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Talking about sexual and reproductive health through interpreters: The experiences of health care professionals consulting refugee and migrant women

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ABSTRACT

Objective: This study aimed to explore the health care professional (HCP) experiences of working with interpreters when consulting refugee and migrant women who are not proficient in English around sexual and reproductive health (SRH) issues, in order to identify service and policy implications.
Methods: Semi-structured interviews were conducted with 21 HCPs, including: nurses (8), general practitioners (GP) (5), health promotion officers (5), sexual therapists (2) and one midwife. Interviews were audio-recorded, professionally transcribed and thematically analysed using socio-ecological theory.
Results: Overall HCPs stated that language and cultural discordance were barriers to SRH communication with refugee and migrant women. The lack of women interpreters and concerns with the interpreters such as lack of health/SRH knowledge were the main considerations HCPs reported related to working with interpreters when consulting refugee and migrant women.
Conclusion: Communication barriers in the provision of SRH services to refugee and migrant women may not be avoided despite the use of interpreters. Great attention needs to be paid to the availability of women interpreters and training of interpreters to work in SRH.

Introduction

Australia's population growth can largely be attributed to skilled migration, family reunion and humanitarian programs, with a significant number of arrivals coming from non-English speaking countries [1] In 2011, 20% of migrants to Australia reported speaking a language other than English at home and 3% said that they had limited English proficiency [2]. Similarly, the majority of family stream migrants had low English proficiency, with only 52% speaking fluent English where another language was spoken [3]. Further, 30% of the humanitarian stream migrants did not speak English well, or at all, upon arrival in Australia [2]. These statistics suggest that migrants may experience language barriers when accessing health and other services, as English is Australia's official language.

In this paper, the term 'refugee and migrant women' refers to refugee and migrant women from culturally and linguistically diverse backgrounds. Previous research suggests women from refugee and migrant backgrounds experience unmet sexual and reproductive health (SRH) needs [4] leading to unintended health outcomes [5]. Many of these women also experience communication difficulties in the form of limited spoken English when accessing SRH care [4,6]. Furthermore, refugee and migrant women have reported that despite having access to brochures and booklets covering SRH topics, these materials were of no benefit due to the women's limited English language comprehension [6,7]. Language and communication have frequently been mentioned as an interpersonal barrier to providing SRH care, especially where health care professionals (HCPs) were unable to provide adequate information or advice to these women [8]. These findings indicate that addressing language barriers among refugee and migrant women should be prioritised to ensure equity in SRH care access and utilisation [4]. However, there are some further considerations.

Within a number of cultural contexts, the discussion of SRH is considered as a societal taboo, which has several implications for HCP consultations [9]. Some refugee and migrant women may feel unable to freely discuss their SRH needs, making it harder for HCPs to determine and provide appropriate care [10]. Issues of cultural competency have also been established, with HCPs experiencing difficulties in initiating SRH discussions with refugee and migrant women [8]. Equally, the

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presence of an interpreter for refugee and migrant women not proficient in English may further complicate the patient-provider interaction during SRH consultations [11]. Given that interpreters are often of the same cultural background as the women seeking care, concerns about privacy and confidentiality may contribute to a women's reluctance to access care [10]. The use of male interpreters may also exacerbate women's discomfort about discussing their SRH issues openly as women in some cultures are not encouraged to discuss sexual health issues with men, let alone a male interpreter not known to them [12,13].

The number of people requiring interpreters in order to access health care is projected to increase given Australia's increased intake of refugees and asylum seekers [14]. Currently, refugee and migrant women can be provided with telephone interpreter services via the publically funded Translating and Interpreting Services, or through state-funded services [14,15]. Some state governments and various hospitals in Australia also provide free healthcare interpreting and translation services through professional healthcare interpreters when patients use public health services [16]. It has been established that using professional interpreters positively impacts on health care access and quality for patients with limited English language proficiency [17]. For example, Jacobs and colleagues [18] reported that the use of professional interpreters eliminates disparities between English language proficient and non-proficient patients in flu vaccination and blood testing. Similarly, migrant and refugee women who use interpreting service are more likely to visit clinics for breast cancer screening [19] and participate in mammography [20]. Professional interpreting service also reduce unnecessary healthcare expenditure by improving access and utilisation of preventive health service [21] and the burden on family members [11].

