and people-centredness (World Health Organization, 2019a). By emphasising the provision of effective and safe health care services, WHO aims to promote positive health outcomes for all members of society. The WHO definition can be viewed as a framework for all countries and health care providers to follow to achieve these outcomes. However, achieving positive health outcomes for all individuals requires careful consideration of the quality of health care services provided. According to the WHO, this involves providing health services that are timely, equitable, integrated and efficient. The goal is to provide the best quality of health services to the right health

care users at the right time and in the most effective way, resulting in the best possible outcomes for patients and the population as a whole (World Health Organization, 2019a).

In New Zealand, the Minister of Health (2003b) defined quality of care as the extent to which health services can improve the health outcomes of health care users and people with disabilities, while being consistent with the latest health care knowledge. The provision of high-quality services and an ongoing commitment to quality improvement by health service providers is essential to ensure that health care users' outcomes are strengthened. To achieve such commitment, the Quality and Safety Commission of New Zealand (QSCNZ) is responsible for assisting health care providers in improving service quality. The New Zealand Health and Disability Services Act 2001 has been established to provide high-quality and safe services to health care users and the general public (Minister of Health, 2003b; World Health Organization, 2019b).

Based on the definitions outlined above, it is evident that the quality of health care services is vital for meeting the needs of health care users and ensuring their satisfaction. Therefore, exploring how the quality of health care services impacts the satisfaction of Kurdish immigrants with New Zealand's health care system can assist with answering the research question.

2.5   Forms of quality in health care services

The term of quality can be categorised into two components: technical quality and functional quality (Donabedian, 2005). Technical quality refers to the clinical skills and accuracy of procedures used by health care providers to diagnose and treat health care users. This is include the skills of medical staff, such as physicians, nurses and laboratory experts (Langins & Borgermans, 2016; Rashid & Jusoff, 2009). On the other hand, functional quality focuses on the ways health care services are delivered to health care users (Donabedian, 2005; Endeshaw, 2021; Zarei et al., 2012). According to Mosadeghrad (2013) technical quality refers to the core services offered and their outcomes, whereas functional quality emphasises the delivery process or how the health care user receives the health care service (Rashid & Jusoff, 2009).

Health care service researchers argue that technical quality may not be an effective measurement tool for evaluating the quality of health care services by health care users compared to functional quality (Abbasi-Moghaddam et al., 2019; Alhassan et al., 2015). The authors note that most health care users lack knowledge on how to evaluate diagnostic tests and processes effectively, despite technical quality playing an essential role in producing positive or negative outcomes related to the health care users' health issues. In contrast, health care users rely on functional quality as a measurement tool to evaluate and rate the overall quality of health care services delivered. Functional quality is a key component to health care users when evaluating their satisfaction with the quality of health care services. The health care users evaluate the quality of health care services in terms of cleanliness, facilities, the attitudes of managerial and health care professionals and the food menu (Rashid & Jusoff, 2009). Thus, due to the lack of expertise, health care users focus on the caring (functional) performance of health care providers and tend to ignore the curing (technical) performance and may not distinguish between the two performances in health care settings (Apesoa-Varano et al., 2011; Fiala, 2012).

In conclusion, health care users tend to depend on functional quality rather than technical quality when evaluating the quality of health care services. While technical quality plays an essential role in producing positive or negative outcomes related to health issues, health care users may not have the necessary expertise to evaluate the service based on functional quality alone. Functional quality represents the interactions between health care professionals and health care users during the delivery of services. Examples of functional quality include cleanliness, facilities, attitudes of managerial and health care professionals and food quality. Therefore, it is crucial for health care providers to pay attention to both technical and functional quality to ensure high-quality health care services that meet the needs of health care users.

2.6   Overview of Kurdistan region and Kurdish immigrants in New Zealand

The Kurdish people, also known as Kurds, are a distinct ethnic group living in several countries, including the South-eastern part of Turkey, North-eastern Syria, northern and eastern Iraq, North-western Iran and South-western Armenia (see Figure 4) (Al-Allawi et al., 2010; Hovsepyan et al., 2016; Leezenberg, 2016; Najmabadi et al., 2001). The Kurdish

people, who are the most populous ethnic group in the Middle East with around 30 million individuals, have not been able to form a nation-state with complete independence (Gunter, 2011). However, the Kurds have a unique culture and language called Kurdish, which comprises various dialects (Ahmed, 2016). On 5 March 1991, the Kurds in Iraq launched an uprising against the regime of Saddam Hussein to gain their freedom. Following this, on 19 May 1992, the Kurdistan political parties conducted an election to select members of the parliament of the Kurdistan Region in Iraq, which led to the establishment of the Kurdistan Regional Government (KRG) (Hevian, 2013; Voller, 2015).

Since establishment of the government, the Kurdish people have been struggling for autonomy and recognition of their cultural and ethnic identity in various parts of the Middle East. Despite creating their own government, parliament and judicial council, the Kurds in Iraq are still under the sovereignty of the Iraqi government. Likewise, the Syrian Kurds have also declared self-rule due to suppression and denial of their rights by successive Syrian governments (Radpey, 2016). However, the Kurds in Iran are excluded from the political system and are under the control of the Iranian government (Akbarzadeh et al., 2019). Similarly, the Turkish government denied the Kurdish ethnic identity and referred to them as *mountain Turks.* Kurdish populated areas in Turkey are ruled under martial law, leading to an ongoing conflict between the Turkish government and the Kurdish population (Gurbuz, 2016). The majority of the Kurdish people in Iraq are Sunni Muslims, but there are also many who follow other religions and creeds, including Yezidi, Zoroastrianism, Judaism and Christianity (Aqrawi, 2015; Loizides, 2010). There is a significant Christian population in Kurdistan, with an estimated 320,000 living in the region (Ali, 2015). Christians in Kurdistan belong to different churches, including the Catholic, Orthodox, Assyrian Church of the East, Armenian and Chaldean Catholic churches (Canada: Immigration and Refugee Board of Canada, 2009).

Figure 4

The Kurdish Inhabited Areas in the Middle East

Note. Adapted from (Furian, 2016)

2.7 Kurdish diasporas in the Western Europe and New Zealand

The emergence of Kurdish diasporas in developed countries and the West dates to the late nineteenth and early twentieth centuries. However, it was the economic boom of Western Europe in the 1960s that created opportunities for Kurdish male workers to migrate and work in Germany, France, Sweden and the Netherlands (Hassanpour & Mojab, 2005). The civil war between the Kurdish political parties, particularly the Kurdistan Democratic Party (KDP) and the Patriotic Union of Kurdistan (PUK) between 1994-1998, also resulted in a large number of Kurdish people fleeing to Western Europe, America, Canada, Australia and New Zealand (Stansfield, 2003). The presence of Kurdish

migrants in New Zealand dates to the 1990s. In 1996, the majority of Kurdish migrants arrived in New Zealand after being granted refugee status by the United Nations High Commissioner for Refugees (UNHCR) in Pakistan (Abdullah Zadeh, 20 July 2020) (personal communication with the former head of the Kurdish Community). Between 1992-2000, the UNHCR also supported other groups of Kurdish immigrants from Iraq, Syria and Turkey to obtain residency in New Zealand (Abdullah Zadeh, 20 July 2020).

According to Stats NZ Tatauranga Aotearoa (2018a), there are 921 Kurdish people living in New Zealand. However, the actual number may be higher, as Abdullah Zadeh (20 July 2020) has suggested that many Kurds in New Zealand have not disclosed their identity to the government (see Chapter 1, section 3). This may be due to security concerns and difficult political, economic and social conditions in their countries of origin, which have forced many Kurds to flee Iraq, Syria, Iran and Turkey. In the late 1990s, a significant Kurdish migration population became apparent in New Zealand, with communities of Kurds in various parts of Auckland, such as on the North Shore, as well as in South and West Auckland.

2.8 How do health professionals value health care user satisfaction?

The importance of health care user satisfaction as an indicator for evaluating the quality of health care services has been widely acknowledged by researchers, health professionals and health care settings (Bhanu, 2010). Gentry and Badrinath (2017) define value in health care as the net benefit, taking into account the difference between the benefit and the harm done by a service and the amount of resources invested. Porter (2010) adds that value in the health care sector should be based on outcomes rather than inputs and measure by results and not the quantity of services delivered. However, with the current technological developments in the health care sector, increased aged population and rising burden of chronic disease, many countries struggle to deliver appropriate health services to their health service users (GBD Ageing Collaborators, 2022; Maresova et al., 2019). Bastemeijer et al. (2017) suggest that autonomy holds significant value for users of health services, while O'Keeffe et al. (2016) advocate for the consideration of health service users' opinions, asserting that their involvement fosters improved interactions between service users and health care professionals. Involving health service users is supported by Bastemeijer et al. (2017)

who state that health service users prefer to participate in the decision-making process with their therapist or health service providers. The decision-making process is related to the health service user's own contribution to the treatment process through their narrative about their health condition. Additionally, compassion, which consists of empathy, confidence, friendliness and nonverbal communication, is another key value for service users (Bastemeijer et al., 2017). O'Keeffe et al. (2016) argue that health service users believe that talking to health service providers openly about their pain helps to strengthen the relationship between health service users and their physical therapist.

Furthermore, professionalism and responsiveness are two significant values for health service users, particularly for Kurdish health service users. Health service users prefer to contribute to the treatment process and be valued by health service providers while making decisions about their health issues (Karadaghi & Willott, 2015). However, health service providers in Kurdistan tend to make decisions that are not health service user-centred, resulting in Kurdish health service users lacking opportunities to contribute to their care plans (Karadaghi & Willott, 2015). Additionally, Kurdish health service users prefer to be treated by professionals in a culturally appropriate way, which is referred to as cultural safety in health professions (Wepa, 2015, 2016).

According to Curtis et al. (2019), cultural safety refers to a framework for delivering quality care by recognising power imbalances and respecting the rights of health service users from diverse cultural backgrounds. Cultural safety involves a shift in thinking and attitudes towards cultural differences, aiming to create an environment where individuals feel respected, understood and safe in seeking care. For health service users, safety is a subjective word that gives them the right to approach and use health care services if they feel safe (Curtis et al., 2019; Ramsden, 2002). Thus, health service users have the power and rights to evaluate health care services by using or refusing the services.

Cultural safety is an essential component of healthcare that necessitates active participation from healthcare workers and organizations to reduce bias and promote equity in the workforce and work environment (Health Quality & Safety Commission, 2022). Wepa (2015) stated that by prioritising cultural safety, we can ensure that all

individuals in New Zealand receive the high-quality care they deserve and ultimately improve their health status and well-being. Furthermore, it is essential to understand the specific health care needs and expectations of different cultural groups. For instance, Kurdish health care users value responsiveness and expect to be heard by health service providers when discussing their health issues. Kurdish health care users also prefer to receive sufficient explanations about their health problems (Shukor et al., 2017).

In conclusion, health care service providers need to be aware of and consider the values and preferences of health service users, particularly those from diverse cultural backgrounds. By doing so, health care providers can improve the quality of care and user satisfaction, ultimately leading to better health outcomes.

2.9   Health service satisfaction among migrants overseas

This section outlines the challenges faced by immigrant health care users when accessing health care services and their interactions with health care service providers. The following three subsections will investigate the challenges faced by immigrant health care users in terms of their cultural, background and language differences when interacting with health care professionals. The chapter will conclude with a discussion of how immigrant health care users interact with the laws and health standards of the host country.

2.9.1   Interaction with immigrant health care users

Most of the selected literature focused on the challenges faced by immigrant health care users in their interactions with health care service providers in the host country. According to international research, these challenges include cultural differences, language barriers and the low literacy of the health care system of the host country (Håkonsen et al., 2014; Suurmond et al., 2013; Terraza-Núñez et al., 2011). Håkonsen et al. (2014) conducted research on cultural barriers faced by non-western immigrants in Norway and found that effective interaction between immigrant health care users and health care service providers was impeded. The research described how the cultural beliefs of Muslim men towards women hindered effective interaction between the two groups. The norm of patriarchy in some Muslim cultures served as a barrier for

Norwegian health care staff to identify and address the health issues of female migrants holistically. Health care providers were reluctant to communicate with women who wore burqas (Islamic style of clothing which covers the whole body of women from head to feet), as their communication was often mediated through their husbands. Although the provision of opportunities for Muslim husbands to communicate with Norwegian physicians displayed respect for their religion and culture, it had the drawback of potentially limiting the physician's ability to conduct a comprehensive health assessment. As a result, health issues such as stress or mental disorders, which could be linked to traumatic experiences in the immigrants' countries of origin, could have remained undetected and unresolved (Håkonsen et al., 2014; Suphanchaimat et al., 2015).

Research conducted by Rosenberg et al. (2006) in Canada found that language challenges contributed to physicians avoiding exploring the traumatic experiences of immigrant health care users in their countries of origin. Similarly, a study by Hultsjö and Hjelm (2005) in Sweden revealed that language and communication barriers led health care staff to take medical histories superficially, making it difficult to identify the hidden health issues of immigrant health care users. Dauvrin et al. (2012) conducted research on delivering health care services to Irregular Migrants (IM) in Europe and found that health care staff in emergency departments were less affected by cultural and language barriers. However, health care professionals in mental health and primary health care departments were more influenced by these barriers due to the need for extensive communication with the health care users to explore their health issues holistically.

Moreover, cultural beliefs, particularly gender preferences, among immigrant health care users played a critical role in providing health care services Suphanchaimat et al. (2015). Lyberg et al. (2012) reported that male interpreters faced difficulties in understanding the needs of female immigrant health care users receiving maternity care. Female health care professionals in Europe sometimes experienced a lack of respect and mistrust from immigrant health care users (Englund & Rydström, 2012; Lyberg et al., 2012; Manirankunda et al., 2012; Suphanchaimat et al., 2015; Worth et al., 2009).

To further elaborate, it is important to recognise that language barriers, cultural differences and lack of familiarity with the health care system can greatly impact the connection between health care providers and immigrant health care users. This relationship can either positively or negatively affect the accessibility of health care services for immigrant health care users. Positive relationships can lead to better access to health care services, while negative relationships can prevent them from accessing the services they need (O'Mahony & Donnelly, 2007).

Studies conducted in New Zealand have shown that there is inequality in the utilization of health care services between immigrant health care users and host country users. Anderson (2008) found that immigrant health care users faced language barriers when accessing primary health care services. Bidwell (2013) reported that minority populations and poorer health care users in New Zealand are less likely to access health care services due to language, geographical, financial and cultural barriers. Akhtar et al. (2022) conducted research on Pakistani immigrant mothers in New Zealand and found that the lack of health care knowledge and different expectations prevented them from accessing health care services. The mothers also perceived unsatisfactory experiences with health care professionals, such as the lack of availability of General Practitioners' appointments and long waiting times in emergency departments. These barriers ultimately limited immigrant health care users' utilization of health care services in New Zealand.

In conclusion, the challenges faced by immigrant health care users in the host country impact their ability to access necessary health care services, which can have negative consequences for their health outcomes. Health care providers must address these challenges to ensure that immigrant health care users have equitable access to health care services.

2.9.2   Interaction with health care providers

In today's health care system, the interaction between health care providers, particularly medical professionals and health care users is vital in evaluating the quality of health care services delivered. This relationship has a significant impact, both positive and negative, on the outcomes of the health care services provided (Johnson, 2019). As such, it is essential to explore and analyse how these interactions affect the health outcomes of health care users.

To address the challenges in these interactions, health care users are concerned about the inadequacy of human resources, particularly skilled medical professionals and the capacity of health care providers to provide health care services (Akhavan, 2012; Hultsjö & Hjelm, 2005). According to Straßmayr et al. (2012), the shortage of highly skilled mental health professionals among European health care providers is a significant challenge for immigrant health care users. Specifically, the shortage of mental health professionals in Europe with expertise in treating traumatised migrants is a barrier for health care providers in delivering adequate health care services to immigrants. Another communication challenge faced by immigrant health care users is the lack of professional interpreters. Although health care institutions provide interpreting services, whether face-to-face or over the phone, the availability of such services does not guarantee the quality of health care (Suphanchaimat et al., 2015). Straßmayr et al. (2012) argue that the shortage of qualified interpreters trained in mental health disorders is a barrier for health care providers.

The significance of communication and language for diagnosing and treating health care users with mental health disorders cannot be overstated. Despite the importance of interpreting services, Farley et al. (2014) claim that it is a time-consuming service. Providing interpreting service over the phone also contributes to a higher workload of medical staff (Eklöf et al., 2015). As a result, medical staff experiences difficulties regarding the time allocated to health care users. Accessing interpreting services requires more time compared to appointments without the use of interpreters and medical staff must consider the requirements of the content involved (Lindsay et al., 2012).

In addition, interpreting health issues of health care users with the use of difficult vocabularies in health care can pose difficulties for interpreters, according to (Akhavan, 2012). As a result, it is critical to choose interpreters who are familiar with the culture and accent of immigrant health care users to effectively communicate with them. Moreover, inadequacy of medical staff with diverse ethnic backgrounds can be a key hurdle in interaction with health care providers. Immigrant health care users may encounter problems with the availability of health care staff who can understand their needs and the capacity of health care providers in delivering health care services. Nicholas et al. (2014) suggests that this can be solved by hiring different health care staff from different ethnicities that can serve as cultural brokers between immigrants and health care providers.

Research conducted by Gray et al. (2017) on Pacific health care users in New Zealand reveals that health care staff sometimes struggled with interpreters in terms of interpreting medical terms to the Pacific health care users. The struggle was due to the difficulty in providing professional and qualified interpreters who can interpret medical vocabularies effectively to Pacific health care users. As a result, Pacific health care users show dissatisfaction with the work of interpreters which results in negative interaction between them and New Zealand health care providers. Gray et al. (2017) suggest that professional interpreters need to be trained in medical terminology and strengthen their medical vocabularies to enhance the interaction between health care staff and immigrant health care users.

Contradictions between health service provision guidelines and immigrant health care users' beliefs and attitudes can also hinder the interaction between health care staff and immigrant health care users (Worth et al., 2009). For instance, health care staff in the United States of America are delivering medicine to HIV positive immigrants at places outside of their homes, which contradicts the service provision guidelines of the health care providers that state it should be delivered inside the health care centre. This adaptation is meant to prevent disclosing the HIV positive status of female immigrants to their male partners (Foley, 2005; Suphanchaimat et al., 2015). According to Høye and Severinsson (2008), any contradictions between health service provision guidelines and immigrant health care users' beliefs and attitudes may increase the stress of health care staff. For example, health care staff in an intensive care ward in Norway may feel

stressed due to the availability of many family members of the immigrants' health care users in the ward visiting their patient. This adaptation hinders the health care staff's normal practice of providing health care services to the health care users (Wachtler et al., 2006).

In conclusion, the quality of interactions between health care professionals and immigrant health care users determines the perception of the latter about the quality of health care services. Positive and effective interaction results in positive health outcomes for immigrants, while negative interactions may lead to dissatisfaction with the health care services in the host country.

2.9.3   Interaction with health care system

This section explores the relationship between immigrant health care users and professional health care standards as well as the health care system of the host country. Health care policy outlines the delivery of health care services and how society members, including immigrants, can access these services (Donnelly & McKellin, 2007). However, there are variations in the health care policies of different countries with regards to accessing health care services. While some countries have relaxed policies towards the access of immigrants to health care services, others only allow legal or documented migrants to access health care services (Lebano et al., 2020; Suess et al., 2014). Health care systems are designed to provide universal access to health care services for all, including immigrants (both documented and undocumented). However, the reality is that immigrants, especially undocumented ones, may be unable to exercise this right due to financial constraints and administrative procedures. Canada provides an example of how these factors can limit the health care rights of migrants (Munro et al., 2013).

Despite the restrictive policies in place, health care staff and providers are finding ways to treat undocumented immigrant health care users. In Canada, health care providers argue that denying health care services to undocumented immigrants puts the future health of the national population at risk, which will ultimately increase the cost of future health care services for the government of Canada once these individuals are granted permanent residency (Villegas & Blower, 2019). Thus, fear of increasing the cost of future health care services is seen as a reasonable excuse to provide health care services

to undocumented immigrants, as it benefits public health by preventing the country from experiencing national health threats.

It is worth noting that while some countries have relaxed policies towards immigrants' access to health care services, others only allow legal or documented migrants to access such services (Guinto et al., 2015; Lebano et al., 2020; Onarheim et al., 2018; Yan, 2016). In New Zealand, for instance, undocumented immigrant health care users are not eligible to access publicly funded health care services unless they can provide documents related to their immigration status (Ministry of Health, 2022a). This lack of eligibility for care presents a significant barrier for undocumented immigrants in accessing health care services in many countries, including New Zealand (Donnelly & McKellin, 2007). Similarly, in Philadelphia state in the United States, to be insured with health care providers, immigrant health care users must provide proof of address to health care settings, which can prevent African immigrant women who do not have any documents showing proof of address from accessing health care services (Foley, 2005; Suphanchaimat et al., 2015).

Although the health care systems in host countries may be open to universal access for citizens and immigrants, including documented and undocumented immigrants, administrative processes and cost burdens are key factors that limit the right of migrants, particularly undocumented migrants, to access health care services. However, the efforts of health care staff and providers to find excuses to provide health care services to undocumented immigrants benefit public health and prevent the country from experiencing national health threats.

Furthermore, it is noted that there are other challenges that undocumented immigrants face when accessing health care services, including the emotional challenges experienced by health care staff when rejecting to treat undocumented immigrants. According to Kurth et al. (2010), health care providers often feel uncomfortable refusing care to undocumented immigrants, but are legally required to report their presence to the police or other authorities in some countries such as Germany and Lithuania. However, most health care providers choose to treat undocumented immigrants as they recognise the potential risk to public health if left untreated and view it as their ethical and social responsibility (Castañeda, 2008; Dauvrin et al., 2012; Dwyer, 2004; Kurth et

al., 2010). While health care policies vary by country, undocumented immigrants are generally not eligible for publicly funded health care services, as they are required to provide documentation related to their immigration status to be eligible for care (Ministry of Health, 2022a).

Undocumented immigrants encounter multiple barriers when attempting to access health care services in their host country, as suggested by the literature. Table 3 provides a summary of these obstacles. The data sources for the barriers to health care access included in Table 3 are diverse. For Australia, the data came from Au et al. (2019) and Murray and Skull (2005). For New Zealand, the data were sourced from Anderson (2008), Ministry of Social Development (2008), DeSouza (2006), Hobbs et al. (2002), Mortensen and Young (2004), North et al. (2004), Wong (2015a) and Kanengoni et al. (2018). The United Kingdom (UK)'s data were obtained from Giuntella and Nicodemo (2016) and Giuntella et al. (2018), while Lebrun and Dubay (2010) and Derr (2016) provided the data for the United States of America (USA). For Canada, the data were sourced from Whitley et al. (2017) and Kirmayer et al. (2011), while Kohlenberger et al. (2019) and Olausson et al. (2016) provided the data for Austria and Sweden, respectively.

Table 3

Barriers to Accessing Health Care Services in New Zealand and Other Countries

Barrier to health care access	Australia	NZ	UK	US	Canada	Austria	Sweden
Unfamiliarity with health system	✓	✓	✓				
High- cost	✓	✓	✓	✓		✓	
Language proficiency	✓	✓		✓	✓	✓	✓
Cultural differences in assessment and treatment	✓	✓			✓		
Financial needs	✓						
Legal barriers	✓		✓				
Waiting time			✓			✓	
Lack of insurance				✓			
Lack of mobility and ability to take leave at work to visit hospitals				✓			
Fear from treatment or doctors						✓	
Lack of trust to the doctors						✓	
Low treatment by doctors							✓
Unclear type of health services can be accessed		✓					
Lack of awareness of the available health services		✓					
Lack of appropriate health information resources		✓					
Lack of interpreting services		✓					

2.10 Determinants that influence immigrants' accessibility to health services.

Immigrants are widely regarded as a vulnerable population, with a higher risk of experiencing adverse physical and psychological health outcomes (Derose et al., 2007). The World Health Organization (2022) reports that millions of immigrants worldwide, particularly low-skilled immigrant workers, face poorer health outcomes than their host populations. This continued poor health status of immigrants could have a negative impact on the world's efforts to achieve sustainable development goals for immigrant populations (Matlin et al., 2018). Therefore, the principle of *the right to health for all* drives host countries to address the health needs of immigrant populations within their health care systems. Ensuring access to health care services that are sensitive to the

needs of immigrants is key to strengthening and maintaining the health care systems of host countries (World Health Organization, 2022).

According to the World Health Organization (2022), immigrants are not inherently less healthy than citizens of the host country. Rather, there are several key determinants affecting their health outcomes. One major determinant is the immigrant's legal status, which refers to their status as either documented (lawful) or undocumented (unlawful) immigrants (Arbona et al., 2010; Hacker et al., 2015). Undocumented immigrants have a lower chance of accessing health care services. For instance, in the United States of America (USA), approximately 45 percent of undocumented immigrants lack health insurance coverage, which is essential for accessing health care services (Bustamante & Beltrán, 2020; Chang, 2019). Every individual, whether a citizen, documented, or undocumented immigrant, must show their legal status to be insured and access health care services. Therefore, an immigrant's legal status plays a key role in restricting their access to health care services in the host country.

Residential location is an additional factor that impacts immigrants' ability to access health care services. In comparison to regular residential locations, immigrants' new destinations typically have less established health care safety networks, fewer competent health care providers and less immigrant advocacy organisations. As a result, immigrants often face numerous obstacles when trying to access health care services in their new location. For instance, when compared to immigrants in traditional destinations, such as major cities in the USA, Somali and Hispanic immigrants in relatively small populations in new areas rely more on emergency departments for their care (Derose et al., 2007; DeShaw, 2006; Tolbert & Henry, 2006).

Additionally, newer immigrants residing in new destinations often have less communication with long-term immigrants who arrived in the country earlier. Newer immigrants may not know many people they can turn to for assistance with language interpretation and health care system knowledge, leading to delayed access to health care services until their health issues become unbearable. This situation frustrates health care providers, as they are unable to deliver proper health care services to immigrant health care users and causes dissatisfaction among immigrants who do not obtain suitable health care services (Derose et al., 2007; Waters & Jiménez, 2005).

Consequently, immigrants who reside in new destinations outside of big cities with large immigrant populations have less chance of accessing health care services than those located in major cities.

Furthermore, limited English proficiency is a significant barrier to immigrant health care users in accessing health care services in the host country. Immigrants who have limited proficiency in the host country's language are less likely to have health insurance as their primary source of accessing health care services in countries such as the USA, Australia and the United Kingdom. Limited English proficiency can lead to lower rates of preventive health care (Ali & Watson, 2018; Luiking et al., 2019) and it also affects immigrants' understanding of medical reports related to their health issues. For example, less educated immigrants often encounter difficulties understanding written health instructions. Health care providers are required to have qualified interpreters to interpret and translate between physicians and immigrant health care users. However, in many cases, interpretation services are provided by ad hoc interpreters who may not be the most suitable option for health care providers. These ad hoc interpreters may be family members, friends, or health care staff members, but they may not possess the necessary skills, training, or impartiality required for accurate interpretation (Flores et al., 2012). According to Huang et al. (2019) professional and trained medical interpreters are rare in many health care providers in the USA. As a result, limited English proficiency is likely to have a negative influence on immigrant health care user's satisfaction with the care quality delivered (De Moissac & Bowen, 2019). Therefore, limited English proficiency is a significant barrier for immigrant health care users to access health care services provided in the host country.

In addition to the aforementioned factors, stigma and marginalisation also play a significant role in preventing immigrants from accessing health care services in their host country. Stigma can be described as a social process that involves categorizing and separating individuals or groups based on factors such as socioeconomic status, race, gender identity, sexual orientation, migrant legal status, or age (Nyblade et al., 2019). On the other hand, marginalisation refers to the exclusion of individuals or groups from accessing health care services, which puts them at a higher risk of experiencing poor health outcomes, low self-esteem and a lack of self-efficacy (Baah et al., 2019).

Immigrants, especially undocumented individuals, are often stigmatized and marginalized due to their traditional dress, cultural practices and religious beliefs. As a result, many of them are reluctant to seek health care services in their host country, which deprives deserving immigrants of the necessary safety net (Derose et al., 2007). For instance, a study found that 22% of North African women immigrant health care users experienced discrimination from French health care service providers (Rivenbark & Ichou, 2020). Therefore, stigma and marginalisation are significant barriers for immigrant health care users to access health care services in their host country.

To elaborate further, financial income issues and low health literacy can lead to a lack of knowledge about preventive health care and delayed seeking of medical attention. Immigrants with low income may face financial barriers to accessing health care services, which could limit their ability to obtain proper treatment and medications (Derose et al., 2007). Additionally, fear of detention and deportation can discourage immigrants from seeking medical care, which can lead to untreated health conditions and poor health outcomes (Viruell-Fuentes, 2007)

Moreover, administrative barriers, such as complicated paperwork, insurance eligibility requirements and long wait times, can also prevent immigrants from accessing health care services. Administrative barriers can be particularly challenging for immigrants with limited English proficiency and those who are unfamiliar with the host country's health care system. These challenges can contribute to poor health outcomes and dissatisfaction with the quality of care received by immigrant health care users (Documét & Sharma, 2004; Rivers & Patino, 2006; Szaflarski & Bauldry, 2019; Viruell-Fuentes, 2007).

2.11 Immigrant alternative health-seeking strategies

To address the issue of limited access of immigrants to health care services in host countries, alternative health-seeking strategies have been observed. These strategies may include self-medication practices, communication with health professionals in their home country and the use of health insurance cards from citizens of the host country (Biswas et al., 2011; Stuttaford et al., 2014). According to research conducted in Denmark by Biswas et al. (2011) undocumented Bengali immigrants living in Denmark reported that they have limited access to health care services due to their

undocumented status. Consequently, undocumented immigrants rely on alternative health-seeking strategies, such as contacting health professionals in their home country to discuss their health issues and gaining medical advice from them. Additionally, undocumented immigrants contact their own networks in their home country to send them medicine to the host country.

Undocumented immigrants in Europe face numerous barriers to accessing health care services, including fear of being discovered by the police and deported to their home country. This fear has led many undocumented immigrants to seek alternative strategies, such as self-medication and borrowing entitlement forms from citizens of the host country, in order to access health care services (De Vito et al., 2015). However, Biswas et al. (2011) noted that undocumented immigrants sometimes use old prescriptions and contact their own networks without receiving medical follow-ups or adjustments. For example, undocumented immigrant health care users in Denmark may borrow medicines from their network friends who have the same health issue. Nevertheless, these alternatives could potentially harm their health and undocumented immigrants acknowledge that there are no other options to access health care services.

In conclusion, the alternative health-seeking strategies adopted by undocumented immigrants in host countries are driven by a range of factors such as fear of being reported to the authorities, limited language proficiency and lack of knowledge about the local health care system. These challenges often force them to look for alternative ways to access necessary medications. Undocumented immigrants' resort to various options such as borrowing insurance or medical cards from friends, contacting their friends and family back in their home country for advice and using old prescriptions without proper medical follow-up or adjustment. It is important to note that these alternatives may potentially harm their health.

2.12 Evaluation of health service quality

In the field of health care service quality evaluation, there have been several studies that emphasise the importance of assessing health service users' perceptions and internal service performance. Donabedian's model, according to Talsma et al. (2014) is among the most commonly used methods in this area. Furthermore, Jain and Gupta (2004) suggest that the SERVQUAL scale is another widely used measurement model that can

be applied to assess service quality across different service organisations. The SERVQUAL model stands for *Service Quality* initially consisted of a ten-dimension conceptualisation of service quality, but after undergoing several revisions, it now encompasses five dimensions, namely tangibles, responsiveness, empathy, assurance and reliability (Parasuraman et al., 2002) (see Table 4).

Table 4

The Description of SERVQUAL Dimensions

Dimensions	Descriptions
Tangibility	Including the visual appearance of physical facilities, the state of equipment, the demeanour of personnel, and the quality of communication materials. For example, medical instruments, physical facilities, neatness of employees' uniforms, well-maintained rooms, good lighting in every room, suitable temperature in the rooms, delicious meals served, and the scent in every room is refreshing.
Reliability	The ability to perform the promised service dependably and accurately. For instance, appropriate employee responses, medical treatments, available and adequate family visiting times, and all equipment (AC, TV, radio, lights, etc.,) work properly.
Responsiveness	The willingness to help health care users and to provide prompt service. Such as, staff shows a sincere interest in solving problems and quick medical treatment response when the elderly need it.
Assurance	The knowledge and courtesy of employees and their ability to convey trust and confidence. For example, staff has the knowledge to answer questions and acts courteous with elderly.
Empathy	The provision of caring, individualised attention to customers. Staff has the patient's best interest at heart and build with them long-term relationships

Note: Adapted from (Ko & Chou, 2020)

The debate on which model is superior in assessing health service quality remains ongoing. Chang and Chang (2013) argued that the SERVQUAL model is more practical in calculating the gap between health service user expectations and perceptions of service quality, Bosmans et al. (2009) found that SERVQUAL is the more commonly used model in examining service quality across different sectors. Conversely, Hearld et al. (2008) suggested that Donabedian's model is widely used in evaluating health care service quality in various health care providers. According to Hoff et al. (2004), Donabedian's model assesses health care quality based on three domains: structure, process and outcomes, with each domain having a significant impact on health service user

satisfaction. These domains are usually analysed separately to identify their specific effects on health service user satisfaction.

Various instruments have been used by researchers to measure service quality, including the domain-specific model by Cengiz and Fidan (2017), Health care Service Quality (HEALTHQUAL) model by Barrios-Ipenza et al. (2020); Juwaheer and Kassean (2006); Lee (2017); Nemati et al. (2020), the Public-Hospital Service-Quality (PubHosQual) model by Aagja and Garg (2010), Service Performance (SERVPERF) model by Cronin and Taylor in 1992 (Brady et al., 2002) and Service Quality in a Hospital (HospitalQual) model by Itumalla et al. (2014). In this research, Donabedian's model will be used to evaluate the quality of health care services in New Zealand. This model is widely accepted and examines health care quality through three levels: Structure, Process and Outcomes (SPO) and seven pillars, including efficiency, optimality, acceptability, legitimacy and equity Ibn El Haj et al. (2013). Like the SERVQUAL scale, Donabedian's model is used to measure the difference between the expectations and perceptions of health care consumers about health care services.

SERVQUAL is a popular tool for measuring health service quality and has been compared to other models such as Donabedian's model. Parasuraman et al. (2002) designed SERVQUAL as a variant of other models and Dopeykar et al. (2018) have used the most recent version of the SERVQUAL model to measure dental health service users' satisfaction in a dental practice. Dopeykar et al. (2018) confirmed that the SERVQUAL instrument can measure the lowest and highest scores of health service users' satisfaction within dental clinics. According to Manulik et al. (2016), the SERVQUAL scale is superior to other models because it measures the gaps between health service users' expectations and perceptions of received health care services. This approach enables the measurement of health care consumers' expectations before their perception of the quality of service.

Advocates of SERVQUAL argue that it is superior to Donabedian's model because it enables the identification of areas where service improvements are needed based on health service users' expectations. For example, if the tangibility dimension's measurement is below the health service users' expectation, the health care provider may need to improve its infrastructure (Butt & de Run, 2010). Furthermore, Kalaja et al.

(2016) added that SERVQUAL can be used to compare performance in different parts of the service and the instrument is applicable across various service sectors, cultural backgrounds and different countries. Additionally, the SERVQUAL questionnaire is pre-described and can be adapted to fit different service settings.

2.12.1 A closer look at Donabedian's evaluation model.

Avedis Donabedian developed a model in 1966 that aimed to assess the quality of health care services (Wong et al., 2013). According to Donabedian, improving the quality of health care services depends not only on enhancing technical services but also on improving the interpersonal quality of health care services. Technical health care services refer to the medical treatment process, while interpersonal health care services relate to the appropriate communication between the health care provider and the health service users regarding their treatment (Endeshaw, 2021). Effective communication skills such as talking, listening and nonverbal communication are essential in providing high-quality health care services and achieving patient satisfaction (Berman & Chutka, 2016).

Zarei et al. (2012) elaborated on Donabedian's model by highlighting the distinction between technical care quality and process or functional quality. Technical care quality pertains to the accuracy of medical examinations and procedures, while process or functional quality focuses on the ways and methods of delivering health service quality to health service users. Donabedian's model identifies three domains that can be used to evaluate the quality of health services: Structure, Process and Outcome (SPO) (see Figure 5). Structure refers to the physical and organisational components of health care, such as buildings, facilities, human resources (staff), financing and equipment. Process encompasses the mechanisms for interacting with and facilitating health care users through delivering health services. Finally, Outcome refers to the influences of health care quality on health service user satisfaction levels. Various studies have examined Donabedian's model and highlighted its usefulness for evaluating health care quality (Berwick & Fox, 2016; Khamis & Njau, 2014; Qu et al., 2010; Sword et al., 2012; Wong et al., 2013).

To address the potential drawbacks of Donabedian's model, some researchers have pointed out the difficulty in establishing a clear relationship between the three domains

(SPO) Liu et al. (2011). It can be challenging to determine whether certain factors are strictly part of Structure, Process, or Outcomes, as there may be similarities between them. However, despite these limitations, Donabedian's model has proven to be a useful tool for evaluating and improving health care quality through examining the SPO in health care providers.

In this research, Donabedian's model will be used as an alternative to the SERVQUAL model to assess the quality of health services delivered by health care providers in New Zealand. By using Donabedian's model, the researchers hope to gain a better understanding of the quality of health care services in New Zealand and identify areas for improvement. Donabedian's framework has been recognized by the World Health Organisation (WHO) as the most suitable model for increasing health care user awareness and satisfaction with outcomes (Ghaffari et al., 2014). This model focuses on outcomes as a criterion for health care user satisfaction and emphasises that the three domains of quality of care (structure, process and outcome) work together and affect each other to help health care providers deliver better quality health services and satisfy their users (Tossaint-Schoenmakers et al., 2021). Within Donabedian's model, the outcome domain assesses the effects of health service quality on health service users' health status. It is widely acknowledged that satisfaction with the quality of health care provided can have a positive impact on the health status of both the user and their family. As a result, the outcome domain should reflect the health service user's preferences rather than those of the health care provider.

