

# Availability, Accessibility, Acceptability, and Quality of Interpreting Services to Refugee Women in New Zealand

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## Abstract

A significant number of people have been displaced from their country of origin and become refugees. Good health is essential for refugees to actively engage and take up opportunities within the society in their host countries. However, negotiating a new and unfamiliar health system hinders refugees' ability to access and make use of the available health services. Communication difficulties due to language barriers are the most commonly cited challenges faced by refugees in accessing and utilizing health services post-resettlement. In this study, we aimed to examine effectiveness of interpreting services for refugee women in New Zealand. Data were collected through three sources: focus groups with Bhutanese women, focus group with Bhutanese men, and individual interviews with health professionals. The findings of this study reveal inadequacies and constraints in the provision of a socioculturally and linguistically effective interpreting service to Bhutanese women and provide evidence for recommendations to address these inadequacies.

## Keywords

communication; interpreting and translation; health literacy; refugee women's health; community navigator; qualitative research design; New Zealand

## Background

In 2018, 70.8 million people have been forcibly displaced from their country of origin worldwide due to persecution, conflict, violence, or human right violations. Of these, 25.9 million were recognized as refugees, whereas 3.5 million were asylum seekers (United Nations High Commissioner for Refugees [UNHCR], 2018). As refugees are forced to flee their native country to escape war or oppression, they are deprived of security, social and educational life, employment, and health prosperity for many years (Dator et al., 2018; Dowling et al., 2019; Swe & Ross, 2010). It is essential for refugees to have good health for them to actively engage and take up opportunities within a new society in their host countries. However, refugees continue to suffer from complex physical, mental, and social health problems post-resettlement (Lifson et al., 2002; Maier & Straub, 2011; Searle et al., 2012; Swe & Ross, 2010; Tiong et al., 2006; Varkey et al., 2007).

The World Health Organization's (WHO; 2016) Availability, Accessibility, Acceptability, and Quality (AAQ) framework considers access to health care from a human rights perspective. However, negotiating

a new and unfamiliar health care system hinders refugees' ability to access and make use of the available health services. In particular, women face a number of barriers in accessing health services, most commonly related to communication difficulties, financial hardships, difficulties in navigating health and social systems, and acculturation challenges (Berthold et al., 2014; Henry et al., 2019; Mistschke et al., 2011; Morris et al., 2009; Sheikh-Mohammed et al., 2006). Although most refugee women resettled in Australia have a desire to attend English classes, barriers include transport issues, long waiting periods, inadequacy of the hours allocated, and limited child care arrangements (Casimiro et al., 2007).

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Communication difficulties due to language barriers are the most common challenges faced by refugees in accessing and utilizing health services post-resettlement (Berthold et al., 2014; Henry et al., 2019; Mistschke et al., 2011; Morris et al., 2009). In a qualitative U.S. study, Mistschke et al. (2011) interviewed 21 (13 women, 8 men) refugees. There was a consensus among all the participants that their inability to communicate in English was a significant barrier to surviving in the United States. Many felt lost, confused, and frustrated because of the language barrier. They perceived gaining competency in English would be the main key to unlocking opportunities for employment, education, health, and financial advancement. However, many reported that they were unable to access English classes due to the associated cost, and they strongly felt that free English classes would provide them with English learning opportunities, which in turn would help them secure jobs. Securing jobs would help them feel more positive about their lives (Mistschke et al., 2011).

Similarly, in a qualitative pilot study, Morris et al. (2009) explored health care access issues of refugees in the first year post-resettlement in San Diego. In total, 40 in-depth interviews were conducted with 10 health care providers, 14 staff of resettlement agencies, and 16 refugee informants. Language was perceived by participants as a major barrier for accessing health care. Importantly, most refugee participants reported they utilized health care services only when they were very sick or not at all, mainly because of communication challenges. Furthermore, health service providers shared their difficulties in making a proper diagnosis when communication was broken and consultation time was limited, and they were concerned that such situations could potentially compromise the quality of care they were providing to refugees (Morris et al., 2009).

The findings of a recent study conducted in Germany (Henry et al., 2019) are consistent with those of the U.S. studies (Mistschke et al., 2011; Morris et al., 2009) in regards to language and communication challenges faced by refugees. In this qualitative phenomenological study, Henry et al. (2019) interviewed 12 pregnant Arabic-speaking refugee women and explored these women's experiences of accessing health care in Germany. Not being able to communicate with health professionals due to language barrier and lack of access to interpreters led to significant fear and anxiety on these women concerning childbirth. They reported to feel powerlessness, when treatment was carried out without their understanding and consent. The communication barriers with midwives led to health complications such as breastfeeding problems and infections. It is important to note that to overcome the language barrier, one of the women took her 15-year-old daughter to the delivery room for translation, which

reported to be an emotionally stressful situation for both mother and daughter (Henry et al., 2019).

