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Factors Contributing to Delays in Health-Seeking Behaviours Among Pakistani Communities in Sunderland

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Abstract

Background: Health inequalities persist among UK ethnic minorities, with Pakistani communities experiencing pronounced delays in health-seeking behaviour (HSB), leading to poorer outcomes. Even though national studies have highlighted broad barriers for Black, Asian, and Minority Ethnic (BAME) groups, there is a critical lack of nuanced, qualitative research that focuses on specific subgroups, specifically the Pakistani community, in understudied, high-deprivation contexts like Sunderland. This study aimed to explore the cultural, social, and structural factors contributing to delays in health-seeking behaviour among adults within the Pakistani community in Sunderland, UK.

Methods: A qualitative, interpretivist phenomenological design was employed. Semi-structured interviews were conducted with Pakistani community aged 24-50, including healthcare professionals. Data were analysed using Braun and Clarke's reflexive thematic analysis facilitated by NVivo software.

Results: Three key themes were identified: (1) Navigating the Healthcare System, where complexities, digital exclusion, and nuanced communication barriers (medical jargon, accents) impeded access; (2) Generational Tensions, revealing a divide between traditional, fatalistic health beliefs in older generations and more proactive, health-literate attitudes in young generation, especially UK-raised youth; and (3) Systemic Delays and Trust Erosion, where pervasive NHS waiting times, perceived discrimination, and dismissive care experiences fostered distrust and led to medical tourism.

Recommendations: Incorporate co-designed Health System Navigators into high-need GP practices. Ensure communication is accessible by using multilingual and plain English and provide staff training focused on cultural safety and clear speech to minimize jargon and accent barriers.

Conclusion: Delays in health-seeking behaviour are a rational response to overlapping cultural practises and systems failure, and not patient choice. The erosion of trust is a vital consequence.

Keywords: Health Inequalities, Pakistani Community, Health-Seeking Behaviour, Healthcare Access, Health Literacy

Introduction

Health-seeking behaviour is a central concept in public health, encompassing a complex decision-making process shaped by individual, societal, and healthcare system factors [1]. It is conceptually separated into illness behaviour (actions taken before diagnosis) and sick role behaviour (actions after the diagnosis) [2]. Early access to health services plays a vital role in disease prevention and early intervention, but large disparities exist worldwide and within the UK, especially among ethnic minority groups [3, 4, 5]. Only about 56 percent of non-communicable disease adults worldwide access formal care and demonstrating huge disparities in early diagnosis and treatment [6].

In the UK, although the National Health Service (NHS) has committed itself to providing universal care, ethnic health inequalities are well-documented. Pakistani, Bangladeshi, and Black Caribbean communities and others report worse health outcomes at younger ages than the White British population [7, 8]. As an example, South Asian women are more likely to die during childbirth, in part because of insufficient use of services, and South Asian patients with inflammatory bowel disease experience delays in specialist referrals [9, 10]. These inequalities are worsened in areas such as the Northeast of England, which has the lowest life expectancy and the largest within-region health gaps in the country [8]. This context highlights that health-seeking behaviour is not merely a personal choice, but it is a dynamically developing process due to the interaction of personal perception, social-cultural norms, and systemic accessibility [11]. The research attempts to investigate this complex interplay, specifically among the Pakistani community in Sunderland, a group that is still facing a lag in receiving timely medical care [12].

Regardless of the consistent evidence of ethnic health disparities, there are still significant gaps. Qualitative, community-specific studies on the Pakistani community in Northeast England are limited. Numerous studies do not provide disaggregated data and conceal community-specific issues, and not many studies relate local service design to the lived experiences of patients. In addition, medical experts tend to refer to cultural aspects as the main causes of delays, a framing that may ignore structural failures such as poor interpretation services, inflexible procedures, and unconscious bias [17, 18].This study aimed to explore the social, cultural, and system-level factors that contribute to delays in health-seeking among Pakistani adults in Sunderland.

Method

The qualitative methodology with a phenomenological design was utilised [18, 19]. This methodology is concerned with the in-depth examination of human lived experience and is best suited to examine the underlying causes of delays through the insider perspective of those who have encountered them [19, 20]. It acknowledges various subjective realities, which is critical when exploring a phenomenon that is driven by different cultural beliefs and systemic barriers [21]. Although producing rich, in-depth data that is time-consuming to analyse, this trade-off was considered as a requirement of the depth of understanding needed [22].

