

**Training our Community Translators: NGOs Providing Language Services in Rural
Community Healthcare Systems**

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Abstract

As the Spanish-speaking population in the United States has continued to grow in recent years, increasing by 1.9% every year between 2015 and 2019 (Noe-Bustamante et al., 2020), the healthcare system has attempted to adapt to these demographic shifts, seeking to provide non-English speaking clients with access to healthcare services. However, the language barrier between patient and provider has been a problem for many hospitals and healthcare systems, especially in rural communities. Translation in and of itself is very difficult; finding ways to communicate words and ideas across languages and cultures takes specialized knowledge and years of training. One struggle that non-governmental organizations (NGOs) face is providing healthcare to rural communities (Maulik et al., 2015). These organizations often rely on volunteer and student-run systems that provide a range of proficiency and competence (Showstack 2019). As such, Spanish-speaking patients who need language assistance often receive inconsistent and uncertified language access services across different phases of patient care. Although research suggests that effective training in interpretive and translation services is necessary in order to improve services to patients, thus far, most research to date has been only considered in urban healthcare centers rather than rural ones (Metzger et al., 2014). This research project seeks to address the following question, *How can an NGO in a rural area more effectively train interpreters to better serve Spanish-speaking clients?* My research shows that further training is required of the interpreters and translators of a Healthcare NGO through regular assessment, training by a community member, and regular interaction with the changing rural community in which the NGO is situated. This is an important study because in many ways language has become a social determinant of health; if minority language groups are unable to communicate their needs within the healthcare system, they may be unable to receive help (White et al., 2018).

Introduction

According to the US Census, approximately 37 million people in the nation speak Spanish at home. Out of those, over 16 million speak English “less than very well” (2015). This sector of Spanish-speakers would benefit from having an interpreter during healthcare interactions. This communication gap that exists between patients and providers is typically described as a barrier that patients are responsible for bridging. However, communication is the key for healthcare providers to be able to diagnose and treat patients and thus should not be a limiting factor that discriminates certain demographics from being able to receive quality care.

In the United States, the Affordable Care Act requires that health care facilities that receive federal funds offer interpretation services to patients who have limited English proficiency (Showstack, 2019). Over the years, several different styles of interpretation have been put into practice in an attempt to meet this requirement. Most hospitals use remote human interpreting services or interpretation machines (Small, 2015). These types of interpretation include interpretation over the phone, videoconferencing, and using audio devices. However, most of these methods have some restriction that limits their ability to translate body language, tone, and cultural euphemisms that are often used to communicate within the context of patient-healthcare provider interactions (Showstack, 2019). Additionally, the mandates do not apply to NGOs, who are typically not federally funded and who may not have the ability to hire or fund interpretation services at their facility. These organizations often rely on volunteers, uncertified employees, and the patient’s family members to fill in the language gap (Showstack, 2019).

Considering rural communities in particular, healthcare NGOs are one of the few ways for rural communities to receive healthcare. As of 2020 there are approximately 57 million people living in rural communities within the United States (Duffin, 2020). Rural communities by nature have less access to resources this is mirrored in rural NGOs as well. In rural

communities, there may be a lack of translators and interpreters trained in working with diverse populations. However, since culturally embedded beliefs, practices, and expressions often depend on the linguistic, ethnic, and cultural background of the patient, translators must be equipped to navigate health-related beliefs, terms, and practices of non-English-speaking communities. For example, some Latino and Hispanic families believe in folk illnesses such as “empacho” (stomach discomfort), “susto” (panic related illness), or “mal de ojo” (evil eye) (American Academy of Pediatrics, 2020). Interpreters must understand these beliefs and practices so as to communicate them in a culturally sensitive way to the healthcare practitioner.

Another challenge that plagues rural communities is that there may be a lack of diversity within the dialects of Spanish represented by translators and interpreters. Spanish has numerous regional dialects- each with their own lexical items, expressions, and pronunciation – resulting in a working-class speaker from rural Guatemala sounding very different from an educated speaker from metropolitan Madrid. Not only is it difficult for patients in rural communities to find adequately trained Spanish-speaking interpreters and translators of any Spanish dialect, but depending on the background of the patient, it can be even more challenging to find one that can effectively communicate in the dialect he or she needs.

