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Research

'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality Use of Medicines

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Abstract. Reforms to the Australian health system aim to ensure that services are accessible, clinically and culturally appropriate, timely and affordable. During the reform consultation process there were urgent calls from stakeholders to specifically consider the health needs of the thousands of refugees who settle here each year, but little is known about what is needed from the refugee perspective. Access to health services is a basic requirement of achieving the quality use of medicines, as outlined in Australia's National Medicines Policy. This study aimed to identify the barriers to accessing primary health care services and explore medicine-related issues as experienced by refugee women in South Australia. Thirty-six women participated in focus groups with accredited and community interpreters and participants were from Sudan, Burundi, Congo, Burma, Afghanistan and Bhutan who spoke English (as a second language), Chin, Matu, Dari and Nepali. The main barrier to accessing primary health care and understanding GPs and pharmacists was not being able to speak or comprehend English. Interpreter services were used inconsistently or not at all. To implement the health reforms and achieve the quality use of medicines, refugees, support organisations, GPs, pharmacists and their staff require education, training and support.

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Introduction

Since 1945, Australia has resettled over 700 000 refugees and humanitarian migrants, nearly all of whom have complex health needs (Cheng *et al.* 2011). Women refugees have been routinely exposed to violence and extreme poverty (Costa 2007), which can also negatively impact on health. The World Health Organization cites barriers to accessing health services as an important factor of inequity (Muecke 2010) advocating for reforms to address the needs of those for whom 'service availability and social protection does too little to offset the health consequences of social stratification' (Muecke 2010, p. 1).

Although general patient access to primary health care is not routinely measured (Reed *et al.* 2008) an indication of services comes from two Australian studies. In South Australia a survey indicated issues for accessing general medical practitioners (GPs): 39% of people were able to see a GP on the same day as their request for an appointment, 33% were able to visit the GP within 1 or 2 working days, but 20% waited more than 2 working days. Respondents with lower levels of household income were more likely to report longer waits for appointments (Reed *et al.* 2008). A second study found that the main reasons given by respondents for not being able to access health care when it was required were that waiting times were too long and that there were no appointments available (Australian Bureau of Statistics 2009).

For people from different cultures, the invisibility of migrant needs, service-utilisation patterns and low levels of staff cultural competence can lead to services being less accessible to some community members (Proctor 2004). Other negative influences on refugee access to health care services include a range of language, literacy and communication difficulties (Proctor 2004). Low health literacy is associated with poorer health outcomes and poorer use of health care services (Berkman *et al.* 2011). People on low incomes can also experience poor housing, poor nutrition, depression and poor hygiene (Klein 2004), adding to the burden of disease.

A core requirement of Australia's National Medicines Policy (NMP) is the Quality Use of Medicines (QUM). QUM is a recognised field of research and practice in pharmacy, public health and medicine understood as an approach to managing medicines that includes: selecting medicine-management options wisely; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively. The definition of QUM applies equally to decisions about medicine use by individuals and decisions that affect the health of the population (Department of Health and Ageing 2009). Within

What is known about the topic?

- Refugees from minority cultures experience a range of barriers to accessing primary health care and achieving the Quality Use of Medicines, including language, literacy and communication difficulties.

What does this paper add?

- All stakeholders including refugees, general practitioners, primary health care staff, pharmacists and pharmacy assistants require education and support to communicate and interact effectively and achieve the Quality Use of Medicines.

different cultures there are diverse understandings of traditional and Western medicines and it is unclear what QUM means or how it can be achieved for individual refugees and the population of refugees living in Australia. Access to medicines is central to both the NMP and achieving QUM. The Federation of Ethnic Communities Councils of Australia and the National Prescribing Service recognise that achieving QUM in the non-English-speaking community is an under-researched area and in 2009 implemented a project called 'Multicultural Community Quality Use of Medicines' to gather information on this topic. QUM will not be achieved if refugees face barriers to accessing primary care.

Language difficulties and the need for interpreter services are consistently noted in the literature as key systemic barriers to health care and one of the most significant access barriers (Bulman and McCourt 2002). Evidence suggests that the use of interpreters improves both the quality and safety of health care (Phillips 2010) and the appropriate use of interpreters forms part of the Royal Australian College of General Practitioners Standards for General Practice. The Australian Department of Immigration and Citizenship provides a fee-free interpreter service to both GPs and pharmacists. The South Australian Interpreting and Translating Centre (SAITC) is the state organisation available for providing on-site and telephone services. Despite professional standards and the free Telephone Interpreting Service (TIS) available to GPs, the TIS is underused and often not well understood by GPs (Phillips 2010). Some of the reasons for the underuse of interpreter services by GPs include faith in 'in-house' bilingual staff, beliefs about the preference of patients for family members to interpret and a lack of practice systems to contact interpreters (Phillips 2010). A lack of time for GPs to organise interpreters during consultations is also a common reason given for not accessing interpreter services.