Refugee women have relatively low levels of education and English language proficiency compared with refugee men. Language was identified by several studies as the biggest problem impacting refugee women's ability to communicate with health professionals as well as to blend into the their host nation's society (Ager & Strang, 2008; Casimiro et al., 2007; Deacon & Sullivan, 2009; Henry et al., 2019). Importantly, one of the refugee women in Casimiro et al.'s (2007) study related her experience of not being able to speak English as like being in a cage or like a bird with no wings.

The "Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations" (1996; hereafter called "The Code of Rights") Right 7(1) outlines that every person has the right to make an informed decision regarding the use of health care services. However, it is important to receive correct information to make informed decisions, and communication plays a vital role for sharing information effectively and appropriately (Berry, 2007). As Berry (2007) suggests, communication needs to be person-centered and informative. Importantly, culture and ethnicity can influence significantly how people communicate their health care needs. Within many western countries, including New Zealand, the dominant model of health is from a biomedical perspective but there are different models of health elsewhere in the world.

Bhutanese refugees are Bhutanese citizens of Nepali ethnic background. Religious and cultural beliefs can strongly influence how Bhutanese people perceive illness and treatment and how, when, where, and with whom they communicate their health care needs. Coming from a patriarchal society (Cultural Orientation Resource Center [CORC], 2007; Shakya & McMurray, 2001), many Bhutanese women have little or no opportunity for education, which may hinder interactions and their ability to benefit from health information materials that are written in English. Although there is an increasing body of research on refugee resettlement communication issues globally, there is little information about the role of interpreters in health care settings after resettling in a host country. In this study, we explore Bhutanese refugee women's experiences of utilizing interpreting services in primary health care settings after resettlement in New Zealand.

## Method

The study design and methods have been reported previously (Shrestha-Ranjit et al., 2017). The broader focus of this study was to explore Bhutanese women's experiences of accessing and utilizing primary health care services in

New Zealand. This article specifically focuses on the effectiveness of interpreter services for Bhutanese women in accessing primary health care services, the challenges they encountered and the ways in which they responded to these challenges. Nepal has a patriarchal society and often husbands and other male relatives exercise considerable influence over the public activities of women including making decisions about women's health care needs (CORC, 2007; Human Rights Watch, 2003; Manchanda, 2004). Therefore, it was considered important to explore Bhutanese men's perspectives about the effectiveness of interpreting services in New Zealand in meeting the health needs of Bhutanese women. Furthermore, this study explores health professionals' experiences of accessing and utilizing interpreting services while working with Bhutanese refugee women, their satisfaction with interpreting services, and elicits comments and suggestions regarding interpreting services provided to these women. This study, to our knowledge, is the first of its kind in New Zealand, which intended to gain insights into evidence of effectiveness of primary health care practices including interpreting services by exploring perspectives of those who are at the heart of health care: service users and service providers.

### *Design*

This study utilizes a qualitative design because it allows the researcher to focus in depth on issues important to the study (Lincoln & Guba, 1985). A qualitative design is pragmatic, interpretive, and grounded in the lived experiences of people (Marshall & Rossman, 2011). As such, qualitative design is relevant to this study, which involves an exploration of Bhutanese refugee women's experiences in meeting their health needs. The naturalistic/constructivist paradigm of inquiry (Guba & Lincoln, 1994; Lincoln & Guba, 1985) guides this study, which investigates phenomena as they occur naturally. This study utilizes a case study as the strategies of inquiry (Yin, 2009) to examine the contemporary phenomenon of Bhutanese refugee women's health care needs in their real-life context within the boundaries of their social system.

### *Conceptual Framework*

The WHO's (2016) AAAQ framework provides the conceptual framework to structure the findings of this study. The AAAQ framework considers access to health care from a human rights perspective. According to this framework there must be adequate and efficient health services (Availability) that are physically accessible and affordable to all without discrimination (Accessibility). Similarly, the health services must be ethically and culturally appropriate for people from different backgrounds (Acceptability).

Furthermore, health services must be scientifically sound with high quality (Quality).

### *Setting and Participants*

The study was conducted in two regional towns of New Zealand where most Bhutanese refugees have been resettled by the New Zealand government. The participants were purposively selected from Bhutanese refugee women and men and from health professionals. Bhutanese women and men were eligible to participate if they were resettled in New Zealand for a minimum of 6 months, they were able to speak and understand English or Nepali, and they were aged 18 years or above. Those who were living in New Zealand for less than 6 months might have had no experiences or very limited experiences of utilizing interpreting services in New Zealand; and those who could not speak either English or Nepali would not be able to express their experiences. The inclusion criteria for health professionals included doctors, nurses, and midwives, who were directly involved in providing primary health care services to the Bhutanese refugee community in those two regional towns.

Ethics approval was obtained from Human Research Ethics Committees of two relevant organizations. Potential participants were provided with both a written and verbal explanation of the nature and purpose of the study. Prior to each focus group and interview, written consent was gained from the participants. The participant information sheet and the consent form for Bhutanese participants were written in English and Nepali. No names or identifying information were gathered. It was assured that their participation was voluntary, and they were free to withdraw during the study at any time.

