12971683

Request # 12971683

FEB 03, 2004

Ariel To: 162.129.60.21

Johns Hopkins University
William H Welch Medical Library
1900 East Monument Street
Baltimore, MD 21205-2113

2/3/04

DOCLINE: Journal Copy Epayment

Title:	Prehospital and disaster medicine : the official journal of the National Association of EMS Physici
Title Abbrev:	Prehospital Disaster Med
Citation:	2001 Oct-Dec;16(4):252-6
Article:	Communicating across cultures: improving translati
Author:	Bolton P; Weiss W
NLM Unique ID:	8918173 Verify: PubMed
PubMed UI:	12090206
ISSN:	1049-023X (Print)
Publisher:	Jems Pub. Co., [Solana Beach, CA] :
Copyright:	Copyright Compliance Guidelines
Authorization:	EMP
Need By:	N/A
Maximum Cost:	**$25.00**
Patron Name:	bOLTON, pAUL - tn: 270038
Referral Reason:	Other
Library Groups:	RESOURCE,EFTS
Phone:	1.410.955-3418
Fax:	1.410.955-8020
Comments:	**FOR ARIEL REQUESTS, PLEASE: 1 ARTICLE PER TRANSMISSION**
Routing Reason:	Routed to DCUGWU in Serial Routing - cell 2
Received:	Feb 03, 2004 (01:59 PM EST)
Lender:	George Washington University Medical Center/ Washington/ DC USA (DCUGWU)

This material may be protected by copyright law (TITLE 17,U.S. CODE)

Bill to: MDUJHU

Johns Hopkins University
William H Welch Medical Library
1900 East Monument Street
Baltimore, MD 21205-2113

Communicating Across Cultures: Improving Translation to Improve Complex Emergency Program Effectiveness

Paul A. Bolton, MB, BS; William M. Weiss, BSc

Center for International Emergency, Disaster and Refugee Studies, The Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland USA

Correspondence:
Paul Bolton
45 Gilson Road
Scituate, MA 02066 USA
E-mail: pbolton@jhsph.edu

Keywords: complex human emergencies; cross-cultural; disasters; ethnographic methods; qualitative methods; translation

Abbreviations:
CE = complex emergencies

Abstract
Translation is a vital activity in Complex Emergencies (CEs) in which the responders and the affected populations do not share the same language or culture. This particularly applies to CEs in developing countries in which a lack of local resources usually results in the importation of foreign aid workers. This paper describes many of the common issues surrounding translation that can affect CE response effectiveness, issues that frequently are not appreciated by aid workers, including clinicians. The authors describe how these issues can arise, their effects, and outline approaches to addressing them.

Bolton PA; William M Weiss WM: Communicating across cultures: Improving translation to improve complex emergency program effectiveness. *Prehosp Disast Med* 2001;16(4):252–256.

Introduction

Most Complex Emergencies (CEs) occur in developing countries that encompass a wide variety of cultures. The lack of preparedness and poverty inherent in many of these areas result in more severe effects than would be experienced during disasters in developed countries. The enhanced need—coupled with a limited response capacity—often results in the temporary importation of clinicians and aid workers from other cultures, particularly during the acute response phase.

These outside workers rely on local translators and interpreters to communicate with those affected by the disaster. Usually no other resources are used to bridge the gap in understanding between those providing assistance and those receiving it. In this article, the reasons this single resource, as it is currently used, is insufficient for cross-cultural communication is explored along with the problems that can result (and have) when mistranslation occurs. The article also outlines a set of principles and approaches that relief workers can use to recognize and address this problem, and directs the reader to several resources that they can consult for further information. Only those aspects of misunderstanding or miscommunication related to poor translation are covered.

