

**Communication at the Health Care Coalface: Lessons from selected
clinics in Port Elizabeth**

THESIS

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DECLARATION

I, the undersigned, hereby declare that this thesis is my own original work and has not, in its entirety or part, been submitted at any university for a degree.

SIGNED:

A handwritten signature in black ink, consisting of a large, stylized capital letter 'R' followed by a smaller capital letter 'D'.

DATE: 14 December 2011

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ABSTRACT

This thesis analyses the state of health care in South Africa with particular reference to a clinic and the Provincial Hospital in Port Elizabeth, Eastern Cape. The complexities of health care provision in a diverse sociolinguistic environment where certain languages are emphasized over others, forms the cornerstone of the research. The research focuses on health care in a complex multi-cultural environment.

The goal of the research is to present a coherent and robust translation framework for the development of suitable materials to enhance communication across language and cultural barriers in the health care sector. A model (based on research completed in the USA) is presented as a possible alternative in the final chapter of the thesis.

The initial part of the thesis builds on the work of scholars in language planning and sociolinguistics more generally in order to locate this research within an appropriate theoretical and methodological framework. The thesis emphasizes the need for developing a patient-centered approach to health care where language usage must be of crucial importance. The research suggests that the intercultural concept of "mindfulness" as developed by Gibson (2002) must also form part of such an approach. The initial phase of this thesis therefore presents a case for multilingualism within the health care sector and it suggests that an appropriate language planning framework is necessary for this objective to be achieved.

The latter part of the thesis engages with translation strategies that can be used to enhance communication within the health care sector. Appropriate terminology development, for example in relation to diabetes terminology is required in order to allow patients to engage with material in their mother tongue. Challenges to effective translation are analysed and examples of inappropriate translation are presented. The link between language planning and translation is made. It is acknowledged in this thesis that developing appropriate translation strategies within the health care system is fundamental to enhancing communicative effectiveness at the health care coalface. The use of appropriately trained interpreters is also recommended in the thesis.

The above research is undertaken with reference to two health care facilities: the Provincial Hospital and the KwaZakhele Health Care Centre. An ethnographic study of these two facilities is also presented in order to assess issues such as overcrowding and how issues such as these can contribute to communicative ineffectiveness by placing undue pressure on both patient and health care provider. A comparative study of these health care facilities is presented.

Finally, the thesis unpacks the challenges that face health care provision in South Africa and a model is suggested that could be used to improve the situation in all health care facilities in the country.

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CHAPTER 1

HEALTH AND LANGUAGE

1.0 Introduction

Health care and the treatment of disease and other conditions are essential cornerstones of social well-being in any context. Crucial to the efficacy of this is the use of language and language policy. 'Depending on one's culture, there are nuances that may be significant to health-seeking behaviours, attitudes, diet, whom individuals prefer to receive care from, whether or not individuals return for care' (Rose 2011). Health care is applied and delivered within a cultural milieu and culture as a general term includes a mix of relationships, attitudes, values and customs (Donini-Lehnoff and Henrick 2000). Consequently, this milieu has a marked impact on the quality of the care received by patients and, by extension, the status and delivery of health care within any society.

Health care within a multi-cultural framework presents a number of challenges, with the role of language and communication being of central importance. From the development of translation services and structures, language training for health practitioners and other language resource development activities to language policy directives, the role of language can be argued to be the key fulcrum around which the quality of health care rotates. The goal of this research project aims to present a coherent and robust translation framework for the development of suitable materials to enhance the communication across language and cultural barriers in the health care sector in South Africa. Using empirical research conducted and data gathered at selected clinics (KwaZakhele Community Health Care Centre & the Provincial Hospital) in Port Elizabeth - Nelson Mandela Bay, a model will be developed and solutions tested and replicated where applicable.

The language usage by the medical fraternity often differs from the everyday language used by patients. Communication may occur in a language that a patient may only have a rudimentary understanding or perhaps no grasp, English as an example, (Crawford 1999). In order to develop a coherent understanding of the context of language usage in the health care sector in South Africa, a sample has been gathered in the following Port Elizabeth health care facilities: KwaZakhele Health Centre and the Provincial clinic. This data gathering exercise was undertaken in collaboration with doctoral Pharmacy students from Rhodes University who were undertaking their clinical practice. The research exercise focused on the language usage associated with the diagnosis, treatment and care of diabetes patients. The research extended to all the relevant written material that health practitioners supplied to their patients and the communication strategies utilized in the delivery of health care information.

One of the key findings that the research generated was that patients tend to be misinformed in terms of the most appropriate use of their medication. This may be due to the lack of effective communication between the patients and the health care practitioners and, perhaps even more importantly, that materials are largely provided in English. Consequently, the patients simply do not understand what they are being instructed to do with their medication and/or are not able to read the relevant prescription label.

Language and language policy is an extremely important issue in South Africa, with its diverse cultures, languages, religions and ways of life (The Constitution of the Republic of South Africa stipulates that all eleven languages should be treated as equal, thus promoting multilingualism, but such policies are largely still invisible in the public service. English and Afrikaans continue to dominate, leaving the other nine indigenous languages struggling to find purchase. Mamphela Ramphele (Sunday Times, 8 March 2009) argued that the government needs to make an ambitious commitment to reverse the decline of the various indigenous languages; she makes the observation that South African Airways must be the only state carrier where

people are not greeted in the dominant local languages. This situation offers a suitable shadow variable for what is occurring in the health care centres across the country.

South Africa now has eleven declared official languages but two (English and Afrikaans) seem to be 'more official' than others, and are used in both the public and private domains of the nation-state. This inequality in the status of languages questions the official status of the other nine languages. Pertinent to this discussion is the observation by the International Peace Research Institute in Oslo:

'The standardization of languages and in particular the nations-states insistence on shared national language, constitute a national threat against the well-being of many inhabitants of many areas who are more or less involuntarily become citizens of some nation-state' (International Peace Research Institute, 1991).

Kaschula and Anthonissen (1995) continue as follows:

'If a language is afforded official status the MT speakers of that language are particularly advantaged. Their MT will be the language of the education; it will be used in the parliament, in court and in business...[O]n the other hand if a national language is not afforded the official status the MT speakers...[I]n order to progress socially or professionally the speakers will need to develop proficiency in at least one of the official languages' (Kaschula & Anthonissen 1995:56).

They conclude that, using your MT in ordinary everyday activities gives you security and certainty about your surroundings that is seldom appreciated until you have to get by without it.

Extending Kaschula and Anthonissen's logic to the health care context, the role and importance of the use of mother tongue (MT) cannot be overstated, arguably alongside education; health is the key element for the achievement of a good quality of life for all people.

One of the crucial factors is that there are stumbling blocks in the implementation of a multilingual policy. There is a lack of reliable information concerning the cost of implementation, detail about what services are needed or wanted and in which languages. English is dominant and widely used in the civil service and government; African languages are not used freely in all domains. Further to this, many speakers of African languages are not familiar with the written variety of their home languages, let alone a second language (Heugh 2002). Despite these hurdles and obstacles, there are campaigns and awareness programmes, and one has addressed the problems associated with the diagnoses and treatment of diabetes. In this case materials were produced in isiXhosa. This is a similar area to the one that this research addresses, and the programme is evaluated and used as a backdrop for developing a model.

Approximately only 2% of the available health care material is communicated in African Languages, including isiXhosa (Heugh 2002). It is argued that developing new material in all languages would be too expensive, but Heugh observes that any such translation activities would only account for 2% of the total health budget (Heugh and Mahlalela 2002). According to Crawford (1999) the use of properly trained translators and interpreters would greatly alleviate the present situation and could actually lead to cost savings, for example where medication is inappropriately used, resulting in the treatment having to be repeated. Therefore, it is imperative to address the communication problems in order to ensure that the patients receive appropriate information in the form of pamphlets, posters and brochures in the appropriate language , for example isiXhosa, in the Eastern Cape.

The research conducted here has assessed the present quality of translation, and attempted to evaluate whether poor translation results in incomprehensibility of information. At present there are few suitably qualified African Language translators, and most are operating on a part-time job basis (Crawford 1999). As a result of this lack of translation

resources there are few suitably translated materials in isiXhosa that are of a quality that supports effective health care in a multilingual context.

Problems relating to; the intention of the text translator, the reader, the setting of the text, the quality of the writing and the authority of the text, were investigated. Two key essential questions arise from a translation point of view; firstly whether the message contained in the text correlates with the intention of the original sender, and secondly whether the message is correct in isiXhosa (Bell 1991). In effect is the health care message pertinent to the treatment of isiXhosa diabetes sufferers being communicated in a suitable, practical and also cost effective manner? If the message is not communicated effectively then treatment will not be successful and at best may be prolonged or repeated.

The lack of effective communication contributes towards marginalized communities becoming further excluded socially, culturally, and economically, due to the fact that in most cases they are not suitably conversant or totally lack any English (Osborn 2006). These factors play an important role in terms of the native speakers of isiXhosa developing a negative attitude towards their own language (Somhlahlo 2009). One of the other factors playing a role is the decline of African language usage, by MT speakers themselves, there is a growing bias in favour of English, they view it (English) as a language of aspiration (Sunday Times: 25 April 2004). This has resulted in a Eurocentric approach where home languages are de-emphasized in the health sector (Webb 1995).

Bamgbose (1991) observes that most university students do not see the value of studying African languages as they are in regular contact with a large number of people who speak English. African languages are then neglected by mother tongue speakers who would ordinarily be able to use them for communication purposes, for example, in medical treatment, where both the patient and the pharmacist are native speakers of isiXhosa. It is also crucial for the health practitioner to be familiar and understand the

language of the patient and to engage the patient in that language and ideally to have a similar if not identical cultural background or at least a suitable level of cultural sensitivity.

