
HOSPITAL CLEANER AS INTERPRETER: LACK OF LANGUAGE SKILLS AND CULTURAL AWARENESS LIMITS ROHINGYA ACCESS TO HEALTH CARE

Summary: what you absolutely need to know

1. Communicating with patients in their language is not a priority in many health facilities. Many facilities make no specific provision for interpreting support, in what appears a worsening of the situation since Translators without Borders' last detailed study in 2018. Assumptions that interpreters are no longer needed are not supported by patients' widespread experiences of miscommunication. Women, older and less educated people, and people living with disabilities are likely to suffer most from a lack of language support in Rohingya.

2. Poor intercultural communication compounds resource constraints. Patients often reported behavior by medical and non-medical staff of health facilities that they perceived as lacking respect, compassion and interest. Resource constraints, particularly a shortage of medical and female staff, create a situation where doctors lack time to listen and explain adequately, and patients are tired and impatient after waiting several hours for a consultation. The impact on the quality of communication is predictable; so too is the resulting frustration and diminished access to care for patients. Many turn to commercial providers and unlicensed practitioners for treatment instead, paying with cash or the sale of their food rations for services they are meant to receive for free.

3. Staff too are frustrated in their efforts to provide effective health services - although they don't always see that they can be part of the problem. Many staff see Rohingya rejection of unfamiliar or culturally unacceptable medical practices as an obstacle, but it's one that can't be overcome without communication and mutual respect.

4. Reprioritization of effective and culturally appropriate communication is needed to improve the effectiveness of patient care. That requires donors to resource the language and communication support that patients and staff need, building on existing tools and capacity. It also requires primary health care providers to reassess what they can do to ensure effective and respectful communication with patients is given real priority in all health facilities.

Communication challenges combine to make seeking health services in one of the camp health facilities an obstacle course for many. Figure 1 describes a patient's experience of doing so. It is a composite account drawn from the experiences described to researchers by patients, or observed by researchers on site.

Figure 1: The obstacle course of accessing health care in the Rohingya camps

A composite summary of firsthand accounts and observations

Obstacle 1: the security guard

Researchers witnessed guards turning away patients at the gates of several facilities. Their tone and language were rude. They questioned patients about their medical condition and sent them away, telling them there was no medicine for them at this facility.

Obstacle 2: the triage nurse

Researchers observed that staff members responsible for triage often did not make eye contact with the patients. Patients use hand gestures to help make themselves understood by Chittagonian- or Bangla-speaking staff, but the staff don't look at them.

Obstacle 3: the wait

Patients reported routinely waiting for hours to see a doctor, sometimes as much as six hours for an appointment. In many facilities there are not enough seats for those waiting, so many have to stand in line for long periods. People whose age, disability or medical condition makes it hard for them to stand are not routinely given priority for seats or appointments. Many facilities also lack screened breastfeeding areas, so new mothers must breastfeed without privacy.

Obstacle 4: the consultation

In many facilities there is no interpreter or volunteer to help, so the patient is alone with the doctor or nurse in the consulting room, trying to explain their problem in Rohingya and understand the response in Bangla or Chittagonian. It is often hard to understand, and hard to know what is understood. The doctor is typically short of time and can seem reluctant to listen or respond to questions or give additional explanation. Visual communication aids like posters and flash cards are rarely available. If communication breaks down, the doctor calls on an untrained Rohingya or Chittagonian speaker, sometimes a cleaner, to interpret.

Obstacle 5: the lack of recourse

When the medicine prescribed isn't available, or isn't what the patient expected to receive, they aren't allowed back into the consulting room. Efforts to explain to other staff are a struggle because of language barriers. The patient returns home without the care they were looking for.

