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Somali Refugees in Buffalo: The Impact of Language Barrier on the Health Care Access

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Abstract

Over the course of the last decade, the United States of America has resettled many refugees from different parts of the world as part of its yearly refugee intake; upon settling to United States, refugees face challenges as they adjust to their new communities and new environments. The impacts of language barriers and health disparities among immigrant groups and refugees in the country have become increasingly unquestionable and clear. Due to inability to speak and communicate in English, current refugees in the U.S are facing problems when accessing healthcare facilities. The U.S. government and healthcare providers are trying hard to narrow and eliminate this problem but due lack of effective strategies these challenges remain poorly understood. However, this paper will focus on one such group of refugees: Somalis who live in Buffalo. It will view them from a variety of perspectives. It will also investigate how the language barrier stops those trying to access healthcare in the community.

This project involves investigating how language barriers can adversely affect quality of health care; this research has been done by examining participants' experiences and perceptions towards accessing healthcare facilities. The instrument used in this study consists of face to face and semi-structured interview. The researcher collected numerical data by using quantitative and qualitative methods. Upon investigation of the research questions, it becomes clear that there is a huge language gap between the healthcare providers and Somali patients. The results collected shows that language and cultural issue are the biggest challenges Somalis face in Buffalo. Finally, this research highlights the importance of providing adequate information, guidance and cultural awareness to the Somali community in Buffalo

Keywords:Somali Refugees, Healthcare United States, Language barrier, Interpreters

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Chapter I: Introduction

Refugees in the United States come from all over the world, where they practice different religions and cultures. But they do share some similar characteristics and challenges. Significantly, refugees share similar reasons for leaving their home country. According to UNHCR (2015), in 2014 there were 19.5 million registered refugees all over the globe that were all escaping war, civil unrest, potential violence, tribal conflict and even terrorism. Historically, the United States of America has accepted many refugees from different parts of the world however, refugees face challenges as they adjust to new communities and new cultures. This paper focuses on one such group of refugees, Somalis who live in Buffalo, NY. Although this group of refugees face a number of different challenges, this research specifically investigates how language barrier issues impact individuals trying to access healthcare services.

Lee et al. (2003) and numerous other researchers agreed that immigrants and refugees will not be able to receive quality healthcare they need if there is inadequate and inappropriate communication between providers and patient. This will negatively affect the relationship and the interaction between providers and the patient. The fact is that, some refugees will prefer to stay home if they cannot find professional interpreters. And because of this problem, most of them will likely suffer stress, depression and other diseases (Walker & Barnett, 2007). Patients whose primary language is not English will also have difficulties understanding the importance of being insured and treated (Feinberg et al., 2002).

Researchers have noted that, refugees and immigrant groups also experience problems with follow up treatments and creating appointments, as compared with other nonimmigrant patients (Karter et al. 2000). Most refugees and immigrants have untreated health conditions and for this reason they are more likely to be admitted to the hospital (Lee et al., 2015). This will

increase the number of medical errors, stress and depression, and because of that, healthcare providers may struggle to communicate effectively with refugee patients, or even get necessary information regarding refugees' health conditions wrong. However, this will result in patients being treated badly. The only way this can be prevented is using professional medical interpreters (Flores et al., 2003).

Communication in accessing health care is a serious issue for all kinds of refugees. Effective communication and adequate interpreter services are some of the most important tools Somali refugees need in order to help their families (Carroll, Epstein, Fiscella, Gipson, Volpe, & Jean-Pierre, 2007). Sometimes, miscommunication and language difficulty can be life threatening because they typically reduce access to healthcare and interactions between doctors and patients (Flores, 2005). It also leads to medical errors and stress (Derose & Baker, 2000). Healthcare providers can overcome linguistic barriers through the use of professional interpreters and translators, thereby enhancing patient satisfaction. According to the Somali community leaders in Buffalo, one of the greatest challenges all ethnic groups face is a shortage of interpreters in Buffalo and New York State in general. Moreover, the city is characterized by high levels of health disparities between social, racial, and ethnic groups. Therefore, it is important to teach and train clinicians about how to overcome language barrier (Diamond & Jacobs, 2009).

In reference to the refugee group being investigated here, most of the participants reported that the biggest problem they have in Buffalo is that professional Somali interpreters are limited, and those interpreters that are currently available are not well trained or prepared. The result of this lack of training leads to inaccurate medical interpretations that subsequently result in frustrated clients and unnecessary psychological distress among patients (Kim et al., 2011),

not to mention detrimental medical outcomes that could have been avoided with proper understanding on the behalf of the patient (Collins et al. 2002: 9).

Therefore, the primary purpose of this research is to identify how language barriers can adversely affect quality of health care. Specifically, the paper seeks to understand this phenomenon from the perspective of Somali refugees in Buffalo, by examining the main challenges faced when accessing healthcare services and how barriers language affects their ability to access healthcare. As such, the secondary purpose of this research is to educate healthcare providers about what specific language dynamics are important for consideration when servicing this group. In so doing, healthcare providers can more directly attend to health disparities among this population (National Center for Health Statistics, Healthy People 2000, 2010). Additionally, this research will also attempt to analyze other related factors that influence communicational exchanges between this group and the healthcare system, such as cultural differences and patient satisfaction, which may also act as challenges to access healthcare service provision (Lee, 2003).

Currently, the biggest problem refugees face is that the U.S. healthcare system is largely designed toward helping only people who speak English (Timmins, 2002,). Non-English speakers are likely to be underserved and they receive lower quality of care because they are unable to communicate (Russell, 2009). However, understanding the importance and the role of language in this regard is crucial. And, if no change is made to the way healthcare service providers communicate with this segment of Buffalo's population, this group's social relationships and general wellbeing could be seriously damaged, which may have adverse social effects on other segments of the city's population.

History of Somalia and Somali Refugees in the U.S.A. and Buffalo

Somalia is located in the horn of Africa. It is a country that has experienced much political instability during the past decade. In 1990 the president of the Somali Democratic Republic, Siad Barre, was overthrown, which resulted in political instability, clan warfare, and inter-clan fighting. Thus, this period was marked by the most intense conflict because the Somali clans fought for control of land and power. Since 1991, Somalia was not under control of a functioning national government and still is ruins.

As a result, United Nations has reported that more than one million Somalis fled to neighboring African countries as well as to Europe and North America. The United States is home to the largest population of Somali refugees in North America. Most of Somali refugees resettled in the U.S through the United Nations Refugees Agency. However, prior to their arrival, Somali Refugees spend decades, waiting in refugee camps until they can finally be resettled to the United States or Europe. According to American Community Survey data (2010) almost 150,000 Somali refugees are currently living in United States. Many Somalis settled in areas where Somali communities already existed in the United States and large numbers of them settled in Minnesota, Ohio and New York (Buffalo).

Minneapolis is a home to the largest Somali community in North America. Most Somali refugees have chosen Minnesota because of family related issues, culture, education, and the high employment opportunities (Wilhide, 2018).On the other hand, there are a large number of Somali refugees in Buffalo and according to partnership for public good (PPG), New York State has resettled over 3,600 Somali refugee's majority of Somali families have settled in Buffalo making up the second largest refugee group in Buffalo. Somali refugee's population in Buffalo dramatically changed over the past decades as per Somali elders in Buffalo and most of the Somalis resettled in Buffalo decided to move and start their life in other big cities such as

Minneapolis. Buffalo's largest Somali populations are currently living in the West-Side area where they are trying to contribute to the community, business and infrastructure. They have local corner stores, community places and they help each other when one of them needs help.

Lastly, in the last few years, the number of Somali refugees annually resettled by the U.S is dramatically increased and there are limited studies that address Somali refugee's challenges. It is important to note that, healthcare systems are also dealing with an increasing range of culturally and linguistically diverse communities that is why the purpose of this research is to understand the role that language plays in creating barriers to healthcare access. However, relevant information related to the history and background of Somali refugees in the U.S. were reviewed and presented in this chapter. The following chapter will present a discussion and review of previous research that focused on linguistic challenges and barriers to healthcare access.

Chapter II: Review of Related Literature

Over the course of the past decade, the impacts of language barriers on health outcomes among refugees and minorities have become increasingly clear (Ferguson et al, 2002). While there is an effort to acknowledge and address linguistic barriers, learning by trial remains the most common form of education on the current health care system in the United States (Burgess, 2004). However, a number of studies have been conducted across United States that address and acknowledge the impact of language barriers on the health care system. Much of the research has focused on Spanish speaking communities and comparatively little is known about Somali refugees in the United States (Karliner, and Jacobs, 2007). Several researchers indicate that, refugees and other minority groups are understudied and there is an information gap on refugee's health disparities in the United States (Kandula et al., 2004). Therefore, this cannot be applied to all refugees because refugee's health status, background, and culture differ from that of immigrants and non-immigrant populations in the United States (Cunningham et al, 2008).

However, this review will attempt to examine and analyze previous studies by explaining the refugee's health disparities in the United States. Under this review the researcher will look at communication in healthcare, cross- cultural communication and patient satisfaction. Also, since most of the refugee's population specifically new arrivals do not have the ability to communicate effectively in English, the researcher will attempt to analyze the importance and the role of effective communication when accessing healthcare facilities. Then, the review will move to quality of interpretation services provided by offering strong examples and explaining how it affects refugee's healthcare access.

Communication in Healthcare

Although a lot of people think, communication is a simple term and easy to define the fact is that it is more complex, and scholars define the word communication in different methods. By definition, communication is the process of passing information and understanding from one person to another (Davis, 1967). Communication is also a process of transmitting and receiving verbal and non-verbal messages. It is considered effective when it achieves the desired response or reaction from the receiver (Murphy, Hildebrandt & Thomas 1997). Based on the definitions above, communication is important for both the sender and the receiver. In order to have an effective communication between both parties the message and information exchanged should be clear and understandable

In healthcare, communication is an interaction, connection or conversation between healthcare providers such as doctors/nurses and the patients/family members. Communication between refugee's patients and healthcare providers who are linguistically different can either have positive or negative impacts on the relationship and interactions between doctors and patients at every level of the health care system (Morris, M., et. al, 2010). Thus, building strong relationships between providers and refugees is very important in healthcare setting and this will have a positive impact such as trust and mutual satisfaction. If there is misunderstanding between patients and physicians, the outcome will lead to medical errors and lower healthcare access as indicated by Jacobs et al. "The conversation between physician and patient has long been recognized to be of diagnostic import and therapeutic benefit" (Jacobs et al., 2001: 468). Moreover, Collins et al. indicates that "Effective communication between patient and doctor is critical to good medical outcomes" (Collins et al. 2002: 9).