This close relationship between language and culture makes it essential to addressing linguistic patterns of societies when investigating cultural issues. This adds more gravitas to language issues pertinent to the health care context. Health care is a central element of any socialisation process, 'the problem of socialisation enters into all the social sciences in some way. This problem revolves partly around the dual nature of the task' (Bernstein 1971:294). Consequently, language is the most important social expression of bodily experiences through oral and other language gestures (ibid).

This points to a need for effective language planning and policy with its accompanying implementation strategies within the health care sector (Bangbose 1991). Academic institutions in South Africa should play a role in promoting African languages. This can be achieved by recruiting more students into the study of African language. Capable translators are needed and universities are key to producing them. A language is considered intellectualized if it can be used for educating a person in any field (Sibayan 1999). Such an intellectualization process will contribute to a growing cohort of suitable translators with the associated contribution to the use of African languages more widely in the delivery of services. In the health care sector quality translation of texts from English into isiXhosa of documents (pamphlets, posters and brochures) will make a significant contribution to the quality of health care and the experience of the patients.

This research has endeavoured to achieve the following objectives:

- To assess how translation is undertaken in the selected clinics.
- To assess the suitability of the translated material available.
- To provide a comprehensive overview on how translation in health care is addressed.

- To identify gaps, overlaps in translation and to identify and publicise innovations and best practices.
- To develop a suitable model for promoting the effectiveness of communication in health care facilities

The findings hopefully assist in forging transformation in medical communication between health care practitioners and diabetes patients. The research also analysed the actual communication between health practitioners and diabetes sufferers and the translated material available to support their treatment. Furthermore, it has generated a possible solution to the current problem associated with poor translation structures and materials.

The research is interpretive and qualitative in approach. Questionnaires, observation and interviews were utilised for data collection purposes. The research targeted two health care facilities: The Provincial Centre and a township clinic, namely KwaZakhele Health Centre. The site in the township is more convenient for people living in the surrounding area, in terms of accessibility. Participants in the study were diabetes patients over thirty years of age. The Provincial Clinic located in the city is less accessible for those located outside the City limits and is predominantly used by patients located within this radius. Those living within this area that are likely to be better educated, and indeed more affluent, may prefer to consult General Practitioners with the potentially resultant skewing of the demography of the datasets. The language issues pertinent to the study are consequently less pronounced at this site.

The study used questionnaires that were completed by diabetes patients (see Appendix 1). They were designed and prepared by selecting certain words and phrases in isiXhosa. This was to ascertain whether they attach the exact meaning to what has been translated. A total of 100 questionnaires were placed in a box in each site, under the supervision of a health practitioner.

The research also included observation of consultations and the management of patients. This generated first-hand experience and ethnographic information relevant to the research. These activities were complemented by individual interviews, aimed at gaining information from health practitioners and diabetes patients who participated in the study. Open-ended questions were used to assess the communication between health practitioners and the patients in terms of effectiveness and satisfaction.

Permission was obtained in writing by way of a consent letter from the District Manager of Health in the Health Department for undertaking the research. Meetings were conducted with the relevant Health Department Heads in order to explain the purpose of the research. All participants were assured of anonymity and confidentiality in terms of all information supplied. The feedback from two sites was compared and contrasted with the main aim being to gauge effectiveness of communication and quality of translated texts and their reception by patients.

1.1 Conclusion

In the chapter that follows a review of previous research will be presented. This will form a backdrop against which the rest of the thesis will be developed. It is imperative to acknowledge that the health care of a society is directly linked to the well-being, productivity and political stability within any particular society. Arguably South Africa still has some way to go in this regard as evidenced in this thesis.

CHAPTER 2

COMMUNICATION STRATEGIES IN HEALTH CARE

2.0 Introduction

Given the key role that health care services play in the well-being of individuals and the community in general the provision and quality of any health sector, offers insight into the state of a society. In societies which are characterized by high levels of diversity and linguistic capabilities, the challenge of delivering equitable health care standards is essential to maintaining a stable social environment. Key to this is the statement, 'Understanding a patient's needs is more than just knowing the language' (Umass 2007:2). In this chapter the status of languages and language policies in health care will be investigated in general terms to offer an intellectual framework upon which to build the study at hand.

2.1 Language in Health Care

Effective communication is an essential ingredient in dispensing of coherent and successful health care. The patient's access to suitable health care information and treatment is built on their ability to absorb the relevant inputs in a manner that easily translates into their context and life experiences. Consequently, all aspects of their contact with health care structures needs to carry a high degree of cultural competence and by extension needs to engage the patient in their lingua franca as often as possible.

'There is a large body of evidence which shows that that the use of language is very important in health care situations' (Gesler 1999:13). This is not a ground-breaking observation, however, Gesler continues to recognise that despite the extensive literature regarding language and health, and the context in which language is used specifically within the different health care situations is less well documented. 'However, relatively little attention has

been paid to *where* language is being used, although it would seem that whether, for example, a patient is talking to a doctor in the privacy of a consulting office or in a busy ward would make a difference to what is said or how it said' (ibid:13). This can be extended to include what is heard and/or understood. This contention leads Gesler to argue that the variable of place needs to be brought into play when addressing the language in health debate; in a South African context with the disparity of past policies the issue of place in a wider sense is of great significance. This study through selecting two very disparate centres offers a sense of the wider spatial context within which issues of the patient-health practitioners exchange occurs can be further investigated. Despite the significance of this issue the initial language barriers which are the focus of this study need to be explored and how they are addressed identified to create a fertile environment for these further studies.

The lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals. In South Africa patients mostly speak a language other than English at home. In most cases those patients who do not understand English, are most likely not to understand their medication prescribed to them. Non-English speaking patients are less likely to use primary and preventive care and public health services and more likely to use emergency rooms. Language difficulties and inadequate funding of language services are major barriers to patients accessing health care. Care providers are faced with a great challenge to determine which language is mostly appropriate for use by their patients. The health care system cannot hope to meet the challenge of affording patients appropriate access to quality health care without adequate attention and resources being applied to address the problem.

Language is one of the many tools of medicine. Language can educate and inform or confuse and mislead. Language can inspire or alienate, cherish or insult. It is increasingly recognised that communication between health professionals and patients is one of the most important aspects of the

healthcare relationship and yet the way language is used in the health service is often opaque, alienating and disrespectful. For example, recently the emergence in the media and in management speak of the term 'frequently flyer' to describe those frail, mainly older people who come in and out of hospital, on a regular basis. This is demeaning and trivializes the experience of the relevant patients. It implies that these patients desire regular trips to hospital, that they are collecting points, that they enjoy the health and life threatening roundabout of continual admission, treatment and discharge.

The health services uses language in this way to shift the blame. By using 'frequent flyer' it is implied that patients are acting out of choice whereas of course people who are forced to attend hospital too frequently are a sign of failure within the health sector.

2.2 Overcoming Language and Cultural Barriers

Overcoming language and cultural barriers to health care is critical to the well-being to the many patients that have little or no English language skills. If the quality of health care is to achieve the highest possible standard these barriers must be traversed as effectively as possible. Language and culture is a very complex field in any context not least in the health care sector. Culture is variously defined but invariably includes aspects of values, customs, beliefs and rituals (Lazear 1997). 'Societies may include a number of cultures and languages' (Lazear 1997:1). South Africa is typical of a multi-cultural and multi-lingual country.

The health care delivery system is hard-pressed to handle this diversity. Health care providers in major cities, such as Nelson Mandela Bay, in particular, deal with a variety of languages and cultures. Language remains a critical road block to quality health care to those whose native tongue is not English. Communication barriers complicate the delivery of health care, adding pressure to the need for translation services in health care system.

Patients who do not understand English need qualified translators to describe potentially complex medical problems and treatment plans or suitable translated and accessible materials. Words that English-speaking patients may use, such as 'diabetes' or 'allergies', often do not have equivalents in other languages. Further, communicating subtle distinctions can be very challenging and essential to effective health care. These subtleties are invariably a factor of the cultural context and experience that the patient brings to any consultation process.

The cultural element needs to be front and centre of any effective health care practitioners engagement with patients, 'language, illness beliefs, personal significance of pain and suffering, and the socially learned ways of behaving when ill are ...always... culturally shaped phenomena' (Kleinman 1991:7).

Coupled to this cultural phenomena is the impact of language and requires some consideration of Whorf's observation: 'language determines experience and therefore produces separate cultural worlds', these separate worlds can contribute to '...misunderstandings, which occur at the level of close interactions between individuals where language looms very large...' (Ardener 1982:3-4). Immaterial of the perspective taken on the view of linguistic determinism and relativity, it is clear that the language of consultation in the health care context is key to the effectiveness of any such health care activities. Good observes, 'physicians and their patients categorize signs and symptoms differently, ascribing significance based on personal experience,' (Good 1994:90-91). Developing a suitable bridge between source and target language within a health context is essential to ensuring the effectiveness of any health care responsibilities.

Against this back-drop the translation of health materials and conversations by an unqualified translator is prone to omissions, additions, substitutions, volunteered opinions and semantic errors that can seriously distort care. In addition, the use of untrained translators can result in a breach of patient

confidentiality. Reliance on translators and interpreters who are not trained in the ethics of interpretation and translation can result in a lack of understanding on the part of the patient and/or a reticence to speak openly. This can be exacerbated when children are required to translate on behalf of their parents around sensitive issues such as: spousal abuse, intimate difficulties and sexual practices.

The lack of appropriate translation services also affects the cost of care. Non-English speaking patients may be reluctant to deal with providers who cannot communicate with them, seeking care only when their conditions become acute and more costly. Further, to fill the gaps created by the language deficiencies, doctors may resort to a battery of expensive tests and/or other practices to arrive at effective diagnosis. Language differences have almost certainly caused the treatment of non-English speaking patients to be more time consuming and have been shown to delay a correct diagnosis and to increase the chances that the patient being unable to follow the health practitioner's instructions.

