


# ‘Look, wait, I’ll translate’: refugee women’s experiences with interpreters in healthcare in Aotearoa New Zealand

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## ABSTRACT

This study aimed to explore refugee women's experiences of interpreters in healthcare in Aotearoa, New Zealand (NZ). Semi-structured interviews were conducted with nine women who arrived in NZ as refugees. Analysis involved a ‘text in context’ approach. An iterative and interpretive process was employed by engaging with participant accounts and field notes. The various meanings behind participants' experiences were unpacked in relation to the literature and the broader socio-cultural contexts in which these experiences occurred. Findings highlighted issues with professional and informal interpreters. These issues included cost, discrepancies in dialect, translation outside appointments, and privacy. Findings indicate ethical and practical implications of using interpreters in healthcare for refugee women. A step to achieving equitable healthcare for refugee women in New Zealand entails putting in place accessible and robust communicative infrastructure.

**Keywords:** access, barrier, ethics, interpreter, language barrier, refugee, translator, women.

Safe and optimal healthcare requires a clear exchange of information between healthcare providers (HCPs), people accessing services, and their families or carers. Language barriers are often a major obstacle to migrants receiving equitable and high-quality healthcare in host nations (Boyle *et al.* 2020). Communication barriers in healthcare for migrants can lead to health disparities (Hadziabdic and Hjelm 2014) and inappropriate and inadequate treatment (Hadziabdic and Hjelm 2014; Alananzeh *et al.* 2018), resulting in unnecessary health expenditure (Lindholm *et al.* 2012; Alananzeh *et al.* 2018).

Refugee health is an area of key concern when considering issues of health equity in host countries (Sweileh *et al.* 2018; MacFarlane *et al.* 2020). Aotearoa, New Zealand (NZ) is one of 37 countries that accept refugees within Refugee Resettlement Quota Programmes (UNHCR 2019). NZ accepted 750 refugees per annum since 1987, until the quota was raised to 1000 per annum in July 2018 (Immigration New Zealand 2020). The highest number of refugees arriving in NZ in the past 8 years were from Syria, Myanmar, Colombia, Afghanistan, Bhutan, and Iraq (Bellamy 2020). Refugee communities often have significant health and social needs, which impact their quality of life alongside health and social service utilisation (McLeod and Reeve 2005). Specifically, refugee women’s experiences are vital to understanding issues of inequity in the health system, particularly given that services (including health) for female refugees are described as ‘gender-blind’ (Refugee Women’s Resource Project 2003). Explorations into the barriers in accessing healthcare experienced by refugee women internationally (Bhatia and Wallace 2007; Clark *et al.* 2014) and in NZ (Shrestha-Ranjit *et al.* 2020; Cassim *et al.* 2021) have repeatedly discussed the language barrier, requiring the use of either professional or *ad hoc*, personally known interpreters.

Research with refugee women (predominantly from the US and Australia) indicates that professional interpreters are associated with a higher likelihood of adherence to screening, for instance, for breast and cervical cancer and mammography

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(Mengesha *et al.* 2018; Parajuli *et al.* 2020). However, research also suggests that most professional interpreters do not understand and thus are unable to translate ‘health language’ (Mengesha *et al.* 2018). Concerns relating to confidentiality when the interpreter is part of the same community, judgement by interpreters, and people specifically requiring female interpreters (e.g. during physical examinations or when discussing sexual and reproductive health) have also been raised by HCPs (Odunukan *et al.* 2015; Mengesha *et al.* 2018). Alternatively, refugee women use family members as interpreters, thus raising concerns regarding the ethical implications of discussing personal and/or sensitive health issues (Mengesha *et al.* 2018). Many of these studies involve HCP perceptions of the use of interpreters and involve a broader focus on refugee women’s overall experiences in healthcare, of which interpreters are only a minor part of the findings reported.

Literature describing the use of interpreters in primary healthcare in NZ (focusing broadly on people with limited English proficiency, including refugees) echo some of the findings from the international literature. The inappropriateness of using young children as interpreters, issues of privacy within small communities, and the appropriacy of using family members or friends as interpreters are highlighted (Gray *et al.* 2011a, 2011b, 2012; Seers *et al.* 2013; Gray and Hardt 2017; Hilder *et al.* 2017, 2019a, 2019b; Gray 2019). Recent work by Shreshta-Ranjit *et al.* (2020), particularly with refugee Bhutanese women in NZ, also support these findings. Overall, such works call for better language support infrastructure in NZ.<sup>¼</sup>

To contribute to the existing global and local literature on interpreters and the experiences of refugee women in healthcare, more research needs to be conducted to obtain an in-depth and focused understanding of refugee women’s experiences with interpreters in healthcare, particularly in the NZ context. This article contributes to the sparse literature in NZ exploring the perceptions of refugee women relating to interpreters in healthcare. Specifically, we explore this issue for refugee women as a group with particular experiences different from other people who may use interpreters.

