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When Words Fail: International Migrants' Experiences with Language Barriers in the Turkish Healthcare System

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Abstract This study aims to reveal the language-based challenges migrants face in accessing and utilizing healthcare services, as well as the solution strategies they adopt, based on qualitative research conducted with 57 migrants from Afghanistan, Syria, Iraq, and Iran who migrated to Turkey. The data were collected in Eskişehir over a 10-month period in 2023. The findings resulted in the emergence of four main themes. The first theme, fragile independence, illustrates how migrants attempt to overcome language barriers through personal initiatives, such as using translation tools or self-medication. The second theme, solidaristic dependency, highlights how migrants rely on informal networks, family members, or paid interpreters to access healthcare services and demonstrate solidarity. The third theme, isolation, uncovers the processes of exclusion, withdrawal, and silencing experienced by migrants who lack linguistic, social, and economic resources. The experiences reflected in these three themes lead migrants from different backgrounds to perceive intergroup inequality driven by language barriers, which is encapsulated in the final theme, hierarchy. This study makes an original contribution by demonstrating that language functions not only as a key social determinant of health but also as a mechanism of power that actively produces, maintains, and reinforces social and structural inequalities within and among migrant communities.

Keywords International migration · migrant health · language barrier · sociology · Turkey

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Worldwide, 122.6 million people had been forcibly displaced as of June 2024. Among the total number of displaced people, 68.3 million were internally displaced, 37.9 million were displaced as refugees, 8 million were displaced as asylum seekers, and 5.8 million were in need of international protection (UNHCR, 2024a). It is noteworthy that 32% of this forcibly displaced population is distributed across five receiving countries (UNHCR, 2024a): Iran (3.8 million), Turkey (3.1 million), Colombia (2.8 million), Germany (2.7 million), and Uganda (1.7 million). Half-year data for 2024 showed that 3.1 million Syrians under temporary protection and 194,637 individuals under international protection were registered in Turkey (UNHCR, 2024b). In terms of countries of origin, 102,306 migrants of Iraqi origin, 103,922 migrants of Afghan origin, and 9,280 migrants of Iranian origin were living in Turkey at that time, most of whom had spent roughly half their lives there (UNHCR, 2024b). None of these groups have refugee or conditional refugee status or are under subsidiary protection as required by law. While Syrian migrants have temporary protection status, Afghan, Iraqi, and Iranian migrants are those who have applied for international protection but have not yet been accepted or those whose applications have been approved and have received an international protection identity documents. Turkey is not a destination country for either of these statuses.

Turkey has long been home to migrants arriving from different countries and speaking different languages, and this has increased the significance of language barriers in health in Turkey. Studies on the language barriers of migrants (e.g. Torun et al., 2018; Kikhia et al., 2021) have predominantly focused on a single migrant group. The present study, on the other hand, offers the findings of research conducted with migrants to Turkey from four different countries. The aim is to examine the position of international migrants in the face of the language barriers they experience in accessing health services and the strategies they use to overcome those barriers. Since Turkey receives migrants from many countries, it is important to address the position of migrants in the face of language barriers from a comparative perspective. This study aims to reveal how migrants to Turkey from four different countries navigate language-based barriers in accessing health services, discussing the findings sociologically. Its unique contribution lies in its comparative and in-depth analysis of how migrants from different countries navigate language-based barriers in accessing healthcare in Turkey, revealing the distinct strategies they develop and the structural challenges that shape these experiences.

Language barriers and structural barriers in migrants' access to health services

Various studies have identified individual and structural barriers that hinder migrants' access to health services (Chauhan et al., 2010; DiGiacomo et al., 2010; Hiçdurmaz & Yüksel, 2020). At the individual level, migrants face obstacles arising from language and cultural differences, inadequate health literacy, and difficulties navigating health systems (Chauhan et al., 2010). Additionally, the fear of deportation due to reports by health personnel and feelings of insecurity or uneasiness further complicate access (Hiçdurmaz & Yüksel, 2020). At the structural level, bureaucratic procedures, referral systems, resource constraints, short consultation and treatment times, and limited interpreter services create significant challenges. Furthermore, deficiencies in translated information (Chauhan et al., 2010; DiGiacomo et al., 2010), prejudices, stigmatization, and perceptions of migrants as a threat exacerbate these barriers (Hiçdurmaz & Yüksel, 2020). The strong link between language barriers and systemic issues such as limited interpreter services,

the transfer of misinformation, and resource constraints alongside individual factors highlights the need for a multidimensional approach. Given this complexity, researchers argue that communication problems and language barriers constitute the most significant obstacles to accessing health services (Jacobs et al., 2004; Paudyal et al., 2021).