Even with these limitations, patients in rural communities have been found to still perceive health-related NGOs positively because “community members frequently associate [them] with the healthcare improvements” (Biermann et al., 2016). These improvements provide some of the only access to affordable healthcare that these communities receive, thus patients will accept uncertified translation because it is all that is offered. These unofficial modes of translation and interpretation services, performed by people with a wide range of language skills and medical knowledge, may result in errors in translation and interpretation, impacting the

medical services that the patient receives and potentially putting their health in jeopardy (Cohen, 2016). This disparity limits patients' ability to communicate effectively with their healthcare provider as well as the provider's ability to communicate the patient's medical options, treatments, or results. In the case that non-English speakers rely on young family members as translators -such as a child- the pressure that they face in interpreting medical information that they may not be linguistically, emotionally, or intellectually prepared to discuss may cause emotional trauma within the family (Showstack, 2019).

Statement of the Problem

Although research suggests that effective training in interpretive and translation services is necessary in order to improve services to patients, thus far, most research to date had been only considered in urban healthcare centers rather than rural ones (Metzger et al., 2014). This research project seeks to address the following question: *How can an NGO in a rural area more effectively train interpreters to better serve Spanish-speaking clients?* In this paper I will analyze what current NGOs are doing to train their interpreters and the effectiveness for both the interpreter and the patient, in order to ascertain how NGOs in rural communities can more effectively train their interpreters to better serve Spanish-speaking clients. I focus on four main topics: How NGOs function as a part of the rural communities they serve and the importance of maintaining this connection, remote human interpretation which has been used in an attempt to provide more options for resources in rural communities although it typically takes the human factor out of the equation, the essentiality of steeping interpreters and translators in cultural knowledge of the demographic they serve so that translators can be as language concordant as possible, and finally, why it is important the children, family members, and uncertified

interpreters are not used in healthcare interactions due to the psychological trauma and stress that this causes.

Linguistic Barriers to Healthcare

The importance of bridging the language gap within the healthcare context has also been studied in various International communities, but never applied to rural communities within the United States. One study done by Terui (2017) studied how language barriers present unique challenges to the development and implementation of health care practices. Specifically, she analyzes language barriers in Japan and the United States and how context determines the differences in patients' quality of care (2017). They found that disparities occur in 2 main groups: direct and indirect pathways (Terui, 2017).

Direct pathways to health disparities include an individual's normative beliefs associated with languages and language barriers that act as a stressor. Sometimes cultural backgrounds encourage behaviors known to increase the risk of illness, such as unhealthy diets, substance abuse, and harm inflicting rites of passage based on tradition (Terui, 2017). The language barrier directly influences the action of these potentially harmful barriers while simultaneously limiting one's knowledge as to the resources and care available for treatment. Another direct pathway that encourages patient health disparities is the stigma and discrimination that occur at the presence of a language barrier. These stigmatized identities that are created through social interaction restrict the target individual's ability to seek help without a large amount of psychological stress attached to every interaction (Terui, 2017).

Indirect pathways that lead to health disparities include the lack of available resources and health literacy. Health literacy is defined as the ability of an individual to obtain, process, and understand basic health information and services needed to make appropriate health

decisions. Due to the most common language in the United States for advertisements and medical education being English, this means that anyone who has less English proficiency will likely have low health literacy as well (Terui 2017). Another indirect pathway that creates health disparity is the language discordance in clinician-patient interactions. If healthcare providers are unable to access their patients' medical history due to a lack of ability to communicate accurately, those providers will not be able to diagnose and treat patients as accurately. Terui (2017, p. 218) states that "researchers reported that LEP [low English proficiency] patients have poorer understanding of instruction and medications, tend not to follow recommendation for medical treatments, fail to pay follow up visits, and are admitted to have longer or shorter hospital days."