Data Collection

Semi-structured interviews were chosen as the primary data collection method; as a powerful tool for investigating individual perspectives, beliefs, and lived experience [23, 24]. The interview guide was created in a cyclic process that included a literature review and discussion with the supervisor. It encompassed seven main areas: understanding of healthcare/illness, cultural/religious influences, language/communication, trust/past experiences, structural barriers, health-seeking patterns, and suggestions for improvement [25].

One eligible person piloted the guide to test clarity, flow, and duration, resulting in a refinement in terminology [26] Interviews were conducted in Sunderland, which is a relevant context as it has a large population of South Asian residents and recorded health inequities [27]. Locations encompass private rooms in community venues or online via Google Meet, as per participant preference.

Sampling and Participants

A combination of purposive and snowball sampling was used to recruit participants [28, 29]. Purposive sampling was used deliberately identify individuals who had firsthand experience of delays, whereas snowball sampling was used for assessing hard-to-reach participants via referral [29].

Inclusion criteria were adults aged ≥18, self-identifying as Pakistani heritage, Sunderland residents for ≥1-year, English proficiency, and personal experience/observation of healthcare delays. Exclusion criteria were age <18, non-Pakistani heritage/nationality, non-residence in Sunderland, non-English speakers, and no experience of the phenomenon.

Recruitment entailed the use of posters through community centres, mosques and social media. Nine participants (3 female, 6 males; age 24-50; a combination of healthcare professionals and community members) were recruited with informed consent. The sample size was decided by the principle of data saturation, which occurred after Nine interviews, since no new themes were introduced.

Ethical Considerations

Ethical approval was obtained from the University of Sunderland Ethics Committee. To ensure anonymity, participants were assigned pseudonyms, and all identifiers were removed from transcripts. Signed consent forms, audio files, and transcripts are stored in the encrypted, password-protected OneDrive of the university in accordance with the UK Data Protection Act 2018 and will be safely deleted upon project completion [30]. Each interview was followed by a debriefing session to resolve any potential distress.

Data Analysis

Data were analysed using Braun and Clarke's framework for reflexive thematic analysis, a systematic yet flexible method for identifying and interpreting patterns [31]. The data were managed and organized with NVivo software assisting in a rigorous and transparent analytical process [31, 32].

It was analysed using an iterative six-phase methodology of Brun and Clark that included familiarisation with the data, systematic coding, generating initial themes, reviewing and developing themes, refining and defining themes, and report production [32, 33] NVivo was used to enable coding, retrieval, and relationship exploration between codes and themes, where all analytic decisions were made by the researcher [33, 34].

Results

Results of the semi-structured interviews on factors contributing to delayed health-seeking among Pakistani adults in Sunderland. The analysis discovered three key themes: 1) Navigating the Healthcare System: Literacy, Language, and Communication; 2) Generational Tensions in Cultural Norms, Beliefs, and Stigma; 3) Systemic Delays, Trust Erosion, and Medical Tourism.

Participant Demographics

Nine participants (3 female, 6 male), aged 24-50, were interviewed. The sample included UK-born and Pakistan-born individuals, as well as healthcare professionals. All are referred to by pseudonyms (P1-P9).

Table 1: Participant Demographics

Participant ID	Age	Gender	Ethnicity	Profession
P1	24	Male	Pakistani	Anaesthetist
P2	29	Male	Pakistani	Student
P3	50	Male	British Pakistani	Nurse
P4	35	Female	British Pakistani	Pharmacist
P5	27	Female	Pakistani	Engineer Designer
P6	45	Female	British Pakistani	Self Employed
P7	39	Male	Pakistani	Doctor
P8	38	Male	Pakistani	Student
P9	50	Male	British Pakistani	IT

Visualizing the Data: Insights from an NVivo Word Cloud

A word cloud generated from interview transcripts highlighted frequent terms: "understand," "health system," "family," "help," "urgent," "time," "appointment," "long," and "community." This provided preliminary validation of the key themes: struggles with system navigation, the central role of family, and the barrier of waiting times.

Theme 1: Navigating the Healthcare System: Literacy, Language, and Communication

This theme underscores the barriers that participants encounter in learning and accessing the NHS, which tend to frustrate individuals and make them unwilling to pursue care. The challenges differ drastically from the more direct pathways in Pakistan, where patients are not required to have a GP referral to see specialists.

Sub-theme 1.1: Limited System Literacy:

There was confusion among newcomers and those without prior medical knowledge regarding the GP-led system, referral processes, registration procedures, and the responsibilities of various services, including A&E and specialists. Frustration, helplessness, and delayed engagement with healthcare are frequently the result of this lack of system literacy.