Linguistic access is not well developed in many health care contexts, and several factors create barriers in the health centres that were investigated, these included:

- The number of languages spoken in the Nelson Mandela Bay has grown dramatically due to the influx of foreigners.
- Translation services cost money, and current levels of funding are inadequate.
- State and health care providers have been slow to bill Medicare for the administrative costs associated with providing language services.
- Many health care providers are uncertain about the extent to which they can and should provide health care, including translation services.
- There is often little public support for the affected minority group.

Although there are state laws requiring access to linguistically appropriate health care, they are largely unused in health care. Ferguson and Candib (2002) assert that disparities in health outcomes among ethnic minority and racial groups have become increasingly clear. More over these writers believe that, while the reasons for these disparities remain poorly understood, the relationship between the health care provider and the patient may be an important factor. If the patient's cultural and linguistic issues are not considered, this can result in; the taking of inaccurate histories, decreased satisfaction with care, non-adherence, poor continuity of care, less preventive screening, miscommunication, difficulties with informed consent, inadequate analgesia, a lower likelihood of having a primary care provider, decreased access to care, use of harmful remedies, delayed immunizations, and fewer prescriptions.

Language barriers in health care are a reflection of the status and currency of language policies in any country. Therefore, developing a coherent understanding of the language use in health care contexts is an ideal mirror for the wider social context of language. In the health structures it is important to recognise that the cultural milieu that the patient hails from is an essential consideration of how they experience the health care context. Therefore, the need to traverse the cultural barriers extends to overcoming the language hurdles, 'by framing language as a medium of cultural expression and exchange, interpreters effectively moderate information flow as bilingual/bicultural filters between monolingual participants. In hospitals, interpreters function as cultural brokers in assessing patient needs and managing care' (Castle 2007:10). It is this role as cultural filter that needs to inform the translation activities with the health care sector, if the patient experience is to be of the highest possible quality.

2.3 Towards a Language for Health Care

Hurdles associated with multi-lingual patients may act as an argument for the development of general principles that could promote the effectiveness of health care delivery. It is unlikely and not feasible to create a unique language of communication within the sector; although this would promote quality of the care given and help minimize the trauma of that could accompany the receipt of care. This lack of viability points to the need for a coherence in the application of translation resources and establishment of suitable translation structures.

Frank Luntz in his defence of President Obama (2009) offers some insights into generalized characteristics that contribute to quality health care in any context (Luntz 2009):

- Humanize your approach
- Acknowledge the 'crisis' or suffer the consequences.
- "Time" is the government healthcare killer
- "Getting the treatment you need, when you need it"
- " One-size-does-NOT-fit-all"

Given that Luntz's list is focused on the USA with its changing demographic his lack of a cultural dimension is stark.

The lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals. In South African patients most people speak a language other than English at home. In most cases those patients who do not understand English, are most likely not to understand their medication prescribed to them. Non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms.

Luntz's characteristics offer suitable framing references for the consideration of the language issue within the South African context, a full analysis of this potential is beyond the scope of this study, however, a brief treatment of each will highlight this potential.

- **Humanize your approach** – In order to humanize the approach on the part of the health care practitioners, cultural and language sensitivity needs to be the cornerstone of any effective health care approach.
- **Acknowledge the 'crisis' or suffer the consequences** - The need to recognise that for the patient there is a crisis of some sort, this can often be by-passed due to the lack of suitable communicative success, consequently, in multilingual environments, the health care worker should consider embarking from the position of crisis and move towards diagnosis from this position.
- **"Time" is the government healthcare killer** – 'Time is money' is the aphorism and is poignant in most government services and is a key variable in health care contexts where language issues are important, the need for translation structures and facilities can lead to increased pressure on time, however, the long-term impact needs to be considered in each case.
- **"Getting the treatment you need, when you need it"** – The quality and effectiveness of health care is predicated on a suitable communicative environment allowing the patient to adequately offer the health care provider insight into their ailments. Any weaknesses or inadequacies in the exchange between the two parties are likely to lead to misdiagnosis or inferior/incorrect medication and medication regimes.
- **"One-size-does-NOT-fit-all"** – One of problems associated with language difficulties and cultural differences is that any care dilutes to a lowest common denominator approach that is fraught with prejudices and misinterpretations. When coupled to the demands for effective time

management this approach delivers short-term efficiencies which may and often do mask long term problems, such as return visits, ineffective treatments and other factors which add other pressures to the system.

The scope for overhauling the health care sector is by definition limited by a plethora of factors. However, the need for apply continuous quality improvements (CQI) activities must be a key focus. The application of effective language policies offers an important route to enhancing this need for on-going improvement.

As indicated above there are obvious limits to the creation of a health care language practice, however, Luntz's characteristics do offer a framework that can be used as metrics for assessing the use of language within the sector and assist in the identification of suitable strategies for language usage overhauls.

2.4 Developing a patient centred approach

Understanding patients' perceptions and concerns is a key to improving quality. There is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes.

There is growing international demand for health care services and this has added to the pressure to improve quality in a cost effective manner. One of the key focus areas in delivering to these demands is to enhance a patient centered approach (Doctors and Society 2002).

In the previous section, Luntz's characteristics offered a sense of the elements that create a quality health services; these offer a base upon which to build a coherent patient centred care (PCC) service. Sillow-Carrol et al

offer the following core components of suitable PCC environment (Sillow-Carrol et al (2006:4-6):

- **Welcoming environment** – the provision of a space for waiting and interactions that are familiar and welcoming. This aspect is very important when considering rural patients visiting urban clinics, such as those studied. Language resources are a key aspect of developing this type of environment.
- **Respect for patients' values and expressed needs** – here language skills and cultural sensitivity are essential, if the patient is able to communicate effectively their needs will be better enunciated and, by extension addressed. Coupled to how comfortable the patient feels from their initial contact with a health care facility is the degree to which they feel confident in terms of the communicative environment.
- **Patient empowerment or 'activation'** – the authors argue that patients should be encouraged and educated to be more active participants in the whole process, to 'expand their role in decision-making, health-related behaviours, and self-management' (Ibid:4). Again the implied cornerstone for achieving this is effective communication, which is addressed in the next point.
- **Socio-cultural competence** – developing the competence of all levels of the health care sector is imperative if PCC is to be achieved. Here the various stakeholders need to 'understand and consider culture, economic and educational status, health literacy level, family patterns/situation, and traditions; communicate in a language and at a level that a patient understands' (Ibid:5). This aspect is essential within the multi-cultural milieu operative at the Centres that were investigated. This is critical when the patient and the health practitioners are from different cultural backgrounds. Moreover, a Centre's ethos has to be firmly predicated on a cultural empathy which recognises the potential for cultural and contextual dissonance that a patient may experience.

- **Coordination and integration of care** –recognising the possible sense of disorientation and discomfort experienced by a patient, due to reasons other than their health status necessitates a seamless as experience for the patient as the facilities and practitioners can achieve. This calls for coherence between all the structures and agents, requiring acknowledgement of all factors that will have an impact on the patient's overall experience and enhance the treatment.
- **Comfort and support** – ensuring the overall patient experience is positive requires that they are comfortable and have access to the requisite emotional support structures that mitigate against any unnecessary trauma beyond their health concerns.
- **Access and navigation skills** – here the whole experience should be as efficient as possible, minimised waiting times, suitable opening times, ensure that the patient is conversant with the procedure and processes.
- **Community outreach** – it is essential that any health care facility engages with its local community; this promotes its ability to offer PCC through a greater awareness and understanding of the context within which the majority of the patients reside. Moreover, this promotes a Centre's ability to offer wider health care benefits through education and training.
- **Feedback and measurement** – any effective PCC has to be predicated on robust feedback and measurement structures, this can be achieved through actively seeking suggestions and treating negative feedback in a coherent manner in terms of offering insight into how the quality of care can be improved.
- **Patient/family involvement** – the role and importance of family in any health care process can never be overstated. In contexts, like the researched Centres, family often carry wider responsibilities in terms of taking care of patients, to acting as translators and a significant part of

the after consultation care and support. With young members of the family often enjoying better language skills than the older generations, their role in the translation process needs to be welcome while at the same time being treated with sensitivity in terms of the nature of the ailment.

- **Workforce development** – PCC is inevitably built on a solid foundation of effective education and training for health care professionals. ‘Employ, train and support a workforce that reflects, appreciates, and celebrates the diversity of communities and cultures that the organization serves’ (Ibid:5). A key tenet of this is the language skills of the health care professionals and their cultural sensitivity; training in this area can often seem cost intensive but it needs to be evaluated against the costs of misdiagnosis and unsuitable use of medication.
- **Leadership** – The concept of PCC is unachievable without clear leadership and support from management for all aspects of the delivery of care. This points to further training and development requirements where leadership is found to be lacking or where insufficient capacity exists.
- **Involvement in collaboratives, and pilots** – the authors of the report argue that any centre should actively seek out opportunities to participate with pilots and engage in co-operations with other organisations ‘to ‘push the envelope’ in developing new methods to operationalise patient-centred principles’ (Ibid:5)
- **Technology and structural support** – obviously technology offers scope for enhancing the patient experience, internal communications and diagnosis. However, this scope must be assessed against the access to technology that the target communities enjoy and the demands on workforce development, in order to ensure that it is suitably applied. Moreover, the language of technology may potentially result on another layer of discomfort.

- **Integration into institution** – achieving PCC requires extensive buy-in from all strands of the institution, with all relevant personnel recognising their role in the achievement of this objective for the quality of health care provision.