The findings reported in this article are part of a broader study exploring the experiences of refugee women in the NZ healthcare system (Cassim *et al.* 2021). In this article, we specifically discuss the findings relating to participant experiences with interpreters.

## Methods

Semi-structured interviews were carried out with nine women who arrived in NZ as refugees and resided in Hamilton. All participants were of the Islamic faith, and their countries of origin included: Eritrea, Afghanistan, Syria, Somalia, and

Thailand. Their ages ranged 20–50 years and they had lived in NZ for 1–19 years. Recruitment was carried out through snowball sampling via the researchers’ networks with refugee resettlement services and a local community Trust for Ethnic women. MA (also a Muslim female who arrived in NZ as a refugee) contacted the participants, explained the details of the project, and scheduled the interview. Each interview was 1–2 h in duration and occurred at the participants’ homes or a local cafe. Seven interviews occurred in English, one in Farsi and another in Arabic. MA was fluent in Farsi, and so she translated the interview. A female professional interpreter translated the interview with the Arabic-speaking participant. The participants discussed their experiences with interpreters in primary and secondary healthcare settings.

Interviews were audio-recorded and field notes were documented. Audio recordings were transcribed, and pseudonyms were used to maintain the anonymity of participants. Analysis involved a ‘text in context’ approach. Four researchers (SC, MA, JK, FB) employed an iterative and interpretive process, engaging with participant accounts and field notes to unpack the various meanings behind participant experiences in relation to literature as well as the broader socio-cultural contexts in which these experiences occurred. Analysis was carried out individually by all four researchers and then together as two groups (one with SC, MA and FB, and the other with SC, MA and JK) to ensure a rigorous process.

## Ethical approval

Ethical approval for this project was obtained from the University of Waikato Human Research Ethics Committee – HREC (Health).

## Results

Findings were grouped into two broad themes, based on issues relating to the healthcare system and those relating to privacy.

### Healthcare system

Key issues relating to the healthcare system included cost, discrepancies in dialect, and translation requirements outside HCP appointments.

### Cost

Participants highlighted that not all low-cost primary healthcare providers offered interpreters as part of their service. Instead, if participants wished to use a professional interpreter, they were required to cover the cost themselves, which was often unaffordable. As Asma explains:

...I always ask the reception, ‘do you guys provide an interpreter?’ They say ‘no, [patients] need to bring one

themselves'. But it's a very high cost, especially for refugee women. It's like [NZ]\$90 or \$100 per hour, for interpreter fees. (Asma, 20s, Afghanistan)

### Language discrepancies

Once participants got a professional interpreter for their appointments, many found that HCPs spoke in medical jargon, which the interpreters often could not translate back. Rashda, who works in healthcare, describes two instances where the interpreter did not have the expertise to directly translate the medical terms that the doctors discussed:

...the translation is not what the doctors say, so there are like gaps. So now I have to stop the [interpreter] and say 'look, wait I'll translate' and then I'll have to translate exactly word by word, you know, what the doctor said. (Rashda, 30s, Somalia)

...it's hard to translate the medical terms like I'll give an example, my uncle was sick and they did a scan for him and there was a cyst. So [the interpreter] translated, and they said 'you have cancer'. And my uncle calls me really upset and all that and I call the doctor and said 'is there anything that you found on the scan? My uncle's really upset. Anyway, I'm on my way', and he's like 'oh yeah come come'. So, when I came [to the hospital], I was very you know, 'what kind of cancer? what stage?' and he's like 'where did that information come from?' I said 'the person that translated'. Maybe he didn't know how to say a cyst. And so [say that]: 'I don't know how to say a cyst in Somali, to be honest' you know? And so sometimes I think how they translate the medical term is not accurate, and can be a little bit misleading. (Rashda, 30s, Somalia)

Another problem that participants faced was relating to the differences in dialect in a particular language based on the specific regions women came from. NZs relatively small population means that often people cannot get interpreters who speak in their particular dialect. For instance, Zaiba explains that despite people from different regions in Afghanistan speaking the same language, the differences in dialect mean that people from these regions often cannot understand each other. Zaiba recounts her experiences supporting other female refugees:

So they asked for an interpreter, but because, like Afghanistan is such a big country as well, and there's so many accents and dialects, and so many, you know, different groups. And then, so they had asked for an interpreter and the interpreter came, but they will speak a different dialect, and they didn't understand it. So they just left. (Zaiba, 20s, Afghanistan)

### Beyond the appointment

Participants described instances where the language barrier affected their access to healthcare outside of the actual HCP appointment. Interpreters (if available) are offered only for an appointment, however, people need to have a basic grasp of the English language to make an appointment with a HCP, either through the phone or through a website. Asma explains how some women face difficulties even making a GP appointment without a professional interpreter:

I was helping one of my friends and she had some problems. I let the reception know – so the problem was in regards to the timing [of the appointment]. So my friend couldn't talk with the reception properly about the time of the appointment and she couldn't understand it. ... so she asked my help and then I talked to the reception. I let [the receptionist] know that 'every time you make an appointment with this lady, can you put it in your file somewhere that she needs an interpreter?' But the receptionist doesn't want to do it and the receptionist was rude. She doesn't want to accept that okay, yeah, it's our fault so I'm gonna put it in the file. And I'm asking 'can you please make a note in the file?' but she's like 'no'. So like my friend needs to ask for an interpreter every time. I was like 'see she has the language problem so how is she gonna ask for an interpreter? Asking needs to be in English!' (Asma, 20s, Afghanistan)

In such instances, people have to resort to asking friends or family members to translate and navigate the appointment making process for them. This sometimes involves advocating for them. Participants having to ask family or friends to translate in this manner is an issue of privacy.

### Professional and 'informal' interpreters

Issues relating to professional and 'informal' interpreters in this study were primarily based around privacy and family members and community members acting as interpreters.

### Friends and family as interpreters

Women who went to HCPs that did not offer free interpreters as part of their service or those who could not afford the additional cost of a professional interpreter often had no choice but to ask their family or friends to act as interpreters. Thabasum's parents regularly asked their friend to translate for them until she and her brother were old enough to take up the responsibility:

...My dad's friend can speak English very well, she translates for us and after maybe one year or two years my brother or me go to translate for my parents. (Thabasum, 20s, Thailand)

Asking family members, especially young children to translate, brings an array of problems alongside it. Asma explains how a young boy had intentionally mistranslated what the doctor said to him, as he was too scared to tell his parents that he needed surgery:

...So they take their son to the GP and he ... needed to do an operation, a surgery in his throat, but he [the son] was scared. So he actually interpreted wrong to the parents. So he said the doctor said everything is okay, because he doesn't want to do the surgery. So, that's why there were heaps of delays in his surgery until later the parents find out that no, he needed to do the surgery! Because he's a child, he's gonna be scared. (Asma, 20s, Afghanistan)

Another example was when a young girl interpreted for her parents. Asma's friend related the story to her:

...But she said the way [the HCPs] talked to her daughter, made her cry. But her daughter was not actually crying [at the clinic] because she was shy. But when she came home, like she was crying because they [the HCPs] were arguing with that kid. Yeah. (Asma, 20s, Afghanistan)

### Breaching privacy

Even when a professional interpreting service is used, given that these communities are often small and close-knit, many participants found that there was a very high chance that the interpreter would be someone they knew from the community. This was a problem, as many participants did not want the members of their wider community to know about their personal health issues. As Zaiba and Asma explain:

...Because it's such a small community here, there's a high chance that you know that interpreter. And if it's a personal thing, you're not gonna want that person there. Yeah. So like, and one of the ladies here, she never takes an interpreter with her. I always go with her because she doesn't feel comfortable with sharing whatever she wants to share with the interpreter. Because she's like, I will know that person. And I don't know how confidential they will be. (Zaiba, 20s, Afghanistan)

[Women in the community] are not very comfortable with interpreters because we've got to face them in the community. So they need to be able to get the interpreter from somewhere else if they don't want to see the interpreter [later on]. Some of the women maybe they don't want to see the interpreter and they don't want anyone to become aware of: 'okay this person has this problem'. So I believe they need to have this option that they can get interpreters from somewhere else in NZ like maybe I don't know, like Christchurch, Wellington on the

phones... So if they're sure that their name will not be revealed to the interpreter, and the interpreter is not from the community, it's someone that they don't know. So they easily can, you know, talk [to the HCP] about their matter. (Asma, 20s, Afghanistan)

Overall, participants highlighted the systemic barriers and risks of using professional interpreters in healthcare, while also illustrating the advantages and disadvantages of using professional interpreters, particularly in smaller communities. The use of professional interpreters may mean that young children or other family members will not have to translate for themselves or other people. However, professional interpreters can be expensive, unavailable outside of appointment times, and may create concerns relating to accuracy, privacy, and confidentiality.

