Compromised communication: a qualitative study exploring Afghan families and health professionals' experience of interpreting support in Australian maternity care

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ABSTRACT

Introduction Difficulties associated with communication are thought to contribute to adverse perinatal outcomes experienced by refugee background women living in developed countries. This study explored Afghan women and men's experience of language support during pregnancy, labour and birth, and health professionals' experiences of communicating with clients of refugee background with low English proficiency.

Methods Interviews were conducted with (1) Afghan women and men in the first year after having a baby in Australia, by multilingual, bicultural researchers and (2) midwives and medical practitioners providing care to families of refugee background. Analysis was conducted thematically.

Results Sixteen Afghan women, 14 Afghan men, 10 midwives, five medical practitioners and 19 community-based health professionals (refugee health nurses, bicultural workers, counsellors) providing maternity or early postnatal care participated. Midwife and medical informants concurred that accredited interpreters are generally booked for the first pregnancy visit, but not routinely used for other appointments. Very few Afghan participants reported access to on-site interpreters. Men commonly interpreted for their wives. There was minimal professional interpreting support for imaging and pathology screening appointments or during labour and birth. Health professionals noted challenges in negotiating interpreting services when men were insistent on providing language support for their wives and difficulties in managing interpreter-mediated visits within standard appointment times. Failure to engage interpreters was apparent even when accredited interpreters were available and at no cost to the client or provider.

Conclusions Improving identification of language needs at point of entry into healthcare, developing innovative ways to engage interpreters as integral members of multidisciplinary healthcare teams and building health professionals' capacity to respond to language needs are critical to reducing social inequalities in maternal and child health outcomes for refugee and other migrant populations.

INTRODUCTION

Communication between healthcare providers and clients is fundamental to quality, safety and effectiveness of care.[1–3] Language discordance, where healthcare providers and clients do not speak the same language, is a recognised barrier to communication and in turn a potential contributor to disparities in health outcomes. This is emerging as a major issue for many developed countries, particularly those that have sizeable migrant populations with low proficiency in the national language. A growing body of literature documents differentials in access to healthcare and health outcomes among migrant and refugee populations in high-income countries.[4–7]

When communication barriers exist, the quality of care for clients with low English proficiency diminishes.[8] Consequences include late presentation of symptoms, poor understanding of treatment plans and reduced likelihood of participating in medical decision making.[2 8 9] There is robust evidence that engagement

of accredited interpreters in healthcare results in more effective clinical treatment, greater client satisfaction,[1 2] better health outcomes[8 10 11] and improved access to services, including preventative healthcare.[12–14] Despite compelling evidence of the benefits of engaging accredited interpreters in healthcare, recent studies indicate variability in doing so, even when interpreting services are available and accessible. An Australian study found that a client with low English proficiency had only a one in 100 chance of having a professional interpreter engaged when required in a primary care setting.[15]

International literature sheds light on the factors at play for clinicians when communicating in situations of language discordance, and how they decide to 'get by' without interpreting support or 'get help' from a professional interpreter.[16] Studies of clinician–patient communication in paediatric and chronic disease management indicate that 'getting by' unaided or using a family member to interpret is common practice, despite recognition that this may lead to more errors in communication and worse clinical outcomes.[2 17] The Confidential Enquiry into Maternal Deaths in the UK has repeatedly identified use of family members to interpret as a contributing factor to maternal deaths in the UK. In the most recent report, one of the top 10 recommendations from the Enquiry was that all women who do not speak English have *all of their care* mediated by professional interpreters.[18]

Limited attention has been focussed on communication between health professionals and pregnant or childbearing women in situations of language discordance. The perinatal period is unique in terms of the number of contacts that women and their family have with the primary and secondary health services over a period of around 12 months. Pregnancy care aims to promote the health of the mother and developing fetus, and in so doing prevent complications. The sharing of information between women and health professionals is critical in optimising maternal and infant health outcomes. Australian quality and safety standards promote the use of accredited interpreters in health services.[19 20] However, routinely reported maternity hospital performance indicators suggest that there is significant variability in the provision of interpreting services across Australian public maternity hospitals.[21]

Caring for clients with low English proficiency is a major challenge for Australian maternity services, where around 30% of women receiving pregnancy care are migrants to Australia,[22] the majority born in countries where English is not the first language.