In fact, one study explored how international NGOs in rural communities are perceived and have indicated the importance of culturally competent communication between patients and their healthcare providers. Biermann's (2016) study looked at the effect an NGO has on the community, how its health services are perceived by the rural population and how it can contribute to reducing barriers to health care. Ecuador was chosen because of its widespread poverty and lack of official governance in rural communities. The NGO collaborated closely with the public services already in place to deliver health services. Data were collected using focus groups and interviews of community members, healthcare personnel and community health workers that had links to health services. The result of this study showed that it was beneficial to work closely with systems that were already in place in rural communities so that the population perceived that the NGO positively and related it to community improvement. This closeness with the community allows the NGO to be responsible and anchored to the community that it serves

rather than its funders. However, these studies have never been applied to NGOs and healthcare systems within the United States.

Understanding NGOs in rural communities

The global rural population is approximately 3.4 billion people (Biermann et al., 2016). This fact makes it crucial to provide quality service from the NGOs already placed in these communities to aid them. Health NGOs, or NGOs focusing on strengthening healthcare services, typically focus on three core functions: delivering health services, providing capacity building, and influencing policy. NGOs play a key role in healthcare improvements in low- and middle-income countries because of their lack of connectedness to government entities (Biermann et al., 2016). NGOs also have flexible organization and require some amount of community involvement to be successful and be cost effective. Community connectedness has been found to be a predictor of health outcomes due to its key role in the physical and mental health of the individual within a community (Deitz et al., 2020). By being involved in the community, the NGO is able to connect to the community and react effectively to the direct healthcare needs. This reaction also causes the indirect improvement of the community by pooling knowledge and resources so as to further the health options of the individuals. In the same way that their community connection is a great strength, it can also be a downfall in that NGOs are restrained in their access to resources because they require regular donor support. This lack of resources can involve anything from physical goods to lack of expertise in their medical staff. This is especially true in rural communities that, by definition, already have fewer resource options (Macpac, 2018). Rural residents typically have to travel longer distances to receive healthcare services, are older, poorer, and sicker than urban residents (Macpac, 2018).

It is also important to understand what motivates translators both volunteer and professional what slows their efficiency in communication, and where they feel they are lacking in resources. Behmen et al. (2019) surveyed 176 registered volunteer translators from the Cochrane Croatia “Plain Language Summaries” translation project done in 2012. The survey aimed to find out what were the characteristics and motivation of volunteers. The survey was self-administered by lay individuals as several of the translators did not have a medical education. The results showed that most of the translators used some aid such as dictionaries, grammar books, and internet tools such as Google Translate. Most (73%) of translators stated that the primary motivation for being a part of the PLS translation project was to contribute to the community and learn new and useful information. Many of the volunteers expressed a decrease in output of translations over time and voiced that reminders, feedback, and education are interventions that should be tested to increase productivity and motivation. Further education, specifically in cultural mannerisms and phrases, like those mentioned earlier, is mentioned by several translators throughout the survey. Several studies of professional translators and volunteer translators revealed that there were indeed ways of increasing their confidence in their own translation abilities and truly improving their language/vocabulary in a target language. If translators received more feedback about translation quality, in other words were regularly certified, if they were given workshops and cultural learning tools that would enhance their experience (Behmen et al., 2019).

Remote Human Interpretation

As technology has developed and become more available, it has been applied to several fields including interpretation and translation. It began with the internet word to word translation dictionaries and moved to over the phone, videoconferencing, and translation done completely

electronically. The over-the-phone method requires the interpreters to be connected to the speaker and listener via telephone. The interpreter would translate the audio only of the interaction. The video conferencing option allows for an interpreter to see the body language of either speaker but creates an electronic barrier and is only available to places with access to Wi-Fi and devices such as computers, tablets, or smart phones. The use of audio devices that eliminate the tone and body language of the conversation and are simply the directly translated words, sometimes without the correct syntax of the target language. Clients in general prefer some sort of human involved translation because it allows for translation of all aspects of communication such as body language and tone. Likewise, Villarreal (2017) also asserts the importance of face-to-face training tested on 49 speech pathologists. Her study found that face-to-face training helped the participants feel more confident in their knowledge of the target language and helped them maintain that confidence even two months after the program had ended.