Participants reflected on these difficulties:

> *P1: "Like my cousin, who aren't very familiar with the healthcare system, it's really difficult for a common person to understand, especially the referral process from GP to hospital."*
> *P9: "My friend in Sunderland tried to book a GP appointment but didn't know what to do: how to access the GP, what they would ask, or what he should ask. There's a lack of awareness about how to use the system and benefit from it."*
> *P5: "Many Pakistani residents are challenged in understanding how the healthcare systems work, such as knowing where the service is appropriate for their needs and how to navigate the referral between GP and specialist."*

Participants highlighted the key difference between the health systems in the UK and Pakistan: in Pakistan, people go directly to specialists without seeing a general practitioner (GP) first. Furthermore, British Pakistanis who have lived in the UK for a long time find it easier to navigate the healthcare system, while newcomers often struggle to understand how it works.

> *P4: "Things are getting better every day. Most services have moved online. For example, some of my friends' surgeries are online: in the morning, they submit the form, and someone calls them back. maybe because new people, when new immigrants came here to the UK, faced this problem."*

Sub-theme 1.2: The Digital Divide and Administrative Hurdles:

The shift to a digital-first strategy, including online forms and applications, has become a significant barrier. Participants observed that this model presupposes a given level of digital literacy and familiarity with formal, and, in many cases, complicated, English language questionnaires. Such an assumption may cause disconnection in individuals accustomed to closer or more immediate means of access.

> *P2: "Because we're not used to booking appointments via apps or online forms, it feels different. There are many questions, and not everyone has a healthcare background, so many people don't understand the process... In Pakistan, you typically go straight to your doctor or the emergency department, pay the fee, and get seen, no forms required."*

Sub-theme 1.3: Linguistic and Accent Barriers Beyond Basic Language:

Participants generally reported that basic language difficulties were mitigated through family support or formal interpretation services. Many felt that communication was manageable with the help of relatives or professional interpreters when available:

> *P6: "Language, no, I don't think so. Even if someone here doesn't speak English, they usually have someone at home... they can easily ask for a translator... It's not a big issue nowadays."*
> *P3: "There are language barriers... but there are still options available. They call the interpreter... sometimes the relatives go with the patient... So there is always somebody around to translate... generally it's not a problem."*

However, the reliance on both informal and formal translation solutions is not always seamless. Significant issues arise regarding the availability and awareness of professional services. Participants reported firsthand experiences highlighting this challenge, stating that:

> *P7: "It is a big problem, and translators are not always available. So, when my parents visited me, I was a translator for them."*
> *P5: "Professional translation services are available, but not everyone knows how to request them. And they are not always provided quickly."*

This systemic unreliability is particularly consequential in discussions of sensitive health conditions, discouraging care-seeking; when family members serve as interpreters, many patients feel inhibited from communicating openly with clinicians.

> *P8: "In some cases, people avoid going to the doctor because they do not want to share personal health matters with family members."*

Although the inability to speak English fully was proven to be less prevalent, the participants pointed at more subtle barriers to communication. These were issues of decoding strong local accents and fast speech among the healthcare staff and medical jargon (particularly with non-doctor staff). The above barriers represent a form of knowing and not translating and are upheld even in individuals who possess workable English.

> *P1: "I've seen doctors who are communicating in a very clear and simple language."*
> *"I have seen the nurses, and especially the health care assistant; they use the very strict British accent, which is very difficult to understand. So, I think there is no language barrier, but the accent barrier is there. They use very jargon words..."*
> *P8: "It is challenging for many in my community: medical letters, prescriptions, and doctor instructions are often written in formal English that is hard to understand. For those who don't read or speak English well, this creates confusion and sometimes results in missed appointments or incorrect use of medications."*

Theme 2: Generational Tensions in Cultural Norms, Beliefs, and Stigma

This theme brings out a distinct generation gap in cultural attitudes that determine health-seeking behaviour. The elderly community is more likely to adhere to the old norms, fatalism, and avoidance of services due to stigma, whereas the younger ones are more likely to be health literate, open, and interested in formal care. All these opposing opinions are core to the realisation of delays in accessing healthcare on a community-wide level.