This is a very comprehensive list and the scope for achievement is constrained by a number of potential barriers. Sillow-Carroll et al offer the following as factors that can act as barriers to the achievement of effective PCC (ibid:6):

- Difficulty recruiting and retaining underrepresented minority physicians;
- Lack of defined 'boundaries' for outreach staff who may be overwhelmed dealing with interrelated health, social, cultural, and economic issues of patients;
- Strict hiring requirements that pose obstacles to hiring neighbourhood residents;
- Lack of tools to gauge and reward PCC performance;
- Financial constraints;
- Traditional attitudes among staff unwilling to change the "old school" provider/patient relationship or acknowledge and address cultural and socio-economic issues; and
- Fatigue and competing priorities.

All of these are present in differing degrees in South African Health Care Centres and the sector as a whole, presenting different challenges and actions. However, to this list the problems associated with multiculturalism and multilingualism present further barriers in the South African context. This is to a key element of the achievement of PCC which is the level of

health literacy, by enhancing the level of health literacy is a key step towards effective PCC.

2.5 Health literacy as delivery paradigm

Communication between the patient and the health worker is very important. Adherence to a medical regimen requires that patients understand the instructions given by the health professional. They must also understand the consequences of non-compliance. Therefore, ensuring health literacy among patients is vital. Basic literacy is a prerequisite for health literacy, the level of health care literacy is very low resulting in inability to understand the nuances of their illness

Individuals who are proficient can read and understand most textual and numerical information in a health encounter. They are able to read and understand complex documents or recognise which legal documents pertain to a given health related situation. People with intermediate skills have some difficulty dealing with complicated text and documents, but they are able for example to determine a healthy weight based on body mass index or administer medications at correct times relative to meals based on a prescription label. A person with basic skills can read and understand a short simple explanatory pamphlet and follow clear language sensitive instructions. Those with very limited skills can spot an appointment date on a card or identify how often someone should have a specific medical test based on the information in a pamphlet.

Even individuals with adequate-to-good literacy skills may find the health care labyrinth difficult to navigate. Understanding health information requires more than basic literacy to interpret instructions and use that information to make a decision. With medical advances, the number of potential treatments increases the need for patients to keep up with complex medical regimen. It can be argued that the average consent form and

patient-education brochure are only easily accessible to a person with a tenth-grade reading level to facilitate patients' comprehension.

Conversely, high-level professionals may suffer from information overload. Greater access to health information on the internet may confuse these patients, because they are not of appropriately prioritising their findings.

The Centre for Health Care Strategies, Inc. in their fact sheet on health literacy quote the Healthy People 2010, as defining health literacy as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions'. While the AMA Council of Scientific Affairs, quoted in the same fact sheet offer the following for functional health literacy as 'the ability to read and comprehend prescription bottles, appointment slips, and the other essential health related materials required to successfully function as a patient'.

The problem with poor health literacy is that it leads to suboptimal outcomes. Poor literacy is a stronger predictor of a person's health than age, income, employment status, educational level, or race. 'Several studies have indicated poor health status is disproportionately high among patients with low functional health literacy' (Centre for Health Care Factsheet). If one extrapolates the results found with other chronic diseases such as asthma and diabetes, poor health correlates with poor outcomes due to patients' decreased awareness of preventive measures and their limited ability to follow self-care instructions to manage their disease. It becomes a financial strain on the health system due to errors in medication leading to increased hospitalization, overuse of the emergency department, and a greater severity of illness and the resulting disability.

Certain segments of the population are at greater risk of the aforementioned problems due to basic health literacy scores. The elderly people, members of lower socioeconomic groups, individuals who did not complete high school, minority and immigrant populations, and people with chronic mental

and/or physical conditions have lower levels of literacy. This group of people have a lower income and educational level than the higher-literacy group. They also exhibit lower compliance with prescribed medical therapy. Most patients of diabetes demonstrate this problem. These patients have a poor understanding of diabetes and miss more appointments.

Improving communication with patients is essential in addressing health disparities. The process starts with the health care practitioner. Bourdieu (1991), points out that any communication (mono- or multilingual) is a linguistic exchange, which in itself is an economic exchange. He continues to argue that this economic exchange materializes within a symbolic relation of power. Adding that, the doctor is a producer, endowed with knowledge that the patient needs. In most cases the patient is somewhat less powerful. The translator, endowed with bilingual ability, is also a producer, and the monolingual interlocutors are consumers. Therefore, the translators who have had diverse cultural experiences may be endowed with a linguistic habitus that allows the patient and the health practitioner understands each other.

Effective communication between the patient and the health care provider can be improved in some of the many ways namely:

- The health care institutions serving a multilingual population should provide brochures available in multiple languages.
- Information should be organised so that most important points stand out.
- Salient points should be written down.
- The amount of information provided should be limited.
- Show or draw pictures. Visual images can improve the patient's recall of information and understanding.
- Simple language should be used.

By engaging in these activities the health care provider can improve health literacy and the quality of the health care delivery system, thus opening the ability for the facility to provide PCC.

It is essential that the health care professional is aware of the impact of low functional health literacy in terms of its impact on the patient's experience and risks. According to the Centre for Health Care Factsheet, a person with low health literacy is less likely to:

- Understand written and oral information
- Act upon necessary procedures and directions
- Be able to navigate the health system

The fact sheet continues and argues that a person with low health literacy is more likely to:

- Receive health care through public financed programmes
- Incur higher health care costs

On the face of it these two seem contradictory but when taken in terms of the other factors, people with low health literacy are likely visit the centres more often with the associated costs of transport, lost employment and other indirect costs.

Many of the challenges associated with health care literacy call for significant investment in education and training and, of course, language structures. However, the long term returns with regard to decreased visits to centres and better results from medication make this an essential area that must be addressed.

2.6 The need for translation services

Translation makes it possible for people to enjoy the right to access to information. Health education posters are placed in health care centres to

disseminate information and support the need for health care literacy. For this information to be accessible, it must be in languages that are accessible to the target audiences. Given that the majority of the patients are more at ease with local languages than English, translation into the local languages is one way of improving the level of health literacy within the community. Translation activities are therefore a necessary, but not sufficient condition for the achievement of PCC. Translation is less commonly a language service than interpretation within the health care centres. Translated materials are found in health care centres, but tend to be of a poor quality. In some cases, it can be difficult to assess if the material is a product of translation or not. It is only possible to assess if translation activities have been applied if more than one language version of the same text appears side by side. In addition, official correspondence within the health care facilities are made using English, while professional titles and names of departments and sections continue to appear in English. However, the latter may be a consequence of a lack of suitable local language alternatives. Another possibility is that the use of English is supposed to symbolise the high status function of the domain. In the case of lower status functions, such as warnings or posters on symptoms and signs of diseases, local languages, such as isiXhosa, are used in translation. Translation of health care discourse into indigenous languages cannot be done satisfactory achieved without addressing terminology development.

Whilst interpretation is basically free since the centres do not tend to hire professional interpreters, the same does not apply to translation. In order to have a document translated, a competent individual or institution has to be hired to undertake the task. Secondly, the demand for interpretation is real time based. For example, where a patient does not speak a common language with a service provider it necessitates the use of an interpreter. On the other hand, the need for translation is more speculative. It requires a sense of leadership and insight to the needs of the patient community, it requires a needs analysis or an understanding of when a patient might

request a translated version of a document. Without a clear demand for translation, there is the danger of creating translations that are in fact not required or even used. In addition, one can never be certain that people take the care to read the translated materials. This should be appreciated within the context of South Africans' lack of a reading culture. Another consideration with translation at the health care centre: What target language(s) are materials to be translated into?

2.7 Mindfulness and Health Care

Recognising the need for translation is essential to the enhancement and promotion of effective PCC and the overall quality of the health care sector. But of equal importance is the concept of mindfulness. The concept of 'mindful' communication is considered by Kaschula et al in the context of the courts in South Africa where it can be argued the consequence of cultural miscommunication or 'cultural noise' clouding understanding can have as dire consequences as in the health care context (Kaschula et al 2008:3). Gibson observes:

'[i]ntercultural communication takes place when the sender and the receiver are from different cultures. Communication can be very difficult if there is a big difference between the two cultures; if there is too much "cultural noise", it can break down completely' (Gibson 2002:9)

This 'cultural noise' has many synonyms in the health care sector and any effective consultation and treatment regime must be sensitive to this situation. Mitigating to this is the need to create structures that can assist the patient's orientation to what may be an alien environment and full of confusion and general discomfort.

The idea of 'mindfulness' is introduced by Eades (2005) in the context of the Australian court system, where communication with Aborigines is characterized with the 'perception of differences' (Eades 2005:307). One of the examples cited is the fact that for many from the Aboriginal communities,

direct questions are not important in terms of gathering information and can often result in silence as a response which is the correct cultural response (Eades 2005). Such responses run contrary to Standard English usage and Eades refers to a handbook that has been published for those in the legal profession in Australia to promote cultural awareness and 'mindfulness' (Kaschula et al 2008:3).

2.8. Conclusion

Creating this 'mindfulness' would be a good contribution towards the context within which many health care services are delivered in South Africa's cultural milieu, this would allow health care practitioners who may be less culturally aware to enhance the quality of their services to their patients.

CHAPTER 3

MULTILINGUALISM, LANGUAGE PLANNING AND HEALTH CARE IN SOUTH AFRICA

3.0 Introduction

Effective Language Planning is essential in South Africa for developing suitable communication strategies in the workplace. Further to this, there must be implementation of these language plans in order to further enhance the effectiveness of these strategies. What follows is an expose of how language planning has come about in South Africa and how it has possibly affected communication within the health care sector.

