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ORIGINAL ARTICLE / ORİJİNAL MAKALE

Determination of perceived language barriers according to Syrian refugees visiting two hospitals in Ankara

Ankara'da iki hastaneye başvuran Suriyeli mültecilere göre algılanan dil engellerinin belirlenmesi

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ABSTRACT

Objective: The aim of this study is to determine perceived language barriers in accessing healthcare services according to Syrian refugees and the methods they used to cope with this problem. **Methods:** The study was a descriptive study. A survey was carried out among Syrian adults visiting two hospitals in Ankara. **Results:** Of the 221 participants, 11.1% stated that they speak Turkish, 48.5% of them used hospital interpreters while 20.6%, 17.6% and 13.2% of them did not get any help, used ad hoc interpreters and used a private interpreter respectively. Employment status and having social relationships with locals had statistically significant relationships with learning the Turkish language. The language barrier was more common, among participants, who were married, unemployed, illiterate, had no Turkish-speaking relatives or had diseases. Gender, economic status, having Turkish-speaking relatives and having diseases were variables showing association with the method they used to cope with the language barrier. **Conclusion:** More disadvantaged refugees in terms of socio-economic factors should be prioritized in policies and projects aiming to reduce language barrier in accessing health services. Additionally, supporting refugees regarding employment and social relationships with locals would contribute to eliminate language barrier in accessing healthcare services.

Keywords: Language barrier, healthcare services, Syrian refugees, migration, Turkey

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ÖZ

Amaç: Bu çalışmanın amacı Suriyeli mültecilere göre sağlık hizmetlerine erişimde algılanan dil engellerini ve bununla başa çıkmak için kullandıkları yöntemleri belirlemektir. **Yöntem:** Çalışma tanımlayıcı tipte bir çalışmadır. Ankara'da bulunan iki hastaneyi ziyaret eden Suriyeli yetişkinler arasında bir anket uygulanmıştır. **Bulgular:** 221 katılımcının % 11.1'i Türkçe konuştuğunu, % 48.5'i hastanede tercümanlık hizmeti kullandığını, % 20.6'sı, % 17.6'sı ve % 13.2'si sırası ile, yardım almadığını, o an uygun olan Türkçe bilen bir kişinin tercümanınlık yardımını ve özel tercüman kullandığını belirtmiştir. Türkçe'nin öğrenilmesi ile istihdam durumu ve yerel halkla sosyal ilişkilere sahip olma istatistiksel olarak anlamlı ilişki göstermektedir. Evli, işsiz, okuma yazma bilmeyen, Türkçe konuşan akrabası olmayan veya hastalık deneyimi olan katılımcılar arasında dil engeli daha yaygındır. Dil engeli ile baş etmek için kullanılan yöntemler ve şu değişkenler arasında istatistiksel olarak anlamlı ilişki tespit edilmiştir: Cinsiyet, ekonomik durum, Türkçe konuşan akrabalara sahip olma ve hastalık deneyimi olma. **Sonuç:** Sağlık hizmetlerine erişimde dilin bir bariyer olmaktan çıkmasını sağlamak için uygulanacak politikalarda ve çalışmalarda sosyo-ekonomik faktörler açısından daha dezavantajlı mültecilere öncelik verilmelidir. Ayrıca hem istihdam açısından hem de ev sahibi toplumla ilişkilerin kurulması açısından mültecilerin desteklenmesinin, dil bariyerinin sağlık hizmetlerine erişimde bir problem olmasın eliminasyonuna katkı sunacağı düşünülmektedir.