Inequalities in maternal and child health outcomes among women of different ethnic or cultural backgrounds are pronounced. Australian evidence indicates that women of likely refugee background giving birth in the state of Victoria, where many refugees settle, have more than twofold higher rates of stillbirth, fetal death in utero and perinatal mortality compared with Australian born women.[23 24] Patterns of health service usage are also disparate with women of refugee background less likely to attend care in the first trimester of pregnancy as recommended by national guidelines and more likely to attend emergency departments for obstetric complications.[23 24] Similar findings have been reported internationally.[25 26]

This paper presents findings of a study conducted with Afghan families in Melbourne, Australia. Between 1998 and 2012, people who were born in Afghanistan formed the largest group of migrants to Victoria, with around 6200 settling in the state in this time period, the vast majority in recent years coming as refugees.[27] A complementary study explored the experiences of health professionals involved in the provision of maternity and early postnatal care of Afghan women and families.

The primary aims of the paper are to (1) describe Afghan women's and men's experiences of language support during pregnancy check-ups, labour and birth; (2) explore health professionals' experiences of communicating with Afghan and other refugee clients with low English proficiency; and (3) consider implications for health services and health policy.

METHODS

Setting

The study was conducted in 2012–2013 in two outer suburban municipalities of Melbourne. Public maternity services in the region are provided by one large health network comprising three public hospitals providing maternity care to over 8000 women each year. Around 10% of women giving birth at these hospitals come from refugee-source countries. Options for public antenatal care include hospital clinic care with midwives and medical practitioners, community-based care or shared care with a general practitioner. Irrespective of the model of pregnancy care, women booked as public patients have labour and birth care provided by hospital staff. State governments have fiscal and policy responsibility for Australian public hospitals.

Hospital-based midwives and medical practitioners in this region and their clients can access hospital employed on-site accredited interpreters or accredited interpreters from an external agency. A central booking service organises interpreters for scheduled appointments with some flexibility for the provision of interpreters on an on-call basis for unscheduled or emergency episodes of care. Interpreter bookings are made by hospital clerks who collect data at first point of contact and by clinic reception staff. In the event that a hospital-based interpreter is unavailable, health professionals are encouraged to use a centralised telephone interpreting service.[28] Community-based medical practitioners receive fee-free access to

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telephone interpreting services on demand or can book face to face interpreting services.

Data collection

Data collection methods were informed by consultations with Afghan community members and health professionals providing services in the region. Consultation and data collection with community members were undertaken by two researchers of Afghan background, one woman and one man (referred to as 'community researchers' below).

Interviews with Afghan women and men

Afghan women and men were invited to take part in the study by the community researchers.[29] Women and men who were born in Afghanistan, aged ≥18 years and who had a baby that was around 4–12 months of age were eligible to participate in the study. Recruitment methods informed by the community consultation included the community researchers working with the project's community advisory group, key community leaders and community groups (eg, playgroups) to identify eligible community members and invite them to take part in the study.[30] Interviews were undertaken in the language preferred by the participant. Interviews were audiotaped with permission of participants.

The interview schedule drew on issues raised in the community consultations and questions asked in a 2008 Victorian population-based survey of recent mothers.[31 32] The schedule was piloted with six community members and translated into Dari by the community researchers.

Participants were asked what language they spoke at home, whether they could read and write in their spoken language and how well they and their spouses spoke English. Participants' responses were recorded verbatim. Women were asked if they had needed an interpreter at any time during pregnancy and/or in labour and birth and prompted to describe their experience of interpreting support from family members and professional interpreters during these episodes of care. Men who were present at pregnancy visits and/or during labour and birth were also asked these questions.