Sub-theme 2.1: Persistent Traditional Practices and Fatalism in the Older Generation:

Older Pakistani first-generation people tend to stick to self-treatment, herbal medicine, and a fatalist perception of illness. The beliefs discourage early access to healthcare and normalise late help-seeking:

> *P4: "Asian community, many would rather not take medication, saying, 'What's going to happen will happen,' and that treatment won't change the outcome."*
> *P3: "The old people...go for the like herbal remedies or local remedies, traditional remedies thing. They try those first."*
> *P6: "I think Pakistani nature is like they will try to sort their health themselves. They will try whatever they know on themselves."*

Sub-theme 2.2: The Younger Generation: Navigating Between Two Worlds:

Younger, particularly UK-raised Pakistanis, show markedly different behaviours, characterised by stronger digital and health literacy, greater awareness of mental health, and a mediating role between their elders and the health system:

> *P4: "However, the younger generation is more aware of illness and is trying to manage things in a better way."*
> *P6: "With generations, obviously, our grandparents didn't have anything to think about, like depression or anything like that. Now, in our generation, we know that depression does exist."*
> *P8: "Elders who don't even know a single word of English have their children act as interpreters with the health care."*

Sub-theme 2.3: From Taboo to Talk-A Generational Shift in Stigma:

Stigma around mental and sexual health remains strong among older adults, but is weakening among younger people, who are more willing to acknowledge and discuss such issues:

> *P2: "Among South Asian people, it's in our culture that people say, 'You're still young, what mental health should you have?'... the family or parents will just laugh it off... or might even rebuke him or her for it."*
> *P3: "When I was in my teenage years. It was a big issue to discuss the sexual issues. But these days, maybe education levels have gone up, or it's the media, or whatever, people are more aware of their sexual health and are more open to discussing things."*
> *P4: "There is more and more awareness of mental health now because there is more and more advertising, education, and learning about it."*

Sub-theme 2.4: Gendered Health: Evolving Modesty Concerns:

Gender-concordant care preferences are culturally relevant yet more flexible in interpretation by the younger generations. The elderly consider it a necessity, whereas the younger generation regards it as a kind of luxury and no obstacle:

> *P3: "Women trust women more than men…women are more comfortable with women doctors."*

Theme 3: Systemic Delays, Trust Erosion, and Medical Tourism

This theme captures the operational failures of the NHS, characterised by chronic delays that erode trust and lead to adaptive strategies like medical tourism.

Sub-theme 3.1: Pervasive Delays and the Normalisation of Waiting:

Participants reported unacceptable waiting times across all levels of care, from GP appointments to emergency treatment.

> *P3: "One of my friends had a nerve trap. They investigated for a whole year, and after that, they gave him an operation date one year later. In the meantime, he flew back home and had the operation done."*
> *P6: "I was hospitalised because of a kidney stone... I went at around 11:00 p.m., and everything wasn't completed until 10:00 in the morning. It felt quite delayed when I was seeking urgent help. The pain was really, really severe; I was literally on the floor..."*
> *P1: "I called my GP, and they tried to arrange my first booking with them, even after a 2-week wait, for a single observation... it took, I think, 3 to 4 months to book that appointment... The UK system is very, very*

> *bad in responding to urgent cases."*
> *P9: "So the UK system is very, very bad in responding to urgent cases, and urgent cases are just as important as emergency conditions because it's affecting your daily life… It's not affecting only one person; it affects multiple people… we, as a Pakistani people…we leave everything … We try to support him and try to seek help for him."*

Participants noted that emergency responses to life-threatening events such as myocardial infarction remained strong, but urgent yet non-critical cases were often met with slow responses, especially in Sunderland:

> *P1: "If the person has MI or any severe traumatic condition, accident. So here in the UK, the ambulance system is good."*
> *P2: "The response time of the ambulance, because I've experienced it here in Sunderland. I think it's a bit more. You can see it a bit slow. Because I've experienced one here in Sunderland and one in another city, like so. Yeah. And I think it's a bit slow."*

Sub-theme 3.2: The Critical Consequences of System Failure:

Delays led to worsening health, psychological distress, and the common practice of "medical tourism" to Pakistan.