Anahtar kelimeler: Dil engeli, sağlık hizmetleri, Suriyeli mülteciler, göç, Türkiye

Introduction

Since the Syrian War which started at 2011, 6.3 million Syrians have been internally displaced, over 1 million fled to Europe[1] and more than 5 million fled to neighbouring countries, seeking refuge in Turkey, Lebanon, Jordan and beyond.[2] Turkey has a Syrian population of over 3.6 million, most of them stay outside the refugee camps.[3] Healthcare services for Syrian refugees are provided free of charge. Syrian refugees benefit from the same healthcare services provided for Turkish citizens.[4] However, many of them might not receive optimal healthcare due to various factors that affect the process of accessing healthcare services. Language barrier is one of them. Language is a major barrier for patients who do not speak the same language with healthcare providers, especially for vulnerable groups like refugees.[5] Its effects vary from understanding of available health services to socialization and integration problems. [6-9] In the US, it is well established that language barriers create health inequalities for patients with limited English proficiency.[10] These patients have fewer access to adequate healthcare, and lower rates of physician visits and using preventive services.[11-13] Limited English proficiency patients often have worse adherence to treatment and follow-up for chronic diseases, decreased comprehension of their diagnoses and treatment after emergency department visits, decreased patient satisfaction, and increased medication complications.[14-16] Language concordance in healthcare services in US tended to be linked with better compliance, enhanced appointment keeping and less emergency visits among patients[14], provided an improved chance in obtaining appointments for medical follow-ups[17] and improved health status assessments. [18] Non-English speaking refugees in Australia also felt incapable of getting proper healthcare services.[19] In a Swedish study, 36% of the participants who spoke different languages experienced poor quality of communication and more than half of them received little

information about how to get healthcare services.[20] In a Dutch study, being from a different ethnic group was shown as a risk factor for not receiving proper healthcare services during pregnancy .[21] Similar findings were revealed in UK, where women whose main spoken language was English reported higher levels of continuity at each phase of healthcare during pregnancy than women whose main spoken language was not English. [22] There are few studies regarding language barriers in accessing healthcare services among Syrian refugees, these studies also revealed that the language was one of the issues that restrained accessing to healthcare services or overwhelmed the healthcare system in Canada, Germany and Turkey. [4,7,23]

As well as professional interpreters[24,25], family members and friends are also utilized as interpreters.[26] The use of children as interpreters is debated in some studies.[27] In other studies, refugees were anxious that interpreters were not re-telling their stories precisely[28], resulting in misdiagnosis or incorrect treatment. Some of them were concerned that personal information was being shared with others in the community.[29] Some studies argued that gender concordance of interpreters also facilitated communication [30,31]; however, it is also noted some female patients were not concerned by its absence. [32] Turkey has hired Arabic-speaking interpreters for state hospitals and Syrian physicians in migrant health centres to overcome the language barrier.[6,33] However, the number of interpreters is insufficient to assist all needy patients.[34], Unspecialized or ad hoc interpreters might not always be able to translate accurately, might not be medically competent.[35,36] Syrian refugees in Turkey frequently reported that the language barrier makes receiving healthcare services quite challenging.[37-40] However, little is known about the dimensions of this barrier among the Syrian refugees in Turkey or anywhere else. Hence, the aim of this study to determine perceived language barriers in accessing healthcare services according to Syrian refugees and the methods they used to cope with this problem, when they do access healthcare services.

Material and Methods

This descriptive study was carried out in two state hospitals in Ankara, Turkey between November and December 2017. These hospitals were "Ankara Training and Research Hospital" (ATRH) and "Numune Training and Research Hospital" (NTRH). The Syrian refugees in Ankara are mainly living in the neighbourhoods of the Altindag district, where both of the hospitals are located. ATRH is the nearest state hospital to the neighbourhoods where the Syrian refugees live. In ATRH, two interpreters have been employed, while one interpreter has been working in the NRTH. All the participants were Syrian, above 18 years old, native Arabic speaker and registered under 'temporary protection' status for Syrian refugees in Turkey. All the foreigners (including the refugees) visiting ATRH has to register at a certain place, before they are referred to the clinics, which made it easier for us to recruit them. There was no such a process at NTRH. Permissions to conduct the study were obtained from the "Ministry of Interior Directorate General of Migration Management, Ankara Provincial Health Directorate" and both ATRH and NRTH, as well as an ethical clearance from the "Hacettepe University's Ethical Committee". A questionnaire, prepared by the authors based on the relevant literature, was used as the survey instrument. It was prepared in Turkish, afterwards was translated to Arabic by the first author, then retranslated to Turkish by a professional translator. The two versions of the Turkish questionnaires were compared, and there was no major difference between two versions. The questionnaire was administered face-to-face by trained three interviewers, who were native Arabic speakers. The appropriateness of the questionnaire was checked with a small group of Syrian refugees and changes were made as necessary before it was carried out. The questionnaire contained 38 questions covering the following issues: Socio-demographic information, level of knowledge on Turkish and other languages (The certification for the languages was not asked; only the statement of the responders was recorded). Socioeconomic information,