Interviews and focus groups with health professionals

The project's stakeholder advisory group played a key role in the recruitment of health professionals by identifying key contacts in their organisations to promote the research and encourage participation. Following promotion of the research in this way, several health professionals contacted the research team to indicate interest in participating. The names and contact details of other health professionals were forwarded by key stakeholders (with consent), and a member of the research team made contact to confirm interest in participation. To be eligible to take part, health professionals needed to have recent experience of providing maternity or early postnatal care or managing services providing maternity or early postnatal care to Afghan families. Participants were invited to participate in an interview or a focus group. Focus groups were arranged where a number of eligible participants from the same facility had agreed to participate and agreed to do so in a focus group.

The interview schedule for health professionals focussed on their experiences of working with Afghan families, and other families of refugee background. Informants were asked to reflect on how they identified and responded to the needs of clients for interpreting support. The same interview schedule was also used in focus groups.

Analysis

All interviews were digitally recorded. Interviews conducted in community languages were transcribed into English by the community researchers. Cross-checking of all transcripts was undertaken by the research team (initials removed for review). Analysis was approached thematically, using Green *et al*'s[33] framework of immersion, coding, categorisation and development of themes. All transcripts were coded manually by the community researchers and cross-checked (by FF, SW, ER, JY) and entered into NVivo10. Based on the completed coding of the first four transcripts (two women and two men) a coding manual was developed and used to code remaining transcripts. Discussion among the research team was done to place all codes into logical categories. From this seven, major themes were identified and the theme of 'language services and communication' is reported in this paper.

Interviews and focus groups with health professionals were conducted by the research team (ER, JY). Transcription was undertaken by an external agency and cross-checked by ER for accuracy. JY read all of the transcripts. The data were analysed thematically. All transcripts were coded using NVivo software (by ER) into practical categories and overarching themes.

Other themes have been published elsewhere.[29 30]

Data presented in this paper draw on the experiences of midwives and medical practitioners providing antenatal and intrapartum care.

Ethics

The project was approved by the research ethics committees of the Victorian Foundation for the Survivors of Torture and The Royal Children's Hospital.

RESULTS

Participating Afghan women, men and health professionals

Gender-specific, individual interviews were undertaken with 16 women and 14 men. All interviews with women were conducted in Dari. Eleven men

were interviewed in Dari or another Afghan language and three in English.

All participants were born in Afghanistan. Between them, the participants spoke six languages other than English, including Dari, Pashto and Arabic. Half of all participants (15/30) had been in Australia for ≤5 years. Half of all participants had not completed secondary school (15/30). All women and men spoke an Afghan language at home.

Five participants noted that they were not literate in their spoken language. In response to the question 'How well do you speak English?', five of the 16 women said their English was 'good', six reported that their English was 'OK' and five did not speak English at all or not well. Nine of the 14 men reported that their English was 'good'. The majority of women indicated that they required interpreting support in pregnancy (13/16), including two women who said that their English speaking ability was 'good' and all women who reported that their English was 'OK'.

Thirty-four health professionals, including midwives (n=10), general practitioners and obstetricians (n=5) and community-based health workers (n=19 refugee health nurses, bicultural workers, counsellors) providing maternity care and early postnatal care to women of refugee background, participated in an individual interview (n=17) or focus group (n=4 groups, 17 participants). The participating midwives and medical practitioners worked within one of the three public hospitals of the local health network and provided maternity care. Some general practitioners were community-based. All had experience of caring for Afghan or other families of refugee background.

The use of accredited interpreters in maternity care

The first contact with hospitals usually occurred at the 'booking visit' which involves taking a client history, psychosocial assessment, arranging screening tests and discussion of options for care for the remainder of pregnancy. Health professionals reported that an accredited interpreter was generally booked to attend this visit. Occasional problems encountered included the booking of interpreters who may not speak the language and dialect of the client:

> He was good but he was a Dari speaker and I was Hazaragi speaker and this difference of the language made it difficult for me to understand everything that he said. [Afghan woman, participant 8]

Professional accredited interpreters were used less frequently for subsequent appointments including when tests were being conducted. Several women reported being told to 'take a family member who can speak English with you ' for pathology and imaging screening.