Recommendations for humanitarians

- Provide **interpreting support between Rohingya and Bangla as standard in all health facilities**.
 - Interpreting should be by trained Rohingya speakers, or Chittagonian speakers trained in the linguistic and cultural differences between the two languages.
 - Prioritize training for female interpreters, as Rohingya women typically have less opportunity to learn Chittagonian or Bangla words and can speak less freely about sensitive health issues with a man.
- Support medical staff to communicate effectively, drawing and building on existing resources.
 - Use and expand existing **multilingual terminology resources for the health sector**¹ in collaboration with language experts.
 - Expand the use of **visual communication aids** and evaluate their appropriateness and impact for improving patient consultations.
 - Prioritize **verbal communication in Rohingya** without mixing in words from other languages.

¹ Translators without Borders, Bangladesh glossary <https://glossaries.clearglobal.org/bangladesh/>

- Address a **widespread lack of respect in dealings with Rohingya patients** among medical, administrative and security staff.
 - o Provide **cultural awareness training** for all staff of health facilities, and monitor its implementation.
 - o End the **practice of informal triage** by security guards and other staff.
- Take the **practical steps possible to improve patients' experience**.
 - o Provide **more comfortable waiting conditions** such as increased seating, private space for breastfeeding, and specific provision for people who have difficulty standing for long periods.
 - o Increase the **number of female medical staff and community health workers and volunteers**, especially for sexual and reproductive health consultations and pregnancy-related care.
- Support further research into Rohingya patients' perspectives on health care as a basis for **increasing trust and cultural understanding** between patients and health facility staff.

Interpreting support is not widely available to overcome the language gap between patients and medical staff

Many health facilities do not routinely offer interpreting support or communication aids

"There is no interpreter in the health facilities. This is a big problem and they should keep someone to assist with language so that the doctors understand the situation of the patients correctly."

– Female Rohingya patient, 37 years old, Camp 2W

No interpreting support is routinely provided for patient consultations in the facilities the research team visited, or in many other health facilities in the camps, judging by interviews with 29 patients, 10 medical staff, 2 managers, and 11 community health workers and volunteers.

Eight patients reported that they had asked interpreters, volunteers or family members to interpret for them in the past. Twenty-one said they had had no interpreter and communicated directly, although most of these said they would prefer to have an interpreter. None of the medical staff or community health workers and volunteers interviewed reported any such provision, and patients only spoke of interpreters being routinely available at the Turkish field hospital and facilities run by Médecins sans Frontières (MSF). Interpreting support is widely welcomed where it is available; interviews suggest this is largely to support international rather than Bangladeshi medical staff. As a 45-year-old woman in camp 8W described: *"[At the MSF hospital] if I can't explain well, I speak through the interpreter and the interpreter explains everything clearly to the doctor."*

In the absence of interpreters, patients try to describe their health problems to Chittagonian- or Bangla-speaking medical staff, who respond in Bangla or Chittagonian, sometimes mixed with Rohingya words. When the medical staff feel there is a communication problem, they may call on a Chittagonian- or Rohingya-speaking staff member or volunteer to support: *"I don't use interpreters. If I need any help with language challenges, I ask the cleaner."* The ad hoc interpreter will not typically be trained for that role, which will often not be part of their job description. Calling on a cleaner to interpret was a practice mentioned by staff and patients alike; however patients said that sometimes even cleaners are unavailable or unwilling to interpret.

Some patients did report that they would prefer to speak directly to a doctor or medical staff, rather than through an interpreter. Seven patients did not trust interpreters to communicate their health issues accurately to medical staff. This seems to depend on an interpreter's background and training: some would only trust Rohingya interpreters, while others said any interpreter should have language or terminology training.

The 11 community health workers and volunteers interviewed do not routinely support communication between patient and doctor during medical consultations, although some are occasionally asked to do so. Only three had received any training on communicating with patients; four had received no specific training for their work at all, and eight called for additional training, on topics including communicating with patients and with people living with disabilities, community engagement, and psychosocial support and counseling.

Graphic communication tools like flash cards and posters can help relay information accessibly when language barriers are a problem. Yet not one patient had seen such tools in a consulting room, and the only medical staff who used them were two midwives.

Patients often struggle to understand the information provided and to make themselves understood

"Always the communication doesn't work well as I sometimes face difficulties to understand what the doctor says, and the doctor has the same problem."