Causes of Poor Translation

Every instance in which an aid worker deals with an individual affected by a CE is a meeting between two experts. The aid worker brings all the knowledge and experience of his/her profession to the interaction. The affected person brings all of her/his respective knowledge and experience of her/his own situation. In most relief programs, the only means of communication between these respective experts are translators of varying ability who are not experts in humanitarian assistance or even in the plight of most local people. This section describes some of the issues that affect this interaction and reduce the accuracy of translation, as well as suggestions for improvement.

The most common causes of inaccurate translation include: 1) some

words and concepts are not directly translatable; 2) translators vary in their level of expertise; 3) when translators have difficulty, whether due to incompatibility of concepts or their own limitations, they are unlikely to admit problems; 4) persons who can translate are different from most of the community; 5) translators may misunderstand (and may abuse) their role; 6) translators may be intimidating to the person being interviewed; and 7) unrealistic expectations. Each of these causes is discussed below.

1. Some Words and Concepts Are Not Directly Translatable
This is particularly true for many diseases. People in other cultures often group symptoms into syndromes that are different from the disease descriptions used in western countries. This can mean that there is no close local equivalent for some clinical diseases. For example, in western Angola, the authors found that the local population did not recognize malaria or pneumonia as distinct illnesses, even though trained health workers working in the area knew that both were common. Villagers recognized all of the symptoms of these diseases, but combined them into very different syndromes based not on apparent causation but on the perceived frequency with which symptoms occur together. The closest equivalent to malaria was Cachomba, which is characterized by fever, anemia, a large spleen, and difficulty breathing. Cachomba is said to occur only in children ≤3 years of age; >3 years of age there is no equivalent syndrome. In the case of pneumonia, the situation even is more difficult, since rapid breathing and fever are common accompaniments to many illnesses, including Cachomba. Hence, local people did not recognize pneumonia symptoms as a separate illness, but considered them as elements of many illnesses, including minor disorders.

Clearly, aid workers should not refer to malaria or pneumonia among this population. If they do, translators will be forced to choose the closest alternative; and this alternative may be inaccurate and may vary between translators according to their understandings of what the aid worker is trying to say.

Aid workers can address this issue (and reduce the pressure on translators) by learning the local words for important concepts. This includes understanding of how these concepts differ from the worker's own ideas. In the case of clinical medicine, this means learning how people understand the health problems affecting them—the local names of diseases, their major symptoms, and perceived causes. Then, clinicians should select the local syndrome(s) most similar to the diseases affecting local people, and use these terms when communicating through a translator. In this way, the clinician and translator always will be using the same term, and there will be no confusion between the clinician, translator, and local people about what it is they are talking about.

This information on local perceptions comes from short ethnographic interviews by trained local aid workers. Ethnographic methods are used because they emphasize the use of open-ended questions and not leading the respondent. This is important particularly during humanitarian relief operations, in which those affected by the disaster are trying to determine which answers will result in more assistance.[1] Therefore, interviews not based on ethnographic methods are likely to be influenced by leads provided by the interviewer and not really reflect local thinking.

There is a wide variety of ethnographic interviewing methods. The steps that can be used for learning about local syndromes through the use of ethnographic interviews consist of free listing, composite listing, and key informant interviews. For rapid assessments in CEs, the authors usually begin with free listing. In this method, interviewers ask a standard question that is answered in the form of a list. For example, a free list question could be: "What problems hurt children in this community?" All interviewers ask the same question and record all responses in the interviewee's own words (hence, data collection is done best in the local language). After probing to create as extensive a list as possible, the interviewer then asks for a brief description of each response, which is recorded similarly using the interviewee's own words. At least 10 persons are interviewed, and the results collapsed into a composite list. Those responses that are of interest to the aid worker—for example, health problems in the case of clinical aid workers—then are used as the basis for the more extensive key informant interviews. These are in-depth interviews with persons known to be knowledgeable about these issues, such as traditional healers in the case of health issues. These interviews provide detailed information on the relevant local concepts identified in the free lists, such as (in the case of health) knowledge about the symptoms, their perceived causes, and treatments of local illnesses.

