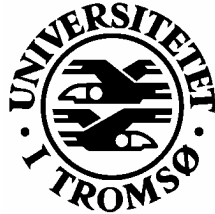


**Master of Public Health Thesis (HEL-3950)  
(Folkehelsevitenskap)  
Department of Public Health, Community Medicine**



**Faculty of Health Sciences, University of Tromsø  
Norway**

**Topic:**

**How Language Barriers affect the Quality of Health Care in  
Resettling Refugees: a synthesis of studies about refugees' perceptions of  
health care, especially primary care in European host countries**

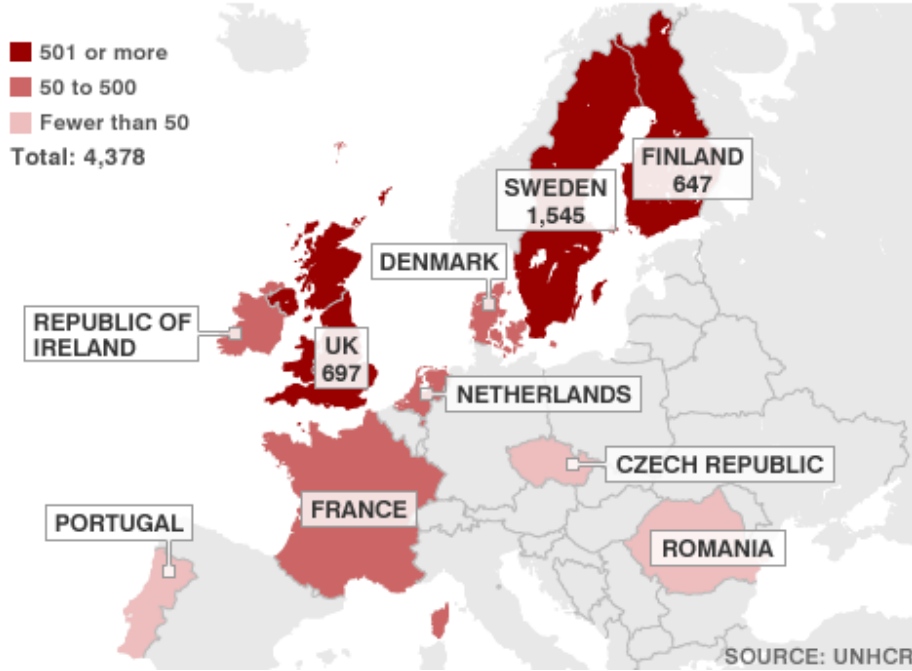
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***Deadline for submission: 1 August, 2010***

To risk fleeing from your own home may be costly, choice may not be right, but it's for a better future! (Anonymous source)

Number of refugees resettled in EU states, 2008



NB: Quota-refugee countries not mentioned here have no data for resettling refugee in 2008. Like Norway and others with huge asylum population, more focus was placed on managing their respective internal asylum burdens rather than on resettling new refugees.

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Importantly, I want to thank my supervisor, Professor Knut Holtedahl, for his constructive inputs and valuable reflections that led to the completion of this work. And lastly, I would like to pay a special homage to the millions of struggling and courageous refugees and displaced persons lingering in and around camps and still keeping the hope alive. This courage, I strongly admire. Never give up, there is always light at the end of the tunnel!

Yours,

Ken E Marblow,

Tromsø, 11 July 2010

## **B- ABSTRACT**

**Background:** The relationship between migration and health is real. Language barriers between health professionals and resettling refugees pose serious challenges in meeting health needs. In order to understand the different levels of impact this may have on refugee health conditions, their views, perspectives and reflections need to be considered.

**Aim:** To derive a holistic approach of the impacts of language barriers from the perspective of refugee patients. Interpreters' roles were investigated.

**Study design:** Synthesis (thematic) of qualitative studies.

**Method:** Medline, EMBASE and PsychINFO databases were searched. Studies were screened for relevance and appraised for quality. Thematic approach was used to synthesize findings. **Results:** From the 1989 abstracts, 17 studies from six countries were included in the final synthesis: UK (n=6), Switzerland (n=3), Netherland (n=3), Sweden (n=2), Ireland (n=2), Spain (n=1). They examined the general perspectives of how new refugees view their own health conditions after primary care visits with physicians. Studies showed that three major barriers affected their health: language, socio-cultural, and socioeconomic. Knowledge of local language may change one's health perception over time. **Conclusion:** A framework is suggested to reduce the impacts of language barriers in healthcare, and to help decision or policy making concerning resettlement and refugees. Having identified the different elements involved, future research is still needed to examine the real extent of the impacts on refugees (trust, satisfaction, confidentiality, etc.) during their stay.

**Keywords:** Language barriers, health care, refugee/patient, physician, interpreter, UN/UNHCR, resettlement program

## **1. INTRODUCTION**

### **1.1. Migrants and Refugees throughout history**

The practice of seeking refuge or granting asylum to people fleeing from persecution is one of the earliest hallmarks of civilisation. This can be backed by research references found in old sacred manuscripts and texts written 3,500 years ago, at the height of emergence of the great early empires in the Middle East such as the Hittites, Babylonians, Assyrians and ancient Egyptians (1). Migration is an old phenomenon used by our ancestors to travel from place to place with the intention of, more or less, permanently settling in a new location for socio-economic reasons. In addition, it has been observed that involuntarily or forceful movement of people because of wars has been an important factor to this increase in trend.

Today, violent conflicts (conventional, civil and ethnic wars) ensuing from sociopolitical instabilities are said to be the main cause of large involuntary or voluntary movements of people all around the world. As the result of this, one has to flee and seek refuge in safe haven because of the unwarranted persecution and severe threats posed to their wellbeing- environmental, security, socio-cultural and economic conditions. It is clear that this phenomenon of migration is rising to an astonishing level as more refugees produced from wars and other forms of violent conflict are being found everywhere. This sensitive and vulnerable group of people comes from different cultural backgrounds, which may present a serious challenge for integration in their new communities and new life- traumatic scars, language barriers and their health impacts.

Stimuli for migration may either be sociopolitical (man-made) conditions- wars, inadequate food, water supply and other forms of violence, or natural disasters - climate change, volcanic eruptions. These huge movements of people are observed all over the world; in particular, more people are fleeing from poor or unstable developing countries towards the developed or industrialized where more opportunities are available. In view of this, the health problems associated with migration are real and can pose challenges to the general population of host country in terms of infectious diseases. The fear of outbreaks and spreading of infectious diseases due to constant human contacts are current, thereby forcing every individual and governments to undertake serious preventive measures (AIDS ravaging Africa and poor countries, Bird flu, Swine flu from Mexico, etc.). In relation to this, Austveg mentioned some examples of migration related diseases of past and present global impacts: the cases of the Black death- commonly known as “*Svartedauen*” (*Norwegian language*) that killed about 25 million persons worldwide; measles, that also took the lives of many children in many nations (mainly non-immunized children in parts of the Americas) (2).

In our times, new outbreaks of epidemiological diseases have been named according to their places of origins (*Spanish sickness in 1920, Asian Sickness- around 1950, etc.*). In so doing, the challenges related to most of these health problems can be exacerbated by language discordance, cultural differences between health professionals and patients, low health literacy, thus also resulting into poor physician and patient relationship and quality of health care. The above mentioned condition may often lead to worsened psychosocial state of health associated with provocation, frustration and suspicion (2). These observed



factors and already existing stigmas make the host population to see them as being “vulnerable”, “sickness bearers”, “unhealthy”, etc.

The Triad *disease, illness and sickness*, have been used in applying to medical, personal or social aspects of human ailments. Understanding the concept of this complex phenomenon may vary from culture to culture and from scholars to scholars. These different levels of understanding are rooted into cultural construction of the society. In addition, constant changes and developments in societies, will give us diverse interpretations of disease, illness and sickness (both subjective and objective). Thus, it is said that disease is abnormality (biochemical, physiological or psychological); illness is deviation from normality, but resting on one’s own experience of symptoms or feelings; and, sickness is a social role of those defined as disease or illness (3). The mass exodus of refugees within a challenging global context may fall under any of these concepts as well.

### **1.1.1 Aim of the study**

The main aim of this paper is to identify perceived barriers to health care for refugees with respect to the language situation of host country, through published qualitative research studies. Such barriers, often underestimated and not really taken into account when meeting patients’ health needs, pose serious challenges for health care practitioners in offering services to resettling refugees, as well as challenges for the refugees’ attitudes and actions in a new environment.

## **1.2. Refugees and refugee agencies in modern times**

Protecting refugees became the main work of the United Nations High Commission for Refugees (UNHCR), which was established in 1950 by the United Nations (UN) General Assembly as the refugee agency (1). This agency succeeded earlier agencies having similar international accord in dealing with the refugee issue, like the League of Nations High Commissioner for Refugees, United Nations Relief and Rehabilitation Administration (UNRRA), which served as ad hoc global administrative body that provided protection for refugees victimized by World War II.

Prior to the establishment of the UNHCR, Fridtjof Nansen, a Norwegian scientist and explorer, served as High Commissioner for Refugees of the then League of Nations from 1922, which had the primary task of catering to the huge refugee problems emerging from wars, sociopolitical instabilities, including millions of fleeing Russian refugees from the communist's regime. But this was met with enormous difficulties in finding a durable solution to refugee problems, coupled with poor international cooperation and power struggles. The outbreak of the Second World War (WW II) which lasted from 1939 to 1945 approached slowly but surely. This war created the need to found a new internationally acceptable body that would be mandated to find a lasting solution to the refugee crisis. After WW II, the UN was founded, and some special agencies were also needed, one after another, to help take on this urgent tasks- UNRRA, the first agency; later, the International Refugee Organization (IRO) and then UNHCR.

The UNHCR 1951 Geneva Convention and its 1967 protocol laid the foundation for restoring hope and human dignity in millions of refugees all around the world (1, 4). But there continues to be widespread criticisms of some cases of inactiveness or malpractices of the UN, UNHCR and other organs of the UN in spite of the huge positive impacts made on many lives. An example in the “Mail and Guardian” online news dated September 8, 2008, stated that the local office of the UNHCR in South Africa was accused by the Aids Law Project (ALP) of not playing its role in protecting those that are supposed to be under its mandate. The accusation also meant failure to address the issues of victims of xenophobia at the same time, selective attacks on foreigners and refugees. Other visible criticisms are in countries where so-called UN peace keeping mission officers were engaged in illegal businesses and sex scandals, and not protecting innocent populations under threat. The Congo (Democratic Republic), Somalia, Liberia, etc. are some examples. In referring to its primary purpose of firmly safeguarding the rights and well being of refugees, it also provides humanitarian assistance to other persons “of concern,” including internally displaced persons (IDPs) from wars or natural disasters who fit within this same international legal framework. For instance, the UNHCR provides relief supplies and services to victims of natural disasters (Tsunami disaster in the Indian Ocean) which are normally not part of its mandate (1).

