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## REVIEW



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# Immigrant parents' experiences of accessing child healthcare services in a host country: A qualitative thematic synthesis

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## Abstract

**Aim:** To explore voluntary immigrant parents' experiences of child healthcare services in host countries.

**Design:** Thomas and Harden's qualitative thematic synthesis method.

**Data Sources:** Five electronic databases (CINAHL, Medline, PubMed, Psych INFO and Web of Science), were systematically searched from January 2000 - October 2018.

**Review methods:** Included studies focused on voluntary migrant/immigrant parents' experiences of child healthcare services. Data were abstracted independently by two authors. Critical Appraisal Skills Programme tools were applied, and qualitative thematic synthesis was performed.

**Findings:** Nine studies were eligible for inclusion. Five descriptive themes were identified: (a) seeking information and reassurance, (b) seeking information from "people like me", (c) comparison between child healthcare services in home and host countries, (d) effective communication, and (e) cultural isolation and perceived discrimination. Three analytical themes emerged: navigation of parenting in a health context in a new environment; trust; and balance.

**Conclusions:** Many immigrant families reported positive experiences, others felt patronized and disrespected, leading to a lack of trust and making them less willing to access universal child health care. Trusted advocates, who are culturally competent, have a role in helping immigrant parents navigate the child healthcare system and negotiate with healthcare professionals. Health registration of children of immigrants may encourage the uptake of universal healthcare services. More research is required into the specific health needs of voluntary immigrants.

**Impact:** Less is known about the experiences of voluntary immigrants than those of refugees/asylum seekers in accessing child healthcare. Navigating health systems is difficult. This can be due to language difficulties, differences in systems of healthcare, and differences in culture/health beliefs. When both parties have some understanding of the others' healthcare practices and beliefs, balance can be found; helping the families to positively compare healthcare and incentivising them to engage in universal child healthcare.

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## KEYWORDS

child health, experiences, family, immigrants, nursing, systematic review, thematic synthesis

## 1 | INTRODUCTION

According to the United Nations (2017), a person who moves from their country of birth, for a period more than 1 year, will be categorized as a long-term immigrant and the new host country will be considered as their usual place of residence. By 2017, approximately nine million, of the estimated 258 million people worldwide, living in a country other than that of their birth, were resident in the United Kingdom (United Nations, 2017). Their health and that of their children, is of ongoing concern (Abubakar et al., 2018; Johnson et al., 2004).

## 2 | BACKGROUND

Migrants are categorized into two broad groups. The first group are asylum seekers and refugees, who have left their native countries because of adverse conditions there. Refugees and asylum seekers, because of their circumstances in and indeed after, entering a new country, may expect to encounter adverse health issues and this has been the subject of significant research interest (Johnson et al., 2004; Markkula et al., 2018; O'Donnell, Higgins, Chauhan, & Mullen, 2007; WHO, 2017). The second group of migrants generally move to another country by choice, for study or work. For the purpose of this paper, we will call this latter group "immigrants" and it will not include refugees or asylum seekers. This group will be the focus of this paper. When considering healthcare experiences, it is crucial to distinguish between immigrants and asylum seekers/refugees, as they may have different citizenship rights according to their immigrant status, including the right to access healthcare services (Bloch, 2000; Hjern & Bouvier, 2004) and, therefore, may have very different experiences. As much of the published research does not differentiate between immigrants, as defined here and refugees/asylum seekers, it is difficult to know if immigrants and their children experience similar problems as refugees/asylum seekers.

## 3 | THE QUALITATIVE THEMATIC SYNTHESIS

### 3.1 | Aim

The aim was to explore the experiences of voluntary immigrant parents, accessing healthcare services for their children in a new host country.

### 3.2 | Design

A systematic search of the literature was conducted using guidance (Booth, 2016) and reported using ENTREQ guidelines

(Tong, Flemming, McInnes, Oliver, & Craig, 2012) followed by a qualitative thematic synthesis, based on the method described by Thomas and Harden (2008). Thomas and Harden's method (2008) is specifically designed to synthesize qualitative data, such as those generated from the experiences of the parents in these studies, with a view to facilitating healthcare improvements (Tong et al., 2012).

### 3.3 | Search methods

The PICO framework (Population, Phenomena of Interest, Context; The Joanna Briggs Institute, 2014 p. 12) was used to assist in structuring the review question: population, immigrant parents; phenomena of interest, parents' experiences; and context, child healthcare services in a host country. The initial search was developed using keywords and their related Medical Subject Heading (MeSH) terms. The electronic databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, PubMed, Psych INFO, and Web of Science were searched for relevant literature published between January 2000 and October 2018 (Booth, 2016). An example of the search strategies applied is provided in Appendix S1.