The structural vulnerability approach (Quesada et al., 2011) examines health problems not only in relation to individual or biological factors but also in connection to economic and political structures. This approach argues that multiple factors such as migrants' positions in the labour market, citizenship status, social class, and ethnicity shape their health status in layered ways. When their positions in the social and economic hierarchy are lower, migrants encounter more barriers to accessing health and social services, while the additional language barrier further increases their vulnerability to health risks. Economic exploitation and cultural discrimination, along with symbolic violence, create structural vulnerability. Quesada et al. (2011, p. 1) emphasize that poor health results from various forms of violence embedded in a social and political context that largely ignores those affected by structural vulnerability. Social power relations and hierarchical social structures determine individuals' vulnerability (Leatherman, 2005). Social hierarchies, reinforced by symbolic classifications of worth (Bourdieu, 2000), historically entrenched ethical and normative discourses (Foucault, 1972), and stigmatizing practices (Goffman, 1963), shape this vulnerability just as much as the economic dimensions of structural violence. Economically exploited and politically dependent individuals internalize externally imposed perceptions of their own worthlessness. This internalization, which shapes their "habitus" (Bourdieu, 2000) or "subjectivity" (Foucault, 1972), operates as a form of symbolic violence (Bourdieu, 2000) and leads them to perceive their imposed insecurity as natural and deserved.

Therefore, language barriers in healthcare do not merely create communication difficulties for migrants; they also function as a form of symbolic violence that reinforces their marginalized position in the social hierarchy, reflecting structural vulnerability. These barriers not only hinder migrants' access to health services but also further isolate them, diminishing the recognition of their social value and subjectivity. In this context, language barriers serve as a tool of structural inequality in healthcare and social discrimination against migrants, ultimately deepening the obstacles to their right to health. Beyond language barriers, economic constraints also prevent some migrants from accessing healthcare, such as their inability to afford interpreter services. This situation highlights what Nancy Fraser (1997, pp. 22-23) described as the "double burden" faced by marginalized groups, who simultaneously experience economic inequalities and a lack of cultural recognition.

As Giddens (1984) observed within the framework of structuration theory, structures do not solely determine individuals' actions and positions; people also have the capacity to influence, reproduce, or limit these structures. To impact structural boundaries, migrants must either engage with their local communities or migrant networks to increase their social capital or they must skillfully navigate non-human actors such as technology, documents, and institutions, as highlighted in actor-network theory (Callon, 1984). Furthermore, both the structural vulnerability approach (Quesada et al., 2011) and Crenshaw's (1989) intersectionality perspective emphasize that migrants who face multiple forms of oppression are at heightened risk of exclusion from both economic and social life due to language barriers. This exclusion becomes even more complex when compounded by the class-, ethnicity-, and gender-based discriminations they encounter.

Language barriers constitute a significant obstacle to migrants' access to housing, employment, and healthcare services in destination countries. Furthermore, these barriers impede their ability to combat discrimination in all its dimensions. The inability to communicate in the local language poses challenges in

employment, emotional adaptation, and social integration. Anderson (2013) highlights that language is not merely a tool for communication but also a determinant of social belonging and exclusion. Limited language proficiency hinders migrants' adaptation to society, makes it difficult for host communities to accept them, and exacerbates their social exclusion (Ayon, 2015), further contributing to negative health outcomes (Yoo et al., 2009). Overcoming language barriers is crucial not only for migrants' well-being but also for fostering a healthier and more cohesive society.

Among the critical roles played by language in communication, it allows individuals to accurately express their health concerns and receive appropriate treatment. While basic language skills may suffice for addressing daily needs, they often fail to support the articulation of medical issues and the effective navigation of healthcare services (Clark et al., 2004). Language barriers in healthcare settings complicate communication between patients and healthcare professionals, preventing them from obtaining accurate diagnoses and appropriate treatment (Green, 2017). Migrants with limited language proficiency may struggle to describe symptoms accurately and provide a comprehensive medical history, which can delay their efforts to seek healthcare services or lead them to disengage from the system entirely. Research indicates that when migrants face language difficulties, they report symptoms less frequently, whereas those with higher levels of language adaptation are more likely to seek medical assistance (Bischoff et al., 2003). A systematic review of 14 studies conducted in the United States showed that language barriers negatively affect patient-physician communication, reduce patient satisfaction, and compromise the quality of healthcare services (Al Shamsi et al., 2020).