### **1.2.1 Resettlement and Repatriation....**

The work of the UNHCR is not only to protect and assist refugees as mentioned but also to provide and seek solutions to their plights. There are three durable solutions; *voluntary repatriation, local integration and resettlement*. It helps refugees voluntarily repatriate to

the homeland if conditions warrant, or helps them integrate in their countries of asylum. In practical term, this means that the burden of refugees' plights and eventual responsibilities are taken over by the various countries where they are resettled respectively. These countries offering resettlement to refugees are usually signatories to a special agreement with the UNHCR. At times, the UNHCR quota refugee or partner-countries may not have the capacity of hosting a large number of refugees. However, non-signatory countries or former resettlement countries like France and Germany, also accept and canton asylum seekers and unspecified immigrants on humanitarian grounds.

Thus, resettlement is a process whereby particularly vulnerable refugees are identified in a country where they have sought refuge and resettled into a safe country, which has agreed to resettle them. However, there are conditions that determine whether resettlement to a third country is the safe and viable solution for refugees, for example, protection, security and better future. Only a small fraction (about one percent) of the millions of refugees in the world, according to UNHCR report for 2007-2008, is referred by the UNHCR for resettlement. Resettlement under the auspices of the UNHCR has a dual role. It serves as an instrument for ensuring the protection of refugees and it is one of the three durable solutions mentioned. Thus, resettlement addresses the special needs of refugees which cannot be met adequately in the country of refuge or asylum. In related development, the establishment of the Working Group on Resettlement in the mid-90's, a consultative body comprising of the UNHCR and resettlement countries, became essential to fostering partner's efforts, and enhancing resettlement as a tool of

international protection, a lasting solution and a responsibility and burden-sharing mechanism.

### **1.2.2 Overview of the UNHCR's Quota Refugee Program (QRP)**

Recently, an overview by the UNHCR of the present plights of refugees everywhere compels it and local field partners, other international aid organizations (Red Cross, MSF, WFP, Norwegian Refugees Council, etc.) to prioritize the need of providing various forms of support to these suffering people. UNHCR as such, continues to ask developed countries to provide sanctuaries to vulnerable refugees. Countries choosing to be part of the refugees resettlement change from year to year based on their own internal socio-political priority-setting, the need to honor international obligations and their ability to cope and provide the right kind of resettlement “introduction program” to these new arrivals. In most resettling countries, the package will mainly include: learning the local language (theoretical and practical), equal access to health care and social benefits, and dignified treatment. Currently, there are 11 governments (*Australia, Canada, Denmark, Finland, Ireland, New Zealand, the Netherlands, Norway, United Kingdom and the United States*) have agreed with the UNHCR to help resettle and provide protection for these deserving refugees in their respective countries (5). This is more than past year where nine industrialized countries (*Australia, Canada, Denmark, Finland, New Zealand, the Netherlands, Norway, Sweden and United States*) were willing to resettle refugees. This shows that more countries are gradually seeing the need.

The total number of refugees and internally displaced persons (IDPs) under the care and control of the UNHCR is roughly estimated at 25 million, practically unchanged since 2007, and together accounting for three quarters of all those falling under UNHCR mandate. According to the UNHCR report for 2008, there were 10.5 million refugees and 14.4 million internally Displaced Persons (IDPs). Moreover, this amount excludes the 4.7 million Palestinian refugees under the supervision of the United Nations Relief and Works agency for Palestinian Refugees in the Near East are not included (UNRWA) (5). The latter has a similar function as the UNHCR, except that it has a specified but local mandate to cater only to the plights of Palestinian refugees (see table 1).

Pakistan hosted the largest number of refugees worldwide, followed by Syria. Pakistan held this same position in relation to economic capacity (733 refugees per 1 USD Gross Domestic Product or GDP/PPP=Purchasing Power Parity per capita) followed by Democratic Republic of Congo, 496 per 1 USD GDP (PPP) per capita, and so forth. Meanwhile, Germany comes in this same category as the first developed country at 26<sup>th</sup> place with 16 refugees per 1 USD GDP (PPP) per capita (6). But, the United States remains the world's top refugee resettlement countries, also with the largest single recipient of asylum claims, seconded by France, and next by Canada. The UK and Germany subsequently claimed the fourth and fifth rankings respectively (7). Germany, France and other developing countries that are already overwhelmed by huge immigrant intake, still see the need of offering shelter to fleeing and stateless persons despite the serious impacts of asylum wave. In this regard, Germany is said to be the first country in Europe hosting the largest number of refugees (582,700) up to the end of 2008 (6). On

the one hand, Australia, Canada, Sweden, Norway and others provide sizeable number of places annually, while Italy, Greece, Switzerland, Spain, Nordic countries and others (USA, Canada, etc.) continue to be concerned about large influx of asylum seekers in their respective countries, many poor and developing countries also experience similar trend. In recent times, the European and Latin America countries have seen some increases in resettling of refugees in recent years.

**Table 1. Summary of categorization of displaced population in 2007-2008.**

Category of displaced population	2007 (in million)		2008 (in million)	
	Total	Protected/assisted by UNHCR	Total	Protected/assisted by UNHCR
Refugees under UNHCR mandate	11.4	11.4	10.5	10.5
Refugees under UNRWA mandate	4.6	-	4.7	-
<b>Total number of refugees</b>	<b>16.0</b>	<b>11.4</b>	<b>15.2</b>	<b>10.5</b>
Asylum seekers (pending cases)	0.7	0.1	0.8	0.2
Conflict generated IDPs	26.0	13.7	26.0	14.4
<b>Total number of refugees, asylum seekers and IDPs</b>	<b>42.7</b>	<b>25.2</b>	<b>42.0</b>	<b>25.1</b>

NB: UNHCR= United Nations High Commission for Refugees, UNRWA= United Nations Relief and Works Agency for the Palestinian Refugees in the Near East; IDPs= internally displaced persons

Although efforts are being made by the UNHCR to curtail and manage the huge burden of refugee under its control, differences in seasonal increases have been observed among asylum seekers (10%) and IDPs (over half-million).

### **1.3 Europe's contribution to establishing Peace and assistance to refugees**

Europe is known for its history of major armed conflicts or violent events that have affected the lives of its population (World War I, World War II, etc.) and people elsewhere. As such, it is forced to play an important role in hosting, formulating and facilitate international peace agreements that helped resolve conflicts. This initiative led to the formation of a global monitoring framework like the League of Nations, UN and its established agencies and many more. Among the approximately 29 nations represented at the Geneva Convention, 17 came from Europe (*Austria, Belgium, Denmark, France, Germany, Greece, the Vatican, Italy, Lichtenstein, Luxembourg, Monaco, Netherlands, Norway, Sweden, Switzerland, Turkey and the United Kingdom*), Yugoslavia (Balkans- was then under the former Soviet Union) and the rest were non- European countries (*Australia, Brazil, Canada, Colombia, Egypt, Iraq, Israel, Venezuela and the United States of America*). Cuba and Iran attended the convention but only as observers. Denmark was the first country to ratify the treaty on the 4<sup>th</sup> of December, 1952 and there are now 147 signatories to either the Convention or the Protocol or to both. The first specific mandate with enormous challenge upon its formation was to solve the huge problems of European refugees after the Second World War. One of the main principles agreed on at the convention is that refugees should not be expelled or returned “to the frontiers of territories where [their] life or freedom would be threatened” (4). As conflicts



mushroomed around the globe, this definition of who is, or should be a refugee widened going beyond geographical boundaries, backed by *1967 Protocol*, the *1969 Organization of African Unity Convention*, and some other treaties, but clearly excluding fighters, terrorists or people guilty of serious offences (1).

With this acknowledgement that most European and Nordic countries have positively contributed to refugee wellbeing through the resettlement program, the economic burdens and benefits for host nations cannot be ruled out. Still, the need for offering help to other needy populations elsewhere continues to rise, posing different types of challenges in meeting these needs. Because of the complex nature of the different categories of vulnerable persons involved, we would like to focus mainly on resettled refugees into European countries through bilateral agreement (referred to as quota refugee program (QRP)) between the UNHCR and the host government in the past two decades.

## **1.4 Definition of some important concepts**

### **1.4.1 A refugee**

Legal experts and specialists in this field are still finding it difficult to come up with the right definition of the word “refugee”. The original term “refugee” seems to lie in a Latin verb: *refugere*, meaning to retreat by fleeing (8). The word was first used in its modern sense as adjective in the seventeenth and eighteenth centuries (9). On the one hand, a more acceptable, commonly used definition is an individual who, “*owing to a well-founded fear for reasons of race, religion, nationality, attachment to a particular social group, or political opinion, is outside the country of his nationality, and is unable to or,*

*owing to such fear, is unwilling to avail himself of the protection of that country”* (1, 4).

This definition was formulated from the Geneva Convention and covers those under the arrangement of 12 May 1926 and 30 June 1928, or under the Convention of 28 October 1933. It also includes events occurring in Europe and elsewhere before 1951 (4). In our times, the definition has embodied a wider scope due to the urgency involved in providing protection and assistance for different categories of needy people. In so doing, stretching the UNHCR mandate to cover seven population categories, and two additional sub-categories later, referred to as “persons of concern to the UNHCR” (6).

#### **1.4.2 An asylum seeker**

An asylum seeker is a person also affected and fleeing from conventional warfare, civil wars or other forms of threat against his life. What is special about this group is that they are without status; they struggle for a “safe haven” all by themselves and seek humanitarian protection from persecution back home. The trend shows that most asylum seekers and migrants from poor, war-ravaged countries undertake all sorts of risky endeavours to enter industrialized countries. Upon arrival, they spend a lot of time in reception camps of the host country while waiting for their fate to be decided. In most cases, delays and uncertainty concerning their status in these camps may lead to negative consequences on the general health and wellbeing of asylum seekers. In particular cases, the risk of mental health illnesses are reportedly high in this group. Throughout this thesis, the use of the term “*refugee*” will usually refer to “*refugee and asylum seeker or unspecified immigrant*” arriving or living in the countries of concern. Any single use of these words outside of this context will be explained.

### **1.5 My choice of topic based on personal experience**

My personal experience as a refugee who lived in two civil armed conflicts gives me a better insight of the daily struggle for survival, at the same time facing the challenges of preserving ones basic values, norms and beliefs. Perseverance and endurance are basic qualities needed if one is to overcome the ills of this human-made tragedy. These different experiences are sometimes hard to describe because of the traumatic, humiliating, discriminatory and flash-back images associated with them, First, I had to flee from a brutal, civil war in Liberia in 1990 that killed over 250,000 people, ruining the lives of many families and structures of the nation “forever”.

Secondly, living under different phases of armed conflicts in the Ivory Coast that later ended into a full-scale civil war was more traumatizing for me. This divided my first host country into two equal parts, the “*rebel northern stronghold*” and the “*Government-controlled southern*” territories respectively since 2003. Violence (abuses, extortion and tortures) against refugees continued to be experienced at different levels of the society by uniformed officers. Also, well organized socio-ethnic discriminatory actions against immigrants were a normal routine. How can one develop positive “spirits” in the wake of such a dreadful and challenging period? This is left with how one develops an inner capacity to move on. Learning a new language to fit in a new society will require tremendous efforts. Learning to write and speak the French language was a necessity because I needed to navigate my way through the system (school or work). Using different strategies, I purchased bilingual books and dictionaries (French-English) to do a lot of self-reading at home. Speaking and writing formal French was my utmost goal,

building social network were also part of my challenge. Despite all of this, the challenges still existed at different levels, at the academic and society level (xenophobia, socioeconomic, etc.).

