

Training medical interpreters for Eritrean asylum seekers in Israel:

Preliminary notes and observations

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Graduation, September 2014

Introduction

In May 2014, Israel's first medical interpreting course for Tigrinya- and English-speaking asylum seekers commenced. Besides being unique and inspiring, the course challenged not only the organizers and the participants, but also the Israeli medical establishment, civil society, and policy-makers at large. In this article, we share some of our main insights following the course.

Israel's geographic, cultural, and religious characteristics make it an immigrant country, both to Jewish newcomers and non-Jewish migrants. In addition, it is home to some indigenous minorities, the largest being the Israeli-Arab and the (Jewish) ultra-Orthodox communities. In light of this, one could expect a policy and practice of language services for the many language minorities, aimed at helping them consume the vital services, e.g. health, law enforcement, welfare, and education. In reality, awareness of the need for institutionalized, professional language services is only beginning. When Africans seeking work began entering Israel in the early 1990s, and more so since 2006, when the first Africans seeking asylum arrived, they too inevitably encountered this challenging reality, which compelled them to face enormous language and cultural barriers. Moreover, the inhospitable political situation surrounding their entry discourages state actions to establish language services.

In an attempt to minimize the language and cultural gaps asylum seekers face in their encounter with the Israeli health care system, a joint initiative of scholars and one of Israel's largest public hospitals led to the opening of the first medical interpreting course for Tigrinya and English speakers. The trained interpreters, it was hoped, would then assist their community members in their encounters with the Israeli health system and may even be employed by hospitals or clinics. This article describes the unique features of the course, and analyzes the complexities of the training and its aftermath. It will begin with a brief socio-political background to the phenomenon of African asylum seekers in Israel.

African asylum seekers in Israel: Socio-historical background

Between 2006 and 2012 — first in a trickle, later in large numbers — 64,638 African men, women, and children entered Israel by crossing its long, permeable border with Egypt in quest of asylum. The first to arrive were mainly from Sudan, both its southern and western (Darfur) regions. At the beginning, most of them were apprehended by Israeli soldiers and incarcerated for some months, later to be released with no clear policies regarding work and habitation. Following their release, most opted to go to Tel Aviv, where they found cheap housing and work.

The increasing violence in both Sudan and Eritrea spread, along with reports that it was indeed possible to enter Israel via its porous border, and the numbers of those entering seeking asylum rapidly increased from 2,813 in 2006 to 5,382 in 2007, and 9,142 in 2010.¹ Although the first to enter were from Sudan, since 2007, 66% of those seeking asylum are Eritreans,² some of whom had already lived as refugees, mainly in Khartoum and Cairo, while others arrived directly via the Sinai desert.³ Local and international aid organization estimates suggest that 50% of those arriving via Sinai have suffered severe violence at the hands of the local Bedouin, as well as having been compelled to pay up to \$50,000 in ransom for their release from torture camps where they were kept prisoner before being smuggled into Israel.

By 2007, it became clear that Israel was facing a mass phenomenon, and various attempts to classify those crossing its southern borders were made, using terms such as “survivors of the Darfur genocide”, “refugees”, “asylum seekers”, “labor migrants”, and even “infiltrators seeking a better life”. The unexpectedly large wave of non-Jewish asylum seekers challenged Israel’s under-resourced asylum procedures and lack of legislation to enable implementation of its obligations under the United Nations Refugee Convention of 1951, resulting in an enormous backlog in asylum applications.⁴ Meanwhile, many African migrants remained without clear status, and consequently had limited access to health care and welfare services.

A successful court appeal in 2007 by Israeli and refugee-founded NGOs against the Prevention of Infiltration Law meant that Israel no longer subjects border crossers to indefinite and unreviewable detention. Yet, as the numbers of those

¹Population, Immigration and Borders Authority, “Foreigners’ Data in Israel, summary for 2014,” February 2015. (Hebrew). Accessible at:

http://www.piba.gov.il/PublicationAndTender/ForeignWorkersStat/Documents/sum2014_final.pdf

² Ibid.