Due to the novelty of using technology and remote interpretation (such as Google Translate and video conferencing technology) in healthcare centers there are very few studies done on how they can harm patient and healthcare provider relations. However, in the short term, problems have already begun to surface. According to Metzger et al. (2014, p. 303), “There is a persistent lack of policy on reliable communication support services”. Most non-human translation services are still in their developing stages and thus create generic services that often miscommunicate ideas between patients and the healthcare system (Metzger et al., 2014). However, video remote interpreting has had higher satisfaction rates between patients and healthcare providers (Azarmina & Wallace, 2005). Korak (2010) found that patients and healthcare providers preferred video conferencing over any other mechanized interpretation

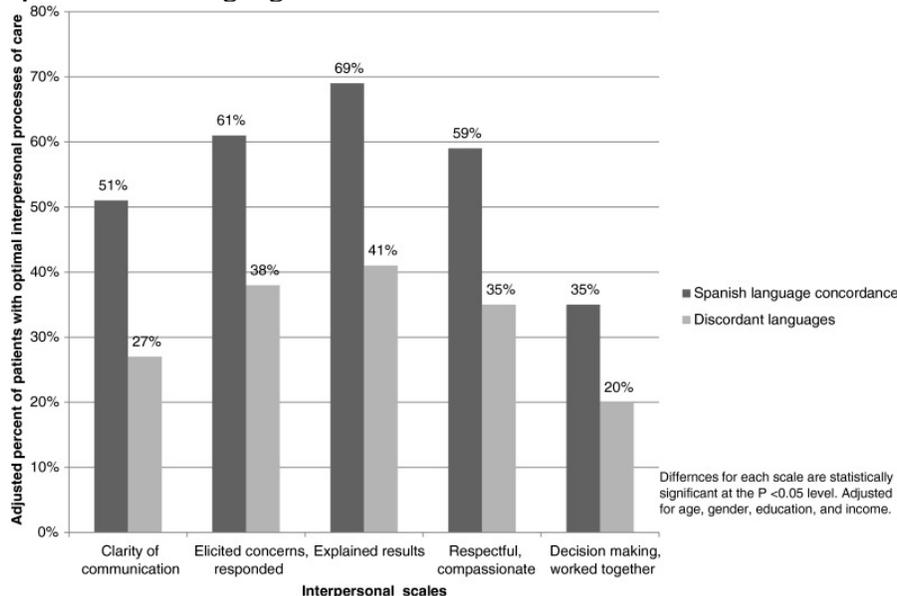
service because it provided a social presence; however, participants still expressed preference in wanting an in-person interpreter for better accountability and reliability, especially when internet and computer malfunctions became a problem. Patients often complained that the equipment created more of a barrier that further disconnects them from the healthcare provider. (Metzger et al., 2014).

Cultural training

Many of these ideas are applied only to NGOs in countries other than the US when NGOs here are in just as crucial of a need of quality translation as those who are foreign.

Another way of ensuring cultural training is through language concordant translation. Language concordance can be defined as a clinical encounter where the patient and the healthcare provider speak the same non-English language in the sense that each are fully able to express their ideas and needs verbally (Molina & Kasper, 1970). Language dis-concordant encounters can hinder the ability to communicate nuances within a language that are essential for understanding. Molina and Kasper (1970) state that “Language concordance is a particularly important foundation to gain trust, optimize health outcomes, and advance health equity in diverse patient populations”. The trust that language concordance creates is crucial in a patient’s healthcare because their health outcomes often depend on their feeling of shared goals with their healthcare provider. Language concordant interpreters act as the medium in which healthcare providers and patients can have this trust without either one having to be fluent in the other’s language. An interpreter that is able to translate tone, body language, and cultural medical beliefs has become essential to the future of healthcare. The benefits of language concordant care can be seen in the following table (Detz et al., 2014).