### *Data Collection*

Data were collected by Jagamaya whose background is Nepali, and she shares the common language as well as cultural and religious understandings with most Bhutanese refugee women. As Jagamaya grew up in Nepal, she is familiar with the Nepalese culture and some of what it means to be a Nepali woman. Jagamaya's cultural sensitivity and care with which she engaged with people and organizations is a strength of this study. Data collection for this study was conducted in two stages. Stage 1 comprised five focus groups with 32 Bhutanese women, aged 18 to 82 years, and one focus group with eight Bhutanese men, aged 26 to 55 years. As preferred by the participants, all focus groups were conducted in Nepali language. The number of participants in each focus group ranged from four to eight. Focus groups were continued until data saturation occurred, meaning no or

little new information was generated (Krueger & Casey, 2015). The duration of each focus group ranged from 86 to 115 minutes. All focus groups took place at the local community halls. A topic guide was used to explore participants' experience of accessing and utilizing interpreter services: factors that might have facilitated or hindered them to access and utilize interpreting services, and their suggestions for improvement to interpreting services to better meet their needs.

The Stage 2 of this study involved individual interviews with 12 health service providers including five nurses, four general practitioners (GPs; doctors), and three midwives. Among the 12 participants, all the nurses and midwives were women and two of the four GPs were men. All health professional interviews were conducted in English. A semi-structured interview topic guide was used to explore health professionals' satisfaction with interpreting services, challenges that they may have encountered in accessing the services, and suggestions they may offer to make the interpreting services more effective and appropriate for Bhutanese refugee women. The duration of the interviews ranged from 27 to 90 minutes depending on the amount of time each participant could volunteer.

### Data Analysis

Audio-recorded focus group data were transcribed in Nepali and then translated to English by Jagamaya. A bilingual person of Nepali origin with a PhD degree moderated the translation and also conducted back-translation of some sections of the data to ensure rigor in the translation process. The health professionals' individual interview data were also transcribed by Jagamaya. A thematic approach was used to analyze the data. The six phases of thematic analysis described by Braun and Clarke (2006) guided the analysis: familiarization with the data, coding, searching for themes, reviewing themes, defining and naming themes, and writing up. Data analyzed by Jagamaya were then reviewed and discussed with Elizabeth, Deborah, Jane, and Ineke thereby reaching consensus for each identified theme.

Various strategies recommended by Guba and Lincoln (1994) were considered to enhance the trustworthiness (quality and rigor) of the data generated in this study. We used different methods and multiple sources to collect data (triangulation) to enhance the credibility of the findings. Furthermore, the participants were given the opportunity to go through a summary of their specific data to confirm that the interpretation was correct before proceeding with analysis (member checks). In addition, there was a translation and back-translation process to further ensure the accuracy of the interpretation of data in this study.

## Findings

### The Bhutanese Women and Men's Perspectives

A total of 32 Bhutanese women and 8 Bhutanese men participated in this study. Bhutanese women's age ranged from 18 to 82 years and men's age from 26 to 55 years. On average, these women and men had lived in New Zealand for 4 years. All the women and men spoke the Nepali language at home. More than half of the women did not get opportunity to attend a school, which means they did not have any formal education. Out of the 32 women, only seven were in paid employment, whereas six out of the eight men had formal education and four out of the eight were in paid employment. In this section of the article, we present common findings that emerged from the focus groups.

*Language barrier inhibiting access to health care.* Women talked about how being unable to communicate in English stopped them from accessing needed health services:

When we become unwell we wouldn't have a clue about where to go and what to do. This creates constant mental tensions . . . We don't know language and therefore, sometime we don't go to see a GP or hospital, we stay at home hiding and ignoring our illnesses.

That their language barrier stopped them from attempting to engage with health services is not surprising given the lack of clinic responsiveness:

When we try to make an appointment by calling a receptionist, sometime we struggle to understand each other and then the receptionist hang up the phone. This has happened to me. Some of them get angry when they cannot understand what we say.

If they did manage to obtain an appointment, women reported being sent home when they did not have an interpreter, without getting their health checked:

It has been difficult due to language problem; let's say for a moment, we manage to reach to the hospital or clinics but for many of our people they need to return back without health check due to language problem.

These data highlight a serious issue in accessing health services for Bhutanese women, particularly for those who did not have anyone in their family who is able to communicate in English:

I have a problem, my children are very young; my uncles, aunties as well as my father and mother, all of them cannot speak English at all.

Women felt that they were not adequately prepared for basic communication in English, and therefore, they wished to have the English learning opportunity for longer period of time:

We were just able to speak English as like one year old baby, they sent us to do an aged care course. It would have been better if they gave us more time to learn language and to have a better understanding of a new environment.