In Australia, in conjunction with the NMP, pharmacists, pharmacy practice and the provision of medicines are aspects of achieving QUM. Pharmacists have the potential to play an increased role in health care and the provision of patient-centred care services in the community. The Pharmaceutical Society of Australia (2004) released a position statement on the health care of refugees, recognising that their health needs are significantly different to the general population and confirming that pharmacists have an important contribution to make in increasing access to medicines, providing medicines information and delivering culturally appropriate services. However, of ~5000 approved community pharmacies in Australia, only 1200 have registered for the TIS (Department of Immigration and Citizenship 2009).

Accessible and culturally appropriate health services are required to meet World Health Organization standards, profession-specific policies, the Australian NMP and to achieve QUM but little is known about the needs of refugees from their perspective (McKeary and Newbold 2010). The aim of the present research was to investigate access to primary health care and achieving the QUM as experienced by refugee women living in a local government area of South Australia.

Methods

This research was exploratory and utilised participatory methods during its planning and implementation. Stakeholders were consulted during the planning of the research and in developing the discussion topics used during the focus groups. Focus groups were identified by stakeholders as the most appropriate method to gain in-depth understanding of the women's issues, utilising group-work techniques to draw out information from participants, encourage discussion among group members and ensure all participants were provided with opportunities to speak. The group environment encourages discussion, increases motivation to address critical issues, enables the group leader to direct the discussions toward focal points and allows all significant points of view to be expressed. Communication between participants is part of the data collected – group processes allow participants to 'explore and clarify their views in ways that would be less easily accessible in a one to one interview' (Kitzinger 1995, p. 299). Broad discussion topics allow participants to 'explore the issues that are important to them, in their own vocabulary' (Kitzinger 1995, p. 299). 'Listening exercises', such as focus groups, are also useful to help plan 'user-driven research' and produce useful and practical outcomes for those involved (Lomas *et al.* 2003, p. 383).

Data analysis

Researchers preserved participant confidentiality and anonymity by removing any identifying information from the raw data. All group discussions were audio recorded and data was transcribed verbatim and analysed thematically to highlight four key themes. Data analysis was based on the framework method (Ritchie and Spencer 1993). Familiarisation with the data was achieved as the researcher personally transcribed the voice recordings of the focus groups and repeatedly read the transcripts. A thematic framework was identified during this process according to issues that were important to participants and themes manually recorded on the transcripts. Charting was achieved by moving specific quotes to appear under the main themes to explain the attitudes, experiences and behaviours of participants to meet the aim of the research.

Ethics

Refugees are considered a highly vulnerable group due to their past experiences of torture and trauma and their mental and physical health. The ethics application and approval process for

this study took approximately 1 year. This ethics section provides a detailed account of the issues that require attention in an ethics application, intended to assist researchers who wish to work with refugees and asylum seekers to prepare ethics applications. This research was approved by the University of South Australia Human Research Ethics Committee.

During the planning stages of the research, attention was paid to the need for interpreters. Some of the potential participants in this study were considered by stakeholder-organisation staff to be sufficiently confident and competent in speaking English to participate without an interpreter. Other women who could not speak English were invited to attend groups according to their common language with accredited interpreters. Country of birth and religion were also considered in grouping people together. These issues were discussed in detail with stakeholder-organisation staff before participants were invited, to ensure that no potential issues or conflicts were overlooked. When interpreters were used the researchers met with them before each group was conducted so that the consent process, the aims of the research and the discussion topics could be clearly articulated to the groups by the interpreters. During the planning stages of the research much consideration was given to developing the group discussion topics in conjunction with stakeholder-organisation staff. The focus of the discussions was on present issues directly related to experiences of using health services and medicines while living in Australia, rather than potentially traumatic past events. Participants were given the contact information for the researchers and the Executive Officer of the University of South Australia Human Research Ethics Committee.