Interpreter support in migrant health

When migrants cannot communicate with healthcare professionals fluent in their native language, they often seek assistance from interpreting services (Garcia Roy et al., 2004). Healthcare providers can help mitigate these language barriers by employing professional interpreters, a step widely recognized as essential for improving the quality and accessibility of health services (Green et al., 2005; Binder et al., 2012). In Turkey, the government launched the SIHHAT Project (2016–2020) and extended it through phases II and III (2021–Present), currently operating 179 Migrant Health Centers across 32 provinces (Republic of Turkey Ministry of Health, 2025). Nevertheless, despite these efforts, interpreter services remain insufficient to meet the growing demand.

Bischoff et al. (2003) noted that language barriers among asylum seekers limit their access to healthcare services, while professional interpreters play a crucial role in improving this process. Migrants who receive healthcare services with interpreter assistance report higher satisfaction and a greater sense of security, whereas the lack of interpreters intensifies feelings of loneliness and distress (Binder et al., 2012; Floyd & Sakellariou, 2017). Trained interpreters not only facilitate communication but also promote cross-cultural understanding, enabling healthcare providers to address both medical and socio-cultural factors more effectively (Durieux-Paillard, 2011). Despite its advantages, the use of interpreters in healthcare presents several challenges. One major concern is that interpreted consultations tend to be longer, which may reduce the number of patients that healthcare providers can treat and impact the efficiency of healthcare services (Binder et al., 2012). Additionally, concerns persist regarding interpreters' proficiency in medical terminology and the accuracy of information transmission (Sandre & Newbold, 2016). Therefore, it is crucial that interpreters receive adequate training and develop a strong foundation in medical knowledge (Bischoff et al., 2003; Paudyal et al., 2021). However, the persistent shortage of qualified interpreters frequently leads to a reliance on family members or friends instead of trained professionals (Atkin, 2008; Kletečka-Pulker et

al., 2019). This reliance creates additional dependency, particularly for vulnerable migrant groups such as the elderly, women, and pregnant individuals (Floyd & Sakellariou, 2017; Pot et al., 2020).

Working with untrained interpreters from the same community poses additional risks, including the misinterpretation of medical instructions (Clark et al., 2004), privacy concerns, and the fear that sensitive health information may be disclosed within the community (Binder et al., 2012). Untrained interpreters may distort patients' statements, omit key details, or speak inappropriately on their behalf (Durieux-Paillard, 2011; Ross, 2020). Researchers have put forward alternative interpretation methods such as telephone interpreting, intercultural mediation, and written informational support (Novak-Zezula et al., 2005) to address these challenges.

Telemedicine, also referred to as telehealth, has emerged as a promising solution for bridging language gaps in migrant healthcare. Telemedicine enables healthcare providers to deliver services remotely, benefiting regions with a shortage of healthcare professionals and facilities, and studies have shown that its applications for migrant groups can be functional and cost-effective (Cusack et al., 2008). Another proposed solution is the use of online translation tools in medical interpretation services (Al Shamsi et al., 2020). However, these tools still often fail to accurately convey medical terminology and cultural nuances, increasing the risk of misdiagnosis and medical errors (Patil & Davies, 2014).

Methodology

This study is based on data collected as part of a large-scale research project supported by a state university in Turkey, with ethics committee approval obtained (*for blinding of the study, further details about the institution are not provided at this time*). The authors of this paper are members of the project team and were directly involved in data collection, analysis, and interpretation. We designed the research using a qualitative methodology and employed a descriptive multiple case study design (Baxter & Jack, 2008) to avoid treating migrants as a homogeneous group and to capture variations among different migrant communities.

We focused solely on the four largest international migrant groups in Eskişehir, Turkey, including Syrian, Afghan, Iraqi, and Iranian migrants and excluded individuals from other countries and former migrants who had later become Turkish citizens. We did not otherwise consider legal status, with the sole inclusion criterion being international migrants of the specified nationalities residing in Eskişehir. A total of 57 migrants were selected using purposive and snowball sampling methods. We conducted face-to-face semi-structured interviews (average duration: 55 minutes) directly with Turkish-speaking participants and with the assistance of a professional interpreter for those with limited language proficiency at locations chosen by the participants, predominantly in their homes. To provide further contextual insights, we also interviewed two non-governmental organization (NGO) experts working with international migrants in Eskişehir. Prior to the interviews, we informed the participants about the study and obtained their consent for both participation and audio recording. The data collection process spanned 10 months in 2023. The interviews were stored in a password-protected folder. Table 1 summarizes the general social, economic, and demographic characteristics of the participants.