Figure 5

Donabedian's Model for Examining Health Care Quality
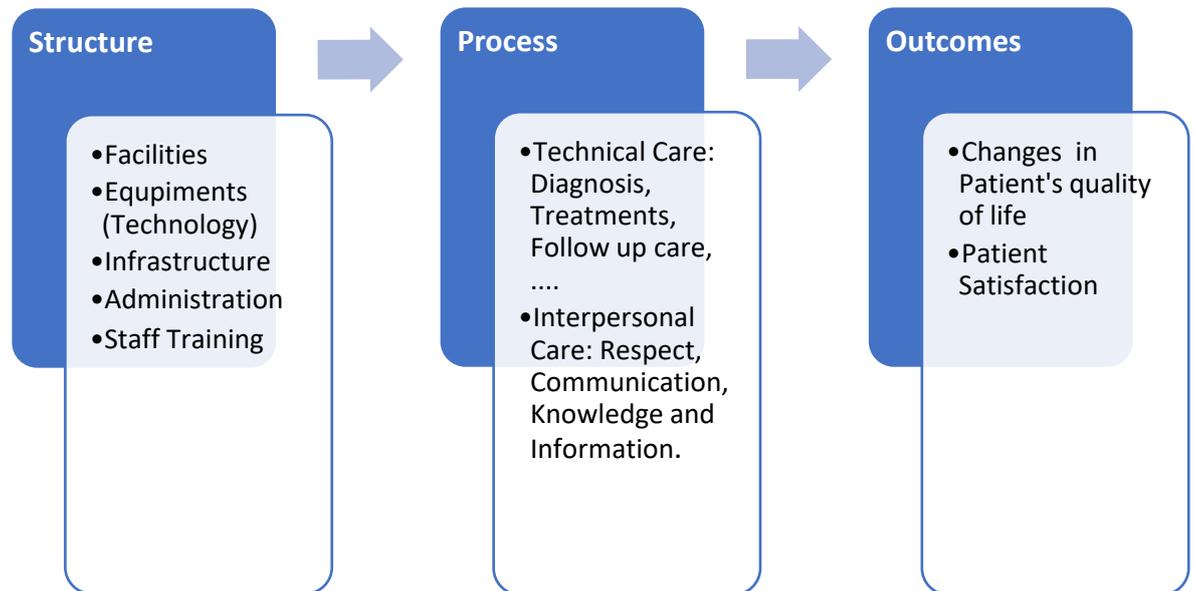
Donabedian's theory emphasises the importance of treating the three domains (SPO) equally to effectively monitor health care quality. He noted that the SPO approaches are complementary and must be used collectively to comprehensively examine health care quality (Qu et al., 2010). Evaluating health care quality using a whole framework that includes all three approaches (SPO) is likely to provide a more accurate assessment of health care quality. Thus, according to Donabedian's model, the relationship between Structure, Process and Outcome and seven dimensions constructs the total health care quality measurement (see Figure 6) (Ameh et al., 2017).

Donabedian (2005) highlights that while some outcomes, such as death rates, are generally easy to measure, others, like health service user satisfaction, can be more challenging. Therefore, this research aims to evaluate the outcomes of health care services as an indicator of quality of health services. The outcome of the health care system is described by its efficiency and quality of care (Kringos et al., 2010). The outcome measurement tool describes the influence of health care on the health status of health care users (Mainz, 2003). It can also represent the degree of health service users' satisfaction with the quality of health care services. Moreover, outcome indicators may include improvements in health care users' knowledge and positive changes in their attitudes toward the health system (Mainz, 2003). This approach

intends to differentiate between the means of providing health care (such as technical tools) and obtaining ends (like the level of satisfaction) among health care providers in New Zealand. Furthermore, Donabedian's framework suggests that there are seven dimensions or pillars that can be used to measure the quality of health services (Peters et al., 2012). Table 5 detailed about Donabedian's dimensions used in assessing the quality of health care services (Ameh et al., 2017).

Table 5

Donabedian's Dimensions (Pillars) Used in Measuring the Quality of Health Services

Dimensions	Descriptions
Efficacy	refers to the capacity of health care interventions, based on scientific knowledge and technology, to achieve improvements in health outcomes under optimal or controlled conditions.
Effectiveness	refers to the extent to which realistic and feasible health outcomes are achieved through the delivery of appropriate and effective health care services.
Efficiency	refers to cost reductions without compromising effects, or without diminishing attainable improvements in health.
Equity	equity in health care refers to the fairness in the distribution of health care services and benefits among members of a population, irrespective of their social, economic, or demographic characteristics, to ensure that everyone has access to health care services and benefits on an equal basis.
Optimality	refers to achieving the best possible balance between the benefits and costs of health care interventions, where the benefits are measured in terms of improvements in health outcomes and the costs include not only the financial costs but also the potential risks, harms and other negative consequences of the interventions.
Acceptability	Encompasses accessibility of health care and interpersonal health service user-provider interaction. Or conformity to the wishes, desires and expectations of health service users and their families.
Legitimacy	legitimacy in health care refers to the degree to which a health care institution and its delivery of services are socially acceptable and consistent with ethical principles, values, norms, laws and regulations.

Table 5. described the seven dimensions of Donabedian's model that health care providers can use to understand the perspectives of health care users regarding the quality of the services delivered. Each dimension serves as a reference guide for the provider to improve the quality of their health care services.

Figure 6

The Interconnection Between the Dimensions and Domains of Quality of Donabedian's Model
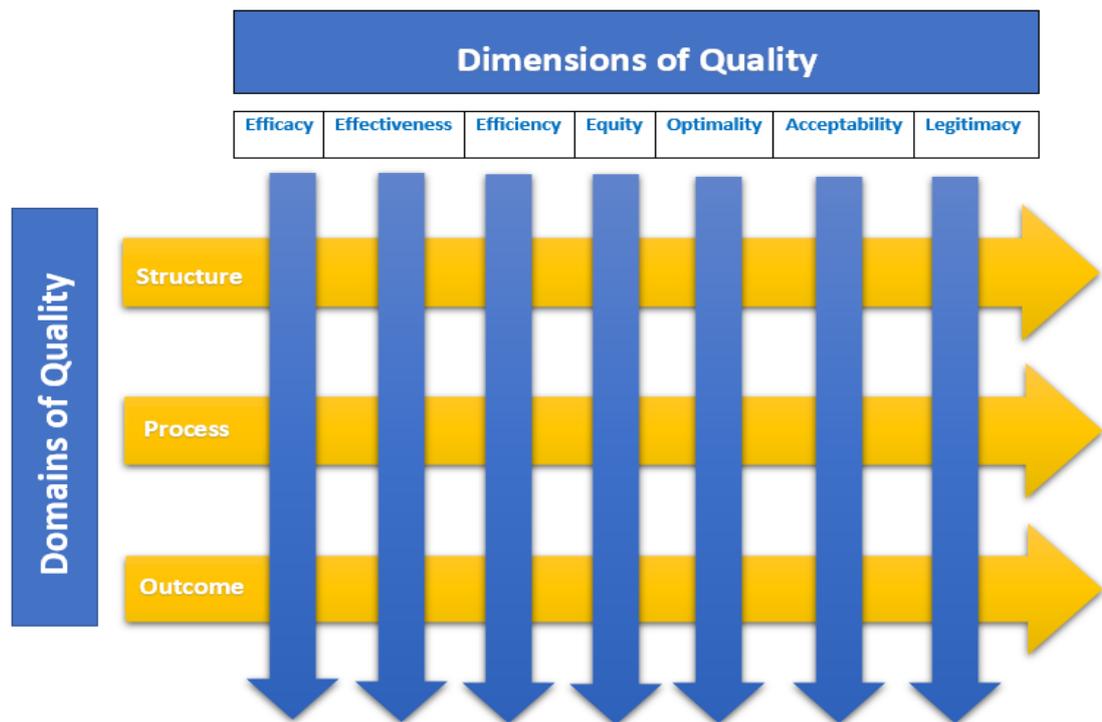
Note: adapted from (Byrne et al., 2020).

2.13 Research conducted using Donabedian's model.

Several studies have employed Donabedian's model to assess health service users' satisfaction with the quality of health care services (see Table 6). Some of these studies focused on investigating the level of interconnections between the SPO concepts to enhance the quality of health services delivered to health care users. Others aimed at achieving significant health outcomes for health service users and scaling up the health services. Additionally, some researchers assessed the ability of health care staff members to cope with new technological advancements in their work. Another aspect of assessing health service quality by researchers is examining health service user

satisfaction. Therefore, this study also contributes to evaluating the quality of health care services as perceived by Kurdish immigrants in New Zealand using Donabedian's comprehensive health care quality evaluation framework (SPO).

Table 6

The Studies Conducted Using Donabedian's Model

Country	Details of the research conducted
Japan	Title: Patient perception of nursing service quality; an applied model of Donabedian's structure-process-outcome approach theory
	Authors and Year: (Kobayashi et al., 2011)
	Objectives: to apply Donabedian's structure-process-outcomes model in order to classify and evaluate patients' experiences with nursing services.
	Data: 1,810 health service users at general wards in Japan in between 2005–2006
	Methodology: Structure, Process, or Outcomes (SPO) in Donabedian's model
	Results: Donabedian's framework was utilised to verify health service users' experiences with nursing services.
The UK	Title: Effectiveness of a voluntary family befriending service: a mixed methods evaluation using the Donabedian model
	Authors and Year: (Gentry et al., 2018)
	Objectives: To present the findings of an operational evaluation that utilises robust routine work to generate generalisable conclusions.
	Data: Data was gathered from a total of 96 individuals, consisting of 41 qualitative interviews and quantitative analysis of routine data from 5,740 visits made between July 1, 2014, and July 1, 2016.
	Methodology: A stakeholder survey with both qualitative and quantitative components conducted in a cross-sectional manner.
	Results: Data collected from Home-Start Suffolk (HSS) service users revealed that HSS was perceived as an effective support service for families in need.
South Africa	Title: Relationships between structure, process and outcome to assess quality of integrated chronic disease management in a rural South African setting: applying a structural equation model.
	Authors and Year: (Ameh et al., 2017)
	Objectives: Obtain the optimal health service user health outcomes and scale-up medical services in research about chronic communicable and non-communicable diseases (NCDs).
	Data: 435 Chronic Disease Health service users and operational managers of all seven Primary Health Care facilities in 2013
	Methodology: In this cross-sectional study, Donabedian's theory was operationalised through a structural equation model.
	Results: relationships between domains of Donabedian's theory (structure, process and outcome) was considered in the Integrated Chronic Disease Management (ICDM) model.
Canada	Title: Donabedian's structure-process-outcome quality of care model: validation in an integrated trauma system.

Saudi Arabia (header spans from above)	Authors and Year: (Moore et al., 2015)
	Objectives: Assess the effectiveness of an incorporated trauma system in connection with SPO constructs.
	Data: Obtained from 57 Canadian provincial trauma centres and 63,971 health service users) in between 2005–2010.
	Methodology: Donabedian's framework using quality indicators (QIs) which was improved and validated before.
	Results: The research observed a significant positive correlation between SPO domains
Iran	Title: Application of Donabedian quality-of-care framework to assess the outcomes of preconception care in urban health centres, Mashhad, Iran in 2012
	Authors and Year:(Ghaffari et al., 2014)
	Objectives: to identify preconception care quality in the health centres.
	Data: Data were collected from 350 women who received preconception care in reproductive age in urban health centres of Mashhad, Iran.
	Methodology: The Donabedian's model was used to design the questionnaires about preconception care of women.
	Results: The results of the study show that about 75% of the health service users were satisfied with receiving preconception care
Sweden	Title: The structure of quality systems is important to the process and outcome, an empirical study of 386 hospital departments in Sweden
	Authors and Year: (Kunkel et al., 2007)
	Objectives: Explore how hospital human resource's staff (clinicians, nurses and managers) confront the new technological developments to maintain a high level of quality care
	Data: The data were collected from 600 hospital departments
	Methodology: Donabedian's SPO theory to describe the health care quality systems and find out the relationship between the SPO components
	Results: The research has observed a robust relationship between components of Donabedian's model (Structure, Process and Outcomes).
United States of America	Title: Evaluating the Quality of Acute Rehabilitation Care for Patients with Spinal Cord Injury: An Extended Donabedian Model
	Authors and Year: (Qu et al., 2010)
	Objectives: The objective of the study was to evaluate the standard of rehabilitation care provided to patients with spinal cord injury (SCI) using Donabedian's structure, process, outcome model.
	Data: The study primarily utilised data retrieved from the National Spinal Cord Injury Database (NSCID), which has been collecting information on new SCI cases in the United States since 1976.
	Methodology: The researchers employed cluster analysis, univariate variance analysis and multilevel analysis.
	Results: The study's findings revealed a significant disparity between the number of therapists available and the amount of therapy provided to patients.
Saudi Arabia	Title: Quality of nursing care in Saudi's health care transformation era: A nursing perspective

	Authors and Year: (Alkorashy & Al-Hothaly, 2022)
	Objectives: The objective of this study was to examine nurses' perceptions of the Quality of Nursing Care (QNC) using the Donabedian model as a framework.
	Data: The Data collected from 639 nurses who were working in tertiary hospital in Saudi Arabia.
	Methodology: A convenience sampling was adopted to conduct this cross-sectional study.
	Results: The study found that nurses held a positive overall perception of the Quality of Nursing Care (QNC).
China	Title: Exploring pathways to outpatients' satisfaction with health care in Chinese public hospitals in urban and rural areas using patient-reported experiences
	Authors and Year: (Wang et al., 2019)
	Objectives: The objective of this study was to assess the general satisfaction and experiences of outpatients in Chinese public hospitals.
	Data: The study collected data from a patient survey conducted in 2016, which included 4782 outpatients from 9 city-level (urban) and 16 county-level (rural) public hospitals located across China.
	Methodology: The study utilised Chi-square tests to evaluate the variations in patients' experiences and general satisfaction between rural and urban areas.
	Results: The study found that, in comparison to respondents in rural areas, those in urban areas reported higher rates of satisfaction and positive experiences across most aspects.
Netherlands	Title: Relationships Between Context, Process and Outcome Indicators to Assess Quality of Physiotherapy Care in Patients with Whiplash-Associated Disorders:
	Authors and Year: (Oostendorp et al., 2020)
	Objectives: The objective of this study was to investigate the associations between context, process and outcome values in assessing primary care physiotherapy for patients with WAD (Whiplash-Associated Disorder).
	Data: The study collected data on 810 patients with WAD from patient records in primary care physiotherapy practices over a period of 16 years.
	Methodology: The collected dataset, known as RCD-WAD, was retrospectively analysed and classified into context, process and outcome variables.
	Results: The identified relationships between chosen context, process and outcome variables were reasonable to moderate.
Australia	Title: Using the Donabedian framework to examine the quality and safety of nursing service innovation
	Authors and Year: (Gardner et al., 2014)
	Objectives: The objective of this study was to assess the safety and quality of nurse practitioner services using the Structure, Process and Outcome audit framework.
	Data: The study utilized multiple data collection approaches, including a stakeholder survey (n = 36), in-depth interviews with 11 patients and 13 nurse practitioners and analysis of health records data on service processes.

	Methodology: the design of A mixed methods was used within the Donabedian framework.
	Results: The study concluded that adequate and detailed preparation of the Structure and Process components is imperative for the successful implementation of a service innovation.

2.14 Why the health service user's point of view?

Asking health care service users to provide feedback on their experiences can not only improve health services, but also enhance clinical effectiveness (Dickinson et al., 2014). Therefore, health care providers aim to meet and exceed health care users' expectations by focusing on their satisfaction, which is known as person-centred care (Berhane & Enquselassie, 2016). Agency for Healthcare Research and Quality (2022) recognises person-centred care as one of the six domains of quality health care. This approach allows health service users to express their values, preferences and experiences and health care providers prioritize listening to and understanding the perspectives of health care users (Wong et al., 2020). The ultimate goal of providing good quality health care services is to satisfy health care users and thus, health service user satisfaction is a significant indicator to evaluate the performance of health care providers and the health system as a whole (Prakash, 2010). The quality of health care services is no longer measured solely from an internal focus. It is now considered essential to take external measures from health care service users themselves (Vinagre & Neves, 2008). Berger et al. (2020) have examined the major forms of evaluating the quality of health care services, which include voluntary events, health care user surveys and informal feedback.

Voluntary events are channels offered at the customer service of the health care provider, such as face-to-face feedback, email, telephone, social media networks and more. Health care user surveys are another approach that health care providers adopt in receiving perspectives of health care users after they receive services. These surveys can be done either online through specific websites, which are sent to the health care user, or through telephone surveys. Finally, informal feedback is used by health care users to express their perspectives about health services to the staff verbally.

In conclusion, health service users' opinions are fundamental to improving health care services quality. evaluating health service quality without considering the viewpoint of

health service users is futile. Health care service organisations now realise that collecting health service user feedback plays a significant role in improving the care of their health service users.

2.15 Summary of the chapter

This chapter has reviewed various areas related to the quality of health care services, including the forms of quality in health care services and their evaluation. The chapter has also focused on health care service satisfaction among migrants overseas and the interactions between health care users, providers and the health care system and laws of the host country. Furthermore, the chapter has explained Donabedian's model of evaluation of health care services, which is a well-known model in the health sector. According to this model, evaluating the quality of health services can be achieved through three domains: Structure, Process and Outcome (SPO). The Structure domain includes buildings, facilities, human resources, financing and equipment, while the Process domain includes the mechanisms for interacting with health care users by delivering health care services. Finally, the Outcome domain consists of evaluating the impact of the quality of health care services on health service users' satisfaction.

The chapter has highlighted the significance of evaluating the quality of health care services from the perspective of health care users. Health care providers are no longer solely evaluating their health services based on internal feedback (from staff), but they are also collecting feedback from external factors (health care users). This is aligned with the Donabedian model, which emphasises that the enhancement of the quality of health care services depends on both technical and interpersonal services. Interpersonal health care service includes providing appropriate communication to the health care user regarding their treatments.

Chapter 3 : Research Design

3.1 Introduction

In this thesis, the first chapter outlined the research aims, which were to investigate the perceptions of health service quality among Kurdish immigrants in New Zealand and identify any barriers Kurdish immigrants faced when accessing health care services. The previous chapter provided relevant background literature on the research topic. In this chapter, the research methodology and methods employed to conduct this research are detailed. The chapter is divided into two main sections.

The first section outlined the methodological framework used in this research, including the research philosophy, justification for using pragmatism, research approach, research strategy and justification for the chosen approach. The second section explains how data was collected and analysed in the study and the research method used.

3.2 Research questions

Chapter one outlined the primary aim of this research, which is to investigate the satisfaction of Kurdish health care users with the quality of health care services in New Zealand. To provide a clear context for the research design and methodology, this chapter includes a presentation of the research questions, as follows:

- What are Kurdish health service users' experiences of New Zealand health care service delivery and do health care services meet health service users' expectations?
- How does the quality of health care services impact the satisfaction of Kurdish immigrants with New Zealand's health care system?
- What are the enablers and barriers for Kurdish immigrants to engage with health service delivery in New Zealand?
- What changes, if any, are required to improve the health care system to meet the needs of Kurdish immigrants in New Zealand?

3.3 Research methodology and method

This section provides an overview of the research methodology and methods used in this study. Research methodology, according to Mackenzie and Knipe (2006); Williams (2007), refers to the overall approach associated with the theoretical framework of the research project. Additionally, Goundar (2012) describes research methodology as the science of studying how research is conducted, including the steps and procedures used to describe, explain and predict phenomena. Fellows and Liu (2022) suggest that research methodology refers to the procedures of logical thought applied to a specific examination and it includes a set of rules and guidelines that assist the researcher in evaluating the knowledge of the research study.

In contrast, research methods refer to the systematic modes, specific strategies, procedures, tools and techniques used for data collection, interpretation and analysis (Long, 2014). Research methods include theoretical and experimental studies, as well as numerical and statistical schemes (El-Gohary, 2010). For instance, data collection methods may involve surveys, interviews, focus groups, observations and so on (Choy, 2014). These methods are designed to help researchers generate data and find a solution to a problem. For example, scientific research methods explain the research issue based on collected facts, observations and measurements (Goundar, 2012).

Research methodology and methods have been widely used in various research areas, including health care services, to generate data and find solutions to research problems. Basinga et al. (2011) used a quantitative survey method to collect data on the influence of maternal and child health services in Rwanda. Hutchison et al. (2011) relied on published literature related to primary health care in Canada. Mosadeghrad (2014) conducted in-depth individual and focus group interviews to recognise factors affecting the quality of health care services in Iran. Black et al. (2011) used a systematic review method to explore the impact of E-health on the quality and safety of health care. Grace and Higgs (2010) used several qualitative research methods, including focus groups, case studies and key informant interviews, to understand patients' and practitioners' experiences of integrative medicine. Mirzaei et al. (2013) conducted qualitative interviews with patients, carers and health care professionals to investigate the challenges faced by people living with a disease such as diabetes. Van Lith et al. (2013)

used mixed-method research to address the evidence base for art-based practices and mental health recovery.

The research methodology embodies the philosophical assumptions of the research and plays a fundamental role in guiding and selecting the research method (Long, 2014; Slevitch, 2011). Choosing a particular research methodology and method must be compatible with research objectives, questions, data collection and analysis techniques and the research problem (Vogt, 2008). The researcher's philosophical position may also influence the methodological selection for the research (Holden & Lynch, 2004). Moreover, the research method shapes the research design and is critical for other research processes, such as selecting the sampling method, coding and analysis (Vogt, 2008). Therefore, selecting an appropriate research methodology and method is essential to fulfilling the research objectives and responding to the research questions. The researcher's beliefs, values, assumptions and standards about truth and how knowledge is created also influence the choice of research methods, which is known as research philosophy (Saunders et al., 2019; Žukauskas et al., 2018).

The research in this study has been guided by the pragmatism research philosophy, which aims to investigate assumptions and hypotheses relevant to the quality of health care services in New Zealand from the perspective of Kurdish immigrants. To test these assumptions and hypotheses, the research employed in-depth qualitative interviews with Kurdish health care users in New Zealand, which captured their perceptions, opinions and attitudes towards the quality of health care services. To analyse the collected data and explore themes, the thematic analysis method was used. The following sections will provide a detailed discussion and justification of the chosen research methods, including the use of qualitative methods and data collection and analysis methods.

3.4   Research philosophy and paradigm

According to Saunders et al. (2019), research philosophy refers to a set of fundamental beliefs and assumptions regarding how researchers approach the development of knowledge. At every stage of research, researchers must consciously be aware of encountering new key assumptions that may assist in developing new knowledge in the research area. These assumptions may be about the realities that the researcher

encounters in the research (ontological assumptions), or about human knowledge (epistemological assumptions) and how the researcher's values affect the research process (axiological assumptions) (Saunders et al., 2019; Scotland, 2012) (see Table 7). Therefore, key assumptions shape the researcher's understanding of research questions, the methods used and how to interpret research outcomes (Kivunja & Kuyini, 2017; Saunders et al., 2019). This research adopts a pragmatism research philosophy to investigate the quality of health services in New Zealand assuming that does not meet the needs of Kurdish immigrants, the Kurdish immigrants are unable to fully access health care services in New Zealand and Kurdish immigrants are not satisfied with the quality of health care services in New Zealand.

According to Saunders et al. (2019), research philosophy pertains to the development of research assumptions, their nature and knowledge. Assumptions are considered fundamental statements of logic and reasoning that depend on the researcher's knowledge and insights (Žukauskas et al., 2018). These assumptions serve as sources of research (Kivunja & Kuyini, 2017), with each researcher having their own perspective on the nature of truth and knowledge development researchers (Cohen et al., 2002; Wright et al., 2016). The researcher's assumptions about knowledge, reality and truth guide their selection of a particular research approach, formation of research questions and methodological process to achieve research objectives (Kaushik & Walsh, 2019). The researcher's view of the world, also known as a research paradigm, may influence the design of the research. According to Anand et al. (2020), Thomas Kuhn defined a paradigm as the complete set of principles, customs and practices that are commonly held and applied by members of a particular scientific community.

To add, Kaushik and Walsh (2019); Kivunja and Kuyini (2017) described paradigm as a conceptual model used by researchers to examine the research problem and find solutions. Researchers classify research paradigms based on their different views and beliefs, with the most common paradigms being positivism, interpretivism, realism and pragmatism (Saunders et al., 2019). These paradigms differentiate between qualitative and quantitative research methodologies (Johnson & Onwuegbuzie, 2004), with ontological and epistemological assumptions characterising paradigms' contributions to knowledge construction (Weaver & Olson, 2006). Therefore, this research explains the

ontological and epistemological assumptions to assist the researcher in selecting the best-fitting research method.

Ontological assumptions. In research, ontology refers to a philosophical perspective that deals with the nature of social entities (Bryman, 2016; Don-Solomon & Eke, 2018). Specifically, it relates to the question of whether the reality of social entities is objective and external to individuals or subjective and constructed on an individual basis (Coghlan & Brydon-Miller, 2014; Creswell & Plano Clark, 2011; Dick, 2015). By defining ontology, researchers can identify their opinions about the nature of reality and what exists in the world. Ontological positions are often categorised as objectivism and constructivism, depending on the assumptions made about the nature of reality (Levers, 2013).

Objectivism is an ontological position that considers social phenomena as outer facts that exist independently from our perception or influence. It asserts that social phenomena are present in our lives and language without our conscious awareness of them (Ruiz, 2009). This means that social phenomena and the types we use to understand them are considered to be objective and separate from individual actors (Bell et al., 2022).

In terms of ontological positions, *Subjectivism or Constructivism* is an alternative view that suggests social actors are constantly creating social phenomena and their meanings (Al-Saadi, 2014). Bryman (2016) implies that social interactions and a constant state of revision are producing social phenomena. However, in this research, the reality of the quality of health care and health care users' satisfaction is perceived as truth and reality and thus the research takes a more objectivist approach. The existence of health care users' satisfaction and service quality facts in the New Zealand health care system suggest that social phenomena are independent of actors (Bell et al., 2022). The goal of health care providers was to improve service quality to result in health care users' satisfaction and the truth and reality of this can be apprehended by understanding how Kurdish health care users in New Zealand perceive health services to achieve their satisfaction. To achieve this objective, Donabedian's model (Structure, Process and Outcomes- SPO) was used to develop semi-structured questions in face-to-face interviews with Kurdish health care users about their perception of the quality of health care services in New Zealand. Through open-ended interviews, the Kurdish health care

users shared their experiences with health care providers in New Zealand, allowing the researcher to take an objectivist approach to finding responses to the research questions and achieving the research objectives.

Epistemological assumptions. Epistemology is a fundamental assumption that underpins the investigation of what can be known and how knowledge can be measured (Lillrank, 2015). It is concerned with the study of knowledge and can be approached from different perspectives (Bell et al., 2022; Sandoval & Millwood, 2007). Knowledge can be seen as objective and theoretically available to everyone or subjective, depending on individual experience (Hiller, 2016). In this research, I adopt a pragmatist view of epistemology. This approach allows researchers in social science to move beyond objectivist conceptualisations and gain insight into the links between knowledge and action. By adopting a pragmatic approach, I aimed to explore the practical implications of the research findings and consider how they can be applied in real-world settings. This will help to ensure the relevance and usefulness of the research outcomes.

The possibility exists for knowledge to be translated into action (Kelly & Cordeiro, 2020). This research aims to evaluate the satisfaction of Kurdish health care users with the quality of health care services, utilising Donabedian's model (SPO) of measurement. The primary objective of this study was to establish the relationship between the quality of health care and health care users' satisfaction, with a focus on identifying the reality and truth of this relationship. To achieve this objective, data will be collected through face-to-face interviews with Kurdish health care users in New Zealand and previously conducted research will be examined. Donabedian's model is used in this study to develop knowledge related to the relationship between health care service quality and user satisfaction. The model proposes measurable dimensions of health care service quality (Donabedian, 2005), which enable a comprehensive evaluation of the health care service quality and provide valuable insight into the factors that impact user satisfaction.

It is worth noting that the relationship between health care service quality and user satisfaction is an external reality and truth that exists independently of the researcher's interaction and behaviour. In line with a pragmatist epistemological position, this research aims to determine the applicability of Donabedian's model to Kurdish immigrants in New Zealand. By examining the applicability of Donabedian's model to

this group, I aim to contribute to the existing literature and improve the overall quality of health care services for Kurdish immigrants. The identification of the most effective dimensions of health care quality will also provide insight into the areas that require improvement in the providing of health care services, thereby improving the satisfaction and overall health outcomes of Kurdish health care users in New Zealand.

Table 7

The Philosophical Assumptions as a Multidimensional Set of Continua with Two Sets of Extremes

Assumption type	Questions	Continua with two sets of extremes	
		Objectivism ⟷	Subjectivism
Ontology	What is the nature of reality? What is the world like? For example: What are organisations like? What is it like being in the organisation? What is it like being a manager or being managed?	Real External One true reality (universalism). Granular (things). Order	Nominal/decided by convention. Socially constructed. Multiple realities (relativism). Flowing (processes) Chaos
Epistemology	How can we know what we know? What is considered acceptable knowledge? What constitutes good quality data? What kinds of contributions to knowledge can be made?	Adopt the assumptions of the natural scientist. Facts, Numbers Observable Phenomena Law-like generalisation	Adopt the assumptions of the arts and humanities. Opinions written, spoken and visual accounts. Attributed meanings Individuals and contexts, specifics
Axiology	What is the role of values in research? Should we try to be morally neutral when we do research, or should we let our values shape research? How should we deal with the values of research participants?	Value-free Detachment	Value-bound Integral and reflexive

Note. Adapted from (Saunders et al., 2019, p. 135).

Table 8. discussed and have distinguished four primary trends of research philosophy, namely, positivism, critical realism, interpretivism and pragmatism (see Table 8).

3.4.1 Positivism

One of the research philosophies that aims to understand human behaviour through observation is positivism. Positivism adheres to the belief that true knowledge is obtained through experiences and can be achieved through observation and experimentation (Antwi & Hamza, 2015). As explained by Bhattacherjee (2012), positivism recognizes social science research as a tool for learning about social phenomena and their interconnections. This is accomplished by discovering and documenting general causal laws. Positivism supports the application of natural science methods to the study of social reality and beyond.

Bell et al. (2022) listed various principles of positivism, which consist of phenomenalism, deductivism, inductivism, objectivity and a clear differentiation between scientific and normative assertions. According to these principles, social phenomena can be recognised as knowledge if they are confirmed by the senses (*Phenomenalism*) and the key objective of all theories is to produce hypotheses that can be examined and evaluated (*Deductivism*). In addition, knowledge can be acquired through the collection of facts that serve as the foundation for laws, through the use of *Inductivism*. Science should be conducted *Objectively*, without being influenced by personal values or biases. Moreover, there is a clear differentiation between scientific statements and normative statements, where the validity of normative statements cannot be verified through the senses, as implied by *Phenomenalism*.

Positivistic researchers argue that knowledge is objective and measurable using independent properties, according to Antwi and Hamza (2015). This approach suggests that the research should be conducted in a systematic and rigorous manner to provide valid and reliable findings that can be generalised to the larger population. In addition, positivism is focused on uncovering truth through experimentation and relies on quantitative methods. It employs a deductive reasoning approach that helps researchers collect numerical data, often through surveys (Heeks et al., 2019a).

The positivism philosophy is not applicable to this research as it relies on quantifiable observations that are analysed through statistical methods. However, the data collected for this research were obtained through semi-structured face-to-face interviews on the quality of health care services in New Zealand. As such, this research focuses on

qualitative data that cannot be systematically quantified. To analyse this data, thematic analysis was utilised, which is an appropriate method for qualitative data and generating outcomes.

3.4.2 Critical realism

Critical realism is a philosophical paradigm gaining popularity in social science research that differs from the positivist and interpretive views (Haigh et al., 2019). It separates the 'real world' from the 'observable world' and suggests that unobservable structures can lead to observable events, according to Roy Bhaskar, who developed critical realism in the 1970s. The observable world is constructed based on human perspectives and experiences and critical realists argue that understanding the structures that produce events is essential for comprehending the social world (Fletcher, 2017; Lewis, 2001; Whiting & Pritchard, 2020; Wynn Jr & Williams, 2012). Realism is a philosophical perspective that holds that reality exists independently of human thought or perception. When humans observe reality, they may gain more confidence in its existence (Maxwell, 2012). For instance, every member of society has the right to access health care services, even if they are not aware of this right (Wynn Jr & Williams, 2012).

However, this research does not employ critical realism as a research philosophy because the realist methodology is mostly difficult to focus on the daily issues of individuals. In other words, this philosophy does not examine the Kurdish immigrants' daily struggles with the quality of health care services in New Zealand, but rather concentrates on the reality of existing health care services. To investigate any health care issues, a prescribed method is necessary, which critical realism does not offer (Vincent & O'Mahoney, 2018).

3.4.3 Interpretivism

Interpretivism is a research philosophy that focuses on the development of knowledge in society by examining how humans create meanings for the issues they encounter. This philosophy is based on idealism and is associated with a group of diverse approaches, including phenomenology, hermeneutics and social constructivism (Collins, 2018). The hermeneutic approach, which is the philosophical basis of interpretivism philosophy, is used by researchers to make sense of the meaning of textual data that may not be clear to everyone (Oerther, 2020).

According to Saunders et al. (2019), interpretivism emphasises that humans create meanings for the issues they encounter, which makes them different from physical phenomena. Levers (2013) asserts that interpretivism is a social constructivist paradigm, which argues that reality is constructed through human experiences and social contexts (ontology) and can be studied through subjective interpretations of its participants (epistemology). In addition, Antwi and Hamza (2015) suggest that interpretivist researchers believe that social reality can be accessed only through social constructions such as people's experiences, languages and shared meanings. To further clarify, explains that the interpretive paradigm is grounded in both observation and interpretation methods (Antwi & Hamza, 2015).

Interpretivist researchers use observation to collect data about phenomena and then use interpretation to make meaning of that information. The interpretive paradigm aims to achieve a deep understanding of events or phenomena through the shared meanings that people assign to them. Individuals use their own words to express their experiences of a phenomenon and qualitative researchers use the interpretivism paradigm to interpret and make sense of social reality because people do not perceive social phenomena directly (Rashid et al., 2019).

The interpretivism paradigm is often criticised for its potential for bias due to the subjective nature of the researcher's interpretation. Bhattacherjee (2012) notes that the researcher's influence during data collection may impact the participant's viewpoint on social reality. Ritchie et al. (2014) also acknowledge that researchers may influence the data collected through their interpretation. Due to these limitations, the research at hand does not utilise the interpretivism paradigm. In particular, the researcher may inadvertently shape the responses of Kurdish health care users in New Zealand, leading to biased data. Furthermore, any information gathered using this paradigm may be limited to the specific context of the research, as the shared meanings and beliefs of the participants may not be generalisable to other settings.

3.4.4 Pragmatism

Pragmatism is a research paradigm that emphasises the significance of selecting the methodology that is fitting the research questions and the research problem being investigated (Brierley, 2017). Unlike other research paradigms, pragmatism prioritises

the outcomes of the research over the methods used (Creswell & Plano Clark, 2011; Goldkuhl, 2004; Kaushik & Walsh, 2019). This paradigm allows researchers to use both qualitative and quantitative methods and/or combine both positivist and interpretive approaches in one study. Researchers employing pragmatism argue that the research questions are the most important determinants of the research philosophy (Heeks et al., 2019b; Kaushik & Walsh, 2019; Zefeiti & Mohamad, 2015).

In the realm of research, Brierley (2017) posits that a pragmatic approach is better suited to answering research questions than relying on assumptions such as ontology or epistemology. This means that rather than prioritising theoretical frameworks, the focus should be on what works in practice. In a similar vein, Saunders et al. (2019) state that pragmatism asserts that the research question is the most important factor in determining the appropriate epistemology, ontology and axiology to adopt. This implies that the choice of approach relies on the research question at hand and one approach may be better suited than others for addressing specific questions.

Given these tenets, this research is guided by the principles of pragmatism. The research seeks to answer questions about the quality of health care services provided to Kurdish health care users in New Zealand. To achieve this, the research employs a 'what works' approach that prioritises practical solutions over theoretical frameworks. By adopting this approach, the study aims to provide insights into the experiences of Kurdish health care users and identify opportunities for improving the quality of health care services in New Zealand.

3.5   Justifications for using pragmatism.

The adoption of pragmatism philosophy in this research is motivated by the potential to produce practical results, as posited by (Johnson & Onwuegbuzie, 2004). This philosophical stance also allows for the formulation of pragmatic questions that are relevant to the evaluation of the quality of health care services for Kurdish immigrants in New Zealand. For instance, the study seeks to investigate the experiences of Kurdish health care users in relation to the delivery of health care services in New Zealand. Additionally, the research aims to examine the impact of the quality of health care services on the satisfaction of Kurdish immigrants with New Zealand's health care system. Another important question that this research seeks to answer is the

identification of enablers and barriers that affect the engagement of Kurdish immigrants with health care service delivery in New Zealand.

In line with the tenets of pragmatism, the research emphasises the importance of linking knowledge to action (Long et al., 2018). By adopting a pragmatic approach, the study aims to produce research findings that can be translated into actionable recommendations for improving the quality of health care services delivered to Kurdish immigrants in New Zealand. By focusing on practical solutions, the research aims to provide insights that are relevant and useful to policymakers, health care providers and other stakeholders involved in the provision of health care services in New Zealand. The primary focus of this research is to identify what changes, if any, are necessary in the New Zealand health system to address the needs of Kurdish immigrants. The study aims to gather data that is relevant to making informed decisions and taking actionable steps towards improving the quality of health care services in New Zealand (Glasgow, 2013). To achieve this goal, the research adopts a pragmatic approach, which emphasises finding practical solutions that will work best for improving the health system in New Zealand.

By using a pragmatic research design, the study aims to answer the research questions related to the quality of health care services provided to Kurdish immigrants in New Zealand. The focus of the research is to identify any issues that exist in the health care system and propose actionable recommendations that can help improve the system. Therefore, the researcher is conducting the research in an innovative and effective manner, as guided by the principles of pragmatism. The philosophical stance of pragmatism differs from other philosophical positions such as idealism, realism and rationalism. Idealism holds that the mind is the source of knowledge, whereas pragmatism rejects this notion. Realism, on the other hand, suggests that knowledge reflects reality, while pragmatism does not rely on such claims. Furthermore, rationalism posits that rationality is the key to reliable knowledge, an idea which is opposed by pragmatism (Cornish & Gillespie, 2009).

Pragmatist researchers focus on the practical nature of thought and action as the foundation and test of knowledge. The validity of knowledge is determined based on its contribution to human actions (Cornish & Gillespie, 2009; Kivunja & Kuyini, 2017; Wolfe,

2012). In other words, the value of knowledge lies in its ability to inform and improve human action. Therefore, pragmatism emphasises the practical application of knowledge in solving real-world problems rather than abstract theoretical considerations. Pragmatism is concerned with solving practical problems in the real world (Creswell & Plano Clark, 2011; Kaushik & Walsh, 2019; Yvonne Feilzer, 2010). Therefore, this research adopts a pragmatist approach to identify solutions to the health care system issues faced by immigrants, particularly the Kurdish community in New Zealand (Evans et al., 2011). The research aims to find practical solutions to the problems faced by this community, such as issues related to the quality of health care services and barriers to access. By using a pragmatic approach, the research seeks to identify effective and efficient ways to improve the quality of health care services and ensure that Kurdish immigrants in New Zealand can access the health care services they need.

In this research, the pragmatist position ensures that both the researcher and participants (Kurdish health care users) remain independent of each other. It also ensures the participants are questioned without any influence from the researcher and pragmatism helps to ensure that the results belong fully to the Kurdish health care users. The alternative research philosophies to pragmatism are positivism and interpretivism. Pragmatism was chosen as the research philosophy for this study as it allowed for an unbiased and independent approach to data collection from Kurdish health care users. The alternative philosophies of positivism and interpretivism were not suitable for the research objectives. Pragmatism philosophy is situated between the two extremes of positivism and interpretivism and has been widely used in various research areas such as health psychology, education, non-government organisations, social work and sport psychology (Clarke & Visser, 2019; Cornish & Gillespie, 2009; Giacobbi et al., 2005; Kaushik & Walsh, 2019; Kelly & Cordeiro, 2020; McKerchar, 2008).