**Access to interpreters.** Women spoke of their inability to communicate their health problems with their GPs and other health professionals by themselves. They reported that there was no provision of a face-to-face professional interpreter service in GPs' clinics, although this service was available in the hospital. Bhutanese people had identified an urgent need for interpreters in this region and requested multiple times with the Refugee Services (refugee resettlement agency) for the provision of an interpreter:

If we became unwell and went to see GP with no interpreter—we would not understand each other. We have requested for an interpreter but we have not got one yet.

The issues related to using a family member for translation were commented on frequently across all focus groups. Many participants commonly used one of their family members, usually a child, as an interpreter as they did not have another option available to them. However, the participants mentioned that they did not feel comfortable sharing some of their personal and sensitive health issues with their children:

There could be some sensitive issues (confidential matters), which we cannot tell to our children/family members. In this way, our health problems are hidden . . . Also, how can a child tell such sensitive issues openly to a doctor? It would be very difficult to both sides.

The participants also raised their concerns about possible negative impacts that their children could have because of interpreting their health problems:

My sister had some health problems and she went to see a GP with my son who is 25 years old. My son came home and said that he felt ashamed while doing interpretation and, therefore, he will never do that again.

Male participants further confirmed that face-to-face professional interpreter services were not available in GPs' clinics, which they perceived as a big problem in utilizing health services by the Bhutanese women:

There is no provision of an interpreter at GPs' clinics . . . Children need to translate with pressure although they

cannot translate some of the Nepali words that their parents say.

As illustrated in the following excerpt, one of the male participants acknowledged that Bhutanese women experienced difficulties in expressing their personal health problems with their children as this was not in traditional Nepalese culture:

Our mothers and sisters don't feel comfortable to tell their personal health issues in front of their children. This is because of our traditional practices related to our religion and culture. Therefore, it would be helpful if GP could find an appropriate interpreter; preferably women interpreters.

Two of the male participants also reflected on their experience of doing interpretation for their own family and highlighted some of the practical and potential ethical challenges:

Many times when a doctor ask question to my parents, I start speaking before my parents get chance to speak. Many people need to take their young children for interpretation, who would not understand what confidentiality means. Therefore, if it is possible from your place, it would be better if we could completely eradicate this practice of using family members as interpreters from our community.

**Interpreter acceptability: characteristics and quality.** Women wished to have a female professional interpreter who could speak Nepali but preferably was from outside of their community. For example, the following comment was made by a 37-year-old married woman who required hospitalization while she was pregnant. In the hospital, she needed to use a male interpreter, who was known to the Nepali-Bhutanese community in the area:

I was not able to hold any food or water due to constant nausea, vomiting. The interpreter (. . . sir) . . . I had to share many of my personal and sensitive matters in front of him as there was not any Nepali female interpreter in the hospital. I did that for survival although I needed to hide my face and eyes as I was so ashamed. Even when I see him now, I still feel very ashamed.

The woman regarded the interpreter with respect as she often used the title "Sir" when referring to him, and the shame and guilt she felt in needing to share her intimate information in front of the male interpreter. It appeared that this experience had a long-term impact on her as the woman mentioned she still felt ashamed when she saw the male interpreter. Another woman agreed,

. . . We can't share our women related health problems with a male interpreter . . . Some time we experience painful

lumps in different parts of our body, which would be difficult to show to a male interpreter.

Some participants preferred trained, professional interpreters who would be more familiar with medical terms and, therefore, would translate more accurately, which would avoid or minimize misdiagnosis and wrong treatment:

They may not be familiar with medical terms, which could cause misunderstanding while translating; and which could lead to a wrong diagnosis and treatment. Therefore, it would be better to have an interpreter from the relevant field, who could be more familiar with medical terms.

In addition, many participants also shared their concerns about possible compromise in their privacy and confidentiality while using their local community people as interpreters:

If we have our own community people as interpreters, we fear that they could share our issues to others within our community. This has been happening . . . we fear if they don't maintain our privacy and confidentiality . . . Whereas, we have no such fear when using language line (phone interpreting service) as we don't know each other, we don't need to tell our name.

*Interpretation takes time impacting on quality of services.* Most participants mentioned that the consultation time with their GPs had been inadequate resulting in a lack of comprehensive health assessments and incomplete and/or inappropriate treatments. They perceived that the standard 15-minute consultation time was unrealistic for those who required translating. Needing to say the same thing twice requires double the time (30 minutes). Several participants reported that they often go to see their GPs for multiple health problems but "GPs tell us to focus on one main problem even though we may have many problems." Importantly, many participants perceived that they often had an incomplete health check due to the time limit leading to improper diagnosis and inadequate treatment of their health problems:

Time is very short. We need translating, so how can we do that in 15 minutes? They stop after 15 minutes and tell us to make another appointment. We need to pay same amount of money again for another appointment . . . Children don't know the actual meaning of those words and they ask back to us and we need to say same thing twice. In that situation, doctors question us saying why we were speaking in Nepali.