Resettlement into Norway, in my opinion, offers me and others, a better prospect and a promising future where past traumatic experiences may take a new shift. The issue of language and communication difficulties also exists like in my previous setting. In fact, western societies are better organized when it comes to caring for refugees, and have programs that are laid-out to meet needs and improve communication skills among individuals. One needs to work rigorously, and one also needs help from support structures in order to get proper care, access to treatment and other important services. Without this, the scars may never heal. The potential impacts of the gaps in accessing health care (wrong diagnosis and treatment) due to language and cultural barriers may be experienced by refugees at different levels of migration or resettlement. This sparked in me the urge to explore the perceptions of health care received by refugees with respect to their backgrounds, in particular, the impact of language or communication barriers in accessing health care. Thus, I hope to identify possible contributions in improving refugees' health conditions.

## **1.6 The health of refugees**

### **1.6.1 Refugees, resettlement and barriers to healthcare**

Refugees resettled or migrating to industrialized countries are likely to be at higher risk than other immigrants for several known determinants of poor health including poor

nutritional status, reduced social support, and traumatic experiences. This is being addressed largely in terms of infectious disease and other public health risks to host country nationals. These health challenges will obviously demand regular contact between physicians and migrant refugees, including specialists in institutions. In addition, it is known that both internally and externally displaced refugees are exposed to various health problems and needs that are dominated by serious and often overlooked mental and psychological problems that are linked to past traumatic experiences (10, 11) and many bring with them somatic diseases related to poverty, malnutrition and poor previous access to health services. The lack of good understanding of refugees' problems and cultural values have resulted to obstacles in delivering effective health care and mutual trust between health giver and health care receiver, especially in primary care. This relationship is an important concept in health care.

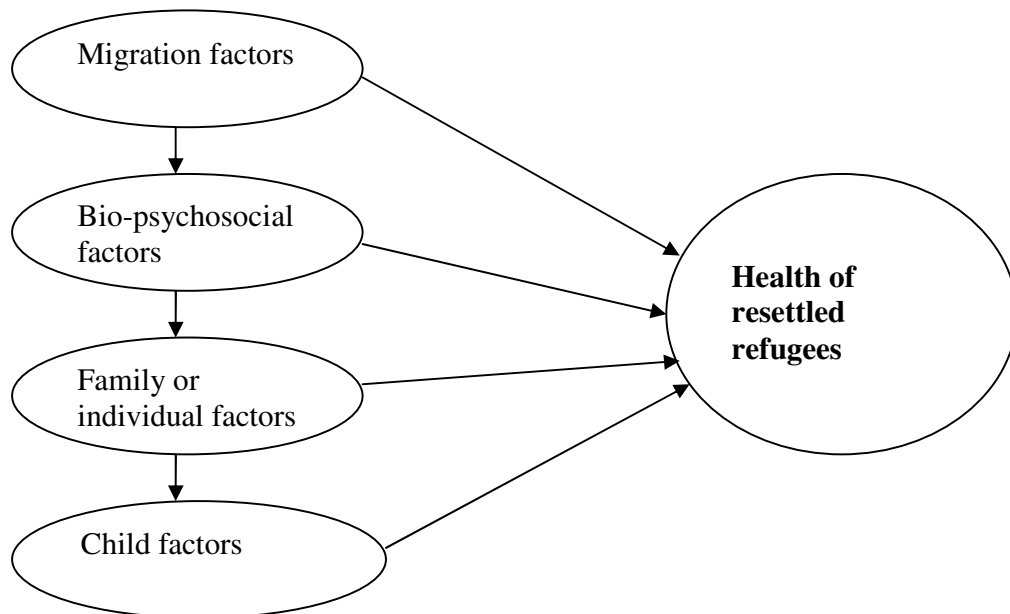
Importantly, language plays a serious role in influencing the expression and personal perception of psychological conditions (12-14). Also, language problems hinder general practitioners (GPs) understanding of patient's needs and may lead to decreased symptom reporting, fewer appropriate referrals, poor service and dissatisfaction (15,16). In addition, the specific cognitive, emotional and symbolic meanings of words can become effective mainly if they can be understood and communicated evenly among peoples. Interpreters are useful in areas where the problem of language creates communication difficulties. Translation is feasible (17), though not an easy task and rates of missed diagnosis can be very high without cross-cultural diagnostic methods. Increased cultural awareness and sensitivity is said to facilitate communication, management and

compliance in consultations with people of different cultures (18-20). Cultural awareness is particularly important when meeting the care and other needs of refugee populations due to the limited local language proficiency of refugees in the receiving country. Refugees' countries of origin usually have different explanatory models of distress which if not considered, may differ from the refugees' countries explanatory models and models of distress (21-24). This may lead to difficulties in diagnosis and initiating treatments in areas such as psychological therapies. Language barriers among refugee patients have been observed and documented in many areas and lead to inadequate health care or poor medical attention in resettling countries (25). In addition, cultural and language barriers are two interdependent or inseparable factors that play an important role in determining health and wellbeing of refugees. A holistic approach of refugees' experiences and underlying problems, combined with empathy and careful work, may produce more precise diagnose (26, 27) and more adequate referrals and therapy.

### **1.6.2 Summary of factors contributing to many health problems in displaced or resettling refugees, based on the conceptualisation by Gagnon et al. (28).**

The vulnerability of refugees directly exposes them to different kinds of diseases and health problems of unimaginable scales. Below, figure 1 shows a summary chart of the relationship between multiple factors that are connected to refugees' health and table 2 lists details for each of the four main factors contributing to refugees' health (28).

**Figure 1. Summary chart of multiple factors and refugee health**



**Table 2. Factors associated with/contributing to refugees health conditions**

**Migration factors:**

- \* Forced to leave country
- \* Decision to migrate
- \* War in source country
- \* War and threats in second country of asylum
- \* History of torture/ mistreatment
- \* Family separation
- \* Relocation in new country
- \* Attitude toward immigrants
- \* Legal status
- \* Camp/detention/prison experience
- \* Contact with country of origin
- \* “Like community” in new country
- \* Length of time in new country
- \* Official language ability (& access to learn languages)
- \* Discrimination experience
- \* Acculturation
- \* Health insurance
- \* Access to translation

- \* Work permission
- \* Access to services
- \* Traditional services availability
- \* Access to translation services

**Bio-psychosocial factors:**

- \* Age
- \* Education
- \* Religion
- \* Nutritional status or Diet
- \* Infectious disease or exposure to disease(s)
- \* Environment (weather, city, neighbourhood, etc.)
- \* Solving problem through the right channels
- \* Employment/unemployment history
- \* Income history (household, dependents, etc.)
- \* Stress/anxiety
- \* post traumatic stress disorder
- \* Somatisation
- \* History of substance abuse
- \* Services available or received (western/traditional)
- \* Cultural acceptance/challenges
- \* Socioeconomic Status
- \* Injury
- \* Social support

**Family/Individual factors:**

- \* Gender rights/ equality issues
- \* Family values
- \* Cultural beliefs/ challenges
- \* Morals
- \* Individual contribution
- \* Integration/assimilation (new culture...)
- \* STI/HIV (treatment/prevention)
- \* Extensive medical check-ups (infection)
- \* Pregnancy/childbirth history
- \* Current history of pregnancy/childbirth
- \* Gender's role in families/workplaces
- \* Hygiene and knowledge of what to do in case of health threats, emergency,



services received, etc.)

- \* Family planning
- \* Post-abortion care
- \* Gender violence/genital complications  
(rape, circumcision...)
- \* Communication problems in primary health  
(care understanding information given by health professionals)
- \* Men losing prior authority/  
responsibility in their families.
- \* General health care/behaviours
- \* Immunisation
- \* Work/language school/Home
- \* Depression/stress/ anxiety in parents.

**Factors associated with refugee children's health, either newly arrived or**

**born in host country:**

- \* Cultural understanding of health needs
- \* Cultural confusion, assimilation and adaptation
- \* Identity problems
- \* Parental-child interaction
- \* Abuse of minors' rights to self determination and accomplishments by minors
- \* Home/school education and societal expectations/material wellbeing
- \* Family quarrels/ physical fights (between parents, parent-child, etc)
- \* Substance use/smoking/alcohol use
- \* Past trauma (rape, abuse, genital mutilation...)
- \* Feeding (breast, traditional...)
- \* General health
- \* Socioeconomic (home/clothing...)
- \* immunization/ child safety/  
history

### **1.6.3 Refugee migrants and infectious diseases in Europe**

Infectious diseases are still important all over the world, but they are no longer an important cause of mortality in industrialized countries. This is very different in poor countries where almost half of all deaths are still due to infectious disease (29). Among the infectious diseases, the re-emergence of TB among vulnerable population poses challenges to public health in areas where they are less controlled. In 2007, there were 21% reported cases of TB, with a proportion ranging from 26% to 79% in 17 countries. Overall 27 countries reported “areas of origin” of TB cases which were dominated by foreign cases; with cases recently observed in younger age groups having foreign backgrounds which are associated with higher treatment defaults and poor outcomes (29). According to the European Center for Disease Prevention and Control (ECDC) registrations of cases among nationals decreased in all countries between 2001 and 2007, but with cases of foreign origin increasing in 2005, and then decreasing in 2006 and 2007 respectively (30).

Human Immunodeficiency Syndrome (HIV) is an important health issue in most European countries with comparatively low (high) levels of incidence and prevalence depending on individuals concerned and their source of origin. Unsafe sex among men who have sex with men and unsafe injecting practices (sharing infected needle) are infectious. Migration also influences the epidemiology of HIV in Europe, and according to ECDC report, 46% of all cases of heterosexually acquired HIV infection in Western Europe in 2005 to be associated with migrants from high prevalence countries. Spain registered high rates of women sex workers and the UK reporting infected migrants

between 2004 and 2006 from mainly Sub-Saharan Africa, accounting for ninety percent of the total 70% HIV incidence in migrants. Belgium and France also reported increase in AIDS cases among migrants and foreign-born by 50% and 20% in this same period. Sweden, Italy, Ireland, Germany, Netherlands and Spain also observed disproportionate representation in HIV statistics of foreign-born cases in their respective countries (30).