³ Since the outbreak of the second Sudanese civil war in 1983, which displaced some 4 million Southern Sudanese and left nearly two million dead, Egypt has been host to a large Sudanese population. The struggle between the government in Khartoum and the Sudan People’s Liberation Movement/Army (SPLM/SPLA) formally ended with the Comprehensive Peace Agreement in January 2005. Since 2003, however, a separate conflict in Darfur, Western Sudan, has killed 300,000 people and displaced 2.7 million.

⁴ In his annual report, submitted to the Knesset on 20 May 2008, the Israeli State Comptroller revealed that Israeli authorities have recognized only 11 out of 909 asylum applicants in 2005 as refugees; 6 out of 1,348 applicants in 2006; and 3 out of over 3,000 applicants in the first nine months of 2007. The Comptroller’s report stated that officials took six months to reject asylum seekers and almost three years to decide cases deemed worthy of adjudication. See: *State Comptroller Annual Report*. Jerusalem: Israeli Parliament Press, May 2008.

entering doubled, Israel decided in 2007 not to deal with individual requests for asylum (as required by the UN), but rather granted all Eritreans and Sudanese collective protection, which provided them only temporary protection from deportation, with no other rights.⁵

Number of Africans entering Israel via its southern border seeking asylum⁶

2006	2007	2008	2009	2010	2011	2012	2013	Total entry	Total in the country as of 2013
2,813	5,382	9,142	5,305	14,747	16,851	10,365	15	64,638	55,195

As the numbers of those seeking asylum kept rising, prevention of their entry became one of the government’s main missions. Indeed, by 2013, the flow of asylum seekers practically halted, mainly due to the completion of a fence on the Israeli-Egyptian border, the amendment to the Prevention of Infiltration Law, and the declaration of a policy to incarcerate African asylum seekers for years in *Holót* detention facility.

The constantly changing in regulations concerning asylum seekers, alongside daily new procedures, makes it practically impossible for asylum seekers to plan their lives or even just to live day to day. In other words, fragility and uncertainty become the dominant features of the lives of asylum seekers in Israel.

The Eritreans in Israel

As the medical interpreters’ course was designated for Eritreans, we shall focus our socio-political background on them. Note that Eritrea is considered by the UN and all Western countries to be one of the most abusive and violent regimes.⁷ President Isaias Aferweki is described as totalitarian, following a Maoist ideology and principles of self-reliance (Hirt 2013). Eritrea’s regime is considered a highly totalitarian personal rule, with a militarized society that systematically crushes any autonomous public spheres of debate or action. In 2002, Eritrea extended its

⁵ This status must be renewed every three months (Gilad 2010).

⁶ For details see: Government of Israel, Interior Ministry, Population, Immigration and Borders Authority, “Foreigners’ Data in Israel, summary for 2014,” February 2015. (Hebrew). Accessible at: http://www.piba.gov.il/PublicationAndTender/ForeignWorkersStat/Documents/sum2014_final.pdf

⁷ [UN Human Rights High Commissioner](http://www.unhcr.org/refugees/UN-Human-Rights-High-Commissioner)

compulsory military duty to all Eritreans for an indefinite duration. This duty includes six months of military training followed by forced labor in construction projects (Hirt 2013, Hirt and Abdulkader 2013). Since mid-2012, all Eritrean men between the ages of 50 and 70 are compelled to perform militia duty with no duration limit⁸. All this led to high rates of Eritreans fleeing their country.⁹

As aforementioned, in 2013 there were 36,436 Eritreans seeking asylum in Israel, 7,000 of them women,¹⁰ the vast majority 20-35 years old, most from Senafe and environs, Asmara, and the Gash-Barka region in the west¹¹. The majority are Christian and belong to the country's largest ethnic group, the Tigrinya.¹² Most reside in Tel Aviv, though some reside in Jerusalem, Ashdod, Arad, and Eilat. In Tel Aviv they are mostly concentrated in the southern, run-down neighborhoods.¹³ A small number are self-employed, while the majority work in menial jobs in hotels, catering and cleaning services, and restaurants¹⁴.