It is agreed, that effective communication in healthcare is a major challenge specifically when it comes to follow up appointments. Sarver and Baker (2000) have identified that language barrier reduces the chances that a patient is given a follow-up appointment after an emergency department visit. A key argument is that certain patients such as non-English speakers require more time and attention no matter if they successfully complete their follow up appointment or not. Studies indicated that when there are communication problems, there will be a chance that providers may not give follow up appointment to their patients or patients may not ask about the need for follow up visit (Sarver and Baker, 2000). Follow-up visits are important part of caring for the patients therefore, healthcare providers should assess' refugees' level of understanding English language because sometimes refugees are not familiar with the importance of follow up appointment, and in such situation, they will need an adequate information and effective communication in order to help them express their feelings and emotions. The provision of language support will help refugee patients in terms of understanding all the medical information provided and the more adequate information given to patients, the better the medical outcomes' (Kaplan, Greenfield & Ware et al, 1989).

In addition to language and communication being a challenge for ethnic minority groups, they often come to the US with poor mental health and other chronic diseases. Studies in many countries found that new refugee's arrivals have high level of past trauma, exposure to violence, rape and other history of sexual violence which needs to be addressed clinically. Studies also proved that patients with a limited English stays in hospital for longer hours (John Baptiste et al 2004). It is not because of the type of sickness they have but, in most cases, it is because of their inability to communicate with healthcare providers (John Baptiste et al 2004).

Another study describes that doctors and nurses are spending more time with non-English-speaking patients because of language and cultural barriers (Tocher and Larsen, 1999). Due to many languages spoken and different cultures practiced by immigrants in Buffalo research indicates that the most difficult issue is explaining symptoms and identifying treatment (Karliner et al, 2004). In this regard, health care providers should provide maximum attention and certified interpreters that can help diagnose and treat refugee's common health problems.

Language and communication affect all stages of health care access at the same time it can have an impact on patient experience, satisfaction and treatment process (Morris, M., et. Al, 2010). This can directly or indirectly affect refugees' short term or long-term health status. Some researchers agreed that due to lack of proper interpretation services and refugees inability to read written materials it is not easy to address and find solution for the most common communication complaints such as poor attitude, long waiting times and misunderstanding issues especially when refugees' patients do not speak the local language for example a "Somali refugee delivered her baby on the doorstep of a hospital when there was open after-hour emergency services on the other side of the building" (Morris, et al, 2009). This means that, the inability to speak and read English can have a negative impact on refugee's health status. On the other hand, when treating such community primary care providers should pay close attention to different factors such as cross-cultural communication and this can be done or addressed through hiring bilingual medical interpreters that can a sure patient has understood all the information and prescription provided.

Effective physician-patient communication is critical to good medical care and this demands additional knowledge, experience and skills. The review above indicates substantial evidence of language barrier on effective physician-patient communication and their adverse

effects on quality of care that may be related to health disparities. There is a need to support refugees in understanding healthcare system. Although it is not easy to get certified medical interpreters then, intensive continuing education of nursing staff can improve interpersonal fluidity in clinical practice (Robinson and Gilmartin, 2002).

Timmins, (2002) have clearly explained factors that affect the ability to access health care system in the United States. Timmins have examined the impact of linguistic barriers such as spoken language, healthcare literacy, quality of care, health status and the degree of medical errors between health care providers and patients from the perspective of Latino community in the U.S. The main objective of this study was to educate and provide basic knowledge for the health care providers and other institutions about how to bridge language barrier. To consolidate evidence further, most of the studies examined found a significant adverse effect of language on the quality of care (Timmins et al 2002). The result found clearly indicated that there is strong evidence that shows people with limited English are at risk for experiencing decreased access to health care and poor relationship with care providers due to a limited English proficiency. The literature also indicated that race; ethnicity and language greatly affect the quality of doctor-patient relationship and because of this issue minority patient are more likely to choose minority physicians and clinics (Ferguson and Candib, 2002). Therefore, healthcare providers need to be more effective in developing good relationship with refugees and other minority's patients.

Cross-Cultural Communication

Cross-cultural communication is the process of understanding how people who have different culture, norms, belief, history and background interact and communicate. Understanding cross cultural communication is very important for the healthcare

providers. Sometimes if providers don't pay much attention to refugee's culture and beliefs it may cause potential issues such as misunderstanding and misinterpretation.

A number of studies reviewed the role of culture in primary care. According to Rothschild (1998) "Physicians who actively seek to understand their patients' cultures will find their simple efforts amply rewarded by improved patient access to health care, increased patient satisfaction, and greater clinical effectiveness". The author discussed about the importance of addressing patient's culture and beliefs and encouraged providers to come up with strategies that can help them to avoid miscommunication or misunderstandings.

Sometimes, with all the good will and intention to help refugees, misunderstanding between patients and doctors is always possible specifically when there is cultural difference between providers and refugees. For example, it may be social acceptable in the United states for a woman to have a male doctor while some other countries such as Somalia women will always prefer to have another female doctor rather than male doctor. And these differences may lead to patients to feel uncomfortable during healthcare access. On the other hand, to obtain information from a patient who may not want to share with you demands additional skills from the healthcare practitioners and cultural skill will be a very important asset in such situations (Campinha-Bacote& Munoz, 2001).

The power of cultural awareness helps nurses and other healthcare practitioners to understand the emotions and the feelings of refugees. Therefore, a cultural competent healthcare provider can help the patients to understand more about the medical process. Not only that, Healthcare practitioners who are cultural competent also understands how facial expressions, cultural difference and beliefs can lead to miscommunications and misinterpretation. Numerous studies indicated that cultural competency works, but healthcare providers needs to understand

which cultural competency techniques are effective when and how to implement them properly (Betancourt, 2003). When healthcare providers fail to understand and provide linguistically appropriate services the relationship between providers and patients will suffer.

With the increased number of refugees coming to the United States, some refugees do speak English but not very well they can at least try to communicate. As such, not only does speaking a language provide access to healthcare, but the culture nuance of certain dialects is important as well. Evidence indicated that due to cultural reasons some refugees will underuse their healthcare plan (Uba, 1992). Because if there is a cultural gap and patients feel uncomfortable then, they will definitely prefer not to comeback. Although some of the findings have shown weak evidence regarding this issue, most researchers agreed using bilingual interpreters, educating nurses and addressing their cultural beliefs will increase the degree of accuracy and healthcare access.

It is important to note that some cultures are strict, and it is inappropriate for a man and woman to interact with each other at every level of the health care system, from making an appointment to prescription which means different ethnic groups process healthcare information differently because of their culture and beliefs (Brach & Fraser 2000). For example, a Somali woman who cannot speak English will prefer a female interpreter rather than a male interpreter when visiting clinics. Some women feel uncomfortable having male interpreter because she has to share her personal stories with the interpreter and because of her shyness she will not be able to express her feelings or problems. On the other hand, when doctors, nurses and dentists want to share medical information with their patients and the patient cannot speak English then, some provider

will decide to use jargons or body language which can bridge language barriers to some extent, but the fact is that some facial expressions or body languages are complex and can have different meaning in different cultures.

A study conducted by Cioffi (2003) recommended that the combinations of different techniques that can help providers to effectively communicate with patients therefore such combinations includes prioritizing access to appropriate linguistic services, providing nurses the support they need, increasing nurses' understanding of legal issues within patient encounters, supporting nurses to translate their awareness of cultural diversity into acceptance of, appreciation for and commitment to patients and their families (Cioffi ,2003) . However, it is not easy to learn and understand all the norms and cultures of minority groups in the country but understanding how people of diverse cultures and belief perceive about the healthcare is crucial.

There are limited studies showing strong evidence about the relationship between cultural competency training and improved medical outcome and the fact is that there are only a few high-quality studies that have examined the link between cultural competence training and positive medical outcome (Lie et al, 2012). Although cross-cultural training helps physicians avoid cultural conflict while improving their ability to understand cultural beliefs for patients from diverse backgrounds but a direct relationship between cultural training and improved patient outcomes remains to be revealed (Coleman, 2011).

Patient Satisfaction

Patient satisfaction is a process that determines how well the patient was treated and how much satisfaction they received. According to the literature the concept of patient satisfaction is very complicated, and it is determined by information and communication (Heidegger, et al. 2006). However, understanding factors that can affect patient's satisfaction is very crucial in this chapter. These factors include the relationship between healthcare providers and patients,

patient's expectations, healthcare literacy, effective communication, health status and accomplishments. Those factors can have both positive and negative impacts on patient's outcome. Since outcome is a key factor of quality care then patient satisfaction will also be part of quality care (Heidegger, et al. 2006). For example, if healthcare providers in Buffalo improve their relationship with refugee's patients then, it will help them develop a mutual trust and that can have positive impact, positive outcome and positive satisfaction.

The terms 'patient satisfaction' and 'patient experience' are at times used interchangeably in the literature (Berkowitz, 2016). Numerous researchers conducted a systematic review and extensively studied about measuring patient satisfaction and suggested that, language barriers may have a negative impact not only patient's satisfaction and their families but also healthcare providers (Flores, 2005, et al.). These studies provided a link between quality of care, patient expectation, experience and satisfaction but most of the results had low reliability and uncertain validity (Gill& White, 2009). But it is widely agreed that if the patients are not satisfied with their treatment it will affect achieving healthcare goals (Vuori,1991).

Gadalean, Cheptea, and Constantin (2011) conducted a study in Romania in order to evaluate patient satisfaction. The Authors examined factors that are important for both patient satisfaction and dissatisfaction. According to this study factors investigated includes proper treatment; compassionate treatment; clear explanations about treatment; no pain; demonstration of proper concern and many other factors which can affect satisfaction scores. The authors also examined factors such as communication, accommodation facilities, factors arising from the lack of personal, pain and lack of sleep which can negatively affect dissatisfaction scores. In this study, a sample of 106 patients hospitalized in the intensive care unit of the Institute of Oncology in Romania was used. The study described and highlighted the importance of effective

communication in healthcare setting and results found indicated that satisfaction score is highly influenced by education level, diagnosis and emotional attitudes (Gadalean, Cheptea, and Constantin, 2011).

A number of other studies also focused on the level of refugee's satisfaction, patient perception about the healthcare providers, and experience when accessing healthcare. According to Kupfer and Bond's study (2012) quality of healthcare provided will always have an impact on the level of patient satisfaction which means that, if quality of healthcare provided is high then, level of satisfaction will most likely increase and vice versa and that is why it is important healthcare providers to understand the concept of patient satisfaction and experience. Other researchers argue that since the quality and the outcome of healthcare depends on patient satisfaction then, it is highly important healthcare providers to be held accountable for the quality of healthcare they provide and patient experience (Price et al. (2014). The use of patient satisfaction measures in the health sector is very important and has been mandatory in some countries like French hospitals (Boyer et al., 2006).