> *P1: "If someone is suffering from tonsillitis, they need an antibiotic, and when you try to book your appointment, you get an appointment after three months... So what will you do? I have seen many people. They try to supply some antibiotics from their home country..."*
> *P7: "Even for minor issues, like small dental abscesses or tooth decay, people often fly back home to get treated immediately. It's very expensive here, and it also takes longer."*
> *P6: "I've decided that if they won't look into it, I will have to take my daughter back to Pakistan. At least we can go through blood tests and any further tests she needs."*

Sub-theme 3.3: The Active Erosion of Trust in Services and Staff:

The frequent observation of long waits, poor evaluation, and perceived rejection led to the decreasing trust in services. Some participants also described discriminatory appointment practices within certain GP surgeries:

> *P5: "One of my friends... was in severe pain. She went to the hospital and, after waiting almost four hours, was given only Panadol and sent home. This left her feeling that her condition wasn't taken seriously and made her lose confidence in the service."*
> *P3: "I also experienced appointment delays. The GP surgery there was largely Group A management and doctors... it felt as though Group A patients were given priority for appointments... As a Pakistani, I struggled to get an appointment... I felt non-Group A patients were not given the same value."*
> *P1: "Doctors and nurses are people whom people trust, but the behaviours and knowledge of healthcare assistants are not sufficient... they don't have sufficient time to give proper time to the patient, so patients get desperate, and, obviously, if someone becomes desperate, their trust level is lost."*

Sub-theme 3.4: Adaptive and Avoidant Coping Strategies:

In response, individuals used a mix of adaptive behaviours (consulting pharmacists) and avoidant strategies (self-medication, herbal remedies). Most preferred to exhaust household remedies before seeking formal care:

> *P4: "First step is remedies in the house. Then we contact the pharmacist in our community. If they can't help, then we go to the GPs."*
> *P6: "I think Pakistani nature is like they will try to sort their health themselves. They will try to look for over-the-counter medication. They will try like herbal... they will try whatever they know, they will try on themselves."*

Thus, delays stem from the interaction of cultural beliefs, coping strategies, and systemic constraints rather than personal choice.

Discussion

Participants described significant challenges in understanding and navigating the NHS, particularly when comparing it to the more direct healthcare pathways available in Pakistan. Recent migrants expressed confusion about the GP-led system, referral requirements, and registration processes, which often resulted in frustration and hesitation to seek care. This echoes evidence that limited health-system literacy among immigrant and minority groups leads to inappropriate or postponed service use [11, 35]. Targeted orientation for new arrivals and peer support from younger, socially connected migrants may reduce these early access barriers [36].

Participants also had a difficult time navigating healthcare because of communication barriers. Even though the language barriers were not pronouncedly reported, most participants referred to accent and medical jargon as the primary barrier, whereas with the help of family translators or available translators, the language barrier was not generally a significant issue. Some of the English-speaking interviewees were unable to comprehend the strong British accents, fast speech, and complicated written messages. This nuance is based on the existing evidence: language is often cited as a significant obstacle [37] but our findings suggest that dialect and specialised vocabulary have a larger impact on the situation with a significant number of UK Pakistanis. This is in line with the fact that Gu and Shah [38] have observed that even English speakers might fail to understand each other when there are accent differences. The insights demonstrate that the provision of interpreters is not sufficient; the improvement of communication, the reduction of jargon, and the awareness of the complications connected with the accents can improve the perception of patients and the experience in general [38].

One of the primary structural barriers was the transition to digital-by-default healthcare, such as online bookings and e-consult systems. These platforms excluded older participants and those with lesser digital/English literacy, commonly postponing or avoiding appointments because of this. This mirrors wider concerns that the rapid expansion of digital health accelerated during COVID-19 has intensified inequalities for ethnic minorities and older immigrants [39] Our findings support evidence that digital exclusion is a structural issue contributing to unequal access [40, 41]. Providing non-digital alternatives, such as dedicated phone lines or in-person support for completing forms, may help ensure that digital innovations do not inadvertently marginalise underserved groups.

The results of our research on navigating the healthcare system show that minority communities need to be better supported in terms of health literacy and accessibility. They highlight the language and literacy barriers and consider the effect of accent and style of communication. The solutions should be provided to patients by creating multilingual health information and community education, as well as to health care providers by means of educational programmes on clear communication and cultural competence. The discovery of such issues as the perception of accents is the key to reducing the ethnic gap in health and ensuring the timely access to the medical distribution, so that the NHS would be capable of communicating with the patients more efficiently [16].

This theme shows that the generational differences are highly intense in determining health-seeking behaviour among the Pakistani community. The elders tended to adopt fatalistic attitudes, resort to traditional medicines and took long before seeking formal care because they viewed illness as something that was predetermined and they reacted better to spiritual or homemade therapies. These attitudes are indicative of the findings of Ahmad [42], Ahmed [43] and Kokab *et al.* [44] who noted that older Pakistanis still rely on traditional medicine and do not use biomedical services, as well as self-medicate instead of consulting early [45].