health status and language barrier. Health status of the refugees were identified by two questions asking about their self-evaluated health condition and diagnosed chronic diseases. There were nine questions for identifying the problems they face in accessing healthcare services and how they cope with them, with a focus on the language barrier. The statistical software "IBM SPSS Statistics 23.0" was used to enter, clean, and analyse the data. For the study sample characteristics frequencies and percentages were reported. For cross-tabulations, statistical significance was determined using the Pearson Chi-Square test. Due to the imbalance in the distributions of the variables, a new categorization process was performed by merging the subgroups into major groups for the following variables: Age, marital status, number of the children, education level, type of living place in Syria, duration of stay in Turkey.

Results

A total of 221 Syrian refugees were surveyed. Of them, 75 were interviewed in NTRH, 146 were interviewed in ATRH. 46.6% of the participants were males, 53.4% of them were females. The mean age was 36 years old (SD: 13.6), the oldest refugee was 85 years old and the youngest was 18 years old. Most of them (81.9%) were married and 75.1% of them were married in civil marriage. All the single people have no children, while all the participants who have been married, have one or more child, with a mean of 3 children (SD: 2.29). None of the participants has arrived to Turkey before 2011. 88.9% of the participants have never stayed in a refugee camp before. The majority of the participants (80.2%) were not working at a paid job at the moment the study took place. 12,9% of the employed participants had permanent job with a regular monthly income. Half of the participants assessed their economic status as moderate. When participants were asked to assess their economic status before they migrated to Turkey; more than 40% of them thought that they were living in good or excellent economic conditions. (Table 1).

Table 1: The characteristics of the study population

		Frequency(n)	Percent(%)
Study setting (N=221)	Numune Hospital	75	33.9
	Ankara Hospital	146	66.1
Gender (N= 221)	Male	103	46.6
	Female	108	53.4
Age groups (N= 221)	25 >	49	22.2
	26-50	128	57.9
	50 <	44	19.9
Marital status (N= 221)	Civil Marriage	166	75.1
	Religious Marriage	15	6.8
	Single	36	16.3
	Divorced /Widow / Widower	4	1.9
Number of Children: (N= 221)	0	36	16.3
	1-3	99	44.8
	4-6	67	30.3
	7 <	19	8.6

Education level: (N= 221)	Can't read and write	44	19.9
	Able to read-never made it to school	20	9.0
	Primary school	86	38.9
	Secondary school	31	14.0
	High school	16	7.2
	College/ University	24	10.9
Duration of time in Turkey (N=216)*	Less than one year	18	8.3
	One year	14	6.5
	Two years	46	21.3
	Three years	84	38.9
	Four years	25	11.6
	More than Five years	29	13.4
Whether stayed in camps (N= 217)*	No	193	88.9
	Yes	24	11.1
Duration of time in camps: (n= 18)	0-6 Months	3	16.7
	7-12 Months	10	55.6
	13< Months	5	27.8
Knowing the Turkish language: (N= 217)*	Knows	24	11.1
	Still learning	83	38.2
	Doesn't know	110	50.7
The place where they learned the Turkish language: (N= 107)	At work	40	37.4
	Free course	19	17.8
	Social relationships	33	30.8
	Internet	12	5.4
	Native	1	0.9
Other languages they know: (N= 221)	None	196	88.7
	French	1	0.5
	English	24	10.9