Similar to migrants around the world, most Eritreans are healthy and consume minimal health services. On the other hand, this population underwent persecution and imprisonment, and some still have physical injuries. Some were tortured and suffered horrific abuses on their journey to Israel, resulting in high prevalence of PTSD, depressive and adjustment disorders. Against the backdrop of this complex and fragile reality, we held our unique professional course offered to Eritreans in Israel.

An acute need: Unwelcome immigration with limited health services

While based on "justice, equality, and mutual aid", the 1995 Israeli Health Insurance Act applies solely to Israeli habitants and not to the foreign communities in Israel, including asylum seekers. Though legally required, many were not insured by their employers, regarding their legal obligations to provide health insurance, or

⁸ [Human Rights Watch World Report, 2014](#)

⁹ According to the UNHCR, over 305,000 Eritreans (about 5% of Eritrea's population) have fled during the past decade. [ibid.](#)

¹⁰ Population, Immigration and Borders Authority, "Foreigners' Data in Israel, summary for 2014," February 2015. (Hebrew). Accessible at:

http://www.piba.gov.il/PublicationAndTender/ForeignWorkersStat/Documents/sum2014_final.pdf

¹¹ Terdman Moshe, the issue of "refugees" from Darfur and Eritrea: the Interviewer's perspective," in Sofer Arnon, ed. Refugees or Migrant laborers, Haifa University Publication, 2009 (Hebrew)

¹² Though some are Tigre, Afar, Bilen, and Rashaida.

¹³ Gilad Natan, 2011. The effect of non-documented migrant workers on the Israeli labor market. Israeli Knesset, Research and Information Center, January 16th.

¹⁴ *ibid.*

because they did not work full time. Therefore, most asylum seekers are uninsured and rely upon the Patients' Rights Act (1996), which grants them access to emergency services only. They receive treatment in emergency situations in public hospitals' ERs, and in most cases the treatment costs become a lost debt for the hospital¹⁵. In some situations, asylum seekers arrive at hospitals in severe medical conditions that could have been avoided had they received prior medical care. Others arrive at ERs with non-emergency situations that would ordinarily be treated on an outpatient basis had they access to community medicine. Needless to say, treatment of chronic illnesses and severe diseases is very limited. Both situations increase the already overextended workload in the ERs, in the latter case evincing frustration and angry responses on the part of staff, who do not understand why a patient shows up at the ER with a minor medical problem.

Another common phenomenon is pregnant women who show up at ER without having received any prenatal care or screening for infectious diseases (e.g. HIV, syphilis and hepatitis). The medical staff unjustly fears contamination, and that fear, together with cultural and language gaps, adds to the already-high tension in the delivery rooms.

It is clear that if primary healthcare services were available to non-insured people, the number of patients arriving to the ERs would significantly drop, as well as the number of those who arrive to the hospital in a severe or complicated condition due to lack of preventive and / or follow-up care. As a last resort, community medicine services are available either for those few migrants whose employers provide them with private insurance, or through the two mainly volunteer-staffed clinics in Tel Aviv run by Physicians for Human Rights and by Tèrem, the Ministry of Health's public clinic.

Israel being a country of immigrants notwithstanding, Tigrinya, the language spoken by most of the 45,000 Eritrean asylum seekers, is hardly spoken outside of the asylum seeker community. This barrier exacerbates the difficult aforementioned conditions: lack of health insurance and hardly any health rights, substandard living conditions, high levels of stress due to state-orchestrated inhospitable policies,

¹⁵ In 2010, Sourasky Hospital alone reported lost debts totaling over \$5 million resulting from treatment of patients with no legal status.

differing health concepts, and hardly any knowledge of Western health practices and the Israeli system.

Hence, growing calls indicating the acute need of trained medical interpreters in Tigrinya led the authors to initiate the first course for medical interpreters enrolling 21 Eritrean men and women, all themselves asylum seekers. The first author, head of the African Studies Department in Tel Aviv University, and the third author, an oncologist at Sheba Hospital who established the Social Clinic (a clinic for cancer care for uninsured patients) therein, were the initiators, and soon were joined by the second author, who has expertise in medical interpreting training. Their initiative obtained the support of the Social Clinic at Sheba Medical Center and the African Studies program at Tel Aviv University. Additional financial support was provided by the United Nations High Commissioner for Refugees (UNHCR).