> When I did my glucose test I had no interpreter booked for that appointment. After consuming the fluid my condition was very bad. I was fainting but I was not able to let the staff know about my condition. I had to wait until I was better. If I had an interpreter I could have let them know about my condition. [Afghan woman, participant 5]

Except at the 'booking visit', it was more common for the telephone interpreter service to be used. This was true for both hospital and community-based pregnancy visits. While some midwives and medical practitioners felt that women liked the security and anonymity of a telephone interpreter, others identified problems such as delays in waiting for a connection via the telephone.

> We are using phone interpreters at the moment, which I don't like. I just think it's impersonal and it takes up time, when you're first trying to get the lady into the room and you're waiting for an interpreter to ring back and some ladies can speak a little bit of English, some ladies can't speak a thing so you're trying to do some kind of sign language of "can I check your blood pressure?" and "baby moving?" so otherwise you're stuck there waiting 10 minutes or so for the interpreting service to ring back and then you've got 10 minutes left of your appointment… [Midwife, participant 32]

The preference for female care providers, as well as interpreters, was a strong theme in interviews with Afghan women and men. For many, availability of a female interpreter was seen as critical to women disclosing health or family concerns, asking questions and seeking clarification at pregnancy visits. Women who had pregnancy check-ups mediated by a female interpreter who spoke their language were overwhelmingly positive. Conversely, several women noted that they were embarrassed to ask health professionals about 'feminine issues' via a male interpreter.

> I was not comfortable with male interpreters at all; therefore, I had to keep all the questions to myself because it was embarrassing to ask the doctor about any feminine issue through him. [Afghan woman, participant 15]

Several participating professionals noted that some accredited interpreters were members of the local Afghan community and expressed concern that conversations about sensitive issues were difficult in these circumstances. Difficulties were described in situations where there was a possibility that personal information could become 'community' gossip'.

> She (Afghan patient) didn't feel that that interpreter was safe, she felt that her information had been spread around the community. [Doctor, participant 41]

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Family members interpreting during pregnancy, labour and birth

Most Afghan men accompanied their wives to all antenatal appointments. Several men noted that they felt 'obligated to go to the hospital (in Australia) for every appointment' in order to support their wives and to interpret for them.

> Because my wife couldn't understand English they (the midwife and doctor) had to tell me so I could tell my wife. [Afghan man, participant 19]

Women also commented on the fact that their husband interpreted for them.

> We have never had interpreters because we never needed one (husband interpreted) and they also said that it was very expensive on the government as well so we never asked for one. [Afghan woman, participant 14]

> No I didn't need an interpreter…my husband would come with me for all the appointments and would ask them about anything that he wanted to know. [Afghan woman, participant 11]

The almost ubiquitous involvement of husbands generated dilemmas for participating midwives and medical practitioners. Of particular concern was how best to manage when husbands insisted that they interpret for their wife.

> They (husbands) come in for all the appointments. So there's a couple of things with that, some of them… we don't like using the partners to interpret but some of them insist and refuse an interpreter, say "I don't want to have an interpreter, I can speak English, I will interpret". Usually we get around that by saying oh well your English is really good, I can tell that but you possibly don't know very much about medical things and when we need to talk to her about medical things you might not be able to interpret what we want to say. And sometimes you get a few that just flatly refuse and then you just do the best you can. [Midwife, participant 49]

In some instances the husband was happy for the interpreter to be involved in the appointment, but interjected when he did not want some information to be passed on to his wife.

> I've had a face to face interpreter where I was talking to the lady. She was in the last month or so with her pregnancy…and I was explaining everything, the changes that happen to the cervix in preparation for labour and what to expect in labour…, and her husband said…and he spoke English like I do, and he said "interpreter I don't want you to tell her that", and the interpreter said "I'm sorry I have to tell her that". He said she doesn't need to hear that, and I went "yes she does…" I suppose he thought he was protecting her. *[Midwife, participant 32]*

A small number of health professional participants had a preference for using family members as interpreters.