Most participants perceived that there had been delay in diagnostic investigations, referral and treatment processes leading to long suffering and poor health outcomes. They mentioned that their GPs did not refer to specialists or

conduct investigation procedures in a timely manner, which led them to experience the same health problems for a long period of time with no improvement from the treatments provided by their GPs:

When we go to see GPs repeatedly, they should look at the problem thoroughly. Not sure if it's due to their weakness or ours, they say they will refer us to the hospital next time, then again next time . . . for the same case . . . We had one incidence with that GP related to a serious health problem to one of our relatives; the GP did not do proper diagnosis and treatment, kept giving the same medicines again and again for long time and the health condition got worse.

*Language barriers and service acceptability.* The language barrier for Bhutanese women further challenged the delivery of acceptable health services. Participants identified service providers' lack of familiarity with refugees' health background and suggested that service providers needed to consider the difficult journey that refugees had endured, and that they required taking different approaches to assess refugees' health care needs effectively in a comprehensive way:

GPs don't have health records (newly arrived) and the women have language problems. Because of this GPs cannot understand the actual health problems leading to a superficial treatment . . . The outcome of these problems are: wrong diagnosis, wrong medications, not being able to cure on time and chronic sufferings . . . Therefore, we wish that they (doctors) see people from refugee backgrounds, either male or female, differently as outsiders and look at their health issues more carefully through a comprehensive assessment. This is because refugees have had significant tortures in the past; they did not come from a safe and good environment.

*Lack of access to information for medicines.* In addition to concern about assessment and diagnosis, language difficulties impacted women's health when they received inadequate information about their medicines from GPs and pharmacists:

In the camp, they (doctors) always used to explain us about the time for taking medicines; whereas here, they (doctors) just write that down. Those who are able to read and understand, they can take the medicine correctly but for us . . . We don't understand at all, so we bring the medicines and show that to our children, they write down the time/frequency on the cover of the medicines; then we follow that instructions provided by our children for taking the medicines.

Several women reported that they sometimes would not take their prescribed medicines because they would not know when and how much to take. The following comments indicated that these women did not take their

prescribed medicines as they were worried about possible adverse effects from not taking medicines at appropriate time with appropriate dose:

Sometimes we don't take the medicine; we just keep that at home because of not being able to understand about what is written by the doctor . . . If we could not understand about the medicine then the same medicine could also kill us.

*Solution: accessible and acceptable English language support services.* The participants suggested providing health services that addressed their health needs in a holistic way. They spoke about identifying and involving health service providers who are from Bhutanese-Nepali background. Likewise, they suggested a longer consultation time with GPs for more thorough health assessment. It was also the participants' request to have professional interpreter services with female interpreters at GPs' clinics, so that they could avoid using their family members/children as interpreters:

We have been constantly telling to the refugee services staff about the needs of interpreters for us here . . . This issue has been a huge problem for us and we are hopeful that you will be able to help us to solve this problem. That's why we came here today even leaving our young, breast-feeding babies at home.

### *Health Service Providers' Perspectives*

Health professionals who were involved in providing primary health care services to the Bhutanese refugee community in the two regional towns were invited to participate. A total of 12 individual interviews were conducted with health professionals including four GPs, five nurses, and three midwives. On average, participants had 15 years of experience in their respective professions ranging from 2 to 43 years. The interviews highlighted a number of challenges that health professionals encountered in accessing and utilizing interpreters while addressing health needs of Bhutanese refugee women.

*Communication difficulties.* All health professionals agreed that the language barrier would be the biggest challenge that Bhutanese women encountered while accessing and utilizing health services in New Zealand:

I think language is probably the biggest challenge . . . often family would come in and one person would speak English . . . often a younger male and it's very hard for the women to communicate any more intimate problems.

As illustrated above, participants perceived that Bhutanese women had difficulties in expressing their health needs and in understanding the advice about treatment that they

received. They observed that the older Bhutanese appeared to have more difficulties in communicating compared with the younger aged Bhutanese:

The older women and men would probably be harder because they don't express a lot . . . their faces are like blank how I see them . . . so, you don't know if you are right or wrong or if you are really offering them support . . .

Most participants perceived that Bhutanese women were experiencing difficulties in understanding and navigating the New Zealand health care system:

If they are not familiar with the health system, sometime we say "you need to have blood tests" but I am not sure if they understand where to go for the blood test or if they need an X-ray and where they need to go for an X-ray . . . They're having to negotiate with all the different providers.

*Legal and ethical issues associated with communication barriers.* During interviews, health professionals mentioned that they were struggling to maintain safe professional practice in providing services to Bhutanese refugee women. One of the main concerns they raised was about gaining informed consent before carrying out procedures, "How do you get an informed consent when they don't understand what you are saying?" They had to weigh up performing procedures without women accurately understanding what was going to happen, against the women's entitlements for services:

The main thing is that doing things like vaccinations and smears . . . when you don't think they fully understand what's going on . . . it's really hard and then to ring them up for the results.