11.1% of the participants expressed that they can speak Turkish. Half of them expressed that they cannot speak Turkish language at all, while the rest of them were still learning Turkish from different sources. Of the responders, who could speak or were learning Turkish, 37.4% and 30.8%, learned the language at work and from social relationships respectively. Internet was also one of the sources to learn Turkish among study participants The majority of participants mentioned that they have at least one Turkish friend or neighbour. Half of the participants who have Turkish friends or neighbours stated that they have 4-6 Turkish friends or neighbours. The majority of the participants who stated that they have Turkish friends or neighbours, assessed their relationships with them as negative, however, more than half of them (52.4%) stated that their Turkish friends and neighbours help them anytime they need them. 36.4% (n:52) of them stated that their Turkish friends and neighbours were unhelpful when they were in need of their assistance. Almost half of the participants (48.9%) have got relatives who can speak Turkish. Of them 55.7% said that their relatives help them whenever they need (Table 2).

Table 2. The Socio-economic characteristics of the study population

		Frequency (n)	Percent (%)
Current employment status (n=217)*	Jobless**	174	80.2
	Permanent job	28	12.9
	Temporary job	15	6.9
Employment status in Syria (n=221)	Jobless**	140	63.3
	Permanent job	65	29.4
	Temporary job	16	7.2
Self-assessed current economic status (N=221)	Good	8	3.6
	Moderate	112	50.7
	Bad	67	30.3
	Very bad	34	15.4
Self-assessed current economic status compared to other families in the environment (N=221)	Good	8	3.6
	Moderate	155	70.1
	Bad	35	15.8
	Very bad	23	10.4
Self- assessed economic status when they were in Syria (N=221)	Very Good	31	14.0
	Good	59	26.7
	Moderate	91	41.2
	Bad	28	12.7
	Very bad	12	5.4
Have Turkish friends or neighbours: (n=221)	Doesn't have	78	35.3
	Has	143	64.7
Number of Turkish friends or neighbours (n=117)	1-3	24	20.5
	4-6	59	50.4
	7-10	18	15.4
	11<	16	13.7
Assessment of the relationship with their Turkish friends or neighbours (n=143)	Very Good	8	5.6
	Good	4	2.8
	Moderate	35	24.5
	Bad	68	47.6
	Very bad	28	19.6
Having relatives, who speak Turkish language (n=221)	Doesn't have	108	48.9
	Has	113	51.1
Number of first-degree relatives, who speak Turkish language (n=113)	0	35	31.0
	1-3	53	46.9
	4-6	17	15.0
	>7	8	7.1
How helpful were the Turkish friends or neighbours in case of need for language problems (n=143)	Always helpful	75	52.4
	Sometimes helpful	16	11.2
	Unhelpful	52	36.4

How helpful were the relatives in case of need for language problems (n=140)	Always helpful	78	55.7
	Sometimes helpful	19	13.6
	Unhelpful	43	30.7
Similarity of the Turkish culture comparing to Syrian culture (n=217)*	Very different	50	23.0
	A little different	44	20.3
	Similar	108	49.8
	Exactly the same	8	3.7
	Doesn't know	7	3.2

* Differences in total n are due to missing values in each item.
** Not working at a paid job