Chronic and untreated health problems, childhood diseases and vaccination of children are special situations that compel refugee parents to visit primary care and are required to understand and apply recommendations or health advice given to them. The case of vaccine preventable diseases like hepatitis A and B still pose serious challenges to the European public health systems. Some of the explanation is exacerbated overcrowded population partly caused by mass movements of people from different cultures, poor hygiene, and limited access to some basic facilities (clean water and sanitation) especially in Southeastern and Southern Europe. The mode of transmission varies from contaminated food, water, injecting drugs and sexual contacts. Several outbreaks have been reported in Luxembourg (2000), Italy (2002), UK (2003), Denmark (2004), and Germany (2004) (30). Overall, it can be said that appropriate health care for migrant population is in the interest of both the migrants and the native populations. And, this is so not only for infectious diseases, but for all kinds of disease which affect smaller or larger communities in the host country.

#### **1.6.4 Global challenges when forced migration increases: also an EU Issue**

Immigrants and refugees sometimes confront the same challenges. European immigrant

populations also face disadvantage of health risks other EU countries. A recent study done in EU among Finnish immigrants showed that differences in culture and ethnicity associated with immigrants affect access to the right kind of health care, treatment and often lead to higher medication safety risks (31).

In addition, outbreak, renewal and prolongation of violent conflicts, also hosting immigrants, have and will always influence peace and security, as well as health conditions in many regions of the globe. For the last two decades, the number of refugees fleeing from different armed or violent conflicts to near and far away countries for “safe-havens” has rapidly increased. According to available information, there were 42 million forcibly displaced people worldwide at the end of 2008 (32). The total number of refugees in Europe, including those in refugees-like situation, to a little over 1.6 million at the end of 2008, contrary to over 1.5 million at the start of the same year (6). As illegal immigrants entering industrialized countries increase, the number of individuals seeking asylum or refugee status in the so-called “44 industrialized countries” (see annex) have also fluctuated dramatically for the past two years, and they make asylum and refugee data available to the UNHCR on a regular basis (7). An estimate of 185,000 applications were reported during the first six months of 2009, which was 10 percent higher than during the same period in 2008 (168,900) because of changes due to seasonal pattern. Also, Thirty-eight European countries in this same report recorded 139,600 asylum applications during the first semester of 2009, i.e., a 13 percent increase for the same period of 2008 as compared to 11 per cent drop (123,000) in second semester of the same year (7).

These changes also show a drop in the number of refugees under the UNHCR for the first time since 2006 in regions where refugees are sheltered, constituting a decrease of about one million refugees compared to the year earlier (11.4 million). In addition, the drop in the levels of asylum applications can be attributed to forceful or voluntary repatriation carried out by individual governments wanting to curtail the high rates on immigration in their respective countries (5), usually in consultation with the UNHCR, IOM and the authorities in refugees' home country.

### **1.7 Possible theoretical approaches**

Models, theories, constructs, hypotheses and sometimes ideas may be seen as heuristic devices, not as sacred truth. Changing social phenomena in the face of development help us to rethink and gather evidence for knowledge. This approach is holistic and should be interpreted consistently and explicitly. This is, to some extent, what we described in the methods section, but this approach can be supplemented by some reflections about theoretical ways of looking at our subjects.

#### ***Life-world and System-world***

Habermas, a famous German philosopher and social scientist, discusses '*how speaking and acting objects acquire and use knowledge*'; and how their views and perception can be rightly interpreted and understood in the "*system*"- meaning predefined situations, or modes of coordination, in which the demands for communicative action are continued, within legally specified limits. This system world is different from each individual's

*“life-world”* – referring to background resources, contexts and dimensions of social actions that enable people to act on the basis of mutual understanding. Such understanding is based on cultural systems of meaning, institutional orders that stabilize, directly or indirectly, patterns of action, and personality structures acquired in family, church, neighborhood, school, etc. (33). Within all these various philosophical conceptualization and interpretations, this model focuses on the role of language in fostering communication and understanding and producing other benefits that cannot be underrated. The topic of this thesis can be seen as an analysis of how refugees’ life-world meets and must face realities in a foreign system world.

### **1.8 Salutogenic theory- a guide to health promotion**

In related development, other models also focus on factors that support human health and wellbeing, rather than on factors that cause disease. The salutogenic theory developed by the medical sociologist Aaron Antonovsky (34) is a more viable paradigm for health promotion research and practice. The sense of coherence (SOC) framework is offered as a useful tool for taking a salutogenic approach to health research. This central idea of SOC is based on acceptance of one’s situation as it comes, and developing the necessary inner resources, called generalized resistance resources- “GRRs”, to counteract a range of psychosocial stressors. Experiencing challenges with a lot of motivation may help a person to looking and feeling healthy in spite of psycho-somatic problems. With unknown prevalences of mental disorder among millions of refugees, it is better to place emphasis on free expressions of refugees’ experiences (their views and meanings). This

is in order to detect potential risk and carefully seeing the need for setting priority during screening exercises and primary care visits carried out by health professionals (35).

In a recent systematic review of surveys of refugees resettled in western countries (36), it was shown that refugees are about ten times more likely than non-refugees to have post traumatic stress disorder; suggesting that tens of thousands of refugees worldwide and former refugees resettled in western countries probably have PTSD. In addition, findings from 20 eligible surveys covering 6743 adult refugees from seven countries show that 9% (99% CI 8-10) were diagnosed with PTSD and 5% (4-6%) with major depression with evidence of much psychiatric comorbidity. In addition, another five surveys of 260 refugee children from three countries showed a prevalence of 11% (7-17%) for PTSD (36).

The salutogenic theory draws attention to people's ability to cope with and manage potential sources of illness conditions (PTSD, stress, depression etc.) that could normally alter a person's state of health. The theory may be applied to understanding why some refugees can be at high risk or easily develop mental health disorder and others not, entirely depending on the way one adapts to coping and managing strategies. The aim is here is not only to treat symptoms but to point out the reality that people have some choice living positively to combat the risk of developing mental or psychological health past and present traumatic experiences. It is a concept largely used in health promotion.

On the conceptual level, health promotion is associated with the WHO vision of “*Health is a state of optimal physical, mental and social well-being, and not merely the absence of disease and infirmity.*” Meanwhile, the definition of health promotion, according to the European Regional Office Ottawa Charter “*...is the process of enabling people to increase control over, and to improve their health (34).*” In order to control and make an impact in health promotion actions and initiatives, one must master language or have alternative ways to communicate. A successful health promotion will have important economic benefit for an individual as well as for the society. This would decrease the need for spending on disease and allow people to be more economically productive (less absenteeism, greater work efficiency, and many more). This is the same principle that guides screening programs in areas where refugee are taken because of major health risk associated with them.

## **2. METHODS**

### **2.1 Selection of literature**

We performed a qualitative literature study using the following procedures: First, identifying and evaluating literature on the relation between communication barriers and (poor) health outcomes for the migrant-refugee population group consulting in primary healthcare (usually during first-time visitation). And second, deciding selection criteria based on quality of literature concerning the state of health of the refugee population (psychosomatic health in relation to issues of culture and language in host countries).



### **2.1.1 Identification of relevant studies**

The principal definition for the search was on studies using qualitative methodology with a main focus on newly arrived refugee patients' experiences in primary care of their host countries and how they evaluate the system. The Medline, EMBASE and PsycINFO databases were searched from January 1989 to current.

#### ***Search strategy includes:***

1. refugees OR immigrants
2. language barrier OR communication barrier OR qualitative research OR interview  
OR perception OR focus group
3. Health care quality OR quality of health care
4. #1 AND #2 AND #

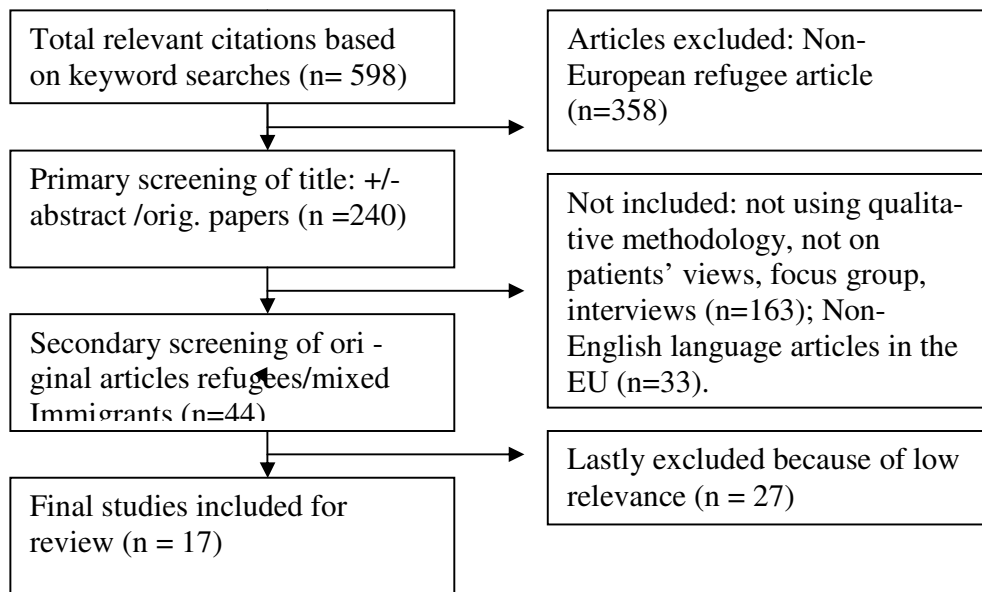
Citations and abstracts that were not directly relevant to our key searches were excluded and the primary and secondary steps for the screening of the remaining papers or publications began (Figure 1). Most citations were screened on the basis of their title or abstract, and the original paper was explored in case more detail was needed. In the primary screening qualitative research on refugee patients' views of their encounter with primary using focus group or interview were identified. While in the secondary screening, citations were scrutinized to see if they were to be explored.

### **2.1.2 Inclusion/exclusion criteria of the study**

Studies were included if they were written in English and took into account the overall health condition of resettled refugees in Europe (EU and Nordic countries), mainly those countries that are signatories to the quota refugee program, using focus group and interview models respectively. For example, this will include general health care in areas like nursing, medical, surgical and psychosocial care (primary, ambulatory and secondary). These selected countries were mainly signatories to a bilateral cooperation with the UN/UNHCR known as the quota refugee program.

Furthermore, the role of translation and interpreter services during and after medical and related care consultations were considered. Studies also include articles that focusing on the perception or evaluation of both doctor and refugee patient in a “doctor-patient relationship” and unspecified refugees (asylum seekers, extended or acquired refugee status through family reunion, etc.). Articles were excluded when they either did only take into consideration the views of health care providers alone and not the targeted population or did not meet the methodological criteria or could not simply be accessed from the particular database because of technical problems. Abstracts and full copies of selected articles were assessed to be included in the review.

**Figure 2. A summary flow chart of study inclusion /exclusion process/search results**



Results from the searches yielded 598 (i.e., 289 for Medline, 189 for Embase and 120 for Psychinfo). As the initial search strategy had low specificity for qualitative papers, the majority of the papers were rejected because they were not qualitative, not covering refugees' own experiences/views, or non-European. Qualitative based interviews with qualitative analysis were not rejected. We also searched for articles on health professionals (physicians, nurses and health researchers) reporting of direct experiences with refugee patients. After this selection process 44 articles remained and were photocopied. Further consideration of exclusion criteria yielded the 15 published articles. A supplementary search in Google found two more articles that fitted into our selection criteria and added, making up the total final to 17 articles that seemed to have satisfactory design, analysis and findings. Although finding a universal appraisal skill for this kind of study method is still a scholarly debate, a framework based on Critical Appraisal Skills

Programme (CASP) quality-assessment tool for qualitative studies (37) for the final 17 studies was used.