Despite the increased focus on patient satisfaction and its complexity, studies continue to prove that predictors of patient satisfaction play key roles in improving the outcome and the experience of patients. According to Jackson, Chamberlin, and Kroenke (2001) study unmet expectations and doctor–patient communication are the most important factors that affects satisfaction scores. Sometimes it is difficult to determine if the patient is satisfied or not because their expectation is not clearly known at that moment. There is a general expectation which everybody knows but each patient has specific needs and expectation in their mind. Studies argued that patient's thoughts and expectations about the doctors, nurses and healthcare plays an

important role when measuring satisfaction scores. Failure to understand perceived thoughts and expectations will result in patient dissatisfaction (Bell, Robert A., et al 2002).

In the healthcare sector, there is an urgent need to understand the relationship between patient satisfaction versus the quality of healthcare and the medical outcome because patients are demanding good service from healthcare providers therefore, it is important for the healthcare providers to make good decisions that can potentially help people of diverse cultural backgrounds.

A study conducted by Asgary & Segar in 2011 indicated that there is a significant inter-related barrier that exists at the individual, provider, and system levels and this prevents them from identifying the best technique to use and when. The authors recommended that promoting community-based organizations, enforcing the use of trained medical interpreters, and improving cultural competency can help improve healthcare access. Therefore, most of the studies are limited to one geographical area or one community while other studies could not provide strong evidence about how these factors are related to each other. But the fact is that such studies could still be important in providing strong perspective and strategies to address healthcare barriers.

Quality of Interpretation Services

Quality of interpretation service in the healthcare sectors requires extensive research. This is because non-English speaking patients have the right to understand every aspect of the medical process from making appointment, signing consent forms to follow-up visits. Due to international migration, it is universally agreed that accurate and effective communication both verbal and nonverbal is crucial to quality of medical care. But the lack of access and availability to trained medical interpreters resulted to the reliance on *ad hoc* interpreters (Bischoff & Hudelson, 2010).

Most of the current healthcare providers do have interpretation services but sometimes, providers still rely on patients' relatives and friends. Several researchers have been critical of using family members or relatives to interpret (Gerrish et al. 2004). It may seem appropriate and easy to use member of their family as an interpreter, but it affects the quality of interpretation, privacy and dignity of the patients and it is not recommended at all (Szczepura, et al 2005).

According to the article, Language Barriers to Health Care in the United States (Flores, 2006) large numbers of U.S residents speak language other than English. Yet, most of these residents who need urgent medical interpreters have no access to them and they commonly use family members and friends as interpreters. The author focused on the importance of effective communication and explained how the interpretation of one single word can lead to delayed care and medical error. Therefore, providing professional medical interpreter services is very important and can increase healthcare access. There is another study which indicated that provision of professional interpreter services and improved physician–patient relationship increases delivery of health care to limited-English-speaking patients (Jacobs et al 2001).

Baker, Parker, Williams& Pitkin study (1996) "Interpreters are often not used despite a perceived need by patients, and interpreters who are used usually lack formal training in this skill". In many instances making professional interpreter services available to all patients is not easy task. But the fact remains the same that professional medical interpreters are important element in the quality care for patient from diverse populations. Not only providing professional medical interpreters can help but also giving them, a formal training can help them to understand more about the patient needs and culture. Failure to provide medical interpreters raises risks of medical error and patient dissatisfaction and in terms of the quality of interpreting (Baker, Parker, Williams& Pitkin study, 1996).

Translation of Written Material

There is a difference between translation and interpretation services. Translation is the process of changing written materials or conversion of written message from one language to another while interpretation is basically listening, analyzing then changing the message into another language. In the healthcare sector, it is important to understand that these are different and in order to obtain effective communication medical interpreters must have both education and skills necessary to do both interpretation and translation services. Refugee's patients may not be able to read written materials and they require access to someone who can read it to them. Sometimes they cannot even read when written material is translated and patients may be confused about their medication. Therefore, it is the responsibility of the providers to make arrangements for the provision of interpretation services.

Misinterpretation or inadequate communication between healthcare providers and the patient is a common problem in healthcare setting and this can lead to errors and negative consequence (Flores, 2006). However, the use of bilingual health professionals and well-trained interpreters is highly recommended and will most likely minimize the negative impacts of language barriers and will increase the degree of accuracy by bridging language gap between patients and providers (Timmins, 2002)

Gerrish, Sobowale, and Birks (2004) conducted a study by examining the utilization of interpreting services from the perspectives of the nurses, interpreters and minority ethnic communities. Focus groups were the main focus of this study and the authors used five groups from district nurses, health visitors, practice nurses, community midwives and specialist nurses, three groups of interpreters' and five groups of participants from Arabic, Bengali, Cantonese, Somali and Urdu Communities. The findings from this study suggested hiring bilingual medical

interpreters and training current nurses would improve the quality of care. On the other hand, lack of training or providing Inadequate training of nurses and interpreters adversely affects the quality of healthcare (Gerrish, et el. 2004). The results indicate that many participants relied on family members and friends to interpret for them because there is lack of provision of professional interpreters. Few participants had experience using professional interpreters and interpreting services are either inadequate or inappropriate. Due to the ever-increasing number of medical errors led by lack of professional medical interpreters some patients feel confused and there is strong evidence that shows if refugee's patients are less satisfied with the interpretation services available or with treatment provided they will decide to discontinue using prescribed medication or accessing healthcare facilities.

Roberts, Irvine, Jones, Spencer, & Williams (2007) also examined the importance of language awareness among nurses, midwifes and health visitors. The researchers used stratified random sampling and distributed self-administered questionnaire of healthcare professionals working in the public, private and voluntary sectors of healthcare in Wales, UK. A sample of 3358 healthcare professionals was surveyed; the results found indicated that language training is an important method to enhance the quality of care for minority language speakers. This study concluded that cross-cultural communication is enhanced by NMHV language attitudes as well as their proficiency levels.

Although a lot of different studies may have answered important questions regarding linguistic barriers, patient's satisfaction, quality of healthcare service, availability of interpreters and so many other factors being a challenge to refugee population. Further studies with a larger sample size are needed to explore the best solution and technique to use, how use and when to use it. Health care providers also need to find strategies to minimize the medical errors while

improving quality of healthcare care. In addition to that, providers also have to avoid using untrained interpreters such a family member and friends (Timmins, 2002). It is convenient but not necessary.

In summary, this chapter has provided a review of the past literature and it has critically analyzed the gap and the strength of prior research studies. There is one common factor which most of the researchers agreed and it is the link between provision qualified medical interpreters and healthcare outcome. Similar problem is faced in both refugees and other immigrant population in the country and the fact is that in order to provide proper technique and strategy of overcoming language barriers, certified medical interpreters and cultural training is needed, both for patients and providers of health care services. The current literature and previous studies also suggested many ways of managing linguistic challenges but the degree of medical errors and linguistic barriers in healthcare does still exist. Overall, until there are enough bilingual or well-trained medical interpreters/staff the linguistic issue will remain visible.

Chapter III: Methodology

This study seeks to expand our understanding of the impact of a language barrier on the healthcare access as the Somali refugees settle into the United States (Buffalo). However, from the perspective of the Somali population in Buffalo, the researcher attempted to find the impact of linguistic barriers on healthcare access and refugees experiences towards healthcare.

Research Design

This project is a qualitative exploratory study from the Somali refugee participants through individual interviews with the researcher of the study. The reason why the researcher selected this type of study is to develop new ideas and assumptions related to the research questions (Cuthill, 2002). Exploratory design also helped the researcher to set direction for future research (Stebbins, 2001). Exploratory design also provided an opportunity to understand more about the nature of the problem Somali refugees face when accessing healthcare services. This study also gave the Somali population an opportunity to present their view and experience towards healthcare systems in the country. The main goal for data collection and analysis was also to make sure participants experience and views remains connected to the results.

To ensure the trustworthiness of the data, informed consent was needed. The researcher prepared a consent form. The description of this form was also translated into Somali. Then, potential participants were invited to take part of the study. During the recruitment process the researcher explained to the participants the purpose of the study, time frame, inclusion criteria, procedures and benefits. Furthermore, it was made clear to all Somali participants that they could withdraw from the study at any time or choose not to participate at all without being penalized.

One of the challenges of the data collection process was recruiting potential participants because some refugees were afraid, and they believed that taking part of this research might put

them in trouble while others where shy because they did not want talk about or disclose their inability to speak English. Participants reported that there is no accurate data showing exactly how many Somali refugees are currently living in Buffalo because most of Somalis move to Minneapolis and other big cities after a couple months of their arrival. The main reason is that some are looking for better employment opportunities while others have family members living in Minnesota and this was the biggest challenge in terms of recruiting potential participants.

Interviews

Given the exploratory nature of this study a qualitative interview was used as the main source of collecting data. A qualitative interview gives participants an opportunity to share relevant information in their own voice, intonation, body language etc. (Opdenakker, 2006)**.** The data was collected from both newly arrived Somali refugees and other Somali residents in Buffalo, regardless of their time spent in US and gender. Face-to-face and semi structured interviews were conducted in Somali and English and sometimes the researcher had to translate interview questions into Somali and then translate back into English. The interview took about an hour. Participants were asked the same interview questions consisting of 20 to 30 items (see Appendix A). These questions focused on their experiences/expectations, their interaction with healthcare providers and how language barriers affect their ability to access healthcare and their intention to return. The interview questions were critical for both recruitment process and data quality. During the interview process the researcher read the consent form into Somali and asked participants if they are willing to sign the consent form. This took more than an hour because the questions have to be translated into Somali and then translated back into English.

The researcher also collected potential participant's data such as, gender; number of years lived in the United States and in Buffalo. Most of the interview questions

mainly focused on Somalis perception/ views towards health providers, level of satisfaction and experience. Since most of the Somalis in Buffalo know each other this type of research was kind of sensitive due to cultural issues, for example a lot Somali woman prefer not to answer questions like age or marital status. However, knowing the researcher encouraged a lot of potential participants to participate and disclosure their personal information (Crowley, 2007).

During the interviews process, participants were also asked additional questions and comments. Each interview was transcribed in Somali and English, then arranged and coded according to the source of information. At the end of the interview, the researcher translated some of the materials into English, checked accuracy of translation, made written corrections and clarifications and then transcripted the information for analysis.