Despite 66.5% of the respondents stated that they did not have any mental or physical diseases, only 5.4% of them thought that they were in a very good health condition. 72.3% of the respondents mentioned that they were in a moderate or a bad health condition. The majority of the participants, were using state hospitals in order to get healthcare services, while 17.8% of them visited family health centres. 3.7% of the respondents mentioned that they did not visit any healthcare services before. Of the respondents, 51.4% thought that the language barrier plays an extremely negative role in accessing healthcare services. Only 22.9% (n: 22.9) of them said that the language barrier doesn't have any adverse effect on them. 51.1% of the respondents, stated that they experienced not being able to access healthcare services despite their need due to language barriers, and 14.2% of these people stated that they face this problem all the time. 40.7% of them have faced the inaccessibility to healthcare services because of language barriers at least a few times, and 34.5% of them have faced this problem more often. Almost half of the participants (48.5%), used hospital interpreters when they access healthcare services. While 20.6%, 17.6% and 13.2% of them tried to manage the situation by himself, used ad hoc interpreters such as friends or family member and used a private interpreter respectively. Furthermore, the percentages didn't change too much about the method, they had used during the previous visit to a healthcare service. While 64.9% (n: 131) of them thought that the method they have used during the previous visit was effective, 11.9% (n: 24) of them thought that it wasn't effective at all and 23.3% (n: 47) of them believed that it was partly effective (Table 3).

Table 3: The health status of the study population

		Frequency(n)	Percent(%)
Self-assessed health status (n=217)*	Very Good	12	5.5
	Good	48	22.1
	Moderate	76	35.0
	Bad	81	37.3
Existence of previously diagnosed mental or physical disease (n=221)	Doesn't have any	147	66.5
	Has	74	33.5
Ability to Access healthcare services (n=221)	Able to access	209	94.6
	Didn't need healthcare services	12	5.4
Type of the healthcare service, they usually use (n=219)*	Family Health Centre	39	17.8
	State hospital	172	78.5
	Didn't need healthcare services	8	3.7

Perceived effect of language barrier (n=214)*	Does not have any negative effect	49	22.9
	Partly has a negative effect	55	25.7
	Has an extremely negative effect	110	51.4
Despite of need, experienced not accessing healthcare services (n=221)	Hasn't experienced such a situation	84	38
	Have experienced	113	51.1
	Didn't remember	24	10.9
Despite of need, how often they experienced not accessing healthcare services (n=113)	At least once	12	10.6
	A Few times	46	40.7
	Often	39	34.5
	Always	16	14.2
Coping method (N=204)*	Hospital interpreter	99	48.5
	Private interpreter	27	13.2
	Ad hoc interpreter (Friends or family member)	36	17.6
	Managed himself	42	20.6
The method perceived as most useful (N=206)*	Hospital interpreter	97	47.1
	Private interpreter	24	11.7
	Ad hoc interpreter (Friends or family member)	44	21.4
	Managed himself	41	19.9
The method used during the previous visit to a healthcare service (N=207)*	Hospital interpreter	98	47.3
	Private interpreter	27	13.0
	Ad hoc interpreter (Friends or family member)	32	15.5
	Managed himself	50	24.2
Was the method used during the previous visit to a healthcare service effective? (N=202)*	Effective	131	64.9
	Wasn't effective	24	11.9
	Was partially effective	47	23.3

* Differences in total n are due to missing values in each item.

To determine the statistically significant differences in frequencies between (i) perception of language as a barrier, (ii) methods they used to cope with the language barrier and other variables, cross tables were created. Perception of language as a barrier was more common, among participants, who were married, jobless, illiterate, had no Turkish speaking relatives or had diseases (Table 4). Gender, economic status, having Turkish-speaking relatives and having diseases were variables showing statistically significant difference with the method they used to cope with the language barrier. Males used the hospital interpreter, while females preferred using Ad hoc interpreter more. The better the self-assessed economic status was, the more use of the hospital interpreter was reported. Also having Turkish friends, neighbours or relatives who can speak Turkish language, was associated with more using of Ad hoc interpreters. Finally, existence of previously diagnosed mental or physical disease was associated with using the hospital interpreter as a favourite method to cope with the language barrier (Table 5).