Studies were included if they were qualitative, published in English, in a full-text format in peer-reviewed journal between January 2000 and October 2018 and focused on migrant/immigrant parents' experiences of all types of universal child healthcare services such as health visiting, developmental assessment, or provision of additional healthcare. Included studies focused on 'migrant' and 'immigrant' parents' experiences, as, despite the definition of immigrants adopted for this review, these terms are used interchangeably in the published literature. Studies that specifically focused on refugees/asylum seeker parents' experiences were excluded. Studies that explored immigrant parents' experiences of paediatric palliative care were also excluded, as it was anticipated that these families might have very different healthcare experiences to those in receipt of 'universal' healthcare services.

### 3.4 | Search outcome

The systematic search yielded 148 studies. Retrieved studies were exported into RefWorks (ProQuest, 2015) and duplicates were removed. Two reviewers independently screened study titles and abstracts; and 44 studies were retained for full-text review. After two reviewers applied the inclusion and exclusion criteria independently, 35 studies were excluded as they focused on asylum seekers, refugees or undocumented migrants, considered service provider opinions only, or were not published in English. Eight

studies wholly met the inclusion criteria and were included in this review. One additional study (Ny, Plantin, Dejin-Karlsson, & Dykes, 2008) that did not fully meet the inclusion criteria (as they only discuss the experiences of middle eastern men during the births of their children in a host country) was nonetheless included as the research team believed that it informed the current thematic synthesis (Figure 1).