Searches arrived at cover wars and violent conflicts over the past two decades that resulted into increasing global refugee burden. It is believed that this single period produces more isolated violent events contributing to huge numbers of homeless, traumatically stressed refugees in our modern times. Studies on refugees' experiences (perception, reflections or views) in resettlement countries in the EU and Nordic countries that are member of the UN quota program (mentioned earlier) were selected. Relevant studies done in other EU countries where asylum seekers or unspecified immigrants are high were also considered. The reason for widening the scope of selection criteria to include studies on asylum seekers and unspecified immigrants is that most of them are often victims, either directly or indirectly of violent conflicts and life threatening events, who later end up in getting status as refugees. Thus, they are given residence to legally stay in host countries as considered by the UN charter or International Laws on Human Rights or the Geneva Convention (5).

## **2.2 Analysis of selected studies**

### **2.2.1 Thematic synthesis**

Thematic synthesis, a relatively rudimentary version of narrative reviews (38) was used to identify the topics or themes in each study. Such a process may provide us with a more organized, structured way of trying to analyzing these topics. In the case where interviewers talked with refugee patients and healthcare professionals or deliverers, only

the views of the patients were included. Serious consideration was given to studies focusing on triangular interactions between doctors, patients and interpreters and their views, perceptions or perspectives of primary health care. In addition, direct reporting of refugees' health conditions and experiences by general practitioners or health professionals through recorded interviews and genuine documentation was reviewed for inclusion. After reading the articles several times, we proceeded by summarizing (and providing) a key theme for each study. This was a data processing covering different aspects of the relationship between health care quality and language or communication barriers. Transfer of selected textual excerpts from the studies method/techniques (field notes, transcript from interviews, focus group, etc.) to thematic summaries helped identifying and comparing the concepts involved.

### **2.3 Ethical approval**

No ethical approval was needed as the study only draws on previously published material.

## **3. RESULTS/FINDINGS**

Consistently, the studies pointed to the impacts of language barriers on the quality of healthcare of refugees in the health care delivery systems. Thus, fifteen of the seventeen articles were centered on experiences, views and reflections about language in primary care. Interpreters or their services were also said to be determinant factors. The remaining two are centered on socio-cultural and socioeconomic barriers which can influence refugees' health conditions (discrimination, joblessness, education level, etc.). However,

it is not always simple to differentiate the relationship between culture, languages and barriers associated with socioeconomic status.

The problem of language is intertwined with or may influence some socio-cultural factors (levels of trust, cooperation, respect, etc.). The socio-cultural related barriers may also lead to other predictors of health care quality in refugees and shape users' and providers' perceptions of health care, that is, the triadic relationship physician-interpreter (mediator)-patients. Based on these realities, three main themes thus emerge from our literature study. These three can influence the quality of healthcare of resettling refugees: language, other socio-cultural experiences, norms, behaviors (original identity, prior knowledge, adaptation, institution context, etc.) and socio-economic linked with poverty affecting most migrants in the host country. In all of this, the refugee may experience the difference between his or her life world and the system world meeting him in the new country. The following is an effort to summarize findings related to these two barriers (39).

The characteristics of the 17 studies are summarized in Table 3. The various aspects may serve to generate analytical categories and develop some explanations for the phenomenon in question.

**Table 3. Characteristics of Studies in the literature synthesis**

Study	Country	Topic	Methodology		Participants					
			Interviews	Focus group	Questionnaires	Ref /Immigr	GP/nrs	Int.	Others	
Wiking et al	Sweden	General (Triangular) perspectives			Yes		Yes	Yes	Yes	
Agudelo-Suarez et al.	Spain	Socio-economic	Yes	Yes			Yes			
MacFarlane et al	Ireland	Language barrier		Yes			Yes			Yes
MacFarlane et al	Ireland	Language barrier	Yes				Yes			
O'Donnell et al	UK	Expectations/Trust (Healthcare systems)	Yes	Yes			Yes			
Bhatia and Wallace	UK	General (health) experience	Yes				Yes			
Palmer and Ward	UK	Mental health	Yes				Yes			
O'Donnell et al	UK	General Experience	Yes	Yes			Yes			
Ny et al	Sweden	Men's Healthcare experience (maternal/child)	Yes	Yes			Yes			
Suurmond and Seeleman	Netherland	Barriers (inter-cultural context)	Yes				Yes	Yes		
Ndirangu and Evans	UK	General (health) experience	Yes				Yes			
Bischoff et al	Switzerland	Language barriers	Yes				Yes /	Yes		
Harmsen et al	Netherland	Cultural (language barrier)	Yes				Yes			Yes
Papadopoulos et al	UK	General ( health) Experience	Yes		Yes		Yes			Yes
Harmsen et al	Netherland	Intercultural differences			Yes		Yes			
Hudelson	Switzerland	Language barriers (Cross-cultural)	Yes					Yes	Yes	Yes
Bischoff et al	Switzerland	Language barrier			Yes		Yes	Yes		

The aims, participants and key findings are summarized in table 4. The studies obtained were conducted in six European countries- UK (n=6), Sweden (n=2), Netherland (n=3), Ireland (n=2), Spain (n=1) and Switzerland (n=3) respectively. Participants varied with ages and included refugees (asylum seekers, unspecified immigrants) and professionals from a broader spectrum of the health care delivery system (doctors, nurses, and other health care providers). But the main focus here has been to explore the impacts of language barrier on newly arriving and resettled refugees encountering primary health care services. Their experiences, as seen from the studies, are based on varied circumstances described above (figure 1). These factors may have direct or indirect impacts on the already fragile health of a refugee.



**Table 4. Summary of search of the 17 studies: aims, participants and key findings**

<u>Study</u>	<u>Aims</u>	<u>Participants</u>	<u>Key findings</u>
Wiking et al, 2009	<p>Describing some aspects of 3 perspectives in a triangular meeting between immigrant pat., interpreters and GPs: experience with comm., reflection and interaction in primary care.</p> <p>Secondly, analyzing pat. satisfaction and factors influencing that: culture, personality, wishes; ethical issues, etc.</p>	<p>182 respondents: (52 patients, 65 GPs, 65 interpreters), with 40 match consultations. Questionnaires sent to patients, GPs and int. by receptionists at 12 primary health Care centers (PHCCs). Patients were from the 3 main minority ethnic groups. Background on age and sex were also known.</p> <p>STATA used for statistical analyses, no significant test done because of small study size.</p>	<p>Majority of the 3 categories were satisfied with consultation.</p> <p>2/3 reported good health (self-reported health).</p> <p>P-value significant for: respect for patients' personality, wishes &amp; culture.</p> <p>25/52 reported language communication problem.</p> <p>Small size study affect findings.</p> <p><i>Bias:</i> limited insights in systemic aspects of triangular meeting and interrelation because analyses did not cover the same questions.</p>
MacFarlane et al, 2009	<p>Arranging and negotiating the use of informal interpreters in general care, view the impact of language barriers from the perspectives of refugees/asylum seekers. Strategy used to work and act together in a co-operative manner.</p>	<p>26 Serbo-Croats and Russian refugees, data drawn from CARE project which adopts a PLA strategy. Also, core group of 5 representatives from refugee community was part of the research team.</p> <p>Peer researcher collected and recorded data using PLA card sort techniques to summarise participants' key themes.</p>	<p>Participants are unsettled over benefits of use of family members/friends as interpreters and how to manage the burden associated with language barriers.</p> <p>They also claim that use of informal interpreters was worrisome and frustrating can lead to misdiagnosis.</p> <p>The issue of confidentiality in a small community was of concern to service users.</p>
Agudelo-Suarez et al, 2009	<p>Discover the perceptions of discrimination and how it affects immigrants working condition and health.</p>	<p>158 immigrant men &amp; women mainly from Africa, South America &amp; Romania.</p>	<p>Language barriers may lead to discrimination against immigrants, which can affect mental health and access to healthcare. Suggestions of integration policies, teaching of social</p>

		Semi- structured interviews for focus and interview groups, in their respective cities. Information audio-recorded and textually transcribed.	and labor rights in countries of origin & host country.  Differences in getting jobs were observed because of Cultural and language barrier.
MacFarlane et al, 2008	'...need for language assistance in general practice consultations, examining the experience of, and satisfaction with the methods language assistance used. GPs views on the impacts language assistance methods used when consulting with refugees/asylum seekers.	80 GPs in the study, response rate of telephone survey was 70%; Mean age was 49.9, 40/56 were male GPs, 30 of which work in single handed practice. The mean number of refugee & asylum seeker patients was 18, with range of 1-196.  Telephone survey chosen over postal survey.  SPSS (Windows: version 11.0) used to analyse and double check.	79% experience need for language assistance, 89% used some forms of interpretation during consultations with ref. patients. 48% would prefer a one-to-one prof. interpreter. Confidentiality, mis-interpretations, and recognized lack of medical terminology were of concerns in the informal interpreters.  These findings are from qualitative studies and provide important accounts of refugees, asylum seekers and GPs' experiences based on context involved.  Language assistance needed in majority(77%)of the consultation.
O'Donnell et al, 2008	'Explore how migrants previous knowledge and experience of health care influences their current expectations of health care	52 persons, ages ranging from 20-57 years (31 female, 21 male)  Two methods of data collection: focus and interview groups.	Asylum seekers/refugees previous health knowledge of health care in their country of origin has an impact on their expectations and trust building in general practice in the UK.  Interpreter's role suspicious, no trust in the interpreters.
Harmsen et al, 2008	Investigating immigrant patients satisfaction and their perception of quality of care with respect to some personal characteristics (cultural views and language proficiency).	663 patients from 38 general practice were interviewed. 20-item questionnaires on patient's cultural background. Quote-mi questionnaires containing	Patients with modern views were more negative towards cultural aspects of care as compared to those with traditional views. Professional interpreters not mentioned.

ethnic-specific sub-scale. Descriptive statistics applied.