– Male patient, 65 years old, Camp 2W

In the absence of interpreting support, language barriers are a consistent source of problems for patient consultations. Rohingya-speaking patients are usually alone with a Bangla- or Chittagonian-speaking doctor or nurse. One 60-year-old man in Camp 2W described a situation common to many of the patients interviewed: *"They don't use interpreters. I have to communicate with the doctor by myself. Sometimes it is hard for me to understand but I don't get any interpreting support."*

Patients interviewed said they use Rohingya to communicate at health facilities, but receive medical information in Bangla or Chittagonian: *"Sometimes it is hard to understand the doctor's language because some doctors speak Bangla during the consultation"* (male patient, Camp 8W). While some reported that this was not a problem, many accounts described confusion and frustration, despite similarities between Chittagonian and Rohingya². Patients described the efforts they make to understand: *"I can understand the language a bit and try to listen carefully"* (female patient, Camp 24). Another recalled: *"I felt like he explained but it is hard for me to understand and identify"* (male patient, Camp 24). All 10 medical staff interviewed speak either Bangla or Chittagonian as their first language. Six use Bangla and three Chittagonian to communicate with patients, and seven use or try to use Rohingya – although some acknowledged that their knowledge of the language was limited.

Just over half of the patients interviewed (16 out of 29) said they are usually given a chance to ask questions if they don't understand the information provided, or are able to do so. Eleven felt unable to ask: as one male patient in Camp 2W described, *"I don't have an opportunity to clarify: if we missed anything, it's gone."* Several patients reported that they have a chance to ask questions, but doctors are rude or dismissive in answering. Others may ask questions of community health workers, who are perceived to be more approachable.

Communicating the symptoms and history of their health problem is often a challenge too. *"We speak in Rohingya and try to speak in Chatgaya (Chittagonian) or Bangla, but sometimes it is difficult to make them understand,"* explained one woman in Camp 2W. Only 11 of the 29 patients interviewed feel they are usually able to communicate their health problems. Eleven also felt they would not have an opportunity to correct information that is wrongly understood or communicated.

² Translators without Borders (2019) A Healthy Discussion: Rohingya Language Guidance for Healthcare Workers. https://translatorswithoutborders.org/wp-content/uploads/2019/07/Health-Guide-Rohingya_ENG.pdf.

People living with disabilities were more likely to feel they were unable to communicate their condition fully to medical staff even during what they considered a positive experience of seeking health care. Five of the nine people living with disabilities interviewed described such difficulties. One 60-year-old man from Camp 2W explained: *"As I have a disability and hearing problems, it is especially hard for me to explain my health condition properly. There is no one in the consulting room to explain for me. The doctor just pretends to listen to my problem seriously."*

Fourteen of the 29 patients interviewed could give no positive example of their experience seeking health care. Eight of these patients described feeling that doctors don't understand when they describe their medical condition; community health workers were available to help relay the information for just one of the eight. On the other hand, several patients described good communication experiences with doctors, particularly when doctors understand and are understood by patients and treat them with kindness and respect.

Those patients who find it easiest to understand are those who speak at least some Bangla or Chittagonian. Monolingual Rohingya speakers face greater challenges when there is no interpreting support, and several participants suggested that women in particular would benefit from having an interpreter present.

Treatment without information is likely to be ineffective

"I can do nothing. I have to follow whatever the doctor says."

– Male patient, 90 years old, Camp 8W

As a result of these communication difficulties, patients often feel they don't get the right treatment for their condition; several described being given a few paracetamol tablets, which they saw as inadequate. One male patient in Camp 2W remarked: *"Sometimes we feel very confused because even if I tell them that I have a disease called jaundice, I don't get medicine for that."*

Missing information on the treatment prescribed can make it ineffective. One 37-year-old woman in the same camp recalled: *"When I asked for advice about how many times I should take the medicine, they said: 'It's written there - you don't need an explanation.' But we can't read."*

Communication difficulties and power dynamics often make it hard for patients to question a medical decision that they disagree with or feel is based on a misunderstanding. Fifteen patients said there is nothing they can do about it if they feel they have not been fully understood - they either just accept whatever treatment is offered, or go straight home without a solution to their problem.