Sample Selection

The Somali population in Buffalo is relatively small compared to other cities in the United States, because of that the researcher tried to avoid any kind of sample selection bias. In order to do that, the researcher decided to include a broad range of Somali population in Buffalo representing a variety of ages, gender, region and time spent in the US. The main reason was to enrich the data collection process by including participants with a range of experiences. This also helped the validity and the reliability of the data.

According to Partnership for the Public Good (2015), from 2002 to 2014 a total of 9,723 refugees resettled in Erie County, 1,980 of these refugees were from Somalia. Therefore, some of the participants reported that due to high unemployment rate Somalis faced and other family related issues. Most of Somalis resettled in Buffalo decided to move to Minneapolis and other big cities after their arrival and because of that reason there is no accurate data available showing exactly how many Somalis refugees are currently living in Buffalo. However, in reference to the reason mentioned above, the researcher decided to use a sample size of 50 individuals. The

sample entailed Somali community leaders, elders, women and young adults. Potential participants were recruited through Somali Stores and Mosques. The researcher is also Somali and speaks the same language, therefore due to cultural sensitivity this was a key to the feasibility and success of this research, at the same time it ensured Somali views are heard and their challenges are identified. The researcher also acknowledged the culture of this community and decided to collect as much data as possible. Eligible participants were Somali adults (>18 years old), born in Somalia, and currently living in Buffalo**,** NY**.**

The researcher used a convenience sampling method. This sampling method has been chosen because it allows the researcher to get the basic data, it is simple, affordable, and saves time (Etikan, Musa, & Alkassim, 2016)**.** This sampling method has disadvantages which is the possibility of being biased and this means that it could over-represent or under-represent the views of a specific population and that could also affect the validity of the data and thus it cannot be applied to the entire population. Most of the participants were not be able to speak, read or write English fluently; therefore, convenient sampling also allowed the researcher to approach whoever he can in their free time and wherever was convenient without interruption. It also helped and allowed the researcher to visit Somali Stores and mosques and recruit participants for this survey.

However, understanding the shared values and norms of this community were very crucial in the study process. The ability to speak Somali language and understand participants' culture and norms helped the researcher to connect with Somali participants and identify with their cultural nuances. It also eliminated factors such as cultural difference and language proficiency which is always a major challenge when recruiting research participants (Patel, Doku, &Tennakoon, 2003). Lastly, after collecting the numerical data the researcher used

quantitative and qualitative methods to interpret, transcript, analyze, and present the results that has been collected.

The researcher collected key demographic characteristics relating to the participants: 29 participants (58%) were male while 21 participants (42%) were female. At the same time, 27 participants (54%) did not complete high school, 14 participants (28%) had some high school/GED, 7 participants (14%) said they have a college degree while the other 2 participants (4 %) answered they have a bachelor's degree. According to their employment status, 38 participants said they are employed, 12 participants said they are currently unemployed and lastly, when participants were asked about their marital status 48% said they are married, 42 % single and 10% replied divorced as illustrated in the table below.

Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	29	58.0	58.0	58.0
Female	21	42.0	42.0	100.0
Total	50	100.0	100.0	

Level of Education you have completed

	Frequency	Percent	Valid Percent	Cumulative Percent
Did not complete high school	27	54.0	54.0	54.0
Some high school/GED	14	28.0	28.0	82.0
Some College	7	14.0	14.0	96.0
Bachelor Degree	2	4.0	4.0	100.0
Total	50	100.0	100.0	

Are you currently employed

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	38	76.0	76.0	76.0
No	12	24.0	24.0	100.0
Total	50	100.0	100.0	

Marital Status

	Frequency	Percent	Valid Percent	Cumulative Percent
Married	24	48.0	48.0	48.0
Single	21	42.0	42.0	90.0
Divorced	5	10.0	10.0	100.0
Total	50	100.0	100.0	

Chapter IV: Results

There are a lot of Somali refugees who came to Buffalo for the last couple decades, most of this community were living in refugee camps until migrating to Buffalo. According to the 2000 U.S. Census, Somalis are part of 12,856 people of foreign-born citizenship, who are currently living in Buffalo. Most of the participants who lived in Buffalo for almost 20 years told the researcher that the Somalis are more and more likely to move to other States for several reasons such as difficulties to get an interpreter, employment, housing and several other reasons. If they don't get the kind of support they want there is a reasonable chance that they will move again and again. The result reported between 2003 and 2013 indicated that 1,980 Somali refugees resettled in Erie County and more than 70 % are reported that they are currently living in different states. The U.S. Office of Refugee Resettlement reported that due to several reasons this kind of immigration is more likely to happen for the first one or two years of refugees' arrivals.

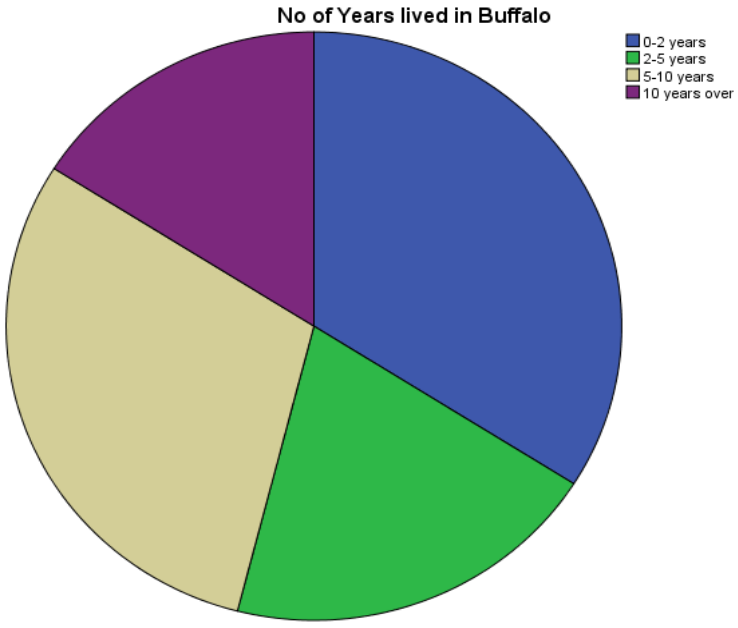
At the end of collecting the numerical data; the researcher decided to arrange, code, transcript, analyze, interpret, and then finally present the results that has been collected by using quantitative and qualitative methods. This allowed the researcher to understand Somali refugees' interaction with healthcare providers, their experience and if language barrier increases or decrease healthcare access.

According to the results found in this study it indicates that 34% of the participants lived in Buffalo only 1 or 2 years and they told the researcher that they might decide to move to other states if they get the chance because they are always seeking a lower cost of living, better employment opportunities and a larger community that they share their experiences and cultures with. One of the other reasons is also to join other family members who are living in other states.

20% of the participants in this study lived in Buffalo between 2 to 5 years, while another 30 % lived in Buffalo between 5 to 10 years and 8 participants (16%) out of the 50 participants interviewed lived in Buffalo more than 10 years.

A newly arrived refugee from Somalia said “I have a big family back home in Somalia and I have to pay their bills and my bills too. all I am looking for is a job, it doesn’t matter where, and I am always ready to move to other states.” One of the Imams (a community leader) also said that “We always try to help the newly arrived refugees, but it is really hard to make them stay in Buffalo”. This is significant because Somali immigrants are more likely to move because of the purpose of family and community reunification or seeking affordable housing and employment with good pay. Therefore, it is understandable and most new arrivals could not speak English which means it will be difficult for them to get decent job and if they don’t get a job they will not be able or afford to pay high rents in some areas. The study findings indicated that a lot of Somali families first came to Buffalo and then chose to move to Minnesota.

Figure 1: Number of years lived in Buffalo

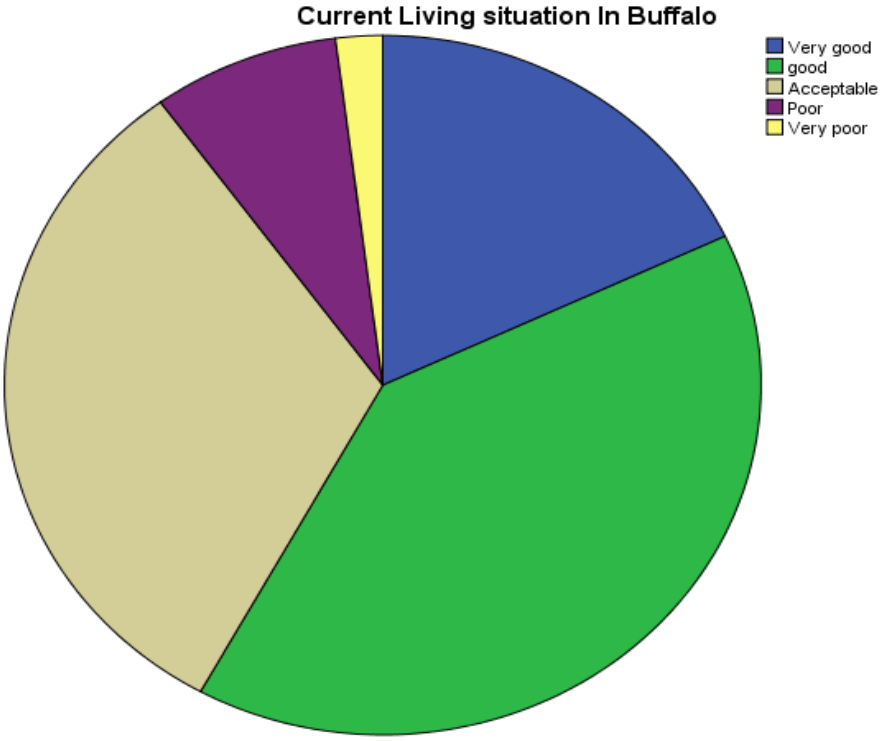


As stated in the above figure most of the participants agreed that secondary immigration is always possible in the Somali community of Buffalo for several reasons. The researcher also asked about their current living situation in Buffalo. Many participants interviewed agreed that their current living situation is not bad but given the difficulties involved in refugee resettlement process they were not happy with the resettlement agencies in Buffalo. This is because they have not provided the ultimate help and support they hoped for. Most of the resettlement agencies do not directly nor indirect help or support refugee families beyond the initial 8 months of their arrival. However, findings from this study suggests that understanding the nature of the problem and extending both financial support and other services beyond the 8 months after their arrival, would definitely change refugees perception towards resettlement agencies and they will have a better life during the adjustment period.