Ndirangu and Evans, 2008	To explore African women migrants experiences of coping with HIV and their views of the city's HIV services.	8 African women from 3 different countries: Congo (n=1), Malawi (n=2) and Zimbabwe (n=3) aged between 30-50.  Semi-structured interviews were conducted.	Their ability to live positively with HIV is shaped by migration history, legal status, experience of stigma and their Christian faith. Evidently, access to health services was highly valued as source of support/advice.
Bhatia and Wallace, 2007	To determine the views of asylum refugees about their overall experiences in general practice and suggest improvements to their health in primary care.	Not really known, approximately 15 to 25 participants.  Semi-structured interviews using frame work approach. Interview recorded and transcribed verbatim and transcripts analysed.	3 themes were identified: Difficulties encountered by refugees in the healthcare system, Impacts of the difficulties on refugees, and How refugees would like to improve their experiences in the healthcare system.  Altering of help seeking behaviour among refugees because of stigma associated with refugee status.  Issue of confidentiality.  Bias: small size, 11 respondents from one setting (refugee center).  Social status barrier makes accessing public services more difficult.
Palmer and Ward, 2007	'...attempts to redress the balance between service provider and user by prioritizing user perspective.'	21 interviewees (11 men, 10 women), 10 of which were conducted with an interpreter. 15 of the interviewees were accessing mental services.	Findings report a variety of holistic factors (socio-cultural,...) contributing to exacerbating the mental health state of refugee migrants.
O'Donnell et 2007	Identifying the barriers and facilitators to accessing medical	Unspecified, (not less than 196 person, both	Different levels of barriers to health care reported among asylum seekers:

	& dental health care	focus group and interviewees.	<ul style="list-style-type: none"> <li>- Long waiting time to get an appointment with a GP.</li> <li>- Poor interpreter service, not organized or reliable. communication problems For non-English speaking asylum speakers creating needs/gaps in service provision.</li> </ul>
Ny et al, 2006	Experience of men from the Middle East In Swedish maternity and child health care.	16 participants: 10 arabic men from the Middle east participated in 3 focus group discussion, and 6 men (Swedish speaking) from same region participated in individual interviews.	3 main categories were developed: meeting empathic professionals; finding new position in family; experiencing social demands (cross-cultural experience).
Suurmond and Seeleman, 2005	Investigating the views of physicians and immigrant patients through interviews.	Physicians (n =18), patients (n = 13); both groups come from a variety of disciplines and different backgrounds. Patients age range varied from 20 – 78, with poor socio-economic status. Patient group seems to be representative for men and women.  Semi- structured interviews conducted.	<p>Cultural factors play an important role in physician- patients shared decision-making.</p> <p>Gaps in communication because of language problems.</p> <p>Bias and stereotyping can influence exchange of information and contributions by parties in shared decision-making.</p>
Papadopoulos et al	Experiences of migration adaptation and settlement and their relevance to health	106 Ethiopians living in the UK.  Semi-structured depth interviews band questionnaires in the study design. Home interviews done	<p>Difficulties with immigration system, housing and social services. Feelings of social isolation.</p> <p>Different understanding of health and sickness concept.</p> <p>Sought help of GPs despite difficulties linked to language barriers and poor health knowledge.</p>
Bischoff et al,2003	Examine to what extent language concordance can affect nurses' assessment of asylum	723 screening interviews (questionnaires) conducted asylum seekers between from	Communication quality was good (37%) of all interviews; poor communication (35%) res-

	seekers' health problems and referrals.	June and December 1998.	pectively depending on on the asylum seeker's mother-tongue.
	Doing Systematic interviews That will facilitate access to health services, detect health problems among asylum seekers and subsequent referral to care.	The majority came Europe (Balkans), followed by Africa.	Language concordance contributes to better symptoms reporting and referrals.
Harmsen et al, 2002	'...investigating relative influence of parental ethnic background, GP's perception of parental cultural	87 participants of different families. 48 (55%) from ethnic minority (mainly Turkish, Surinamese), 39 (45%) parents of Dutch origin.  These were parents with children aged 0-12 years that visited the GP for a new or recurrent problem.	Mutual misunderstanding in the immigrant group was more than 3 times higher than in the Dutch group (33% to 10%), also highest in the partly traditional/partly western group.  High rate of health problems in ethnic minority children linked to poor or doubtful communication during consultations.
Hudelson, 2004	Exploring medical interpreters experiences and perspectives regarding patient-provider communication difficulties.	9 interpreters, 6 female 3 male, majority from the Balkans. Small sample of interpreter key-informants, unspecified number.	3 key areas of differences/ misunderstandings based on mutual lack of awareness between patients and physicians: 1. Idea about patient health problem, 2. Expectation of the clinical encounters, 3. Verbal and non verbal communication style
		in-depth inter views were conducted.	
Bischoff et al., 1999	Spoken language in medical consultation in an out-patient clinic.	1091 Patients of mixed origins. <i>Response rate of 72% (about 786 participants)</i>	High rate of language discordance between physician and patients.  Physicians have better language skills individually than their patients.  Small-scale study using informal and formal interpreters: Non- French speaker- 17% of consultation using informal

### **3.1 Language**

Language proficiency and culture orientation programs form part of a resettlement “introduction” package for resettling refugees within a given period of time, but there are challenges as well. Language barriers hinder adequate detection of cases in traumatized refugees which led to misdiagnosis and lower referral for further healthcare (15). A study carried out in the Netherlands reports that ethnic-specific issues, connected with western and traditional views, affect outcome of patient’s self evaluation of care. It also points out that important variables such as ethnicity, age, gender, education, cultural views and language proficiency can influence patient’s evaluation of quality of care (16). When physician and patient do not speak the same language, exchange of information is hindered. It is then more complicated for patients to share their different views and expectations of health (40). The older the patients, and the more modern views they have, the more positive views they have about GPs, but this is more negative for those with lower education, poor language proficiency. Age or duration of stay may play a mediating role in language learning ability (16).

#### **3.1.1 Interpreted consultations in health care delivery- formal and informal**

The choice of identifying (the right) interpreters where service providers and users do not understand the same language is a difficult task (40). This is undertaken by both the physician and the patients in expectation of getting a better health care quality. The general view is, to some degree of evidence, that professional interpreters facilitate

communication between physicians and patients, create awareness of cultural understanding in health care delivery and improve symptoms reporting. Most refugees using formal interpreter services report some level of satisfaction with their GPs (41), except in areas where interpreters lack the proper interpreting skills or lack cultural knowledge of the patient and the actual setting. The use of a formal interpreter during consultation is necessary to facilitate communication and understanding; and to arrive at appropriate diagnosis and treatment; but they were either nonexistent or not available in many cases during consultations with patients (39, 42). Studies experiencing lack of access to professional interpreters at general practice consultations, and the choice of using informal interpreters (family members, friends, etc.) became the only available option. These same studies also raised serious concerns about interpreting errors, confidentiality and misdiagnosis associated with the use of informal interpreters or family members as interpreter (39-43). The quality of service delivered by health professionals will depend largely on the type of interpreter and the quality of interpretation done (16, 44).

The use of an informal interpreter can pose some problems for individuals and services. In some areas, patients experiencing availability of, and heavy reliance on informal interpreter from service user's social networks (friends and relatives) did not adequately overcome the issue of language barrier. This may lead to a low level of trust and confidence building in a system, not the least, to skepticism, dissatisfaction and exposure to future health risks. Health professionals see ethical problems with the use of friends, family members and children as interpreters contrary to some patients' wish of an

interpreter that will defend him/her and communicate his/her views. They claim to have a feeling of confidence and support when describing their health problems through a self-negotiated interpreter, but the issue of maintaining trust and confidentiality was raised (44). People face a double challenge consisting of being obliged to translate into one's own language what the matter is, and then trust that this is translated precisely as it was said. Nevertheless, this is how the system ideally should work.

### **3.1.1.1 Confidentiality/Trust**

Patients' benefits and satisfaction in primary and general care should matter a lot to GPs. Good communication and mutual understanding around culturally sensitive things are important for building trust and confidence. The studies show how resettling refugees experience different levels of ethical problems because of inability to communicate in the local or official languages. Language differences, when seeking health care, leads to problems with establishing trust and low level of confidence in oneself and in the system, especially on the side of the receiving end (refugees). Sharing deep secrets even with a doctor seems to be embarrassing; with an interpreter, more difficult and uncomfortable where they are not sure of the interpreter's role and understanding of their (professional) culture. This practice is more accentuated among female/patients with strong cultural attachments, and with those who do not understand treatment and therapeutic approaches. Professional interpreters having better cultural understanding will improve the quality of communication between doctor and patient, which is necessary for trust. Their absence may create uncertainty surrounding informed consent or ethical dilemmas. Confidence in a system is increased when there is a common understanding among service providers



and users based on respect for ones values and identity. Right diagnosis and treatment procedures are some examples of trust-confidence-building outcomes.

### **3.1.1.2 Cultural/health beliefs and prior knowledge of health**

The diverse backgrounds of refugees (cultural, health and socioeconomic) affect their understanding of health in many ways, thereby making access to health care and social services more or less of a problem. Cultural values and health beliefs play an essential role in consultation with patients and vary according to their different origins. Actually, refugee patients want their health problem to be viewed holistically, taking into account some kind of cultural explanatory model of their illness and not only a biomedical model which is mainly centered on western-styled medicine. Trying to communicate certain culturally sensitive issues can be a difficult (reproductive or personal health issues, for example) and serve as a barrier to accessing health care. Hence, the challenges that come with understanding the immediate settings will exist- for examples, having pain, comfort; or understanding trust, care system, new culture, medical terminology and so forth. More health users had no prior knowledge of a western health care model, and said that they were not given the kind of treatment they deserved, in comparison to their home country (39). Having no or limited knowledge of how the western system works and the difficult bureaucratic challenges of they face (long waiting lists, conditioned social and health care, discrimination, etc.) may lead to altered help-seeking behaviors and other forms of psychological manifestations (stress, anger, etc.) (44). Unfamiliarity with some local culture and medical terminology are also part of communication barrier. Additionally,

some cultural or anatomical reference terms cannot literally be translated in to some other languages. It is difficult to have a perfect translation of many words and phrases (45, 46).

Experiences in the health care setting can be more confusing, stressful and traumatic due to the fact that refugee immigrants may refuse to adapt to the conditions of their new system and its health care models. This also means holding unto conservative beliefs (religious beliefs and/or traditional practice) in order to give themselves hope and spiritual support and at the same time masking their problems to avoid ridicule or prejudices (result of negative cultural interpretations associated with accepting some illness status (depression, stress...) (45) because of one's strong traditional-thinking (16). Such an attitude can be unhealthy and detrimental and may lead to obstacles in accessing health care and the benefits thereof. Moreover, it can hinder understanding the causes of one's health problems in order respond adequately or immediately to providing the real needs. Refugee patients, coming from diverse cultural backgrounds, are not familiar with booking appointments by way of telephone or drop-in days before the actual meeting with a physician. Long waiting queues, openness in sharing personal information with a stranger, with some degree of consideration for couple (husband and wife), is not common in most culture.

### **3.1.1.3 Interpreter's account**

Misunderstanding in communication can come from several sources other than problem relating to language differences. The wishes and beliefs of patients were not always considered by physicians during consultations. Interpreters described many situations

where communication difficulties were observed between patients and physicians. These descriptions were based on the types of patient (age, education level, nationality, socioeconomic status, etc.) and the health problem involved (47). Here, interpreters reflected on three major areas where physicians and patients likely differ: ideas about patient's health problem, that is illness perspectives-causes, treatment and meaning; expectation of clinical encounters- that is comparing health care experiences between home country and resettlement country which influence their expectations of health care in the west; verbal and non-verbal communication styles- that is, physician using gestures that had different meanings to both parties, and some of these gestures were interpreted as insults from refugees' cultural contexts (48).

