Linguistic and socio-cultural barriers

The problem

Linguistic and cultural barriers are systematically identified as one of the major challenges related to the refugee crisis. These barriers lead to communication problems that have adverse effects on the quality of care and patient health outcomes. For example, during the phase of admission and diagnosis clinical interviews may be misleading and only minimal medical information may be obtained. If adequate language support is not available, it is difficult to establish the patient's native language and identity; patients have difficulty describing symptoms and understanding diagnosis and health conditions. During treatment language discordance and cultural differences may lead to lack of trust on the part of patients towards physicians and patients may feel that the provider does not care; patients may have poor understanding of current treatment or follow up care, and it is difficult to obtain informed consent for therapeutic measures. In the same way the absence of language support at the moment of discharge may lead to having discharge instructions given in writing but in the local language, inappropriate linkage to health and social services in the community for the management of chronic illness or health behaviours. For example, in one Greek focus group the case was presented of a child with a brain tumour and the impossibility of explaining this to the father. As long-term treatment may impede asylum seekers from continuing their journey to the country in which they would like to settle, without adequate communication parents may decide to take their sick children with them.

Evidence on the barrier

Lack of interpretation and translation services is identified as a significant determinant of access to and utilisation of healthcare for the refugee population (Asgary & Segar, 2011; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Newbold, Cho, & McKeary, 2013; Szajna & Ward, 2015). In many Member States no, or insufficient professional interpreters or intercultural mediators are available. In practice interpreting / intercultural mediation is often carried out by NGO members, volunteers, other refugees or professionals who have not been trained in this domain. Many problems related to this situation are being reported.

In general, lack of adequate language support complicates the provider-patient encounter, generating fewer empathic responses, decreased rapport, less patient satisfaction, and increased medical error (Asgary & Segar, 2011). In particular, poor communication and inability to overcome language barriers negatively affect both the quality of health assessment and the number of migrants attending the health assessment during the asylum seeking process (Jonzon, Lindkvist, & Johansson, 2015). There is evidence that refugees experience significant difficulties in making clinical appointments because of their low proficiency in the host-country language (Cheng, Vasi, Wahidi, & Russell, 2015; Clark, Gilbert, Rao, & Kerr, 2014). Furthermore, refugee patients tend to fail to attend follow up visits and revert to A&E services. Comprehension of written instructions for follow-up healthcare services and informed consent forms to be signed, are also identified as significant barriers and deterrents to accessing healthcare services by refugees and healthcare providers (Cheng, Drillich, & Schattner, 2015; Szajna & Ward, 2015). Importantly, language is also a barrier to the use of prevention services. A great deal of research has shown that migrant women have fewer mammograms, screening and pap tests (Saadi, Bond, & Percac-Lima, 2012).

The impossibility of resolving linguistic barriers makes it extremely difficult to handle socio-cultural barriers that may further impede the care delivery process. Patients coming from Syria and Iraq, for example, may sometimes vehemently refuse to be treated, or have their spouses treated, by a care provider of the other sex. This is worse if care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East.

Although services do provide professional interpreters at times, their number is too limited and care providers rely mainly on family members and friends as interpreters (MacFarlane et al., 2009). Many studies show that language barriers are more complex than mere issues of interpretation and include recognition of literacy levels when refugees lack the necessary vocabulary to describe their conditions, complicating diagnoses, follow-up care and instructions (McKeary & Newbold, 2010). Concerns about accuracy and confidentiality emerge if an informal interpreter from the community is used as an interpreter (Cheng, Drillich, et al., 2015).

Finally, gender concordance, trusting relationships, and using the same person to interpret at each visit is presented as a beneficial in patient-provider communication (Bischoff, Hudelson, & Bovier, 2008).

Evidence on solutions

Since linguistic and socio-cultural barriers lead to communication barriers and as these are among the biggest obstacles in providing comprehensive and quality health care to refugees, the introduction of a large number of professional interpreters as well as intercultural mediators in EU health care systems is necessary[1]. The provision of practical support for refugee patients to register, make appointments and attend services by engaging interpreters to ensure clear explanations about unfamiliar clinical processes and treatments has proved to be effective in improving access (Bradby, Humphris, Newall, & Phillimore, 2015).

Language competence alone is not considered sufficient to facilitate effective clinical communication across language/cultural barriers. Hence the recommendation is to work with professional interpreters/mediators who have acquired both the necessary communication skills and knowledge as well as the vocabulary needed to work in the medical sector as part of their training. However the successful employment of interpreters and/or intercultural mediators is inseparable from the development of a culturally competent health care system. McKeary and Newbold argue that from a system perspective, the solution must be addressed at a policy/governmental level by acknowledging that accepting refugees must be simultaneously recognised with healthcare budget (McKeary & Newbold, 2010).

There are different models for implementing interpreting services (e.g.: face-to-face and telephone/video remote interpreting, intercultural mediation, etc.) and specific tools to facilitate medical consultations (e.g.: anamnestic questionnaires to gather the medical history of the patient; multilingual posters to aid migrants to explain their symptoms and health needs). Translation tools should not be focused only on health care but should also include administrative procedures in general.