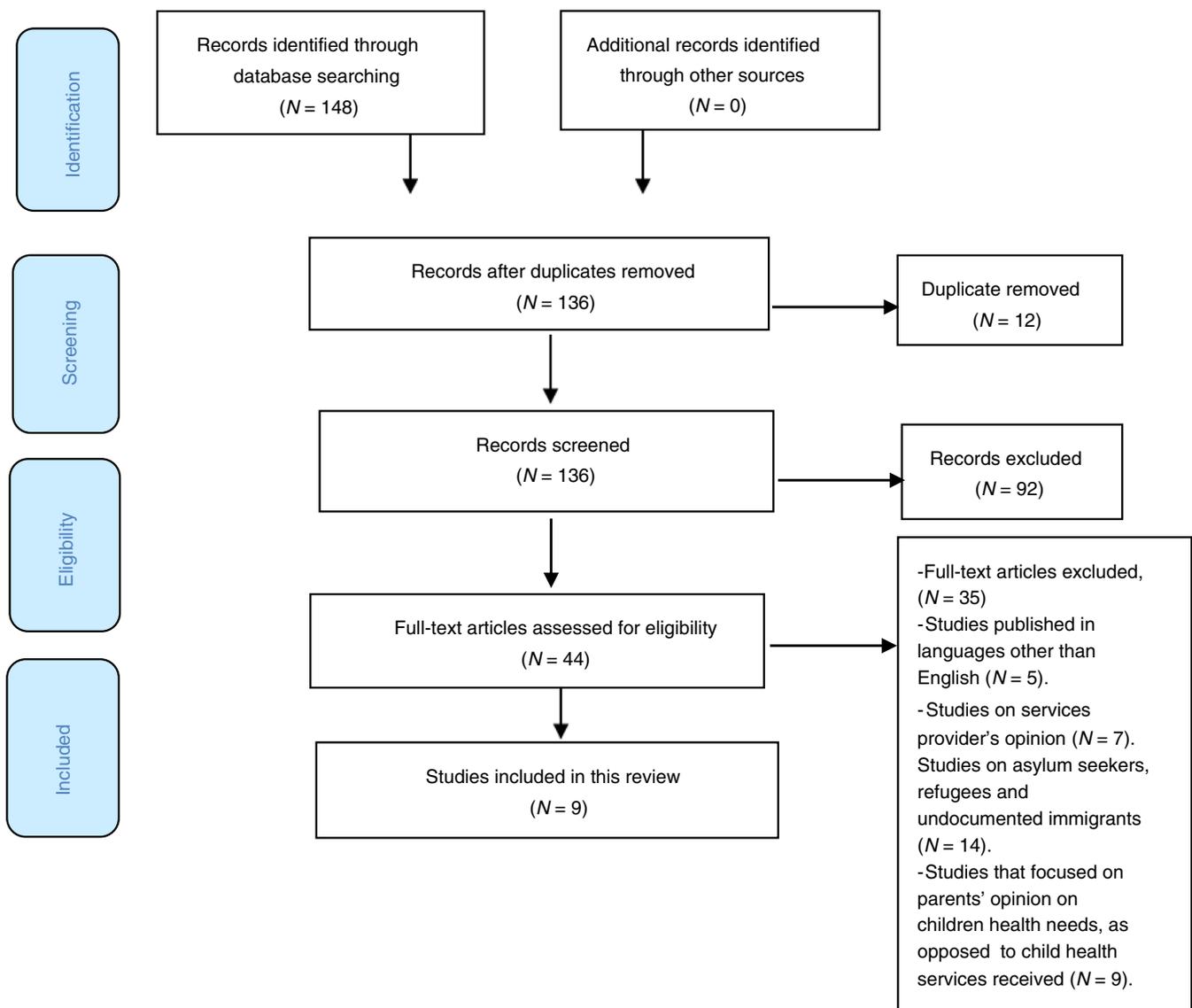
### 3.5 | Quality appraisal

Included studies ( $N = 9$ ) were scrutinized by two reviewers using the quality appraisal checklist for qualitative studies (CASP, 2016): (Appendix S1). No eligible studies were excluded as, in a qualitative thematic synthesis; all studies that inform the research question are included, regardless of quality and of their absolute adherence to the PICO (Thomas & Harden, 2008).

### 3.6 | Data abstraction and synthesis

Data abstraction was performed independently by two reviewers, using a study-specific data abstraction form, developed a priori. After piloting, the final form abstracted data relating to author, year of publication, study aim, participants, study methods and design, data collection and management, findings, strengths and limitations of each study. Any differences in interpretation between the reviewers were resolved by discussion in the research team.

The qualitative thematic synthesis method proposed by Thomas and Harden (2008) was adopted to analyse all included studies. This method involves three unique stages. Firstly, line-by-line inductive coding of the whole studies was performed using NVivo11 (QSR, 2019). Secondly, similar codes were grouped together to help create several descriptive themes. These are the first two stages of the method. The researchers ensured consistency by continually reviewing the coding process, to determine similarities and differences in codes. In the



**FIGURE 1** Prisma flow diagram: This demonstrates the steps taken during the literature search and selection process [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

final stage three reviewers analysed and synthesized each descriptive theme to answer the review question, which helped in achieving 'going beyond' the content of the original studies. By repeating this process with each descriptive theme, higher analytical themes emerged.

## 4 | FINDINGS

### 4.1 | Characteristics of included studies

Nine qualitative studies were eligible for inclusion in this review (Table 1). Participant numbers ranged from 11 – 52. Participants typically were fathers and mothers, with one study interviewing grandmothers and parents (Garg et al., 2017). One study included parents, service providers and children (Sime, 2014) and one study interviewed only fathers (Ny et al., 2008). Participants in the included studies came from a range of countries and were typically recruited through centres that serve immigrants.

The included studies were conducted in the USA, Sweden, the UK, and Australia. Studies aimed to explore or identify immigrant parents' experiences of child healthcare services, parents' experiences of primary care (Berlin, Tornkvist, & Hylander, 2010; Clark, 2002; Garg et al., 2017; Mangrio & Perrson, 2017; Ragavan, Li, Elwy, Cowden, & Bair-Merritt, 2017), parents' perspectives of healthcare for children with health needs (Son, Moring, Igdalsky, & Parish, 2018), parents' perspectives on their children's health status after immigration (Condon & McClean, 2017; Sime, 2014) or fathers' experiences of maternal and child healthcare services (Ny et al., 2008). Different data collection methods were employed: three studies used focus group interviews (Condon & McClean, 2017; Ny et al., 2008; Sime, 2014), four studies used semi-structured interviews (Berlin et al., 2010; Mangrio & Perrson, 2017; Ragavan, 2017; Son et al., 2018), one study used in-depth interviews and a focus group (Garg et al., 2017) and one study used unstructured interviews (Clark, 2002).

Following quality appraisal, no study presented enough concern for the research team to consider excluding it from the analysis. All included studies justified their chosen research methods adequately. There were minor concerns as to how the sample was recruited in three studies (Berlin et al., 2010; Ny et al., 2008; Sime, 2014); mainly as they were purposive samples but there was little information on how the participants were selected. Ny et al. (2008) report that approximately one third of participants approached did not consent to take part. This could indicate that those (Middle Eastern men discussing their partner's obstetric care) who did take part held different views on the phenomena of interest than the participants. When using focus groups there is, as always, a fear that participants would not be confident enough to express their true opinions, specifically with immigrants who may not be proficient in the language in which the focus group is conducted. However, all studies were conducted by experienced research teams.