As shown in Figure 2 below, among the 50 participants interviewed, 18% agreed that their current living situation in Buffalo is very good; most of them own houses, have jobs and lived in Buffalo for more than a decade. Another 40% of the participants agreed that the current living situation in Buffalo is good, most of this group are able to speak English and are currently employed, while 32% said it is acceptable, finally 8% agreed it is poor and 2% said very poor as shown in figure 2 below. The last 8% and 2 % who agreed their current living situation is poor told the researcher they have difficulties in learning the language and they tried to get job, but they could not get it.

One of the participants said “It is not always easy for everybody to learn English and get a job. Since I am not able to speak English it is hard for me to know the services that are currently available for the refugees.”

Figure 2: Current living situation in Buffalo



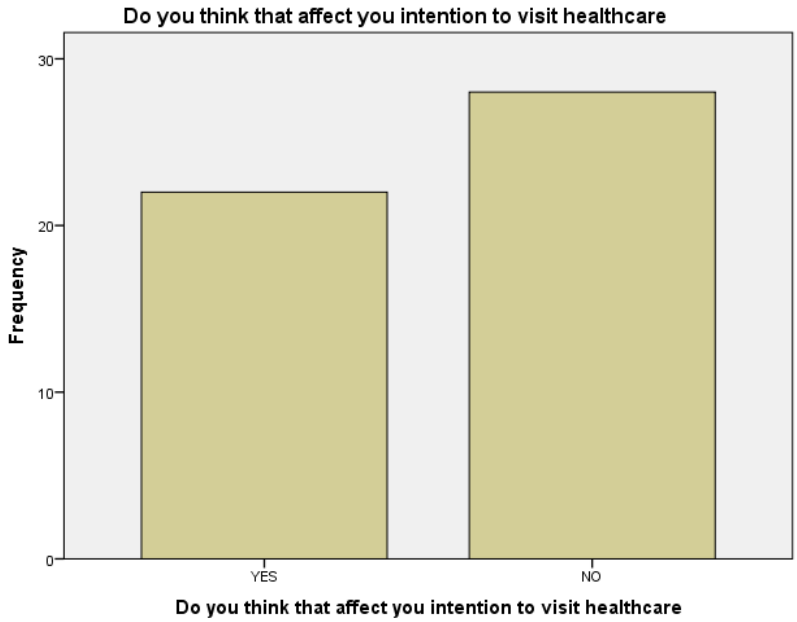
To better understand the impact of language on the healthcare, the researcher investigated how many participants were able to communicate in English (reading, writing and speaking). The results show that 27 (54%) of the participants said “Yes” they can speak, read and write English, 23 (46%) of the participants said “No” they can’t. It is noted that a high level of language proficiency is a key aspect of employment opportunities and better lives. The 23 participants who said they can’t speak English told the researcher that they are currently facing huge difficulties when accessing healthcare, employment and transportation. This provides a strong indication that receiving support in each of these areas is not going to be easy without the ability to speak even a little English.

On the other hand, most of the refugees often have some sort of health problems or post-traumatic stress disorder because of their past experiences related to violence and torture. They may frequently need to visit healthcare centers for these reasons. Participants were asked if

language barrier affects their intention to visit healthcare centers. The result indicated that 44% answered “Yes” and 56% said “No”. This means that out of 50 participants 22 of them said “Yes” and 28 of them said “No”. Participants who said “No” told the researcher that most of the clinics and healthcare centers they visited either had Somali interpreters or phone interpretation services. While the other group who said “Yes” told the researcher that they don’t want the interpreter to know their personal health status or disclose their personal information.

This study revealed that many Somali refugees do not regularly access health services because of several reasons such as language barrier, culture or other individual issues. This can affect all stages of health care access. Women participants also told the researcher that they don’t want to be seen by a male doctor because their religion does not allow a male doctor to help her when a female doctor is available. Therefore, factors such as cultural expectations of care can really affect refugees’ health status both in the short- and long-term

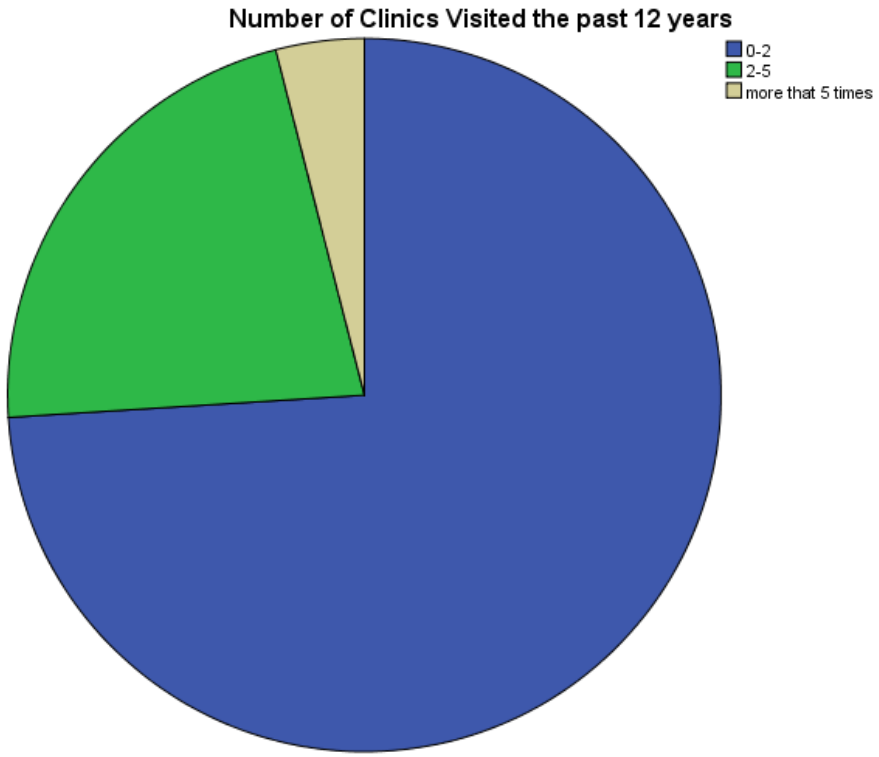
Figure 3: Do you think language barrier affects your intention to visit healthcare?



During the interview process the researcher also asked participants to talk about the number of clinic visit they have had in the past 12 months and at the same time to talk about their experience. First, when asked about the number of clinic visit they have had in the past 12 months, 74% replied between 0-2 times, 22% between 2 to 5 times and 4% said more than 5 times. This result indicates that despite the efforts and intentions of the healthcare providers to help refugees there may be other factors that can reduce healthcare access. it is always important to understand and predict refugees' expectations towards healthcare facilities.

One of the participants said, "I don't like to visit clinics and emergency because even if I need something simple they make me to wait too long". Therefore, in some situations refugees may have had unrealistic hopes of receiving immediate treatment for their conditions. But several challenges emerged can lead to poor satisfaction and may lower healthcare access.

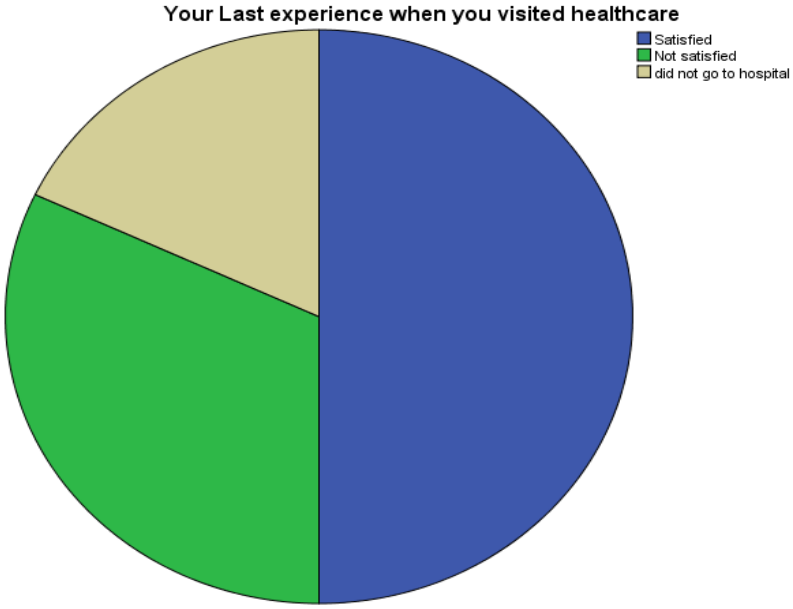
Figure: 4. Number of clinics visited for the past 12 months



Again, when participants were asked about their experience 50% (25 participants) reported that they had good experience and they were satisfied with the kind of care they received. 32% (16 participants) reported they have bad experience, did not like the service they received. 18% (9 participants) responded they did not go to clinics or hospital in years and they said they can't remember as shown in figure 5 below. The result shows that majority of the participants were satisfied with the care received through the healthcare system. However, some of the participants were complaining about health insurance companies, length of waiting times and access to interpreters.

One participant stated that "I don't remember the last time I visited clinics because every time I get sick I will read Quran and pray Allah to ease my pain because I believe the Quran a major cure for many diseases"

Figure: 5. Tell me about your last experience when you visited healthcare facilities

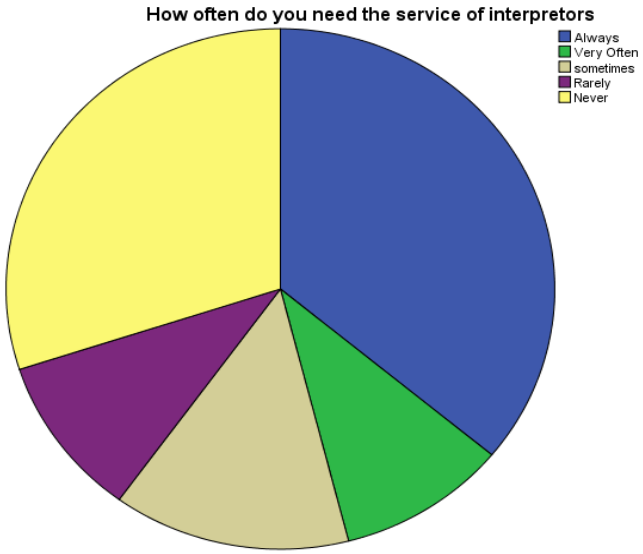


Not only are refugees facing this type of challenges but healthcare providers are also having major challenges in dealing with refugees and immigrants from different cultural backgrounds, religion , ethnics and healthcare systems that is why it is important to address such challenges, create mutual understanding, and ideal environment for both the refugees and health care providers.

A large number of Somali Americans are limited in English proficiency (LEP), but little is known about the impact of interpreter services on the quality of health care. Studies have found that the availability of bilingual medical interpreters can improve both communication and relationship between doctor and patients, increases level of patient satisfaction and reduces medical errors.