Table 8

The Comparison of Four Research Philosophical Positions in Research

Ontology (Nature of reality or being)	Epistemology (What constitutes knowledge)	Axiology (Role of values)	Typical methods (Data collection techniques)
Positivism			
Real, external, independent one true reality (universalism) granular (things) ordered	Scientific method observable and measurable facts law-like generalisations numbers causal explanation and prediction as a contribution	Value-free research researcher is detached, neutral and independent of what is researched researcher maintains an objective stance	Typically deductive, highly structured, large samples, measurement, typically quantitative methods of analysis.
Critical realism			
Stratified/layered (the empirical, the actual and the real) external, independent intransient objective structures causal mechanisms	Epistemological relativism knowledge historically situated and transient facts are social constructions historical causal explanation as a contribution	Value-laden research researcher acknowledges bias by world views, cultural experience and upbringing researcher tries to minimise bias and errors.	Retroductive, in-depth historically situated analysis of pre-existing structures and emerging agency range of methods and data types to fit the subject matter
Interpretivism			
Complex, rich socially constructed through culture and language multiple meanings, interpretations, realities flux of processes, experiences, practices	Theories and concepts too simplistic focus on narratives, stories, perceptions and interpretations of new understandings and worldviews as the contribution	Value-bound research. researchers are part of what is researched, subjective researcher interpretations key to contribution researcher.	Typically, inductive. small samples, in-depth investigations and qualitative methods of analysis.
Pragmatism			
Complex, rich, external 'reality' is the practical consequences of ideas flux of processes, experiences, and practices	The practical meaning of knowledge in specific contexts 'true' theories and knowledge are those that enable successful action. Focus on problems, relevance problem solving and informed future practice as a contribution	Value-driven research. Initiated and sustained by the researcher's doubts and beliefs researcher's reflexive	Following research problem and research question range of methods: mixed, multiple, qualitative, quantitative, action research emphasis on practical solutions and outcomes

Note. Adopted from (Saunders et al., 2019, pp. 144-145)

3.6 Research approach

A research approach refers to the logic and rationality of the research. It refers to the methodology used to collect and analyse data, which is based on the researcher's knowledge of the literature and the approach used to gather and analyse the data (Sutrisna, 2009). The two main approaches that involve the relationship between theory and research are deductive and inductive reasoning approaches (Bell et al., 2022). According to Soiferman (2010), the deductive approach starts with a general theory and moves towards specific observations, while the inductive approach starts with specific observations and moves towards broader generalizations or the development of new theories. Deductive reasoning is often used to test theories and laws, while inductive reasoning is more commonly used to generate new theories or themes in a research area (Creswell & Clark, 2017; Soiferman, 2010). The deductive reasoning approach originated in the natural sciences, while the inductive reasoning approach emerged with the development of social sciences in the twentieth century, as researchers became wary of relying solely on deductive reasoning (Saunders et al., 2019).

Figure 7. provides the difference between the deductive and inductive approaches, the deductive approach starts with a theory or general statement that is then tested through observations and experiments to arrive at a specific conclusion. On the other hand, the inductive approach starts with specific observations and patterns to develop a general theory or conclusion. This approach is more common in social science research, where researchers often start with exploratory research to generate hypotheses and theories.

Figure 7

The Differences Between Deductive and Inductive Reasoning Approaches
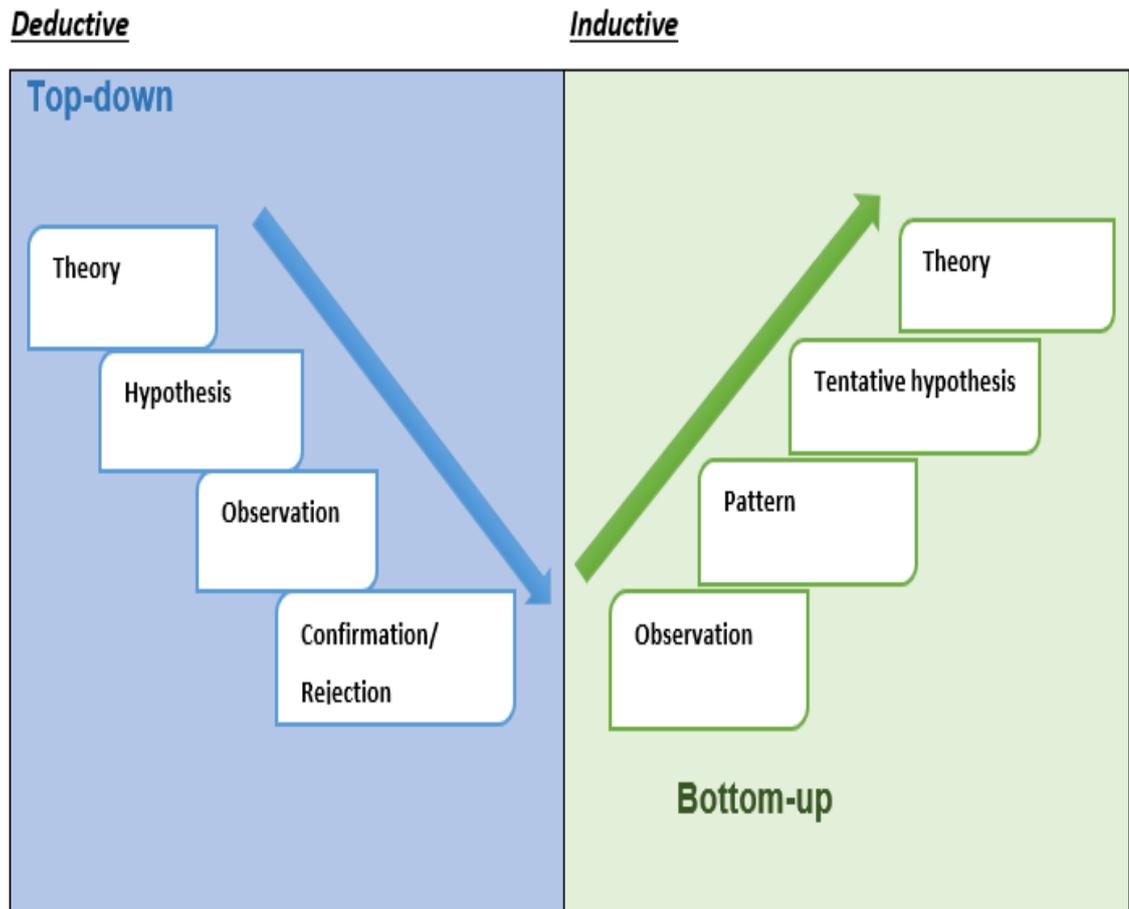
Note. Adapted from (Othman & Ibrahim, 2013, p. 29).

Table 9 presents a comprehensive breakdown of various approaches, one of which is abduction. Abduction specifically entails the creation of a hypothesis in order to elucidate an observation. This process involves formulating a reasonable explanation that fits the available evidence (Saunders et al., 2019).

Table 9

The Major Characteristics of Induction, Deduction and Abduction

	Deduction	Induction	Abduction
Logic	In deductive inference, when the premises are true, the conclusion must also be true	In inductive inference, known premises are used to generate untested conclusions	In an abductive inference, known premises are used to generate testable conclusions
Generalisability	Generalising from the general to the specific	Generalising from the specific to the general	Generalising from the interactions between the specific and the general
Use of data	Data collection is used to evaluate propositions or hypotheses related to an existing theory	Data collection is used to explore a phenomenon, identify themes and patterns and create a conceptual framework	Data collection is used to explore a phenomenon, identify themes and patterns, locate these in a conceptual framework and test this through subsequent data collection and so forth
Theory	Theory falsification or verification	Theory generation and building	Theory generation or modification; incorporating existing theory where appropriate, to build new theory or modify existing theory

Note. Adapted from (Saunders et al., 2019, p. 153).

3.7   The chosen research approach: deductive

To find logical answers to the research questions based on Donabedian's framework (SPO), a deductive approach was employed in this study. The key assumptions were that the quality of health services in New Zealand is inadequate for Kurdish immigrants, they face difficulties in accessing health care services and they are dissatisfied with the quality of health care services in New Zealand. To test these assumptions, this research utilised a deductive reasoning approach. Specifically, the research explored the quality of health care services in New Zealand, using Donabedian's framework to understand the

perspective of Kurdish immigrants. This approach was deemed appropriate to answer the main research question and its sub-questions (a, b, c and d) provided in Chapter 1.3.

The deductive reasoning approach involves starting from the top, which is the theory or hypothesis and then observing and evaluating the data gathered from the Kurdish immigrants (from the top to the bottom) to either confirm or reject the generated theory. In this case, data was collected from experienced Kurdish health care users in New Zealand and the results will be analysed to determine whether they added to the formulated theories generated from Donabedian's model (SPO). By using this approach, the researcher was able to examine a specific set of data gathered from Kurdish health care users and form general conclusions based on existing knowledge among Kurdish immigrants in New Zealand. This approach also aids the combination of observations with practical information to reach a conclusion.

In summary, this research will use the deductive reasoning approach to conduct a qualitative method of thematic analysis by examining recorded interviews. This approach will work from the top-down by using the gathered data to confirm or reject the Donabedian's framework (SPO) and generalization or build a broader theme of an accepted principle (Creswell & Clark, 2017). To evaluate the health service user's satisfaction with the quality of health care services in New Zealand, face-to-face interviews will be conducted with Kurdish immigrants.

3.8   Research strategy

A research strategy is a vital component of any research project. It provides a general or step-by-step plan of the actions that researchers take to answer their research questions (Saunders et al., 2019). This plan serves as a roadmap for the research process, enabling researchers to systematically conduct their studies and produce high-quality results (Wedawatta et al., 2011). For the purposes of this study, an ethnographic research strategy was employed to observe the behaviour of Kurdish health care users in New Zealand and their perceptions of the quality of health care services. Ethnography is a qualitative research method that aims to describe and understand the cultural characteristics of a social group or system (Allen, 2017). Rather than simply studying a group of people, ethnography enables researchers to gain insights and learn about them on a deeper level.

One effective way of gaining insight into a group of people is through immersion, which involves in-depth observation of their behaviours (Jones & Smith, 2017). This naturalistic research style encourages researchers to embed themselves within a group to observe its customs, patterns of behaviour and way of life. To immerse themselves in the day-to-day lives of a group, researchers commonly use one-on-one interviews with members of the group (Howlett, 2013; Morgan-Trimmer & Wood, 2016). These interviews allow researchers to gather detailed information and gain a better understanding of the group's perspectives and experiences.

Given that this study aims to investigate the quality of health care services in New Zealand, the ethnographic research strategy offers valuable insights for exploring and evaluating the health care system in this context. Through this strategy, the researcher is able to gather raw data directly from Kurdish health care users and evaluate their satisfaction with the quality of health care services in New Zealand. The use of the ethnographic strategy is justified by the research questions, which start with the word *what* and *how* and seek to uncover phenomena related to Kurdish health care users in New Zealand. Specifically, this study seeks to identify the barriers to engaging with health care service delivery in New Zealand, as experienced by Kurdish health care users. As an exploratory study, it aims to shed light on the experiences of Kurdish health care users with the New Zealand health care system.

The ethnographic approach proved useful in identifying the expectations of Kurdish health care users regarding New Zealand's health care system. Additionally, it facilitates the analysis of the quality dimensions that played critical roles in their satisfaction with health care services as immigrants in New Zealand. Consequently, the quality of health care services in New Zealand requires extensive investigation.

Through the ethnographic approach, the researcher was able to explore and observe the quality of health care services from the perspective of health care users' expectations, as well as through practice and action research (Black et al., 2021; Reeves et al., 2013). Ethnography relies on in-situ observation or interaction (Rouncefield, 2011). Therefore, the use of one-on-one interviews in this research facilitate interaction between the researcher and Kurdish health care users, enabling the uncovering of their behaviours and attitudes towards the quality of health care services in New Zealand.

This method also assists to identify and analyse issues to meet the needs of Kurdish immigrants in New Zealand.

3.9   Research method

Having discussed the philosophical approach, research strategy and justifications for their selection in the preceding sections, the remainder of this chapter will continue to achieve the research aims by examining the research methodology employed for data collection and analysis. Research methodologies can be broadly classified into qualitative and quantitative methods, with the combination of both referred to as the mixed-method approach. Although the original intention of this research was to employ a mixed-method approach, the COVID-19 restrictions made it necessary to shift towards a qualitative approach. Due to COVID-19 restrictions, individuals were unable to move freely, making it difficult for the researcher to collect a large sample size of 400-500 participants. Consequently, the researcher was limited to using a qualitative method which required a smaller sample size for data collection.

3.10 Qualitative research

Qualitative research is a research methodology that focuses on collecting and interpreting data in the form of words, as opposed to numbers. It aims to explore the nature of a particular phenomenon by interpreting the meaning that people bring to it. To achieve this, a range of materials such as personal experiences, case studies, interviews and observational, interactional and visual texts are collected to describe the moments of individuals' lives (Denzin & Lincoln, 2011). According to Busetto et al. (2020, p. 1) qualitative research is characterised by its use of "data in form of words rather than numbers". It involves interpreting naturally occurring phenomena in the social world through a variety of interpretive techniques that describe and decode these phenomena (Al-Busaidi, 2008). In qualitative research, words are used as the primary form of data (Saunders et al., 2019).

The primary objective of qualitative research is to gain a deep understanding of a particular phenomenon by exploring the perspectives and experiences of the individuals involved (Agee, 2009; Busetto et al., 2020). Qualitative research can help identify patterns, themes and meanings that are often overlooked in quantitative research,

which typically relies on numerical data. As such, it is an essential research methodology for understanding complex human phenomena and providing valuable insights into individuals' experiences and perspectives.

This study employed a qualitative descriptive research approach to investigate the behaviour, thoughts and feelings of Kurdish health care users towards the quality of health care services in New Zealand. Specifically, this study aimed to collect the perspectives of Kurdish immigrants in New Zealand. Face-to-face interviews was used as the primary method of data collection, allowing participants to provide detailed information about their experiences with the health care system over the past decade. The use of a qualitative descriptive method enabled the research to generate new insights into the quality of health care services for Kurdish immigrants. By collecting and analysing rich, descriptive data, the study aimed to uncover the experiences, perspectives and opinions of Kurdish health care users, which could help inform the development of culturally appropriate health care services in New Zealand.

3.10.1 Justifications for using the qualitative descriptive method.

Despite the challenges and dilemmas posed by the COVID-19 pandemic in data collection, the outcomes of this qualitative descriptive research are critical to enhancing the quality of health care services and improving health care users' satisfaction in New Zealand. It is essential to note that the participants in this research were the main contributors to its success. Their experiences, perspectives and opinions must be valued and promptly documented, interpreted and analysed to produce high-quality outcomes (Chafe, 2017; Smith et al., 2019). This study recognised the importance of participant perspectives and aims to provide a platform for Kurdish health care users to share their experiences and opinions regarding the quality of health care services in New Zealand. By acknowledging the importance of participants in qualitative research, their voices were heard and their experiences were represented in the study's outcomes, which can contribute to the improvement of the quality of health care services and the overall satisfaction of health care users in New Zealand.

Qualitative descriptive method provides a comprehensive and in-depth understanding of the quality of health care services in New Zealand. By focusing on the details of participants' experiences, thoughts, and feelings, qualitative descriptive research allows

the researcher to explore the quality of health care services in New Zealand. Further, qualitative descriptive method was a useful method because the research questions were exploratory seeking to uncover new insights about the quality of health care services among immigrants, focusing on Kurdish health care users. Additionally, qualitative descriptive research was flexible and adaptable, enabled researcher to adjust his methods during the study based on emerging findings, ensuring a holistic exploration of the topic. Furthermore, it was well-suited method for studying quality of health care services in New Zealand or reluctant immigrants, as it emphasises participant voices and perspectives, promoting a more inclusive research approach. likewise, qualitative descriptive research often results in rich, detailed narratives that are accessible and meaningful to a wide audience, making it an effective method for communicating research findings to both academic and non-academic audiences (Sword et al., 2012; Vaismoradi et al., 2013).

The aim of data collection in this study was to obtain an in-depth understanding of the needs of Kurdish health care users in relation to the quality of health care services in New Zealand. By identifying and analysing the key dimensions that influence the quality of health care services for Kurdish immigrants in New Zealand, the researcher aimed to shed light on the factors that contribute to their satisfaction or dissatisfaction with the health care system. To achieve this, the researcher opted to use a qualitative descriptive method, specifically semi-structured interviews, to explore and understand the views of Kurdish health care users. This approach was chosen because it allowed for a more detailed exploration of participants' experiences and perspectives, which can be difficult to capture using quantitative methods alone.

It was recognised that the researcher's relationship with the Kurdish community in New Zealand would play a critical role in the conduct of semi-structured interviews, interpretation and analysis of data. Therefore, careful attention was paid to building trust and rapport with participants to ensure that their voices were heard and valued throughout the research process. By prioritising the perspectives of Kurdish health care users, this study aimed to contribute to the development of more culturally appropriate health care services that better meet the needs of diverse communities in New Zealand.

Conducting qualitative descriptive research through face-to-face interviews is valuable in gathering first-hand documentation of health care users' experiences with the quality of health care services. Furthermore, it provides an opportunity to identify recommendations for improving the quality of health care services. In the context of this research, conducting in-depth interviews with Kurdish health care users was particularly significant to understanding their concerns and needs in a developed health care system such as New Zealand. By collecting highly detailed and personal experiences from the Kurdish health care users, this qualitative descriptive research aimed to identify any necessary changes to improve the quality of health care services provided to them. Therefore, the qualitative descriptive method was key in achieving the objectives of this research.

3.10.2 Challenges in qualitative research in health care

Qualitative research has its challenges, including the researcher's subjective interpretation of the data and the need to ensure participant involvement and privacy. According to Hoover (2021), the burden of conducting interviews, investigating, observing, documenting and interpreting the data falls heavily on the researcher. Rolfe et al. (2018) also note that researchers must consider the privacy of the participants involved in the research and avoid tokenism, where participants feel that their participation is merely symbolic and not adequately heard. Despite these challenges, qualitative research can provide valuable insights into complex phenomena, such as health care experiences among immigrant communities and help identify areas for improvement.

Selecting the appropriate sample size or relevant study groups is also vital, as the participants must accurately represent the group population that will be affected by the research to ensure credibility and transferability (Elo et al., 2014; Hoover, 2021). Furthermore, researchers should ensure that their research questions are consistent with their methodology, have adequate methodological knowledge and consider the philosophical underpinnings of qualitative methodology (Khankeh et al., 2015). Similarly, Holloway and Galvin (2016) highlight the need for qualitative researchers to have a solid understanding of the relationship between philosophical assumptions, research questions and methodology before beginning their research.

One of the biggest challenges faced by qualitative researchers, according to Cypress (2019), is collecting data in naturalistic settings such as hospitals, homes, or communities. Researchers may encounter obstacles such as closed or controlled field sites by gatekeepers, or the need to obtain permission to enter open sites. To gain access to these sites, researchers must establish and maintain trust with participants and the organisation in which the data will be gathered. Finally, Hoover (2021) emphasises that qualitative research must produce outcomes that are relevant and meaningful to the participants or population being studied. If the outcomes lack relevance, the research will have less impact. Thus, it is critical for qualitative research to generate knowledge that can support actionable outcomes.

Throughout this research, I encountered several significant challenges, particularly with regards to data collection. One of the major challenges I faced during this research was the sole responsibility for conducting interviews, which proved to be a significant burden. I faced additional tasks such as designing interview questions and preparing participant information sheets that outlined the potential risks and discomforts associated with participation in the research. These additional responsibilities added to the challenge of conducting interviews alone and required careful attention to detail and thorough preparation to ensure a smooth and successful data collection process. Furthermore, I documented and interpreted the data from Kurdish to English by myself, as most of the participants preferred to use their mother language (Kurdish) to answer the research questions. This translation process was time-consuming and required a significant amount of effort to organise the data effectively.

Another major issue encountered during data collection was gaining access to the participant's homes. The Kurdish culture and Islamic rules dictate that a woman cannot be alone in a room with a man who is not a member of her family or relative. This posed a significant challenge for the researcher as it meant that additional family members needed to be present during interviews, which could impact the quality and authenticity of the data collected. Conducting research in a cultural context that has specific social and religious customs can present challenges for data collection. These challenges can include issues around translation, data organisation and access to participants. To mitigate these challenges, it is essential to consider the cultural context of the research

carefully and take steps to ensure that the data collected is of the highest possible quality.

To ensure successful data collection in this research, it was important for the researcher to obtain access to participants' homes before conducting interviews. However, this process was not without its challenges. The researcher encountered situations where interview schedules needed to be changed and rescheduled due to the absence of a third party at the participant's home, as is required by the Kurdish culture and Islamic rules. Additionally, the COVID-19 pandemic led to several weeks of postponement of data collection to follow the necessary protocols to ensure everyone's safety. On top of that, there were also cases where interview dates needed to be postponed due to participants contracting the virus. Despite these challenges, the researcher made significant efforts to minimise their impact and successfully conduct interviews and collect data. By working with participants to find suitable interview locations and adhering to COVID-19 protocols, the researcher was able to navigate the obstacles and gather the necessary data for the study.

3.11 Data collection method

Based on the research design and method of analysis, this study employed one type of data collection, specifically primary data collected through one-on-one interviews with Kurdish health care users residing in New Zealand. The chosen data collection method was robust, as it served multiple objectives. Firstly, the qualitative data obtained was well-suited to provide evidence-based responses to the research questions, in line with the research assumptions. Secondly, the use of qualitative data allowed for the efficient evaluation of extensive information that may not have been collected through other methods. Finally, the one-on-one interview approach enabled the establishment of credible baseline data with regards to truth value, consistency, neutrality and applicability (Noble & Smith, 2015) which may be applicable to other immigrant groups through rigorous data analysis.

The remaining sections of this chapter will discuss the procedure for data collection, including the eligibility criteria for participant recruitment, the recruitment process, the data collection method, which involves conducting interviews, as well as the data

analysis process. Additionally, this chapter will present the rigour of the qualitative research method, as well as ethical considerations and challenges.

3.11.1 Eligibility criteria for participant recruitment

Several inclusion criteria were established for participant recruitment in this study. Firstly, eligible participants were required to be 18 years old or older. Secondly, eligible participants must belong to the Kurdish ethnic group. Thirdly, potential participants must have proficiency in either the Kurdish and/or English language. Fourthly, potential participants must have had previous experiences with health care services in New Zealand within the past 10 years. Finally, eligible participants must be permanent residents of New Zealand.

3.11.2 Recruitment process

The researcher was already acquainted with the New Zealand Kurdish Community (NZKC), a nationwide non-profit organisation established to support and unite Kurdish individuals residing in New Zealand (Pajooh, 2021 April 19). As a Board member and secretary of the NZKC, Houshyar Pajooh confirmed the presence of numerous Kurdish individuals who regularly participate in the organisation's meetings and events (Pajooh, 2021 April 19). In this study, the researcher drew on the support of the NZKC to connect with Kurdish individuals. The NZKC's Facebook page was utilised to advertise the study and recruit more participants (see Appendix D- invitation letter).

In addition, the researcher utilised the NZKC's connections to reach out to the Kurdish population residing in New Zealand, inviting them to express their interest in participating in the study. Upon receiving approval from the Auckland University of Technology Ethics Committee (AUTEC) with the number 21/271 on 02 August 2021 (see Appendix A), convenience sampling was employed to recruit 20 participants (11 male and 9 female). Convenience sampling is a non-probability sampling technique commonly utilised when collecting data from easily accessible populations (Etikan et al., 2016; Greener, 2008; J. Jager et al., 2017). The researcher worked with the participants to arrange a suitable time and location for conducting face-to-face interviews. The interviews took place either at the participants' preferred location, typically their homes, or at an AUT campus.

Prior to commencing data collection, four potential participants (n=4) residing in both the North and South Islands of New Zealand withdrew from the study. The reasons cited for withdrawal included relocation outside New Zealand, concerns related to COVID-19 and reticence towards being involved in the research topic. Despite rescheduling interview sessions multiple times for those infected with COVID-19, participants declined to take part in the study.

On the other hand, a few potential participants (n=4) were disqualified from the study due to their inability to attend the scheduled interview sessions, lack of response to the researcher's attempts to contact them and providing limited responses consisting of 'yes' or 'no' to the research questions.

3.11.3 Key justifications for adopting convenience sampling.

Convenience sampling is a widely utilised method in qualitative research for several justifiable reasons (Andrade, 2021; Jager et al., 2017; Stratton, 2021). Firstly, it is often more practical and cost-effective than other sampling techniques, especially when researchers have limited resources and time constraints. This method allows researchers to select participants based on their availability and accessibility, making it easier to gather data quickly and efficiently. Secondly, in certain qualitative studies where the focus is on understanding specific, context-bound experiences or perspectives, convenience sampling can be appropriate. For instance, when studying a small, closely-knit community or a specific workplace, convenience sampling can provide valuable insights into the unique dynamics of that group. Additionally, in exploratory research where the goal is to generate hypotheses or initial insights, convenience sampling can serve as a useful starting point (Simkus, 2022). Convenience sampling enables researchers to examine the topic and design more focused, in-depth studies based on the preliminary findings. However, it is crucial for researchers using convenience sampling to acknowledge its limitations, such as potential selection bias, and to carefully consider the generalisability of their findings to broader populations.

In this study, the utilisation of convenience sampling was necessitated by the limited availability of resources and time constraints. By selecting Kurdish health care users readily accessible for face-to-face interviews, the research process was expedited. This approach was appropriately chosen to examine the experiences of Kurdish health care

users regarding the quality of health care services in New Zealand. Given the relatively small size of the Kurdish community in New Zealand, convenience sampling emerged as a suitable method to gather in-depth insights into their satisfaction with health care services. The research enabled the researcher to focus on this specific demographic, shedding light on their unique perspectives and experiences.

3.11.4 Data collection: Interviews

In this study, data was collected using the semi-structured in-depth interview method, which is a commonly used qualitative research strategy, especially in health services research (DeJonckheere & Vaughn, 2019). This method involves the researcher asking participants predetermined, yet open-ended questions about the topic at hand. Unlike the unstructured interview format, the semi-structured approach provides the researcher with more control over the conversation and allows for more focused exploration of research questions (Jamshed, 2014).

During the semi-structured in-depth interview, the researcher engages in a dialogue with the participants and may ask follow-up questions to gather more information. This approach enables the researcher to explore the participants' thoughts and beliefs about the topic in a more comprehensive way, as it allows for the collection of open-ended data (DeJonckheere & Vaughn, 2019). To gather in-depth data related to participants' experiences, adopting a one-to-one interview method is preferable over focus groups (Bolderston, 2012). To explore the effects of health service quality on user satisfaction, it was essential that participants were given enough time to express their opinions. I provided each participant with approximately one hour to speak freely to ensure that the necessary depth of data was collected (Jacobsen, 2020).

While one-to-one interviews offer the benefit of allowing participants to share their experiences in greater detail, focus groups have the advantage of minimising researcher bias (Nyumba et al., 2018). In focus groups, the researcher's role was less prominent, which allowed participants to interact with one another and potentially provide more diverse viewpoints. However, it is essential to note that the dynamics of focus groups can vary widely and participants may not always feel comfortable sharing their experiences with others.

The decision to adopt a one-to-one interview method or a focus group for data collection depends on the research goals and priorities. One-to-one interviews provide participants with the opportunity to provide in-depth data, while focus groups may minimise researcher bias. Ultimately, the choice of data collection method should align with the research question and the goals of the study. The semi-structured interview method has certain disadvantages that need to be considered. One potential issue is the problem of inhibited feeling, which can arise when participants are asked to respond to sensitive questions in a direct interview. This can lead to socially desirable responses, as opposed to more genuine answers that might be provided through a self-completed questionnaire (McIntosh & Morse, 2015).

Another disadvantage is the potential influence of the interviewer's physical appearance on the responses given by participants. Unwanted physical appearances of the interviewer, such as facial and voice attractiveness, BMI and height, can affect the responses given by participants, leading to similar answers (Jæger, 2016; McIntosh & Morse, 2015). This can be particularly problematic if physical attractiveness is perceived differently across different cultures or communities. Additionally, conducting face-to-face interviews can be expensive in terms of both time and money. Compared to conducting interviews via telephone or the internet, fewer face-to-face interviews can be completed in a given time, which may limit the sample size or reduce the generalisability of the findings (McIntosh & Morse, 2015).

Despite these disadvantages, the semi-structured interview method can still be a valuable tool for collecting qualitative data. Researchers can mitigate potential issues related to inhibited feeling and interviewer physical appearance by using a sensitive and non-judgmental approach and creating a comfortable environment for participants. Additionally, the cost of face-to-face interviews can be justified in cases where the research aims to collect detailed data. Ultimately, the choice of data collection method should align with the research question and the goals of the study.

The interview guide used in this research was based on the seven measurement dimensions of Donabedian's model which consist of efficacy, efficiency, effectiveness, acceptability, optimality, legitimacy and equity (Berwick & Fox, 2016). By aligning the interview questions with these dimensions, the researcher was able to gain a

comprehensive understanding of Kurdish health service users' experiences with the quality of health care services in New Zealand. To facilitate comprehensive data collection, the researcher employed a mobile phone voice memo recorder to record the interview sessions. This allowed the researcher to capture all the information discussed during the interviews for later analysis. The interviews ranged in length from 19 to 77 minutes, with the majority of interviews lasting between 23 and 77 minutes.

To conclude with, using Donabedian's model as a framework and recording the interviews with a mobile phone voice memo recorder were effective strategies for collecting detailed and comprehensive data on Kurdish health service users' experiences with health care services in New Zealand.

3.12 Sample size determination

Sample size determination in qualitative descriptive research often involves the concept of data saturation. Data saturation refers to the point in the research process where gathering more data does not lead to new insights or themes, indicating that the existing data already sufficiently represents the range and depth of experiences related to the research topic (Saunders et al., 2018). Unlike quantitative studies where large sample sizes aim for statistical power, qualitative research focuses on the richness and depth of information (Hennink & Kaiser, 2022). In this study, researcher employed convenience sampling approach, selecting participants who can provide diverse perspectives and in-depth insights about the quality of health care services in New Zealand. The decision to stop data collection was made when data saturation was achieved. This means that researcher continued gathering and analysing data until redundancy was observed, ensuring that the emerging themes are well-developed and comprehensive (Vasileiou et al., 2018).

In this study, the data collection process was thoroughly carried out until a point of saturation was reached. Specifically, data from participants 19, and 20 exhibited redundancy and failed to introduce novel insights into the interview responses concerning the quality of health care services in New Zealand. Consequently, the researcher deemed the information gathered from the sample of Kurdish health care users (n=20) in New Zealand to be comprehensive and representative. The concept of data saturation functioned as a guiding principle throughout the research, signifying that

a thorough exploration of the research questions had been achieved. This comprehensive dataset formed a robust foundation, enabling the formulation of meaningful conclusions regarding the evaluation of Kurdish health care users' satisfaction with the quality of health care services in New Zealand.

3.13 Techniques applied for accessing to the fieldwork and participants.

In qualitative descriptive research, accessing fieldwork and participants involves employing specific techniques to ensure a comprehensive understanding of the research context. Researchers often begin by establishing relationships and gaining trust within the community or setting they wish to study. This can be achieved through networking, community engagement, and obtaining permissions from relevant authorities (Guillemin et al., 2018). Convenience sampling was used to easily access the fieldwork and population (Etikan et al., 2016; Greener, 2008; J. Jager et al., 2017). In this study, the researcher worked with the respondents to arrange a suitable time and location for conducting in-depth face-to-face interviews. The interviews took place either at the participants' preferred location, typically their homes, or at an AUT campus.

 Convenience sampling was used as a valuable technique for reaching participants within close-knit or hard-to-reach communities like Kurdish community. Ethical considerations, such as obtaining informed consent and safeguarding participants' confidentiality, were integral to the process. Further, building rapport through preliminary interviews or informal conversations also enhanced the researcher-participant relationship, encouraged participants to share their experiences openly. These techniques not only facilitated accessing to the field and participants but also contributed to the richness and depth of qualitative data. Consequently, they ensured a comprehensive exploration of the quality of health care services from the perspectives of Kurdish healthcare users in New Zealand.

In the pursuit of establishing a strong rapport with participants, the researcher employed a series of deliberate techniques and strategies (Carter et al., 2021; DiCicco-Bloom & Crabtree, 2006; McGrath et al., 2019; Prior, 2018). Notably, research demonstrated genuine interest in participants' responses by *actively listening* to what they say about their experiences about quality of health care services in New Zealand. Additionally, showed his *empathy* and understanding towards participants' feelings and

perspectives to create a supportive environment during interviews. Moreover, researcher treated participants with *respect*, regardless of their background or opinions. He also showed appreciation for their time and willingness to share their experiences.

Likewise, researcher *shared a brief personal story* related to the topic chosen for research to make participants feel more comfortable. Further, researcher was *transparent* and clearly explained the goals of the study. Researcher also constantly demonstrated reliability, integrity, and confidentiality to *build trust*. Participants were assured that their personal information and responses will be handled with utmost confidentiality. Finally, the researcher *expressed genuine gratitude* for participant's contributions and their valuable input. Thus, the researchers could create a positive and supportive atmosphere, that enabled participants to share their experiences openly and honestly.

3.14 Data analysis

The thematic analysis method was chosen for this qualitative research as it is a useful approach for exploring patterns and themes in qualitative data, particularly in large datasets (Braun & Clarke, 2006; Nowell et al., 2017). Thematic analysis enables researchers to identify and analyse the various dimensions of a phenomenon (Braun et al., 2016; Guest et al., 2006; Saldaña, 2021). Thematic analysis was well-suited to this research because it aligned with the research objectives and methodological approach. By analysing the interview data thematically, I was able to identify recurring patterns and themes in the data, providing insight into the experiences and perceptions of Kurdish health service users regarding the quality of health care services in New Zealand.

To conduct thematic analysis, Braun and Clarke (2006) provide six phases, with *the first phase* being the familiarisation with the data. According to this phase, the researcher needs to be very familiar with the entire collected data. To achieve this, Maguire and Delahunt (2017) advise researchers to immerse themselves deeply in the data through repeated readings (at least once before coding) to understand the meanings and find the themes of the data. In this research, data was collected through semi-structured interviews with Kurdish health care users in New Zealand. The researcher transcribed the interviews into written form to conduct a thematic analysis (Vaismoradi et al., 2013).

Although some of the interviews were conducted in English and others in Kurdish, the transcribing process began in the original language of each interview.

This study utilised verbatim transcription in the Kurdish language as the primary basis for data analysis. Although recording and transcribing interview sessions can be a laborious process, they are essential components of in-depth qualitative research (Loubere, 2017). The transcripts of the interviews were then organised and managed using NVivo Software, an industry-standard tool (Doyle, 2019).

The second phase of this study involved generating initial codes from the familiarised and transcribed data collected during the first phase. In this phase, codes were used to identify the main features of the data that were of interest to the researcher. These codes represent the most significant elements of the raw data and were evaluated to gain insight into the phenomenon under investigation (Braun & Clarke, 2006). For this research, the raw data was coded and organised to identify similarities among the information provided by participants regarding the quality of health services in New Zealand. To ensure that the codes only related to or addressed the research questions, the researcher followed the guidelines established by Maguire and Delahunt (2017) during this phase.

In this study, coding schemes were developed to identify the variables necessary for analysing the research questions. These variables were linked to the concepts of Donabedian's model and its dimensions for health care quality and could be carefully read and reviewed. The obtained variables were analysed using the theoretical and conceptual framework of Donabedian's model to identify the barriers to engagement with the New Zealand health care system. The researcher coded the interviews meticulously to answer the research questions. To ensure the reliability of the findings, two steps were taken to avoid potential bias and ensure consistency between the researcher's interpretation and that of others.

First, some of the interviews were given to another researcher to code and the findings were compared to those of the primary researcher. The results were consistent with the primary researcher's outcomes, indicating the reliability of the coding process.

Second, the primary researcher asked another researcher to review the research outcomes to identify any gaps in the argument that may have been overlooked. The reviewer affirmed the researcher's conclusions, which were deemed reasonable based on the interviews.

After completing the initial phases of coding, organising and modifying data, *the third phase* in qualitative research is to identify themes. In this phase, the researcher examines the list of codes generated during the data analysis process and categorises them into themes. A theme represents a pattern that captures a significant aspect of the research questions. To achieve this, the researcher collated all the relevant coded data and analysed the codes to identify patterns that could be combined into overarching themes.

To facilitate this process, the researcher employed various visual representations, including tables, mind-maps and name codes with brief descriptions on separate pieces of paper. Such tools can aid in the organisation and synthesis of data to form coherent themes. These techniques are recommended by researchers such as Braun and Clarke (2006); Nowell et al. (2017); Vaismoradi et al. (2016). Thus, identifying themes is a critical phase of qualitative research that requires attention to detail and an ability to synthesise and organise data effectively. By employing visual representations and categorising codes into themes, researchers can produce a coherent and compelling analysis that enhances the overall quality of their research.

This study focused on examining the quality of health care in New Zealand and the researcher identified themes that corresponded to the research questions. To achieve this, the researcher analysed and combined codes generated from the data collected. The NVivo Software was utilised to facilitate the third phase of the research process, which involved searching for and forming themes.

Braun and Clarke (2006) distinguish between two types of themes: explicit semantic themes and deep latent themes. Explicit semantic themes are based on the surface meaning of the data, while deep latent themes go beyond the surface and explore underlying meanings. In this research, the researcher focused on identifying explicit semantic themes and did not examine deep latent themes. Instead, the researcher

analysed the data on a surface level, seeking to understand the explicit meaning of what the participants said or wrote in response to interview questions.

By focusing on explicit semantic themes, the researcher was able to provide insights into the quality of health care in New Zealand based on the data collected. However, it is worth noting that exploring deep latent themes could potentially provide additional insights into the underlying factors that contribute to health care quality in New Zealand. Further research could be conducted to investigate these deep latent themes and provide a more comprehensive understanding of health care quality in New Zealand.

This study focused on analysing data from Kurdish health care users, with the aim of identifying themes on a semantic level and interpreting and describing them on a deep 'latent' level. Rather than simply explaining the views expressed by the Kurdish immigrants regarding how to improve the quality of health care services in New Zealand, the analysis aimed to provide a deeper understanding of these views and their underlying meanings. The study included a wide range of Kurdish participants, with over 20 individuals represented and 15 developing themes were modified to create a new model for health care quality. To refine and develop these themes, the researcher compared them to the Donabedian model of quality and sought feedback and guidance from his supervisors. These comparisons and discussions helped to refine the themes and develop new ideas.

In conclusion, this research provides a detailed understanding of the views of Kurdish health care users in New Zealand and offers insights into how these views can be used to evaluate and improve health care quality. The use of an inductive approach, combined with comparisons to established models, helped to ensure the rigor and validity of the analysis.

The fourth phase of the data analysis process involves reviewing and modifying the themes that have been identified. During this phase, the researcher will organise and develop the themes in order to create a coherent pattern that accurately reflects the data (Maguire & Delahunt, 2017). In this research, the researcher combined all the data that was relevant to each theme using NVivo Software, which helped to streamline the process.

During the review phase, the researcher assessed each theme to ensure that it was supported by the data. Any themes that were not supported were discarded and new themes were created to account for the data. Additionally, the researcher refined the identified themes to ensure that themes formed a coherent pattern with the data. As Braun and Clarke (2006) suggest, it is important for researchers to discard themes that do not fit with the data and create new ones as necessary. Thus, the review phase is critical to ensuring the validity and reliability of the study. By carefully reviewing and refining the themes, the researcher can create a coherent and accurate representation of the data that can be used to draw meaningful conclusions and inform future research.

The fifth phase of the research process involves defining and naming the themes that have been identified. During this phase, the researcher further refined the themes to identify their essence and ensure that themes accurately represent the data (Maguire & Delahunt, 2017).

In this research, the researcher refined the themes to obtain a satisfactory representation of the data and then presented them for analysis. Through this process, the researcher was able to identify the relationship between the themes and how themes are related to the research questions. The responses from the participants provided valuable feedback and concrete suggestions about how to improve the quality of health care in New Zealand. By identifying and naming the themes, the researcher was able to draw meaningful conclusions about the data and use them to inform future research and policy decisions.