. . . this lady has no idea what a smear is about, and so we ended up role playing to the lady like this is what we want you to do; and I thought it is so not right and also it is not right for her not to have smear either, isn't it? We have a massive dilemmas, I want to go up high here (hand gesture) but I know that the care I am giving to them is low here (hand gesture), which is really hard to cope with as a professional, we do try our best but I know it is different in theory and in practice.

Although nurses and midwives expressed their frustrations and concerns about their current practice situation, they mentioned that they never had an opportunity to convey their concerns to any individuals or authorities. Overall, service providers identified a number of barriers that were preventing them from maintaining legal and ethical standards in their professional practice. They also identified challenges in supporting Bhutanese women to exercise their rights to make an informed choice and give informed consent.

Some of the Bhutanese women were able to communicate better in Hindi, and therefore, they went to see the GPs who could also communicate in Hindi. This situation appeared to have impacted on the enrollment of Bhutanese refugees within their local GP practices. Some of the GPs appeared to have refused to enroll Bhutanese women (although they lived locally) at their practice due to communication difficulties. Rather, they referred these women to those GPs who could communicate in Hindi. Importantly, most of the Bhutanese women were not able to drive but they could visit their GPs if they were available within a short walking distance. However, if their local GPs refused to enroll them, then that could have prevented these women from accessing primary health care services when needed:

I have noticed that a lot of patients are transferred from other practices to here . . . I have noticed that certain clinics will not enroll them or not enroll them for long; and that's a bad thing in a way because they should be able to go anywhere.

*Challenges in accessing and utilizing interpreter services.* Language difficulties were also a significant barrier for health professionals in addressing health needs of Bhutanese women. Generally, interpreter services would address such communication needs in health care practice. However, participants across all three disciplines identified a number of barriers that prevented them from utilizing the interpreter services effectively. The data suggested that there were three types of interpretation/translation options in the primary health care setting: use of face-to-face independent, professional interpreter services; phone interpretation language services; and families and friends as interpreters. Out of the three options, using family members, often children, as interpreters appeared to be the most common practice in the primary health care settings because of the difficulties encountered in accessing other forms of interpreting options. However, that was not the preferred option for most service providers as they had a challenging experience working with family interpreters:

I don't know if they (Bhutanese women) are comfortable using family members/children as interpreters, but I think it is a disaster . . . but it happens . . . and I am certainly not comfortable with it.

It is totally unacceptable to use family member, a child as an interpreter . . . it should not be happening at all, they should be getting an interpreter.

Most participants mentioned that there were no independent professional interpreter services in primary health care settings. These services were only available in the hospital settings:

Unfortunately, we don't have any independent interpreter service available . . . if women were to use the services up in the hospital, they are entitled to the interpreting services but within the community they are not entitled to it.

Regarding the phone (Language Line) interpreter services, some participants mentioned that they had used the service and, in general, they found phone interpreting useful:

If I need an independent interpreter, if I don't want to use the local guys for sensitive issues, I use Language Line and they are pretty good.

However, making a booking in advance appeared to be a challenge for the health practitioner leading to underutilization of phone interpreting service:

We don't use Language Line as much as we could or should . . . The disadvantage of the Language Line is that you have to book it for the time that person is here and you often have to keep to time but it's just difficult . . .

Importantly, midwives reported that the phone interpreting service was not available for them to use in providing maternity services to Bhutanese women, "There is no Language Line in our service, they still have to pay for it . . . it just comes down to money and funding."

GPs appeared to struggle to obtain a clear picture of health problems that Bhutanese women were having due to the language barrier. This lack of information was perceived by the GPs as a constraint for accurate diagnosis and appropriate treatment of Bhutanese women's health problems:

One of the patients said that she had a sore knee . . . as she was putting hand on her knee but her relative was saying ankle (anatomical part was not clear), so, that's the most difficult part that I have found with them.

*Time constraints: a significant barrier to quality services.* Time constraints in addressing health care needs in a comprehensive manner was one of the most frequently made comments by the service providers. The standard consultation time with a GP was only 15 minutes and, importantly, the study data suggested that there was no additional time allocated for providing health services to the refugee population, although often this population group has communication difficulties requiring interpreter services and also it has complex health needs requiring more time to address such needs:

All our appointments are only 15 minutes and that is the same for everybody even if they have an interpreter; so, there is a quite a bit of time pressure for us to get through everything . . .



Similarly, one of the nurses identified time constraint as a significant challenge in addressing complex health care needs of Bhutanese refugee women:

They have got so many problems, they have got diabetes, they have got respiratory problems, they have got sight problems, they need home help . . . With dealing with all of that there is another part of me that kind of forgets about everything that comes from their culture because you got such a short time, and there is so much to deal with . . . ; it does become very difficult.

The data indicated that there was no workload adjustment or support for staff in consideration of the complexity involved in addressing health needs of the refugee population.

Most service providers preferred to have access to culturally appropriate professional face-to-face interpreters in providing health services to Bhutanese women, “It would be better to have somebody face to face; and also it would be better to have female interpreter because men may not be culturally appropriate.”