Some researchers choose to recruit only participants who spoke the language of the host country (Mangrio & Perrson,

2017) whereas others used translators who spoke the native language of the participants (Garg et al., 2017); either scenario is likely to have presented some difficulty during focus group discussions. Sime (2014) chose to look at the families' experiences through the eyes of the children rather than their parents, but they justified their decision and methods well. All included studies gave a good or adequate description of their data collection and analysis and presented their results in an understandable way. A summary of the quality appraisal of each study is presented in Appendix S2.

### 4.2 | Descriptive themes

Five descriptive themes were identified from codes generated following line-by-line analysis of the included studies. These themes are discussed in detail in the following sections:

#### 4.2.1 | Descriptive theme 1: Seeking information and reassurance that child health and development is on track

The need for reassurance about child development was found to contribute to parents' willingness to search for information and to use child healthcare services (Garg et al., 2017; Ragavan, 2017; Son et al., 2018). Garg et al. (2017) demonstrated that parents access child healthcare services to understand if the development of their children is normal or abnormal:

*just to know that they're on track, they're going the right way. (Garg et al., 2017, p. 5)*

Parents believed determining that their child's development was on track, at an early age, would prevent their child from experiencing future health issues and help parents to address their child's development needs:

*It's a good thing...it shows the baby's development—their weight, their length... (Garg et al., 2017, p. 6)*

Most parents believed that child health assessment would give them the opportunity to obtain more information about their child's development and help prevent any health-related problems in the future. However, several parents believed that healthcare experiences had not met their prior expectations and believed that assessments were "too simple":

*The routine check-up here is too casual. ...Very careless. In China, visits include a lot of examinations and doctors provide detailed explanations on everything. But here, they only check your weight [and] height. (Ragavan et al., 2017, p. 3)*

**TABLE 1** Characteristics of included studies

Author(s), Year Country	Study aim	Study design	Study sample characteristics	Data collection methods
Clark, 2002 USA	To explore Mexican-origin mothers' experiences with children's healthcare services.	Qualitative study Ethnographic method	<ul style="list-style-type: none"> <li>- Immigrant mothers who were (Hispanics, Mexican Americans, or Latinas) aged 19–35 years old,</li> <li>- Most participants were educated.</li> <li>- Income: lower and middle- income status.</li> <li>- A year living in the country: not reported.</li> <li>- Half of the participants were first generation immigrant; the other half was up to 6th generation but considered themselves ethnically Mexican or Latino.</li> </ul>	Standard ethnographic method, unstructured interviews
Ny et al., 2008 Sweden	To describe how men from the Middle East experience maternity, child health care and becoming a father in Sweden.	Qualitative study	<ul style="list-style-type: none"> <li>- 16 Middle Eastern immigrant fathers.</li> <li>- Level of education: three participants with a university degree and six currently in employment.</li> <li>- Income: not reported</li> <li>- Years living in the country 1–3 years.</li> </ul>	Focus-group and individual interviews
Berlin et al., 2010 Sweden	The aim of the study was to construct a theoretical model that could promote further understanding of the variety of experiences of parents of foreign origin regarding their interaction with the PCHC nurses at PCHC services.	Qualitative study Grounded theory methodology	<ul style="list-style-type: none"> <li>- 21 immigrant parents from Africa, the Middle East and South Europe</li> <li>- Level of education not reported</li> <li>- Income: not reported</li> <li>- Years living in the country: 1–22 years.</li> </ul>	Interview
Sime, 2014 UK-Scotland	To examine the lived experiences of migrant children and their parents post-migration, including their views of statutory health provision	Qualitative study	<ul style="list-style-type: none"> <li>- 57 immigrant children with parents from (Bulgaria, Czech, Poland, Romania, Lithuania and Slovak).</li> <li>- Level of education: not reported.</li> <li>- Income: not reported.</li> <li>- Years living in the country: not reported.</li> </ul>	Focus group and family case study.
Mangrio and Perrson, 2017 Sweden	To explore non-European immigrants parents' experiences with Sweden's Child Health Care system.	Qualitative study	<ul style="list-style-type: none"> <li>- 19 immigrant parents from (Afghanistan, Chile, India, Iraq, Kurdistan, Kuwait, Lebanon, Pakistan, Palestine, Venezuela, Vietnam.</li> <li>- Level of education: not reported</li> <li>- Income: not reported</li> <li>- Years living in the country: not reported.</li> </ul>	Parents interviews.
Ragavan et al., 2017 USA	To explore Asian immigrant parents' view of well-child visits experiences	Qualitative study	<ul style="list-style-type: none"> <li>- 51 immigrant parents from China, Vietnam, and India</li> <li>- Age of participants: 18–55 years old.</li> <li>- Level of education: most of the participants were educated.</li> <li>- Income: parents were employed.</li> <li>- years living in the country:1–22 years old.</li> </ul>	Semi-structured interviews.
Garg et al., 2017 Australia	To describe and explain parental experiences for accessing developmental surveillance and anticipatory guidance for children	Qualitative study	<ul style="list-style-type: none"> <li>- 39 immigrant parents and 1 grandparent from Vietnam, England, Afghanistan, Peru, Philippines, Australia, Cambodia, Iraq, India, Brazil, Middle East (Arabic speaker) and Caucasian</li> <li>- Level of education: Different levels of education from primary school, UG degree, PG degree.</li> <li>- Income: not reported</li> <li>- Years living in the country: 6–35 years.</li> </ul>	Focus groups and in-depth semi-structured interviews
Condon and McClean, 2017 UK	To explore parents' views on maintaining children's health following migration	Qualitative study	<ul style="list-style-type: none"> <li>- 28 immigrant parents from (Romania, Roma, Somali, Poland, Pakistan).</li> <li>- level of education: most of the parents were educated.</li> <li>- Income: Low income as most parents were unemployed, mothers at home and student.</li> <li>- Years living in the country: 10 years.</li> </ul>	Focus group