The final phase of data analysis is producing the report. This phase begins once the researcher has fully worked-out themes and is ready to conduct the final analysis and write-up of the report (Braun & Clarke, 2006). The Figure 8 explained the thematic analysis process.

Figure 8

The Thematic Analysis's Six Phases of Data Analysis
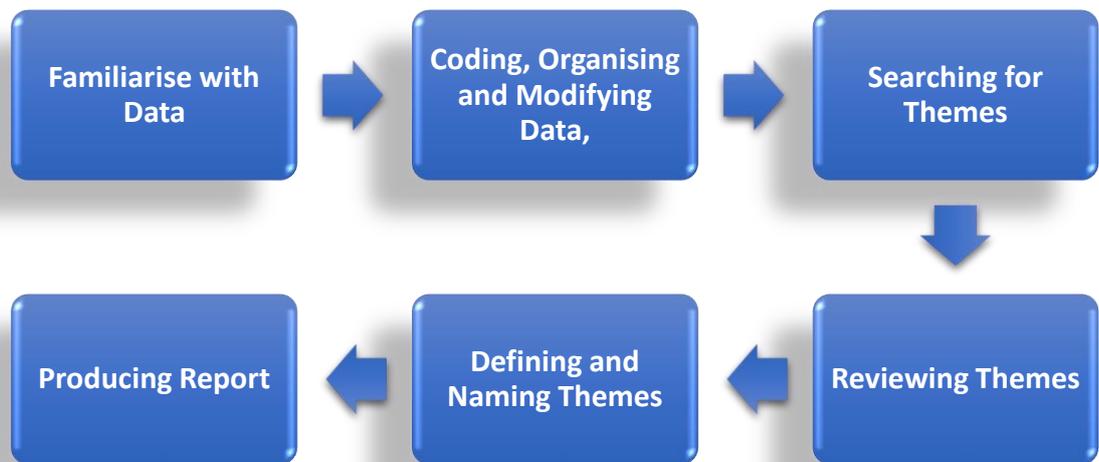
Note. Adapted from (Braun & Clarke, 2006).

3.15 Rigour in qualitative research

3.15.1 Reflexivity

The concept of rigour is essential in evaluating the quality of research, from data collection to analysis (Given, 2008). According to Roberts et al. (2006), rigour, or trustworthiness, is a way of demonstrating the legitimacy of the research process and producing reliable research outcomes. In this study, the two most significant aspects of rigour are reflexivity and transferability. Reflexivity refers to the researcher's self-appraisal of their position in the research process (Korstjens & Moser, 2018; Palaganas et al., 2017). It involves critically evaluating the researcher's role and positionality in creating knowledge (Berger, 2015). As Berger (2015) notes, the researcher must carefully self-monitor to acknowledge and recognise that their position may influence the research process and outcomes.

To produce independent knowledge and avoid bias, this research emphasises self-knowledge and a better understanding of the researcher's role in the research process (Probst, 2015). By doing so, the research can establish trustworthiness, which is essential for producing reliable outcomes. Therefore, in this study, the researcher must pay close attention to reflexivity and transferability to produce trustworthy research.

The personal experiences of the researcher can introduce bias into the study (Pannucci & Wilkins, 2010), especially when investigating the perspectives and satisfaction levels of Kurdish health service users in New Zealand. As a member of the New Zealand Kurdish Community (NZKC) who has lived among Kurdish residents for three years and established strong relationships with them, the researcher's presence during the interviews could have influenced the participants' responses. Additionally, the researcher's interpretation and translation of the interviews could have affected the research outcomes. This situation is commonly known as the 'insider' role, where the researcher belongs to the population being studied. According to Dwyer and Buckle (2009), an insider researcher shares language, experiential base and identity with the participants, facilitating their acceptance and openness during data collection and leading to a more in-depth and trustworthy data.

Therefore, acknowledging the insider role status is essential for the researcher to ensure rigour and avoid bias. In this study, the researcher needed to be reflexive and self-aware to identify and manage his potential impact on the data. By doing so, the study could obtain reliable and valid results, increasing its transferability and usefulness.

The researcher in this study may be considered an insider due to his friendship experiences with some of the study participants, specifically those whom he interviewed in the North Shore suburbs of Auckland, where he resides. However, the researcher's status as a researcher prevents him from being a complete insider. In this research, the only commonality between the researcher and the study participants, the Kurdish health care users in New Zealand, is their living experiences, which places the researcher in a middle ground between an insider and outsider role. To ensure rigour and avoid bias, the researcher must be reflective and aware during the data collection, analysis and interpretation stages (Dwyer & Buckle, 2009).

During the interviews, whether the participants were familiar or not, the researcher made an effort to maintain a neutral role and create a comfortable environment for open and honest conversations. Furthermore, the researcher was mindful of maintaining a neutral stance during data analysis and interpretation, actively seeking different viewpoints to avoid personal biases. This approach ensured that the research

findings aligned with the study objectives, increasing their reliability and trustworthiness.

3.16 Ethical challenges and considerations

To conduct qualitative research ethically, it is essential to address and consider various ethical challenges and principles. Qualitative research often requires close engagement with individual research participants, making ethical considerations an important component of the research process (Arifin, 2018; Sanjari et al., 2014). To ensure ethical standards were met in this research, the researcher submitted an ethics proposal application with the number 21/271 to the Auckland University of Technology Ethics Committee (AUTEC) for approval. The application was approved on 02 August 2021 and data collection began after receiving the approval. Additionally, before each interview, potential participants were given a copy of the approval, a Participant Information Sheet and a Consent Form (see Appendices B and C) to ensure their informed consent.

Informed consent and voluntary participation. The principle of informed consent is a fundamental ethical consideration in research that requires researchers to ensure that participants are aware of the purpose and goals of the study. According to Sanjari et al. (2014), informed consent involves the responsibility for researchers to voluntarily inform participants about the importance and aims of the research. Arifin (2018) further emphasises that this process should be voluntary, meaning that participants should not be coerced or compelled to participate in the study. In addition, Sanjari et al. (2014) suggest that the essential components of informed consent should be communicated to participants in a language that is comprehensible to them. This is often achieved through the use of a printed Participant Information Sheet (Yip et al., 2016). Such a document typically outlines the nature of the study, the participant's role in the research process and the potential risks and benefits of participation.

In this research, the researcher followed the principles of informed consent by emailing and personally explaining the ethics to the Kurdish health care users. The consent form included various elements such as the nature of the study, the participant's role in the research process, the statute and identity of the researcher, the aims and objectives of the research and how the collected data will be used (Richards & Schwartz, 2002). The researcher informed the participants that their information would benefit health care

users and contribute to the development of health policy in New Zealand. Additionally, the researcher provided adequate time for participants to answer questions and make an informed decision.

Do No Harm. One of the key ethical principles in research is the minimisation of harm to participants. In this study, the researcher took steps to ensure that the participation of the Kurdish health care users would not result in any harm to them. Specifically, the researcher provided assurance to the participants that their involvement in the study would not create any harmful situations for them. By minimising the potential for harm, the researcher was able to sustain the integrity of the research process while respecting the rights and welfare of the participants. Additionally, the researcher maximised the potential benefits of the study, which included contributing to the development of health policy in New Zealand and benefiting health care users.

Privacy and Anonymity. Richards and Schwartz (2002) note that privacy and anonymity are critical aspects of research ethics, particularly in terms of protecting the personal information of study participants. Personal information may include sensitive details such as name, identity, age, religion, salary, or any other information that could potentially influence a participant's perception of the research if revealed (Guillemin & Gillam, 2004). It is important to note that cultural factors can also impact the type of personal information that participants are willing to share. For instance, in Kurdish culture, it is not customary to ask individuals about their age or salary. In light of these cultural considerations, the researcher took steps to ensure that the privacy and anonymity of the participants were maintained. Specifically, the researcher did not ask participants for any personal information that was not necessary for the research. By doing so, the researcher minimised the risk of participants feeling uncomfortable or vulnerable during the research process. This approach not only upholds ethical standards in research but also helps to build trust between researchers and participants.

Intrusiveness. In research, intrusiveness refers to the degree to which the research process intrudes on the time, space and personal lives of participants (Lichtman, 2013). To respect the autonomy and privacy of participants, the researcher in this study took steps to minimise intrusiveness during data collection. Specifically, the researcher considered the busy schedules and work hours of the Kurdish participants and chose

appropriate times for data collection. By doing so, the researcher was able to avoid causing any significant disruptions to the participants' daily routines or personal lives.

Inappropriate behaviour. The principle involves avoiding any conduct that could be considered personal or sexual in nature towards participants (Lichtman, 2017). In this study, the researcher was mindful of the cultural and religious norms of the Kurdish participants, which prohibit a man from sitting alone with a woman in a room. To ensure the comfort and safety of all participants, the researcher took steps to maintain appropriate boundaries during data collection. For instance, the researcher ensured that a third party, such as a family member or a chaperon, was present during interviews with female participants. This approach is consistent with ethical principles that require researchers to respect the cultural and religious values of participants and avoid any behaviour that may cause discomfort.

Cultural barriers. In Kurdish culture, it is customary for women to seek permission from male family members, such as their husband, father, brother, or son, before participating in research. To respect this cultural practice, the researcher provided sufficient time for female participants to discuss their decision to participate with their male family members. This allowed the women to seek permission and receive support from their male relatives, which may have increased their comfort and willingness to participate. By providing time for female participants to seek permission from male family members, the researcher was able to ensure that the study was conducted in a culturally sensitive and respectful manner.

3.17 Summary of the chapter

This chapter has presented a comprehensive overview of the research design, including the research methodology and methods utilised for conducting the study. The rationale behind selecting the specific research pragmatism, deductive reasoning and ethnography as the research philosophy, approach and strategy, respectively, has been provided. The research method section has discussed the use of face-to-face interviews as a qualitative method for data collection from 20 Kurdish health care users in New Zealand's cities of Auckland, Hamilton and Christchurch. The primary data obtained from the interviews were analysed using the NVivo Software.

Chapter 4 : Research Findings

4.1 Introduction to the Chapter

This chapter presents the findings of a research study that aimed to evaluate the satisfaction of Kurdish health care users with the quality of health care services in New Zealand. The research questions were formulated to understand the experiences of Kurdish health care users and how they perceive the quality of health care services in New Zealand. The data collection process involved conducting one-on-one interviews with Kurdish health care users in February and March of 2022. The interview questions were designed to cover various aspects of health care users' experiences with the quality of health care services in New Zealand, as well as the enablers and barriers Kurdish health care users encountered when accessing these services.

The research questions addressed in this study are as follows:

1. How do Kurdish health care users feel about the quality of health care provided in New Zealand?

   - What are Kurdish health service users' experiences of New Zealand health care service delivery and do health care services meet health service users' expectations?
   - How does the quality of health care services affect Kurdish immigrants' satisfaction with New Zealand's health care system?
   - What are the enablers and barriers for Kurdish immigrants to engage with health service delivery in New Zealand?
   - What changes, if any, are required to the health system to meet the needs of Kurdish immigrants in New Zealand?

To evaluate the quality of health care services delivered in New Zealand from the perspective of immigrants, Donabedian's model of quality of health care was used. This model is based on three domains, which are Structure, Process and Outcomes (SPO) (Donabedian, 2002). This chapter presents the study findings that provide insights into the satisfaction of Kurdish health care users with the quality of health care services in New Zealand. Additionally, the chapter discusses the enablers and barriers faced by

Kurdish health care users when accessing these services. The chapter also identifies areas for improvement in the health care system to meet the needs of Kurdish immigrants in New Zealand.

This chapter presents the results of interviews conducted with Kurdish health care users in New Zealand to evaluate their satisfaction with the quality of health care services. The chapter begins with a discussion on the reasons for participants visiting health care providers and their recent experiences with the health care system in New Zealand. Approximately 75% of the participants reported visiting health care providers for their own health services, while 25% accompanied their family members or acted as interpreters. The interview questions focused on various aspects of the health care users' experiences with the quality of health services delivered in New Zealand. The chapter concludes by presenting the key themes and sub-themes generated from the data collected from the participants, which will inform the recommendations for improving health care services for Kurdish immigrants in New Zealand.

4.2   Methods

Thematic analysis by Braun and Clarke (2006) was used to generate themes from the data gathered from Kurdish health care users. This approach is commonly used by researchers to explore patterns in qualitative data and analyse large sets of (Braun & Clarke, 2006; Clarke & Braun, 2018; Maguire & Delahunt, 2017; Nowell et al., 2017). Thematic analysis was used in this study to understand the different dimensions of the quality of health care services in New Zealand, as outlined in Chapter Three. The use of NVivo Software helped to organise and manage interview data, allowing for the identification and development of themes. NVivo software was used to help search for and develop themes from the interview transcripts. This software is an industry-standard tool that is commonly used by researchers for organising and managing qualitative data (Doyle, 2019; Mattimoe et al., 2021). The process and rationale behind using thematic analysis were discussed in detail in Chapter Three.

4.3   Descriptive results

4.3.1   Population characteristics

This section provides an overview of the participants in the research, including their demographic information and characteristics. The data were collected from twenty Kurdish immigrants residing in different cities across New Zealand and Table 10 presents a summary of their sex, age, language of the interview and location. The age range of males was 21 to 61, while females were 31 and above 61. In this research, the Participant were used as pseudonym for participant names.

Table 10

Overview of The Participants' Characteristics

No.	Pseudonym	Sex	Age	Language of Interview	Location
1	Participant 01	M	Above 61	Kurdish	Manurewa, Auckland
2	Participant 02	M	51-60	Kurdish	Mount Albert, Auckland
3	Participant 03	M	Above 61	Kurdish	North Shore, Auckland
4	Participant 04	F	31-40	English	North Shore, Auckland
5	Participant 05	F	51-60	Kurdish	Manurewa, Auckland
6	Participant 06	F	51-60	Kurdish	Papakura, Auckland
7	Participant 07	F	Above 61	Kurdish	Massey, Auckland
8	Participant 08	F	51-60	English	Hamilton
9	Participant 09	F	31-40	Kurdish	Hamilton
10	Participant 10	M	51-60	Kurdish	Hamilton
11	Participant 11	F	31-40	English	Henderson, Auckland
12	Participant 12	M	31-40	English	West of Auckland
13	Participant 13	F	31-40	Kurdish	Christchurch
14	Participant 14	M	41-50	Kurdish	Christchurch
15	Participant 15	M	51-60	Kurdish	Christchurch
16	Participant 16	M	21-30	English	Auckland
17	Participant 17	F	31-40	English	Auckland
18	Participant 18	M	31-40	Kurdish	Auckland
19	Participant 19	M	51-60	Kurdish	Auckland
20	Participant 20	M	41-50	Kurdish	North Shore, Auckland

Of the participants, 55% were males and 45% were females, with an equal number from Hamilton- the Waikato region and Christchurch- the Waitaha- region 15% and 70% from Auckland- Tāmaki Makaurau- area (Figure 9). In terms of education level, 25% of participants completed junior and below, 40% completed high school and above, 20% completed undergraduate studies and 15% completed postgraduate studies (Figure 9). Of the interviews, 70% were conducted in Kurdish and 30% were conducted in English. Overall, the majority of participants lived in Auckland, consistent with the 2018 New Zealand census data on Kurdish immigrants (Stats NZ Tatauranga Aotearoa, 2018b).

Figure 9

Education Level and Residence of Participants
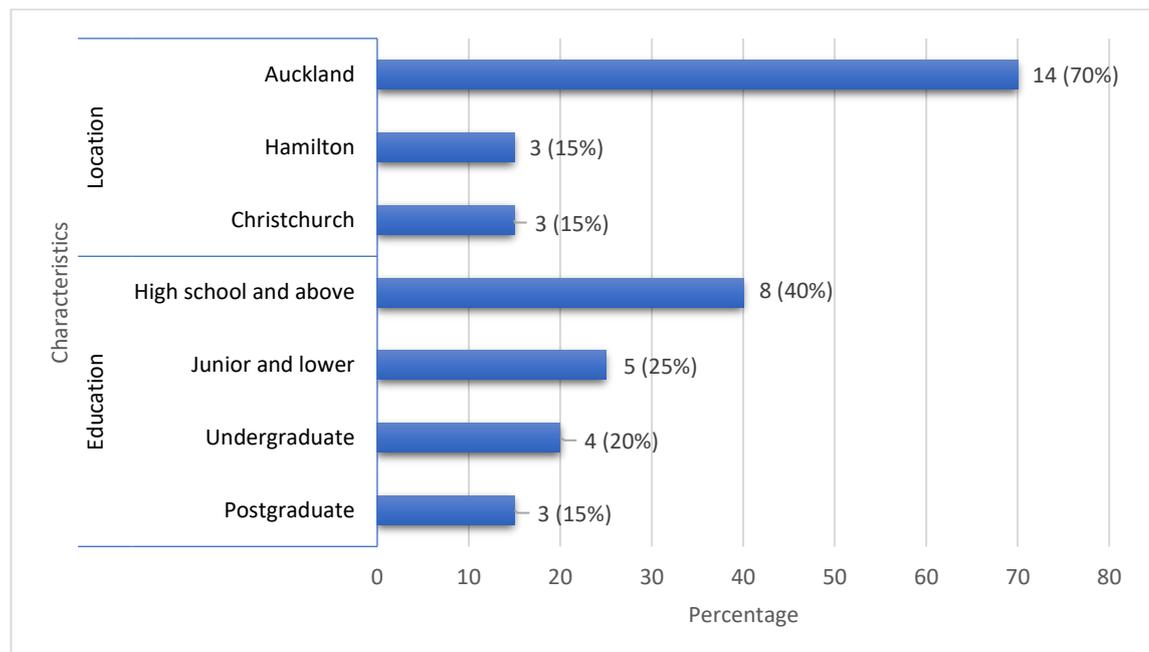
4.4   Key themes

After obtaining approval from the Ethics Committee at the Auckland University of Technology (AUTEC) with the ref. 21/271 on August 2, 2021, twenty Kurdish immigrants were recruited through an advertisement on the Kurdish Community Facebook page. Convenience sampling, a type of non-probability sampling technique was used recruit participants to collect data from an easily accessible population (Etikan et al., 2016; Greener, 2008; J. Jager et al., 2017). Data collection continued until data saturation was

reached during the 20th interview, meaning that no new information was obtained beyond what had already been identified in previous interviews (Dong et al., 2022; Hennink & Kaiser, 2021) By using this saturation criterion, which takes into account the study's goal and population size, the study was able to ensure the reliability and robustness of the data gathered. The sample of 20 Kurdish health care users was sufficient to answer the research questions and meet the study's objectives, ensuring the credibility of the study (Dong et al., 2022; Hennink & Kaiser, 2021). Therefore, further data collection was unnecessary.

The data collected in this study was analysed using NVivo 1.6.1 (1137) Software. To generate four key themes and eight sub-themes, the study adopted six stages of thematic analysis, as explained in Chapter 3.11, following the method proposed by (Braun & Clarke, 2006). The key themes and sub-themes were based on the participants' experiences with the quality of health services in New Zealand. The first theme focused on the barriers faced by Kurdish health care users when accessing health care services, including both personal and external impacts. The second theme highlighted the key dimensions of health care quality that play a significant role in determining their satisfaction with the services they receive. The third theme described the physical and psychological health care environment and how these factors impacted participants' satisfaction with the quality of care they received. Finally, the fourth theme examined Kurdish health care users' satisfaction with the ethical considerations of health care services, including confidentiality and respectfulness. Figure 10 displays the main themes extracted from the participants' responses to the interview questions, which aimed to evaluate their satisfaction with the quality of health care services in New Zealand.

Overall, the study's findings provided valuable insights into the experiences and perspectives of Kurdish health care users and the aspects that impact their satisfaction with the quality of care they receive.

Figure 10

Key Themes and Sub-Themes Obtained from Interviews Conducted with Participants
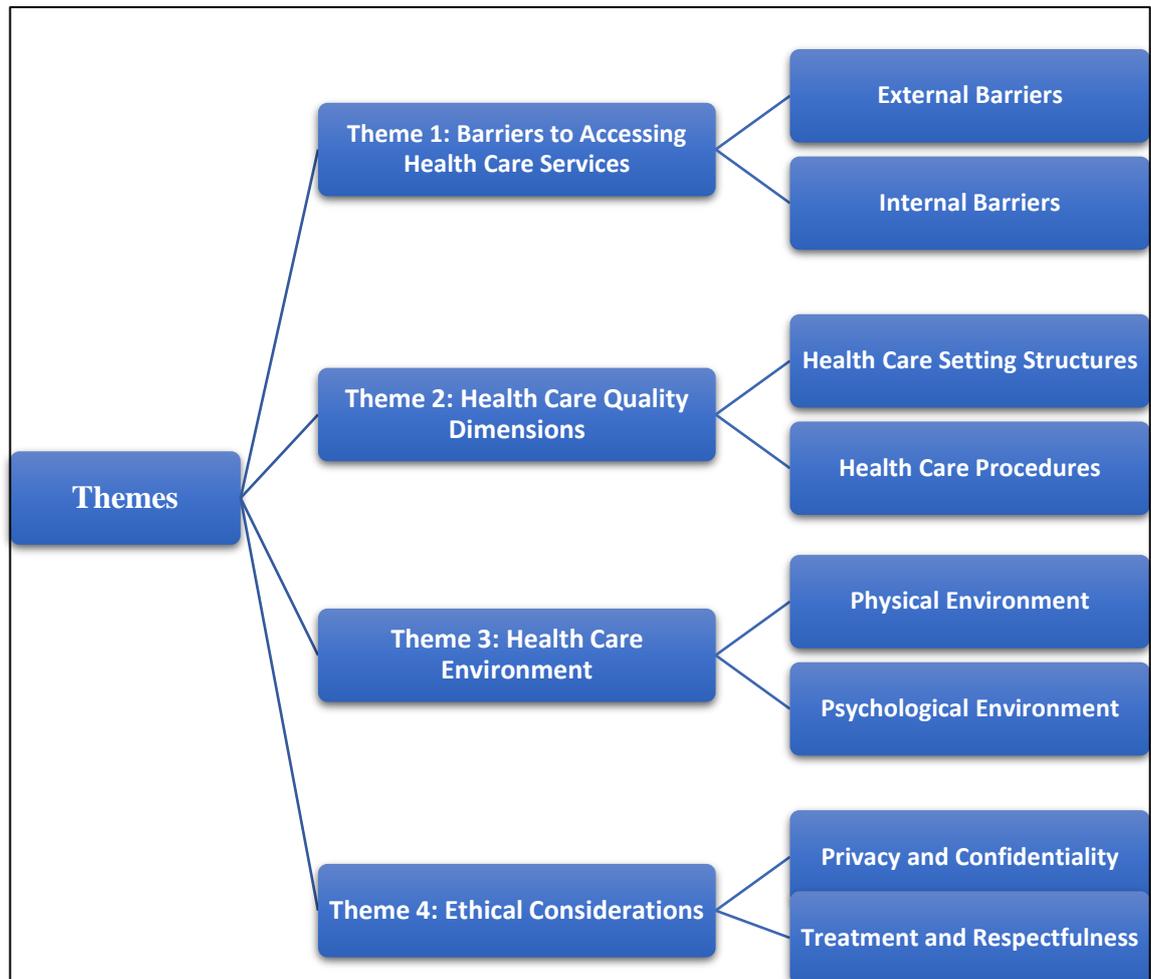
Table 11 provided an example of research questions, probes, participants' responses, initial coding and themes. By analysing the interviews, this research identified key themes and sub-themes related to the quality of health services in New Zealand. Table 11 illustrated the process by which the data were collected, analysed and categorised into themes and sub-themes. In this table, the research questions and probes used to elicit participants' experiences are listed, along with some sample responses. The initial coding of the responses is also provided, which was used to identify themes and sub-themes.

Table 11

Interview Questions, Participant's Responses, Initial Codes and Themes

Interview Questions	Probe	Example	Code	Sub- theme	Theme
What is your recent experience with the health care in NZ?	What was the reason for using health services?	I don't know exactly when it was, but it has been 2-3 months. My wife was sick and less energised, I took her to the hospital.	Recent experience, uncomfortable feeling, being sick		
Tell me about your experience with either health professionals e.g., doctors, nurses, or other health care professionals in the health care services.	Could you please give me some examples of your experiences with doctors in relation to their behavior and patient's treatment in NZ?	Most of the doctors are good, but we cannot hide that there is differentiation and ignorance against patients. For example, when our kid aborted (miscarriage), nurses knew that the kids was died in her tomb. The nurses didn't try to save the kid. The nurse's behaviour made me avoid visiting hospitals.	Differentiation, ignorance, racism. Boring and annoying face, negative experience with nurses.	Internal Barrier	Theme One: Barriers to accessing health care services.
What is your experience with management of health care providers from either reception/phone call booking to managers and other staff such as those doing handling and moving, or waiting room staff?		Generally, the reception staff were good. Whenever I called them to make an appointment or ask a question, they replied to me nicely.	Reception staff were good, replied to calls nicely.		
How did you find the health care provider setting in terms of environment, assessment area and medical equipment, e.g., technological tools like x-rays, etc.	How do physical buildings affect your mood? Do hospitals use new technological developments for diagnosing your health issue?	If you stay in hospital for a long time, it may affect your mood. In those rooms we admitted in didn't have TVs. or anything related to entertainment. No views to view outside. Windows are covered by curtains. Hospitals had good air conditioning. All rooms have water and a toilet. Which is not bad. Their environment is good. regarding hygiene, they are cleaning and changing bed sheets well	Negative impact. No entertainment, No views outside. No TVs., good hygiene services.	Physical environment	Theme Three: Health care environment.
How did you find the ways of assessments and treatment in terms of medical/support staff		They already diagnosed the issue, but the treatments were not good. For example, I got a kind health issue 3 years before COVID-19	No effective treatment. Fear, health secrets, good documentation.	Health care procedure	Theme Two:

behaviour, quality of health care, appropriateness of health care service, confidentiality, documentation?		came. It was a very strong Flu which made me breath hard. I visited doctors, they said it is nothing. Then my family doctor gave me treatment, but it was not effective. I fear my health secrets are to be revealed to the public. I shared my health secrets with my family doctors. I don't want to change my family doctor and move to another doctor because all my files and secrets are with him. Most of the time that we visited hospitals they give us back the discharge document. Good documentation.			Health care quality dimensions.
How did you find the evaluation of New Zealand's health care services in terms of: language and interpreting services? and transport and physical access?	Could you please explain to me if you use interpretation services? How do you access to hospitals?	I never used an interpretation service. I never trust them. However, sometimes we face hardship to understand some medical terms. Physical access is easy, but parking vehicles is not free. We should pay which is expensive.	Mistrust to interpreters, hardship of understanding medical terms, easy physical access, parking problem, high cost of parking.	Internal barrier and external barrier	Theme One: Barriers to accessing health care services.
How did you find health care services in terms of feeling safe and the cost of services?	Are you afraid to visit hospitals because unsecure their services? Do you pay for services?	I feel safe because staff gloves and disposable scrubs/ gown every time. This service is very good. Cost of services is free. I haven't paid yet.	Feeling safe, hygiene services, free cost.	Health care procedures	Theme Two: Health care quality dimensions.
According to your experiences, what are the barriers to accessing health care for Kurdish immigrants?	Could you please tell me what barriers Kurdish immigrants are facing while accessing health services?	Speaking in English language and mistreatment by nurses are barriers to accessing health services. The Kurdish community is very small, and they know each other very well. They prefer to keep their secrets confidential. That's why sometimes they don't use interpretation services. We don't have the skill to discuss with the doctor.	Language barrier, mistreatment by nurses, mistrust to interpreters, no skills of discussion,	Internal barrier, privacy and confidentiality,	Theme One: Barriers to accessing health care services, Theme Four: Ethical Considerations
Tell me about your satisfaction nor dissatisfaction with health care services as a Kurdish immigrant in New Zealand.	What areas of health services made you satisfied and dissatisfied?	The health services are free, and the ambulance service is very good. Ambulance staff do their job properly and they don't hurt patients. I don't like to go to the hospitals	Free services, great ambulance services, mistreatment by nurses,	Health care setting's structure, external barriers,	Theme Two: Health care quality dimensions.

		because of the nurses' behaviors and treatment which annoy me a lot. Waiting for a long time to receive services annoyed me. Many times, we called nurses to help us, but they did not answer. While they help local patients.	waiting for a long time, discrimination.		Theme One: Barriers to accessing health care services.
How could health care services be improved?	Could you please tell me how these issues you mentioned earlier can be solved?	I think the best way is to educate ourselves and know where we can complain and what are our rights in hospitals, specifically complaining about mistreatment by staff to reduce discrimination. And we should try to be calm and explain our problems to the staff nicely and calmly. We must change ourselves to be matched with NZ's health system. Because I don't believe that the system can be changed.	Educating ourselves, Rights to complain, reduce discrimination, talk to staff nicely, adapt to system, system cannot be changed.	External barriers, health care procedures	Theme One: Barriers to accessing health care services. Theme Two: Health care quality dimensions.
Any other thing you would like to add?		I prefer to be healthy so as not to go to hospitals.	Stay healthy, avoid visiting hospital.		

4.5 Theme One: Barriers to accessing health care services.

The findings from the interviews indicated that Kurdish health care users in New Zealand encountered various barriers that hindered their access to health care services. The barriers were classified into two categories: internal or personal barriers and external barriers related to the health care system of New Zealand. The internal barriers included issues that were directly linked to the Kurdish health care users themselves, such as the English language, low health literacy and cultural barriers. The participants expressed that these barriers made it difficult for them to access health care services adequately and Kurdish immigrants were at risk of not receiving appropriate health care services. On the other hand, the external barriers related to the health care system of New Zealand included issues such as COVID-19 protocols, discrimination, shortage of doctors, misdiagnosed health issues, lack of follow-up with health care users' health issues and parking vehicle issues. This section will further detail these barriers to accessing health care services in New Zealand from the perspective of Kurdish health care users.

4.5.1 Internal barriers.

This section focuses on the internal or personal barriers that prevent Kurdish immigrants from fully accessing health care services in New Zealand. Internal barriers, in the context of this research, refer to those issues that are directly linked to the participants themselves and restrict their access to health care services. When asked about the barriers they face, participants identified several issues related to internal barriers, including the English language barrier, lack of health education and cultural barriers specific to the Kurdish community (see Figure 11).

Figure 11

The internal Barriers to Accessing Health Care Services
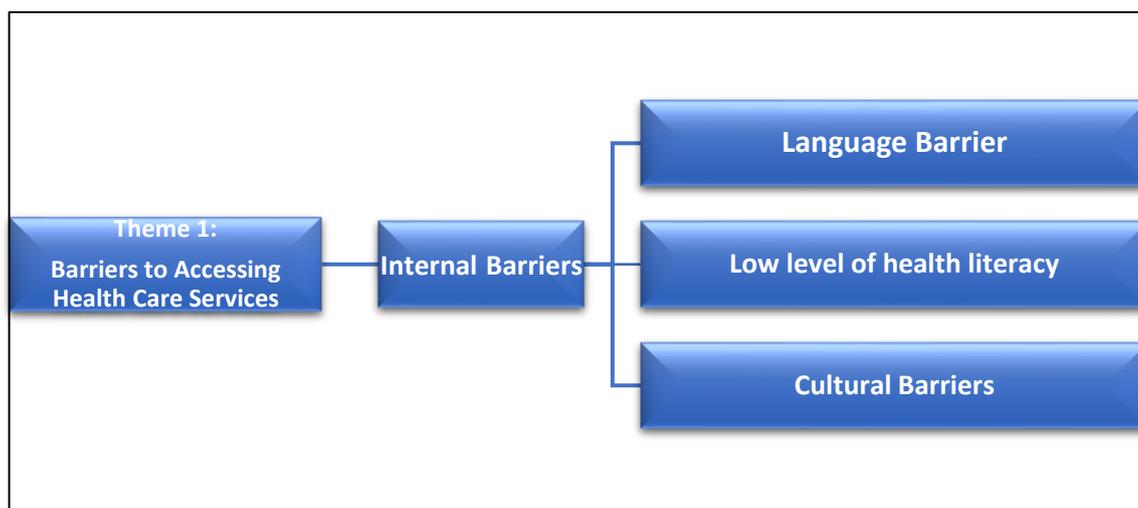
Language barriers

English is the official language of New Zealand, along with the Maori language and is widely spoken by both native speakers and immigrants who are proficient in it as a second language (Ministry for Ethnic Communities, 2013). In the health care industry, proficiency in English is necessary for users to communicate effectively with health care professionals and receive quality health care services. However, first-generation Kurdish health care users in New Zealand, in particular, are experiencing issues fully understanding the English language. The participants in this research demonstrated that many Kurdish immigrants face challenges with the English language when visiting health care providers.

> *'English language is the main issue for Kurdish immigrants to accessing health care services in New Zealand' Participant 14.*

> *'The majority of the Kurdish people who are coming to New Zealand face speaking English language problem' Participant 02.*

The issue of language barriers was further highlighted by another participant who reported difficulties in understanding the medical terms used by health care professionals. She stated that health care professionals often use complex medical terms that she cannot understand, which makes it challenging for her to communicate effectively with them. As a result, she feels like she is not receiving adequate health care services. One participant mentioned that she tends to stay at home and self-medicate

with painkillers or Panadol tablets when feeling unwell, rather than visiting a doctor. When asked why she didn't utilise interpreter services, she explained that only hospitals offer such services.

> *'I hardly understand my family doctor. He also doesn't understand my health problem. Several times happened I felt sick and got pain and I did not visit the doctor. Because I didn't know how to talk in English to explain my health issue. My family doctor never brings an interpreter for me. Only hospitals and specialists provide interpreters. If I don't have an interpreter, I stay home and take Panadol tablets. I am illiterate. Therefore, I have a hard life in terms of language issues in the hospital' Participant 09.*

Several participants in the study emphasised the importance of providing interpretation services. One participant stated that having access to interpretation services was important for her to understand and explain her health issues to health care professionals. She mentioned that she returned home without receiving health care services on occasions when an interpreter was not available.

> *'Because I did not have an interpreter, I returned home without understanding my doctor. I just said thank you and returned home' Participant 07.*

Inadequate language proficiency and unfamiliar accents can pose significant challenges for health care users in accessing quality health care services. For instance, one participant in this study reported difficulty understanding her doctor, who was a native English speaker with a local accent, during her back surgery. Unfortunately, an interpreter was not available to help bridge the communication gap. Figure 12 highlights the important role of the English language and interpreters in facilitating access to health care services for Kurdish health care users. Participants noted that their inability to communicate effectively in English, coupled with the unavailability of Kurdish interpreters, often discouraged them from seeking health care services.

> *'The doctor who did my back surgery asked me to revisit him to check my back. When I visited him, hospital didn't bring an interpreter for me. The doctor was a kiwi doctor (white) which was hard for me to understand. Almost I didn't understand anything from him' Participant 07.*

Figure 12

The English Language as an Internal Barrier
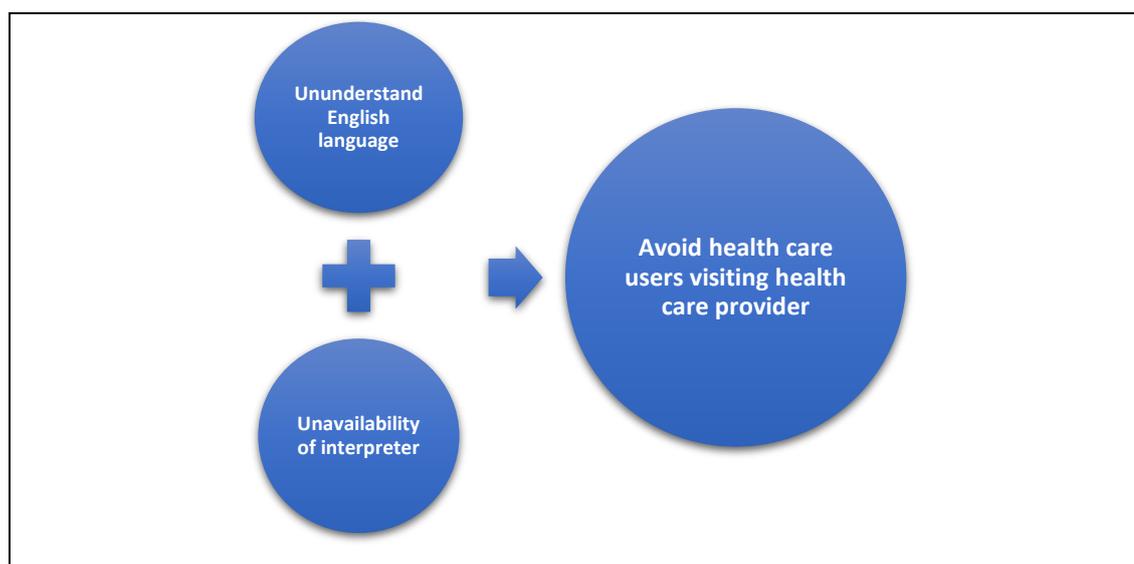
Low level of Health Literacy

Poor health education can lead to health issues lasting longer and prevent a speedy recovery. The relationship between health and education is strong, as being educated about regular health check-ups can lead to a healthier lifestyle (Raghupathi & Raghupathi, 2020). The level of health education varies among different societies, with some societies placing a high emphasis on taking care of themselves by scheduling regular check-ups, while others may ignore their health issues and neglect having regular check-ups.

In this study, a participant reported that she does not take her health issues seriously and does not like taking medication, including Panadol tablets. This self-barrier for Kurdish health care users can prevent them from accessing health care services in New Zealand. Therefore, having sufficient knowledge about health literacy is essential for achieving a healthy body.

> *'One of the barriers is not doing health check-ups. If you have an issue, you go get a check-up. I feel like a lot of the time Kurdish people don't take their health very seriously. This is the lack of education. Despite the fact I say I don't like taking medication, I don't know why, I just don't like it even Panadol I don't like it' Participant 18.*

Cultural barriers

Participants emphasised the importance of cultural sensitivity in providing health care services. Participants pointed out that health care providers should take into

consideration the cultural backgrounds and preferences of their patients. One example is the food menu provided to admitted patients, which is often not suitable for those with Middle Eastern tastes. The food menu issue contributes to participants' dissatisfaction with the quality of food provided. Additionally, admitting both male and female patients in one room is contrary to Kurdish culture, where male and female patients should be allocated to separate wards. These cultural barriers have affected participants' willingness to access health care services. Therefore, health care providers need to be aware of the cultural differences and provide services that respect the cultural beliefs and practices of their patients. Figure 13 illustrates the cultural aspects that participants have experienced while accessing health care services.