Asked how they know if they have been understood, patients often replied that they judge this by whether they receive enough medicine. If they don't receive medicine or enough medicine, they feel they have not been understood. Others reported that they know that something has been communicated because they speak enough of the language to understand.

These communication barriers are not always visible as a problem to those running the health facilities

"In my opinion I don't have any challenges [communicating with patients], but there might be language challenges for my colleagues."

– MHPSS counselor

Medical staff interviewed typically see the language gap as less of a problem than most patients do. This may be partly because patients often feel unable to complain to them, or because they lack the Rohingya language skills to understand such complaints when they are made.

Only two of the 10 medical staff interviewed saw language as a challenge in their communication with Rohingya patients. A Chittagonian-speaking supervisor of community health workers claimed that *“I have never received training or guidance on communication. But as I am Chittagonian I understand the Rohingya language.”* This overlooks the differences between the two languages, which can cause confusion on matters of health as on other topics.³ Yet it is a widely held view, and shared at senior level within some health sector organizations. One senior manager told us their organization didn’t hire interpreters after around 2020, on the basis that after years in the Rohingya response *“people have been exposed to the language and can communicate independently,”* and *“Chittagonian people know to some extent about the Rohingya language.”*

The same manager noted that communication in some fields of medicine, like mental health and psychosocial support, presents more challenges, even for staff with some knowledge of Rohingya. However, a mental health and psychosocial support counselor who uses Bangla to talk to patients felt he had no difficulty communicating with them: *“I feel like Rohingya people understand me as they haven’t complained to me about my language. On the other hand, I understand the Rohingya language like 50% but I can’t speak it.”* This contrasts with the view expressed by one male patient in Camp 2W that *“some Bangla doctors should avoid using Bangla when other people don’t understand.”*

A male midwife admitted that interpreting support would sometimes be helpful, however. *“I am used to communicating in Bangla because it is my mother tongue. Sometimes I feel like the patients cannot understand me well. At such times I need an interpreter.”*

In contrast to patients’ reports of being unable to get clarification when they don’t understand, medical staff interviewed all said that patients are given a chance to ask questions. Several described repeating explanations to patients, and calling a community health worker or volunteer into the consulting room in case something is unclear. A male midwife explains referring patients to a hotline: *“Yes, they are always given a chance to talk. If they can’t understand me the first time, I repeat three or four times so that they can understand me. If they still have any confusion, they can call our hotline number and get clarification.”*

Patchy intercultural communication skills compound shortages of female staff and other constraints

Behavior lacking compassion and respect also affects patients’ experience of seeking health care.

“The doctors don’t understand our language. And when we explain our sickness to the volunteers, they don’t pay attention, they move about while we are talking: they basically do not give that much importance to our sickness. So they can’t interpret how we feel very well, they might miss out so many of the things I said.”

– Female patient, 40 years old, Camp 24

Fourteen of the 29 patients interviewed described staff and volunteers at health facilities behaving rudely towards them at times, and researchers observed instances of such behavior at the three facilities visited. The behavior described often took the form of shouting and verbal abuse. One woman in Camp 2W described visiting

³ Translators without Borders (2019) A Healthy Discussion: Rohingya Language Guidance for Healthcare Workers, https://translatorswithoutborders.org/wp-content/uploads/2019/07/Health-Guide-Rohingya_ENG.pdf

a health facility for treatment for a high fever and vomiting. *“Suddenly one of the nurses was shouting at me very loudly and swearing. [...] When I vomited the nurses asked me to clean it up, although I was unable to move at the time. I felt very sick and disrespected.”*

Another form of rude behavior commonly reported by patients is staff not paying attention when they are describing a problem or asking for clarification. Patient accounts of past experience often included descriptions of medical and other staff being inattentive and impatient with questions; this was especially distressing in what the patient felt was a medical emergency. Researchers observed triage staff looking at their phones while patients described their health problems. As one man in Camp 2W explained: *“The main problem is that the doctor and other workers don’t make an effort to listen to us and they don’t even show us any respect.”*