While researchers can assure confidentiality and anonymity of the content of focus-group discussions through removing identifying material from raw data before its analysis, it is more difficult to exact confidentiality and anonymity between participants outside of the group. This issue was discussed with interpreters before the focus groups were held and agreement was gained from them to replicate this discussion with participants during their involvement in data collection. During the focus groups, the researchers and interpreters discussed with participants the importance of keeping the content of the discussions confidential and anonymous between group members and outside of the groups. The researcher explained to participants that confidentiality and anonymity would be respected by them, but that they could not control what information participants took outside the group. Participants were encouraged to only offer information that was not too personal to be revealed in the group environment. The purpose and aims of the research and the consent process, including confidentiality and anonymity, were explained to participants in everyday language.

Participants

Refugee support-agency staff assisted researchers to recruit participants because they had established ongoing relationships with them. The researchers provided information to the support-agency staff and talked with them to ensure they understood the research. The staff then invited people during their regular and informal interactions with them by providing information about the research and when the groups would be held. Four focus groups were conducted during 2010 with 38 refugee participants, three accredited interpreters and one community interpreter. The number of participants, their countries of origin, languages and use of interpreters are shown in Table 1.

Results

The groups affected by each key theme are summarised in Table 2.

Theme 1: language as a barrier

The biggest single barrier for the Group 2 and Group 3 participants in accessing health care was not being able to speak or understand the English language sufficiently to make a GP appointment. The majority of participants from all groups consistently cited language as a barrier to everyday activities, not only in accessing health care, but also when shopping, banking and looking for work. Group 4 participants reported fewer language difficulties that prevent them from accessing the health care they need.

Theme 2: Western system and understanding of illness

Several participants across all groups had experienced dissatisfaction with the health services they had received, especially when their children were sick being told to 'give paracetamol and come back if the child gets worse' and then worrying that their child might die. One participant said 'maybe lose my child', inferring that she was worried the child would die without medical assistance. Another participant said that she was 'very scared because I can't see anyone', describing a situation where she waited over 1 h with her sick child. A participant with diabetes and high blood pressure said that sometimes she 'doesn't feel good' and when she rings the GP she is told 'we don't have any space'. The same participant has walked to the GP clinic where she was told it was dangerous for her to walk because she was dizzy and that 'maybe you die on the road'. Another participant said that she called an ambulance because she could not obtain a GP appointment, 'you have to phone sometimes

Table 1. Participant countries of origin, language and use of interpreters details

Group	No. of participants	Country of origin	Languages	No. of interpreters
1	15	Sudan, Burundi, Congo	English	0
2	10	Burma	Chin, Matu	2
3	5	Afghanistan	Dari	1
4	8	Bhutan	Nepali	1
Total	38			4

Table 2. Key themes and groups affected

Theme	Groups affected
Language	2, 3
Western system	All
Use of interpreters	All
Education and literacy	1, 2, 3
Local services	All

you can't find a doctor'. Participants in the current study who could speak English and some of those who could not continue to grapple with the complexities of being told that they could not see a doctor straight away. Some participants were confused about the difference between prescription and non-prescription medicines or how the prescription system works. Participants were unsure why sometimes they had to pay to see a doctor and sometimes it was free. Understanding bulk billing and knowing which clinics are free would also potentially increase access to primary health care. One participant said that it is cheaper to see your doctor 'if you are not working but you pay at some and not others'.

Theme 3: use of interpreters

In the current study, only a small number of participants from Group 4 reported initiating the use of an interpreter. Participants in Groups 1, 2 and 3 agreed that they had experienced many occasions when they did not ask for an interpreter and an interpreter was not organised for them. Participant quotes regarding inconsistent provision of interpreters include the following:

Some clinic doesn't call the interpreter

They just go to the clinic, they ask you, they tell you there's no interpreter and you're sent home without help

When we go to the hospital we can't communicate with the doctor so we just go home

When see doctor close to my place here, sometimes yes, sometimes no interpreter

Participants said that often interpreting and translating is conducted by their children. One participant said that she had attended a GP appointment but left without receiving any attention because she could not make herself understood to the clinic staff or the GP and she could not understand them. Another participant said that when she called an ambulance 'they couldn't understand me' and she was unable to obtain emergency assistance. Participants were asked if they had heard of the 'I need an interpreter' card and the majority of participants across groups (and two interpreters) had not heard of the card. A small number of participants said that Centrelink (now called the Department of Human Services) gave them the card but they thought it was only for use at Centrelink.