Language barriers and their effects on health care

It is well known that in medical services worldwide, obstacles arise due to miscommunication between patients and medical personnel. Obviously, cultural gaps, fears, and basic misunderstandings cause further misery to patients who are members of linguistic minorities, as well as to the medical staff. In medicine in particular, mutual understanding is critical to ensure a correct diagnosis, cooperation with treatment recommendations, and satisfaction of patient and provider.

Research shows that language barriers to health care create disparity in access to services, jeopardize the patient's health and welfare, and cost the health care system more (Goldman et al., 2006; Hampers and McNulty, 2002; 1999; James et al., 2005). Furthermore, the use of family members, friends, or untrained staff as ad hoc interpreters may result in additions, omissions, or alterations of the message, unbeknownst to any of the participants (Flores et al., 1999). Only when the intended recipient of the interpreted message responds to it as if s/he heard it in her own language, can care barriers be minimized. Therefore, only the use of trained medical interpreters¹⁶ can assure effective communication between patient and provider.

Extensive research shows that medical interpreters establish effective communication and cross-cultural understanding between a health care provider and a patient (and/or her family) who do not share the same language. The medical

¹⁶ Interpreting refers to oral conversion of messages between two languages, in contrast to translation, which refers to the written form. Usually, medical interpreters do not perform translation work.

interpreter's responsibility is to ensure seamless communication between two parties of differing languages and cultures. Professional interpreters are trained bilinguals who work as per shared standards of practice, and adhere to ethical rules such as accuracy, impartiality, and confidentiality (International Medical Interpreters Association Code of Ethics).

Language access to healthcare services in Israel

Given the many linguistic and cultural communities in Israel, it may be surprising that the impact of linguistic and cultural aspects on healthcare has been acknowledged only in recent years. This lack of recognition is influenced by social, economic, and political factors (Schuster, 2009). The use of language access tools in healthcare, such as interpreting services, professional translators, or multilingual signage, was not institutionalized until February 2011, when the Ministry of Health issued requirements for linguistically and culturally accessible services. Until then, the only basis for interpreting in healthcare settings appeared in the Patient's Rights Act of 1996, which states the providers' obligation to provide medical information "in a manner that maximizes the ability of the patient to understand the information and to make a free and independent choice [thereon]," aimed at enabling informed consent to medical care (section 4, clause 13C). Consequently, institutionalized language services are rare, and in most cases patients and providers rely on broken communication or the aid of non-professional interpreters (Shlesinger, 2008).

A directive issued by the director of the Health Ministry in 2011 requires HMOs to provide culturally and linguistically accessible services. However, this requirement is mainly upheld regarding Israel's native and Jewish minorities, and not in the cases of migrant workers or asylum seekers. Hence, language services through face-to-face or remote (telephone) interpreters are not available for the speakers of the African languages, including Tigrinya.

The training course for medical interpreters

Within this complex reality, the formal objectives of our course were to teach its students how to help patients and workers of the health system to communicate effectively, ensuring appropriate medical care. As newcomers from a traditional society, low-resource medical system, and non-democratic regime, we assumed both the patients and the interpreters to be unfamiliar with some of the most basic

legal and ethical health rights, as well as with the structure of the Israeli medical system, so, in addition to basic science, professional terms, and interpretation skills, the trainees were taught basic knowledge of the Israeli medical system and patients' rights. Those completing the course were presented with a diploma from the organizers, and outstanding graduates were given assistance in finding work in one of the local medical facilities in Israel.