## Discussion

The study suggests that most Bhutanese women were unable to communicate their health problems with their GPs and other health professionals by themselves due to the language barrier. They commonly used one of their family members, usually a child, as an interpreter due to the inaccessibility of professional interpreter services in primary health care settings. Service providers were facing an extremely difficult situation in their practice while dealing with multilayered health needs of Bhutanese women. Most of the service providers articulated that their service would be more effective if they had access to culturally appropriate professional face-to-face interpreters in providing health services to Bhutanese women.

One of the main findings that emerged from this study is that language barrier has been the biggest challenge that Bhutanese women encountered while accessing and utilizing health services in New Zealand. This finding confirms previous studies that also identified communication difficulties due to language barrier as the most common challenge faced by refugees in accessing and utilizing health services post-resettlement (Berthold et al., 2014; Henry et al., 2019; Mistschke et al., 2011; Morris et al., 2009). Bhutanese women perceived that the language learning opportunity was not adequate for them to gain basic functional communication ability in New Zealand. More opportunity to learn English would not only provide them with confidence to communicate with others and become independent, but it might also open up opportunities for employment and social integration. As

Melamed et al. (2019) suggest, continued language learning opportunity enhances refugees’ ability to communicate, widen social support networks, and strengthen their social resilience toward migration related mental health threats. Furthermore, Bhutanese women experienced difficulties in communicating issues related to reproductive health with male service providers and male interpreters due to their sociocultural norms. Therefore, employing more female GPs and having female interpreters would make primary health care more acceptable to Bhutanese refugee women in meeting their cultural and gender-specific health needs. This approach would support the WHO’s AAAQ recommendation that emphasizes all health facilities and services need to be ethically and culturally appropriate as well as sensitive to gender and age for the acceptability of the health services (WHO, 2016).

This study clearly shows the Bhutanese women’s lack of health service utilization in New Zealand was influenced by the inadequate cultural and linguistic understanding of their needs. This finding supports the finding by Stewart et al. (2010) who found an under-use of services and supports when services were not considered to be linguistically and culturally relevant. Caxaj and Gill (2017) also reported language difficulty being a main barrier for Indian migrants to access health care services in Canada, leading to significant impact on their mental well-being and sense of belonging.

It is important to note that there was no provision for professional in person interpreter services in primary health care settings. Hence, Bhutanese women needed to find someone, commonly their families and friends, who could interpret for them. However, Bhutanese women experience difficulties finding an interpreter at the time when they are needed because children are often at school and men are at work during the day. Such a complex social circumstance has prevented them from seeking medical help in the early stages of their illnesses potentially leading to a delay in diagnosis and treatment and to prolonged suffering. These findings are not consistent with the WHO’s human right-based approach for accessing health services, which highlights that health services need to be accessible to all without discrimination (WHO, 2016).

The Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations (1996) was established in 1996 under the Health and Disability Commissioner Act 1994. Since then the Code of Rights became enshrined in law in New Zealand. The Code of Rights grants a number of rights to all consumers of health and disability services and places obligations on providers of those services, including Right 5: the right to effective communication. The Code of Rights supports the concept of cultural safety as it states,

Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori. Right 1(3)

Considering these guiding legal and ethical principles for health care practice in New Zealand, it is expected that health care providers are prepared to deliver culturally safe care to people from diverse sociocultural backgrounds. However, it is important to note that all of the health professionals who participated in this study strongly felt that they were not adequately prepared or supported to address Bhutanese refugee women's health needs in a culturally appropriate manner.

A finding of concern that emerged from this study is that health professionals faced challenging legal and ethical issues in their professional practice while protecting Bhutanese women's rights to culturally competent health services. Importantly, the service providers reported to be struggling to gain informed consent while providing health services to Bhutanese women due to communication barriers. This finding raises concern in relation to adhering to the Code of Rights which states,

Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise. Right 7(1)

However, as outlined by the Code of Rights, every consumer has the right to be fully informed to be able to make a choice or give consent; and, therefore, it is essential to provide appropriate and adequate language support to consumers if the Code of Rights are to be realized in primary health care settings. According to the Code of Rights, it is expected that interpreter services would address such communication needs in health care practice:

Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter. Right 5(1)

This study identified several barriers in utilizing the interpreter services in primary health care settings. Most importantly, there is no provision of a face-to-face professional interpreter service in general practice settings. Although the telephone interpreter service is available to use in general practice settings, this service was reported to be underutilized due to some difficulties in making a booking in advance. In addition, some older Bhutanese women lack of confidence in having phone conversations.

It is important to note that the phone interpreter option is not available for the midwives to use in providing maternity services in the community. Therefore, these midwives have been relying on Bhutanese women's families and friends for interpretation when providing maternity care for Bhutanese women.