These two methods usually are sufficient for learning about local syndromes. They require 2–4 days, depending on the number of interviewers and the variation in responses (greater variation requires more interviews to understand the reasons for the variation). It is not possible here to give more than an overview of these methods, or to discuss the approaches to selecting interviewees, validating responses, and analyzing data. Further information on the use of these methods is available.[2,3]

This approach has the additional advantage of providing information that aid workers can use to make their interventions culturally more appropriate, and therefore, more acceptable to local people. This means not only describing disease in terms of local syndromes, it also refers to avoiding descriptions of causes or treatments that contradict the beliefs of local people. Such contradiction is rarely productive. Even in long-term aid projects lasting years, it is very difficult to change local perceptions. During the acute phase of a CE, it almost is impossible. The result of insisting on a 'western' viewpoint usually is rejection by local people of advice that contradicts local thinking.

2. Translators Vary in Their Level of Expertise
A translator's lack of expertise in the aid worker's own language is readily apparent to the aid worker. Less obvious is a translator's limited proficiency in the language of the affected population. This at most is an issue in areas where several languages are spoken, a common situation in much of the world. Translators and members of the affected population may have varying proficiency in local

languages that are not their "mother tongue". Both may profess ability to speak these languages well, even when that ability is limited to specific topics; for example, common topics of conversation or of the marketplace. When confronted with a translator with limited proficiency in their language, local people may attempt to use the translator's first language (or the translator may insist on using it), resulting in problems of varying proficiency among the respondents.

The approach described previously (understanding and using the local terms for important concepts) is equally important here. Variations in the language proficiency of the translator will have less of an impact when translators do not have to search for local equivalents to key Western concepts. Additional approaches include: 1) using translators only for translation of their mother tongue; 2) using two translators working together in the same interview; and 3) having a trusted translator check the competency of other translators before they are employed.

3. *When Translators Have Difficulty, Whether Due to Incompatibility of Concepts or Their Own Limitations, They Are Unlikely to Admit Problems*

Translators often are paid more than they make doing other jobs. In the midst of a CE, they also may be one of the few local people with a job, and may be the only person supporting an extended family. They are unlikely to admit difficulty in translating if they believe that this would put their job at risk. When faced with a term they find difficult to translate, they may not admit a problem, but instead, choose the term nearest in meaning, even if that term is not particularly close. In cases in which the term cannot be translated directly, different translators may opt for different local terms, resulting in apparent inconsistencies in interviewee responses.

Translators must be encouraged to admit when terms are not directly translatable or where they do not know the correct word. This usually requires reassurance that the translator's job is not under threat. Also helpful is a personal relationship between the translator and aid worker that emerges over time. Having two translators work together also is useful to support contentions by either translator that a term is not directly translatable, and to assist in finding a suitable alternative.

4. *Persons Who Can Translate Are Different from Most of the Community*

Local people who can speak a foreign language usually are better educated than are most of the community, and often are from a higher socioeconomic class. They frequently come from other parts of the country, or they come from the affected area, but have spent time away. For any and all of these reasons, their use of language is likely to be different from most of the affected population, many of whom will be poor (as evidenced by the fact that they live in an area subject to CEs). Frequently, the translators themselves do not realize the extent of this difference. This raises a quandary when choosing a translator: translators with greater English skills (the authors primarily speak English) frequently are better educated and differ in many ways from most of the local population, while translators who are similar to the local population frequently are less skilled in English.

As with the previous issues, we can reduce the impact of the translators by using ethnographic methods to learn concepts and word use directly from the community (rather than the translators). As a general rule in hiring, we prefer local people with adequate English over outsiders with excellent English.

5. *Translators May Misunderstand (and May Abuse) Their Role*

Translators often attempt to do more than provide a literal translation of what is being said. They often summarize or filter out statements they believe are not of interest to the aid worker. Those with more than an average education or experience may be embarrassed by the statements and beliefs of their fellow countrymen, and may not translate them accurately. Since the translator may lack expertise in humanitarian assistance and health, much of this summarization and filtering is inappropriate and important information may be lost.