(Continues)

TABLE 1 (Continued)

Author(s), Year Country	Study aim	Study design	Study sample characteristics	Data collection methods
Son, 2018 USA	To explore how Asian immigrant parents of CSHCNs view their child's health-care access, quality, and utilization	Qualitative study	<ul style="list-style-type: none"> <li>- 22 Asian families (Vietnam and China) with children of special needs.</li> <li>- Level of education: Participants have a different level of education</li> <li>- Income: low income</li> <li>- Years living in the country: 4 and 34 years, with a median duration of residency of 14 years.</li> </ul>	Semi-structured interviews

#### 4.2.2 | Descriptive theme 2: Seeking information and reassurance from “people like me” about child healthcare and development

The desire of parents to seek information and reassurance outside child healthcare services was clearly identified in several included studies (Garg et al., 2017; Sime, 2014; Son et al., 2018). A lack of information and guidance about child healthcare services and being unfamiliar with healthcare services in a new country, motivated parents to obtain information from other sources. These sources included members of the local community, parents who had a child with a similar health condition, their spouse, or older relatives inside the family (Garg et al., 2017; Sime, 2014; Son et al., 2018). For example, Son et al. (2018) found that parents obtained information from other parents whose child had similar health issues, shared experiences, and associated complexities:

*It's even more difficult when we need to find ways to help our children. Therefore, we as parents rely on help from each other. (Son et al., 2018, p. 11)*

Parents were willing to share their experiences in their cultural communities and in communities formed by families experiencing a similar health issue (Garg et al., 2017; Son et al., 2018). Son et al. (2018) found that when parents of children with special needs became familiar with services, they quickly accepted that some familiar healthcare professionals have the ability to support and direct them in caring for their children:

*when they do check my son who has special needs like this they can at least recommend or refer me to specialists instead so that I can be more aware.*

*(Son et al., 2018, p. 9)*

Immigrant parents used a variety of relationships to find out what help was available:

*Mostly the parents of special education (children) tell each other what is good for the children. We are like a sorority... We communicate with each other. If there is any entertainment for the children, we take our children*

*and go together to help them. Besides, the Chinese community is not big and only in [major city]. Therefore, we rely on the support from each other and the friendship among us.*

*(Son et al., 2018, p. 11)*

#### 4.2.3 | Descriptive theme 3: Comparison between child healthcare services in the home and host countries

Using child healthcare services in a new country can produce a sense of uncertainty for parents. Review findings suggested that parents compared new exposure to child healthcare services with prior experiences of similar services in their home country (Mangrio & Perrson, 2017; Ragavan et al., 2017; Sime, 2014; Son et al., 2018). This process of comparison may lead to either positive or negative evaluations of the current experience of using child healthcare services. Mangrio and Perrson (2017) found that non-European parents preferred services offered in the new host country, as they felt that these new services were of higher quality with free and equal access to child healthcare services, which was not available in their home country:

*In Sweden, it is not like in our home country. It is not unpleasant and terrible like it is in my home country... In my home country, the health care you get depends on money and which doctor you have and if you are poor you don't get the same treatment as the rest. It is better for my children to grow up here. (Mangrio & Perrson, 2017, p. 4)*

Son et al. (2018) reported that parents of children with additional needs, while appreciating free access to specific healthcare services, were disappointed with the long waiting time to obtain the insurance required to permit free healthcare access for their child:

*It (the wait) was a big problem... we had to wait for a long time, almost half a year. Waiting is an issue. When we first noticed [child's] problem, he was 20 months old. Because of the very long wait, we applied (for services)*

*as soon as possible. For autism, you need to treat and intervene as early as possible to be effective. The sooner the better. Therefore, this is a problem here we waited half a year.*

(Son et al., 2018, p. 8)

Sime (2014) reported an unusual situation where the host country was a short and inexpensive journey away from the immigrants' home and they had full right of access to healthcare in both countries, as citizens of the European Union. This allowed the choice of having free health services in the host country for which they might have to wait, or a flight home and possibly paying for quicker treatment. They made this choice depending on the perceived urgency of the child's condition, the potential cost of the treatment at home and their own perceptions of the relative merits of the treatment on offer, often depending on the recommendations of friends:

*Well, in Bulgaria it's organized better because you can get access to a specialist quicker – almost the next day. The bad thing in Bulgaria is that there is a big mixture between things you pay for. And here [in the UK] you don't pay for things, but it's difficult to get an appointment and you wait a long time. (Sime, 2014, p. 89)*

When parents did not have the luxury of travel to their home they sometimes viewed the treatment offered in the host country as inferior:

*Mexican doctors give injections to stop diarrhoea quickly, but here, they do not give injections. (Clark, 2002, p. 169)*

In her discussion, Clark (2002) recognized that withholding antibiotic injections for gastroenteritis is evidence based, but this does not alleviate the parents' and their community's belief that "injections" are a gold standard treatment which the host country denies them.

#### 4.2.4 | Descriptive theme 4: Effective communications

Communication was a recurring and important concept in the literature reviewed. Limited communications with and in child healthcare services acts as a barrier to service use and can lead to health disparities (Berlin et al., 2010; Clark, 2002; Garg et al., 2017; Mangrio & Perrson, 2017; Son et al., 2018).

Language issues were the most common barrier which influenced participants and healthcare staff communications and interactions (Berlin et al., 2010; Clark, 2002; Garg et al., 2017; Son et al., 2018), but that was seldom the whole problem. Limited communications with healthcare professionals may make parents feel uncertain and can result in reluctance in parents to ask important health-related questions:

*It gets complicated for us if nobody really tells us. I should ask him; how far can I go with my questions to you? Should I do that? (Berlin et al., 2010, p. 6)*

Unfamiliarity with medical terminology can also limit parents' understanding of their child's healthcare issues and requirements and can limit parent and staff communications. Participants reported that even with a good understanding of English, they require clear information which avoids medical jargon:

*In fact, the doctor has never confirmed to me that he's autistic. They use some medical terms. I didn't know whether he has autism or Asperger's syndrome, not until I received his IEP (individualized education plan, prepared independently of medical staff by the school system). Not until I received his IEP evaluation report in Chinese when he was in seventh grade... I found out he's autistic. (Son et al., 2018, p. 13)*

When interpreters are employed Son et al., (2018) demonstrated that participants are afraid of misinterpretation, particularly when they understand a little English. This may create a barrier to future communication and have negative implications for future access to child healthcare services:

*I do understand a bit of English. But sometimes the interpreter doesn't interpret correctly what the doctor is saying, so then I become disappointed so then I don't want them. (Son et al., 2018, p. 13)*

Although this is not always the case:

*My wife gets a translator as soon as I am working and through that way she gets a lot of information and understands. (Mangrio & Perrson, 2017, p. 5)*

Sharing information and participating in direct conversations with staff, while asking specific questions is crucial for parents. Berlin et al., (2010) reported that parents were anxious about the nurses' motives, especially when the nurse asks what they judge as "pointless questions":

*They can't just ask; they have to tell us more about why they are asking questions like this... (Berlin et al., 2010, p. 5)*

This can be compounded when the parent feels that the healthcare professional is displaying body language which is condescending or judgemental and it is often through non-verbal cues that effective communication is blocked:

*If the PCHC nurse is negative, you feel unwilling instead of wanting to learn, you feel much more ashamed and feel, OK, well, if we go back it'll be the same... that's what*

they (PCHC nurses) think about us. (Berlin et al., 2010, p. 7)

#### 4.2.5 | Descriptive theme 5: Cultural isolation and perceived discrimination

Differences in cultural beliefs, staff behaviours, and previous experiences may lead to cultural isolation and parents perceiving that staff has discriminated against them. Immigrant parents preferred to consult with healthcare professionals who they judged to be culturally competent in terms of language, ethnicity, and beliefs:

*Why did I choose a Vietnamese doctor. ... Of course, the language. ... The second thing is the culture. There are some foods that only Vietnamese feed their children. I don't know if the American doctor understands. (Ragavan et al., 2017, p. 5)*

Discrimination may be overt and unexplained:

*I dislike [major urban medical centre] very much. There is open discrimination by the doctor. I'm not sure whether it is against the Chinese or (my) child's autism. It's blunt and lets you feel it. (Son et al., 2018, p. 11)*

Or it may stem from a lack of understanding of the immigrants' cultural norms and healthcare beliefs:

*Children's doctors should go through training where they learn about the culture, the most common diseases in India, what comes in our genes and blood, what is our average height and what kind of preventive things we do. (Ragavan et al., 2017, p. 5)*

Parents felt that nurses sometimes questioned their parenting skills and did not respect them:

*Some things feel like, yes but I already know this and when they sit and tell you, it makes you feel that they think we don't know anything and we know quite a lot... Unfortunately, this is what they think! (Berlin et al., 2010, p. 5)*

In addition, differences in clothing associated with various ethnic and immigrant populations were linked to cultural barriers which also created feelings of perceived discrimination:

*because of my outfit or because of my scarf (Garg et al., 2017, p. 7)*

but actual and perceived discrimination was often multifactorial and was a theme that ran through much of the reviewed literature:

*Mexican immigrant women faced more access barriers—such as the inability to drive, lack of familiarity with the healthcare system, language discrepancies, and perceived discrimination in services. (Clark, 2002, p. 173)*

#### 4.3 | Analytical themes

Generating analytical themes is dependent on the insight and judgement of the reviewers (Thomas & Harden, 2008). One member of this review team is an immigrant mother of young children living in the UK while another has experience of living abroad with a young family. Three of the authors bring experience as healthcare providers to their interpretation of the descriptive themes.

##### 4.3.1 | Analytical theme one: Navigation

Napier et al. (2014) denied that a conflict between the objectivity of science and the subjectivity of culture is where systems of belief around health and well-being are constructed. They describe diversity between and in cultures from which health related values are formed and these values are constantly changing in response to new experiences. Also, the actual journey made by immigrants to a host country there is a metaphorical journey. Although some of those who migrate to high income countries may be motivated by economic reasons (Atoyán et al., 2016), it is a journey made by choice and, to some extent, planned. In most cases, this planning included purchasing health insurance or paying the equivalent of the UK's Immigration Healthcare Surcharge which enables immigrants to have "free" access to GP and hospital services during the time covered by their visa (Jayaweera & Quigley, 2010). Although this major purchase is often a compulsory part of the immigration plan, it does not always come with a set of understandable instructions, this being even worse for those who enter a new country with the right to use healthcare facilities and so would have even less chance of being offered an orientation. Even UK "resident" parents who are given a Personal Child Health Record, popularly known as the "red book" (RCPCH, 2019) to guide them through their child's normal developmental checks and in spite of a lifetime's experience of the local healthcare system, are often confused when something unexpected, like an acute illness for their child, happens (Neill, Jones, Lakhanpaul, Roland, & Thompson, 2016).

Studies indicated that immigrant parents, trying to navigate an unfamiliar healthcare system for their child or children, which bears little resemblance to what they are used to seeing, met many obstacles. Language was the most obvious barrier, with even the inability to read directional signs in a hospital or health centre potentially causing extra stress and affecting the confidence of the traveller; before they even meet a healthcare professional who may speak a form of jargon which is difficult to those who are fluent in the language to understand. They were attempting to navigate if not in total darkness, at least in a heavy fog.