While any patient could be expected to find such behavior offensive, the offense may feel greater to a Rohingya patient because speaking softly and making eye contact are important markers of respect in Rohingya culture. Another sign of respect in Rohingya is to use the formal word for “you” (*oney* in the singular and *onora* in the plural) to address someone, rather than the informal *tu* and *tura*. Patients reported and researchers observed the use of the informal terms of address, causing discomfort and resentment. In some cases the behavior was on the part of doctors and other medical staff, in others community health workers and volunteers, administrative staff and security guards. Patients experience such behavior as a lack of respect and compassion, often compounding the distress of feeling sick or in pain. Several suggested they are not always treated *“like human beings”* at health facilities.

This directly and indirectly impedes access to care

“I really don’t like to go there. I just go because we have no other option in the camp as we are refugees. I am really really disappointed by their behavior sometimes in the health facilities.”

– Female patient, 63 years old, Camp 8W

In some cases, rude and insensitive behavior by health facility staff directly restricts patients’ access to care. Informal triage is the most direct form of exclusion. Researchers observed security guards at one health facility rudely hailing patients arriving at the gate, demanding to know what they wanted to see the doctor for, and sending them away, saying *“We don’t have medicine for that here.”*

Sometimes this behavior causes patients to stay away from facilities where they feel their health problems are not receiving the attention they need, and look elsewhere for help. Several spoke of selling food rations to pay for treatment and medicines from commercial providers or unlicensed community practitioners rather than going to facilities in the camps. In one such case, a man living with a disability in Camp 24 gave his assessment: *“I really don’t feel good about accessing health care as there is no proper treatment in the hospital. Doctors and other staff don’t try to listen to the history of the condition clearly. In the hospital they usually give paracetamol for any kind of disease.”* Instead he went to a private clinic, selling some of his food rations to do so.

Less obvious to medical staff are the indirect impacts, including a loss of trust in health services, making it harder to address patients’ concerns about some procedures. Ultimately this can result in patients being unwilling to seek or accept medical care that they need.

Just 11 out of 29 patients felt the medical staff at their most recent consultation had listened to them, nine felt their problems were taken seriously, and 12 felt they had been treated with care, concern and respect. Only nine said the consultation had actually resolved their problems. Rudeness discourages patients from asking for clarification if they don’t understand: *“Some [doctors] we can talk with and ask many questions of. But there are so many doctors who speak Bangla and don’t like us to ask questions. If we don’t understand their language, they just ignore it and are rude to us.”*

Repeated experience of what they perceive as disrespect and a lack of compassion causes people to lose faith in the health services in the camps. As one 42-year-old man in Camp 8W told us: *“Sometimes the doctors stay busy with their phones and keep the patients waiting in the consulting room. It’s the same in all the hospitals in the camps. The doctors don’t value the patients.”*

Language and cultural barriers impede the efforts of medical staff to provide patients with quality care

“They cannot be convinced. They do whatever they understand. They don’t listen to us. [...] They can’t be given an intrauterine contraceptive device because they feel nervous. They don’t want to be vaccinated because they think they will die.”

– Midwife

Interviews with medical staff suggest that the communication issues described by patients also impact the staff’s ability to do their jobs. Two of the 10 interviewed mentioned language barriers as the biggest obstacle in their work, and some voiced frustration at the way patients express their dissatisfaction. But the main challenge for six was the difficulty of persuading many Rohingya to accept medical practices that are unfamiliar or in conflict with their religious and cultural norms. These are issues that health providers would be better able to address if they could improve their two-way communication and restore trust with patients.

Gaps in understanding of the need for certain medical procedures are a source of frustration for several medical staff interviewed. Some highlighted the problem that many Rohingya women refuse to have a doctor examine them physically, or to give birth in a health facility: *“If they have allergies or other infections inside their bodies, they don’t let the doctors see in order to provide proper medication. They think the doctor has an evil motive for wanting to see.”* These practical challenges stem from the importance of preserving modesty in Rohingya culture: to avoid the shame of being seen by male staff, many women give birth at home and refuse physical examination by a male doctor.