Table 1

Socioeconomic and Demographic Profile of the Participants

	Syrian (17)	Afghan (16)	Iraqi (16)	Iranian (8)
Gender	6 male, 11 female	3 male, 13 female	8 male, 8 female	5 male, 3 female
Age (min and max)	15-57	22-42	15-53	21-40
No education	10	5	4	0
No knowledge of Turkish	10	6	2	0
Unemployed/Unemployed including housewives	2/8	5/7	4/11	4
Average monthly income ($)	180	202	225	350
Average number of years in Turkey	8.5	4.5	7	8
Average number of children	6.2	2.7	4.6	2
Average household size	7.4	4.8	6	2.5
Has a work permit	1	0	0	1
Lost health insurance	0	10	9	2
Has private health insurance	0	2	0	0

We coded and analyzed the data without using a computer program. The interview transcripts underwent descriptive and systematic qualitative analysis, and we derived themes and categories from the data (see Figure 1). To ensure trustworthiness in qualitative research, we employed several methodological strategies. We made efforts to accurately and comprehensively represent the participants' perspectives, strengthening data verification through direct quotations and providing contextual details alongside participant statements. All authors actively participated in the fieldwork, ensuring researcher triangulation through participant validation and comparisons with previous studies. We shared the selected findings with three participants to confirm their plausibility.

As this study was carried out within the framework of a larger project, oversight by an independent review panel strengthened the study's credibility. None of the researchers, their families, or their relatives have experienced international migration firsthand. However, during data collection, we built strong rapport with participants by assisting them with bureaucratic challenges, which fostered a sense of trust and facilitated more open and in-depth conversations. To minimize potential researcher bias, we employed a strategy of reflexivity (Creswell & Miller, 2000), engaging in systematic self-critical reflection and iterative team discussions. This methodological approach allowed us not only to engage as external observers but also to develop an insider perspective on migrant experiences.

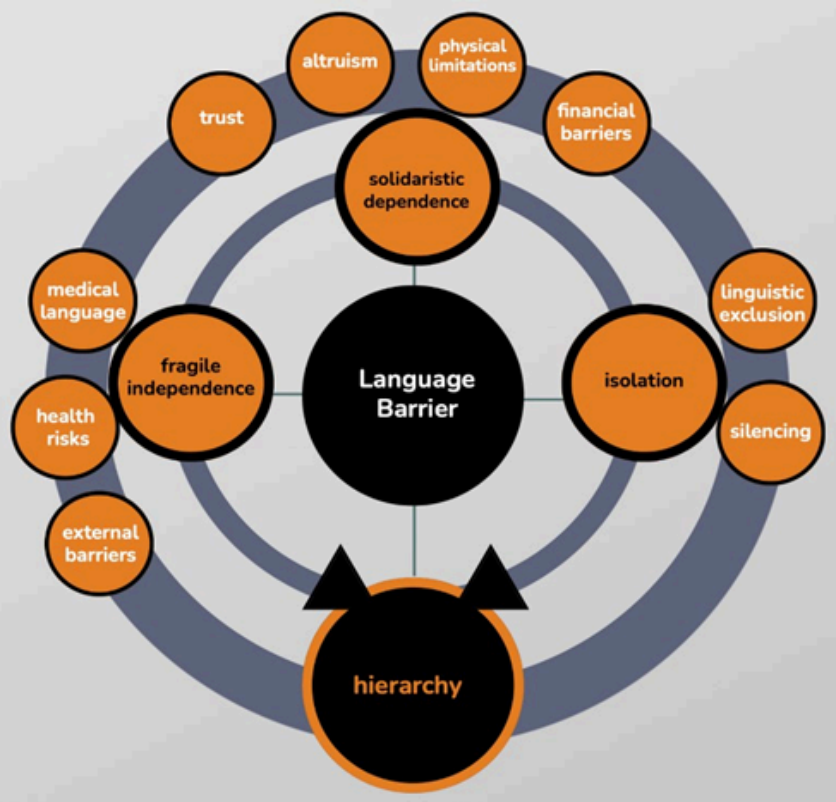
In this study, we use the term "migrant" in a sociological rather than a legal context, not considering the specific legal statuses of participants in the analysis. However, this constitutes a limitation, preventing a direct examination of the impact of varying legal statuses on the participants' experiences. Additionally, the study's exclusive focus on the four largest international migrant groups in Eskişehir, excluding other nationalities, also constitutes a limitation.