Figure 1
The Importance of Language/Culture Concordant Care



Understanding the language is not only understanding the word to word translation, but also understanding the cultural values. These cultural values that effect healthcare relationships range from the gender roles of a culture to their beliefs on how the body works and the way that healthcare practitioners and healers are supposed to function (American Academy of Pediatrics, 2020). This is a crucial aspect especially in the healthcare system because there may be sensitive topics or ways of discussing physical sensations that will allow practitioners to better understand the patient's condition while also being able to provide a more courteous bedside manner for patient comfortability.

Culturally focused training of interpreters and translators in the medical field has been seen to improved patients' experiences with healthcare practitioners. The improvement in communication resulting from the use of translators and interpreters allows for patients to feel more comfortable asking questions to their doctor, thus allowing them to understand their conditions and receive more effective medical advice (Detz et al., 2014) The results found in these studies are often applied to the training of interpreters and translators for healthcare

companies with international reach rather than those within the United States. However, the domestic NGOs are in just as crucial of a need of quality translation as those working overseas.

The use of children as Interpreters

For many non-English speaking families to cope with the lack of quality translation within the healthcare system children of the family are used. These children are those who attend school and can translate between Spanish and English more easily than their parents. They will typically accompany their parents to doctors appointments and checkups to help their parents navigate the healthcare system providing, to the best of their ability, accurate word for word translation. Imagine your daughter or son accompanying you to every medical appointment whether it be an annual physical, a dentist appointment, or even a gynecologist appointment.

The use of children in translation and interpretation for family members has both positive and negative outcomes. Some positives include that children feel their contribution to their family and society as whole become stronger along with their English language ability. The negative outcomes however include possible trauma and stress that affect children into adulthood. It is essential to see both outcomes when looking at this “language brokering” (Showstack, 2019). Typically, families that have their children be their translators are simply trying to accomplish the daily tasks of life and are unaware of the potential stress and trauma that it is causing (Orellana, 2009). This trauma is often referred to as vicarious trauma that is the absorption of another person’s trauma, in this case medical, that happens when the interpreters sense of identity and experience are added to by the patient’s experience (Muller & Vigor, 2013). This trauma can affect your perception of the world around you and change the way that children see their family dynamics. Anthropologists, sociolinguists, and sociocultural researchers have found that children are deeply influenced in their cognitive development, literacy skills, and

social outcomes of engagement by the everyday interactions and roles they play in their family (Orellana, 2009). This is not to say that the use of children as language brokers is all bad nor all good, but rather that it has profound effects on children. It is indeed a part of their everyday life and their function within their family, however it is not a part of their development that they get to choose, as often it is simply a necessity.

This is true especially within medical translation. Orellana notes that, “certain translation events and ways of engaging in them clearly did seem to cause stress and anxiety for some youth. Stress was increased when children felt judged by adults...and when they felt that their words could cause harm to family members” (Orellana, 2009, p. 120). Applying this to healthcare situations, where often it is pain or problems with family members that leads to a meeting with a healthcare practitioner, these situations are filled with stress and tension. Often times, especially with cultural differences, youth are relaying institutional demands to their families and having to manage their own emotions and feelings within that. This can cause major trauma and anxiety in children and is always a danger when using children to translate (Orellana, 2009). The use of children as translators is simply ethically unsound because healthcare systems are unable to ensure only positive outcomes.

Implications/ Action plan

Considering the studies analyzed in the previous sections, I now turn to the creation of an action plan that incorporates the findings of this research. Specifically, I provide recommendations for NGOs in rural communities regarding the design of their training programs for interpretation and translation. A program tested on Spanish-fluent medical and graduate students to serve as interpreters used an ESIP course design that included the following techniques. Understanding of the needs of the patient population through data collection,

requirement of a baseline test for all interpreters to be working at the healthcare NGO, regular technique training by a licensed interpreter, vocabulary review that is culturally relevant done by a member of the community, and a structure that is as interactive as possible. This will allow NGOs to understand the rural communities that they are working with so that their interpreters are language concordant with their patients. The following are the steps to attain this goal.