Recruitment of participants first began using a key informer in the community followed by a short notice in both English and Tigrinya posted on various websites and social networks. Notices were also hung on notice boards in several locations where asylum seekers gather. The notice began with the questions: "Do you have good communication skills? Are you interested in helping other members of the community when they need to visit a hospital or a clinic? Want to learn a new and important skill? Join a Medical Interpreters Course." Though much effort was invested in the publicizing of the course, most participants were ultimately recruited by the key informers, i.e., leading Eritrean and Israeli activists who encouraged Eritreans whom they believed were qualified to enrol. All candidates had to demonstrate a fairly good mastery of either English or Hebrew. Interviews were held between January and February 2014 at a public clinic operated by the Israeli Health Ministry in the bus station in south Tel Aviv, a locale accessible to those living both in Tel Aviv or elsewhere. Thirteen face-to-face interviews were conducted, in addition to three phone interviews. Two candidates were not accepted due to unsatisfactory language skills. Two candidates who were accepted chose not to attend due to work obligations. Five candidates began the course without a formal interview after being referred last minute with solid recommendations regarding their competency.

The course included 70 instructional hours: 60 classroom hours, and 10 hours of practicum. It was one of the largest medical interpreters' training courses in Israel so far (even compared to courses for Israeli bilinguals) and was certainly unique in many senses. The training included the following subjects:

- Structure and function of the Israeli medical system, health rights, and financial issues
- A tour of a hospital to enable understanding of common functions and procedures

- Basic human anatomy and physiology
- Physician-patient interview and communication
- Common medical issues and their treatments, medical procedures
- Concepts of translation (written) and interpreting (oral)
- Techniques of consecutive interpreting
- Best practices and ethical principles of medical interpreting
- Medical terminology in English/Hebrew and Tigrinya
- The emotional and psychological aspects of the interpreter's work
- Intercultural issues in the medical setting
- The 15 class sessions (4 hours each) took place in Sheba Tel Hashomer hospital, Israel's largest health center. The instructional methods used included lecture, exercises, role-playing, and group discussion. A final exam was administered, consisting of three parts: medical terminology, health care-related questions, and interpretation-related questions. The exam was available in English and Hebrew, upon the participants' requests.

Of the 16 participants taking the exam, some were already working as interpreters, either as a designated role or as part of their other job responsibilities. These students had to submit a report on their experiences in interpreting assignments, and relate them to the contents of the course. Those without prior experience performed 10 hours of practical training in interpreting in a medical setting: a clinic for infectious diseases, two primary care clinics, a mother and child clinic, a center for refugee assistance in Jerusalem, and a public hospital.

Five students did not complete the training: one was summoned to Holot detention center, one found a job and a third (who already works as an interpreter) decided to withdraw for personal reasons. Another participant received a visa to Norway (but eventually did not go there) and one student felt he will not pass the exam. This shows, again, the complex conditions and limitations that the students had to deal with, alongside the training.

The graduation ceremony, which took place at Tel Aviv University, was an exciting moment for the participants, their friends and family members who came to honor both they and the instructors.

Studying within extremely challenging conditions

The participants took the course under nearly impossible personal and political conditions. Their status is uncertain, as is their employment and personal welfare. One of our first observations was that almost all participants requested various medical tests, mainly blood tests or chest x-rays, throughout the training itself. All such requests were attended to by the third author. It was clear to us that for most of them, this was the first time they had undergone a medical test in years.

Another main observation was the participants' use of the course setup as an arena to raise and confront medical problems of their loved ones: R's girlfriend had some disturbing symptoms, and was examined in the Social Clinic. After some advanced and costly tests, she was diagnosed with a chronic ear infection that required surgery, but is not life threatening. T, 23, a single parent of two small children, had to care for them after they were diagnosed with ringworm of the scalp. They were isolated for a month at home, denied access to the day care (even within the hospital where the training was held), and since T had to quit her job, she received assistance paying her rent. She took the final exam and failed, but did not show up for a second attempt, even though it was offered to her. R, 20, was one of the most advanced students in the course, with excellent Hebrew and English that she acquired in an Israeli school. She already worked as an interpreter in a hospital, and was an outstanding student. At home, she had to face one of many suicide attempts by her mother, now in her 30's, who had given birth to R at age 14. R still works as an interpreter and a translator.