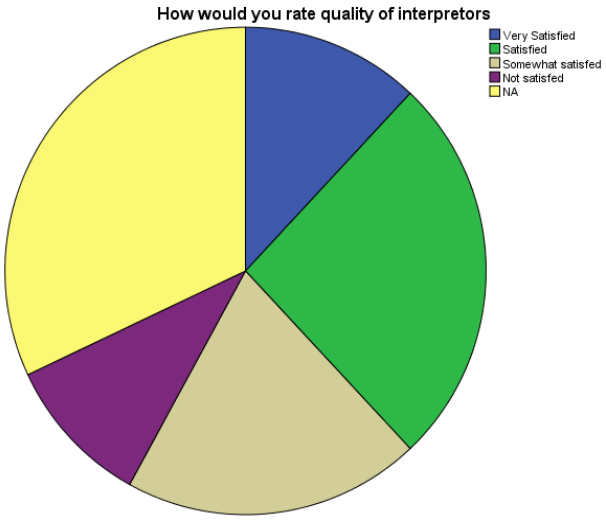
Miscommunication or difficulties to get interpreters can increase the risk of inappropriate treatments therefore during the interview process participants were asked how often they need the service of interpreters? The results show that 36% responded “Always”, which means that every time they visit healthcare facilities they need to have interpretation services, and 10% said “Very often”. While the other 14% said “Sometimes”, 10% replied “Rarely” and lastly 30 % said “Never”. This shows that out of 50 participants interviewed 10 of them needed to have interpreters all the time, and 5 participants said very often, 7 of them replied sometimes and 5 of them rarely which means at some point they all need interpreter service as shown in the figure 6 below. This also provides strong indication that many Somalis in Buffalo speak English “less than very well. Most of the participants also agreed that some of the health care facilities they used provide interpreter services while other providers use phone interpretation services when they need assistance in their desired language.

Figure 6: How often do you need the service of interpreters



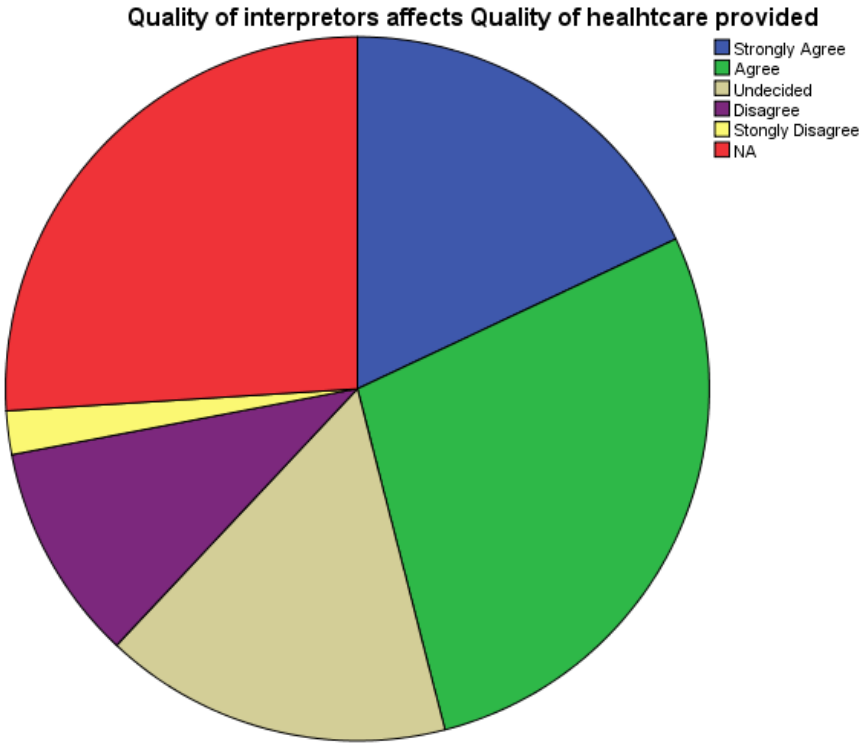
The next question asked was to rate the quality of interpreters that they have been given. 6 participants (12%) responded they are “Very satisfied” with interpretation services they received, and 13 participants (26 %) selected “Satisfied”, 10 participants which equals (20%) “Somewhat satisfied”, and 5 participants (10 %) said “Not satisfied” at all. While the rest 16 participants (32%) were not applicable to answer this question, since they said they speak English and they don’t use interpreters that much.

Figure 7: How would you rate the quality of interpreters that you have been given.



Again, the researcher wanted to know participants views and their perceptions then it was asked if the quality of interpretation they received could have an impact on the quality of health care service provided; the answers are a 5-point liker scale ranging from strongly agree to strongly disagree. However, 9 participants (18%) out of 50 participants answered, “Strongly agreed” and said that if the interpreters do one mistake it can increase the risk of medical errors and inappropriate treatments. Another 14 participants (28 %) answered “Agreed” and stated that interpreters can play a crucial role in the treatment process they can either improve interactions between the patient and doctor or can cause mistreatment and frustration. At the same another 8 participants (16 %) were “Undecided”, they were not sure, 5 of them (10%) selected “Disagreed” while 1 participant (2%) said “Strongly disagree” , lastly, 13 participants (26%) decided not to answer this question because they said they speak English and it does not applies to them.

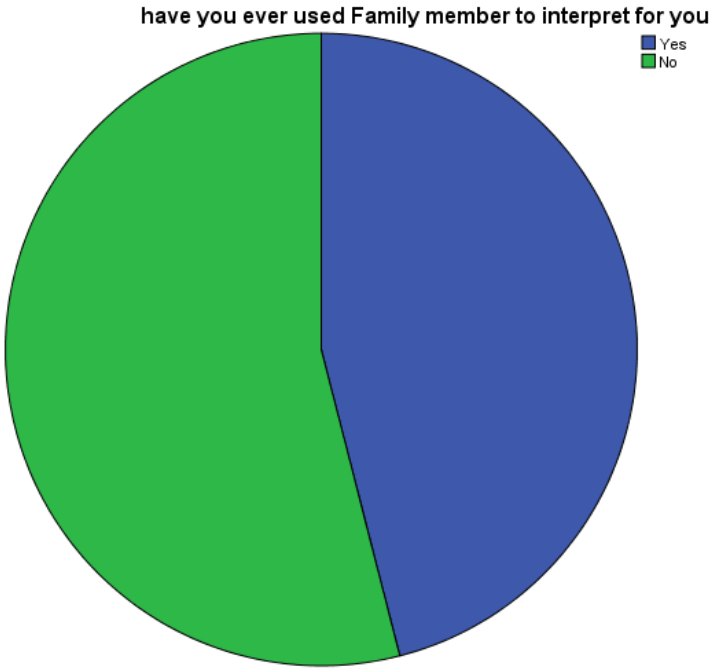
Figure 8: Quality of interpreters can have an impact on the quality of healthcare service provided



With the increased number of refugees coming to the United States, in some situation refugee's patients may not be able to read written materials or speak which will go back to their inability to communicate therefore, they will require access to someone who can read it to them. On the other hand, it is also important to note that bilingual medical interpreters are often in short supply. There are a lot of times whereby refugee's populations are not able to find professional interpreters that can help them. This goes back to the point that indicates there is a huge language gap in America. However, such gap is often filled by ad hoc interpreter, refugees with little English proficiency or bilinguals who can speak these languages.

However, it looks that this issue is complex that is why the researcher decided to investigate the issue of language gap therefore each respondent was asked a series of questions about participant's perceived and thoughts towards using informal interpreters such as family members. First, participants were asked if they have ever used any type of informal interpreters, then participants were asked if they will recommend other refugees to use informal interpreters. There were 50 participants in this study and they were asked if they have ever used any type of informal interpreters, 23 participants (46%) answered "Yes", while the other 27 participants (54%) answered "No". This indicates that the majority of respondents (54%) had never used informal interpreters such as family or relatives. But that does not mean that the majority of respondents had never been in position where they felt they required an interpreter. At some point they used interpreters, but it was not ad hoc.

Figure 9: Have you ever used informal interpreters (Family member or relatives)



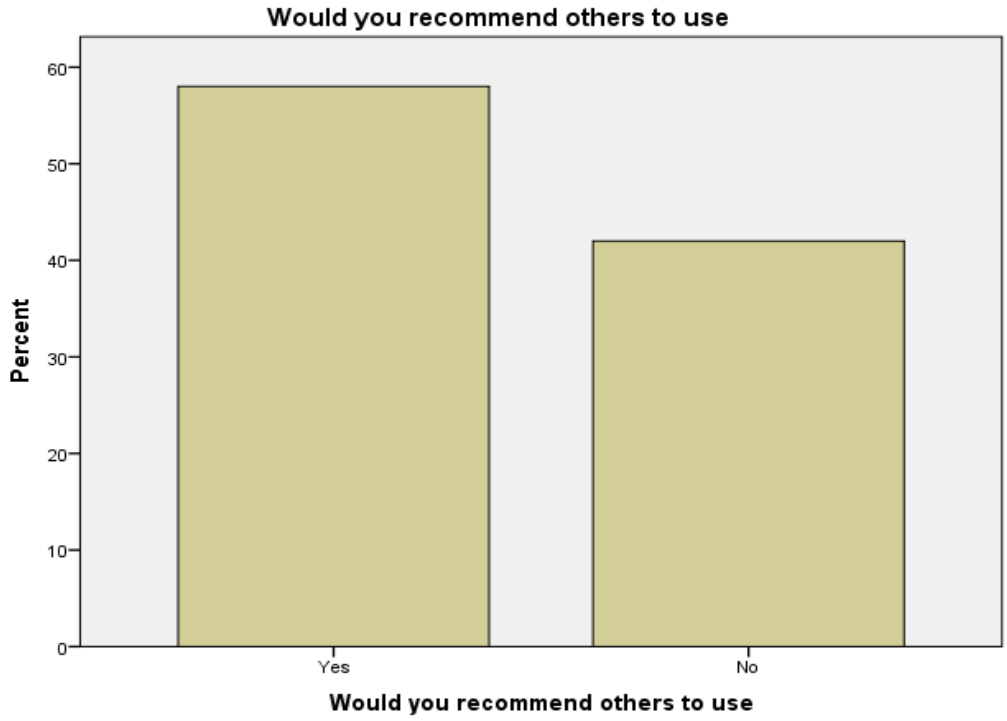
Researchers have found that the use of family interpreters or untrained interpreters is bad practice in the healthcare setting. Regardless of this fact, refugees/immigrants are frequently using as interpreters for their families and friends. During the interview process participants were asked if they will recommend and encourage other immigrant to use informal interpreters, more than half (58%) of respondents answered this question "Yes" while 42% said "No". This strongly indicates that 29 participants were in favor of using family member as interpreters. One of the participants said

"I cannot speak English, I am old, and I have children who are educated, they always help me a lot, if I need the doctor they will take me to the doctor, I trust them more than anyone else. If you have family member who can speak English use them, it is always better and easy to use your family**"**

Most of the participants believe that using family members as ad-hoc-interpreters can save time and from their perspective the most suitable solution is to bring bilingual family members with them if they can find one. On the other hand, 21 participants 42% totally did not

like the idea of using family member as an interpreter and they argued that sometimes family members cannot interpret accurately and they don't understand medical terminology and it can easily cause medical errors as it is illustrated in the figure below.

