Communication and Language Access Is Essential Infrastructure for Deaf Refugees in Global Health

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Refugees with disabilities occupy some of the most underserved positions within often precarious and underfunded global health systems. The compounded effects of forced displacement, disability-related exclusion, and structural inequities embedded within health and social service systems particularly disadvantage refugees with disabilities. Among them, deaf and hard-of-hearing refugees face a distinct and often invisible form of exclusion: the systematic failure to provide accessible communication and language access. This is not a peripheral concern. Accessible communication is foundational to safety, health, dignity, and meaningful participation, yet it remains systematically neglected.

Despite growing attention to health equity, language and communication accessibility for deaf refugees remain structurally underprioritized within both global health and refugee-serving systems. This omission is not benign. It produces preventable harm, delays care, undermines informed decision-making, and erodes the dignity and autonomy of individuals already at heightened risk of exclusion.

Language access is often narrowly understood as simply providing interpreters or translated materials. In practice, communication access for deaf refugees is far more complex. Deafness exists across a spectrum, communication preferences vary widely, and sign languages differ across countries and cultures. Some deaf refugees use national or regional sign languages. Others rely on homesign systems—self-created communication methods developed without access to conventional sign language—or communicate through gestures, written language, lip reading, residual hearing, spoken language, or combinations of these approaches. Access to language, education, and communication opportunities prior to displacement profoundly shapes deaf refugees' communication repertoires, preferences, and support needs. Many deaf individuals also arrive having experienced language deprivation due to delayed or inadequate access to fully accessible language environments prior to migration. Although they often develop diverse communication strategies, standard interpreter services may be ill-equipped to address resulting challenges in communication, comprehension, and information processing. Effective communication may therefore require specialized interpretation teams, including qualified deaf Interpreters, deaf cultural mediators, and interpreters trained to navigate linguistic and cultural differences in high-stakes settings such as healthcare and legal proceedings.

Yet refugee-serving and healthcare systems remain largely unprepared to meet these needs. Despite good intentions, providers frequently lack training in identifying communication barriers, locating qualified interpreters, or working effectively with interpreter teams. Even when services exist, they are often delayed, inconsistent, or inaccessible during critical moments of care. Remote interpretation platforms may depend on stable internet connectivity and appropriate technology that many organizations do not possess. In some settings, individuals are expected to

navigate intake, documentation, and eligibility systems before even establishing communication access.

These failures are not merely logistical problems. They are the predictable outcomes of longstanding underinvestment in sign language access and disability inclusion. Communication accessibility is still too often treated as optional rather than foundational. For example, in the United States, systems frequently default to standardized approaches, such as relying solely on American Sign Language, without recognizing the linguistic diversity of deaf refugee populations or the need for culturally responsive communication strategies.

The international legal framework is unambiguous on this point. The UN Convention on the Rights of Persons with Disabilities (CRPD) includes key articles directly addressing deaf persons, among them Article 9 on accessibility, Article 21 on freedom of expression and access to information, and Article 24 on education — all of which carry clear implications for communication access in health and resettlement contexts. The CRPD is the first international convention to explicitly recognize deaf people as a linguistic and cultural minority and to mandate the provision of professional sign language interpreter services. With 193 state parties, the treaty creates binding obligations that remain incompletely implemented for many deaf refugees.

The consequences are profound. In healthcare settings, communication barriers contribute to delayed diagnoses, misunderstanding of medical instructions, reduced adherence to treatment, and exclusion from informed decision-making. Beyond healthcare, language exclusion restricts access to education, employment, housing, and legal systems. Over time, repeated communication failures erode trust and contribute to isolation, frustration, anxiety, and disengagement from services altogether.

When individuals cannot reliably communicate their needs, ask questions, or understand critical information, uncertainty and fear become part of everyday navigation. Systems intended to provide protection and support can instead deepen exclusion and psychological distress.

Global health and resettlement systems have historically prioritized efficiency, employability, and short-term integration outcomes, often at the expense of those who require sustained and specialized support. Disability inclusion and communication accessibility have remained peripheral to these priorities. Yet meaningful integration, equitable healthcare, and informed participation cannot occur without effective communication. Addressing these failures requires a fundamental shift in how language access is conceptualized. Language access must be recognized not simply as an accommodation, but as essential health infrastructure.

Several concrete steps are required. First, governments, healthcare systems, and refugee-serving organizations must invest in building a robust and culturally responsive deaf interpreter workforce, including qualified deaf interpreters and interpreters trained specifically for medical and humanitarian settings. Second, investment must extend across the full continuum of care and service delivery, from intake and scheduling through informed consent, treatment, follow-up care, and community-based support, ensuring accommodations are established before critical interactions occur, not during or after. Third, standardized early assessment of communication and language access should be embedded across all points of contact. Equally important, these efforts must center on deaf refugees and organizations with lived expertise. Fourth, community-

based deaf-led organizations should be recognized as essential partners rather than afterthoughts. These organizations possess the trust, linguistic expertise, and cultural knowledge necessary to support refugee communities effectively, yet they remain chronically underfunded and insufficiently integrated into formal systems.

The persistence of language exclusion reflects more than a lack of resources. It reflects policy choices and institutional priorities. When a deaf refugee cannot communicate their symptoms, cannot understand a diagnosis, or cannot provide genuine informed consent, the harm is direct and measurable. For many, this begins at the very first system contact. Uncertainty and fear become the texture of daily navigation through institutions that were not designed with them in mind.

Global health actors and policymakers must move beyond documenting disparities to address the structural conditions that continue to produce them. Language and communication access are not an add-on. It is health infrastructure — as essential as diagnostic equipment or clinical training — and is central to health, autonomy, and inclusion. For deaf refugees, the absence of accessible communication is not merely inconvenient. It is a barrier to safety, participation, and survival. Investing in language access is therefore not only a matter of equity, but a matter of justice and a foundational step toward building truly inclusive global health systems.