Despite having these benefits, HCPs generally underuse professional interpreting services and often use patients' family members and friends as interpreters when treating limited English proficiency patients [14,22,23]. The underutilisation of professional interpreters has been attributed to the HCP and receptionist's lack of awareness about the available interpreting services and how to use them [22,23]. There is a need for further research to explore HCPs experience of working with interpreters and refugee and migrant women, in order to identify other factors that may influence HCP's use of such services [24].

Previous research in this field has focused exclusively on access to and uptake of interpreters by GPs [14,22,23], with little or no attention to what happens in the consultation room once HCPs managed to get interpreters. It also lacks specificity with no mention of the type of health care dealt with the use of interpreters. To address these issues the following research questions were explored:

1. What are the experiences of HCPs working with interpreters when seeing refugee and migrant women who are non-proficient in English for SRH issues?
2. What are the SRH interpretation service and policy implications of these experiences for refugee and migrant women not proficient in English?

Methods

Research design

This study is part of a larger mixed methods project investigating the views and experiences of HCPs in providing SRH care to refugee and migrant women in Australia to inform clinical practice and policy. Seventy-nine HCPs completed a survey online that consisted of twenty-four socio-demographic and work experience questions. Semi-structured interviews were then conducted with twenty-one HCPs having diverse professional, cultural and work experience backgrounds to explore the main issues identified from the survey. The current study used semi-structured interview data to investigate the HCP experiences of working with professional interpreters when consulting refugee and migrant women not proficient in English. Thematic analysis was used in the analysis of the qualitative interviews and the socio-ecological model was employed to interpret the data. Give SRH is a broad topic and area of service, some service statistics from the online survey were provided to give a background in relation to the SRH service areas where interaction and communication between HCPs and refugee and migrant women took place.

Table 1
Socio-demographic and work experience characteristics.

Characteristic		Frequency (N)	Percentage (%)
Age (Mean = 50.6 and SD = 12.12)	< 40	7	33.3
	41–55	6	28.6
	56–70	8	38
Occupation	Nurse	8	42.8
	GP	5	23.8
	Health promotion officer*	5	23.8
	Sex therapist	2	9.5
	Midwife	1	4.7
Work experience in years (Mean = 21)	1–10	5	23.8
	11–20	9	42.8
	21 and above	7	33.3
Sector of work	Public	5	23.8
	Private	2	9.5
	Public and private	4	19
	Non-profit/NGO	10	47.6
Refugee and migrant women seen daily	0	7	33.3
	1–5	12	57.1
	> 6	2	9.5
SRH services refugee and migrant women commonly accessed	Contraception	15	71.4
	Pregnancy related (Antenatal care, delivery and postnatal care)	13	61.9
	Abortion	9	42.9
	Infertility	9	42.9
	Sexual pain and discomfort	9	42.9
	Screening (Chlamydia and Cervical cytology)	8	38.1
	Psycho sexual services	7	33.3
	Sexually transmitted infections (Information, screening and treatment)	6	28.6
	Safer sex options	5	23.8
Background of women seen	Afghanistan	11	52.4
	Iraq	9	42.9
	Iran	9	42.9
	Sudan	9	42.9
	Bhutan	6	28.6
	Congo (DRC)	6	28.6
	Somalia	6	28.6

* Includes bilingual health educators and health educator managers.

Participants and recruitment

HCPs were recruited from Family Planning clinics across Australia, Women's Health clinics, private practices and organisations that provide outreach health education and promotion services to refugee and migrant women. Table 1 presents the socio-demographic and work experience profile of the HCPs. The age of the participants varied between 32 and 70 years, with an average age of 50.6 years. The participants included nurses (8), GPs (5), health promotion officers (5), sexual therapists (2) and a midwife. All had worked as HCPs across