Table 4: The distribution of some variables according to perceived impact of language barrier in accessing healthcare services

		Perceived effect of language barrier						Total	P
		Does not have any negative effect		Partly has a negative effect		Has an extremely negative effect			
		n	%	n	%	n	%	n	
Gender	Male	29	29	28	28	43	43	100	0.49
	Female	20	17.5	27	23.7	67	58.8	114	
Current employment status	Jobless	40	23.5	32	18.8	98	57.6	170	0.001>
	Working	9	22.5	19	47.5	12	30	40	
Employment status in Syria	Jobless	18	13.2	43	31.6	75	55.1	136	0.001>
	Working	31	39.7	12	15.4	35	44.9	78	
How helpful were the Turkish friends or neighbours in case of need for language problems	Helpful	25	29.8	24	28.6	35	41.7	84	0.554
	Unhelpful	20	38.5	12	23.1	20	38.5	52	
Having relatives who speak Turkish language	Doesn't have	32	29.6	20	18.5	56	51.9	108	0.013
	Has	17	16	35	33	54	50.9	106	
How much helpful were the relatives in case of need for language problems	Helpful	12	12.9	27	29	54	58.1	93	0.001>
	Unhelpful	17	42.5	11	27.5	12	30	40	
Self-assessed health status	Good	17	29.8	16	28.1	24	42.1	57	0.207
	Moderate	16	22.2	20	27.8	36	50	72	
	Bad	16	19.8	15	18.5	50	61.7	81	
Existence of previously diagnosed mental or physical disease	Doesn't have any	36	25.7	41	29.3	63	45	140	0.036
	Has	13	17.6	14	18.9	47	63.5	74	
Type of the healthcare service, they usually use	Family physician	12	34.3	12	34.3	11	31.4	35	0.039
	State hospital	37	21.9	39	23.1	93	55	169	
Marital status	Married	33	19	43	24.7	98	56.3	174	0.004
	Single	16	40	12	30	12	30	40	

Table 5: The distribution of some of the explanatory variables according to the methods used for coping with language problem

The method they use to cope with language problem											
		Hospital interpreter		Private interpreter		Ad hoc interpreter (Friends or family member)		Managed himself		Total	P
		n	%	n	%	n	%	n	%	n	
Gender	Male	67	67	8	8	8	8	17	17	100	0.001>
	Female	32	30.8	19	18.3	28	26.9	25	24	104	
Self- assessed economic status when they were in Syria	Good	51	60.7	8	9.5	11	13.1	14	16.7	84	0.001>
	Moderate	40	48.2	11	13.3	20	24.1	12	14.5	83	
	Bad	8	21.6	8	21.6	5	13.5	16	43.2	37	
Have Turkish friends or neighbours	Doesn't have	35	46.7	12	16	8	10.7	20	26.7	75	0.103
	Has	64	49.6	15	11.6	28	21.7	22	17.1	129	
Having relatives who speak Turkish language	Doesn't have	56	53.8	12	11.5	8	7.7	28	26.9	104	0.001>
	Has	43	43	15	15	28	28	14	14	100	
Existence of previously diagnosed mental or physical disease	Doesn't have any	57	42.9	19	14.3	21	15.8	36	27.1	133	0.01
	Has	42	59.2	8	11.3	15	21.1	6	8.5	71	

Discussion

The study supplies fundamental information about the language barriers in accessing healthcare services among the Syrian refugees. However, it has some limitations. Considering its' descriptive design, it is not possible to infer causal relationship. Due to the logistical conditions, a representative sample size and a probability sampling strategy could not be used. The study was conducted in the outpatient clinics of two hospitals, hence the sample might not cover the patients who had needed a treatment but avoided visiting hospitals due to language barriers. Additionally, as the data was collected in hospitals, the general health profile may not reflect the Syrian refugees' health conditions in Ankara The majority of the participants were from ATRH, the location of ATRH and the process they followed for registering foreign patients might have played important role in recruiting more participants compared to NTRH. None of the participants came to Turkey before the Syrian conflict started on 15th March 2011. Only 11.1% of the sample had stayed in camps before, as 90% of Syrian refugees in Turkey remain outside of camps[3], our sample presents parallel results in this respect. In the present study, half of the participants mentioned that they did not know the Turkish language at all. This finding demonstrates a higher percentage of refugees with language inabilities in the host-country language than has been found in similar groups. For example, 6.1% of Arabic, Somali, Dari or English-spoken migrants who have been enrolled in a study in Sweden did not understand what was being told and 27.8% of them had low quality of communication[20]. In a study among Syrian refugees in Germany, socialization and integration problems due to the German Language[7] were shown, but most of the participants in our study have Turkish friends or neighbours. However, it may not mean a