### Discussion

This study explores refugee women's experiences with interpreters in NZ healthcare. While many District Health Boards in NZ now have policies on interpreter use, these are far from consistent (for more details on these varying policies see work by [Gray et al. 2012](#)). The findings of this research are largely consistent with previous international and local research relating to the experiences of female refugees and migrant communities in general. Systemic challenges include interpreters not understanding medical terminology, interpreters not speaking the same dialect as the person, and concerns with confidentiality and cost ([Boylen et al. 2020](#); [MacFarlane et al. 2020](#)). Concerns regarding the use of family members as interpreters include a higher likelihood of making errors and misinterpreting or omitting information ([Gray et al. 2011a](#); [Hilder et al. 2017](#); [Boylen et al. 2020](#)). While many of these experiences of refugee women seem to be no different to those experienced by others who need interpreters, what makes them different is context. Refugees arrive in a nation like NZ in search of safety, security, and protection in an attempt to build a new home that is free from the inequities and atrocities from which they have fled. Host nations have an obligation to ensure that the rights of refugee women are upheld and that they do not get re-victimised in their new homes ([Cassim et al. 2021](#)). Research suggests that the experiences of women in healthcare spaces point towards discrimination and othering, where refugee women are inequitably positioned within NZ society ([Kale et al. 2018](#); [Cassim et al. 2021](#)). Addressing barriers experienced by refugee women in relation to interpreters in healthcare may be a small step to helping refugee women access equitable healthcare in NZ, and in turn to truly make this country their home. The findings of this study shine a spotlight on the ethical versus practical implications of using interpreters for refugee women in NZ.



The ethical implications relating to interpreters concern the cultural sensitivity of healthcare staff, the use of children as an interpreter, and misdiagnosis due to a lack of knowledge or omitting information. Primarily, cultural sensitivity highlights the importance of ensuring that HCPs and other non-clinical personnel such as reception staff act in a culturally respectful manner towards refugee women. Refugee women and their support people should not have to advocate for themselves to have a note on their file indicating that they require an interpreter. Research repeatedly highlights the importance of HCPs (primarily doctors and nurses) undertaking cultural sensitivity training when working with refugee communities (Mortensen 2011; Cassim et al. 2021). However, less attention is paid to people's interactions with other non-clinical staff in healthcare services, such as receptionists (Tajeu et al. 2015). Being the first point of contact when a person engages with healthcare services in NZ, it is imperative that reception staff are respectful of and patient with people who are not fluent in English. Particular consideration should be given that people will not have an interpreter present with them when they contact the practice over the phone to discuss an appointment. Much more could be done to assist people with accessing interpreters and booking appointments to increase integrated care and better health outcomes. A good starting point would be to apply the toolkit for interpreters in NZ General Practice developed by Gray and colleagues (Gray et al. 2012).

Owing to the issue of availability and cost, refugee women often have to resort to asking their friends or family to interpret for them. The role of interpretation often falls on children. The most significant ethical issue arises when the child is young. Young children may lack the fluency in both languages and the emotional maturity to act as what is essentially a linguistic and cultural mediator (Finlay et al. 2017). The pitfalls of such a burden were highlighted in this study, with an account of one child being fearful and misinterpreting their diagnosis and the other being distressed after the appointment. Young children should not have to translate a diagnosis for themselves or their family members. Such ethical issues can be avoided by HCPs organising funded professional interpreters for refugee women. Many professional interpreters in NZ are not specifically trained for working in medical contexts. Similar to previous research (e.g. Mengesha et al. 2018), participants in this study highlighted instances of misdiagnosis when the professional interpreter could not accurately translate the word cyst into the Somali language and instead told the person that they had cancer. In NZ, more interpreters working in healthcare settings would benefit from specific training relating to medical terminology and/or 'healthcare language'. While such specific training is available in NZ to varying degrees, interpreters with this training are probably not widely available. HCPs in NZ could be provided with incentives

to ensure or allow work with interpreters who have training in medical/healthcare language.