Results

The data analysis revealed three initial key themes (see Figure 1): fragile independence, solidaristic dependence, and isolation. The fourth key theme, hierarchy, emerged as a broader construct shaped by the experiences encapsulated within the first three themes.

Figure 1

Themes and Categories



Fragile independence

The first theme identified in the data analysis, fragile independence, describes migrants' attempts to overcome language barriers without external assistance. This theme encompasses personal efforts such as using technological translation tools, self-medicating with guidance from pharmacies, and learning Turkish independently through online resources or television. Participants frequently referred to these efforts as "taking care of oneself". Some described their self-taught language skills as a personal achievement.

> After I came here, I couldn't go to school because we had to work. I learned Turkish from the phone and the internet. I learned it on my own. At the moment, sometimes I even work as an interpreter for others. (Afghan, female, 28 years old, secondary school graduate, housewife, 5 years in Turkey)

Achieving independence in overcoming language barriers requires technological literacy, access to the Internet and smartphones, and financial resources to afford paid interpreters. Moreover, independence may reflect personal resourcefulness rather than reliance on social networks, a pattern particularly evident among Iranian migrants. Compared to other groups, Iranian migrants tend to have higher average incomes and, as many have migrated for political reasons, they often avoid participating in social networks, even those formed by their compatriots.

Consistent with previous studies, which have shown that migrants attempt to compensate for inaccessible services by relying on their own means, sometimes even becoming "their own doctors" (Paudyal et al., 2021), independence in this study also arose as a process of "taking care of oneself". However, despite

their efforts to navigate daily communication challenges, migrants frequently report difficulties in accurately conveying their health problems and expressing themselves as intended (Clark et al., 2004; Green, 2017). Even when every word is correctly translated, the essence of the information or the underlying issue may not always fully reach the listener. Similar patterns emerged in this study. An example of the first category within this theme—being caught between medical terminology and everyday language—is illustrated in the following excerpt:

> We go to the neighborhood market or bazaar and meet our needs easily. We don't have any problems there. But going to the hospital is troublesome. Everything is different in the hospital, people, language, everything. We don't understand what they say, neither in the emergency room nor in the normal outpatient clinic. (Iraqi, female, 29 years old, secondary school graduate, housewife, in Turkey for 6 years)

The second category within this theme highlights the health risks associated with attempting to address medical issues outside formal healthcare institutions. This study also found that participants informally acquired medicines without prescriptions. Despite the prohibition against over-the-counter medication sales in supermarkets in Turkey (Official Gazette, 1928), one participant reported purchasing medicine from a neighborhood grocery store when necessary. In another case, a participant who did not speak Turkish described using gestures to communicate her symptoms and request medication from a Turkish colleague.

> When we are sick, dizzy, or weak, we buy medicines such as painkillers or something to reduce fever from the neighborhood grocery store. (Afghan, female, 22 years old, no education, housewife, in Turkey for 10 years).
>
> There was a Turkish sister at work; I would show her my head if I had a headache or press my stomach if I had diarrhea, or cough if I had a sore throat, and she would understand. She would give me medicine, sometimes antibiotics, sometimes syrup, that kind of medicine. (Iranian, female, 39 years old, high school graduate, cleaner, in Turkey for 10 years)

The third and final category within this theme focuses on external barriers, encompassing challenges such as healthcare professionals refusing to accept family members as interpreters or rejecting the use of translation applications such as Google Translate. Additionally, as highlighted by an expert from an NGO working with migrants in Eskişehir, some doctors may also be reluctant to use the telephone interpreting services provided by the Ministry of Health.

> Doctors sometimes do not accept telephone translations; Google Translate may not be accepted. In fact, the Ministry of Health has an interpreting hotline, but no doctor uses it. For health and legal services, there are interpreters for many languages, including Russian. Lawyers and doctors can call and get interpreter support, but they don't. Work has been done for this in accordance with the policies, but it only works in theory, not in practice. (NGO expert)

"Fragile independence" rather than full independence emerges because, as the categories above illustrate, independence does not always equate to strength, cannot resolve every issue, and might even exacerbate health risks. While fragile independence reflects migrants' efforts to be self-sufficient in daily life, those efforts function within a "strategic field of action" shaped by structural constraints (Giddens, 1984).