> *'Also, the food services in hospitals, make me dissatisfied. Staff only provide one type of food which may be not tasty for Kurdish patients. However, nowadays, better than before but still is not good. And sometimes hospitals put male and female patients in one room which is against our culture' Participant 01.*

Figure 13

The Cultural Aspects that Dissatisfied Participants

Dissatisfied health care users
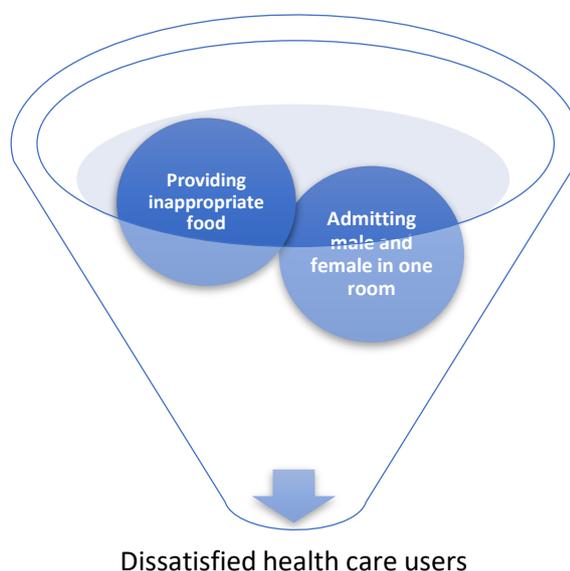
4.5.2   External barriers

Participants in the study identified several external barriers (see Figure 14) that limit their access to health care services in New Zealand. One of the major external barriers is the COVID-19 protocols that have been implemented in health care settings. These protocols often limit the number of visitors that can accompany health care users during

appointments or hospital stays, which can be a challenge for those who rely on family members or friends to interpret or advocate for them. Participants also reported experiencing discrimination in health care settings, which can impact their trust in the health care system and their willingness to seek care. Shortages of doctors was also identified as external barriers, as this can lead to delays in receiving necessary care and treatment. Misdiagnosing health issues was another external barrier that participants mentioned, as it can lead to unnecessary treatments and additional health complications. Lack of follow-up on health issues was also identified as a barrier, as participants felt that health care providers were not always thorough in following up on their health concerns and ensuring that participants received appropriate care.

Finally, participants reported a lack of parking lots for their vehicles as an external barrier, which can make it difficult and inconvenient for them to access health care services. These external barriers can have significant impacts on the health and well-being of Kurdish immigrants in New Zealand and addressing them will require collaborative efforts between health care providers, policymakers and community members.

Figure 14

The External Barriers to Accessing Health Care Services in New Zealand
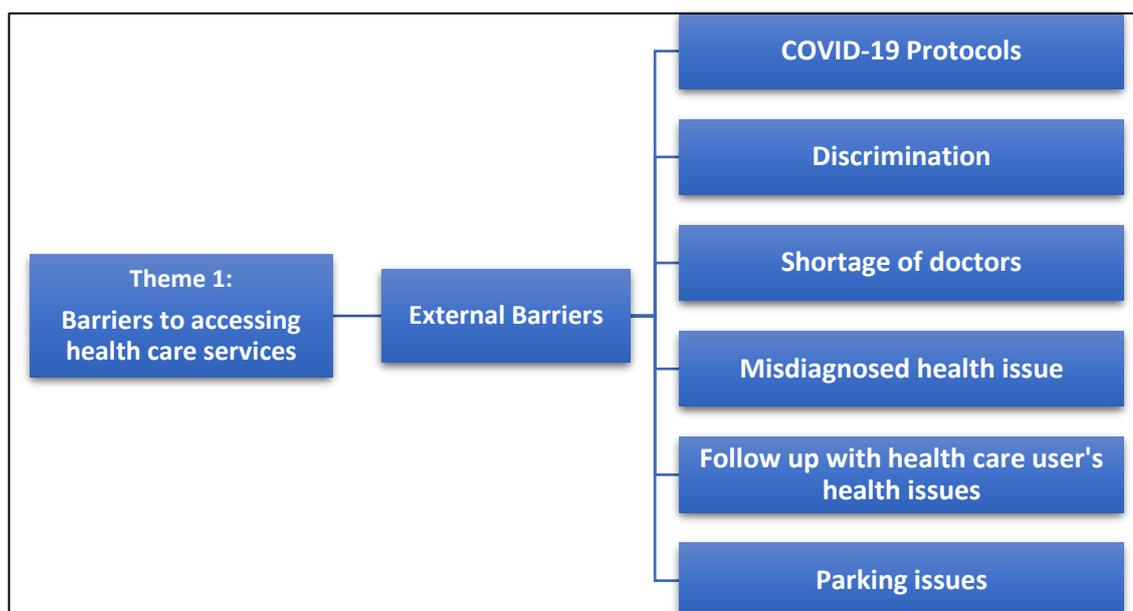
COVID-19 protocols

The COVID-19 pandemic has had a profound impact on the health care systems worldwide, including New Zealand. In response, each country has implemented a set of guidelines and regulations, commonly referred to as COVID-19 protocols, to contain and manage the spread of the virus. However, these protocols have created additional barriers for health care users, including Kurdish immigrants in New Zealand, who face significant challenges in accessing health care services. The protocols restrict the movement of individuals, which has prevented participants from receiving appropriate health care services. Kurdish health care users have reported that the COVID-19 protocols have negatively impacted their ability to access health care services. Kurdish health care users face various challenges, such as transportation restrictions and reduced availability of health care providers due to staff shortages. As a result, participants are less likely to access health care services due to the limitations imposed by the COVID-19 protocols.

> *'….it has been 2 years since I didn't visit my family doctor because of the COVID-19 virus. If I have any health issues, I call him. I am facing big problems about how to make him understand or how I understand him……. Therefore, it is really hard for me to deal with doctors over the phone' Participant 07.*

To add to the challenges faced by Kurdish health care users during COVID-19, participants reported struggling with booking appointments to visit health care settings. One participant shared their experience of having their appointments cancelled and rescheduled multiple times by the health care provider, causing significant delays in receiving necessary health services. Another participant, number 07, highlighted their difficulty in communicating their health issues to doctors over the phone due to language barriers, which was previously discussed as an internal barrier. The difficulty in communication demonstrates the additional challenges faced by Kurdish health care users during COVID-19, including difficulties in accessing timely and appropriate health care services.

> *'…….in the current situation during COVID-19, a few times staff made appointments for us, but they postponed by themselves, not from our side. You know during the last two years, hospitals were making serious protection rules to avoid the virus……' Participant 08.*

Some participants in the study reported that booking an appointment to visit a health care provider is a challenging process. Health care users often must wait for a long time to get an appointment, which can lead to frustration and annoyance. One participant expressed their dissatisfaction with the long waiting times, stating that it made them feel bored and irritated.

> *'If I need to visit a doctor in the hospital, I have to ask my GP to book me an appointment. Recently, because of COVID-19 restrictions, it became hard to get an appointment and must wait for a long time to get it. Even if I want to visit my GP, when I call them, they are saying you may visit us after 3 weeks. I told him, how I can wait with that much pain for three weeks. He replied to me, if you cannot handle it, go to the hospital. When I go to the emergency, I have to wait for at least 5 hours which makes me annoyed and very bored' Participant 17.*

Participants reported that during the COVID-19 pandemic, they have faced challenges with receiving proper treatment services from health professionals. According to one participant, medical staff member seem to be afraid of getting infected with COVID-19, which has led to inadequate services being provided. However, participants themselves have also expressed fear and hesitation about visiting health care providers during the pandemic. Consequently, many participants have reduced their visits to hospitals and other health care settings, which has further affected their ability to access appropriate health care services.

> *'Before COVID-19, health services were better than during COVID-19. Now, medical/ support staff behaviour has changed as nurses have no time to serve us properly like before. Now, nurses are not very helpful because they fear of getting infected with COVID-19.......*
>
> *......I would like to say that during COVID-19, most Kurdish health service users fear of going to the hospital. Therefore, visiting the health centres has reduced to a very low rate' Participant 01.*

To further elaborate on the impact of COVID-19 protocols on accessing health care services for Kurdish immigrants in New Zealand, participants reported several challenges. Firstly, the protocols restricted their access to health care services and prevented them from receiving appropriate health care services. Secondly, participants experienced difficulty in booking appointments and must wait for a long time to get an appointment. Waiting for a long time to get an appointment caused annoyance and

boredom among participants. Thirdly, health care staff members scared of getting infected with COVID-19 and participants were also afraid to visit health care providers during the pandemic, which resulted in reduced visits to hospitals. The outcomes of these challenges are presented in Figure 15.

Figure 15

COVID-19 Protocols as an External Barrier
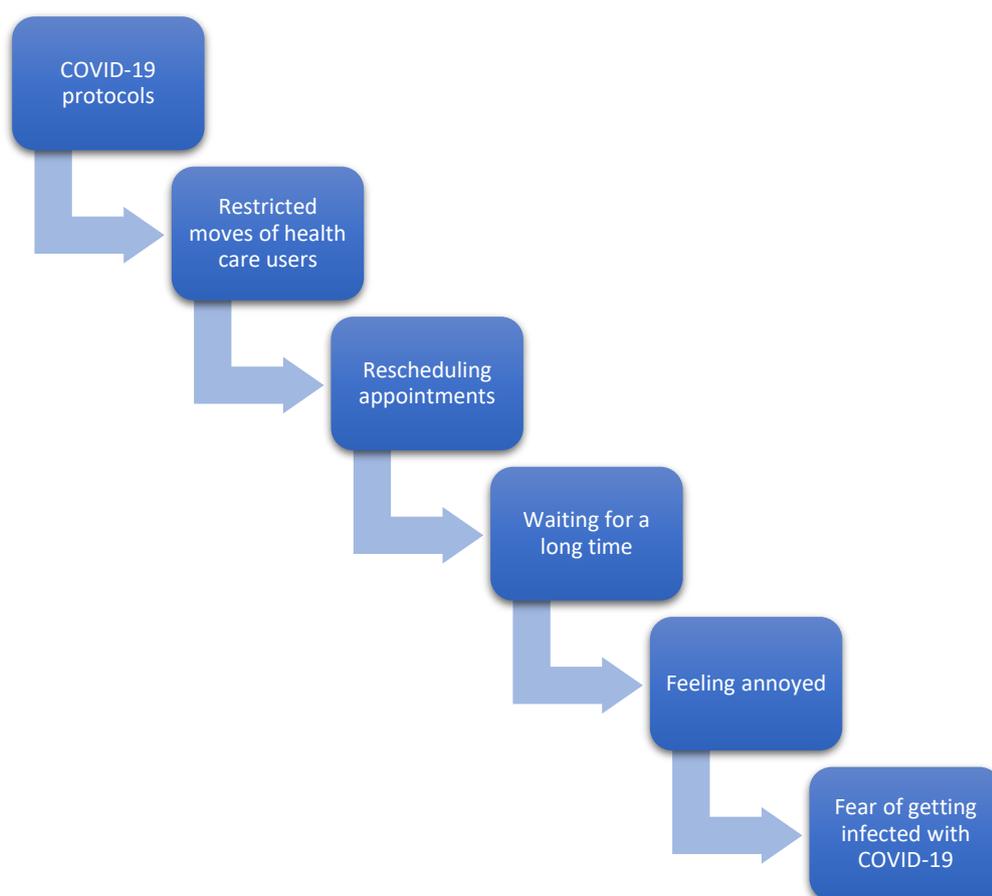
Discrimination

The study included core questions on the experiences of Kurdish health care users with administration staff and health professionals such as doctors and nurses in New Zealand health care settings. These questions were aimed at exploring two areas: favouritism and discrimination. Participants shared both positive and negative experiences with managerial staff and health professionals. Favouritism was identified as a form of discrimination that can be based on culture, ethnicity, origin, personal associations, or friendships (Lasisi et al., 2022). Although participants found it difficult to express their feelings about favouritism, some reported that it exists in reporting processes:

'It is hard to say anything in that regard. It is related to the personality of the doctors…... Sometimes there is favouritism in the health care centres…………I can say that ethnicity plays a key role in receiving health services or being served better. If a doctor is in the same nation that you are, he/she will respect you more than if he/she is not in the same nation. For example, if I see a Kurdish- Iraqi doctor in a hospital, he/she cares me very well more than others' Participant 01.

'I have seen most of the white people break the queue at hospitals………. When we were waiting for accessing health services, I saw a white lady (Kiwi) brought her child to the doctor and the staff took care of her more than I. Nurses took her to the doctor before I. Staff found excuses to give a white lady favouritism, such as her child was vomiting' Participant 09.

Regarding experiences of discrimination, some participants reported facing discrimination from both health professionals and administrative staff members. One participant shared his experience with nurses when seeking health care services for their wife, stating that the nurses were racist and showed annoyance and fatigue towards them.

'In general, nurses are not treating us well. I never felt nurses treating us well as it supposes to. Most of them showed us their annoyance and boringness face either because of racism or something else. Nurses are tired of patients and nurses didn't like patients at all. Nurses think that we 'patients' like a hospital that's why we went there. Nurses feel that they are servants when they help patients. I have never seen and never had a good experience with nurses. I can say that during the last 23 years especially in both Middlemore and Starship hospitals in Auckland. Because of our son's health, we visited them but never had good experiences with them' Participant 02.

Another participant shared her experience of facing discrimination from administrative staff members. She explained that when she was looking for a room to receive health services, some of the staff members were not respectful towards her due to her English language proficiency. She further explained that because she struggled with the language, the staff members were impatient and impolite towards her.

'Some of them are very good but some others are not nicely talking with me……. nurses know that I am not good at the English language, therefore, staff don't respect me or talk to me nicely. Some others are smiling at me and guiding me to the place that I want, and staff ask me to have a seat. staff take me to the room where I am looking for

services. Whereas some others are gesturing me to go to that room without taking me to the place. For me this is a problem because I cannot read what is written in the rooms, how can I find it?' Participant 07.

To further elaborate on the issue of favouritism and discrimination in accessing health care services, participants reported that local patients were given preference over them due to their ethnic origin. Participants also mentioned that the medical staff showed irritation and boredom towards them when they sought medical services. Participants added that nurses treated them disrespectfully because of their limited English proficiency. These experiences have created barriers for Kurdish immigrants in New Zealand to access health care services and hindered their ability to receive appropriate care. Overall, these instances of favouritism and discrimination highlight the need for cultural competence and sensitivity training among health care professionals and the importance of addressing language barriers in the delivery of health care services. Figure 16 illustrates participants' views on the issue of discrimination among health care staff in New Zealand health care centres.

Figure 16

Discrimination Among Health Care Staff in New Zealand
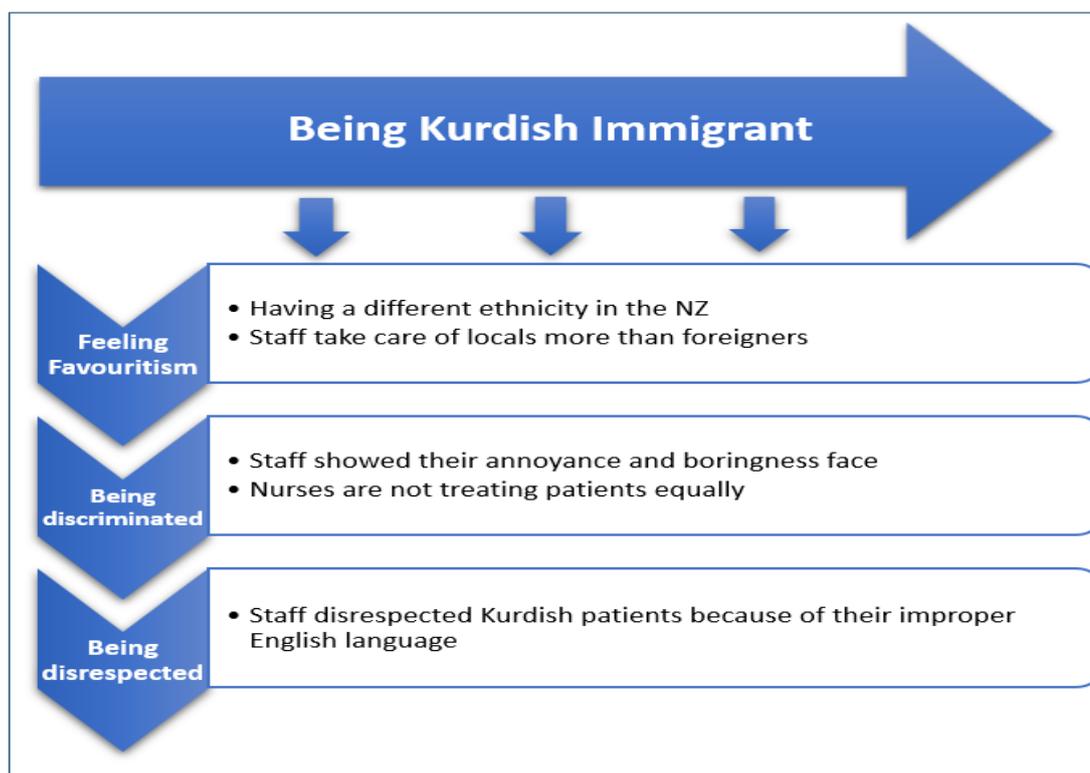
Shortage of doctors

The participants of this study revealed that one of the issues with the health care system in New Zealand is the shortage of doctors. According to their reports, the current number of doctors is not sufficient to provide enough health services to the Kurdish health care users. When asked about the duration of appointments, participants stated that they often must wait for an extended period, sometimes up to a year, to get an appointment with their general practitioner or specialist. Participants attributed the slow booking process to the shortage of doctors in the health care system.

> 'Health care providers are too slow in booking appointments for us due to the lack of the number of doctors' Participant T3.

> 'Last year I went to the hospital for booking an appointment, staff told me that it takes 4-6 months' Participant 13.

> 'For example, for my carpal tunnel surgery I waited a very, very long time. It was almost nine months to a year. However, I was in a high priority because I was pregnant. So, when you're pregnant you know your body swells up. So, for me it was very painful' Participant 18.

Waiting in long queues to receive health care services was described as a major disadvantage by almost all participants. Participants reported that in emergency departments, they often must wait for 5-10 hours or even longer before receiving the necessary medical attention. Participants believed that this issue could be alleviated if there were enough doctors and health professionals to handle the demand. Many participants noted that the shortage of doctors in New Zealand is a significant issue contributing to long wait times and difficulty accessing health care services.

> 'But I have a problem with waiting in line to get a service. I believe that the reason behind waiting in line for a long time belongs to the lack of the rate of doctors. For example, in North Shore hospital, patients are waiting for a long time because there are not enough doctors. If there is enough number, for sure waiting time will be reduced to less than one hour than 3-5 hours' Participant 19.

Kurdish health care users reported avoiding visiting health care providers, especially emergency hospitals, due to long waiting times. One participant shared her experience of waiting for more than seven hours to receive health services in an emergency hospital in Auckland. She explained that due to a lack of beds, participants were forced to stand

up or sit on chairs while waiting. The participants indicated that waiting for a long time in line for health services in emergency hospitals was a negative experience. Participants suggested that increasing the number of doctors and health professionals could help to reduce waiting times. Figure 17 illustrates participants' views on the issue of doctor availability in New Zealand health care centres.

> *'There have been times I and my husband have been so sick, but we have avoided going to emergency hospitals just to not wait in the waiting room. There were times we had to wait about 7-8 hours if not more. It is very difficult when you can't sit or stand for too long because you need a bed and always are the beds are full....... staff could improve this by having more staff, nurses and doctors' Participant 11.*

Figure 17

The Shortage of Doctors in New Zealand
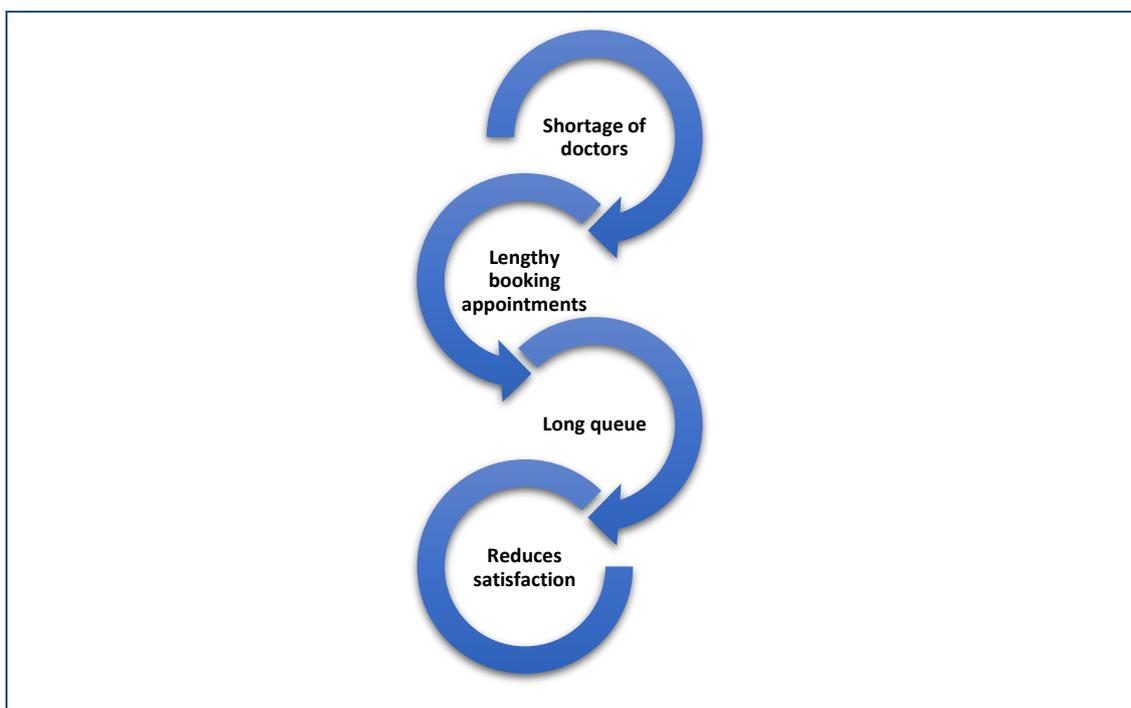
Misdiagnosing health issues

Diagnostic errors or misdiagnosis of health issues is a significant concern for Kurdish health care users in New Zealand, as noted by the participants of this research. Kurdish health care users reported experiencing diagnostic errors in the health care providers in New Zealand. When asked about the barriers to accessing health care services, a Kurdish female participant highlighted that diagnostic errors and the slow process of diagnosis were major obstacles. She described her own experience of having a high temperature,

which doctors failed to diagnose correctly for almost a year. It was only after several attempts that doctors were able to identify the issue was related to her glands. The participant expressed that during that period, she experienced severe pain in her body.

> *'A few years back, I was experiencing a very hot temperature in my body. For one year I was visiting a doctor and staff didn't find the reason. Health staff have done many examines. All my body organs were very hot and experienced a high temperature. Once my doctor told me that my glands are not working…. I experienced pain in my throat, but I didn't know that it is because of my glands. I was thinking that I have a throat issue, but she told me that my glands are not working' Participant 05.*

Another participant commented on the quality of the medicine she received after being diagnosed with a health issue. She reported that the medicine she was given was harmful to her body. She described how, at times, health care providers are providing ineffective medicines to health care users, which can be a significant problem.

> *'Due to taking the cheap quality of medicine, I have got infections in my bladder. My bladder was full of blood. After those medicines changed to better quality, then I have got better health. Therefore, most of the time their quality of services is not appropriate for my health issue' Participant 15.*

Figure 18. illustrates the equation of misdiagnosing health issues, which includes diagnostic errors, the slow process of diagnosing and providing low-quality medicine, has become a significant barrier for Kurdish health care users in accessing health services in New Zealand.

Figure 18

Misdiagnosing Health Issues in Health Care Providers
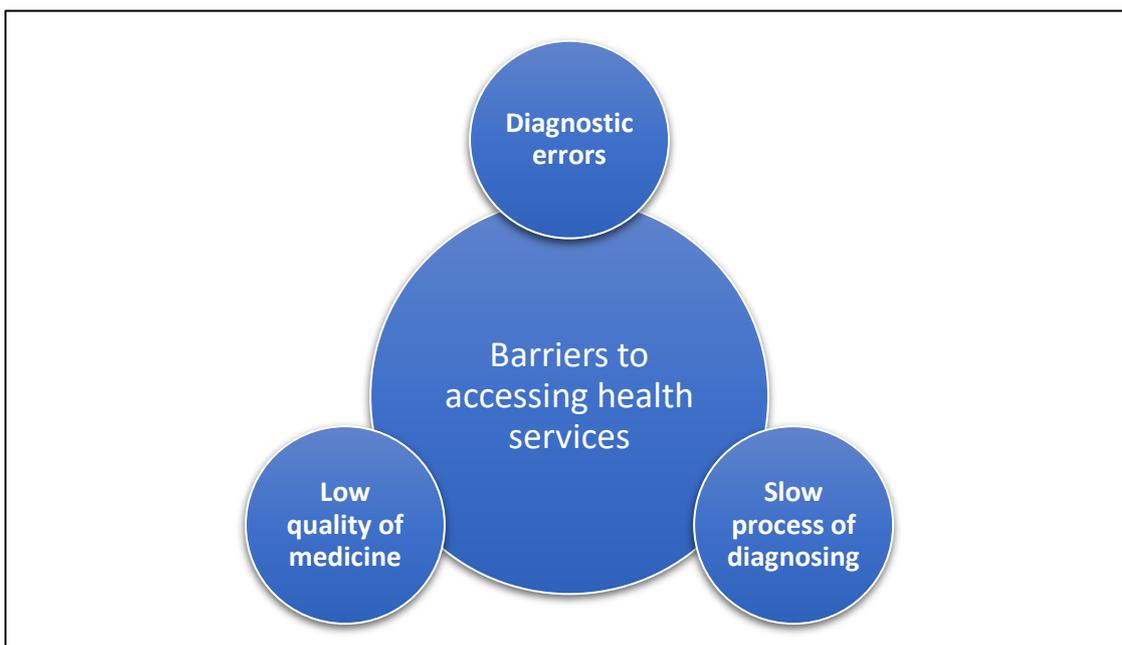
Follow up with health care users.

Participants in the study identified a lack of follow-up by health care providers after receiving services. Follow-up is defined as the ongoing monitoring of a health care user's health over time after they have received treatment (Violet et al., 2020). One participant reported that his health care provider did not contact him after his last treatment to monitor his progress. The lack of monitoring can impede the identification of misdiagnoses or the need for re-examination and treatment adjustment, which can compromise the quality of care received by health care users.

> *'You know I have got a broken foot. After receiving treatment, I was lying in bed. Nobody really told me anything about what is the best way for me to get up… health staff didn't tell me you will experience these kinds of pains. So, in terms of that, there may be some lack of communication or lack of follow-up' Participant 17.*

Parking issues

All participants were asked to respond to the question, "According to your experiences, what are the barriers to accessing health care for Kurdish immigrants?" Participants reported that finding parking spaces at health care providers is one of the significant issues, in addition to difficulties in speaking and understanding the English language.

This section focuses on explaining the parking issues among Kurdish health care users in New Zealand. Participants indicated that finding space for parking vehicles and the cost of parking are key issues for them. A participant from Hamilton city described that there is limited car parking lots around Waikato hospital, including on-street metered parking spaces located throughout the Waikato hospital area. The participant identified that parking is a significant issue for them when they need to access health care services.

> *'Parking is the biggest issue for the patient in the Waikato hospital. There are no spaces for parking our cars. We sometimes park our cars on the street on yellow lines because there are no spaces for parking, then we will be fined. We don't know where to park. However, I go to the hospital at least 30 minutes before the time, I still face hardship to find a space. If I park my car far away from the hospital, I must walk for 30 minutes to reach the hospital's gate' Participant 09.*

Another participant in the study provided additional information about the cost of parking and its impact on Kurdish health care users. According to this participant, in addition to the challenge of finding available parking spaces, the cost of parking is also a significant barrier for health care users. He explained that for the participants who are dealing with chronic diseases, the cost of parking can be an added burden that they are unable to afford. The participant argued that since Kurdish health care users do not earn much, they struggle to pay for the cost of parking in health care providers.

> *'North shore hospital and even Waitakere hospital have a parking problem. The cost of parking also is another problem for health care users, especially for those who are dealing with chronic diseases. Parking for the whole day costs us about 36 dollars which is hard for me and other Kurdish immigrants to afford because we do not have good jobs to earn much' Participant 01.*

To summarise, the main barriers related to parking issues for Kurdish health care users in New Zealand were identified as: 1) providing less parking lots to the health care users, 2) unaffordable cost of parking vehicles especially for the Kurdish immigrants and 3) availability of parking lots far away from the health care provider. These barriers make it difficult for Kurdish health care users to access health care services in New Zealand (see Figure 19).

Figure 19

The Parking Issues as A Barrier to Accessing Health Care Services

To conclude with, theme one discussed the findings from interviews conducted with Kurdish health care users in New Zealand (see Figure 20). The interviews revealed that the health care users faced various barriers to accessing health care services, which were classified into two categories: internal or personal barriers and external barriers related to the health care system in New Zealand. Internal barriers included the English language, low health literacy and cultural barriers, while external barriers related to the health care system included issues such as COVID-19 protocols, discrimination, shortage of doctors, misdiagnosed health issues, lack of follow-up with health care users' health issues and parking vehicle issues.

Figure 20

The Internal and External Barriers to Accessing Health Services

4.6   Theme Two: Health care quality dimensions

The discussion with Kurdish health care users who accessed health care services in New Zealand revealed that health care quality dimensions were a prominent theme. According to their experiences, participants identified several health care quality dimensions that played vital roles in evaluating their satisfaction with the quality of health care services. The health care setting's structures, health care procedures and ethical considerations were among the dimensions associated with their experiences. Participants argued that evaluating the quality of health care services using different

dimensions helped them recognise the rate of their satisfaction with the quality of health care services in New Zealand.

In the following sections, I will illustrate the health care quality dimensions identified by the participants to provide a better description of the quality of health care services in New Zealand.

4.6.1   Health care settings structures

In this section, I will discuss the health care quality dimensions related to the structure of the health care settings in New Zealand, as reported by the participants. Participants identified several quality dimensions that are associated with the health care settings structures, namely, continuous construction and renovation of the health care settings, updating health care products and emergency medical services. The descriptions provided by the participants emphasise the significance of evaluating health care services in relation to the organisational structures of health care providers. This evaluation plays a key role in meeting the participants' expectations and ensuring their satisfaction with the overall quality of health care services.

Ongoing Construction and Renovations.

Participants in the study mentioned that health care providers in New Zealand frequently engage in redesigning and restructuring their physical buildings, which they found to be attractive and satisfying. The participants emphasised that the design of health care buildings is an important factor in their overall satisfaction with the quality of health care services. When asked to share their perspective on the design of health care buildings, one participant highlighted the continuous restructuring efforts undertaken by health care providers. Specifically, he mentioned that the frequent reconstruction of health care buildings in New Zealand positively impacted his satisfaction with the quality of health care services.

> *'I noticed that hospitals have a continuous reconstruction and renewing of the building. Wherever needed to be painted and redesigned, hospitals will do it. It is good' Participant 03.*

Updating health care products.

The use of health care products is intended for diagnosing health issues and facilitating therapeutic processes, which may include improving, maintaining, or preventing the deterioration of health status in patients (Kaplan et al., 2004; Rugera et al., 2014; Sabet Sarvestani & Sienko, 2018). These products encompass a wide range of services and medical instruments, ranging from appointment booking to wheelchairs and surgical equipment (Gupta & Denton, 2008; Jin, 2014). The frequency at which health care products are updated is typically dependent on the budget allocation of the health care provider for that fiscal year.

One of the primary challenges that participants may encounter is the limited budget allocations, which can make it difficult to update health care products and incorporate new medical technologies (Barber et al., 2019; Greiner & Knebel, 2003). Despite these challenges, participants require access to updated health care products to ensure that they receive the best possible care from health care providers. Up-to-date medical equipment may help health care providers offer more effective services to their health care users.

In this research, participants were asked about their perceptions of the medical equipment in their health care provider's setting. The responses were varied, with many participants expressing uncertainty about whether the medical equipment was up-to-date or not.

> *'Well, to be honest, I don't know if medical equipment is updated or not, but staff have worked perfectly fine. I have no idea about medical tools developments, but I can say that some of them are quite updated. I can't compare because I don't work in that area, so I don't know whether medical equipment have been updated or recently or not' Participant 10.*

During the research, a participant located in Auckland city reported that certain departments within health care providers, such as the physiotherapy department, were utilising outdated medical equipment.

> *'I saw in the physiotherapy department at Middlemore hospital, staff still use old and not updated medical equipment' Participant 01.*

Another participant reported that the health care products, specifically medical equipment, were outdated and not regularly updated in hospitals. As a result, the participant experienced delays in receiving the results of their medical check-ups. The participant suggested that delay in receiving health services was due to the use of old machines in the hospitals.

> *'..... I can say that in hospitals, the medical equipment and technological tools are not much developed. For example, sometimes it takes about 2 hours to get the results back. Nurses make me wait for a long time to get the x-ray photo because staff are using old machines'* Participant 09.

Emergency medical services.

Health care settings offer a diverse range of services for individuals with varying health issues and conditions, spanning across different age groups. In a publicly funded health care system like New Zealand, emergency medical services such as ambulance services are available to all individuals. Participants in this research acknowledged the effectiveness of the ambulance service in New Zealand, with one participant highlighting the punctuality of the emergency team. The participant noted that when they called for an ambulance, the team arrived within five minutes, which they considered to be a commendable feat.

> *'Ambulance comes quickly in less than 6 minutes which is a great service.'* Participant 02.

Another participant raised concerns regarding the cost of ambulance services, particularly for individuals with chronic diseases. The participant noted that the charges for using ambulance services were unaffordable for them, with a fee of $70-80 NZD being charged every time they used the service.

> *'I cannot afford ambulance service bills because my husband has diabetes. Sometimes he cannot walk to the hospital, we must call for an ambulance. Each time we will be charged $70 or $80 for using an ambulance. We still paying back the huge bills of using emergency.'* Participant 11.

In conclusion, this section focused on the assessment of health care settings' structure in New Zealand. Participants noted that ongoing construction and renovations were being made to restructure health care buildings with new designs. According to the

participants, these new designs were attractive and positively impacted their satisfaction with the health care services. Furthermore, the research findings revealed that health care settings in New Zealand often provided outdated medical equipment, leading delays in the results of medical check-ups. However, participants also reported that emergency medical services, specifically ambulance services, were commendable. The participants appreciated the punctuality of the ambulance team regarding their arrival time. Nevertheless, the charging bills for using ambulance services were found to be unaffordable for individuals with chronic diseases. (See Figure 20 for a summary of the participants' views on health care settings' structures).

Figure 21

Health Care Setting's Structures
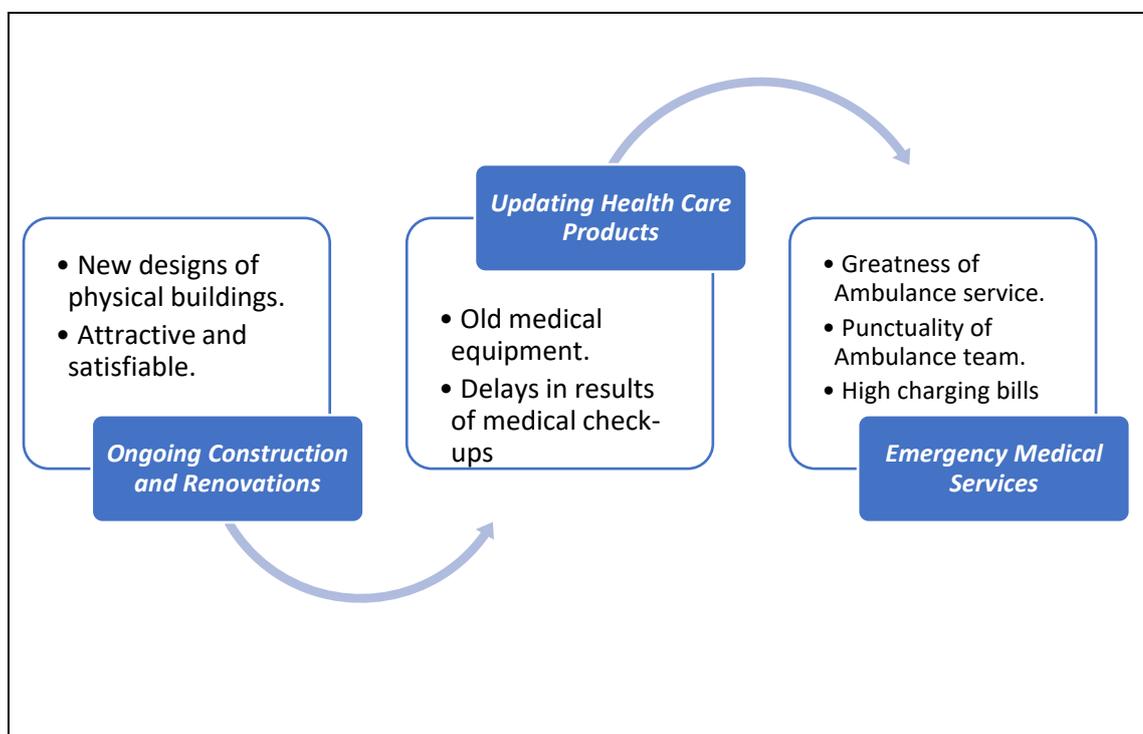
4.6.2 Health care procedures

This section will discuss the procedures implemented by health care providers in New Zealand to ensure the satisfaction of health care users with the quality of health care services. Participants in the research shared their experiences in regard to health care procedures, particularly in terms of three areas of health care services: documentation, communication skills and ward hygiene. Health care procedures are a deliberate set of actions undertaken by health care providers to achieve positive outcomes in delivering health care services (Kruk et al., 2018). In New Zealand, health care providers take

various procedures to ensure the quality of health care services delivered to users (Beaver, 2019). The following sections will examine these procedures, as perceived by the Kurdish health care users who participated in the research.

Documentation

The participants in this research emphasised the importance of keeping health care users' records for the successful delivery of health care services in New Zealand. Participants identified that documentation is a critical component of health care services and that health care settings in New Zealand are meticulous in documenting everything for future use. One participant specifically affirmed that all their records, including health analysis and prescriptions, are well-documented in the Christchurch health care providers.

> *'I can say 100% of all my reports and documents related to my health issue are kept and documented. For example, last year I went to the hospital to check my back pain. After checking my name and date of birth, health staff accessed all information about myself and my health issues. So, health staff all have our reports and prescriptions related to my health issues.' Participant 13.*

One participant expressed admiration for the documentation services provided by health care settings in New Zealand. He highlighted the importance of keeping records and documentation for delivering high-quality health care services. According to the participant, health care providers including General Practitioners (GPs), emergency hospitals and specialists are heavily focused on documentation services. The participant viewed documentation service positively and considered it as a key component of satisfying health care users with the quality of health care services in New Zealand.

> *'For sure there is a very heavy dependence on documentation to protect everybody, the health care system, the patient, the doctor, or anybody who is involved. I think record keeping is quite a big emphasis on it in New Zealand. Like you can get all your information from the hospital which was documented more than 10 years ago. To me, it is a very great service health staff provide' Participant 16.*

Communication skills

To successfully provide health care services in New Zealand, participants identified effective communication skills as necessary. Participants argued that communication

skills are essential life skills that enhance a greater understanding of various cultures and societies. However, despite the significance of communication skills, Kurdish health care users reported dissatisfaction with the quality of communication skills among health professionals. Participants highlighted the issue of ineffective communication between health care providers' staff and immigrant health care users when it comes to accessing health services. They specifically noted that sometimes administration staff members fail to communicate patiently with immigrant health care users. For example, when attempting to schedule an appointment, staff members respond aggressively.

> '.. their communication skills are not good. For example, because the English language is not our mother tongue when a Kurdish patient calls a hospital to book an appointment, the staff member is impatient to listen to the Kurdish patient. The staff directly asked the patient to bring an interpreter. Staff do not give enough time to listen to the patient. Sometimes, staff reply in an angry (aggressive) way which I do not know why?' Participant 01.