- **Educational Inquiry:** One way to recognize and incorporate diverse cultures into the healthcare system is through an educational inquiry, similar to those done in the education system (Levitan & Johnson, 2020). Educational inquiries require interaction, in this case between the NGO and the rural community, to put together information that will allow the NGO to better understand the demographic they are serving. This emphasizes and encourages the community oriented aspect of the NGO. The inquiry would take the form of a survey, some preliminary interviews, questions about some of the resource struggles that the members of the community may have, as well as post appointment questionnaires. This allows for community feedback, a reversal of the typical power structure for those who have limited English ability, and a chance for healthcare providers to provide diverse and accurate language services so that interpreters are language concordant and understand the struggles that those living in the rural community face. It also omits the need for children to be translators specifically in healthcare situations, which are typically stressful and can cause trauma.
- **Initial requirements of interpreters and translators:** it should be an initial requirement of all NGOs before hiring or allowing the volunteered services of a translator to pass a short, accessible, written translation exam created by the American Translation Association for use in rural NGOs. The exam should not be too extensive but mainly focus on the basics

of translation. This allows for the continued use of volunteer translation in rural communities that may not have access to highly certified translators that charge more for their services while simultaneously creating a baseline of understanding so that clients are getting the care they need. The exam should include a passage of text related to the medical field and translate it from the minority language to English. This will then allow the accessor to see what sort of errors are occurring if any and allow for better training of each individual employee.

- Next, interpreters should be required to annually log at least 100 hours (Flores et al., 2012) of interpretation training (virtual or in person) chosen by the NGO. This ensures that interpreters stay up to date with medical information as well as relevant new interpretation research. Some examples of this would be attending webinars provided by licensed interpreters, the American Translation Association, or The National Board of Certification for Medical interpreters. Virtual training would be especially accessible for rural NGOs because people are able to receive training without going long distances.
- Continued language training and culturally relevant vocabulary review for the demographic that the NGO serves. There are three possible ways in which this would work for a healthcare NGO in a rural community. Firstly, the NGO could hire a native speaker in the community to do once a month training of the interpretation staff to create a cultural base from which to work. Another option would be for the NGO to partner with a flagship university within the state to have students and professors who have had experience within the culture come and work with the NGO staff. The final option would be to hire certified interpreters from urban areas to come to the rural healthcare NGO on a weekly basis to provide training for staff and translation for the clients.

- Finally, it will be crucial for the program's success and effectiveness in the NGO to regularly reassess their interpreters' confidence in the language as well as their ability in the language compared with the initial exam and the patients' experience at the healthcare facility. This will allow for the program to remain flexible and accessible for the rural community it serves.

Conclusions

In summary, this paper has investigated the many ways in which healthcare NGOs are an integral part of rural communities but often lack the resources they need to provide quality care to their Spanish-speaking patients. The language barrier between patients and providers is the bridge that needs to be crossed in order for healthcare providers to be able to diagnose and treat patients so that no health disparities of the Spanish-speaking demographic occur. All patients need to be able to access healthcare. The lack of resources leads NGOs to use remote human interpretation or electronic interpretation and family members or noncertified translators. Remote human interpretation and electronic translation limit patients' personal connection with doctors and limit nonverbal communication such as tone and body language. The use of family members as a means of translation has the potential of causing stress and trauma to the family member and increasing tensions within the family. This paper has analyzed studies that have focused on urban populations and international rural communities and made an action plan consisting of an initial baseline assessment for all interpreters functioning at the healthcare NGO, an inquiry of the language and cultural demographic that the NGO serves, regular training of interpreters by a licensed interpreter or interpretation community, the continued review of cultural vocabulary and mannerisms by a member of the target demographic, and regular reassessment of the success of the program for the community and

interpreters to ensure the program is adaptable for each NGO. This will ensure success in the effective training of healthcare interpreters that serve Spanish-speaking communities in rural communities.

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