Challenges faced in accessing health care and other services in host country may vary according to one's ability to communicate in local language (16, 45) and one's status (44, 52). Resettling refugees normally get legal residence status right after approval or arrival to their host country. Therefore, they are given similar rights in accessing basic services and care as the natives, unlike their asylum seeker and illegal immigrant counterparts. As such, the views of the latter case on present system and conditions may have different interpretations reflecting on their culture, prior knowledge of health and developing interpersonal relationships. Thus, resettled refugees for their part seem to have improved health conditions (psychosomatic) with time and with transition from traditional to modern cultural views (16). This transition was mainly observed among refugees who stayed in the same resettlement locality for over two years. Contributing factors like prospects for school, jobs, possibilities of social integration and respect for

one's values, cultural identity all played an important role in this transition. This will be based on the kind of program a system can offer-a well followed-up of language proficiency/learning curriculum, adapting and developing communication skills for understanding local culture and integration.

On the other hand, experiences suggest that refugees having difficulties in learning local language skills and adapting communication of host countries may be liable to developing poor psychosocial or mental health conditions (stress, depression, PTSD, etc.). In addition elderly refugees seem to be less motivated to learn a new language in the absence of “*special stimulant programs*” that can keep them active and serviceable, and taking into consideration their backgrounds, prior experiences and knowledge. For all refugees, their unused professional skills in a resettling country may in the long run increase the risk of mental health problems.

### **3.2 Socioeconomic barriers**

During resettlement, numerous disadvantages may affect refugees' health status. For example, stress, un/under-employment, inadequate social support, etc. In addition, they face challenges in the process of transition from real life experiences to that of a new system. Most refugees need to rebuild their disrupted social network that they had been accustomed to in their home countries. The challenges of newcomers are especially tough in the beginning when they need to learn where and how to get help to “navigate in the system” when support is needed.

Systemic barrier may be described as the difficulties confronted by vulnerable immigrants (refugee, asylum seeker...) in accessing basic facilities like jobs, good education, housing and many more. A refugee's qualifications may not be recognized in their new setting and underestimating their job qualification can affect income possibilities (44). The risk of mental health and being able to cope with past experiences may be altered by society and individual attitudes towards them (language, social isolation, race, etc.). The social support refugees get and the ability to access these systems in host countries differ significantly according to one's status. This serves as a basic factor in determining health, and more importantly, maintaining wellbeing (food, shelter, income, and access to health care and social opportunities (45, 46, 48). One Canadian policy maker viewed the social support system as *"...contextual, because it can mean different things at different moments. What often comes to my mind is the Alma Ata Declaration of the WHO and the understanding of primary health care ... looking at the total being, not only the physical being, but also the mental, psychological, the economic, the political, the social, the cultural. Understanding social support is trying to adopt a kind of framework..."* In short, identifying and providing the right social support when meeting the diverse needs of refugees is one important aspect of tackling this terrific challenge....

Some values (rights, justice, equality, etc.) of the west are not so easy to accept by people of other cultures, in particular the male dominated cultures. Here, the roles of men in making decisions concerning household activities and families benefits have changed

considerably. In the new setting, family responsibilities are to a greater extent shared with wife, children and professional people like teachers and others (41).

## **4. DISCUSSION**

### **4.1 Strength and limitations of the selected studies**

Like any other research method, strength and limits are always present depending on the method used. In our selected studies, many of the interviewees were able to talk out their experiences in depth and detail, and this adds credibility to their stories. Issues behind the action can be demonstrated and that is positive. Moreover, thorough interviewing helps in developing a positive rapport between interviewer and interviewee in a simple, practical and efficient way. In this way, it makes getting data for things that cannot be easily observed possible (feelings, emotions, for example).

Meanwhile, most of the studies reported small-size study populations which may affect findings and the research process leading to findings. This may limit transferability of results to a wider multicultural setting in countries experiencing huge migrants or multicultural populations. The studies used different methods, strategies and style of collecting, processing and analyzing data and information. That is, in-depth, semi structured or open interviews, focus group telephone survey, observation and others in ways that they thought were suitable. A few of the articles are based on questionnaires or other survey data. It means that both qualitative and quantitative data were used in some of the studies. This may be both a strength and limitation of the studies. The strength may refer to the different methods being used to address the same problem, elucidating a

question from different points of view. However, the possibility of arriving at different results could limit or mislead findings. One study did see the necessity of using interpreter in qualitative studies as the data are modified before analysis (44), arguing that transcribing interviews verbatim and analyzing transcripts and contents will contain unreliable, wrong information. This is a potential source of information bias but the use of professionals and those who understand the cultural context when analyzing data still keeps quality information and reduces the bias. Some study participants including professionals working with refugees and community workers who share a similar culture were used during the studies in order to gather information. Participatory research may be regarded as an appropriate ethical approach, allowing participants to express their feelings and interact with each other and the researcher. But there were still ethical sensitivities (use of family/friend as interpreter) and practical challenges (access, sampling, recruitment) in many of the selected studies.

Most of the studies had low level of participants which raise the issue of validity and generalisability. The products of qualitative analyses can range from empirical finding to (other close to the data) to interpretative explanatory theory (farther from the data), depending on the analytical approach and how far the analyst carries the interpretation and synthesis of his/her findings. Analyses from personal accounts can be useful because they will help us understand the social phenomena under varying circumstances and produce rich thematic descriptions that provide insight into the meaning of the “lived experience”. It can also guide us in making right policies that benefit those concerned.

## **4.2 Strength and limitation of my analysis**

We recognize that the people of interest come from a variety of backgrounds where healthcare delivery system is completely different from that of the west and that good or effective health care delivery services for the needy in most developing countries are not always available (39). In so doing, we tried to identify challenges they face when resettling into a new society. My background includes a number of rich varied experiences that are similar to experiences mentioned in the studies.

The articles were repeatedly read with respect to the key terms of interest which are mainly focused on language, culture, perceptions (views) and experiences of health care of refugees in their new resettlement countries. Some special attention was paid to different cultural backgrounds, beliefs, values and locally or generally spoken language “mother-tongue” from refugees’ homeland and how they can influence health conditions of person(s) and the societies. From our understanding, the authors did arrive at similar findings and challenges, that is, pointing out the difficulties culture and language pose for a person (refugee, asylum seeker, etc.) who is trying to settle down in a new system. The impact of language barrier on the quality of health care refugees received can be seen at several levels depending on so many factors: culture, age, sex, education, past traumatic experience, and so forth. In addition, not being able to properly connect between the life-world and system world may worsen the health conditions of new comers. I think this theoretical approach has been useful in my analysis.



The step by step process used to arrive at findings has been described earlier in chapter 2. Asserting the validity of this paper, it was important to check how information was obtained and treated with respect to communicating feelings, thoughts and realities between people and their different cultures. So, it becomes necessary to identify real events into analytical concepts and empirically establish relationships between them. In these relationships, basing on Habermas views, we explained in concept and theory how changes in the different worlds (life-world and system-world) can affect behaviors and which will need careful interpretations. For his part, Antonovsky argued that these changes in behavior may cause different types of stress condition, some of which can be manageable over time. These concepts are often embedded in most public health actions. The relevance of applying the salutogenic concepts may be difficult to identify for individual persons and may be less generally applicable than Habermas' theory, but in several of the in-depth interview studies, quoted salutogenesis seemed relevant for understanding coping with existential and practical difficult (45,46, 48, 49).

### **4.3 Public health implications of my findings**

More than 70% of estimated 25 million foreigners living in the European Union's 27 member states come from Eastern and South Eastern Europe and North Africa. In 2006, 1.8 million people from outside the EU (European non-EU countries, Asia, Sub-Saharan Africa, and Latin America) settled in a new country of residence in the EU (30). It is assumed that refugees and traumatized people form part of this huge immigrant burdens observed in Europe in recent times and the new of health challenges.

The impacts of language barriers on refugees' health in our findings have been also by described by researchers in many different settings, suggesting that people from minority groups do not have equal have access to health services and that language barriers can lead not only to patient dissatisfaction (50-52), but also to health provider dissatisfaction with communication (53). The life world of refugees are often more alien to the system world of the receiving country and that of the nation's citizens. Studies in health care use by refugees in emergency and outpatient services as well as small-scaled survey in Switzerland, similar to many others, show that in most cases health professionals lack pluri-lingual proficiency. In so doing, they have communication difficulties and need linguistic support to communicate with patients of other backgrounds. And, not having an interpreter can affect patients' knowledge of diagnosis and treatment (54, 55). On the whole, a refugee can rarely benefit optimally from possibilities in the public health system, and their health may be affected negatively.

#### **4.2.1 (Primary) health care experiences**

Resettling refugees and asylum seekers are medically screened or examined for infectious diseases like HIV, Tuberculosis (TB), Hepatitis, and other health problems. This is a necessary measure to prevent and treat abnormalities, promote and improve health, and provide a wide range of economic benefits (cost reduction, savings on health, quality of life, etc.) for individuals as well as the society. During this process, little consideration is given to language barriers and the practical impact this may have on medical interviews. In this process, common language shared between patients and physicians or the use of (formal) interpreters can increase the detection of traumatic symptoms in refugees, and

improve eventual referral for further treatment in specialized institution; whereas inadequate language concordance and poor communication, as perceived by researchers, lead to low referral rates to psychological care and underreported PTSD (56, 57). High rate of health problem in ethnic minority children are linked to poor or doubtful communication (40), resulting in relatively high prevalences of serious mental disorder being observed in refugee children, according to another study (36).

Several studies (46, 48) suggest that healthcare provider health models may undermine the role of refugee patients' culture. This also leads to a new concept of labeling and interpreting cultural problems into medical models called *medicalization*. Medicalization of cultural behaviors to fit into current biomedical paradigm is gradually taking medical diagnosis into a new dimension. Today's health management is no more only based on the "*Hippocratic sermon*" or "*do no harm*" principle, but also focused on market-oriented system and economic interest where providing quality health must be maximized. Increases in in-patient/out-patient services, hospitalization, among others to meet with the demand are unfortunately parts of the imperative the system world offers.

Applying this to the salutogenic theory, on the other hand, one expert tried to explain the psychological changes we undergo through a model, *sense of coherence*, and the ability to cope with these changes that may have health implications (34). In this interesting example that I witnessed, a lady with refugee background stripped herself naked (having only long-john underwear) in a public office when her husband asked for separation. The immediate reaction of the family adviser/therapist was to call an ambulance with the

thought that this lady was going mad. In a couple of minutes, the lady concerned was dressed-up again as if nothing had happened. When asked why she acted this way, she responded by saying that she is not going mad, or did not need an ambulance. She was so grieved and shocked about her husband's decision, according to her, and that was her way of expressing it and getting over with her grief. This lady has had prior traumatic experiences of war, seeing civilians being skin-searched and stripped naked at checkpoints for various reasons. In fact, refugees affected by this kind of event do not openly admit or discuss it with others because of the attached health risks. Some also believe that they can handle their psychological or mental conditions themselves with time without, as it is usually done in Africa and other countries after traumatic events, needing help from a doctor or specialist.