### 4.3.2 | Analytical theme two: Trust

When we do not know the way and cannot read the map or chart easily because all the symbols are unfamiliar, we ask people who we think would teach us how to find an efficient and safe route. Learning from other people requires questioning not only the other person's knowledge, but also their intent: and only when both are considered trustworthy will we trust their advice (Landrum, Eaves, & Shafto, 2015). Immigrant parents sought advice, including advice on when it was appropriate to involve healthcare professionals, from family, from their immigrant communities and from parents of children with similar conditions, that is, from people they identified with and whom they trusted.

The synthesized studies of parents revealed that parents not only mistrust healthcare professionals who they suspect of overt discrimination, but also those who are rude or disrespectful, who do not use engaging body language and who do not understand their health beliefs and normal child rearing practices. Napier et al., (2014) recommend that: "building of trust in health care should be prioritized as a cultural value". This involves developing "cultural competence" (Shen, 2015): "a set of congruent behaviours, attitudes, and policies that come together within a system, agency, or among professionals, which enables effective work in cross-cultural situations" (Cross, 1989).

### 4.3.3 | Analytical theme three: Balance

Through promoting cultural competence, healthcare systems should come to accommodate and promote the "cultural construction of well-being" (Napier et al., 2014); but this construction is constantly evolving, in both host communities and immigrant sub-cultures. Immigrant parents, like all parents, are constantly re-evaluating their beliefs around health in the light of exposure to new information, some of which is scientifically based and some of which is learned from "people who they trust". People they trust are usually people from their own culture, as an immigrant and/ or as a parent, but it may also be a scientist or a healthcare professional. Finding a balance between beliefs held and new evidence offered is more difficult in an unfamiliar culture and may be facilitated if bespoke guidance is available to those both using and providing healthcare (Abubakar et al., 2018). There is a need for more than linguistic translation, the accuracy of which has been questioned by immigrants as their language skills improve, but the translation of health philosophies and theories, which should enable two way understanding. There is an established association between higher levels of health literacy, service use and positive health outcomes, with health literacy, in turn associated with good linguistic skills and educational attainment (Sentell & Braun, 2012) Health literacy cannot be seen as a tool to increase compliance, but must be used for patient/family empowerment (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016).

## 5 | DISCUSSION

### 5.1 | Strengths and limitations of this qualitative thematic synthesis

A strength of this review is that the expert research team also have experience of providing healthcare to immigrant families; and of parenting as immigrants in a host country. The homogeneity of the qualitative method allowing synthesis of the data was robust but a weakness may be that among the diverse populations in the literature there were immigrants with long exposure to host healthcare and with different immigration status – they may not all have truly represented our population of interest.

### 5.2 | Confidence in the findings

The researchers who carried out the studies informing this thematic synthesis faced problems in recruiting participants who truly represented the immigrant communities in the host countries, in communicating with the participants and in designing methods that would accurately answer the questions asked. It is both surprising and gratifying to find that there was so much agreement in the descriptive themes generated; and that diverse cultures contributed to the analytical themes. Although there is, as always, a fear that the immigrant families who did not participate faced different challenges than those who did, there is little to suggest that the research on which this synthesis relies was not well-conducted and that it is not well-summarized in this review (Lewin et al., 2018). Consequently, this qualitative thematic synthesis has several important implications for childcare practice, policy, and research.

### 5.3 | Recommendations

At the practice level we suggest that trained cultural advocates; credible, trustworthy people, who immigrant parents can identify with and who are trained in cultural competence, should be employed in child healthcare services to help parents and healthcare staff address cultural expectations, explain local policies, procedures and services and ensure that information is adequately understood by parents. Advocates would support the delivery of high-quality care to children and their parents.

At a policy level, mandatory registration with healthcare services for children of new immigrants would ensure not only that standard checks and vaccinations are offered to this population, but that the healthcare professionals and advocates know of their existence. It would mean that some help may be available to navigate through the new and potentially confusing healthcare system.

It is important that future research differentiate immigrant parents' experiences according to their immigration type. As a group, voluntary immigrants are different from refugees/ asylum

seekers. Understandably, they receive less support than immigrants/asylum seekers on entering the country, but their children's health is still likely to suffer if they struggle to access universal healthcare services. A better understanding of the problems that voluntary immigrants encounter and the solutions they identify is needed.

## 6 | CONCLUSIONS

This study has synthesized research on large group of immigrants, those who migrate by choice. However, the benefit of this synthesis has been a crystallization of the challenges that even people who choose to migrate to a new country of their choice experience while accessing child healthcare services. This will help ensure that health provision and ultimately health outcomes are equitable for native and immigrant children, regardless of their immigrant status and length of their stay in a host country.

## CONFLICT OF INTEREST

The authors have declared no conflict of interest.

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