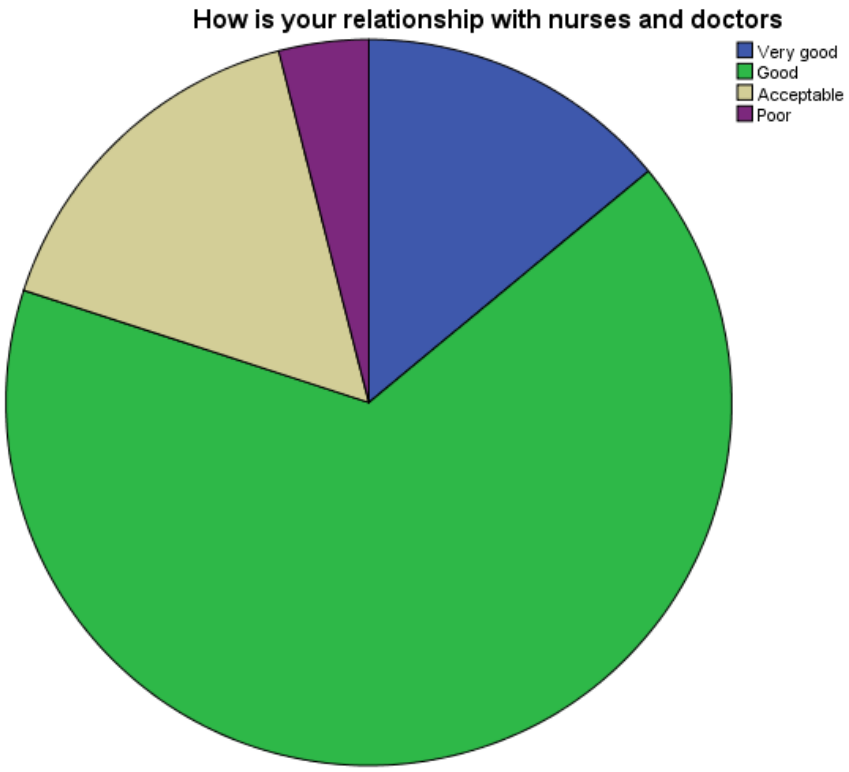
Figure 10: Would you recommend other refugees to use informal interpreters?



Lastly, participants were asked the following question, how is your relationship with healthcare providers? Has your doctors or nurse ever asked you anything which makes you feel uncomfortable and finally if there is anything other than language that prevents them from talking to their doctors/nurses or visiting clinics. The responses to these questions varied, the first question was asking about their relationship with healthcare providers 7 participants 14% answered "Very good" and they said they have a wonderful relationship with the healthcare providers. Another 33 participants (66 %) replied "Good", 8 participants which equals (16%) answered "Acceptable", the last 2 participants (4 %) said they have "Poor relationship" with

healthcare providers. This indicates that the majority of respondents have good relationship with providers as illustrated in the figure below.

Figure 11: How is your relationship with doctors/nurses



Then, participants were asked if providers ever asked them anything which makes them feel uncomfortable. 8 participants out 50 interviewed answered “Yes” while the (84%) which is 42 participants said “No” (Figure as shown in figure:13.). The 16 % percent who cited yes, explained more and majority of their explanations was based on refugee’s unique cultural beliefs and values they have. According to one participants he said, “sometimes nurses or doctors ask people personal question and I don’t like to share or exposure my personal and family issues”.

It is difficult to learn all the cultures, but healthcare providers need to be careful when helping refugee’s population. Finally, participants were asked if there is anything other language

that prevents them from talking to their doctors or visiting clinics, 12 participants (24%) said "Yes", 38 participants (76 %) answered "No" as shown in the figure below.

Figure:12 Is there anything that prevents you from talking to doctors or nurses

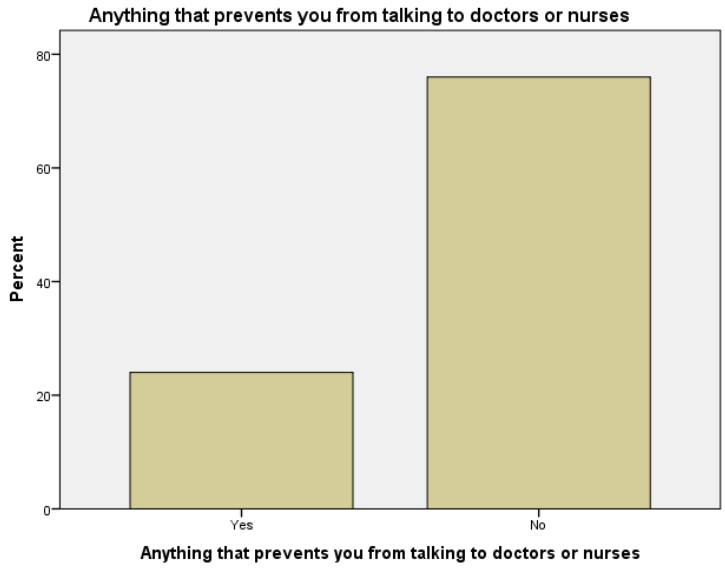
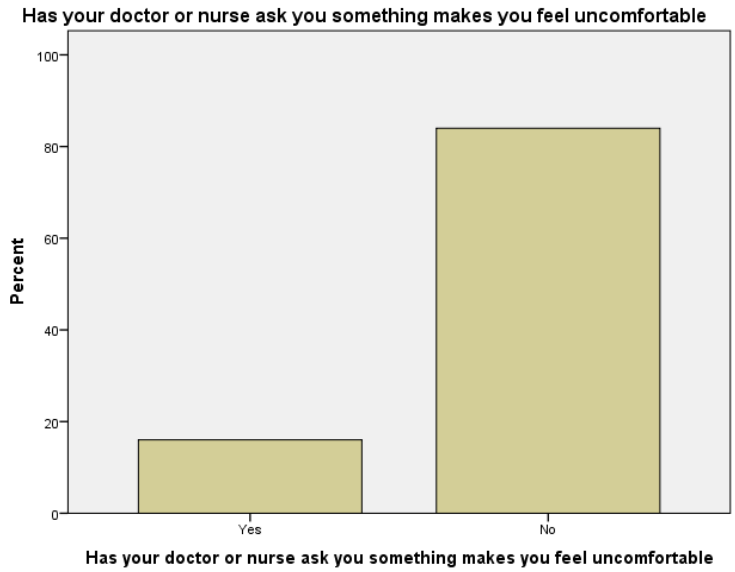


Figure: 13 Has your doctor/nurse ever ask you something makes you feel uncomfortable



Chapter V: Discussion, Limitations, future Studies, and Implications

As discussed in the previous sections of this research, the purpose of this research was to address the challenges Somali refugees face when accessing healthcare facilities. However, in order to do that understanding the cultural issue and values of this community became relevant to this research. Through the face to face interviews with potential participants, it has been found that a lot of Somali patients who are mostly women prefer not to use male interpreters because of patients' privacy, confidentiality, and shy. This means that some of them don't speak English very well and could still decide not to share all their information with interpreters due to cultural issues of this community. On other hand, the inability to communicate directly with the doctors and nurses resulted in a feeling of fear and shy for some of the refugee's patients. In some cases, several Somali refugees expressed feelings of shame about sharing their personal information with interpreters, doctors and nurses. This shows that refugees initially faced significant challenges in accessing healthcare facilities therefore; the researcher proposed that a greater understanding of Somali culture and norms can guide healthcare agencies in improving services for this community.

In the Healthcare setting, researchers advised against the use of family or friends as interpreters, and different studies shows that using ad hoc interpreters can cause more harm than good. For example, during the interview process when participants were asked if they have ever used ad hoc interpreters (46 %) replied "Yes". This indicated the fact that, refugee's patients, doctors and nurses often ignore this issue and use untrained bilingual interpreters that have not been certified as medical interpreters. Most health care providers are responsible for providing interpreting services but when participants were asked if they would recommend other refugees to use ad hoc interpreter's majority of them (58 %) replied "Yes" which indicates that there is a

great chance of medical errors that can happen at any time refugees use ad hoc interpreters. However, majority of the participants agreed that most interpreters are strangers and sometimes they are opposite gender because of that reason they prefer to use family member or friend who can keep their privacy and able to offer language assistant.

The interviews with Somali refugees also showed that language services are frequently provided by Jericho Road Community Health Center and ad hoc interpreters, such as family members, friends. The researcher also found that most clinics that are specific for refugees were able to provide bilingual interpreters and they have also bilingual healthcare workers. But one recommendation from Somali women was healthcare providers need to hire more bilingual female interpreters because during women pregnancy and childbirth, refugee's women prefer a female interpreter rather than having male interpreter and this can help healthcare providers to provide better access and better quality of care.

On the other hand, it is undeniable that the quality of care provided and the relationship between doctors and refugees patients can have an impact not only by healthcare providers and patients but also refugee's family members and their perspective towards healthcare system. In addition to that, due to diverse cultural beliefs and language differences among refugees population, it is difficult for healthcare providers to meet refugee's healthcare needs and expectations. However, this study decided to answer some important questions regarding the best way this community can be helped in terms of language access. This includes providers and government agencies to develop a strategic plan that can promote not only cultural awareness but also appropriate action that can assess the quality of bilingual interpreters.

Another noteworthy issue was identifying not only difficulty in speaking English was the main problem in terms of healthcare access, but also limited transportation and confusion about insurance coverage are all very serious issues in this community. One participant told the researcher that the biggest problem they have as a community is limited transportation and he told the researcher that sometimes getting a driver license is not easy if you cannot speak English then, taking the bus is only the option they have every time they are sick or whenever they want to go to work or shopping, at the same time some refugees are not even able to figure it out how to take the bus which presents a unique challenge for the refugees population.