Translators may purposively ignore or mistranslate statements by those outside of their group, when those statements threaten their group's interests. For example, conflicts of interest have emerged in past relief projects in which members of one ethnic or social group have felt that another group was unfairly advantaged in receiving aid. If the translator who must convey these complaints is from the second group, s/he may feel pressure to downplay these complaints to the aid worker.

Like other workers, translators require not only careful selection, but also orientation and training. This includes those who previously have been employed as translators. Training must include emphasis on providing verbatim translation as much as possible, and should include specific warnings against summarizing or filtering out comments they do not consider important. Instructions to translate no more than two sentences at a time can help to improve translation accuracy. Where inaccuracy still is suspected or there is a possible conflict of interest, a second translator (preferably from a different group than the first) can be asked to replace or work with the first.

6. *Translators May Be Intimidating to The Person Being Interviewed*

This may be because of their relative positions in the community, their gender, politics, ethnicity, or because of judgmental attitudes displayed by the translator. The result can be less forthcoming interviewees or a change in responses to make them more acceptable to the translator.

Addressing this issue requires a knowledge of the ethnic and language groups represented in the population, and their relative size. The pool of translators should come from a variety of backgrounds that reflect the diversity of the population, and used according to the situation and person being interviewed. Part of the training of translators should include insistence that they avoid showing reactions to the comments of either the aid worker or the aid recipient (which also is a useful skill for the aid worker to avoid

influencing how people respond).

7. *Unrealistic Expectations*

In addition to these approaches, aid workers can use the following general principles. The aim of these principles is to improve the accuracy and effectiveness of translators by reducing some of the unrealistic expectations placed on them:

1. *Use clear and simple sentence structures.* Complex sentences, double negatives, and rambling sentences should be avoided. Particularly, the use of double negatives can result in translations that mean the exact opposite of what the aid worker intended;
2. *Use simple words and terms and reuse the same terms whenever possible.* This is important for two reasons:
   a) to avoid taxing the vocabulary of translators; and
   b) uncommon words usually have more complex meanings than do simpler words. Hence, they are less likely to be understood accurately.
3. *Translator should not translate more than two sentences at a time.* When either the aid worker or the community member is permitted to speak at length before translating, the translation usually is a summary of what was said, and is of varying accuracy. Limiting the amount of material that a translator must remember improves the likelihood of verbatim translation. Our experience is that the translator, aid worker, and interviewee readily adapt to this restriction.
4. *Translators should be encouraged to make notes.* These notes can be verbatim transcripts of what is being said. In the case of complex sentences, this reduces the demand on the translator's memory. Notes also can consist of terms about which the translator is uncertain (including definitions) and for which they later can consult to improve their proficiency and accuracy.

Examples of Problems Arising from Poor Translation

In the experience of the authors, failure to address these translation issues can result in one or more of the following problems, which can affect program and/or treatment effectiveness: 1) provision of incorrect treatment or assistance; 2) local people perceive program interventions and treatments as ineffective; and 3) alienation of aid recipients and biased programs.

1. *Provision of Incorrect Treatment or Assistance*

Poor translation of disaster victims' statements can result in the aid worker misunderstanding the nature of the problem. In medicine, the wrong condition may be diagnosed or—where the translator summarizes or screens comments—co-existing conditions may be missed. This can result from the clinician's habit of asking lists of closed questions, such as, "Does your child have a fever?" If the parent's response includes non-fever symptoms, for example, if the parent states, "No, but my child has difficulty walking/headache/ pains,…", and the translator has not been trained, s/he may translate this as a simple negative. Later, the parent may neglect to repeat these symptoms in response to other questions, thinking that the translator already has informed the clinician.