Fear also discourages people from seeking care in some cases described by patients and medical staff alike. Two patients said they or other people did not seek help for a cough or fever for fear of being diagnosed with COVID-19 and taken away to quarantine or even killed. Others shared concerns about surgical interventions during childbirth which contribute to women’s fear of giving birth in hospital. Many women see these as “torture” and not as measures taken when needed to prevent harm to the mother or baby. Cesarean sections, where the baby is delivered through a cut in the mother’s abdomen, are a particular source of fear, but women also fear episiotomies, where a cut is made to enlarge the vaginal opening for the baby to emerge. Medical staff interviewed also say that patients are fearful of the term “referral”, which they associate with being taken away to an unknown location, and don’t come back to the health facility if referral is mentioned.

Such fears and misunderstandings cannot be addressed unless patients feel their concerns are heard and trust the information provided. Patients who reported good experiences at a health facility cited that medical staff “listened” or took their concerns seriously. Medical staff want to provide quality care, but in many cases they are unable to because they lack the constructive dialogue, based on mutual understanding and trust, that might enable them to overcome such concerns. They are aware that, as patients told us, women often don’t feel comfortable even reporting a sexual and reproductive health issue to a male doctor. But other recent evidence suggests that sexual and reproductive health information efforts are changing minds and practices in the camps: appropriate communication and adequate provision for privacy and confidentiality are needed to expand access to needed services.⁴

⁴ Translators without Borders (2022) Bridging Community and Humanitarian Approaches to Sexual and Reproductive Health, <https://translatorswithoutborders.org/resource/bridging-community-and-humanitarian-approaches-to-srh-in-rohingya-communities-report>

Addressing this calls for greater cultural awareness, better-resourced language support for patient-doctor communication, and greater attention to the quality of patients' experience. Medical staff themselves recognize a need for training on Rohingya language and culture to improve communication with patients. Some called for interpreters or more systematic support from community health workers and volunteers, and one called for medical terminology support in Bangla and Rohingya. Another staff member refers colleagues to TWB's multilingual glossary for the Rohingya response. A combination of language support and respect for patients seems effective in facilities run by MSF. One-third of patients interviewed reported positive experiences at MSF facilities, where they described doctors as kind and respectful and medical interpreters as regularly available, which greatly improved their experience in the consulting room.

The evidence of this study also suggests that more than training will be needed to change some attitudes across the whole range of health facility staff, from doctors to security guards. One community health volunteer highlighted the power dynamics which make it hard to escalate complaints about more senior staff: *"During field visits we get a lot of negative feedback from patients. The patients complain that they don't get the right medicine for their disease, doctors use disrespectful words and they have to stand in the queue for a long time as there are not enough seats. I tell them I am noting down the issues and will talk to our supervisor. But the problem is that we can't disclose the issue to the supervisor for fear of losing our jobs."* A culture of compassion and respect requires genuine commitment at the senior levels of health organizations, backed up by consistent oversight, to address the lack of cultural sensitivity illustrated by one midwife's remarks: *"[Rohingya patients'] illiteracy, religious outlook, superstition, should be eliminated. I think if these can be eliminated, many changes and improvements will happen in our communication."*

Other constraints are a factor but practical action could improve patients' experience

"The MSF hospital is very good. They have seats for patients to wait outside the facility, their service is quick, they test your blood pressure, they have male and female doctors, and they explain the treatment process and the cause and consequences of the disease so well."