> I do tend to favour using family members even though, again, that's sort of frowned upon in some quarters. It's not impartial or whatever but it's superior (to telephone interpreting) in many ways…especially when showing women something. [Doctor, participant 47]

While two-thirds of the Afghan participants (20/30) identified that they required an interpreter during labour and birth, most (18/20) had not received any professional interpreting support at any stage during labour or the birth of their baby. One participant reported that a female interpreter was present for part of her labour, and another reported that a telephone interpreter was called when care providers wanted to convey to the woman information about the progress of labour.

Women who were not proficient in English relied on their husbands or occasionally other family members and friends to interpret. Although they appreciated the use of simple language and health professionals speaking slowly, they often reported that they could not understand what was being said. Several women noted that their husband's English was insufficient to be able to understand or explain what was happening.

> They were trying to explain things for me but I mostly didn't understand I would only reply back with yes or no. They were trying to communicate with me through my husband but his understanding of English language was not so good to be able to understand everything. *[Afghan woman, participant 8]*

Two women whose husbands were not present during labour and for the birth said that they requested an interpreter. Accredited interpreters were not provided. Instead, their husbands were contacted by telephone to interpret.

> Yes, I needed one but they didn't have any. So they called my husband and he was interpreting for me over the phone as there was no interpreter available. Even though I asked for one I guess they thought that since my husband was interpreting they wouldn't call an interpreter. [Afghan woman, participant 4]

Based on comments made by the Afghan participants it appears that health professionals are relying on husbands and other family members to both interpret and make decisions regarding consent to medical procedures.

> I interpreted for my wife in labour, till the time they took her for surgery. [Afghan man, participant 26]

> Was a professional interpreter used? [Interviewer]

> I am not sure. They didn't explain the procedure of surgery (caesarean) but I signed the consent form. [Afghan man, participant 26]

Other Afghan participants reported that that they were expected to have someone with them who spoke English, and sometimes the only person able to assist was someone that they did not want to be present.

> If I had a choice I would never have had her (mother in-law) allowed in the room. I didn't want her there… but since I couldn't speak English her presence was needed to support me. [Afghan woman, participant 3]

Some participating professionals noted that women should arrange to have someone to accompany them and provide interpreting support during labour, even though they recognised that refugees were often isolated and unlikely to know someone who speaks English.

Health professionals who have contact with women during the early postpartum period were surprised to hear from their clients that they had no interpreting support in labour. Women reported to these health professionals that they had been frightened during labour and birth and that they only had their husbands with them, who themselves had poor English skills.

Most participating midwives and medical practitioners reported that when women required language support in labour, the telephone interpreting service was used. However, in the sample of Afghan women and men that took part in the study, this appeared to have happened rarely.

DISCUSSION

Key findings

Several studies show that immigrant women experience difficulties communicating with health professionals providing maternity care.[34–36] Surprisingly, few studies have examined migrant women's experiences of using professional interpreters in the context of pregnancy and childbirth.

The study findings indicate a striking reliance on Afghan men to interpret for their wives. The engagement of professional interpreters during pregnancy visits was sporadic and virtually non-existent during labour and birth. The reported dependency on husbands to interpret is contrary to the language policy of Victoria, policies of other Australian jurisdictions and international guidelines.[19] There are many reasons for caution about the use of family members to provide interpreting support in healthcare. In the context of reproductive healthcare, the use of family members to interpret may discourage health professionals from asking women about sensitive subjects such as family violence and inhibit women who are asked from providing full and frank responses.[18]

This is a conundrum for all healthcare providers caring for patients with low English proficiency. In the presence of family members, it is difficult for health professionals to know what language support the patient really wants and challenging to facilitate the use of accredited interpreters within this context. In this study, it is clear that women and men's understanding of access to interpreting services in terms of cost, availability and confidentiality adds to this complexity. For example, some participants did not feel that they had the right to ask for a professional interpreter or to request a different interpreter.

It is also apparent that a number of system and organisational factors constrain the engagement of accredited interpreters. Participating health professionals noted that appointment systems are not sufficiently flexible to allow for the additional time required to conduct interpreter-mediated appointments. Many expressed concern about pressure to use telephone interpreters in preference to on-site interpreters for pregnancy visits. While there was scope to use telephone interpreters in labour, it appears that this rarely happens leaving some women and men without access to an appropriate level of information to make informed decisions regarding obstetric procedures.