3.1 Language usage in South Africa

In South Africa pre-1994, the development of African languages was restricted, in contrast to the development of Afrikaans, which in less than 25 years became the language of instruction in several universities. IsiXhosa, for example, first became a written language in 1824, whereas the first literary work in Afrikaans was in 1832. Two indigenous languages, Zulu and Xhosa, are the most widely spoken languages of the country with Afrikaans third and English fifth. English is in second position as non-primary language. English is the lingua franca of various high-level contexts. In use, English is the major language in the country, being almost the sole language of formal public contexts, with Afrikaans still a factor in the workplace, but with the indigenous languages used almost only for low-level functions, such as personal interaction, cultural expression and religious practice. The system of a language reflects social inequalities, but these are maintained through language use. Among black South Africans, proficiency in Afrikaans and English generally only allows for basic social interaction, and is not at a level, which allows their effective use in higher functions, such as educational development, health related issues, and many more. According to the sociolinguistic survey commissioned by PanSALB (2000), for example, reported that 49% of their respondents often did not or seldom

understood speeches in English. Lack of language proficiency rose to 60% among speakers of Setswana, isiNdebele and Tshivenda, particularly among less educated respondents, respondents in rural areas, and respondents in semi-skilled or skilled communities. The lack of English comprehension skill is also apparent in informal contexts.

The political history of South Africa, deeply embed the main country's languages. Apartheid and colonialism have meant that all the languages have acquired socio-political meanings, with English highly prestigious. Afrikaans generally stigmatized, and the indigenous languages are said to be viewed by many of their own speakers as symbols of being 'uneducated, traditional, rural, culturally backward people with lower mental powers', and as languages which are 'sub-standard' and less capable of carrying serious thought. In language political terms, indigenous languages as well as Afrikaans are 'minority languages', even though they are numerically major languages (Alexander 2007).

Bantu languages and English are in asymmetric power relations; English may become a vehicle for the struggle for power between the different socio-economic groups, and can be used for discrimination and manipulation. Cluver stated that the government never intended to develop African languages into fully standardized languages. It sought to limit them to use within the family, cultural group, Bantustan and the school (Cluver 1989:6).

Language planning is an attempt to interfere deliberately with a language or one of its varieties. Language experts, professionals agreed that a language serves as an identification mark; it gives an individual their personality. A language is a natural possession of every normal human being; through it they express hopes and ideals, articulate thoughts and values, explore experience and customs, and construct our society, and the laws that govern it. It is through language that ideas are conveyed, 'language stands, indeed, as the key component and the barometer of our development' (Alexander 2005:12).

Colonization brought with it various mechanisms to keep the conquered communities suppressed; one of the key tools for subjugation was language. People cannot share power if they do not have access to the language/s used by those in power. Decades after the political 'independence', the situation of African languages keeps on widening inequalities in the fields of science, technique and technology. The indigenous knowledge, science, medicine and local economies have in the process, lost status and become hidden. They are hidden in the local languages, which were excluded from high-level functions by the colonial and neo-colonial rulers of the continent. Ironically, high status has been given to those who use an international language, even when they are monolingual, whereas multilingual speakers of African languages have received little recognition for their communicative gifts and considerable knowledge.

The central institution that should drive language planning is the government, since they have the moral obligation, the authority and power, and resources. Policy makers must engage with language issues from a multi dimensional perspective. Implementing a language policy is not something that can be done overnight. It requires a great deal of long term commitment and energy on behalf of both public and private institutions. Training and incentives should be developed to encourage people to maintain and develop indigenous languages. Language is a key factor in building unity. African languages should be developed and intellectualized so that they can be a pride to Africans, South Africans in this context. Language policies should ensure that indigenous languages are preserved and actively used in all domains. PanSALB promote and create conditions for the development and elevation of official languages. The Khoi, Nama, San and even sign languages, in fact, all languages used in South Africa should be equally recognised.

3.2 Multilingualism as a goal

The African continent is the most multilingual region in the world, and is consequently characterized by extensive multilingual realities (Bokama 1982:77), with a plethora of languages all of which have to a varying degree become victims of English hegemony. There are in the region of six thousand languages used across the two hundred odd countries, which indicate that multilingualism is a global reality. On the continent of Africa there are an estimated 1000 - 1,140 languages are spoken (Voegelin and Voegelin 1964). An important characteristic of multilingual societies is the allocation of functions and distributions of languages across various domains.

In the multilingual context characterized in South Africa the Batho Pele principles aim at providing access to services in the languages of communities to enhance their participation. The Batho Pele principles are firmly predicated on the concept of Ubuntu. Mbigi and Maree define Ubuntu:

'[A]s a philosophy of life, which in its most fundamental sense represents personhood, humanity, humaneness and morality; a metaphor that describes group solidarity where such group solidarity is central to the survival of communities with a scarcity of resources, where the fundamental belief is that "motho ke motho ba batho ba bangwe/umuntu ngumuntu ngabantu" which, literally translated, means a person can only be a person through others' Mibigi and Maree (1995:1).

Against this backdrop the Batho Pele principles are (South African Government Information- Batho Pele – Putting People First)

- Consultation
- Setting Services Standards

- Increasing Access
- Ensuring courtesy
- Providing information
- Openness and transparency
- Redress
- Value for money

These principles offer an insight into the South African governments view for the public services offering to the wider society. Key would be the quality of health services, capacitating public workers, for example, health workers with guidelines for implementing multilingualism, to establish collaborative partnerships with community media, to enhance communication and literacy campaigns to integrate technology in multilingualism. This can be done through applying multilingualism to; official notices, written communication, internal written communication, and oral communication with the public and thus the sector would be better able to meet the Batho Pele principles within the health sector.

Mechanism and strategies for implementation could include:

- Language survey and audits
- Language awareness and campaigns
- Guidelines for language planning and management
- Translation activities
- Interpreting
- Terminology development
- Language technology (lexicon/term, spellcheckers)
- Language code of practice
- Training and capacity building

Promotion of multilingualism requires effort that does not discount the knowledge existing in societies where indigenous official languages are prominent. A community-based multilingualism is the most viable strategy. The engagement of language specialists to assist in the development of functional multilingualism through research and dissemination of findings is important for conducting policy reviews at researchable intervals to monitor progress towards a fully multilingual society, which is essential for enhancing people-centeredness and community participation. A number of structures such as the Commission for Cultural, Religious and Linguistic Rights, PanSALB, as well as other relevant initiatives and Batho Pele principles all assist in the implementation of multilingualism in the public sector.

The solution to the promotion of multilingualism in South Africa is multifaceted. It is therefore impossible that a single solution would be sufficient for achievement of all goals and aspirations for all languages. The option must be available for multiple opportunities and formats for acquiring the skills required to start speaking other languages. The role of academia cannot be underestimated as it is through this structure that language capacity, terminology development and other activities ultimately reside. It is also important to accept that the average person who needs to acquire a measure of multilingualism wants to start off with basic communication and not become a pundit in the field of languages. The future of languages lies in the ability of fellow countrymen and women to use their own and other languages without ridicule and retribution. If too many limitations and restrictions are placed on the use of multilingualism, the majority of other languages would become of increasingly limited academic value.

Language in a community could be a source of ethnic and linguistic conflict. In multilingual societies, minority groups often form language associations to safeguard or pursue the linguistic interests of the community. It creates individual opportunities, and it respects individual differences and preferences. A multilingual language policy has been articulated very clearly by the new post democratic Constitution of South Africa. Flexibility within

regions for developing language policies has been offered. The past seventeen years, the South African government has made considerable progress in supporting its commitment to multilingualism: using language as a framework, it has developed a well-articulated national policy framework, several provincial and local authorities have developed language policies, and it has developed the necessary infra-structure: the Pan South African Language Board with its constituent bodies, the Department of Arts and Culture with its language policy and development bodies, and the Commission for the protection and promotion of religious, cultural and linguistic minorities.

In spite of this extensive network, however, there has been no language political transformation: the language of official business and the linguistic landscape is increasingly English, multilingualism has not yet been meaningfully promoted and the public meaning of the African languages (their social, economic, educational and political value) is largely unchanged. In addition, the language policies which have been developed are either not implemented (including the national, provincial and municipal policies) or counter-productively implemented (such as the language-in-education policy of 1997). In South Africa approximately twenty five languages are spoken, of which eleven have been granted official status in terms of section 6 of the Constitution (Act No. 108 of 1996), on the grounds that their usage includes about 98% of the total population. The official languages are isiNdebele, isiXhosa, isiZulu and siSwati (referred to as the Nguni language group); Sesotho, Sepedi and Setswana (referred to as the Sotho language group); Tshivenda, Xitsonga, English and Afrikaans. Of these, isiZulu is the largest numerically; in the 1996 census 22.9% of the South African population named isiZulu as their mother tongue.

South Africa is therefore a multilingual country. Several indigenous languages are spoken across provincial borders shared by speech communities from different provinces. This is a striking characteristic of multilingualism in South Africa. Multilingual language policy made a

significant break with the rigid policy of Afrikaans-English bilingualism that existed during the apartheid years. As in now, there is a very strong awareness of the need to intensify efforts to develop the previously marginalized indigenous languages and to promote multilingualism if South Africans are to be liberated from undue reliance on the use of non-indigenous languages as the dominant, official languages of the state. The Constitution also states that all the official languages must enjoy parity of esteem and be treated equitably. In theory, the post- apartheid Constitution commits the government to building on an underlying philosophy of pluralism and linguistic human rights by pursuing a policy of multilingualism (Pretorius 1999). Management of linguistic diversity in apartheid South Africa has been made problematic by a lack of a clearly defined language policy, leading to the use of English and Afrikaans as the most dominant languages in the socio-economic and political domains of our society.

An intellectualized language is defined as a language which is equipped with 'more accurate and detailed means of expression, especially in the domains of modern life, that is, to say in the spheres of science and technology, of government and politics, of higher education, of contemporary culture, etc' (Garvin 1973:73). Sibayan (1999:229) considers a language to be intellectualized if it can be used for educating a person in any field of knowledge from kindergarten to the university and beyond; for a language to be used as a lingua academics in all spheres of education it should be intellectualized (Sibayan 1999).

Sibayan's claim that medical doctors say 'intellectualization of isiXhosa as the language of medicine and the medical profession...is a giant undertaking...is impractical and impossible' (Sibayan 1999:229). It is obvious that any task of this nature will seem extensive but if the commitment is forthcoming it is a surmountable one.