In support of social construction of reality, we would like to emphasize on two of the four key social theories for global health discussed by Kleinman (58). The first, holds that social interventions have unintended consequences that can be foreseen and prevented, while others cannot be predicted. Therefore, constant evaluation of unintended consequences is necessary for modification of programs. The second, also founded on social construction of reality, points out that the real world of "materialism" cannot be excluded from those legitimate ideas and practices of our social and cultural settings. This explains social threats and cultural fears posed by certain epidemic diseases and changing health behaviors and practices (58). For example, the different approaches to the spread of swine flu virus, stigma associated with the social construction of mental illness in some settings, etc. are some instances where the tension between local or

individual realities and global policy making become crucial to public health actions. This reminds us of the complex nature of individual experiences and the role played by societies with respect to understanding concepts of illness, sickness and disease in the context of health and culture.

Our findings placed more focus on consultation in primary health care delivery systems in receiving countries because it serves as a gateway to refugees' new experience of health care and follow-up health checks. Patients meet different socio-cultural challenges and tend to form a relationship with health professionals who understand their origin (culture, trauma, status, etc.) and wishes and were able to meet their expectations and needs (40), although other factors like age, gender, frequency or regularity of medical visits and professional skills may play some roles. It is not only refugees who prefer health professionals who appear interested, listening well and explaining clearly, and who were open to discussing and involving the patient in decision making if it is necessary (59). Also interpreters, especially the professional ones, had been careful to communicate patients' feeling and experience, taking into consideration the different levels of 'human communication skill', without adding own feelings and thoughts.

Another aspect of patients' views on maintaining and developing relationship with doctors was based on some indirect experiences with outcomes of problems shared and opinion of friends or family members about patient's state of health. Relationship can be deepened or destroyed by good or bad clinical outcomes; positive or negative reports of a doctor's behavior or practice and even unbalanced interpretation by interpreters. This will

reinforce and challenge patient's opinion of a doctor. For example, the studies tell about doctors who shorten normal routine visits with refugee patients because of communication problems; or proceed directly to physical examinations (body contacts, touches) without prior interrogations of patient. On the other hand, the kind of reception given by friendly health care services staff can create a positive atmosphere and more positive frame of mind about patients' views and experiences- trust, satisfaction, confidence, etc. Refugees' prior knowledge of health and health care systems they come from contribute to the ongoing product of the dynamic aspect of accessing health care. Unprofessional and miscalculated gestures may hinder both patients' knowledge of the doctor and doctors' understanding and knowledge of the patient.

The quality of patient's encounters with his/her doctor is an essential factor for developing and maintaining patient-doctor relationship. Patients complained about difficulties in accessing GPs which can hamper relationship between them and their patients (44). Seeing the same physician (longitudinal care) may improve physician-patient relationship and better understanding each other's cultural identities and respect for one's values. Longitudinal care alone does not guarantee the depth of this relationship, but allow patients to make a choice regarding physicians they want to see. In addition, regularity of patient-doctor encounters and respect for time can also contribute to the development and maintenance of this relationship.

Resettlement of refugees and asylum seekers depend on a wide range of factors including policies of the host country as well as experiences and attitudes of those concerned to

exile. From participants' accounts, duration of stay and lacking privacy, sharing public things like toilets, room, etc. and noise, show mixed results depending on the status of the individuals (44). Comparing this to observations and personal experience, it can be said that language barriers are indispensable keys to integrating into any society, and that refugees' attitudes may change depending on the cultural backgrounds, prevailing institutional challenges and types of status. This suggests that problems refugees encounter are similar in different European countries, and that solutions that take language problems into account are important in all countries.

#### **4.3 Bridging language barriers through interpreting**

Communication difficulties are present even when an interpreter is used in medical consultation, because of the issue of trust and confidentiality and so forth (42-44). On numerous occasions where the services of professional interpreters were lacking informal interpreters were used. Formal interpreters are meant to be used when both health professional and patient believe that patient's language competency is insufficient to benefit from those rights he/she ought to have (43).

In some cases, health services depend mainly on their own language resources by using bilingual health professionals as cross-cultural mediator, and rarely use professional interpreter services. The International Organization for Migration (IOM), in their review of health policies and accessibility to health care for migrants in industrialized countries, found that four out of five of the countries examined had no interpreter services routinely available (60). Basic public health principles embedded in the modern concept of respect

for human rights and democracy also call for meeting the needs of all citizens or residents, irrespective of status or conditions. The Swedish Health and Medical Services Act (1982:763), The Norwegian Health Care System among others, are some good examples.

#### **4.4 Implication for further research and decision making**

Our findings could be of relevance in the process of planning resettlement programs and managing refugees in quota refugee countries in Europe and elsewhere. In particular, this could help in drawing attention to local and national policies where managing refugees and language barriers in healthcare consultations could be a priority. Further research could be directed towards both language and culture, especially interactions between old and new cultures, and the balance between expectations of new language skills and comprehension of when interpretation is appropriate. Research could also focus on specific diseases and health problems prevalent in refugee communities.

#### **4.5 Suggestions for prevention strategies and guide to decision making in health promotion**

The world is changing at an unimaginable pace, with noticeably similar challenges being posed by refugees and illegal migrants in Europe. And, the health care providers cannot remain immune to these global changes in the structures of societies. Therefore, series of strategic measures need to be taken to control and manage the huge impacts of fleeing from human-made or natural disasters into Europe, while safeguarding the wellbeing of the local population and society structures. Moreover, the measures may help in dealing with the transition from inexistent or poor healthcare services to a well organized health



care delivery system focusing on health promotion programs and strategies within the framework of the WHO and the UN millennium development goal (MDG) are all part of the challenges (34). These preventive measures, referred to as *primary and secondary preventive strategies*, can aid in making sound decisions on issues involving refugees' health. The primary prevention strategy will focus on action plans on the local community level and national strategies that provide for the basic needs of refugee migrants, their immediate challenges, ways of adaptation, and skills or competence developments that may have some positive benefits for their health state and cross-cultural integration. This will include: 1- Laying more emphasis on refugees' education levels and an introduction of pre-resettlement language course of resettling country lasting for 3-6 months. 2- Cultural knowledge of refugee's origin and that of host country must form an important part of refugees' introduction program for all (refugees, policy makers, health professionals). 3- Meeting basic health and related needs (compulsory pre- and post resettlement health controls, accessibility to information and providing the right health education, etc); and necessary support system to refugees (language, social and legal, professional skills and cultural orientation) in communities and primary care. This will promote and encourage mutual respect, cross-cultural exchanges that can foster integration and empower refugees. 4- Availability of formal interpreters during health visits for new refugee immigrants and training of informal interpreters to meet society standard (medical, cultural, etc).

Whereas, the *secondary prevention strategy* will focus on a well coordinated global set of activities that will help international policy making in managing migration and refugee

affairs. This will also include: 1- Working out and coordinating a common European approach in developing strategies and policies on migration in line with other global partners. For examples: building on the refugees' capacity, skills and talents nationally and internationally from a multicultural and global perspective. This will also include equipping international health workers in meeting the challenges associated with cross-culture, diagnosis and treatment in health centers of host countries. 2- Supporting refugees' empowerment initiatives through participatory actions, especially getting them involved in decision-making and policies that (will) affect their lives.

These preventive strategies are the main aims of public health actions which are “to measure, explain, maintain and improve the health status of such targeted populations”. It places focus on preventing disease and disability and promoting health. At the same time, recognizes the multi-dimensional nature of the determinants of health and the complex interaction of factors (biological, social, environmental, etc.) that influence health (61). New refugees are a serious public health challenge and bring into view sizeable targeted subgroups within a wider population where communication problems and other factors may influence their health status.

## **5. CONCLUSION**

It is well documented that language barrier is a problem, and that communicating understandably with refugee patients in meeting their health care needs is important. Despite the fact that the use of professional interpreters poses some challenges, it facilitates communication and reduces errors in diagnosis and treatment where patients

and physicians do not speak the same language. Language issues need to form an integral part of health care delivery system, especially for people from vulnerable backgrounds having different language origins.

Resettlement program, like migration, should be subject to continuous and worthy evaluation and change because it nurtures economic development and encourages cross-cultural understanding and exchanges. The economic and humanitarian interests for resettling refugees in Europe are well-established. The need to care for the aging population, transfer of 'know-how' from other cultures and interacting in a new globalized perspective, creating economic empowerment, etc. are some benefits of this. However, the status and different origins of refugees bring into light a range of health issues that are related to communicable or non-communicable diseases, injuries connected to work and environment, and psychological or mental health problems. Emphasizing on prevention strategies (primary, secondary) and health promotions are necessary measures to control any future widespread consequences.

Recognizing the difficult conditions refugees face, Dr. Margaret Chan, former director-general of WHO said "*those who suffer or who benefit least deserve help from those who benefit most*" (62). Therefore, language barriers in health care being one of the main problems encountered by resettling refugees, the right to understand and receive appropriate communication support should be a civil right. Language and cultural differences should be given careful consideration in every inclusive and democratic society that seeks to provide for the needs of all its citizens.

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**(I)- General appendix**

**(a)- Supplementary information/clarification:**

(\*) = “The 44 industrialized countries” (38 European and six non-European States) current providers of asylum seekers’ statistics to the UNHCR according to the Global Trend (June 18, 2009) report. They include 27 Member States of the European Union (Austria, Belgium, [Bulgaria](#), [Cyprus](#), the Czech Republic, [Denmark](#), [Estonia](#), Finland, France, Germany, Greece, Hungary, Ireland, Italy, [Latvia](#), [Lithuania](#), [Luxembourg](#), [Malta](#), the [Netherlands](#), Poland, Portugal, [Romania](#), [Slovakia](#), [Slovenia](#), Spain, Sweden, and the United Kingdom), Albania, Bosnia and Herzegovina, Croatia, Iceland, Liechtenstein, Montenegro, Norway, Serbia, Switzerland, The former Yugoslav Republic of Macedonia, and Turkey, as well as Australia, Canada, Japan, New Zealand, the Republic of Korea and the United States of America.

**(b)- Abbreviations**

EU = European Union

GDP = Gross domestic product

GP = General practitioner

HP = Health professional

IDP = Internally displaced person

IOM = International Organization for Migration

IRO = International Refugee Organization

PPP = purchasing power parity

UN = United Nations

UNHCR = United Nations High Commission for Refugees

UNRRA = United Nations Relief and Rehabilitation Administration

UNRWA = United Nations Relief and Works Agency for Palestinian Refugees in the  
Near East

suppl = supplementary

i.e. = that is

p = page(s)

et al. = and others

etc = and many more/and so forth

**(c)- Synonyms**

Medical consultation = Medical visit

Doctor = Physician, medical consultant

Health professional = Health worker (medical specialist, doctor, physician, nurse, etc.)

Refugee (patient) = (mainly) resettling refugee/ asylum seeker/ immigrant seen by health professionals for medical or health problems or routine controls.