This strategic field of action represents a space where individuals plan their actions, develop strategies, and position themselves within social structures. Despite facing systemic barriers such as language, migrants make strategic choices that allow them to navigate, reproduce, or reshape social structures. However, in their attempts to overcome communicative challenges within linguistic hegemony, they directly experience the consequences of lacking symbolic capital (Bourdieu, 1991).

Misinterpretations, incomplete understandings, and shifts in meaning, whether during direct communication or with an interpreter, are not merely the result of individual linguistic deficiencies. Language functions as a social boundary embedded within power relations (Foucault, 1972). While striving for independence, migrants simultaneously experience exclusion, becoming passive subjects of institutional marginalization. In this context, fragile independence can be understood as a micro-level reflection of neoliberal individualization among migrants. The need to "take care of oneself" is not just a skill or a strategy but also an outcome—and a clear indicator—of a systemic mechanism of isolation.

Solidaristic dependency

The second theme, solidaristic dependency, pertains to reliance on others to overcome language barriers. This dependency may involve family members, migrants or ethnic groups connected through social networks, neighbors, or paid/volunteer interpreters. These relationships may be formal (e.g., hospital interpreters) or informal (e.g., assistance from family members) in nature, and they play roles in making medical appointments, navigating healthcare institutions, and receiving treatment.

The first category within this theme is trust. Næss (2019) found that trust-based service provision, shaped by cultural health capital, is often facilitated by "bridge builders", or relatives who assist with translation services. Similarly, in this study, participants who relied on others to navigate language barriers frequently emphasized the trust they placed in their helpers, particularly in informal support systems. This trust not only provided reassurance but also fostered a sense of solidarity and resilience.

> We always support each other. For example, the other day my uncle had an operation; I stayed with him in the hospital. He has two daughters, they also speak Turkish, but my uncle trusts me more, he says I explain better, he feels comfortable when I'm around. (Iraqi, female, 29 years old, secondary school graduate, housewife, 6 years in Turkey)

The second category within this theme is altruism. As illustrated in the excerpt below, migrants often serve as interpreters for one another without expecting any material compensation. Beyond translation, they also shared their past experiences to help others navigate healthcare services more effectively. This informal support network plays a crucial role in facilitating access to healthcare and strengthening community solidarity among migrants.

> Newcomers don't know anything. We guide them or go with them to the hospital and help them translate. If they go alone or if there's no one who can speak good [Turkish] with them, they are treated very badly in public hospitals. (Iraqi, male, 20 years old, university student, 6 years in Turkey)

The third category in this theme highlights how dependency restricts the range of healthcare institutions that migrants can access. Research conducted in Turkey has previously shown that migrants often feel compelled to choose hospitals where staff speak their language (Göç Araştırmaları Derneği, 2020). This

pattern also emerged in the present study, as participants, especially those without access to informal interpreters, prioritized hospitals based on the availability of interpreters.

For many migrants, even when multiple hospitals offer similar services, the lack of language support confines them to a single institution. The following excerpt illustrates how one participant, despite having multiple healthcare options, opted for one specific hospital solely due to interpreter availability:

> There is no interpreter who speaks our language at Yunus Emre State Hospital. Not at the health center, either. No, no. That's why I only go to the City Hospital, not to the others. (Afghan, female, 31 years old, some secondary school, housewife, 5 years in Turkey)

The fourth category within this theme is financial barriers. Migrants who must rely on paid interpreters outside their own networks face difficulties in overcoming the language barrier due to economic constraints. Syrian migrants, benefiting from strong social networks, are the most likely group to find interpreters of their own language within hospitals. Iraqi migrants, due to the linguistic similarities between Iraqi Turkmen dialects and Turkish, are also less likely to rely on paid interpreters. Iranian migrants, with higher average incomes than other migrant groups, experience fewer financial difficulties in accessing interpreters when necessary. However, Afghan migrants, lacking both strong networks and economic resources, encounter the most significant financial barriers in overcoming language-related challenges in healthcare. Thus, this category particularly reflects the experiences of Afghan migrants, illustrating how financial limitations further hinder access to essential health services.