According to Sibayan, if a language is to be intellectualized it has to encompass various language domains (Sibayan 1999). Accordingly there

are three classes of language domains, namely: non-controlling domains those of the home and lingua franca; semi-controlling domains which include religion, politics, and entertainment; controlling domains chief of which are, government with sub-domain of executive, judiciary, and legislature, education with sub-domains of elementary, secondary, vocational-intellectualized language: each domain, sub-domain sub-domains (field of specialization) have specific registers.

The key task in terms of intellectualization, is the building of support institutions and various structures such as colleges and universities, hospitals; teaching and learning organizations that publish journals in isiXhosa; service agencies such as publishing houses and other structures. The population of a controlling domain, for example the sub-domain of medicine, consists of; physicians, nurses, technicians, nurse aids and others who speak and write the language required in medicine. In the case of isiXhosa speakers, English is the dominant language in this sub-domain. At present medical concepts in isiXhosa do not exist in any significant and relevant forms in terms of the formal medical practices. The principal support institutions in medicine are Medical Colleges, hospitals, pharmaceutical labs, etc. The computer programmes for scans, hospital records are all in English. The intellectualization of isiXhosa as the language of medicine and the medical profession and other controlling domain of a language is a giant undertaking.

Consider another example of the other controlling domains of language such as the sub-and sub-domains of science and technology, e.g. mathematics, physics, chemistry, the agriculture sciences, and other areas of knowledge. The task of building the populations, support institutions and services using isiXhosa to replace English also represents a mammoth task magnitude from both a cost and a human capital perspective.

Language intellectualization is predominately located within the written or printed form of the language and requires that it be used in all relevant

domains. Alexander states that the indigenous languages need to be developed and intellectualized so that they may be a source of pride to Africans, and used as primary tools in the development of the continent. He continues to argue that countries should establish elaborate language policies, which ensure that African languages are preserved and actively used. The most important step is the use of African languages at higher education level, that is, the intellectualization of indigenous languages. English should be the primary language, but be seen as an additional language, because of its colonial past (Alexander 2005).

Marginalized communities are becoming excluded socially, culturally, economically and linguistically, due to their lack of abilities and skills in the use of English, (Osborne 2006). African languages need to restore their value in society. Bamgbose observes that states that most students do not see the value of studying African languages and cultures as they can speak with a large number of people in English (Bamgbose 2003). As a result, African languages lose their value as contributors in the knowledge sector, (Burger and Luckmann 1966). The availability of isiXhosa on the internet will make a contribution to its capacity to intellectualize, allowing it to be used more regularly in all domains, in particular the health sector as in this case. Provided complementary structures are put in place, such as language directives and education and training of staff.

3.3 Towards an effective language structure

Medicine incorporates a large number of new terms in the medical lexicon and medical translators should be familiarised with the medical terminology, if they are to execute their tasks with aplomb. Medical translators' work is diverse. They translate medical documents and patient information, services of medical translation are becoming increasingly in demand. For example, companies selling medical products to speakers of language other than English require suitable medical translation services to ensure that their products are accessible to the widest possible markets and to avoid

incorrect dosages and other potential problems. This is an important segment of the healthcare market and it is likely to grow with the associated increase in the demand for medical translators.

Below are some examples of the translation activities between English and isiXhosa and offer some insight into this emerging terminology development driven by market requirements.

EXAMPLES OF TRANSLATION

Taken from NovoCare

ENGLISH: Diabetes

ISIXHOSA: Iswekile

ENGLISH: Early symptoms

ISIXHOSA: limpawu zokuqala

ENGLISH: Hunger

ISIXHOSA: Ukulamba

ENGLISH: Irritability

ISIXHOSA: Ukungonwabi

ENGLISH: Tiredness

ISIXHOSA: Ukudinwa

ENGLISH: Poor concentration

ISIXHOSA: Ukungaqondi xa kuthethwa nawe

ENGLISH: Later symptoms

ISIXHOSA: Iimpawu ezilandelayo

ENGLISH: Sweating

ISIXHOSA: Ukubila

ENGLISH: Shaking

ISIXHOSA: Ukungcangcazela

ENGLISH: Palpitations

ISIXHOSA: Intliziyo ebetha ngamandla

ENGLISH: Nausea

ISIXHOSA: Uzive ngathi ungagabha

ENGLISH: Confusion

ISIXHOSA: Ukuphazamiseka

ENGLISH: Treatment

ISIXHOSA: Unyango

ENGLISH: Eat a sandwich & fruit

ISIXHOSA: Yitya isonka nesiqhamo

ENGLISH: Immediately eat or drink sugar based foods followed by a sandwich & fruit

ISIXHOSA: Yitya ukutya okuneswekile msinya, okanye cola, igaga leswekile, ubusi. Ulandele ngesonka nesiqhamo.

ENGLISH: Coma

ISIXHOSA: I koma

ENGLISH: Requires hospitalization

ISIXHOSA: Umntu kufuneka alaliswe esibhedlele

ENGLISH: Rotate the injection site/area

ISIXHOSA: Sukuphinda uhlabe kwindawo enye

ENGLISH: Avoid long boots

ISIXHOSA: Sukunxiba i-boots ezinde

ENGLISH: Avoid tight socks

ISIXHOSA: Sukunxiba ikawusi ezikuqinisileyo

ENGLISH: Avoid high shoes with no support

ISIXHOSA: Sukunxiba izihlangu ezichophileyo

ENGLISH: Wear well fitting flat shoes

ISIXHOSA: Nxiba izihlangu ezikulinganayo

ENGLISH : Avoid extreme heat

ISIXHOSA: Suka ngasemlilweni oshushu

ENGLISH: Never put your feet near open heat

ISIXHOSA: Sukusondeza iinyawo zakho emlilweni

ENGLISH: Never walk barefoot

ISIXHOSA: Nxiba izihlangu rhoqo

ENGLISH: Always keep your feet clean

ISIXHOSA: Gcina iinyawo zakho zicocekile

ENGLISH: Dry your feet well especially in between your toes

ISIXHOSA: Zisule zome inyawo zakho ngakumbi phakathi kwenzwane

ENGLISH: Check under your feet regularly

ISIXHOSA: Zihlole ngaphantsi kwenyawo rhoqo

ENGLISH: If you can't see under your feet check with a mirror

ISIXHOSA: Ukuba awuziboni ngaphantsi kwenyawo, sebenzisa isipili

ENGLISH: Never cut corns or use sharp objects on your feet

ISIXHOSA: Ukuzisika ngokwa kanye usebenzise izinto ezibukhali kwinyawo zakho.

ENGLISH: Get help from the clinic or doctor

ISIXHOSA: Funa uncedo kwikliniki okanye kugqirha wakho

From the above it can be seen that much can potentially be lost in translation and the lack of suitable contextual material has the potential to exacerbate any existing condition or symptoms. For example, if instead of 'inyawo', it should have been 'iinyawo'. In English it is in plural form, and yet in the singular when translated, it does not deliver the same meaning. In order to function well, a language must be such that it makes conversation possible,

it is also important that what has been translated be simple and understandable to its target people.

3.4 Conclusion

In this chapter it is suggested that for effective communication to take place in the health care sector there needs to be proper implementation of the language policy that has already been created in South Africa. Further to this there needs to be intellectualisation of African languages in terms of health care terminology. This needs to take place in relation to terminology development that is clear and understandable to the average person who would require access to such terminology.

CHAPTER 4

TRANSLATION AND ITS RELATION TO LANGUAGE POLICY AND PLANNING

4.0 Introduction

This chapter will outline translation and its relation to language policy and planning. The key aspects of translation competencies will be addressed including, linguistic competence, cultural competence, domain-specific competence and communicative competence. These form the cornerstone of any effective PCC goals within the health care sector. As discussed above in a multilingual society the communicative paradigm that characterizes the delivery of health care services is an essential determinate of the quality of such services. This also points to the quality of the patient's experience; poor or ineffective communication will greatly diminish the user's experience and undermine the effectiveness of any medication regime applied.

According to Bassnett and Lefevere (1990), translation is a rewriting of an original text, translation is the replacement of written message with the same written message in another language. Translation is done because of the need to understand and come to terms with others and over above this, there is a need for the languages especially those that are in intellectual disciplines, to enrich other languages. It develops language and has been instrumental in cultural interaction. Translation is a powerful intervention strategy to use to improve African Languages' lexical, syntactic and stylistic intervention. It is also done to promote the culture of reading and improve levels of literacy (Alexander 2002).

4.1 Translation in South Africa

Although physicians of today are better educated and more aware of the demands of their professional, they still on occasions do not communicate effectively with their patients (Jacob et al 2001). This is especially true where the health provider and the patient do not share the same cultural background/understanding/context. Better communication, understanding can improve patient satisfaction and clinical outcome. Medical translation becomes relevant when health providers and patients do not share the same language but also has a role to play when considering the need for cultural understanding or context setting. However, it should be recognised that even on occasion when the health provider and the patient may be sharing the same language and same culture, there may be a requirement for some translation support due to the terms used in medical field.

Social and economic conditions always create a need for translation. All socio-economic challenges are to be conveyed in various languages. It is the communication of the meaning of a source-language text by means of an equivalent target-text. Therefore African languages should be used not only for communication, but also as a reflection of socio-economic progress in African societies. 'If we do not translate one of the most significant resources for conquering isolation imposed by linguistic and cultural differences is squandered, information transfer is lost, scientific discoveries would be unknown' (Alexander 2005:15).

Social conditions across societies speaking different languages always create a need for translation. Translation has played a role in the development of world culture. It is common to think of culture as national and absolute distinct. Language is the reflection of the society's history. A history of world culture from the perspective of translation reveals a constant movement of ideas and forms, of cultures constantly absorbing new influences because of the work of translators. Language is the only social institution without which no other social institution can function.