Further challenges were related with refugee's dissatisfaction and satisfactions with healthcare providers and this can be caused by the communication between healthcare professionals and refugees patients. During the face to face interview majority of the participants told the researcher that they need more information to be given about the process, the right to access healthcare and how the healthcare system works in this country both oral and written formats. This challenge can greatly influence the refugees' experience of healthcare and at the same time it can lower healthcare access and patient satisfaction

The researcher also discovered that lack of knowledge about how to access healthcare services, refugee's rights, gender of the treating doctor, gender of the interpreters and long waiting times for appointments all were the main factors that influenced Somali refugees' experiences and expectation of healthcare. Majority of the participants were complaining about after long waiting hours doctors will not spend enough time with them and this has led frustration and refugees see it as time consuming. However, all these factors mentioned above strongly indicate that there is an urgent need for improvements in patient doctor-relationships, interactions and interpretation services.

On the other hand, it also important to note that some of the respondents were really satisfied with healthcare providers and interpretations services and they reported positive experiences regarding the care and interpretations services provided by their healthcare providers. This group told the researcher that they have good relationship with doctors and nurses and the fact is that most of this group expressed a positive feeling towards their clinics for providing care and helping them and they seemed to be happy with the service they had received.

Recommendations

Increased availability of health-trained interpreters

In healthcare setting, majority of healthcare providers usually get interpreters through interpreter service providers. Sometimes, Interpreters cannot be present when treating refugee's patients and the only option providers have is interpreters over the phone. Therefore, in Buffalo there is a shortage number of Somali Interpreters and that is why majority of the participants recommended using ad hoc interpreters. A lot of studies discouraged the act of using untrained interpreters because of medical ethics, confidentiality, and terminology. Therefore, providers need to be careful of these challenges specifically when dealing with community.

On the other hand, healthcare providers need to consider hiring bilingual female interpreters. One of the most important benefits of hiring bilingual female interpreters is it solves cultural issue and sensitivity at the same time it improves communication, reduces medical errors and increases patient satisfactions. However, without having some male or female bilingual interpreters, the Somali community in Buffalo will continue to suffer this problem.

Providing information, guidance and cultural training

The growing number of Somali immigrants in Buffalo needs more information about how to access healthcare facilities, their rights to access healthcare, get interpreters, health insurance coverage's and all other information's regarding healthcare access. Resettlement agencies and

healthcare providers are trying hard to provide this kind of medical information, but it looks like that is not enough because Somali refugees are struggling to meet their health care needs and expectations during their transition period. Therefore, this study recommends that healthcare providers needs to come with a strategic plan that can help refugees to obtain and understand basic health information while increasing refugee's health literacy

Cultural training; although there is an effort to acknowledge and address cultural issues among refugees population in Buffalo but still misunderstanding and lack of cultural awareness is still the main issue which needs close attention. Healthcare providers also needs to identify and be care full about refugee's culture and norms. Limited cultural awareness on the part of the provider or if the patients get the experience of culturally inappropriate care it will reduce healthcare access. The researcher recommendation is healthcare providers to understand the role of culture in health service use, refugees level of health literacy and provide cultural training that can improve health outcomes and quality of care,

Limitations of the Study

One of the main objectives of this study was to provide sufficient evidence on the impact of language barriers on health access. This study may have answered some important questions regarding language barrier on healthcare access, but it is important to note that there are a few limitations that needs to be mentioned in this chapter. These limitations can really have an impact on the results in terms of both the stability and consistence of the results. One of these limitations includes the sampling method which is convenience sampling. This is non-probability sampling method and most of the participants of this study were recruited from random places wherever the researcher can find them. Therefore, this has disadvantage which is selection bias and this bias can have an impact on the credibility of the study

Another potential limitation was only interviewing refugee's participants' not healthcare providers and other agencies because the main purpose of this study was to investigate these phenomena only from the side of Somali community. This study would have been complete if both healthcare providers and refugees were able to participate. This could also be useful in identifying the extent of problems and find the possible solutions. It is almost impossible to imagine how refugee's challenges can be solved without healthcare providers help and support.

Lastly all participants in this study are Somalis in Buffalo and it is not possible to generalize these findings to all refugee populations in the country. Since refugees are come from different countries, they have different religion and different culture and because of their diversity and difference in language. It is always recommended to study each population separate. The Somali population in the country is also growing more and more and it is also not going to be possible to generalize these findings to all Somali refugee populations in America

Future Research

More research needs to be done with the side of healthcare providers and how providers see the impact of language barrier on the healthcare. Further work is needed to examine both Somali refugees' and healthcare providers' views of healthcare services in a refugee population, The results could help to see their perspectives and view of the healthcare system and it may help to address potential challenges within the healthcare system. Future research could also help identifying on the common challenges to providing medical treatment and suggestions of healthcare providers who work closely with the refugees' populations. Future studies may also include measuring refugee's satisfactions with the healthcare services, continued inclusion of different healthcare providers, benefits of training interpreters, patient-doctors relationships and further exploration of barriers specific to cultural issues

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Appendix A: Interview questions

How long have you been living in Buffalo? Please select one

A. 0- 2years. B. 2-5 years. C. 5- 10 years D. 10 years and over.

How would you rate your current living situation in Buffalo?

A. Very good B. Good C. Acceptable D. Poor E. Very poor

Do you speak English? Yes or No. If yes, how well do you believe you can speak English?

A. Good B. Fair. C. Poor.

Do you know how to write in English? Yes or No if yes, how well you are able to write?

A. good B. fair C. Poor

Do you know how to read English? Yes or No if yes, how well you are able to read?

A. Good B. Fair. C. Poor

If you are unable to speak, read or write in English, do you think that affects your intention to visit clinics and Healthcare centers? Yes or No if Yes, Please explain how?

Tell me about your last experience when you visited a healthcare center?

A. Satisfied B. Not satisfied

Please describe the number of clinic visits you have had in the past 12 months?

When you visit healthcare centers how often do you need the service of interpreters?

A. Always B. Very often C. Sometimes D. Rarely E. Never

What types of services do you receive from health care providers with regards to language access?

How well would you rate the quality of interpreters that you have been given? Please rate the quality of the service you were given.

A. Very satisfied B. satisfied C. Somewhat satisfied D. Not satisfied

How much do you agree the quality of interpretation you received will have an impact on the quality of healthcare service provided? Select one

A. Strongly Agree B. Agree C. D. Undecided E. Disagree F. Strongly Disagree

Have ever used family member or relatives for interpretation? Yes or No If yes, how often?

A. Always B. Very often C. Sometimes D. Rarely E. Never

How well would you rate their quality if you ever used family member to interpret for you?

A. Good G. Fair C. Poor

Would you recommend other refugees to use family members to interpret for them when visiting healthcare centers? Yes □ No If yes, why?

How is your relationship with nurses and doctors? Please rate

A. Very good B. Good C. Acceptable D. Poor E. Very poor

Has your doctor or nurse ever asked you about anything which makes you feel uncomfortable? Yes or No, If yes

Do you think there is anything other than language that prevents you from talking to your doctor or visiting clinics? Yes or No If yes,

What is you gender? A. Male B. Female

What is your Age? Please select the one that applies to you

A. 18-24 years old B. 25-34 years old C. 35-44 years old D. 45-54 years old

E. 55-64 years old F. 65 and over

What is the highest degree or level of education you have completed?

A. Did not Complete high school

B. Some High School/ GED

C. Some College

D. Bachelor Degree

E. Master Degree

F. Advanced Graduate work or PHD

G. Not Sure

Are you currently employed? Yes or No

What is your marital status?

A. Married B. Single. C. Divorced

How many dependents do you have?

Appendix B. Informed consent

INFORMED CONSENT
Somali Refugees in Buffalo: The Impact of Language Barrier on the Health Care Access

Name and Title of Researcher**:** Khadar Maow
Department/Room Number: Public Administration
Telephone Number: 716-292-6757
Email: maowk01@mail.buffalostate.edu
Study location(s): Buffalo, New York

PURPOSE OF STUDY
The purpose of this research study is to identify how language barriers can adversely affect quality of health care. Specifically, the paper seeks to understand this phenomenon from the prospective of Somali refugees in Buffalo, by examining the main challenges faced when accessing healthcare services and how language barrier affects their ability to access healthcare. As such, the secondary purpose of this research is to educate healthcare providers about what specific language dynamics are important for consideration when servicing this group.

SUBJECTS
Inclusion Requirements
You are eligible to participate in this study if you "are at least 18 years of age or older," "Born in Somalia and currently living in Buffalo, New York"

PROCEDURES
The following procedures will occur;

Face-to-face and semi structured interviews will be conducted in Somali. The interview will take about an hour. Participants will be asked the same interview questions consisting of 20 to 30 items. These questions will focus on their experiences/expectation, their interaction with healthcare providers and how language barrier affects their ability to access healthcare and their intention to return. The data collected will be recorded in anonymous form and final results will not be released in any way that could identify you. At the end of collecting the numerical data the researcher will interpret, transcript, analyze, and present the results that has been collected by

using quantitative and qualitative methods. If you want to withdraw from the study at any time, you may do so without penalty.

RISKS AND DISCOMFORTS

There are only minimal risks associated with this study, similar to those encountered in everyday life. Minimal risk is expected such as the inconvenience of the time taken to participate.

BENEFITS

The possible benefits you may experience from the procedures described in this study are access and a copy to a final report/results. No any other direct benefit to the subject is anticipated.

CONFIDENTIALITY

Data Storage

The data collected in this study will remain confidential and protected. All the data collected and other identifying information will be locked in a separate location only allowing primary researcher access and only the researcher will have the key to that location. Part of the data will be stored on the researcher's private computer which is protected by password and is only accessible to the primary researcher. In order to protect all identifying information each participant will be have a study code that is separate from the participant's name. The code that links your name to the data will be kept separate from the study data. All other identifiable data and information about the participant will be destroyed or removed.
All data will be retained for at least three years in compliance with federal regulations.

IF YOU HAVE QUESTIONS

If you have any comments, concerns, or questions regarding the conduct of this research, please contact the researcher at the top of this form.

If you are unable to contact the researcher and have general questions about your rights as a participant, please contact the IRB Administrator, Research Foundation for SUNY/Buffalo State, at gameg.buffalostate.edu.

VOLUNTARY PARTICIPATION STATEMENT

Participation in this study is voluntary. You may refuse to answer any question or discontinue your involvement at any time without penalty or loss of benefits to which you might otherwise be entitled. Your decision will not affect your future relationship with Buffalo State and the researcher. Your signature below indicates that you have read the information in this informed consent and have had a chance to ask any questions that you have about the study.

SIGNATURES

_____

Participant's Signature ***Date***

_____

Researcher's Signature ***Date***