As the course took place, the Israeli government increased the number of asylum seekers who were summoned to Holót detention facility. Hence, stress levels amongst all asylum seekers in Israel rose, making it unavoidable that it entered the classroom along with the students. One student, F, 36, with a disability in his arm, received a summons to Holót. He appealed it in court, and one his arguments was the fact that he was undergoing this unique professional training. His claim was backed by our official letter stating that in addition to being in training, and emphasizing F's key role as a volunteer in the healthcare system. Z, 24, who studied

psychology in Eritrea, was admitted to a university in the US. He thought that this meant his leaving Israel immediately, and discontinued the course. His hopes were shattered when he did not receive a student visa. Z rejoined the course and graduated with excellent grades. Z is still in Israel and works as an interpreter in mental health clinic as well as freelances for a translation agency. K, 27, was one of the leaders of the asylum seekers' protest. He did not attend the course in the beginning due to his political activities. Later he had to part from his pregnant wife of Dutch origin, who feared that their newborn baby would not receive a birth certificate (as is the case with newborns of asylum seekers). Only when his daughter was two months old did K receive a laissez-passer, with which he went to England to reunite with his family. F, 29, was another leading figure in the asylum seekers' protest. He was arrested twice during the course, missed some classes, and received private instruction. He received excellent scores on the final exam.

Despite these unimaginable conditions, the students found a way to take the course and to make the best of it despite their fragile status: They took the opportunity to enhance their intellectual capital, realizing that it would help them whether they remain in Israel or not. Following are some quotes:

“Five years ago I took a short Hebrew course. The situation was bad even back then, and we had visas for two months. But I went to study and people were surprised. I told them, ‘Even if they deport me, this is something I will take with me.’

People wonder why I invest time in the course, and not in my work, in changing the situation, or in leaving the country. I tell them we can do both. Now people see this as a great chance, they have expectations. This is a great chance, a key to what will happen in the future.”

Having learned about medical interpreting as a profession, the graduates now know that it is a growing professional realm, and therefore the training will help them wherever they end up. Taking the course was also considered a step toward self-advancement and empowerment, as one participant, a young mother of two, stated:

“I feel good. I can start [working again]. It's been a long time since I sat, studied, thought. It's exciting to do that again. So far, I only took care of my

kids. Now I start thinking of the future, what's good and suitable for me, and not what others tell me.”

The participants see themselves as cultural liaisons between the Eritrean patients and the Israeli medical system, and they now appear to feel more confident and assured in this role. They would all like to further their education in the health field, as well as in language and interpreting skills. This result demonstrates that medical interpreting is not only a profession that requires continued training, but that the course opened a door to personal and educational development overall. This concept is not taken for granted by those whose legal, social, and personal status is still so fragile.

Impressions of the trainers

For the trainers, the task was challenging yet very rewarding. The teaching experience was better than in other classes we taught: The students were attentive and interested, actively participated, and kept asking questions. They maintained class etiquette (turned off phones, hardly any tardiness, etc.) and their respect for the course and the instructor was apparent.

On the professional level, the curriculum was formulated from scratch, with no specialized teachers or materials. We purchased some materials from abroad, and tried to adapt them to our needs. Our Tigrinya teacher had to prepare to teach medical terminology, since he did not have any experience therein. We had to consider how cultural concepts regarding health, illness, and the Israeli medical system affect provider-patient-interpreter communication.

Otherwise, the modules were similar to standard training in the US and Canada. We wanted to deliver quality training that would enable the students to work as interpreters not only in Israel, but elsewhere in the event that they do not remain here.

The differing education and language levels, as well as the participants' varied medical backgrounds, required flexibility in our teaching methods and in the transmission of the material. Some students received private instruction outside the class sessions, while others received materials in two languages (Hebrew and English) – mainly the younger students whose spoken Hebrew is better than their English.

Beyond the pedagogical challenges, the unique personal and social situations of the participants rendered it impossible to limit ourselves to training only. We listened and helped as much as we could with their personal, health, and legal issues. The second and third authors occasionally felt that they filled more than one role: They were the instructor and course coordinator, but also very much involved in their students' lives and their legal, medical, and personal problems. All the authors felt deeply involved in and committed to the students' success. At the graduation ceremony, they felt as if their own children were graduating.

We believed in the participants' skills and strengths, and in the power this training could give them. While there is much more to be done to improve the conditions of the Eritrean community in Israel, we hope that the training is a small step in granting them access to vital human services.