– Male patient, 55 years old, Camp 2W

From accounts by patients, medical staff, and community health workers and volunteers, it is clear that other factors also impede effective communication. These include the high demand for health services compared with supply, so that staff are under pressure to complete each consultation quickly, and patients are tired and frustrated by queuing for many hours to be seen. A senior manager responsible for multiple primary health care centers stressed that each center typically sees between 250 and 275 patients a day, with a staff of two doctors, two pharmacists, two medical assistants and a small support staff. In those circumstances, *"sometimes we have to skip some information, some important information, because of constraints on human resources."* This is in line with the finding that just 11 of the 29 patients interviewed felt they had been given enough time at their most recent consultation, and that only eight said the doctor had adequately explained the problem and proposed treatment. One 26-year-old woman in Camp 2W complained: *"We can't properly explain our problem to them. They always stay so busy and don't even give us 10 minutes' time."*

Other basic communication resources are also in short supply. Five patients called for more and better use of visual communication aids, with clear graphics and written terminology where possible, although verbal communication was widely preferred. Ten patients requested improvements in verbal communication, especially ensuring verbal communication is in Rohingya without the use of words in other languages. People living with disabilities in the study linked this to the need for improved respect by medical staff when speaking to patients with specific needs.

A shortage of female medical staff, and of specialist equipment and suitable medicines for some conditions, also reduces the capacity of health facilities to meet patients' needs. Addressing those gaps will take resources, at a time when funding for the Rohingya response is tight. Yet reports suggest that some quite basic practical steps are not in place to promote a positive experience for patients. For example, multiple accounts agree that at many facilities there are not enough seats for patients queuing, and patients who have difficulty standing are not given priority for seating or medical attention. Providing mothers with screened areas in health facilities to breastfeed their babies can also contribute to ensuring a more positive experience for patients.

About this study

The quality of patient care, and the role of communication barriers in that, has been a recurring concern in the camps of Cox's Bazar, Bangladesh. ACAPS research published in 2021 found high rates of dissatisfaction with health services among Rohingya patients, compounded by language barriers.⁵ Translators without Borders' 2018 study suggested that community health workers and volunteers who often acted as interpreters in patient consultations could offer a partial solution.⁶ This study, the first phase in a longitudinal review, aimed to understand how that role has evolved, and with it the communication component of patient care.

We heard from a targeted sample of 52 key informants, including patients, medical staff, and community health workers

This study is the first phase in a longitudinal study on the impact of communication issues on access to quality primary health care for Rohingya camp residents in Cox's Bazar, Bangladesh. We selected camps purposively to represent a range of contexts, including older camps (24) alongside camps established more recently. The study used two qualitative research methods:

- **Interviews with individuals** to explore the perspectives and experiences of managers of health facilities, and of three groups involved in patient consultations: patients, medical staff, and community health workers and volunteers.
 - o We interviewed **29 adult patients** aged between 21 and 90 years, 14 women and 15 men, in Camps 2W, 8W and 24.
 - o We interviewed **11 community health workers and volunteers**, five men and six women, in camps 2E and 8W.
 - o We interviewed **10 members of medical staff** in camps 2E, 11, and 25: six men and four women, across a range of roles.
 - o We interviewed **two senior managers of health care organizations** working in different camps.
- **Site observations** at health facilities in camps 2E, 11 and 25.

⁵ ACAPS/IOM (2021) *Añárar Báfana, Our Thoughts: Rohingya share their experiences and recommendations* https://www.acaps.org/sites/acaps/files/products/files/20210427_acaps_npm_cxb_iom_anarar_bafana_our_thoughts_smaller_version.pdf

⁶ Translators without Borders (2018) *Misunderstanding + misinformation = mistrust: How language barriers reduce access to humanitarian services, reduce the quality of those services and aggravate social exclusion for Rohingya communities, Part II: Cox's Bazar, Bangladesh* https://translatorswithoutborders.org/wp-content/uploads/2019/09/ENG-Bangladesh-Report_online_FINAL.pdf

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About Translators without Borders

TWB is a nonprofit organization offering language and translation support for humanitarian and development agencies and other nonprofit organizations on a global scale. TWB Bangladesh has supported the Rohingya refugee response since 2017, providing language and translation support to response partners and conducting research and training to meet the language and communication needs of the Rohingya and host communities. TWB is a cornerstone of CLEAR Global, an initiative launched in 2021 to expand our ambition to help people get vital information, and be heard, whatever language they speak.

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