Translation is a vital aspect of language planning and language intellectualization. Language planning is deliberate language development; changes in the systems of language code or speaking or both that are planned by organizations that are established for such purposes or given a mandate to fulfil such purposes. '[It]...focuses on problem-solving and is characterized by the formulation and evaluation of alternatives for solving language problems to find the best (or optimal, most efficient) decision' (Rubin and Jernudd 1971b:xvi).

Cooper defines language planning as any 'systematic, theory-based, rational, and organised societal attention to language problems' (Cooper 1989:31). Eastman states that 'language planning generally refers to efforts in a socio-political context to solve language problems, preferably on a long-term basis, by heeding the process of language change' (Eastman 1992:96). Therefore language planning refers to any structured, coherent and explicit attempt to design the role a language should have in a society by planning its development, its status and possibly how many people are supposed to use it and in which domain (Fettes 1997).

Effective Language planning comprises the following:

- **Status planning**; that is, the allocation of language functions or 'recognition by a national government of the importance or position of one language in relation to others' (Cooper, 1981:32), i.e. decisions on the role of a language in a country at any level (i.e. national language/s, official language/s, language/s of instruction, etc). Indigenous languages should not be used only as tools for communication but as a reflection of socio-economic progress in African society. African languages should be used for the transfer of knowledge skills – a process that is mediated and conveyed through spoken or written word. It is good to utilise African languages in informal education.
- **Corpus planning** deals with standardization of a language. In this branch of language planning, activities are undertaken to ensure that the

language is able to conform to the demands placed on it because of newly-bestowed function. It involves vocabulary expansion through; terminology development, orthography work, production and publishing of material such as dictionaries, and translation of materials, especially in 'intellectual disciplines'. The lexicon of the language is expanded. Borrowing words from other languages. African languages can be developed through translation. Translation should be used as form of enriching the store of books available in African languages, as expanding the capacity of African languages to 'intellectual' domains. When African languages are developed, it therefore means that the following will come to fore (Bamgbose 1991):

- Unlimited capacity to express technical concepts
 - The abundance of reference books and reading materials
 - Positive attitudes towards them, which continue to be widespread because the languages of the former colonial countries remained the language of power, that is, English and Afrikaans continue to dominate indigenous languages.
- **Acquisition planning:** here planning is focused towards increasing the number of users of the languages. If the status of the language changes, and its corpus expanded such that it is used in other arenas, it could be attractive to other people – thereby increase the users. Status of the language changes, corpus expanded, such that it can be used in all spheres, attracts many people, and thereby increasing users. The correct platform for this is education. Learn the change to acquire (Bamgbose 1991). The speakers of the language should be proud of their language (isiXhosa). African writers should be encouraged to write more books, and be granted incentives in doing so. Hopefully their work will be read and translated, and thereby develop other languages.

In essence, translation is done in order to understand and to come to terms with others, and there is also a need for other languages, especially those

developed in disciplines, to enrich African languages. To improve African languages' lexical, syntactic and stylistic intervention, translation is a powerful intervention strategy that can be used. Translation promotes the culture of reading and improves levels of literacy (Alexander, 2003).

4.2 Hurdles to effective translation

Effective translation can be a debatable subject and driven by context and the needs for which any translation activities are undertaken. In loose social and basic economic contexts the role of translation can be driven purely by pragmatic requirements, which is to ensure that the parties have basic understanding of the communicative experience. However, in certain other contexts (e.g. health and legal proceedings) it can be argued, with some authority, that translation activities need to be as accurate, if not as perfect as possible. Translation is a complex and detailed field of study and it is important to offer some backdrop against which to assess the issues addressed by this study.

When approaching issues of experience in any communicative environment it is necessary to assess the goal of that communicative exchange and in a sense to recognise that all communication is a form of knowledge exchange of some sort or other. Thus pointing to a need to assess what is meant by knowledge, there are many definition for knowledge but in the context of the present study, it is possible to define 'knowledge as being of three kinds: 1) Linguistic knowledge which is independent of context, semantic knowledge; 2) linguistic knowledge which relates to context (e.g. earlier utterances), sometimes called pragmatic knowledge; and 3) common sense, general, non-linguistic knowledge about the real world' (Arnold et al 1994:129). In a multicultural context the interplay between these kinds of knowledge are important and need to be considered when assessing the nature and type of knowledge exchange that must occur. The nature and scope of translation activities must be informed by these knowledge considerations.

Translation can be interlinguistic or intralinguistic, namely within and language as with the former or between languages (Ho 1968:1). In the health care situation where there are indigenous languages that have had limited exposure to western medical parlance, it can be argued that both translation activities are important. Further, it is this need that can add more expense to any effective translation goal.

In the resource-challenged environments that are characteristic of contemporary health care in South Africa, a balance needs to be struck between allocation of limited public resources to interlinguistic and intralinguistic translation activities. This debate is extensive in scope and cannot be addressed in any significant detail at this point, however, it is relevant to give some background in terms the nature to which this debate needs to be embraced in the health care sector. This will offer some framing for locating the research findings and assist in the development of a suitable model for the sector going forward. An attempt to develop this framing will be done by addressing the issue of language and identity.

Joseph Schmied argues that the connection between language and identity, in terms of the use of English in Africa, operates on three levels (Schmied 1991:179):

1. Interlinguistic choice,
2. Intralinguistic choice,
3. Conscious delimitation of certain varieties and features through overt or covert prestige.

The first occurs when the speaker has English skills, while the second pertains to contexts where the speakers have a wider range of interlanguage within English. In the case of the third, this occurs when the community has developed stable attitudes to certain varieties and features in terms of the use of language (Suojanen 1992:9). In the health care context those that are able to make use of even basic English are, as discussed earlier, at a

considerable advantage to those that are only conversant in an indigenous language. It is these patients that form the kernel of the focus of any translation activities; however, by addressing how English is used by second language speakers in these contexts, using Schmied's levels may assist in guiding the balance between intra and inter translation activities.

For example, the balance by second language speakers between code switching and code mixing, may shed light on the degree to which bias should be on intra, isiXhosa medical terminology versus, interlanguage translation activities may achieve the same outcomes. 'Code switching is the use of more than one language in the course of a single communicative episode' (Heller 1988:4). A further more focussed definition refers to code switching as involving the use of two or more languages in the same conversation, 'usually within the same conversational turn or even within the same sentence of that turn' (Myers-Scotton 1993:47). The shifting by a speaker from language A to language B or code mixing tends to be more rapid in the context of a discussion where the speaker is able to call on phrases or words from a second language in the course of a conversation which is conducted in another language (Kaschula & Anthonissen 1995).

The Centres studied under this research exercise made most information available in languages that are sympathetic to the language skills and abilities of the patients. For example, in an area where the health care facility is mostly dominated by isiXhosa speaking patients, health information in the form of charts, pamphlets, etc. is made available in isiXhosa. Such information has been directly translated from other languages, usually English. However, despite these efforts questions have arisen in terms of the quality and effectiveness of these materials.

One of the key issues associated with translation has to be the question of the fact that it is often 'hard for small, often poorly funded organizations to follow a complicated and fast-moving process' (Will et al 2005:25) in terms of the translation needs. It could be argued that the health care sector is not

small but given the diversity and multicultural nature of South Africa, the reality on the ground that clinics and other facilities are de facto small organisations.

Obviously by definition there are many problems associated with effective translation, these include issues of ambiguity, problems associated with structural and lexical differences, and idioms and collocations; these are the most common issues, however, it is important to acknowledge the cultural factors that inevitably come into play and can create a myriad of problems for effective translation. 'The cultural implications for translation may take several forms ranging from lexical content and syntax to ideologies and ways of life in a given culture' (Glodjovic 2010:141). While the author in this case is considering culture in general, the issues are both pertinent and offer an insight to the consideration that needs to be brought to a medical or health culture. Glodjovic continues, 'c}onsidering the cultural implications for a translated text implies recognising all of these problems and taking into account several possibilities before deciding on the solution which appears the most appropriate in each specific case' (Ibid:141).

Recognising the problems of translation is an important consideration but should not act as a justification for abandoning any attempts to create accessible materials and support contexts for patients who may have other language skills other than the dominant language used in the relevant medical or health context.

There is a need for professional translators to ensure meaningful access to healthcare for patients with limited English proficiency. As a result government-funded programmes for healthcare institutions have been mandated to provide translation services to those with limited English abilities. Further funding agencies are increasingly paying attention to issues of cross-cultural and linguistic communication; however these commitments have not resulted in a significant increase in the number of professional translators. Furthermore, many are not suitably registered with

the translation board of South Africa, and they tend to undertake their translation tasks on a part-time job, while occupying other full-time positions. If good quality access to healthcare information is to be made available in mother tongue, it is imperative that the quality and number of professional translation staff is improved and expanded.

4.3 Translation and Health

In a multicultural environment that is the health care sector in South Africa the concept of Language Access Services (LAS) is essential if patients are to receive suitable and quality health care. The LAS issues are no longer limited to countries like South Africa. 'The need for LAS has become increasingly pertinent given the continued growth in language diversity within the United States' (American Institute for Research 2005:1). The same report argues, and concurs with material covered above, that LAS can serve to (Ibid:2):

- Increase access to care – the implications of language barriers can be extensive, from a reticence to visit a health care practitioner to inadequate symptomatic information to eventual misdiagnosis and incorrect medication.
- Improve quality of care, health outcomes, and health status - obviously the general experience and by extension the quality of care is firmly predicated on cultural and language sensitivity. In fact in the case of diabetes patients with limited English skills, the USA experience has show that 'patients who were provided with trained medical interpreters were more likely than limited English proficient patients to receive care meeting selected American Diabetes Association guidelines' (Ibid:2).
- Increase patient satisfaction – there can be little doubt that through the provision of suitable LAS, the overall patient satisfaction levels will be raised, as will the quality, as stated above. Resulting in an overall enhanced patient experience with the consequent improvement in PCC.