The study findings demonstrate that the issue of ensuring engagement of interpreters in maternity care was not just a matter of resources. Failure to engage interpreters was apparent even when accredited interpreters were available and at no cost to the client or provider.

Strengths and limitations

Participatory processes enhanced our capacity to engage with people of refugee background—a group that are often excluded from mainstream research. The same approach was used to engage health professionals in the research, contributing an essential and complementary perspective on the challenges of providing appropriate language services. The community and stakeholder advisory groups that provided assistance in designing and conducting the study have also been involved in interpretation and dissemination of the findings.

We are cognisant that the study has a number of limitations. As an exploratory study designed to examine experiences of care across care episodes, we were limited in the extent to which we could explore specific aspects of care in detail, including communication issues. The study was conducted only in one region of Melbourne and involved only one community group. Funding constraints prevented us from expanding the study to encompass a broader range of communities and regions. However, in disseminating the findings, it is clear that the findings strongly resonate with communities and services in other parts of Melbourne and other Australian states.

Promoting engagement of accredited interpreters in healthcare

Our study findings clearly identify a major policy-practice gap—a gap found by others, in many different health settings and different countries.[37] Laws, policies and guidelines in Australia explicitly or implicitly indicate that health practitioners should engage accredited interpreters when their client's English proficiency is low.[38 39] Government language service policies, situated within discrimination legislation and professional duty of care, explicitly note that family members are not to be used as interpreters.[40]

There is a real risk of safety being compromised if health professionals and patients cannot communicate effectively during clinical encounters. The information that health professionals have to communicate to patients and vice-versa is critical and may be complex and sensitive. Nuances may be significant to what is expressed and heard. For example, the reasons for genetic and other screening tests and interpretation of test results may lead to misinterpretation, confusion and distress if not clearly explained and comprehended. Without adequate information about the signs of maternal and fetal compromise, women may delay seeking prompt care with tragic consequences.[41]

For women of refugee background who have experienced forced migration and the challenges of settlement in a radically different society, social stressors (eg, financial worries, relationship problems) and mental health issues are likely to be pronounced.[29 42 43] Our findings provide evidence that the use of family members to interpret inhibits communication, with the risk that health professionals will fail to identify and respond to sensitive issues such as family violence, depression and anxiety.

Culture and language are inextricably linked.[44] Health literacy—the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions—is an added dimension. Lack of integration of cultural competence, language competence and health literacy are likely to result in healthcare that is unresponsive to vulnerable groups' needs.[45] Building organisational and workforce capacity to engage interpreters requires health professionals to develop a heightened understanding of the migration experience, as well as enhanced communication skills for negotiating language needs in the context of traumatic histories, absence of extended family, low health literacy and changing gender roles.

Identifying a patient's need for an interpreter and preferred language at the point of entry into healthcare, irrespective of whether the contact is scheduled in advance (and making this need known to all clinicians with whom patients are likely to come into contact with), is a critical starting point for engaging the right interpreter at the right time. Ensuring patients have information about language services including availability, accessibility, confidentiality and cost is also essential.

In a variety of health settings, others have noted that the reality of busy clinics and hospitals including time constraints for clinical contact is a reason health professionals opt for the 'path of least resistance' and use family members to interpret.[16] Management of time for interpreter-mediated appointments within fiscal constraints is a challenge for health services. Structuring the length of appointment time proportionate to need is one possible solution. Reorganising public hospital outpatient care with block booking of accredited interpreters for clinic sessions is another. Other potential 'solutions' in the context of maternity care include community and language-specific group pregnancy care sessions combining antenatal check-ups with information and support provided by a multidisciplinary team of health professionals including an accredited interpreter.[46 47]

CONCLUSION

Improving identification of language needs at point of entry into healthcare, developing innovative ways to engage interpreters as integral members of multidisciplinary healthcare teams and building health professionals' capacity to respond to language needs, especially when clients' have experienced trauma that is likely to impact on their capacity to engage with healthcare, are critical to reducing social inequalities in maternal and child health outcomes for refugee and other migrant populations.

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