smooth socialization, because almost half of them (47.6%) stated that their relationships with their neighbours were bad. In addition, knowing the Turkish language also seems to be an important factor for social relations, considering that everyone in the sample who can speak Turkish tended to have at least one Turkish friend or neighbour. Nevertheless, even if the relationships were expressed as bad, more than half of the participants said that their Turkish friends or neighbours help them when they needed help. This finding might suggest that speaking the local language is effective to improve the relationships between the host and guest communities. In this aspect, we can find similar results in previous studies[8,9]. Of the respondents, 5.4% thought that they were in a very good health condition and 72.3% of them mentioned that they were in a moderate or a bad health condition. Another example demonstrates parallel results in a study conducted in Amsterdam [5]; 5.3% of the Turkish and Moroccan study participants self-reported that they were in a very good health condition and 55.4% of them mentioned that they were in a moderate or a bad health condition. In another study among Syrian refugees in Ankara[38], 25% of the participants thought that they were in a poor health condition and 39% of them mentioned that they have poor mental health, and almost all the participants of a study conducted in both Turkey and Syria, describe their mental and physical health as very bad or bad [37]. However, all of these results were self-reported and may be biased due to the high depression prevalence in these settings [37,38,40]. Language barriers was one of the most important barriers to access healthcare services among Syrian refugees in Turkey in different settlements [4,38,39]. Our study shows parallel results in this aspect, in which almost half of the participants considered that the language barrier plays an extremely negative role in accessing healthcare service, and a similar percentage experienced not being able to access healthcare services despite their need due to language barriers. Working participants were more inclined to learn Turkish than unemployed participants. As learning Turkish is vital for overcoming the language barrier, participants who were employed at the time of the study had to struggle less with the language problem in healthcare services. Gender of the participants showed a statistically significant difference with the method participants used to cope with the language barrier. While females tended to use friends, family members or cope with the situation themselves, males preferred to use the hospital interpreters more. Conservative Islamic culture is common among Syrian refugees, therefore female patients may feel uncomfortable to use a stranger to help them in communicating with healthcare providers, especially if the interpreters are males. Other studies also argued that some barriers are created by the strict religious modesty norms of the patients and associated gender preference of their healthcare provider[30,32]. Lack of congruence between the healthcare system and Syrian needs and gender aspects were between the most socio-cultural barriers among Syrian refugees to access healthcare system in Switzerland [31]. Our study emphasizes the importance of gender congruence not just with patients and healthcare providers but also with all aspects of healthcare process. Syrian refugees with previous mental or physical diseases tend to use the hospital interpreter more often than the refugees without chronic diseases. The higher number of visits to the clinics due their diseases, might allowed them to use this service more effectively.

Conclusion

Providing the health services free of charge to refugees is an essential issue in making them accessible, however, other aspects of access such as language barriers should be also considered. According to our study it is particularly important for the refugees, who have lower socioeconomical and educational levels and no or less local social contacts. When providing services to overcome the language barriers these groups should be given priority. Additionally, in a conservative society like Syrian society, gender is an essential issue. This matter should be considered while providing solutions to overcome the language problems in accessing services. It seems that

either the working environment provides suitable conditions to learn the local language among adult refugees or learning the language provides a better chance of employment, hence providing appropriate job opportunities or/and language courses might help refugees to learn the language and correspondingly to integrate in the society and get a better access to healthcare services. Finally, further studies should be conducted to have a better understanding of the language problems that Syrian refugees face with, such as analytical studies and studies that include all actors in such medical encounters; the refugees, healthcare services providers and interpreters.

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