Different options on how the services of professional interpreters could be obtained depend on the characteristics of the health service and its language needs (Wollscheid, Menzies Munthe-Kaas, Hammerstrøm, & Noonan, 2015):

- In-house interpreters / intercultural mediators could be hired as regular staff where the need for a particular language is high or when a single staff interpreter could be qualified to work with several foreign language patient groups.
- Co-operation with external interpreting services implies that interpreters/mediators are hired as hourly, on-call employees or as independent contractors. This is most useful where demand for a

[1] The domain of medical interpreting and intercultural mediation in health is fraught with inconclusive discussions of what the role of different types of 'intermediaries' (interpreters, intercultural mediators, patient navigators, etc.) ought to be. Accepted roles range from that of a 'translation machine' to that of a co-therapist' who is also providing interpretation with somewhere in the middle the 'intercultural mediator'. He/she provides linguistic interpretation, acts as culture broker, helps patients and care providers take up their respective roles, support the development of trustful patient-provider relationship, helps patients navigate the system, and may take up an advocacy role. For a detailed discussion see: Verrept , 2012; Bot & Verrept, 2013; Tipton & Furmanek, 2016; Beltran-Avery, 2001). It should be pointed out that in many projects, e.g. in the US, medical interpreters act as culture brokers and as advocates.

particular language is intermittent or infrequent, or when a health care organisation has fewer common language groups in its service area.

- One particular strategy is the establishment of community-based interpreting/mediation as a shared resource for various health care organisations.

The difference between interpreting and intercultural mediation lies in the – generally - wider role of the intercultural mediator in comparison with that of the interpreter. Both are involved in interpreting, and both may – in some programs/countries, but not in others – in addition act as culture brokers, facilitators, patient navigators and advocates (Tipton, R. & Furmanek, O., 2016). In the absence of a recognised professional profile in many countries, the terms interpreter and intercultural mediator may encompass a variety of tasks that differ, even within the confines of one country, from one program/institution to another. In intercultural mediation programs, the emphasis tends to be more explicitly placed on serving as liaisons between patients and providers, the enhancement of mutual understanding taking into account socio-cultural differences and the reduction or prevention of conflicts. Advocacy, as far as we are aware, is attributed to the intercultural mediator[2], be it at an individual and/or group level. This is not the case in certain interpreter programs. Furthermore, intercultural mediators assist health care organisations in the process of rendering the services offered more responsive to the needs of a linguistically and culturally diverse population. Finally, they may have one-on-one and group meetings with patients and care-providers alike to help them interact as effectively and efficiently as possible. Finally, conflict mediation is part of the task description of intercultural mediators in some programs.[3]

Successful example

Video-remote intercultural mediation (VRIM) in Belgium
(Brussels, Belgium)

Service/department in charge of the measure
Intercultural mediation and policy support unit (FPS Health, Safety of the food chain and Environment) and RIZIV (national health insurance institution)

Description of the measure:
The intercultural mediation service in Belgium was introduced in 1991 and at the beginning it was organized solely with the on-site presence of mediators in health care institutions. The increasing diversity of the immigrant population made it clear that this approach lacked the flexibility needed today. Therefore, it was decided to create and an additional service involving the use of video-conference technology.

Expected outcomes:
To reduce the negative effects of the linguistic, socio-cultural and ethnic barriers on the accessibility and quality of health care.

Achieved outcomes:
This measure makes it possible to provide intercultural mediation in over 20 languages in more than 100 health care institutions in a cost-effective and flexible way. Preliminary evaluations have indicated that the VRIM is a valuable and necessary addition to the provision of on-site intercultural mediation services, which

[2] There are many synonymous terms for this role, including "Link workers" in Scotland; "Community health educators" in the UK; "Aides medico-psychologique" or "Auxiliaires de vie sociale" in France; "Agentes de salud" in Spain; "Agenti di salute" and "Operatori di strada" in Italy; "Zorgconsulenten" in the Netherlands and "Health mediators" in Eastern European Countries.

[3] For an overview of the roles of intercultural mediators – and for the development of a training program in case a such program does not exist in your country/region – see the website of the TIME-project (www.mediation-time.eu). The TIME project (Erasmus+) had as its aim to define the different types of intercultural mediation, the identification of good practices, the development of a professional profile and a training program. The intellectual outputs hereof can be downloaded from the website.

remain the preferred – but often unavailable and unaffordable – option of care providers, patients and mediators alike. VRIM limits the role of the mediator as he/she is not present on-site). In particular elderly care providers sometimes feel ill-at-ease with video-conferencing technology and are reluctant to rely on it. It seems to be important to stimulate and train care providers to use VRIM and to work closely with ICT-departments of health care services to avoid technical issues. Finally, intercultural mediators have to be trained to be able to provide high quality services using video-conference technology.

Resources needed for implementation:
Funding for the mediators, a coordinating team, training for mediators and care providers, an awareness-raising and promotion campaign, good internet access, the necessary hardware and software. A well-developed soft and hard policy that guarantees that no patient data will become public.

Contact: Hans Verrept, hans.verrept@gezondheid.belgie.be

Source: *Interviews and focus groups report*

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