2. *Local People Perceive Program Interventions and Treatments As Ineffective*

When the aid worker and recipient think that they are discussing the same problem (but, in fact, are referring to different issues), explanations by the aid worker as to the cause and correct line of action will appear illogical to the recipient. In clinical terms, mistranslation of an illness can cause the patient to reject as illogical, the explanation and treatment offered by a clinician, or to reject interventions aimed at preventing the disease. When the recipient agrees to try the treatment or intervention, and the situation (as they understand it) does not improve, this can cause a loss of trust in those providing aid. For example, if malaria is translated as fever (a common strategy where there is no local term for malaria), then statements by aid workers that all fever is caused by mosquitoes obviously will be wrong to local people. The effectiveness of mefloquine in curing 'fever' will be contradicted when a child with malaria and another fever-causing illness, remains febrile after taking the medicine.

3. *Alienation of Aid Recipients and Biased Programs*

Alienation may be caused by the use of translators who are different from most aid recipients, or who come from only one of the social strata or ethnic groups that compose the population. For example, when one of us (PB) was working in Bosnia, relief project translators who were Serbs frequently were rejected by non-Serb Bosnians. In Rwanda, the same author found that Tutse translators were evicted from Hutu areas, and accused by local Hutus of "stirring up trouble". Aid programs in which most of the translators and other workers have come from a single group, even have been perceived as existing for that group exclusively. Aid workers may not realize that most of their local staff are from the same group. But, this commonly occurs when the first staff hired refer their friends and neighbors to the aid organization, or where the agency sets up operations closer to one group than another.

When translators come from one group, they may intentionally or even unwittingly suppress information from other groups (see *Causes of Poor Translation*). This can result in greater emphasis on the needs of the translator's group at the expense of others. Bias can be either real (such as the siting of a clinic or well closer to some groups) or apparent (where people believe that facilities favor one group over another).

Discussion

Some of the issues surrounding poor translation have been discussed including how it can occur, its impact of humanitarian aid, and principles for addressing these issues. These principles can be summarized in two approaches:

1. Better training of translators and humanitarian workers to work as a team; and
2. Better understanding by aid workers of local concepts relevant to humanitarian aid.

The first approach refers to the general principles for working with translators (including using clear simple sentences and terms, limiting the vocabulary, and encouraging

note taking). Since they require attention by both the aid worker and the translator, both must receive training. Training should be provided to aid workers and translators together, so that each understands the other's role and what to expect. This is important in building the team mentality essential to successful translation. Further information on these principles, their use in training, and their operationalization is available from the authors on request.

The second approach requires the use of ethnographic methods as part of the disaster response. Although it is desirable that aid workers learn to use ethnographic principles (such as not leading respondents and using open-ended questions), the effort to learn these methods thoroughly and use them to gather sufficient local information requires more time and effort than these workers usually can spare. This includes the effort to seek out and interview suitable key informants. Instead, it is suggested that aid programs address the issues raised by hiring one or two additional staff trained in qualitative and ethnographic methods. Their prime function is to train and supervise local workers to gather this information, which they then pass on to aid workers. Procedures that these workers can use for gathering these data in CEs are available on-line in manual form.[3] These staff also can provide the team training described above for workers and translators on site.

Summary

This paper points out some of the major causes of inaccurate translation in CE programming, their effects on program success, and principles for improving translation. So far, these issues have not been widely appreciated in most relief and disaster-response programs. The approach outlined will require some additional staff and resources on the part of relief programs. However, the additional expense is cost-effective, and will result in more effective and efficient relief interventions.

References

1. Rubin M, Heuvelmans JHA, Tomic-Cica A, Birnbaum ML: Health-related relief in the former Yugoslavia: Needs, demands, and supplies *Prehosp Disast Med* 2000;1–11.
2. Bernard HR: *Research Methods in Cultural Anthropology*. Sage Publications: Newbury Park, 1988.
3. Weiss W, Bolton P: (2000) Training in Qualitative Methods for PVOs and NGOs. Available at http://www.jhsph.edu/refugee/resources.html. Accessed 28 June, 2001.