Hygiene services

To ensure a high standard of health care services, hygiene services should be taken seriously as a primary goal in health care facilities. These services encompass the behaviours and practices that prevent the spread of diseases. Providing hygiene services creates a positive impression on health care users, making them feel safe from infections during their visits. In this research, participants were asked about their perception of feeling safe when receiving health care services. Almost all participants reported feeling safe when visiting health care providers in New Zealand due to the high standard of hygiene services provided every day. One participant noted that after a health care user is discharged, cleaners clean and prepare the bed by changing the linen for the next user. Therefore, health care users feel comfortable and less fearful of getting infected with diseases. Additionally, participants identified that nurses and other medical professionals comply with hygiene practices by changing gloves and scrubs after each use with health care users.

> 'All hygiene services are good. I noticed that when I was admitted for a couple of hours and after the doctor discharged me, the cleaners started cleaning and changing all bed sheets and sanitise the room. Nurses prepare it for the next patients. Therefore, I feel safe because nurses provide a good service in terms of keeping wards and rooms hygiene' Participant 03.

'I many times have seen staff when changing their gloves and disposable scrubs/ gown every time. Nurses sanitise and wash their hands when health staff do medical check-ups for the patient. Thus, hygiene practices are very good that comply with the standards.' Participant 02.

In conclusion, based on the participants' statements, the quality of health care service procedures in New Zealand is summarized in Figure 21. The participants expressed satisfaction with the heavy focus on documentation services by health care settings, as their health data was well-documented for future use. However, the communication skills service was found lacking as health care professionals were reported to be ineffective and even aggressive in their communication with health care users. On the other hand, hygiene services were highly praised by participants as health care providers ensured high standards of cleanliness in all departments. The cleaning teams were efficient in changing bed linen and complying with hygiene practices, which made the health care users feel safe and comfortable during their visits.

Figure 22

An Evaluation of Health Care Procedures in New Zealand
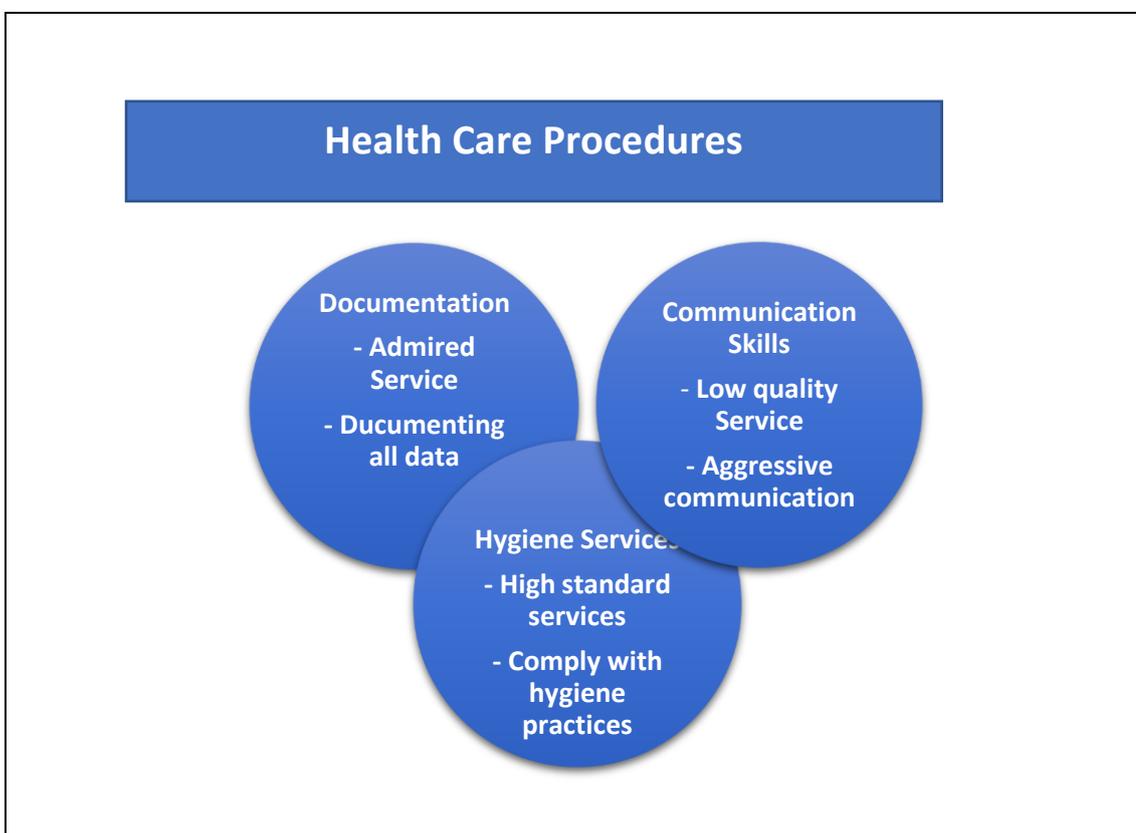
4.7   Theme Three: Health care environment

On of the objectives of this research was to explore the impact of health care provider environments on the health and well-being of health care users. To achieve this objective, participants were asked to assess the quality of health care providers' environment in New Zealand. In their responses, participants provided a comprehensive evaluation of health care services in terms of their environment, covering both physical and psychological aspects. The following section will examine their assessments in more detail.

4.7.1   Physical environment.

The physical environment of a health care setting refers to the observable and measurable aspects that are apparent to health care users. These may include the size and layout of wards and waiting rooms, the temperature of the rooms and the amount and quality of light available in the wards (Drahota et al., 2012; Huisman et al., 2012). As part of the research, participants were asked to evaluate the environment of health care providers and their responses included their experiences of the physical environment. One participant focused on the importance of having a view outside of the room. He reported that during his previous admissions, he was placed in rooms without windows that would allow him to see outside. Furthermore, he noted that even in rooms that did have windows, they were often covered by curtains, preventing him from enjoying the view. The health care user's feedback highlighted the significance of providing health care users with access to natural light and views of the outdoors, which contributed to a more positive and welcoming environment.

> *'…..those times I stayed in the hospital, I noticed that most of the rooms have no views to see outside. Especially if you have been admitted temporarily, the rooms have no views to see outside at all. Windows are covered by curtains….. Sometimes, staff keep you in a room that has views outside but mostly staff keep you in a room that has only walls which means has no views outside at all' Participant 02.*

Another participant provided feedback on the quality of the health care environment in New Zealand. While acknowledging that the physical environment is good, he expressed that health care users often feel uncomfortable. He reported experiencing high temperatures and unpleasant smells in the waiting area, which may contribute to

discomfort and dissatisfaction. Additionally, he noted that the waiting hall is often crowded, resulting in long waiting times to receive health care services.

> *'In general, the hospital's environment is good. Sometimes, in the waiting hall in an emergency department, I felt the environment was not good as the temperature was high. Because the hall was crowded, there were unpleasant smells too' Participant 19.*

In addition to temperature and comfort, another participant provided response on the aesthetic aspects of the health care environment. Specifically, the participant noted the importance of the attractiveness of the paint on the walls and the pictures hanging inside. The participant highlighted that children's rooms were often decorated with bright colours, which can contribute to a more positive and welcoming environment for children health care users. Additionally, the participant praised the historical photos of Māori culture and traditions that are displayed on the walls of Auckland hospital, providing a sense of cultural richness and diversity.

> *'The temperature is normal. The colour of the walls is attractive, especially the children's rooms which are colourful. In Auckland hospital, staff hang Māoris' pictures on the walls. There is a prayer room for Muslims and Indian temple in the basement for praying. In the Muslim's prayer room, hospitals provided tabs for washing our feet and a chair to sit on while washing our feet for the needy prayers like me. Staff provided praying mats to pray on' Participant 06.*

Another participant provided response on the importance of facilities and entertainment for health care users, particularly children and the elderly. The participant noted that children's rooms are made more attractive with cartoon stickers on the walls and that there is a television in these rooms that shows film cartoons, which can help make children feel happy and at ease during their stay. The participant also mentioned that the walls in the elder's rooms were painted in bright and pleasant colours, which can contribute to a more positive environment for them.

> *'Regarding the colour of the walls, I can say that staff are nice and suitable. For example, when we go to the kids' ward, you will see that the walls are colourful. Elders' wards and rooms are coloured in bright colours and nice. but I like when I go to the kid's room, especially the girls' room which is coloured with nice pics and stickers which make kids happy. staff put televisions in the kids' rooms and tune on film cartoons' Participant 09.*

4.7.2   Psychological environment.

The participants in this study identified the health care providers' environment as having a negative impact on their psychological well-being. Specifically, Kurdish health care users reported feeling depressed when visiting health care providers in New Zealand. The health care users' negative experience had a psycho-social effect that led some users to avoid accessing health care providers. Participants described the environment as dull, tense and depressed, with the main hospital in Christchurch being identified as particularly depressing.

> *'I can say that the environment of some rooms in the main hospital is depressing. I feel depressed when I enter those rooms. While the environment of a new hospital is very attractive. The quality of the services in the new hospital is better' Participant 14.*

> *'Christchurch hospital is very old and not attractive. When I enter the hospital, I feel depressed. I don't like the design inside and outside of the Christchurch hospital' Participant 15.*

Another participant in the study described the environment of health care providers in New Zealand as dull. The participant noted that health care users are not entertained by the old electronic devices, such as television and are not excited by the shows playing on television in hospitals. The participants' feedback suggest that the current entertainment options provided in health care settings may not be meeting the expectations or preferences of some users, leading to a lack of excitement and engagement with the environment.

> *'When I go into the meeting room in the hospital, the environment is dulled. There is a TV up there that looks like from the 1970s playing. The TV show is not exciting as nothing fun for patients. Therefore, no one wants to go to the hospital' Participant 18.*

Furthermore, the participants shared their psychological experiences related to the health care environments. Participants from Christchurch city reported feeling depressed when entering the main hospital, stating that its design was unattractive. Some participants also reported that some hospitals still use old television devices and the shows that are displayed were not exciting. These experiences indicate the significant impact of the physical and psychological aspects of health care environments on the health and well-being of health care users.

4.7.3   Summary

Figure 23. illustrated the physical and psychological aspects of health care environments in health care settings in New Zealand, based on the participants' experiences. The participants shared both positive and negative experiences related to the physical environment. Some of the positive aspects include attractive wall colours in children's rooms, Māori symbols and historical pictures on the walls of health care centres. However, the participants also shared negative experiences related to the views of the rooms and temperature. In certain hospitals, the absence of exterior views and the use of immovable curtains to cover windows resulted in congested waiting areas, elevated temperatures, and unpleasant smells.

Figure 23

Participants' Physical and Psychological Experiences with Health Care Environment
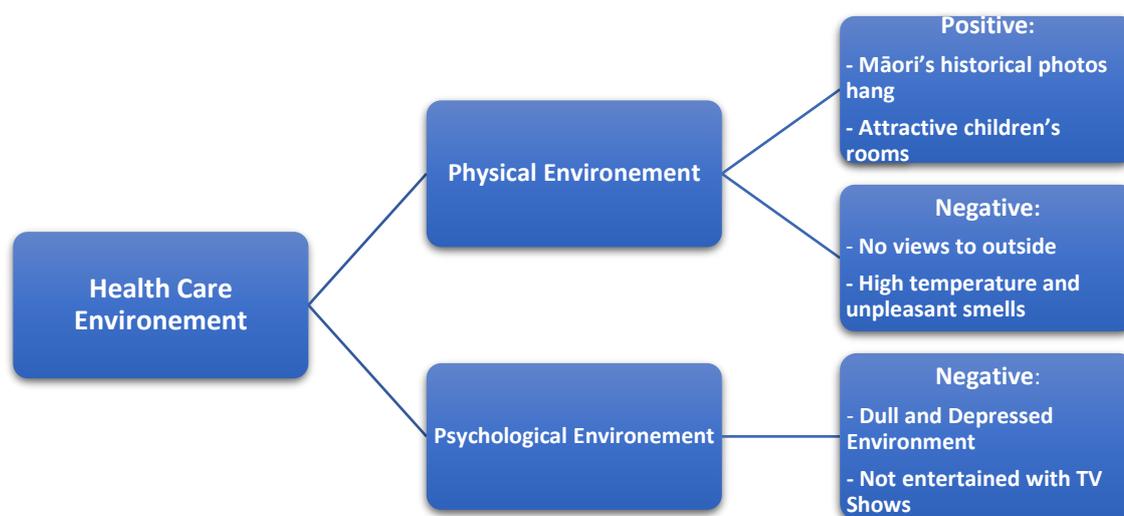
Further, Figure 24 presents a word cloud visualisation that captured the words and phrases used by Kurdish health care users during their interview sessions. The participants shared their experiences with the health care provider environment and evaluated both physical and psychological experiences. The word cloud provides an overview of the most frequently used words and phrases revealing the common themes and issues that emerged from the interviews. This visualisation is a valuable tool for gaining insights into the experiences and perspectives of Kurdish health care users.

Figure 24

Participants' Physical and Psychological Experiences with Health Care Environment

4.8   Theme Four: Ethical considerations

The evaluation of the quality of health care services must consider ethical considerations, such as respecting health care users' beliefs, maintaining confidentiality and avoiding maleficence. Therefore, health care providers' staff members must ensure that health care users' information is kept confidential and their beliefs are respected to deliver high-quality services (Schröder-Bäck et al., 2014). In this study, participants were asked to evaluate the quality of health care services in terms of confidentiality and staff behaviour towards health care users. This section describes the participants' responses regarding confidentiality and staff behaviour in health care settings.

4.8.1   Privacy and confidentiality.

To evaluate the quality of health care services in terms of confidentiality, participants were asked about their experiences. Most participants, more than 80%, expressed their satisfaction with the confidentiality in health care providers. Participants affirmed that health care providers keep medical records of health care user's secret. One participant even stated that in serious cases such as surgeries, health care providers take extra steps to ensure confidentiality. To maintain confidentiality, participants alleged that health care providers require attending an interpreter to interpret and obtain consent from the health care users before starting surgeries. Even when health care users have a family member to interpret and speak on their behalf, health care providers hire an external interpreter to interpret between them.

> *'Actually, I don't think confidentiality has been an issue at all for us. At any point, I can't give you an example of where it is being leaked or breached. Generally, hospitals are very good at maintaining the confidentiality of your secrets and your personal medical histories to yourselves. When I go to the hospitals, I represent my dad and mother. Generally, staff take the utmost care to make sure we have consent, and I am authorised to speak on their behalf. There have been points when it gets to surgery, hospital will bring an interpreter because staff want to be extra sure……. So, generally, I don't have any issues with breaches of confidentiality' Participant 12.*

Another participant expressed a lack of trust between health care users and providers regarding the confidentiality of health records. While health care providers claim that health records are kept confidential, the participant was unsure if they can trust them.

However, the participant did not personally experience any instances of privacy breaches, or his health issues being revealed or leaked.

> *'I honestly don't know if staff keep my information confidential or not. However, staff are saying that they keep confidential, but I don't trust them 100%. I never heard that the secrets of the patients have been revealed' Participant 14.*

4.8.2 Showing respect during treatment.

To evaluate the quality of health care services, it is essential to consider the professional behaviours of health care staff towards health care users. In this study, most of the participants provided feedback on both positive and negative behaviours of health and administrative professionals. Overall, most Kurdish health care users reported that health care professionals and administrative staff were polite and helpful. However, some participants also reported facing disrespectful treatment from nurses and ignorance from doctors.

It is important to note that unprofessional behaviours among health care staff can have negative impacts on the mental safety of health care users and the organisational outcomes of health care providers. Therefore, it is essential to address such issues and promote a culture of professionalism in the health care setting.

> *'About nurses, I can say that I have never seen a good nurse in the hospitals. Maybe nurses don't like my face as I have a beard. I don't have a good experience with them either men or women. I told my wife even if I am about to die, please do not take me to the hospital. I told the doctor that I like to die but not come to the hospital. Because nurses are looking at me down (degrading). Respecting personalities is very important………*
>
> *'……most of the time I have been mistreated in the hospitals by nurses. Even if the nurses were Indians, white, or black people didn't affect them. Staff all are the same' Participant 02.*

In Kurdish culture, it is customary to treat individuals with respect and dignity, especially when they are visiting a new place. The findings of this research highlighted that the Kurdish health care users expected to receive the same level of respect and care when they visit health care providers. The research finding underscores the importance of

providing excellent health care services to all health care users, irrespective of their cultural background.

> *'As human beings, we liked to be treated with respect when we visit anywhere. Explicitly speaking, Kurdish culture and the Middle East society expect to be respected when we visit hospitals or any other places' Participant 12.*

The participants in this study also provided feedback on the positive behaviours exhibited by health care professionals and administrative staff. Participants described them as being empathetic and attentive to their needs. When asked about their experiences with medical and administrative staff, the participants responded that they found them to be helpful and composed. The participants further stated that whenever they required assistance, the staff members were readily available and willing to go above and beyond to meet their needs.

> *'In New Zealand, I feel that majority of health professionals are good, understandable, listen to the patients well and staff are quite patient with us which I think is important when we are unwell……...*
>
> *'………The medical support staff is helpful. Whenever I have got a question, staff will come back to me, staff will help me and guide me to find the place' Participant 10.*
>
> *'I found that administration staff on the sort of face-to-face level are quite good. Staff are very calm' Participant 18.*
>
> *'The managerial staffs are very respectful I never experienced any differentiation or discrimination from them' Participant 19.*
>
> *'I don't have any negative experiences with administration staff. The receptionist and other staff members are good with me. Whenever I have a question to find a place or a room inside the hospital, staff guided me nicely to the place that I am looking for to access health care services.' Participant 20.*

Participants in the study also provided insights into their relationships with health care professionals. Specifically, participants highlighted their positive experiences with nurses and described their interactions as healthy and respectful. For instance, one female participant who frequently visited the hospital with her husband shared that a

nurse was particularly kind and checked up on them during each visit. The participant felt appreciated when a male nurse recognised them and treated them with respect.

Moreover, one participant went as far as calling health care professionals *angels on earth*, further emphasising the positive impact they have on Kurdish health care users. This participant's sentiments were echoed by others who praised the role of health care professionals in assisting Kurdish health care users during their visits to health care providers.

> *'Most of the time staff were very good, very respectful and very helpful. One of the nurses knew me and my husband that have frequent visits to the hospital. Every time he would see us, he would come and check up on us just to see if we are fine or why he (husband) is not getting better. His check-ups on us made us feel so much better'. Participant 11.*

> *'I always say the doctors and nurses in the hospitals are "angels". Staff are angels on earth. Nurses are coming to us to do a blood test, for example, nurses start by laughing with me and talking nicely. Nurses are very respectful and nice to patients. When my dad was admitted to the hospital, Nurses were taking him to the bathroom and showering him. Nurses were cleaning him softly and nicely. Nurses never get bored helping me and my dad in the hospital. Participant 20.*

Figure 23 presents the participants' experiences with ethical considerations at health care providers. Most participants expressed confidence that their privacy related to their health records was kept confidential. Participants reported that they did not experience any breaches of privacy or confidentiality outside of the hospital. However, some participants noted instances of disrespectful treatment from nurses and ignorance from doctors. Despite these negative experiences, most participants described health care providers as polite and understanding.

According to the Kurdish culture, individuals are expected to be treated respectfully when they visit health care providers. As such, participants reported that health care providers' staff were helpful and respectful towards them. The staffs' treatment underscores the importance of upholding ethical principles, such as confidentiality and respect, in health care providers.

Figure 25

The Ethical Considerations at Health Care Settings in New Zealand
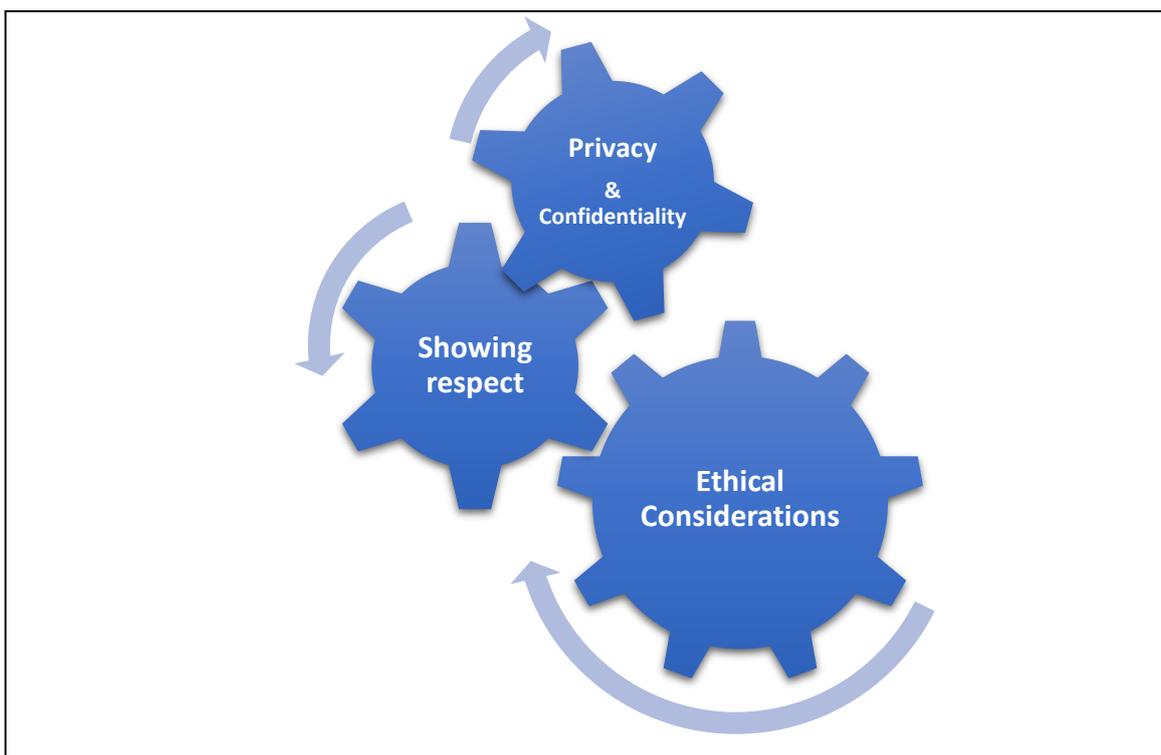
4.9   Summary of the chapter

This chapter provided the findings of a study that involved interviewing 20 Kurdish health care users from three cities in New Zealand, including Auckland-Tāmaki Makaurau- area, Hamilton from the Waikato and Christchurch from Canterbury-Waitaha-region. The study aimed to evaluate the users' satisfaction with the quality of health care services in New Zealand. From the participants' reports, four key themes and eight sub-themes were extracted, which reflect their evaluation of the health care services.

One of the key themes that emerged from the study was the barriers to accessing health care services. Participants identified external and internal barriers that hinder their access to health care services. External barriers included COVID-19 protocols, discrimination, shortage of doctors, lack of follow-up on health issues and parking problems. Participants also identified self-imposed barriers, including language issues, lack of health education and cultural aspects, that limit their access to health care services. Furthermore, participants emphasised the importance of health care settings structures and procedures in evaluating their satisfaction with the quality of health care

services. In addition to barriers and health care setting structures and procedures, participants in the study also highlighted the significance of the physical and psychological aspects of the health care provider's environment in shaping their experiences with health care services. Participants recognised that these aspects could significantly impact their health and well-being.

Furthermore, ethical considerations emerged as another critical factor in evaluating the quality of health care services. Participants identified two ethical challenges that affected their satisfaction with health care services: the right to confidentiality of health records and the behaviour of health care staff towards users. Participants reported that they were generally satisfied with the quality of confidentiality services provided by health care providers, who took their health issues seriously and kept them confidential. Participants also described health care staff as polite and respectful. However, participants reported experiencing instances of disrespectful behaviour from staff and ignorance from doctors (see Figure 25).

Figure 26

Participants' Reports and Key Findings of The Research

Chapter 5 : Discussion

5.1 Introduction

This chapter provides a discussion of the findings from the research conducted in the previous chapter, which examined the experiences of Kurdish health care users in New Zealand and the barriers they face when engaging with health service delivery. First, a summary of the major findings is presented. Next, these findings are contextualised within existing literature to provide a more comprehensive understanding of the research area. The chapter then evaluates the strengths and limitations of the interview study design employed in the research. Finally, recommendations for further research are provided, with a focus on evaluating the quality of health care services in New Zealand from the perspective of immigrants.

5.2 Summary of Findings

This study conducted in-depth face-to-face interviews with 20 Kurdish immigrants from three cities in New Zealand to explore their experiences of accessing health care services. A high population of participants (n=20) of Kurdish immigrants were present in the two North Island study sites, including Auckland and Hamilton. A lesser number of participants (n=20) of Kurdish immigrants were observed in the Christchurch location on the South Island (Stats NZ Tatauranga Aotearoa, 2018b). The study aimed to examine the quality of health care services in New Zealand for Kurdish immigrants, focusing on barriers and enablers to accessing health care services. The research method employed was a qualitative descriptive methodology, using semi-structured interviews to generate new and exploratory data. The semi-structured interview method enabled the researcher to guide the interview process rather than standardise interviews and generate defined data (Dong et al., 2022; Myers & Newman, 2007). The semi-structured interview method allowed for a more flexible and personalised approach to data collection, which was essential in exploring the participants' experiences and perceptions. The study employed a thematic analysis approach to identify four key themes related to barriers and enablers to accessing health care services for Kurdish immigrants in New Zealand. These themes included internal and external barriers, dimensions of health care quality, the health care providers' environment (both physical

and psychological) and ethical considerations. The themes identified provide insights into the challenges that Kurdish immigrants face in accessing health care services in New Zealand, as well as the factors that enable them to receive high-quality care. The following section provides a summary of these themes and their implications for health care services in New Zealand.

5.2.1 Theme One: Major internal and external barriers

The study identified both internal and external barriers that hindered Kurdish immigrants from accessing health care services in New Zealand. Internal barriers refer to considerations that are directly related to the participants themselves, such as language difficulties, low health literacy levels and cultural differences. Participants highlighted the challenges they faced in communicating with health care providers due to their limited proficiency in English. The study also revealed concerns among Kurdish health care users regarding the lack of professional health interpreters. Participants reported that health care providers were not providing qualified interpreters for those who did not speak English as their first language.

In addition to language difficulties, low health literacy levels and cultural differences were also identified as internal barriers that hindered Kurdish immigrants from accessing health care services in New Zealand. Participants reported that their limited knowledge of the health care system and health-related information often resulted in difficulties in accessing appropriate care. Furthermore, cultural differences between Kurdish health care users and the New Zealand health care system were also noted as a significant barrier. For instance, participants raised concerns about the lack of Middle Eastern foods on the hospital menu, which may adversely affect the health and well-being of Kurdish health care users. Another cultural barrier highlighted by participants was the sharing of treatment rooms by male and female patients. According to Kurdish culture, male and female patients must be admitted to separate wards, which contradicts the current practice in New Zealand hospitals where male and female patients are admitted to the same room.

In addition to COVID-19 protocols and discrimination, participants also identified a shortage of doctors, misdiagnosis of health issues and lack of follow-up with health care issues as external barriers to accessing health care services in New Zealand. Participants

in the study reported experiencing barriers to accessing health care services in New Zealand, including the impact of COVID-19 protocols and discrimination from health professionals and administrative staff members. The COVID-19 protocols were found to restrict their access to appropriate health care services. Additionally, a considerable number of participants (n=20) reported feeling discriminated against by both health professionals and administrative staff members. Specifically, participants reported negative behaviour from nurses when inquiring about health services, describing their attitudes as racist and sometimes favouring locals over immigrants while accessing health care services. Furthermore, participants reported that they experienced difficulty in booking appointments with doctors due to a shortage of doctors in their areas, which led to long waiting times and delayed medical attention. Moreover, misdiagnosis of health issues by health care providers caused participants to lose trust in the health care system, resulting in a reluctance to seek medical help. Additionally, participants noted that follow-up with health care issues was inadequate and they did not receive the necessary support to manage their health conditions. Lastly, participants also highlighted the lack of parking spaces for vehicles as an external barrier to accessing health care services, as it made it difficult for them to access health care facilities. Participants noted that finding a parking spot was often challenging and time-consuming, which caused additional stress and inconvenience.

5.2.2 Theme Two: Health care quality.

Based on participants' experiences, the health care setting's structures, health care procedures and ethical considerations are the prominent dimensions that affect health care quality. In relation to health care setting structures, participants reported various health care quality dimensions, including continuous construction and renovation of health care settings, updating health care products and emergency medical services.

Several participants expressed their satisfaction with the new designs of physical buildings and how they positively influence their satisfaction with health care services. However, some participants reported experiencing delays in receiving medical check-ups. To diagnose health issues accurately and prevent any delays in receiving results, participants recommended updating medical equipment to incorporate new technological developments. Furthermore, participants acknowledged that while the

cost of ambulance services may be too expensive for chronic illness patients, it remains an excellent service offered by health care settings in New Zealand.

To evaluate the quality of health care service procedures, participants identified three areas of health care services delivery: documentation, communication skills and ward hygiene. Almost all participants affirmed that their health records, health analysis and prescriptions are documented appropriately. In terms of communication skills, participants described that health care staff are not communicating effectively with health care users and suggested that health care staff needed to be more patient with immigrant health care users. Moreover, almost all participants reported feeling safe when they visit health care providers because of the high standard of hygiene services provided in health care settings every day. Participants emphasised the importance of keeping wards clean and hygienic to prevent the spread of infections and other diseases.

5.2.3   Theme Three: Evaluation of the health care environment.

Participants categorised the health care provider's environment into two aspects: physical and psychological. Regarding the physical environment, participants expressed discomfort and negative experiences related to high temperatures, unpleasant smells in waiting areas and a lack of views outside of admitting rooms. However, participants appreciated that children's rooms were colourful and attractive and equipped with televisions playing cartoon films.

Concerning the psychological environment, Kurdish health care users reported feeling depressed, dull and tense when visiting health care providers. These negative emotions might be due to the lack of an inviting and welcoming environment. Therefore, creating a psychologically friendly environment could be beneficial to promote health care users' overall well-being and satisfaction.

5.2.4   Theme Four: Ethical considerations.

Participants evaluated health care services in terms of two main aspects: confidentiality and respectfulness. Confidentiality of medical records was highly valued, with more than 80% of participants reporting satisfaction with the health care provider's ability to keep their medical records private. In terms of respectfulness, participants generally reported that health professionals and administrative staff were polite and helpful. However,

some participants reported disrespectful treatment from nurses and a lack of attention from doctors, indicating that not all health care providers consistently provide respectful treatment.

5.3 The research findings in the context of other research studies

5.3.1 Health care quality dimensions

In this thesis, Donabedian's Model was used to examine and evaluate the quality of health care services in New Zealand. According to Donabedian, the quality of health care services can be assessed through three domains: structure, process and outcomes, as well as seven dimensions: efficacy, effectiveness, efficiency, equity, optimality, acceptability and legitimacy (Donabedian, 2005). Another model commonly used to assess service quality in various service organisations, including health care service settings, is the SERVQUAL model. The SERVQUAL model comprises five dimensions: tangibles, responsiveness, empathy, assurance and reliability, as noted by (Butt & de Run, 2010).

In addition to Donabedian's Model and the SERVQUAL model, the Institute of Medicine (IOM) has also developed a model for examining health care quality. The IOM's model focuses on six domains, including patient-centredness, timeliness, efficiency, effectiveness, safety and equity (Lachman et al., 2020). Although many health care quality models globally incorporate two or three of these dimensions, the most shared dimensions are effectivity, safety and people-centredness. These dimensions have a long history, dating back to Ignaz Semmelweis, a Hungarian doctor who discovered the significance of hand washing in medical care during the 19th century. Semmelweis found that washing hands in chlorinated lime water before surgery prevented the spread of disease, kept children safe from the flu and reduced infections (Best & Neuhauser, 2004). The Table 9. summarised the common dimensions among health care quality models.

The evolution of health care quality assessment can be traced back to several historical figures. For example, in 1917, American surgeon Ernest Codman introduced the minimum standard strategy to evaluate health care service outcomes, emphasising the importance of improving the quality of health services for effective treatments (Hines et

al., 2020; Marjoua & Bozic, 2012). Florence Nightingale, the English nurse, also played a significant role in health care quality improvement by identifying the link between poor living conditions and high death rates among soldiers treated at military hospitals in the 1850s. More than in battles, the soldiers were dying of diseases such as cholera, typhoid, typhus and dysentery (Fee & Garofalo, 2010). In the 1960s, Avedis Donabedian, an American physician, developed a framework for evaluating the quality of health care and medical outcomes. His model focuses on using health care users' experiences and utilising resources in medical care to improve health care outcomes (Chun & Bafford, 2014).

To further emphasise the significance of health care quality dimensions, New Zealand's health care system has modified its dimensions to include individuals with disabilities. The modification can be observed in the definition of quality of health care. The Ministry of Health of New Zealand defined quality of health care as the extent to which health care services for individuals or populations increase the probability of achieving desired health outcomes and/or promote the participation and independence of individuals with disabilities, while being in accordance with current professional knowledge (Minister of Health, 2003a).

In this study, the health care quality dimensions have been developed by incorporating the fundamental values of quality improvement dimensions and adapting aspects that are specifically relevant to the health care quality of immigrants in New Zealand. The development involves considering the preferences of immigrants for the type of health care services they require, as well as prioritising the promotion and protection of the rights of immigrant health care users in health care settings. For instance, there is a need to focus on the equity dimension by providing health care services to the Kurdish and other immigrant communities that are comparable to those provided to the citizen population of New Zealand. The equity dimension entails respecting the rights of immigrant health care users, such as the right to be treated with dignity, the right to freedom from discrimination, the right to establish effective communication with health care providers and the right to access an adequate standard of health services, as outlined in the Code of Health and Disability Services Consumers' Rights in New Zealand (Cumming et al., 2014).

To further develop the understanding of health care quality evaluation, it is vital to establish an immigrant version of modules for evaluating the quality of health care. While New Zealand has adapted the health care quality module from the IOM's definition of quality of health, there is no literature available to explain the specific needs and preferences of immigrants in terms of health care quality evaluation. It is worth noting that the idea of choosing dimensions for most health care quality frameworks can be traced back to Avedis Donabedian's model, which was first created in 1966. As demonstrated in Table 12, the most common dimensions among different countries' health care systems and frameworks are safety, effectiveness and health care users' experiences.

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Table 12

Health Care Quality Dimensions According to International Health Care System Framework

Health Care Quality Dimensions	International Health Care System Frameworks								
	Donabedian's Model (Donabedian, 2005)	Institute of Medicine (IOM) (Wakefield, 2008)	Council of Europe (Busse et al., 2019)	SERVQUAL (Qolipour et al., 2018)	World Health Organisation (WHO) (Busse et al., 2019)	New Zealand Health Care System (Ministry of Health, 2020)	Australia Health Care System (Australian Institute of Health and Welfare, 2019)	National Health Service (NHS-England Health Care System) (Jones et al., 2021)	Canada Health Care System (Dhalla & Tepper, 2018)
	Efficacy	Safety,	Safety	Assurance	Safety	Safety	Safety	Safety	Safety
	Effectiveness	Effectiveness	Effectiveness	Empathy	Effectiveness		Effectiveness	Effectiveness	Effectiveness
	Acceptability	Patient-centredness	Patient-centredness	Responsiveness	Patient-centredness	Patient Experience	Health Behaviours	Patient Experience	Patient-centredness
	Optimality	Timeliness		Reliability			Continues and Sustainability	Resource sustainability	Timeliness
	Legitimacy	Efficiency	Efficiency	Tangibles	Efficiency		Accessibility		Efficiency
	Equity	Equity			Equity	Equity	Responsiveness	Equity	Equity
						Best value for public health system resources	Socio-economic factors, well-being, Personal biomedical factors	Well-led	

5.3.2 Barriers to accessing health care services.

This research has identified nine distinct barriers to accessing health care services in New Zealand, as reported by participants. These barriers have been categorised into two sub-themes, namely external and internal barriers. The external barriers include COVID-19 protocols, discrimination, shortage of doctors, misdiagnosis of health issues, lack of follow-up of health care users' issues and parking vehicle issues. On the other hand, three internal barriers were identified, consisting of the English language barrier, low level of health literacy and Kurdish cultural aspects.

These findings are consistent with Donabedian's framework for evaluating the quality of health care services in health care settings. Donabedian's framework consists of three domains, namely Structure, Process and Outcomes, which are essential to evaluate the quality of health care services provided. He also identified seven dimensions that can be focused on when evaluating the quality of health care services, namely efficacy, effectiveness, efficiency, equity, optimality, acceptability and legitimacy (Donabedian, 2005).

Despite the similarities between Donabedian's conceptual model and the findings of this research, there is a fundamental difference that needs to be highlighted. Donabedian's model primarily focuses on evaluating health care providers without explicitly considering the role of cultural safety in the evaluation process. However, in countries like New Zealand, it is essential to focus on health care providers' treatment of health care users, in particular immigrants, to ensure cultural safety and equity in health care (Radl-Karimi et al., 2020). Focusing on health care user's treatment is increasingly important due to the current political and economic situations in developing countries such as Asia, the Middle East, Africa and South America, which have accelerated mass migration movements to developed countries like Europe, the United States of America, Canada, Australia and New Zealand. These migrated health care users often face several issues, including language barriers and discrimination against health care providers (Shrestha-Ranjit et al., 2020).

The participants in this research have reported experiencing discrimination and favouritism in health care settings in New Zealand, which underscores the importance of ensuring cultural safety in health care. Therefore, health care providers in New

Zealand need to focus on providing culturally safe health care services that cater to the unique needs of immigrant health care users, including language barriers and cultural differences, to improve the quality of health care services provided.

The conceptual framework proposed by Goddard and Smith (2001) for accessing health care services in the UK is also relevant to the findings of this research. Their framework identified four elements: availability, quality, costs and information, which are essential for accessing health care services. The barriers identified in this research, namely availability, quality and information, align with Goddard and Smith's framework. For instance, Goddard and Smith (2001) argued that certain health care services may not be available to everyone in society and the quality of health care services provided may vary for different groups of the population. Similarly, the participants in this research reported experiencing favouritism from health care staff providers, who did not treat them the same as local citizens (Kiwis). Participants mentioned being subjected to prejudice and favouritism due to their immigration status, English language barriers and Islamic appearance, such as wearing a beard while visiting health care professionals. These experiences indicate that the availability and quality of certain health care services offered to immigrants are not the same as those provided to local citizens.

Moreover, this research has found that the barriers of the English language, low health literacy and cultural safety in accessing health care services in New Zealand are consistent with the findings of Sherif et al. (2022). However, Sherif et al. (2022) did not focus on the role of the English language and poor health literacy in reducing the barriers to accessing health care services for immigrants.

This research found that the English language is a significant barrier to accessing health care services for immigrants in New Zealand. Participants aged between 41-61 and above reported that they struggle to communicate their health issues to health care professionals as they cannot speak English fluently. Additionally, some health care providers do not offer interpretation services and finding qualified interpreters in the Kurdish community is challenging.

According to Gil-Salmerón et al. (2021), a major barrier to accessing health care services in Europe is the lack of translation services. Their study found that immigrant health care users in several European countries, including Sweden, Austria, Bulgaria, Greece, Italy,

Spain and Cyprus, often experience discrimination and struggle to communicate with health care providers due to a lack of translation services. Similarly, participants in a study conducted in New Zealand identified a lack of qualified Kurdish interpreters as a challenge in accessing health care services. The shortage of qualified interpreters is comparable to the findings of Gil-Salmerón et al. (2021) in Europe.