No participants had experienced the use of an interpreter in the pharmacy setting when purchasing medicines. Participants talked about not receiving any medicines information or only basic instructions such as when to take the medicine and how much to take. One participant said that 'if you don't have any people who talk English maybe it is not too good, you have to take someone with you' commenting on the lack of interpreter and translation services in the pharmacy. Another participant said that 'we just put our prescriptions there, bring the medicines home and the children read the label'. A third participant said that 'my daughter without her I can't do anything, shopping, money, there is no other way we don't know what to do, sometimes children have to be forced to help'. Reasons given by participants for their limited verbal interactions with pharmacy staff included their inability to speak, understand or read English. The majority of participants said that when they were given any information it was the 'girl behind the counter taking money' who tried to talk with them rather than the pharmacist, 'the one in a white dress' at the back of the pharmacy.

Theme 4: education and literacy

All participants discussed their difficulties in accessing a GP in a timely way. Participants in Group 4 (from Nepalese camps) experienced noticeably less difficulty in accessing GPs and using interpreters and they talked about receiving many years of education in the camp setting. One of the interpreters commented that many of the women from Groups 1, 2 and 3 had little or no education, were not literate in their own languages and had never lived in a town or city before coming to Australia, therefore there were multifactorial causes to the access and understanding barriers.

Theme 5: local services

The majority of participants did not see local GPs and many said that they travel long distances to see a 'good doctor'. Participant quotes include the following:

Don't know the service here, sometimes too difficult

I travel to Port Adelaide because feel comfortable

[travelling so far to see a doctor] *it's a big problem*

I go to a clinic in [another local government area]

If I call my doctor in this area I don't know what's going on

Participants and refugee support-agency staff said that they did not have enough information about local services, including which ones will initiate the use of an interpreter and which will bulk bill.

Discussion

It is acknowledged that a better understanding is required of the issues raised by participants in this study from the perspective of GP clinic and pharmacy staff, including GPs and pharmacists, receptionists, practice managers, practice nurses and pharmacy assistants. There are several issues from the participant perspective that, if addressed, would improve access to health services and achieving QUM. The discussion of findings is organised using the QUM building blocks that have been proven successful in planning interventions and implementing policy in the health arena where complex responses are required for health practitioners to routinely and effectively respond to culturally and linguistically diverse patients. Implementation of only one of the recommendations is likely to fail unless this approach is harnessed.

Policy development and implementation is the QUM building block that describes policy and protocols that support QUM. Some GP and pharmacy organisations have national policies and procedures but these are not routinely implemented, so a national review is timely to ensure these are in place, ready for implementation. The same organisations need to develop and implement standards and accreditation to match their policies and procedures, accompanied by national training for GP clinic and pharmacy staff. The facilitation and coordination of QUM

initiatives, or ways to advance and coordinate activities within organisations and practice and with other health professionals and organisations, require national, state and local mechanisms for the use of interpreters in GP clinics and pharmacies. Mechanisms would need to be accompanied by appropriate remuneration and incentive for GP clinics and pharmacies to access interpreters and utilise translated medicines information and labels. As a bare minimum, all GP clinics and pharmacies should be required to register with TIS.

The provision of objective information can assist health practitioners to ethically promote medicines and support best practice. Consumer medicines information (CMI) is available for all medicines dispensed in pharmacies, but is not always automatically provided to patients by GPs or pharmacists. CMI is available in some languages other than English but not in any of the languages spoken by participants. To enhance medicines knowledge for refugees, CMI must be translated into prevalent refugee languages, including (but not limited to) Chin, Matu, Dari and Nepali and pharmacists must routinely meet their responsibilities to distribute them. Pharmacists currently have no capacity to print translated medicines labels and this should also be a priority for the pharmacy profession.

Education and training are key elements in overcoming barriers for all stakeholders in routinely responding to non-English-speaking people. The community's awareness of these issues should be addressed through public media campaigns and mainstream education. The New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) (2008) recognises such barriers to learning English as literacy in the first language of refugees and limited or no education. Recognising that refugees need support to learn English and information about how the Western appointment system works (in relation to GPs and booking interpreters), to initiate interpreter services and improve their health literacy, STARTTS (2008) recommend an expansion to the number of hours available for clients to learn English as one strategy to increase participation in the Adult Migrant English Program. If GPs, their staff, pharmacists and their staff were also educated and supported to routinely recognise and respond to refugee patients, it is more likely, with approaches that engage all stakeholders, that access to health services would improve.