> I had a very bad headache and vomiting. I wanted to go to the hospital, but I needed 400 or 500 [Turkish lira] for the examination and tests. I couldn't afford it, so I didn't go. I don't speak the language and I don't know how to read and write, so I have problems. Everyone goes and speaks to get aid money from the state and to get health insurance, but I cannot speak [Turkish]. (Afghan, female, 34 years old, illiterate, housewife, in Turkey for 7 years)

The concept of structural vulnerability, widely discussed in migration and health studies, emphasizes that migrants face disadvantages in accessing healthcare not only due to language barriers but also because institutional mechanisms perpetuate cultural and structural inequalities (Quesada et al., 2011). This vulnerability unequally impacts access to resources and prevents institutional recognition, forming what Fraser (1997) described as a "double burden" in social justice deficiencies. While migrants develop collective resistance mechanisms through solidarity practices to overcome language barriers, the invisible thresholds of the health system simultaneously restrict their access to specific healthcare spaces. Consequently, individuals with limited linguistic capital face repositioning within both institutional and intra-community hierarchies as language shifts from a mere tool of communication to a determinant of the right to health.

Isolation

The theme of isolation reflects the experiences of migrants who lack personal power, social networks, and resources, leaving them unable to resolve their challenges. This theme entails the accumulation of disadvantages stemming from power inequalities across various domains. Isolation often begins with illiteracy in any language, a lack of financial resources, and the absence of social connections, leading to difficulties such as being unable to schedule medical appointments, access healthcare facilities, or even leave home

due to fear of ridicule and discrimination. These experiences contribute to profound feelings of loneliness and helplessness.

Two categories emerged within the theme of isolation: linguistic exclusion and silence. The first category, linguistic exclusion, pertains to the inability to integrate into society due to language barriers. Language acquisition is widely recognized as a crucial element in fostering social integration. The following excerpt illustrates an instance of exclusion resulting from language barriers:

> We feel excluded. For example, I went to the hospital with my friend who had just arrived [in Turkey] and did not speak any Turkish. My Turkish was not as good as it is now, but I still knew a little, so I went with her to help her. I spoke to the secretary at the reception desk at the hospital, but I didn't understand what the secretary said. The secretary said that they needed an extra interpreter for the interpreter herself-that's me. I had my friend with me at that time, but I still felt very lonely. (Afghan, female, 42 years old, bachelor's degree, not working, in Turkey for 3 years)

Another consequence of linguistic exclusion is the experience of withdrawal and silencing. The second category of this theme, silencing, pertains to migrants giving up on speaking, asking questions, or engaging in communication. This phenomenon arises when individuals repeatedly face difficulties in expressing themselves, experience negative reactions, or feel that their voices are not heard or valued. Silencing not only affects their ability to access health services but also reinforces their sense of isolation and exclusion from society.

> They laughed at me a lot because I used the wrong words when I was talking [in Turkish]. That's why I don't speak Turkish, I don't want to speak to people in general, I don't want to go to the pharmacy or hospital. (Afghan, female, 32 years old, illiterate, housewife, in Turkey for 1 year)

Isolation constitutes one of the clearest manifestations of symbolic violence in the Bourdieusian sense (Bourdieu, 1991), as structural inequalities and language barriers faced by migrants in accessing healthcare services reach their most extreme form. From an intersectional perspective, disadvantages accumulated along multiple axes, such as language proficiency, economic insecurity, gender, and citizenship status, lead to the exclusion of migrants from public spaces and social participation (Crenshaw, 1989). In this context, linguistic exclusion is not merely a communication issue but a form of structural inequality that actively restricts access to essential services and rights.

Language barriers, in combination with a lack of socio-economic resources, exclude migrants from hospital services and can entirely disrupt their access to healthcare, sometimes even pushing them to withdraw from the public sphere altogether. In this regard, language anxiety and silencing are better understood through the lens of the concept of stigma (Goffman, 1963) rather than as individual reactions. Migrants who struggle to communicate in their nonnative language often withdraw from interactions, fearing constant judgment and negative evaluation. Over time, this withdrawal transforms into internalized stigma, diminishing their confidence in their own abilities and reducing their social visibility. Particularly in healthcare access, language barriers exacerbate migrants' already vulnerable health conditions and deprive them of self-sufficiency. Ultimately, linguistic isolation acts as a mechanism that not only generates individual anxiety but also excludes migrants from social participation, makes them invisible, and denies them access to fundamental rights such as healthcare.