In my opinion, the lack of qualified health interpreters in New Zealand may be due to a lack of opportunities for training and education in interpretation. The participants in this study reported that the available Kurdish interpreters were not specialised in health care, which made it difficult to translate medical terminology accurately. The lack of specialised interpreters highlights the need for investment in interpreter training programs to ensure that health care interpreters have the necessary skills and knowledge to provide accurate translations in medical settings.

In conclusion, this study has identified several barriers to accessing health care services in New Zealand that are consistent with the findings of international research. Participants reported experiencing favouritism and discrimination, language difficulties and a lack of health literacy when accessing health care services in New Zealand. These barriers were found to be common across different immigrant nationalities. Additionally, some participants reported experiencing other barriers, such as misdiagnosis of health issues, inadequate follow-up by health care staff and a lack of parking spaces for health care users. This study focused on these latter barriers and their impact on the experiences of health care users in New Zealand. The findings of this study emphasise the need for health care providers in New Zealand to address these barriers and work towards improving health care access for immigrant populations. The improvement may involve providing more training for health care staff to ensure that they are able to effectively communicate with health care users from diverse linguistic and cultural backgrounds, as well as implementing policies to address issues such as discrimination and inadequate parking facilities. By addressing these challenges, health care providers can work towards creating a more inclusive and accessible health care system for all New Zealanders.

5.3.3 Health care settings' structures

In this research, the quality of health care settings' structures was evaluated based on three dimensions: continuous construction and renovations, updating health care products and emergency medical services. Kurdish health care users identified these dimensions as playing a key role in assessing the quality of health care services in New Zealand.

One dimension that plays a significant role in the quality of health care settings' structures is ***Continues Construction and Renovations***. Based on one-on-one interviews with Kurdish New Zealanders who utilised health care services, it was found that they are content with the way renovations and construction are carried out in health care providers. Participants expressed their satisfaction with the continued redesigning and repainting of hospitals, which improve the quality of structures of health care providers. The finding related to the quality of structures in New Zealand is consistent with the results of Gesler et al. (2004) in the UK, where the construction of hospitals was found to have a positive influence on health care user satisfaction. The research also demonstrated that new hospital designs have a therapeutic value for health care users. Furthermore, Fiorio et al. (2018) found that health care providers' new designs that focus on centring health care users can significantly increase user satisfaction. Additionally, Siddiqui et al. (2015) showed that well-decorated buildings and accommodations in new health care providers increase health care user satisfaction. These findings are consistent with research on the benefits of providing continuous construction process services. Participants in this study expressed that they feel comfortable and pleased when they observe that health care providers are reconstructing their designs and decors. Participants believed that new designs and constructions improve the quality of health care services and user satisfaction.

Updating Health Care Products: Adopting and using new technological developments in health care settings can potentially improve the quality of health care services delivered and increase user satisfaction. Conversely, updating and upgrading health care products with new and developed technological tools can reduce the health care setting's operating expenses. However, participants in this research have identified that some health care providers in Auckland city, New Zealand, still use outdated machines in diagnosing health issues and therapeutic processes. The findings around using

outdated machines in the NZ health care settings is consistent with research conducted in Australia by Edward Baldwin (2014), which found a lack of modern-looking medical equipment in Australian Unity Dental Centres (AUDC). The lack of modern-looking equipment was recognised as one of the issues affecting AUDC's ability to provide high-quality dental care services to health care users. Baldwin identified this issue as a gap in perception between what dental clinicians think they provide in terms of services and what health care users receive. The reason for this gap is the location of the dental centre in a discrete location where modern-looking equipment cannot be provided.

In addition to the World Health Organization (2012) estimation that a significant proportion (50-60%) of medical equipment in developing countries is outdated or malfunctioning, Wamble et al. (2019) have also highlighted the positive impact of medical device development on health care outcomes. Their research has shown that advancements in diagnostics, prescription drugs and medical equipment have led to improvements in health care outcomes, resulting in increased life expectancy in the United States. However, investing in new medical technologies can be costly for health care providers. Wamble et al. (2019) note that such investments are necessary to improve health outcomes but may come at a high financial cost. The participants of this research emphasised that the use of outdated medical equipment in New Zealand health care settings is causing delays in receiving medical check-up reports and hindering the delivery of better and faster health care services. The primary reason behind the using of outdated issue is the financial inability of health care providers to keep up with the latest technological advancements and adopt new medical devices. Consequently, the inability to afford the cost of new medical technologies is negatively affecting the quality of health care services being delivered.

Emergency Medical Services (EMS) play a vital role in providing immediate medical assistance to individuals facing severe health issues. According to the Ministry of Health (2022b), New Zealand's health care settings offer emergency medical services to people experiencing medical emergencies such as severe bleeding, chest pain, difficulty breathing, choking, fainting, unconsciousness and other serious health problems. The EMS can be provided through various health care providers such as emergency departments, acute care providers like ambulances and paramedics, GPs, medical clinics and nursing homes (Working Group for Achieving Quality in Emergency Departments,

2009). The effectiveness of ambulance services in providing emergency medical care was of particular interest to the participants in this research. The participants reported having a positive experience with ambulance health care services in terms of punctuality. Participants noted that ambulance and paramedics arrive immediately to aid, which is critical in emergency situations. The findings of this research are consistent with those of Lilley et al. (2019), who reported that the average response time for an ambulance to arrive at the scene of an emergency in New Zealand was 14 minutes and 49 seconds. The research also highlighted that ambulances took the shortest route and drove at legal road speed without stopping at intersections.

However, this research also identified that the cost of ambulance health services in New Zealand is too high for immigrants. A participant claimed that each ambulance service usage costs about 80 NZD, which is a significant burden on her budget as she requires ambulance services weekly. The findings of the cost of ambulance services in the NZ aligns with the results of Ogunade et al. (2021), who conducted a study in Canada and found that participants reported that the cost of ambulance and paramedic services was too high for them. The cost of ambulance services has limited the use of ambulance services during medical emergencies and participants of this research expressed dissatisfaction with the cost of such services. Financial vulnerability is common among immigrant families, as noted by Solheim et al. (2022), who attributed language barriers and lack of technology skills as the primary reasons behind the vulnerability of immigrants. Participants in this research shared that they are unable to afford the cost of ambulance services due to their immigrant status and having a family member with a chronic disease requiring regular ambulance services. The issue highlights the challenges faced by immigrants in accessing emergency medical services due to financial barriers, which can lead to delayed or inadequate health care services, potentially exacerbating their health conditions.

In conclusion, the participants of this study evaluated the quality of the structural framework of the New Zealand health care system. While participants expressed satisfaction with the current state of health care services, including ongoing refurbishment and modernisation of medical equipment, as well as emergency medical services, they also identified key areas for improvement in the structure of health care service providers. Specifically, Kurdish health care users highlighted the need for the

updating of health care products in New Zealand's health care providers and expressed their inability to afford the cost ambulance services due to their regular use. Participants emphasised the importance of improving the structure of health care service providers in addressing these issues.

5.3.4   Health care procedures

The provision of Health Care Procedures involves the completion of specific health and administrative tasks for health care users based on prescribed health instructions (O'Donnell & Vogenberg, 2012). These activities are typically learned in health education and training programs and performed by health administrators or professional staff (Ruiz-Ramírez et al., 2021). In this study, participants evaluated the quality of health care procedures, including documentation, communication skills and hygiene services, provided by health service providers in New Zealand. The report about the quality of health care procedures is important because it can help identify areas where improvements are needed to enhance the quality of health care services and ultimately improve health care users' outcomes.

Evaluation of Documentation Services is an essential component of health care procedures as it includes the creation and maintenance of medical records in the form of documents that can be used for future investigations related to health issues, analysis, health care user complaints and compensation cases (Mathioudakis et al., 2016). In this study, participants reported being satisfied with the quality of documentation services delivered by health care service providers in New Zealand, indicating that personal and medical records of health care users are well recorded.

These findings align with a study conducted by Ridyard and Street (2015), that assessed the quality of medical documentation at a university teaching hospital in the United Kingdom. The researchers found that the quality of health care service documentation was of a reasonable standard, with notes and plans related to health care users' health issues being documented contemporaneously by almost 90%. It is worth noting that this study's results differ from the findings of Chiappa et al. (2020), who conducted research in the Emergency Department of IRCCS San Raffaele hospital in Italy and found that proper medical records were challenging. One of the challenges identified by Chiappa et al. (2020) regarding proper medical record-keeping was the increasing rate of health

care users' visits and the involvement of different health care professionals in medical records. Therefore, the emergency departments were unable to record medical records accurately.

Despite the participants' satisfaction with the level of documentation and medical records in this study, they were aware of the need for electronic health records to be enhanced. The need for enhancing electronic health records is supported by the participant's experiences in Christchurch city, who shared his experience with health care settings in Auckland, where his medical records were not available. The negative experience shared by the participant highlights a potential issue in New Zealand's health care system: a lack of interconnectivity between different health care providers. The lack of interconnection between health care providers can lead to situations where medical records are not shared, as experienced by the participants when they visited a health care setting in Auckland. The interconnection issue highlights the importance of a more standardised and accessible electronic medical record system across different health care providers in New Zealand. Electronic Health Records (EHRs) provide a means for health care providers to link together and share health care users' data, promoting better coordination of care and more efficient health care delivery.

Employing a standardised EHR would allow for more accurate health issue diagnoses and improved health care users' care, as health care staff would have access to a more comprehensive medical history of the health care users. Additionally, EHRs would allow health care staff across the entire country to access data of health care users, improving the continuity of care and reducing the likelihood of medical errors due to incomplete or inaccurate medical records. Therefore, it is important for New Zealand's health care system to invest in implementing EHRs to improve the overall quality of health care services provided to health care users.

One of the findings of this research was the *Lack of Effective Communication Skills* among health care provider's staff. In this research, a participant highlighted this concern during an interview when asked about his experience with the management of health care providers, from reception/phone call booking to top managers. Specifically, the participant shared negative experiences with reception staff, claiming that they were impatient and did not listen carefully when booking appointments. The participant

also identified a language barrier that may have contributed to the issue. The finding about language barrier is consistent with the study by Brookes and Baker (2017) in the UK, where health care users expressed dissatisfaction with the interpersonal skills of health care staff, particularly in terms of listening to their concerns. The negative feedback from health care users in the study was related to issues such as online booking appointments and accessibility of care. However, Brookes and Baker (2017) did not investigate the reasons behind poor communication and interpersonal skills of health care staff in their research.

In this study, a health care user expressed dissatisfaction with the communication style of reception staff, citing their impatience while he was booking an appointment to access health care services. The researchers posit that the workload on the staff may be the primary reason for the breakdown in communication between staff and patients. Moreover, due to the COVID-19 pandemic, many health care users were hesitant to visit health care providers and instead opted for virtual consultations through phone calls and emails to receive health advice. As a result, telephone consultations created an increased workload for staff and made them busier. The rise in calls made it difficult for staff to remain patient with health care users, leaving them with limited time to listen to their concerns.

This research highlighted that improving communication skills among health care staff is fundamental to ensuring quality health care services. According to King and Hoppe (2013), proper communication can lead to better understanding and meeting the needs of health care users, thereby increasing their satisfaction with the services provided. In addition, it can contribute to the accuracy and efficiency of health care procedures. Therefore, health care providers in New Zealand should invest in training their staff to improve their communication skills, particularly in listening and responding to immigrant health care users' concerns.

5.3.5 Health care environment

This section examines the health care environment in New Zealand and how health care users evaluate it, both physically and psychologically. Focusing on the ***physical environment***, one participant in the research expressed discomfort with the temperature and smells in the waiting area. Specifically, he noted that the temperature

was high and unpleasant smells were present due to the high volume of health care users in the area. The finding about physical environment is consistent with the research of Elias and Calil (2014) and Tsai et al. (2007). Elias and Calil (2014) conducted research in a public teaching hospital in São Paulo state, Brazil and found that health care users were uncomfortable with the temperature and smells in the health care provider. Participants noted that the air quality was poor and the environment felt stuffy, making it challenging to work in adequate conditions. Similarly, Tsai et al. (2007) found that health care users in Taiwan were dissatisfied with the high temperature in waiting areas. These findings highlighted the importance of maintaining a comfortable and healthy environment for health care users. Furthermore, these findings emphasised it is essential to address concerns around temperature, air quality and smells to ensure a positive health care experience.

In addition to concerns around the physical environment, participants in this research raised the need to have views outside of the health care provider. One participant noted that often admitted to rooms without windows or with windows covered by curtains, making it impossible to see outside. The finding about the views to outside is consistent with research conducted by Douglas and Douglas (2004) at Salford Royal Hospitals NHS Trust in the UK, where participants from different ethnic minorities expressed dissatisfaction with the height of windows that did not offer views outside and did not let enough light into the room. Douglas and Douglas (2004) found that cultural sensitivities played a significant role in participants' views toward health care services delivered in the UK. Additionally, Kotzer et al. (2011) identified satisfactory quality in children's rooms in Colorado health care providers in the United States of America. Parents and family members were impressed by the health care services that included electronics, such as TVs and Xbox gaming devices, in their child's room. The parent's satisfactory finding aligns with the results of this research where participants expressed high satisfaction with the quality of the physical environment in New Zealand. Participants of this research noted that decorating child's rooms with film cartoon stickers on the walls and painting walls with attractive colours were some of the aspects that contributed to their satisfaction.

As a result, participants expressed their desire to improve the quality of health care services provided in child's rooms in New Zealand. These findings highlight the

importance of providing an environment that is both physically and emotionally comfortable for health care users. Incorporating electronics and creative decorations in health care facilities can enhance the health care experience for children and their families, ultimately contributing to better health outcomes.

In the evaluation of the ***psychological environment*** of health care providers, participants in the research shared their negative experiences concerning the interior design of health care facilities and its impact on their psychological well-being. For instance, participants reported feeling depressed whenever they entered Christchurch hospital, to the extent that they avoided accessing health care services at that hospital. This finding suggests that the physical environment of health care facilities can significantly impact the psychological well-being of health care users and should be taken into consideration in the evaluation of health care services. The interior design of health care providers, therefore, has a significant impact on the psychology of health care users and making the design more attractive can help to improve their experience. The finding is consistent with research conducted by Zimring et al. (2004), who found that health care facility design can significantly impact health care users' stress levels and safety. Therefore, the design of health care providers should be carefully considered to ensure that it positively impacts the psychology of health care users. Making health care environments more attractive, calming and welcoming can improve health care users' experiences and contribute to better health outcomes. These findings suggest that providing views outside of the health care provider is crucial for the comfort and satisfaction of health care users and cultural sensitivities must also be considered when designing health care spaces. Ensuring that windows are at a suitable height and allow natural light into the room is an important aspect of health care design.

In addition to the impact of interior design, the study participants also expressed their dissatisfaction with the quality of electronic devices, specifically the television sets. One participant reported feeling disinterested and unentertained by the TV programs on the outdated television sets in the health care providers. The research finding about dissatisfaction with the quality of electronic devices is supported by Zhou et al. (2020), who found that music can be an effective tool for reducing stress and improving the psychological well-being of health care users.

The psychological environment was a significant topic of discussion among the participants of this research during the interview sessions. Participants believed that interior design and television devices, as well as TV programs, played a fundamental role in creating a stressful environment for health care users. experiencing a stressful environment may be due to cultural differences and personal preferences regarding design and TV programs. It is possible that Kurdish health care users are not accustomed to the interior design of health care settings in New Zealand and are not entertained by the TV shows available on the devices. To address this issue, it may be helpful to provide TV programs that are culturally relevant and available in Kurdish, which may increase the satisfaction of Kurdish health care users with the services delivered.

5.3.6 Ethical considerations

Considering the research findings, which highlight the importance of maintaining health privacy and respectful treatment of health care users, this section explores participants' satisfaction and dissatisfaction with the quality of confidentiality and respectful treatment services provided by NZ health care service providers. Furthermore, while most participants reported that their privacy records at health care providers are kept confidential and that they received respectful treatment from administrative staff and health professionals, a minority of respondents reported experiencing disrespectful behaviour from health professionals. The following discussion explores the findings' distinctions and their implications for the quality of healthcare services in New Zealand.

Privacy and Confidentiality: The research findings indicate that while most participants felt that health care providers in New Zealand kept their health information confidential, they still had concerns about the security and privacy of their health records. These concerns align with the results of previous studies conducted in the UK by Whitehead and Wheeler (2008) and in the US by Kaelber et al. (2008) which found that health care users expressed anxiety about safety and privacy of their health records in electronic health care systems. Furthermore, Yau et al. (2011) identified that health care users in Canada were concerned about data management of their health records at health care providers, especially after the adoption of electronic applications. Despite expressing anxiety about the security and confidentiality of their health records, participants of this research did not experience any mismanaging of their health records by health care providers in New Zealand. However, the finding highlights the need for health care

professionals to be sensitive to health care users' concerns and to protect their personal health information from any unauthorised access or disclosure. Moreover, the fact that many participants accompanied their parents and family members to health care providers further underscores their concerns about their privacy.

Participants in this study shared both positive and negative experiences of the *Treatment and Respectfulness* they received from health care providers. Most participants reported positive experiences, where health care professionals treated them with respect and were supportive when needed. The positive experience finding is consistent with the research of Bridges et al. (2021) which was conducted with primary health care users in integrated health care delivery systems in Oregon and Colorado. The research found that treating health care users with respect improved the relationship between health professionals and health care users, leading to increased satisfaction and adherence to treatment plans. Therefore, health care providers who demonstrate respect towards their health care users may improve the overall quality of health care services.

Further, a positive relationship between health care professionals and health care users can improve outcomes in health care settings by promoting mutual respect and care. Participants in this study reported positive experiences of being cared for and respected by health care professionals. Being respected and cared for finding is consistent with the research of Dickert and Kass (2009), who conducted a study with adult health care users in an academic cardiology clinic in Atlanta, Georgia. The research found that respecting health care users includes care as a significant element. Participants in this study expressed appreciation for various forms of respect, with one participant referring to nurses as compassionate and caring professionals. Promoting respect towards health care users may require health professionals to adopt different attitudes and approaches towards health care users' care.

To conclude, the findings of this research suggest that New Zealand health care providers are generally successful in maintaining the confidentiality of health care users' records and treating them with respect. While some participants reported negative experiences with disrespectful treatment from health professionals, most reported positive experiences. The emphasis on respect and care is critical as it is likely to

contribute to better psychological and physical health outcomes for health care users. It is also likely to result in better overall progress and outcomes for health care settings, as it creates a mutual understanding between health professionals and health care users. Thus, health care providers should continue to prioritise privacy and respectful treatment to ensure high-quality health care services for all.

5.4   The Application of Donabedian's model and balances between SPO

Donabedian's model is a widely recognised framework for evaluating the quality of health care services. It emphasises that health care providers' quality of care is influenced by three main components: structure, process and outcomes. Understanding the relationships between these three components is necessary to evaluating health care services' quality from a health care user's perspective (Donabedian, 2005; Hannawa et al., 2022; Mosadeghrad, 2012). Despite the framework's widespread use, there is a paucity of research specifically investigating the relative magnitude of associations between structure, process and perceived quality of care in terms of health care user satisfaction in New Zealand. This research highlighted the need for further studies to explore how these components interact and influence health care users' perceptions of quality of care in New Zealand. Such studies could contribute to improving the quality of health care services provided to New Zealanders by identifying areas for improvement in health care delivery.

Donabedian's theory divides the evaluation of health care services into three main components: structure, process and outcome. *Structure* refers to the underlying resources and facilities that support health care delivery, such as the physical infrastructure, human resources and equipment. Examples of structural factors that can impact the quality of care include the availability of trained staff, adequate staffing levels, the presence of appropriate equipment, budget resources and the physical layout of health care facilities (McDonald et al., 2007).

Process, on the other hand, refers to the actual delivery of health care services and the steps involved in providing care. The process includes all the activities involved in health care delivery, such as diagnosis, treatment, communication between health professionals and health care users, monitoring and follow-up care. The quality of the process is influenced by the competencies of health care providers, the availability of

necessary resources, the appropriateness of the care provided and the level of coordination and communication among health care team members (Moayed et al., 2022; Naz et al., 2022). Lastly, **outcome** refers to the results of care, including health care user satisfaction, clinical outcomes and overall health status. Outcomes can be measured and evaluated in terms of morbidity, mortality, quality of life, health care user satisfaction and cost-effectiveness. The quality of outcomes is influenced by the quality of both structure and process (Wang et al., 2019).

According to Elf et al. (2007), the relationship between structure, process and outcomes in Donabedian's model is complex and dynamic. A high-quality structure, such as a well-equipped and staffed hospital, can lead to better health care processes, such as timely and appropriate treatment, which in turn can result in improved outcomes, such as better health status and reduced mortality rates. On the other hand, a high-quality process, such as effective communication and coordination among health care staff, can lead to better outcomes, such as improved health care user satisfaction and reduced health care costs. The quality of outcomes can also influence the quality of structure and process, as successful outcomes may encourage the allocation of more resources and the adoption of best practices (Kruk et al., 2018). Therefore, it is important for health care providers to understand the interplay between structure, process and outcomes and strive to improve each component. By focusing on improving the quality of structure, health care providers can ensure that they have the necessary resources and facilities to provide high-quality care. Improving the quality of process, on the other hand, can lead to more efficient and effective health care delivery. Finally, by striving to achieve positive outcomes, health care providers can ensure that their efforts are ultimately benefiting the health and well-being of their health care users.

To understand the importance of the positive relationship between structure, process and outcomes from a health care user's perspective, it is essential to evaluate their needs and preferences for improvement (Kunkel et al., 2007). Evaluation for improvement has an additional component known as balancing evaluation, where Donabedian believed that structure evaluation influences process evaluation, which in turn affects outcome evaluation (see Figure 27). Together, these form the basis of what is required for an effective suite of evaluations. A high-quality health care system should have effective structures in place, efficient processes for delivering care and positive

outcomes for health care users. Thus, a balance between these components can help identify areas for improvement and ensure that health care users receive high-quality care (Schang et al., 2021).

Figure 27

Relationships Between Structure, Process and Outcomes of Donabedian's Model
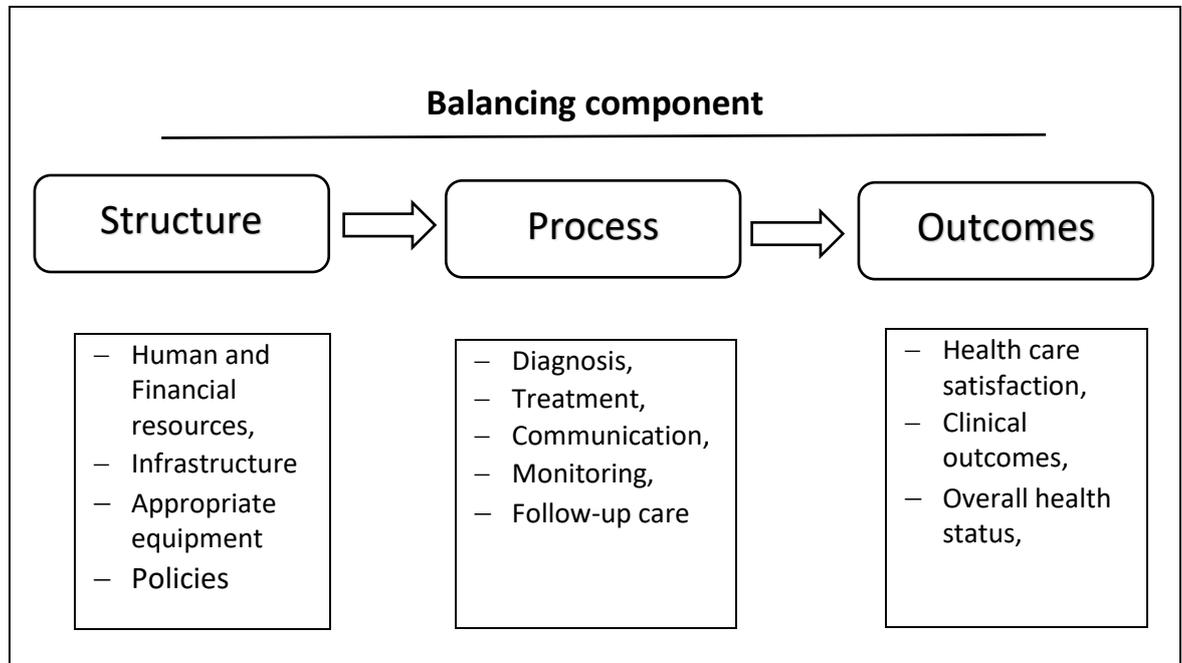
5.5 The extended relationship between SPO

Figure 28 presents the extended relationship between the components of Donabedian's model of quality of care. In this research, most participants expressed satisfaction with the publicly funded health services available to permanent residents and citizens of New Zealand. These individuals are entitled to receive free health services from health care providers in the country.

In the context of Donabedian's model, participants in the study expressed satisfaction with the **structural** aspects of health care facilities. They specifically praised the ongoing efforts to renovate and repaint hospitals, citing these initiatives as pivotal in enhancing the quality of the facilities. The participants also acknowledged the positive impact of continuous construction activities within health care providers, associating these developments with heightened satisfaction regarding the services offered. Notably, their satisfaction with health care services had obvious positive effects on their overall health status. Conversely, participants articulated dissatisfaction with several issues,

including staff shortages, parking challenges, high costs of emergency services, and discomfort caused by temperature variations and smells in waiting areas. Moreover, they highlighted how COVID-19 policies had impeded their access to essential health care services, contributing to their dissatisfaction. This dissatisfaction, as evidenced by their feedback, could directly lead to adverse health outcomes. Hence, a clear and direct correlation between the structural elements and the resultant health outcomes, as outlined in Donabedian's model, was evident from the participants' responses.

In exploring the **process** component, participants in this research shared various concerns that left them dissatisfied with the health services they received. Among these concerns were language barriers, instances of discrimination, misdiagnosis of health issues, challenges posed by COVID-19 protocols, and cultural differences. These dissatisfactory experiences in the process of accessing health care services directly correlated with undesirable health **outcomes** among the Kurdish health care users in New Zealand. Importantly, participants did acknowledge positive aspects within the process component as well. They highlighted the considerate and respectful behaviour exhibited by both medical and managerial staff. According to participants, the professionalism and politeness of the medical team played a significant role in alleviating feelings of anxiety, depression, and physical discomfort experienced during diagnosis and treatment. Moreover, participants expressed satisfaction with the quality of confidentiality services provided by health care providers. This satisfaction indicated their appreciation for the seriousness with which health care providers treated the confidentiality of their health-related issues, as illustrated in Figure 28.In conclusion, Donabedian's theory provides a comprehensive framework for evaluating the quality of health care services. By understanding the interrelationships between structure, process and outcome, health care providers can identify areas for improvement and strive to provide the best possible care to their health care users.

Figure 28

Extended Relationship Between Structure, Process and Outcomes Proposed for Quality of Health Care Services in New Zealand

Structure
- Staff shortage (-)
- Parking issue (-)
- Reconstruction (+)
- Updated products (-)
- Emergency services (-)
- Physical environment (-)
- COVID-19 policies
- Psychological environment (-)

Process
- Language barrier (-)
- Cultural barrier (-)
- COVID-19 protocols (-)
- Discrimination (-)
- Misdiagnosis (-)
- Follow-up issue (-)
- Documentation (+)
- Communication skills (-)
- Hygiene services (+)
- Ethical perspectives (+)
- confidentiality aspects (+)

Outcomes
- Desired outcomes (high quality) (+ -)
- Respect during treatment (+ -)
- Satisfaction with services (+ -)

Note 1: Participants were asked to provide response on their experiences with the quality of health care services. The negative experiences indicated by a '-' sign and positive experiences denoted by a '+' sign.

Note 2: adapted from (Mahdavi et al., 2018).

5.6 Comparative analysis of culturally and linguistically diverse communities in New Zealand.

Comparing and contrasting studies focused on various Culturally and Linguistically Diverse (CALD) communities in New Zealand provides valuable insights into the challenges and experiences faced by different ethnic groups within the health care system (Bartholomew, 2013). Research on these communities, such as the Pacific Islanders, Asian immigrants, Kurdish community, Pakistani and Indian populations and the Maori population, reveals a complex tapestry of health care needs and cultural disticntions (Bartholomew, 2013). Studies examining Pacific Islanders often emphasise the significance of cultural competence in health care delivery, highlighting the importance of understanding traditional healing practices and familial structures (Wilson et al., 2018). In contrast, research on Asian immigrants often examine the impact of language barriers and culture stress on health care access and utilisation (Wong, 2015b). Studies concerning the Maori population, the indigenous people of New Zealand, often focus on cultural revitalisation and the integration of traditional Maori healing methods within the modern health care framework (Ahuriri-Driscoll et al., 2012; Marques et al., 2021; Wikaire, 2020).

Furthermore, studies focusing on the Indian community often underscore the significance of cultural preservation and the challenges related to acculturation, emphasising the need for health care providers to be aware of traditional customs and beliefs. Language barriers, particularly for elderly immigrants, are a common theme in this context (Bartholomew, 2013; Montayre et al., 2019; Somasekhar, 2016). In contrast, the intersection of culture and religion profoundly influences health care practices within the Pakistani community. Religious beliefs and practices can impact decisions regarding treatment, dietary preferences, and the acceptance of certain medical procedures (Akhtar et al., 2022). Therefore, health care providers need to be culturally competent, understanding the distinctions of Pakistani culture, traditions, and the importance of religious observances. Community outreach programs, culturally sensitive health care materials, and interpreters proficient in languages spoken within the Pakistani community can significantly enhance healthcare accessibility and effectiveness.

Similarly, this research focused on the Kurdish community to shed light on the challenges related to barriers to accessing health care services. Language and cultural barriers can create unique hurdles in accessing and utilising health care services. By including the experiences of the Kurdish community within the broader CALD framework, researcher could gain a comprehensive understanding of the multifaceted health care needs in New Zealand. These studies collectively emphasise the importance of culturally sensitive health care services, targeted language support, and community engagement initiatives that respect and address the diverse requirements of New Zealand's multicultural population, including the Kurdish community (Akhtar et al., 2022).

In conclusion, by comparing these studies, researchers can identify common themes such as the importance of respectful communication, culturally sensitive care, and community engagement, while also recognising the unique challenges specific to each CALD community. These comparative analyses contribute significantly to shaping inclusive and effective health care policies and practices tailored to the diverse needs of New Zealand's multicultural society.

5.7   Summary of the chapter

This chapter provides a detailed exploration of the experiences of health care users in New Zealand, specifically focusing on the challenges and barriers faced by Kurdish health care users. The chapter explored different dimensions of quality of health care services and provides a thorough analysis of the state of health care services in the country. The research reveals that Kurdish health care users face significant difficulties when accessing health care services, including discrimination, language and health literacy issues and misdiagnosis of health issues. However, the participants expressed satisfaction with the emergency medical services and identified the need for updated medical tools to improve health care services. The chapter also emphasised the significance of effective communication between reception staff and health care users. The participants indicated their dissatisfaction with the communication style of reception staff, who were often impatient when booking appointments.

Furthermore, the chapter discussed the impact of the physical and psychological environment of health care settings on the experiences of health care users. Participants

reported that the interior design and television devices played a key role in creating a stressful environment, particularly for those who found it difficult to understand English-language programs. Finally, the participants expressed satisfaction with the quality of health care services in terms of maintaining their privacy and being treated with respect by health care professionals.

Chapter 6 : Conclusion

6.1 Introduction

This chapter presents a summary of the main areas covered in this research and its contribution to the field of knowledge. The study focused on evaluating the quality of health care services in New Zealand and the results provided valuable insights into the current state of the health care system in the New Zealand. In addition to the findings, this chapter provided recommendations and practice implications that can be used to improve the quality of health care services in New Zealand. These recommendations are based on the identified strengths and weaknesses of the health care system and can help in addressing the gaps in the delivery of health care services. The recommendations and implications presented in this chapter could be useful to policymakers, health care providers and researchers in the field of health care. Furthermore, the chapter discussed the limitations and constraints that may have influenced the findings of the study. The limitations identified in the research provide an opportunity for future research to address these constraints and enhance the validity and reliability of the results.

6.2 New knowledge and research contribution

The primary objective of this research was to assess the satisfaction of health care users in New Zealand with the quality of health care services provided by health care service providers. Additionally, the study aimed to identify the barriers that immigrant health care users face when accessing health care services in New Zealand. The identification of these barriers aimed to provide insights into the areas that need improvement to enhance the quality of health care services for Kurdish and other immigrant communities in New Zealand in the future. To achieve the quality enhancement in health care services for Kurdish health care users, this study employed Donabedian's model of health care quality, which focuses on evaluating quality of health care services in three domains: Structure, Process and Outcomes (SPO). The research participants were Kurdish health care users who had more than ten years of experience with the New Zealand health care system and were from Auckland, Hamilton and Christchurch cities.

Chapter 4 of this research provides evidence-based knowledge about the quality of health care services in New Zealand generated from the experiences of Kurdish immigrants. The findings highlighted various issues such as language difficulties, discrimination, parking vehicle issues, updating health care tools, communication skills, treatment and respectfulness, among others. This research made a significant contribution to the existing international literature on the quality of health care services in New Zealand. To the best of my knowledge, this study is the first to investigate the perceptions of Kurdish health care users regarding the quality of health care services in New Zealand, both nationally and internationally. However, in Chapter 2, I was able to identify studies that have examined the quality of health care services from immigrant health care users' perspectives in the United States, Canada and various European countries, representing diverse cultural backgrounds. The comparison provided a broader context for the study's findings and contributed to the understanding of the quality of health care services in various regions worldwide.

To conclude with, this research offered a novel perspective on the quality of health care services from the experiences of Kurdish health care users in New Zealand. Additionally, this research contributed to the international literature by highlighting similarities and differences in the quality of health care services among various countries, which could potentially inform policy and practice improvements in the health care sector.

6.3   Implications and recommendations for practice

The principal implication of this research was that it highlighted the challenges faced by immigrant health care users in accessing health care services in New Zealand, particularly among Kurdish health care users. The findings of this research added to the growing concerns that the mainstream quality of health care services in New Zealand may not adequately address the needs of immigrant health care users (Akhtar et al., 2022; Kanengoni et al., 2018). Furthermore, this research underscored the capacity of New Zealand's health care system to improve the quality of health care services for immigrant health care users. The participants of this study stated that the public health system in New Zealand is not well-equipped to provide better health services and achieve high levels of performance. Consequently, barriers to accessing health care services and the poor performance of New Zealand's health care system negatively

impact the health of immigrant family members and, ultimately, the health of society. Therefore, health planners in the Ministry of Health of New Zealand must consider ways to enhance the accessibility of health care services for immigrant health care users. By addressing these barriers, it will be possible to provide better health care services for immigrant health care users and improve the overall health outcomes for the immigrant population in New Zealand.

To further advance knowledge and address the identified gaps, it is recommended that future research explore the implementation and evaluation of health care policies and practices that aim to reduce the identified barriers to accessing health care services. Moreover, the research could investigate the perspectives of health care providers on delivering quality health care services to immigrant communities in New Zealand, which would provide a more comprehensive understanding of the issues and challenges faced by both health care users and providers. To further reduce barriers to accessing health care services, this research recommends that future studies using mixed method (questionnaires and interviews) could be conducted with health care users from different nationalities residing in New Zealand. Their perspectives could assist health care providers, organisations and policymakers in the Ministry of Health in improving the utilisation of health care services and overcoming barriers to access. Additionally, a mixed-method study (combining both qualitative and quantitative approaches) could provide more detailed insights into the experiences of immigrants accessing health care services in New Zealand. These recommendations could facilitate the development of evidence-based interventions to improve health care delivery for immigrant populations in New Zealand.

In addition, promoting interdisciplinary collaboration between the government health centres and reluctant immigrant communities can potentially reduce barriers to accessing health care services. However, ensuring the integration of these two entities can be challenging, as it requires a sufficient yearly budget to organise regular meetings with immigrant leaders to understand their barriers to accessing health care services in New Zealand. Therefore, the New Zealand Ministry of Health should allocate resources to conduct academic research that evaluates the quality of health care services from immigrant health care users' perspectives. Moreover, the government of New Zealand should provide sufficient resources to train health professionals and administrative staff

to enable them to provide high-quality health care services to reluctant communities, including refugees. Such training should include how to deal with and treat immigrant health care users to prevent any forms of discrimination against them.

This research identified limited English language proficiency as a key barrier for immigrant health care users in accessing health care services in New Zealand. The Ministry of Health could address this issue by providing professional Kurdish interpreters who can facilitate communication between health professionals and immigrant health care users. To attract and retain qualified interpreters, health care providers may consider investing in their medical education or providing additional financial incentives.

Moreover, the lack of cultural integration among Kurdish immigrants may also contribute to their challenges in accessing health care services. To promote cultural integration, health care providers could encourage Kurdish immigrants to engage in various activities that reflect the New Zealand culture, such as sports, restaurants, the film industry and religious practices. Additionally, health care providers should improve the communication style of their staff members to ensure effective communication with immigrant health care users from diverse cultural backgrounds. Furthermore, the effects of communication and cultural diversity on the quality of health care services should be incorporated into undergraduate courses for medical science students. The course may help prepare future health care providers to work effectively with immigrant health care users and to provide culturally appropriate care.

To further enhance the quality of health care services provided to immigrant communities in New Zealand, it is important to also address the issue of health care product affordability. The cost of health care products can often be a barrier to accessing high-quality health care services, particularly for low-income immigrant families. Therefore, the New Zealand government should consider providing subsidies for health care products to make them more accessible to immigrant health care users.

To maximise the quality of health care services for immigrant communities in New Zealand, it is also vital to invest in better quality and updated health care products. Such updated products, including X-ray machines, surgical tools, health monitors and so on, can assist health care settings in providing high-quality care to health care users. The development of health care products plays a vital role in reducing tensions between

health care users and providers in terms of the quality of services. New health care products enable services to be provided faster and with more precise medical check-up results, leading to better health outcomes for immigrant health care users in New Zealand.

To conclude with, improving the quality of health care services for immigrant communities in New Zealand requires a multi-faceted approach that addresses various barriers to accessing health care services, including language barriers, cultural differences and affordability of health care products. By implementing these suggestions, the New Zealand government and health care providers can work towards achieving equitable access to high-quality health care services for all members of society.

6.4   Implications for Research

In Aotearoa New Zealand, Kurdish health care users have faced challenges in having their voices heard and in advocating for high-quality health care services. Moreover, the quality of health care services provided to immigrant health care users in New Zealand has not been extensively researched. While Kurdish health care users have shared valuable insights and experiences regarding accessing health care services in New Zealand, there is still a need to better understand the challenges faced by immigrant communities in accessing health care services. Further research on Kurdish and other immigrant cultures in New Zealand could enhance the insights gained from this research. Involving Kurdish health researchers may also provide a safer environment for sharing and investigating personal experiences. Additionally, incorporating a mixed-method research approach for future studies could facilitate the application and development of the recommendations provided in this research.

6.5   Strengths and limitations of research

6.5.1   Strength of research:

This research has several strengths that contribute to its dependability. One notable strength is the use of interview questions to collect raw data, which ensures the findings are consistent and repeatable. The aim of data analysis was to verify that the results of this   research   were   consistent   with   the   collected   data,   thus   increasing   the

trustworthiness of the research. Moreover, any other researcher analysing the data would generate similar results. As such, I can confidently assure the readers of this research that the final report is not misguided (Korstjens & Moser, 2018).

Further, this research has several strengths that contribute to its rigor and trustworthiness. Firstly, this research is the first study to evaluate the satisfaction of health care users with the quality of health care services in New Zealand, particularly among Kurdish immigrants. The research provides detailed perspectives on the quality of health care services in terms of Structures, Processes and Outcomes (SPO), using Donabedian's model, a well-known quality evaluation model in health care.