Training and cost hold practical implications for using professional interpreters in a NZ healthcare setting. In countries such as Australia (e.g. NSW Government 2021) and Sweden (e.g. Swedish Health Services 2021), there are specifically trained medical interpreters who have a grasp of medical terminology and anatomy and can translate related terms to their language. However, such training comes with additional costs, which becomes a further obstacle given that cost is a barrier to accessing interpreters in NZ. Given the already high costs of interpreters, we realise that those with medical training may incur a higher fee. However, research evidence suggests that in the long term, the use of trained medical interpreters is the most effective and cost-effective strategy for ensuring accurate information exchange in cross-cultural settings (Flores 2005; Bischoff and Denhaerynck 2010). A more immediate solution may be for HCPs to speak to people (and interpreters) in a jargon free manner. HCPs could also undertake health literacy training and endeavour to use mainstream interpreters more effectively to overcome issues relating to the use of and/or inability to translate and understand medical jargon. Many primary health organisations (PHOs) in NZ have access to funding for interpreter services particularly targeted at refugee communities. All staff working in PHOs should be aware of this funding and utilise interpreters. Policy-makers or governments could ensure that funding for interpreters is available and accessible across healthcare services in NZ. Given the availability of targeted funding (albeit limited), people who are refugees should not have to bear the cost of interpreters themselves, nor should it serve as a barrier to receiving optimal health care.

Concerns around confidentiality hold practical implications in relation to professional interpreters in healthcare, particularly in small towns. In the specific context of the present study, given that refugee communities often belong to small, close-knit groups based on their countries of origin or ethnicity, professional interpreters are often limited and are well known to people. Despite signing confidentiality agreements as part of their role, previous research indicates that people are often reluctant to share information about their personal health conditions with interpreters (Mengesha et al. 2018). A possible solution could be a nationally coordinated network of (trained healthcare) interpreters whose services can be utilised in person (based on location) or through video conferencing facilities. *Ezispak* is a video interpreting service recently launched for NZ Government services (<https://www.ezispak.nz>). The service comprises a network of interpreters across Australia and NZ, accessible 24/7. While this service is currently only funded for, and available to Government services, the findings of this study suggests that private healthcare services could also benefit from this. Such an initiative can increase the pool of interpreters available to

refugee women, thus accommodating variations in dialect, maintaining confidentiality, and potentially reducing overall cost. Previous research indicates that female migrants prefer telephone or video interpreters, particularly for sensitive issues such as sexual health or during physical examinations (Mengesha *et al.* 2018; Feiring and Westdahl 2020).

Overall, while the use of family and friends as interpreters may often not be the most ideal or ethical strategy, the appropriateness of this practice very much depends on the situation (Gray *et al.* 2011a; Hilder *et al.* 2017). When conditions make the use of family members as interpreters appropriate, for instance, when making an appointment or interacting with reception staff over the phone, they can (and often do) assist. However, having a male family member interpreting for refugee women in sexual health contexts or physical examinations is most likely inappropriate. The participant accounts in this study demonstrate that refugee communities (families and friends) often work together to support each other in healthcare, for instance by interpreting and advocating for each other. This emphasises the importance of recognising the solidarities enacted by communities who find themselves at the margins of an inequitable, neoliberal health system.

This study had several strengths, such as our prioritisation of the perceptions of refugee women's views on using interpreters in healthcare. Our interviews were carried out by a bilingual female from a refugee background. Limitations of our study include our broad focus on interpreters in healthcare in general and our small sample of interviewees. Future research should focus on issues important to refugee women, such as interpreters in sexual and women's health services.

## Conclusion

In a NZ context, discussions on the use of interpreters in healthcare with refugee women are long overdue in the published literature. The findings of this study highlight ethical and practical implications of using interpreters in healthcare for refugee women. Ethical issues include the cultural sensitivity of healthcare staff, the use of children as interpreters, and misdiagnosis due to a lack of knowledge or omitting information. Practical issues include the need for specially trained medical interpreters, cost, and confidentiality. The findings of this study also hold broader implications for providing equitable, culturally safe, humanistic care for refugee women. Health equity for refugee women should be a key consideration for health delivery. Considering a woman's key role in a traditional nuclear and extended family, ensuring equitable healthcare for refugee women can have a much wider bearing beyond the direct impact on women, extending to children and men's health. A step to achieving equitable healthcare for refugee women entails putting in place accessible and robust communicative infrastructure in NZ.

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**Data availability.** The data that support this study are available in the article.

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