The hierarchy established among migrants through language

Experiences such as those outlined in the context of the first three themes led the participating migrants from different countries to construct and perceive a hierarchy among themselves regarding language barriers. This hierarchy is shaped by several factors: the limited number of interpreters available for Persian, Uzbek, Pashto, and Dari compared to Arabic; the fact that only Arabic interpreters are accessible in hospitals providing free interpreting services; the linguistic advantage of Iraqi migrants because of the similarity of Iraqi Turkmen dialects to Turkish; and the generally higher multilingual proficiency of Iranian migrants, many of whom speak English. For instance:

> You give citizenship to Syrians, but they have no [knowledge of Turkish]. They go to the hospital, the doctors say, "Why don't you have an interpreter with you?" Syrians are Arabs, they don't speak Turkish, but why do they get citizenship? They tell us, "You are Turkmen, you are close to us, you are one of us", but they don't give us citizenship. I don't understand how Syrians become citizens; their language is different, their clothes are different, everything is different. (Iraqi, female, 37, literate, not working, in Turkey for 8 years).

> Iranians are better, but what distinguishes me from other immigrants is that I know the language very well. Second, I'm researching a lot now; most recently, I have researched the culture of Turkey. The fact that I have learnt and solved the health system at work distinguishes me from other migrants to a great extent. Because of my experiences here, I have understood the culture much better; that is, I have understood the culture after the rules and laws. I can protect myself better as I have knowledge about how to dress and what to do. I also have a work permit, I have access to health insurance, and my economic situation is better than that of a normal migrant. These are great advantages for me. (Iranian, male, 33 years old, bachelor's degree, interpreter, in Turkey for 5 years)

The linguistic hierarchy among migrant communities arises as a process of social positioning that extends beyond individual competencies and is shaped by structural inequalities. Bourdieu's (1991) concept of linguistic capital is particularly relevant in this context, as language functions not only as a means of communication but also as a form of capital that determines social status. Language use and speech patterns not only signify shared identities but also establish distinctions and foreignness, creating symbolic boundaries between groups (Anderson, 2013).

The concentration of translation services in specific languages, the selective availability of state-sponsored translation services for particular migrant groups, and the role of language in accessing health services further reinforce linguistic inequalities among migrants. In this context, the fact that Arabic-speaking migrants can access translation services more easily while migrants who speak Farsi, Uzbek, Pashto, or Dari are largely excluded demonstrates that language is not merely an individual skill but also a tool of power shaped by institutional policies.

Conclusion

At the intersection of structural vulnerabilities, linguistic hierarchies, and neoliberal individualization, the findings of this study reveal how migrants seek autonomy while struggling with systemic inequalities. Differences in linguistic proficiency and access to translation services create a hierarchical structure among migrants, favoring those with greater advantages while further disadvantaging others. This study

has demonstrated that language is not merely a means of communication but also a form of power that directly impacts migrants' access to healthcare, social acceptance, and economic opportunities. In this context, linguistic barriers should not be seen solely as communication difficulties but also as indicators of institutionalized inequalities within healthcare services. Language functions as symbolic capital, shaping hierarchies among migrant groups based on their proximity to Turkish or their access to translation services. This underscores the necessity of migration and health studies to address language through the lens of social capital and institutional inequalities.

The relationships that migrant communities establish with language do not merely involve communication; they also entail aspects of belonging, identity, and existence. In Theo Angelopoulos's film *Eternity and a Day*, a young boy attempting to travel from Greece to Albania struggles to complete not only his sentences but also his own identity as he tries to express himself in an incomplete language. His linguistic limitations and sense of foreignness reflect the uncertainty of his place in the world and his search for belonging. Similarly, migrants struggle not only to learn a new language but also to create a space in which they can fully express themselves. Recognizing that language is more than just communication allows us to understand that the challenges faced by migrant communities do not simply involve words but also involve securing a space where they can tell their stories and assert their identities. Just as the child in Angelopoulos's film tries to put words together, migrants attempt to exist in new linguistic environments while carrying their histories and identities into these unfamiliar spaces. This process is not merely a linguistic adaptation but also a struggle for cultural and existential recognition.

This study has highlighted the strengths and weaknesses of different migrant groups in Turkey in overcoming language barriers. From a comparative perspective, it becomes evident that migrant groups perceive a hierarchy among themselves based on their varying positions concerning the language barrier. In this regard, this study makes an original contribution by demonstrating that language is both a determinant of health and a tool of power that produces and reinforces inequalities. The findings of this research may serve as a foundation for future studies to develop and test new hypotheses. Additionally, the adoption of a similar framework would allow researchers to examine migrant groups in Turkey who have come from regions outside the Middle East, who were not included in the present study, and provide broader comparative insights that further enrich the literature.

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