Secondly, the study's methodology involved collecting rich and in-depth insights from the participants, rather than limiting the research to statistical analysis of a large sample size. The participants in the study were highly engaged in sharing their insights and experiences regarding the quality of health care services in New Zealand, as well as the obstacles they faced when trying to access those services. Using ethnography and personal narratives, the study was able to provide a comprehensive and in-depth examination of the experiences of Kurdish health care users. Incorporating personal stories and ethnographic observations enriched the findings, emphasising participants' distinctions and subtleties. By utilising these qualitative methods, the study was able to capture the subjective experiences of the participants and provide a more holistic understanding of the issues at hand.

Thirdly, the recruitment process for participants was diverse and broad, including participants from different geographic areas and demographic characteristics such as age, gender and location. The research aimed to provide a wide range of perspectives and to avoid measurement bias, online interviews were avoided.

Fourthly, the study utilised ethnography to provide a rich exploration of Kurdish health care users' experiences, allowing for a more in-depth understanding of their perceptions of the quality of health care services in New Zealand.

Lastly, the research utilised interview questions to collect raw data, ensuring that the findings were consistent, repeatable and dependable, which is significant for the trustworthiness of the research. The data analysis aimed to verify that the results were

consistent with the collected data, ensuring that any other researcher looking at the data would generate similar results.

In conclusion, this research has several strengths, including the use of a rigorous and systematic approach to data collection and analysis, the appropriate sample size and selection and the clear and concise presentation of the findings. These strengths enhance the dependability and trustworthiness of the research.

6.5.2 Limitation of Research:

One limitation of this research was that it relied on qualitative interpretation of participant interviews to evaluate the quality of health care services in New Zealand. While the qualitative interpretation approach empowers participants to have more control over the time and content of the data gathered, it can be difficult for the researcher to objectively verify the findings. The accuracy of participants' responses is important, but it is challenging to verify using this method (Queirós et al., 2017). However, the researcher attempted to maintain transparency throughout the research process and methodology to mitigate this limitation.

In addition, the application of Donabedian's Model of quality of care to evaluate the quality of health care services in New Zealand may have limitations. As discussed in Chapter 2 (Section 10), a major challenge in applying Donabedian's model is establishing a relationship between the three domains: Structures, Processes, and Outcomes (SPO). The difficulty of establishing the relationship is because the Structure and Process domains may have potential effects on the Outcomes of health status (Liu et al., 2011). Another limitation of this research was the potential lack of generalisability of the findings. As the data were collected only in New Zealand, the current sample may not be representative of all Kurdish immigrants in the country due to the convenience sampling technique employed. Although efforts were made to include subjects from different geographic areas, genders and ages, the results may not be applicable to other ethnic groups living in New Zealand or to Kurdish individuals in other countries with different health systems and cultural contexts. To address the lack of generalisability limitation, further research is recommended to investigate similar health care systems in Australia and European countries. Furthermore, the sampling and selection bias, as

well as the fact that only Kurdish health care users were included in the data collection, may affect the generalisability of the findings.

Another limitation of this research was the lack of utilisation of other theories and models of quality of care to evaluate the quality of health care services, which could have contributed to examining barriers to accessing health care services in New Zealand. Moreover, due to the limited literature available on the experiences of Kurdish health care users globally, the researcher had to rely on the experiences of other immigrant health care users in developed countries to contextualise the findings. However, despite the rigorous literature search, there remains a possibility that relevant literature was missed, which could have further enriched the literature review and the research findings. Moreover, this study was conducted with a relatively small sample of health care users and as such, more research is needed to further contextualise and investigate the results. Nonetheless, this qualitative study aimed to include as much as possible the experiences of Kurdish health care users, which may contribute to the overall understanding of health care quality among immigrant populations.

6.6   Conclusion

This research aimed to investigate the satisfaction of Kurdish health care users with the quality of health care services in New Zealand, as well as any barriers they faced in accessing these services. Furthermore, this research sought to identify potential actions that could be taken to improve the quality of health care services for Kurdish health care users in New Zealand, involving the Kurdish community, health care providers, the Ministry of Health and other health care planners. This study was unique in that it was the first to examine the quality of health care services provided to Kurdish health care users in New Zealand through a multi-site approach. To evaluate the quality of health care services, Donabedian's framework, which comprises the three domains of Structure, Process and Outcomes (SPO), was used.

This research has contributed to the understanding of the experiences of Kurdish health care users accessing health care services in New Zealand. The study identified the barriers and enablers that Kurdish health care users face while engaging with health care service delivery. The identified barriers include access to health care services, health care provider structures and processes and immigrant health care users' outcomes.

Discrimination, parking issues, shortage of doctors and long waiting times were some of the significant barriers. Similarly, language barriers, low communication skills among health care staff and ethical considerations were recognised as difficulties and enablers for Kurdish health care users to access health care services in New Zealand.

The findings of this research were consistent with the barriers faced by other immigrant communities to access health care services in the USA, Canada and European countries, as discussed in chapter two. Therefore, the research findings could apply to immigrant communities and health care providers in similar underlying health care systems in the USA, Canada, the UK and Australia. However, it is essential to note that the findings of this research were particularly relevant to the New Zealand context. Moreover, this research was the first to identify the negative effects of COVID-19 on Kurdish health care users in New Zealand. The study found that COVID-19 protocols, rules and guidelines have limited Kurdish and other health care users' access to health care centres to receive health care services. Further, the findings of this research provide specific recommendations for improving the quality of health care services in New Zealand. One of the recommendations is that interdisciplinary collaboration between health care providers and immigrant communities should be fostered to improve the quality of health care services. Additionally, allocating sufficient funding for conducting academic research on diverse cultural backgrounds living in New Zealand could help the government understand the barriers to accessing health services. Furthermore, the Kurdish community is recommended to adapt to New Zealand culture and society to improve their English language skills and effectively communicate with health care providers' staff. Increasing support from the New Zealand government, particularly the Ministry of Health, to immigrant communities may also help improve the quality of health care services provided.

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Appendices

Appendix A *Ethics Approval-AUTEC*

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

13 September 2021
Charles Mpofu
Faculty of Health and Environmental Sciences
Dear Charles
Re Ethics Application: **21/271 Evaluating Health Service Users' Satisfaction with the Quality of Health Services in New Zealand: A Mixed-method Study of Kurdish Immigrants**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).
Your ethics application has been approved for three years until 13 September 2024.
Non-Standard Conditions of Approval
1. Provide translations when they are available.
2. If you decide to do the interviews online, then you will need to evidence consent. Details of how this will be achieved needs to in the Information Sheet and sent to AUTEC for approval. Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to AUTEC before commencing your study.

Standard Conditions of Approval
1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.

4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.

5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.

6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries, please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics.

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat

Auckland University of Technology Ethics Committee

Cc: karwan.manguri@autuni.ac.nz; Wendy Wrapson

Appendix B *Participant Information Sheet*

1. English version.

An Invitation

My name is Karwan Ali Perot Manguri, and I am a PhD candidate at the Auckland University of Technology. I kindly invite you to take part in this research project, with the title: **Evaluating Health Care Users' Satisfaction with the Quality of Health Care Services in New Zealand: A Qualitative Study of Kurdish Immigrants.** This research allows you, as a Kurdish health care user, to express your ideas and experiences about the quality of health services in New Zealand. You are being asked to take part in this research because you are Kurdish, and you are aged 18 and above.

What is the purpose of this research?

The main aim of this research is to evaluate and analyse the quality of health services in New Zealand. Thus, as a Kurdish immigrant, I request you to tell me about your experiences. The recommendations of this research may contribute to policy development specifically related to improving the health care access of immigrant populations. Furthermore, the findings from this research will add to the current literature on the quality of the health care system in New Zealand and its services to other minority groups. The findings of this research will be used for academic publications and presentations and to inform policy on health services for Kurdish immigrants.

How was I identified and why am I being invited to participate in this research?

After receiving your response to the advertisement, you will be selected to take part in this research. You were selected because you met the following inclusion criteria:

- ≥ 18 years,
- Kurdish ethnicity,
- Speaking English and/or Kurdish,
- Has experienced health care in New Zealand within the last 10 years,
- Permanent resident of New Zealand.

How do I agree to participate in this research?

To take part in this research, you will be asked to contact the primary researcher directly at 0220705253. You also be asked to give written or verbal consent. For online interviews, consent will be attained verbally and recorded before starting the interview. Before data collection starts, you will be provided with the necessary forms and/or information. Your participation in this research is voluntary and if you choose not to participate this will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you decide to withdraw, you will be offered the choice between removing data or allowing it to continue to be used. However, once the findings have been produced, the removal of your data may not be possible.

What will happen in this research?

This study will use face-to-face interviews to explore Kurdish immigrants' perceptions about the quality of health care services in New Zealand. Data will be collected from 15 to 20 Kurdish health care users who have had experience with health services in the last 10 years. The target goal is to address the enablers and barriers for Kurdish immigrants to access health service delivery. Also, they will be asked to suggest changes, if any, that are required to the health care services to meet the needs of Kurdish immigrants. The place of meeting will be on the participant's choice which may be at their own home or an AUT campus. Before starting the interview, participants will be provided with a copy of the questions that we are likely to talk about interviewing. Whatever you are saying will be useful and will be recorded and transcribed. Also, you will be receiving a copy of transcribed information which you can leave comments on and return to me. Copies of transcripts will be kept in a locked filing cabinet. If you live outside of Auckland, a zoom- interview will be used.

What are the discomforts and risks?

It is unlikely that you will experience discomfort. You can skip any questions that made you uncomfortable answering them. The nature and process of this research are not expected to cause any distress or discomfort. However, there could be some experiences from participants causing discomfort. For example, you may be asked to share your bad experiences with the NZ health care system which might bring back unpleasant memories to you.

How will these discomforts and risks be alleviated?

This face-to-face interview will be conducted respectfully. You may wish to withdraw your participation at any stage of the research process without giving any explanation. You may show me any signs (waving head or hand) of discomfort or distress during interviewing time. In this situation, the interview can be suspended and recommenced when and if the participant is agreed. If a participant felt any form of discomfort and risk this can be mitigated by referring him/her to the AUT Student Counselling and Mental Health Services. This service can offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly because of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- – drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- – let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling at https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Your participation in this study and the information you share with me can help to develop and change if required, the health care system of New Zealand. Your valuable information may also help to minimise the difficulties confronting immigrants in accessing health care services. On the other hand, for Karwan, the benefits will be achieving PhD qualification and publishing the research outcomes in New Zealand or international credited journals.

How will my privacy be protected?

The researcher will maintain the safety and culturally sensitive information given about visits, access, and delivery of health care services of all ages and genders of participants. Your identity or any other sensitive personal information will be kept confidential. Unless you wish to be identified, I will use only pseudonyms in my notes and records. Your name will not be used in any of the reports or outcomes of the study. Also, the information and identities of participants will be always kept in a secure location and accessed by the researcher and supervisor.

What are the costs of participating in this research?

Taking part in this study will not cost you anything other than approximately one hour of your time.

What opportunity do I have to consider this invitation?

I aim to start interviewing participants on 15 October 2021 (if New Zealand moved to Alert Level 2 or 1). Two weeks before starting interviews on 01 October 2021, I will distribute and advertise the invitation. You will then have two weeks to consider this invitation. Thus, formal data collection will begin on 15 October 2021.

Will I receive feedback on the results of this research?

If you request to be informed of the study outcomes (by ticking a circle on the Consent Forms), I will send you a summary, either to your email or physical address. The report will not use your name to protect your privacy and confidentiality.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Charles Mpofu, charles.mpofu@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Karwan Manguri, karwan.manguri@autuni.ac.nz Phone No.: 0220705253
Project Supervisor Contact Details:
Dr. Charles Mpofu, charles.mpofu@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, **AUTEC Reference number** *type the reference number*.

2. Kurdish version.

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant Information Sheet

Date Information Sheet Produced: 25/08/2021.

فۆرمی زانیاری بەشداربوان

ناونیشانی پرۆژە: هەڵسەنگاندنی ڕێزەی ڕازیبونی بەکارهێنەرانی خزمەتگوزاری تەندروستی لە کواڵیتی خزمەتگوزاربە تەندروستیەکان
لە نیوزیلاند: لێکۆڵینەوەیەک لە دۆزی کۆچبەرانی کورد.

داواتنامە:

بۆ من ناوم (کاروان عەلی پیرۆت- مەنگوری) ە، کاندیدی بەدەستهێنانی بروانامەی دکتۆرام لە زانکۆی ئۆکلاند
تەکنۆلۆجیا. بەڕێزەوە داواتان لێدەکەم کە لەم پرۆژەی لێکۆڵینەوەیە بەشداربن کە تایبەتە بە هەڵسەنگاندنی کواڵیتی خزمەتگوزاربە
تەندروستیەکان بەگوێرەی ڕێزەی ڕازیبونی بەکارهێنەرانی خزمەت گوزاری تەندروستی لە نیوزیلاند: لێکۆڵینەوەیەک لە دۆزی
کۆچبەرانی کورد. ئەم لێکۆڵینەوەیە هەڵێک بۆتۆ وەکو بەکارهێنەرێکی خزمەتگوزاربە تەندروستیەکان بۆ دەربڕینی ڕاو بۆچون
وشارەزایی خۆت دەربارەی کواڵیتی خزمەتگوزاربە تەندروستیەکان لە نیوزیلاند. لەبەرئەوەی تۆ کوردی و تەمەنت ١٨ ساڵ یان
زیاترە، بۆیە داوات لێدەکرێت کە لەم تویژینەوەیە بەشداربی.

مەبەست چیە لە ئەنجامدانی ئەم لێکۆڵینەوەیە؟

مەبەسی سەرەکی لەم لێکۆڵینەوەیە بریتیە لە هەڵسەنگاندن و شیکردنەوەی کواڵیتی خزمەتگوزاربە تەندروستیەکان لە
نیوزیلاند. بۆیە وەکو کوردێکی نیشتەجێ نیوزیلاند داوات لێدەکەم کە ڕاو و بۆچونی خۆتم پێبڵی لەم بوارەوە. پێشنیارو
بیروبۆچونەکانتان لەوانەیە ببێتە هۆی بەرەوپێشچونی سیستەمی تەندروستی نیوزیلاند و سوودبینینی گروپەکانی تری کۆچبەران لە
گەیشتن بە خزمەتگوزاربە تەندروستیەکان. هەروەها ئەنجامی بەدەستهاتو لەم لێکۆڵینەوەیە دەبێتە هۆی زیادکردنی زانیاری لەسەر
کواڵیی سیستەمی تەندروستی نیوزیلاند و چۆنیەتی خزمەتکردنی کەمە نەتەوایەتییەکی تریش کە لە نیوزیلاندن. لەلایەکی تریشەوە،
ئەنجامی بەدەستهاتوو لەم پرۆژەیە بۆ مەبەسی بڵاوکردنەوەی بابەتی ئەکادیمی و سیمینار لەسەر خزمەتگوزاری تەندروستی بۆ
کۆچبەرانی کورد بەکاردەهەندرێت.

چۆن من دیاریکرام و بۆچی داوەتکراوم تا باشداربم لەم پرۆژەیە؟

دوای ئەوەی ڕەزامەندی خۆت دەردەبڕی، تۆ دیاریدەکرێی بۆ ئەوەی بەشداربی لەم لێکۆڵینەوەیە. لەبەرئەوەی ئەم
مەرجانەی لای خوارەوە دەنگگیرتەوە، بۆیە دیاریکراوی.

- تەمەنی ١٨ ساڵ یان بەرەوسەرتر بێت،
- لەنەتەوەی کورد بێت،
- زمانی کوردی یان ئینگلیزی بزانێت،
- بۆ ماوەی ١٠ ساڵ یان زیاتر شارەزایی هەبێت لە سیستەمی تەندروستی نیوزیلاند،
- نیشتەجێی بەردەوامی نیوزیلاند بێت.

چۆن ڕەزامەندی دەربڕیرم بۆ بەشداریکردن لەم لێکۆڵینەوەیە؟

بۆئەوەی بەشداری لەم لێکۆڵینەوەیە، داوات لێدەکرێت کە ڕاستەوخۆ پەیوەندی بە لێکۆڵەرەوەی سەرەکی بکەی لە
ڕێنگای karwan.manguri@autuni.ac.nz یان 0220705253 یان بە ڕەزامەندی زارەکی. هەروەها داوات لێدەکرێت کە ڕەزامەندی
نووسین پێشکەش بکەی. بۆ چاوپێکەوتنی ئۆنلاین، ڕەزامەندی بەشێوەی زارەکی وەدەگیرێت و پێش دەستپێکردنی چاوپێکەوتنەکە
ڕیکۆرد دەکرێت. هەروەها پێش کۆکردنەوەی زانیارییەکان، فۆرمی زانیاری تایبەت بە بەشداربووان. بەشداریکردنت لەم لێکۆڵینەوەیە
ئازادانەیە و ئەگەر بەشداری نەکردنت هەڵبژارد ئەوا نە قازانج و نەزیانت دەتوانێت بتەوەنێت دەتوانێت لە
چاوپێکەوتنە بکشێیتەوە. ئەگەر بڕیاردا کە لە ناوەڕاست یان کۆتای چاوپێکەوتنەکە بکشێیتەوە، ئەوا سەرپشک دەکرێی بەوەی
کە ڕێگا بدەی کە ئەو زانیارییانەی بەخشیوتە بەکار بهێندرێن یاخود نا. بەڵام هەرکاتەک دەرئەنجامی لێکۆڵینەوەکە دەرچوو، ئەوکات
ناتوانرێت زانیارییەکانت بکشێنیەوە.

چی ڕوودەدات لەم لێکۆڵینەوەیە؟

لەم لێکۆڵینەوەیەدا چاوپێکەوتنی ڕووبەڕوو بەکردنیت بۆ تێگەیشتن لە بیروڕای کۆچبەرانی کورد دەربارەی کواڵیتی
خزمەتگوزاریە تەندروستیەکان لە نیوزیلاند. زانیارییەکان لە ١٢-١٣ کورد وەردەگیرێت کە بۆ ماوەی ١٠ ساڵ یان زیاتر بەکارهێنەری
خزمەتگوزاریە تەندروستیەکان. ئامانج لەم لێکۆڵینەوەیە بریە یە لە دیاریکردنی ئەو ئاستەنگانەی کە دێنە پێش کۆچبەرانی کورد لە
گەیشتن بە خزمەتگوزاریە تەندروستیەکان. هەروەها داوا لە بەشداربووان دەکرێت کە پێشنیاری هەرگۆڕانکاریەک پێویست کە
ببێتە هۆی گەیشتن بە پێداویستیە خزمەتگوزاریە تەندروستیەکانی کۆچبەرانی کورد. شوێنی چاوپێکەوتنەکە لەلایەن بەشداربوو
دیاریدەکرێت یان لە ماڵی بەشداربوو دەبێت یان لە کامپەسی زانکۆ دەبێت. پێشئەوەی چاوپێکەوتنەکە دەستپێبکات، کۆپیەک لە
پرسیارەکان دەدرێت بەشداربوو. هەرچی لە چاوپێکەوتنەکە گفتوگۆی لەسەر بکرێ دەربارەی کەرتی تەندروسی نیوزیلاند، ڕیکۆرد
دەکرێی. دواتر کۆپیەک لە زانیارییەکان دەدرێت بە بەشداربوو و ئەویش دەتوانی کۆمێنی لەسەر بدات و دواتر بۆم بگەرێنێتەوە.
زانیاری بەدەستهاتوو و نوسراو لە لۆکەری زانکۆ کە تایبەتە بە پاراستنی فایل هەڵدەگیرێت. هەروەها بۆ ئەوکەسانەی کە دانیشتوی
دەرەوەی ئۆکلانند، ئەوا چاوپێکەوتنەکان لە ڕێگای بەرنامەی (زووم) ەوە ئەنجام دەدرێن.

مەترسی و ناڕاحەتیەکانی ئەم لێکۆڵینەوەیە چین؟

ئەم پرۆژەیە هیچ جۆرە مەترسی و ناڕاحەتیەک ڕوبەڕوی بە بەشداربوو ناکاتەوە. هەر پرسیارێک توشی بێزاری و ناڕاحەتی
کردی، دەتوانی وەڵام نەدەیەوە. سروشتی ئەم لێکۆڵینەوەیە بەجۆرێک کە نابێتە هۆی سترێس و ناڕاحەتی بۆ بەشداربوو. لەگەڵ
ئەوەشدا لەوانەیە بەشداربوو توشی دڵتوندی بێت کاتێک کە داوای لێدەکرێت کە تەجربەبەیەکی ناخۆشی خۆی لەگەڵ سیستەمی
تەندروسی نیوزیلاند باسبکات کە لەوانەیە ڕوداوی ناخۆشی بیربکەوتنەوە.

چۆن ئەم ناخۆشی و مەترسیانە کۆتایی پێ بێنین؟

ئەم چاوپێکەوتنە ڕووبەڕووە بە ڕێزەوە ئەنجام دەدرێت. دەتوانی لە چاوپێکەوتنە بکشێیەوە هەرکاتێک بتەوێت بەبێ ئەوەی
ڕوونکردنەوە بدەی. لەکاتی چاوپێکەوتنە کە ئەگەر هەسست بە ناڕاحەتی کرد دەتوانی بە ئاماژەی دەست یان سەر لەقاندن پێمبڵێی.
لەم کاتەدا چاوپێکەوتنە کە هەڵدەپەسێردرێ و هەرکاتێک بەشداربوو ڕازیبوو ئەوکات دەستپێدەکاتەوە. ئەگەر بەشداربوو هەسی بە
هەرجۆرێک لە مەترسی کرد، دەتوانرێت کەم بکرێتەوە بە ناردنی بۆ ئۆفیسی ئامۆژگاری ئامۆژگاری تەندروسی دەرونی لە زانکۆی ئۆکلاند بۆ
تەکنۆلۆجیا. ئەم خزمەتگوزاریە بەشێوەی خۆرایی بۆ سێ دانیشتنی ئەوا نهێی پێشکەش بە بەشداربوان دەکرێت. ئەم
خزمەتگوزاریەی تەنیا بۆ ئەو بەشداربووانەیە کە تووشی ترس یان دڵەڕاوکێ دەبن لە ئەنجامی بەشداریکردنیان لەم پرۆژەیەدا. بۆئەوەی
لە کامپەسی ناوشار یاخود WB203سوود لەم خزمەتگوزاریە ببیی، پێویستە: سەردانی ئەم سەنتەرەبکەی لە بینایەی ژمارە
ئاگادری کارمەندی پرسگە 9998 921 یان پەیوەندی بکەی بە ژمارە تێلیفۆنی counselling@aut.ac.nz ئیمەیل بنێری بۆ
بکەوە کە تۆ بەشداربووی ئەم پرۆژەیەی و ناوونیشانی لێکۆڵینەوەو ناو و ژمارە تێلیفۆنی من بدە بە کارمەندی پرسگە. دەتوانی
زانیاری زیاتر لەسەر لەم لینکەی خوارەوە بەدەست بێنی

https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

سوودەکانی ئەم بەشداریکردنە چین؟

بەشداریکردنت لەم لێکۆڵینەوەیە و ئەم زانیاریەکانت لەوانەیە ببێتە هۆی گۆڕینی سیستەمی تەندروستی نیوزیلاند. هەروەها زانیاریە گرنگەکانت لەوانەیە ببێتە هۆی کەمکردنەوەی ئاستەنگەکانی بەردەم گەیشتن بە خزمەتگوزاریە تەندروستیەکان. لەلایەکی ترەوە، بەشداریکردنت و زانیارەکانت دەبێتە هۆی بەدەست هێنانی بروانامەی دکتۆرا بۆ کاروان و بڵاوکردنەوەی دەرئەنجامەکانی ئەم لێکۆڵینەوەیە لە گۆڤارە بەناوبانگەکانی نیوزیلاند.

چۆن نهێنیەکانی من پارێزراو دەبن؟

لێکۆڵەر زانیاری نهێنی و هەستیار دەربارەی سەردانیکردن و گەیشتن بە خزمەتگوزاریە تەندروستیان بۆ هەموو تەمەن ز رەگەزەکان دەپارێزێت. ناو و زانیاری کەسی و یاخود هەر زانیاریەکی هەستیار کە دەدرێتە کاروان، بە نهێنی دەمێنێتەوە. تەنیا ئەگەر خۆت وێستت کە ئاماژە بە ناوت بدرێت، لەو حاڵەتەدا بە ناوی خوازراوەوە ئاماژە با ناوت دەکرێت و ریکۆرد دەکرێت. ناوی راستەقینەت هەرگیز ئاماژەی پێناکرێت لە هیچ راپۆرت و بڵاوکراوەیەک. هەروەها زانیاریەکانیش بەبەردەوامی لە شوێنێکی زۆر سەلامەت دەپارێزرێن کە تەنیا کاروان و سەرپەرشتیارەکەی توانای دەستپێگەیشتنیان هەیە.

تێچونەکانی (مەسروفاتی) بەشداریکردن چین؟

بەشداریکردن لەم لێکۆڵینەوەیە هیچ تێچوویەکی نیە جگە لە بەخشینی یەک کاتژمێر لە کاتی خۆت بەم لێکۆڵینەوەیە.

ئایا لەدەرئەنجامەکانی ئەم لێکۆڵینەوەیە ئاگادار دەکرێمەوە؟

ئەگەر داوا بکەیت کە ئاگادار بکرێنەوە لە دەرئەنجامەکانی ئەم لێکۆڵینەوەیە کە لە فۆڕمی رازی بوون دیاری دەکەی، ئەوا پوختەی لێکۆڵینەوەکە یان بۆ ئیمەیلت یان بۆ ئەدرێسی ماڵەکەت دەنێرم. بۆ پاراستنی نهێنیەکان، لە راپۆرتە ناوی راستەقینەت ناهێندرێت.

چی بکەم ئەگەر هەر تێبینیەکم هەبو لەسەر لێکۆڵینەوەکە؟

هەر تێبینیەکت لەسەر ئەم پرۆژەیە هەبوو، پێویستە سەرپەرشتیاری پرۆژەکە دکتۆر چارلس ئاگادار بەکەیەوە بە

هەروەها دەربارەی چۆنیەتی بەرێوەچوونی پرۆژەکە هەر تێبینیەکت هەبوو، پێویستە ئیمەیڵی: charles.mpofu@aut.ac.nz ئیتیک ئاگادار بکەیەوە بە ئیمەیڵی ethics@aut.ac.nz یان ژمارە تێلی 6038 ext 9999 921 (649+)سکرتێری جێبەجێکاری ـ

پەیوەندی بە کێ بکەم بۆ زانیاری زیاتر دەربارەی ئەم لێکۆڵینەوەیە؟

تکایە ئەم فۆڕمی زانیاری و فۆڕمی رازیبونەکە لای خۆت بپارێزە. هەروەها دەتوانی پەیوەندی بە تیمی لێکۆڵینەوە بکەی بەم شێوەی لای خوارەوە:

لێکۆڵەر: کاروان مەنگوری:

Karwan Manguri, karwan.manguri@autuni.ac.nz Phone No.: 0220705253

سەرپەرشتیاری پرۆژەکە: دکتۆر چارلس

Dr Charles Mpofu, charles.mpofu@aut.ac.nz

Appendix C *Consent Form*

1. English version:

For use when interviews are involved.

Project title: *Evaluating Health Service Users' Satisfaction with the Quality of Health Services in New Zealand: A Qualitative Study of Kurdish Immigrants*

Project Supervisor: **Dr Charles Mpofu**
Researcher: **Karwan Manguri**

○   I have read and understood the information provided about this research project in the Information Sheet dated   /   / _._

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○   I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○   I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○   I agree to take part in this research.

○   I wish to receive a summary of the research findings (please tick one): Yes○   No○

Participant's Signature : ....

Participant's Name :   ....

Participant's Contact Details (if appropriate) :

Date :
Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted *AUTEC Reference number* type the AUTEC reference number.
Note: The Participant should retain a copy of this form.

2. Kurdish version:

فۆرمی رازیبوون

ئەم فۆرمە لەکاتی چاوپێکەوتنەکان بەکاردەهێندرێت

ناونیشانی پرۆژە: هەڵسەنگاندنی رێژەی رازیبوونی بەکارهێنەرانی خزمەتگوزاری تەندروستی لە کواڵیتی خزمەتگوزاریە تەندروستیەکان لە نیوزیلاند: لێکۆڵینەوەیەک لە دۆزی کۆچبەرانی کورد.

سەرپەرشتیاری پرۆژە: دکتۆر چارلس

لێکۆڵەر: کاروان

○ ئەم فۆرمەم خوێندەوەو تێگەیشتم لە هەموو ئەو زانیاریانەی کە دەربارەی ئەم لێکۆڵینەوەیە لە فۆرمی زانیاری باسکراوە لە رۆژی:
  / / 20.
○ دەرفەتی ئەوەم هەبو کە پرسیار بکەم و وەڵامیش بدرێمەوە.
○ تێگەیشتم کە لەکاتی چاوپێکەوتنەکاندا تێبینی دەنوسرێت و تۆماردەکرێن دواتر لەسەر کۆمپیوتەر دەنوسرێن.
○ تێگەیشتم کە بەشداریکردن لەم لێکۆڵینەوەیە خۆوستانەیە (ئازادانەیە) کە دەتوانم هەرکاتێک بمەوێت بکشێمەوە بەبێ ئەوەی هیچ زەرەرم پێبگات.
○ دەزانم ئەگەر لە لەم لێکۆڵینەوەیە سەحب بکەم ئەوا بزاردەی ئەوەم دەخرێتە پێش ئەو زانیاریانەی کە پێشکەشم کردون بەکار بهێندرێن یان رەشبکرێنەوە. بەڵام کە دەرئەنجامی لێکۆڵینەوەکە دەرجون، ئەوکات ناتوانم زانیارەکانم سەحب بکەمەوە.
○ رازیم کە بەشداری بکەم لەم لێکۆڵینەوەیە.
○ حەزدەکەم کە پوختەی دەرئەنجامی لێکۆڵینەوەکە وەرگرم: بەڵێ ◯ نەخێر ◯

واژۆی بەشداربوو: ....

ناوی بەشداربوو: ....

ژمارە تەلەفۆن و ئیمەیلی بەشداربوو (ئەگەر گونجاو بوو): ....

بەروار: / / ٢٠٢.

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Appendix D *Invitation to Participate in The Research Study*

1. English version.

Project Title: Evaluating Health Service Users' Satisfaction with the Quality of Health Services in New Zealand: A Qualitative Study of Kurdish Immigrants

Invitation

I kindly invite you to take part in this research project which is about Evaluating Health Care Users' Satisfaction with the Quality of Health Care Services in New Zealand: A Mixed-methods Case Study of Kurdish Immigrants. This research might be of help to you as a Kurdish health care service user as it provides you an opportunity to express your ideas and experiences about the quality of health service delivery in New Zealand. It also will be a chance for you to identify barriers to accessing health care services and allow service providers to better plan necessary changes in the health system of New Zealand.

My name is Karwan Manguri, and I am a PhD candidate at Auckland University of Technology. Interviews with Kurdish participants will be done to collect data. My research assistant and I will be available to do interview. The research assistant will help me in offering confidence for the Kurdish participants during the interviews. A cultural advisor among the Kurdish community also offered to be available for any assistance if required. The main aim of this research is to examine the quality of health services in New Zealand from the Kurdish immigrants' point of view. The insights from this research may assist New Zealand's health policymakers to understand the needs of other immigrant populations regarding their preferences of the quality of health services. Thus, if you agree to be involved in this research, you will be invited to participate in an hour one-on-one interview to answer semi-structured open-ended questions about the quality of health services in New Zealand. I also will be available for an hour to answer your follow-up questions. Participating in this research is completely voluntary and you can withdraw at any time without explanation. You also will be able to withdraw your interview before processing. Your answers and contact details will be kept strictly confidential. The data from this study will be used in the PhD thesis and research publications and reports to the ministry of health if requested. Your name and contact details will not be mentioned in these publications. Also, the New Zealand Kurdish Community (NZKC) will not know who has participated in the research. By replying to this invitation, you show your interest in participation, but you will not be forced to take part.

The following is the inclusion criteria:
- ≥ 18 years,
- Kurdish ethnicity,
- Speaking English and/ or Kurdish,
- Has experienced health care in New Zealand within the last 10 years,
- Permanent resident of New Zealand.

For any further information, please directly contact to me at karwan.manguri@autuni.ac.nz or 0220705253.

Yours Sincerely,
Karwan, Auckland

2. Kurdish version

05/09/2021

داوەتنامەی بەشداریکردن_

ناونیشانی پرۆژە: هەڵسەنگاندنی ڕێزەی ڕازیبونی بەکارهێنەرانی خزمەت گوزاری تەندروستی لە کوالیتی خزمەت گوزاریە تەندروستیەکان لە نیوزیلاند: لێکۆڵینەوەیەک لە دۆزی کۆچبەرانی کورد.

داوەتنامە:

بەڕێزەوە داواتان لێدەکەم کە لەم پرۆژەی لێکۆڵینەوەیە بەشدارین کە تایبەتە بە هەڵسەنگاندنی کوالیتی خزمەتگوزاریە تەندروستیەکان بەگوێرەی ڕێزەی ڕازیبونی بەکارهێنەرانی خزمەت گوزاری تەندروستی لە نیوزیلاند: لێکۆڵینەوەیەک لە دۆزی کۆچبەرانی کورد. ئەم لێکۆڵینەوەیە هەڵێکە بۆتۆ وەکو بەکارهێنەرێکی خزمەتگوزاریە تەندروستیەکان بۆ دەربڕینی ڕاو بۆچون وشارەزایی خۆت دەربارەی کوالیتی خزمەتگوزریە تەندروستیەکان لە نیوزیلاند. دیسان دەبێتە چانسێک بۆئەوەی ئەو ئاستەنگانە دیاریبکەی کە دەبنە لەمپەر بۆ گەیشتن بە خزمەتگوزاریە تەندروستیەکان ودانانی پلانی باشتر بۆ گۆڕانکاری لە سیستەمی تەندروستی نیوزیلاند.

من ناوم (کاروان عەلی پیرۆت- مەنگوری) ە، کاندیدی بەدەستهێنانی بروانامەی دکتۆرام لە زانکۆی ئۆکلاند بۆ تەکنۆلۆجیا. بۆ بەدەست هێنانی زانیاری تەواو و دروست، چاوپێکەوتنی ڕووبەڕوو ئەنجام دەدەم. لە کاتی ئەنجامدانی چاوپێکەوتنەکان یاریدەدەری لێکۆڵەرەوە (لە ناو کۆچبەرانی کورد دیاری دەکرێت) ئامادە دەبێت بۆئەوەی جۆرێک لە متمانە بەخشینە کوردانی بەشداربوو. هەروەها ڕاوێژکاری کەلتوری کە ئەویش هەر لەناو کۆمیتەی کوردی دیاری دەکرێ ئەگەر پێویست بێت ئامادە دەبێت. مەبەستی سەرەکی لەم پرۆژەیە برتیە لە لێکۆڵینەوە لە کوالیتی خزمەتگوزاریە تەندروستیەکان بەپێی بیروڕای کۆچبەرانی کورد. زانیاری بەدەستهاتوو لەم لێکۆڵینەوەیە لەوانەیە هاوکاری بریار بەدەستانی تەندروستی نیوزیلاند بکات تاوەکو لە داواکاری گروپە کۆچبەرەوەک تریش لەبارەی کوالیتی خزمەتگوزاریە تەندروستیەکان تێبگەن. بۆیە ئەگەر ئامادەی لەم لێکۆڵینەوەیە بەشداربی، تۆ داوەت دەکرێ بۆ چاوپێکەوتنێک ڕووبەڕوو تا وەڵامی ژمارەیەک پرسیار بدەیەوە کە تایبەتن بە کوالیتی خزمەتگوزاری تەندروستی لە نیوزیلاند. هەروەها دوای چاوپێکەوتنەکانیش بۆ ماوەی یەک کاتژمێر ئامادەم وەڵامی پرسیاری تایبەت بە ئەنجامی بەدەستهاتوو لەم لێکۆڵینەوەیە بدەمەوە. بەشداریکردن لەم لێکۆڵینەوەیە بەتەواوی ئازادانەیە وبەشداربوو هەرکاتێک بیەوێت بەبێ هیچ ڕوونکردنەوەیەک دەتوانێت بکشێتەوە. هەروەها دەتوانێ چاوپێکەوتنەکەی بکشنێتەوە پێش ئەوەی پرۆسێس بکرێت. وەڵام و ناو و ئەدرێسی بەشداربوو پارێزراو دەبێت. زانیاری بەدەستهاتوو لەم لێکۆڵینەوەیە، بۆ بەدەستهێنانی بروانامەی دکتۆرا و بڵاوکراوە و ڕاپۆرت بۆ وەزارەتی تەندروستی نیوزیلاند بەکاردەهێندرێت. لە هیچ کام لەم ڕاپۆرت وبڵاوکراوانەدا ئاماژە بە ناو و ناونیشانی بەشداربوو ناکرێت. تەنانەت کۆمیتەی کوردی نیوزیلاند-یش نازانێت کە کێ بەشداری کردوە. بە وەڵام دانەوەی ئەم داوەتنامەیە، نیازی بەشداربوونت نیشان دەدەی بەڵام زۆربت لێناکرێت کە بەشداربی.

مەرجەکانی بەشداربوون:

A. تەمەنی ۱۸ ساڵ یان بەرەوسەرتر بێت،

B. لەنەتەوی کورد بێت،

C. زمانی کوردی یان ئینگلیزی بزانێت،

D. بۆ ماوەی ۱۰ ساڵ یان زیاتر شارەزایی هەبێت لە سیستەمی تەندروستی نیوزیلاند،

E. نیشتەجێی بەردەوامی نیوزیلاند بێت.

بۆ بەدەستهێنانی زانیاری زیاتر، تکایە ڕاستەوخۆ پەیوەندی بە من بکە لە ڕێگای karwan.manguri@autuni.ac.nz یان 0220705253.لەگەڵ ڕێزمدا.

کاروان -ئۆکلاند

Appendix E *Interview Questions*

Questions on evaluating Kurdish health care users' satisfaction with the quality of the health care services in New Zealand

1. Gender：Male □   Female □
2. Age：18-30 years □ 31-40 years □ 41-50 years □ 51-60 years □ above 61 years □
3. Education level: Junior and below □ High school and above □ Undergraduate □ Postgraduate□
4. The reasons for the visit:

Interview Questions

5. What is your recent experience with the health care services system in New Zealand?
6. Tell me about your experience with either health professionals e.g., doctors, nurses, or other health care professionals in the health care services.
7. What is your experience with management of health care providers from either reception/phone call booking to managers and other staff such as those doing handling and moving, or waiting room staff?
8. How did you find the health care provider setting in terms of:
   - environment,
   - assessment area,
   - and medical equipment, e.g., technological tools like x-rays, etc.
9. How did you find the ways of assessments and treatment in terms of:
   - medical/support staff behaviour,
   - quality of health care,
   - appropriateness of health care service,
   - confidentiality,
   - documentation
10. How did you find the evaluation of New Zealand's health care services in terms of:
    - language and interpreting services?
    - and transport and physical access?
11. How did you find health care services in terms of feeling safe and the cost of services?
12. According to your experiences, what are the barriers to accessing health care for Kurdish immigrants?
13. Tell me about your satisfaction nor dissatisfaction with health care services as a Kurdish immigrant in New Zealand.
14. How could health care services be improved?
15. Any other thing you would like to add?