When refugee consumers settle into a new area, health literacy courses are needed that take into account childhood illness and the management of pain and fever as well as understanding the difference between prescription and non-prescription medicines, the importance of not sharing medicines (especially prescription) and an explanation of bulk billing, the Pharmaceutical Benefits Scheme, ambulance service and cover, generic medicines and over-the-counter medicines. Health practitioners and practice and pharmacy staff require training and support to identify and respond appropriately to non-English-speaking patients, including training at the undergraduate level for health practitioners.

Strategic research, evaluation and routine data collection are vital elements of achieving QUM. GPs and pharmacy organisations and those that provide support and health services to refugees require a better understanding of the needs of refugees to access health services. It would be useful for SAITC and TIS to collect geographic data about where they provide interpreting services, and to provide that data to GPs, pharmacy organisations and the public to increase awareness of the demographics of the communities they live and work in. A national database that records the use of TIS by GP practices and pharmacies could also potentially assist to inform refugees about their choice of GP and pharmacy.

Limitations

Using interpreters approximately doubled the estimated length of time allocated to cover all of the discussion topics. Explaining the consent process thoroughly took longer than anticipated. Discussion of basic access barriers and medicines use dominated the conversations, even with Groups 1 and 4, speaking in English with no interpreter and those with better education. Further research is required to better understand the cultural appropriateness of services that are received.

Use of existing resources

The use of existing services and resources is one of the principles of QUM. There are many resources available to assist non-English-speaking people and health practitioners and their staff to communicate more effectively both in writing and verbally,

Table 3. Existing resources that may address participant barriers

Interpreter policy	Pam Garrett (2009) from the Simpson Centre for Health Services Research at the University of New South Wales has proposed an evidence-based model for interpreter service policy accompanied by several suggestions for future policy directions aimed at ensuring patient safety.
Interpreter procedure	The Victorian Government, Centre for Culture, Ethnicity and Health produced a Language Services Series in 2010 called 'Developing a Comprehensive Language Services Response'. The Response describes language services, assessing the need for an interpreter, arranging an interpreter and working with interpreters and is a comprehensive, practical tool that could be used by GP clinic and pharmacy staff.
	The Interpreting and Translating Centre in South Australia provides both translating services and telephone or face-to-face interpreting services in all languages spoken by participants except Chin, and a community interpreter was employed during the study.
	'I need an interpreter' cards and translating and interpreting services are all freely available. It appears that there is not a shared understanding, knowledge or routine application of resources like these to improve access to health care, culturally appropriate services, health literacy or medicines use.
	'Point to your language' signs in various languages can help to identify what language people speak.

which may address the issues raised by participants in this study. A summary of recommended resources is listed in Table 3.

Summary of recommendations

Recommendation 1 National review of professional organisations and individual GP and pharmacy practice policies and procedures.

Recommendation 2 Remuneration and incentives for GP clinics and pharmacies to implement routine responses to culturally and linguistically diverse patients and interpreter procedures.

Recommendation 3 All GP clinics and pharmacies required to register with TIS.

Recommendation 4 Pharmacists meet their obligations to distribute CMI to all patients.

Recommendation 5 CMI translated into prevalent refugee languages.

Recommendation 6 Medicines labels translated into prevalent refugee languages.

Recommendation 7 Increase Adult Migrant English Program hours allocated to refugees to learn English.

Recommendation 8 Provide health-literacy education for refugees (including the Western appointment system, treatment approaches, prescribing, health care cards and bulk billing).

Recommendation 9 Education and support for GP clinic and pharmacy staff to respond to culturally and linguistically diverse patients.

Recommendation 10 SAITC and TIS to provide appropriate services and interventions by identifying all languages requiring translators and interpreters, and suitable interpreters employed by them to assist health practitioners to produce and provide translated medicines information to all patients, either written or verbally.

Recommendation 11 Local governments areas to produce a list of 'local' GP clinics that are registered with TIS and have achieved accreditation, that provide bulk billing – include maps, phone numbers and addresses.

Conclusion

Refugees are not a homogeneous group, they have specific physical and mental health needs. The barriers they experience to achieving the Quality Use of Medicines and access to appropriate, timely primary health care services include a lack of English-speaking skills and low levels of education and health literacy. GP clinic and pharmacy staff require support and education to routinely respond to culturally and linguistically diverse patients. A core requirement of Australia's NMP is access to medicines. Achieving QUM is central to the implementation of the NMP. As well as being provided with the most appropriate treatment, to achieve QUM patients must be provided with the knowledge and skills to use their medicines safely and effectively, through good communication with health practitioners and their staff.

Conflicts of interest

None declared.

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