By contrast, younger participants were more health literate, believed in biomedical explanations, particularly with mental health, and had confidence in navigation of NHS systems. They were more likely to be a mediator between the older members of the family, to help them make appointments, communicate, and overcome some of the most held stigmas. It shows broader shifts that Ahmed [43], Hussain *et al.* [46], and Ismail [36] document, highlighting the more active promotion of younger British Pakistanis and their capacity to influence family health decisions.

Generational differences were especially evident regarding mental and sexual health stigma. Older adults often regarded these topics as taboo, reflecting patterns of silence and shame described by Jacobs *et al.* [47]. The younger participants, however, perceived themselves to be more open because of education, media exposure, and public health messages, yet they were not without stigma. The fact that they are ready to address stigma indicates a slow cultural change that can be utilised by interventions through youth-led, digital, and peer-based interventions, and involving community and religious leaders to reach the older adults.

Preferences for gender-concordant care persisted across generations but were interpreted differently. In older adults, gender concordance was a strict factor that postponed care, unlike younger people, who considered it to be a preference and not an obstacle. This introduces some subtlety to the results of Memon *et al.* [37] and Woof *et al.* [48], which indicates a pragmatic attitude in younger women that does not sacrifice modesty but access in a timely manner.

Generally, one of the determinants of health-seeking behaviour is generational position. These results indicate that culture is dynamic and not static, and any interventions should be able to acknowledge internal heterogeneity in the community. It can be especially helpful to use the supportive role of younger family members to facilitate a wider uptake of healthcare services at an earlier age.

This theme highlights how structural failures within the healthcare system, particularly long waits, perceived discrimination, and limited responsiveness, contribute to distrust and delayed care. The respondents also indicated an even delay during GP visits, referrals, and emergencies, which did not promote early interactions and turned waiting into a common practise in using the NHS. This information gets complemented by such reports regarding the disproportionately high rates of hospitalisation of the Pakistani population groups due to the absence of primary care needs [49]. This perception of Sunderland as having poor waiting time goes even further to demonstrate how regional inequalities contribute towards the inequalities at the national level [50, 51].

A striking consequence of these systemic issues was the turn to medical tourism, with many travelling to Pakistan for timely and affordable care. Such a response indicates the lack of trust in domestic services and creates the issue of increasing inequalities, as only financially able people can get care overseas.

Trust erosion emerged as one of the most significant findings. Participants have often mentioned that they felt excluded, discriminated against, or not taken seriously during primary care. These experiences reflect the national survey data about the low levels of trust in GP services among ethnic minority populations [52] and correlate with the studies of discrimination and low uptake of necessary services, including vaccinations [53] The subsequent behavioural alterations, symptom concealment, presentations, and self-management contribution exacerbate the risk of worse outcomes further.

Notably, trust was not uniformly diminished. The participants were confident in emergency care, which they considered to be consistent and efficient. This contextual trust correlates with national results of high satisfaction with acute services and low trust in routine services and primary care of ethnically minoritised groups [52]. This means that to enhance trust, specific intervention in primary and community care, where the central focus is on relational continuity and fairness, is needed.

Nevertheless, the community was resilient and utilised pharmacists, home remedies, and informal networks as alternative routes to formal care. The stepwise method is a logical adaptation to a system that is seen as hard to reach and follows the trends of community- and faith-based coping found in other BAME groups [37]. The identification of these pathways provides the possibilities of specific intervention, including the intensification of pharmacy-based help or the provision of a low-threshold consultation opportunity.

Conclusion

This study illuminates the complex factors underlying delayed health-seeking among Sunderland's Pakistani community. The qualitative, interpretivist methodology demonstrates that it is not only a cultural choice or a personal oversight but a rational reaction to the reality that cultural conventions are interdependent, generations collide and a healthcare system is perceived as slow, complex, and intolerant.

Among the key findings, one can point to the interaction between cultural beliefs and systemic performance in a cyclic way: delays, perceived discrimination, and dismissive care reinforce self-reliance and fatalism and result in a negative loop of failing to seek help in time and contributing to the worsening of health disparities.

In order to break these obstacles, dual steps should be taken: culturally competent, community-based interventions to enhance health literacy and trust and the transformation of NHS operations and communication that are disproportionately affecting minority ethnic groups. The two elements have been necessary since without the aid of navigation there is no adequate support when there are no systemic barriers. This study has offered a more human centred understanding of these issues and it provides the foundation on which more sensible and effective health promotion initiatives can be launched in the society.

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