Although all participants felt strongly about the inappropriateness of using family members as interpreters, they acknowledged that it happened because there were no other options. Bhutanese women were not able to fully exercise their right to effective communication as outlined in the Code of Rights. Considering that effective communication is the key for accurate diagnosis and appropriate treatment, it is essential to provide professional in person interpreters in the primary health care setting if Bhutanese women's health needs are to be addressed effectively. As highlighted by Marcela Garces et al. (2008), the lack of professional interpreters could contribute to miscommunication, medical error, and compromised patient safety.

Health care interpreting requires special training in anatomy, physiology, pathology (Crezee, 2013) as well as decision-making in ethically, culturally, and linguistically challenging complex scenarios (Australian Institute of Interpreters and Translators [AUSIT], 2012; Dean & Pollard, 2011; New Zealand Society of Translators and Interpreters [NZSTI], 2013; Sign Language Interpreter Association of New Zealand [SLIANZ], 2012). Languages of limited diffusion (meaning languages that are spoken by relatively small numbers of people) are a challenge to interpreters, especially if speakers of these languages had interrupted schooling due to their refugee journeys and never enjoyed classroom instruction in their mother tongue (Burn et al., 2014). Interpreters need to have an understanding of the health care system, physiology, and pathology, to be able to unpack complex concepts in plain terms (Magill, 2017). These recommendations are well aligned with the WHO's human right-based approach that emphasizes that all the health services must be scientifically sound and of high quality (WHO, 2016).

Previous research has shown that language and culture-concordant care or assistance by very well trained and knowledgeable bilingual navigators may offer the best outcome. Speaking from many years of experience in coordinating navigators for migrant patient communities in Belgium, Verrept (H. Verrept, personal communication, December 20, 2014) suggests that nurses who are native speakers of the community's language may be the most suitable candidates to be (re)trained as patient navigators. Crezee and Tupou Gordon (2019) describe the success of language and culture-concordant care to the Tongan-speakers in Auckland, where the latter would reveal barriers to care that they might feel embarrassed to discuss with other health professionals. As

Palmer-Wackerly et al. (2019) suggest, establishment of community health worker (CHW) role can be relevant to address cultural communication related barriers when working with ethnic minority populations. As CHWs understand the local sociocultural and linguistic context of minority voices, they are more likely to tailor their services including interpretation support to meet the community needs.

Our findings support practice and policy changes to realize the right to health care for refugee populations in New Zealand. Most importantly, it is recommended to provide face-to-face interpreting services in primary health care practices serving refugee populations. Furthermore, it is recommended to establish community navigators to facilitate coordinated care that meet the sociocultural and gender-specific needs of Bhutanese refugees. It is also recommended to develop health information resources in Nepali language and utilize them to enhance communication with Bhutanese refugees for effective primary health care services. It would be more sustainable to identify resources within the Bhutanese community and utilize them appropriately for mutual benefit. Considering their sociocultural background as well as their lack of familiarity with health service delivery system of their host nations, it is vital to advocate for refugee patients regarding their rights and responsibilities in their host nations.

### **Strengths and Limitations of the Study**

This study has reflected a diversity of viewpoints of service users as well as service providers about interpreter services in New Zealand. The issues raised in this study might also be prevalent among other Bhutanese refugee women or refugee women in general who have been resettled in New Zealand as well as other countries that are accepting refugees for resettlement. A qualitative approach helped to gain deep understanding of the complex situation by giving participants an opportunity to voice their experiences and concerns in their own words. Another strength is that Jagamaya shares a common ethnic heritage with the Bhutanese participants and therefore gaining entry to the group and establishing trust and rapport was easily established. We hold separate focus groups of men from women to ensure that the women's voices were not constrained by the presence of men. Furthermore, the moderation of data translation by a qualified bilingual person ensured that the data accurately reflected the Bhutanese participants' words.

Although this study has contributed to a better understanding of both service users' and service providers' perspectives in regards to the effectiveness of interpreting services in addressing health needs of Bhutanese refugee women, the limitations of the study must be

acknowledged. This study was conducted with one specific refugee population group utilizing a case study approach, which may not reflect the situation in other refugee population groups. Similarly, there is lack of generalizability due to the location of the sample and the voluntary nature of participating.

### **Conclusion**

Past studies suggest that refugees have complex health needs that need to be addressed effectively for successful resettlement. Despite having such complex needs, refugees in general are not accessing or utilizing health services effectively in their host countries. Communication difficulties due to language barriers are the most common challenges faced by refugees in accessing and utilizing health services post-resettlement.

This qualitative exploratory study examined the effectiveness of interpreting services in New Zealand for Bhutanese refugee women. Listening to Bhutanese women and men and health service providers, we identified inadequacies and constraints in the provision of culturally safe and effective primary health services to Bhutanese refugee women. This study provides evidence for recommendations to address these inadequacies. Although this study was undertaken with one specific group of people, the results may be relevant to other minority refugee populations. The findings of this study can be used in planning and implementing future strategies to better address communication supports, and to facilitate accessible, appropriate, acceptable, and quality health services that are the right of minority refugee populations in New Zealand.

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