- Enhance or ensure appropriate resource utilisation – this is a key consideration in terms of building the economic argument for expanding the investment in translation services to promote the quality and reach of LAS. Effective LAS will contribute extensively to the overall efficiency of the system, quicker and better diagnosis, avoidance of unnecessary tests, etc. Prima facie these saving and efficiency gains will far outstrip, in terms of return on investment in LAS.

While the concept of LAS has been implied earlier in this research project, it is introduced here as a key focal point for the concept of effective translation and the role of translation within the sector specifically, to offer a solid and coherent foundation around which to locate the activities of translation and the costs of such activities. However, implicit in the concept of LAS is cultural awareness, which no amount of translation services could adequately address, this indicates the need for a more holistically approach to concept of LAS. Translation is a necessary but insufficient condition for promotion of effective PCC.

Although is patently correct, the creation of a culturally sensitive and aware environment, starts and to a degree ends with translation activities, translated materials and direct translation coupled to a level of empathy that must rise beyond the purely medical considerations. This leads to an argument that the translation activities in a health care context are of a robust two way nature. 'Lack of awareness about cultural beliefs and customs about health can also create mistrust and problems that interfere with good care' (Community Catalyst 2010:1).

In South Africa, the multilingual and multicultural landscape delivers a plethora of challenges, in terms of cultural awareness these can be extensive especially with regard to the balance between traditional and more formal forms of health care. For rural patients the balance tends to be skewed in favour of initial contact with traditional systems for developing conditions. If these are not successfully applied, a formal consultation may

be characterised by embarrassment or lack of desire to be fully honest with the health care practitioner in terms of symptoms and other factors.

This points squarely to the need for workforce development activities, and should include (Ibid:2):

- Provide ongoing staff training on the importance of cultural and linguistic competency and on the health beliefs, practices and values of different cultures
- Regularly assess the attitudes and practices of staff and the policies and structures of organizations to ensure cultural competency
- Include cultural awareness training in the curriculum of all health professional schools
- Mandate cultural competency as part of licensing and continuing education requirement for health professionals
- Recruit bilingual and bicultural health care workers as providers, administrative staff, lab technicians, pharmacists and front line staff

These activities act as complementary to any translation activities and are essential if the LAS are to support a coherent and effective PCC delivery.

4.4 Conclusion

In this chapter the link between language planning and translation has been made. Part of effective language planning and implementation is for this to happen in a practicable way as outlined in the Constitution. Developing appropriate translation strategies within the health care system is fundamental to enhancing communication effectiveness at the health care coalface.

CHAPTER 5

SELECTED HEALTH CARE FACILITIES: LANGUAGE POLICIES AND PRACTICES

5.0 Introduction

In this chapter the research sites are introduced. The ethnographic nature of this study will be related back to the theory that has previously been presented in order to assess what is happening on the ground. In other words the research sites that are outlined below will be used as case studies in order to inform this study.

5.1 Introduction to Motherwell and Provincial Clinics

In this section the research sites for the study will be explored as facilities that are important in creating context and developing an awareness of the environment within which health care services are delivered. Further, it will assist in highlighting the challenges that are faced in terms of the development and delivery of PCC. The research was centred on two Health Care Facilities: a provincial hospital and township clinic, namely, Provincial Hospital and KwaZakhele Health Care Centre. By using these two different sites, situated in markedly different areas and addressing different target audiences, with dissimilar resource bases and facilities allowed for the research to generate a comparative analytical framework in terms of the care extended to diabetes patient from diverse backgrounds. According to Berg, the research site should be a location where:

1. Entry or access is possible
2. The appropriate people (target population) are likely to be available.
3. There is a high probability that the study's focuses, processes, people, programmes, interactions, and /or structures that are part of the research question(s) will be available to the investigator; and

4. The research can be conducted effectively by an individual or individuals during the data collection phase of the study (e.g., an African-American researcher should not undertake research among members of the Ku Klux Klan).

The respective research sites are different in many respects, for example:

- Location
- Demographics of diabetes patients
- Physical building
- Size of the building
- Staff
- Waiting rooms
- Equipment
- Furniture
- Fencing
- Security
- Queue
- Outside chairs and shelter
- Hawkers
- Roads

These differences have implications for the scope for delivering PCC, for the overall patient experience, the availability of resources and capacity to engage in translation and cultural awareness exercises. Further, the respective sites give an insight into the overhang of the previous government's unbalanced approach to health care delivery. The township clinic is typical of an Apartheid facility which was historically reserved for members of the oppressed communities, while the Provincial Hospital was reserved for the white communities. This dispensation has contributed to no small degree to the relative facilities base that is discussed below.

5.1.1 KwaZakhele Community Health Care Centre

KwaZakhele Community Health Care Centre, (shown in fig. 1.) is situated or located in a so-called township of Port Elizabeth, KwaZakhele. It is easily accessible to the patients, due to the fact that most patients walk to the clinic from the surrounding community; therefore, distance does not represent a constraint for the patients. The surrounding community is predominately made up of informal dwellings, commonly known as shacks. Shacks are usually built from cheap and easily available materials, but may include zinc and wood. These settlements are known to be very insecure areas for the uninitiated and many residents would be wary after dark.



Fig. 1. Entrance to the KwaZakhele Community Health Centre

Diabetes patients that receive their treatment at KwaZakhele Community Centre represent the lower socio-economic groups of South African society. They exist within a very challenging environment with limited access to many conventional amenities such as; running water, flush ablutions, electricity and refuse collection. They would, with few exceptions, be living

below the poverty line, with limited economic opportunities. Consequently, their need for suitable health care services is likely to be higher than those who have access to better day-to-day amenities. These patients are faced with many of the bedfellows associated with poverty namely; high incidence of HIV/AIDS, chronic unemployment and inordinate levels of crime and violence. These contribute to the pressing health care needs; coupled to low English language skills levels within the community. Highlighting the challenges faced by the KwaZakhele facility as it aims to achieve PCC. Most diabetes patients in this area suffer from extremely poor conditions and this has been highlighted in the local press (Herald, Tuesday, October 19, 2010). Port Elizabeth is now more commonly known as Nelson Mandela Bay Metro (NMM). More than a third of households in NMM live below the poverty line and the figure is growing as the state of the global economy deteriorates. NMM is located within the Eastern Cape Province of South Africa, and as the major metropolitan area in the province attracts many rural migrants in search of employment. This is a global phenomenon with the concomitant growing pressure on health care services as these new residents enter the peri-urban areas and find employment difficulties they experience a decline in their health. The problems of poverty have implications for the people in KwaZakhele area in terms of diet. Diabetes patients are even more susceptible as their dietary requirements are an important in terms of effective care and treatment.

The physical building of this health facility, as shown in fig. 2, is not ideal, the materials used are cheap, and of a temporary nature i.e. not bricks and cement. The layout is not patient friendly and does not lend itself to PCC. For example; waiting rooms are far from consultation rooms, the walls of the building are very thin, some windows and doors are broken, and floors are not sub-standard. The size of the clinic is not able to cope with the number of patients leading to patients waiting or queuing outdoors.



Fig. 2. Overcrowding

The staff establishment of health workers is such that there is; a superintendent, matron, sisters, nurses and general workers. The clinic gives the impression of being short staffed; this is gleamed from the time that it requires for patient to traverse the complete health care cycle i.e. from arrival through waiting and consultation to receiving medication. Coupled to this is a high health care/patient ratio and a lack of sufficient cleaning personnel makes the maintenance of a high standard of hygiene difficult. These factors militate strongly against achievement of PCC.



Fig. 3. Queuing outside the building

As outlined above the facilities are inadequate in terms of the patients' needs and as figure 3 demonstrates outdoor queuing is common. On occasion the patients start queuing overnight to ensure that they are able to secure health care within suitable times the next day. In some instances the chronically ill or those unable to queue for extended periods often hire a queuing person to secure a place. Other problems include inadequate furniture, fittings and equipment in the facility, as shown in fig. 4.



Fig. 4. Outdated Equipment & Furniture in use at the Centre

The clinic is surrounded by a high-fence, with barbed-wire in the more accessible parts of the fence. This is part of the facility's security infrastructure is complemented by security gates which are controlled at all times. Therefore, access is controlled for both vehicles and people. Public transport in the form of mini-busses and taxis do not enter the facility using areas outside for any passenger collection and drop-off.

As indicated above the basic amenities in the surrounding areas are poor and this situation is replicated inside the facility with no access to water in the waiting areas, requiring patients to ensure they have made suitable arrangements for their own needs. This obviously undermines any attempts to realise PCC.

5.1.2 Provincial Hospital

This hospital is located in Central, Port Elizabeth (Nelson Mandela Bay Metro) and shown by figure 5, below. The health care facility caters for patients in the surrounding area. This area is dominated by the so-called middle class people. This site would be predominately used most probably by urban dwellers within the City limits, they are likely to enjoy higher levels of education, when compared to the patients at KwaZakhele and may prefer to consult General Practitioners. Most of the people in these facilities catchment areas are also likely to be employed and less likely to live in poverty, plus have better English language skills.



Fig. 5. Provincial Hospital, Port Elizabeth

The Provincial Hospital is one of the oldest health care facilities in Port Elizabeth; however, despite its age it enjoys a high level of maintenance. The structure is solid with, no broken windows, neat and tidy lawn, lockable doors; good working condition lifts to the various floors.

The facility enjoys a large capacity and is able to cater for a large number of patients, unlike KwaZakhele there are no patients who are required to wait outside the building, no queues snaking outside and adequate accommodation in suitable waiting areas. Sections are classified according to diseases; there is a separate section for diabetes patients who are treated in exclusive areas. Similar facilities exist for sufferers of other diseases, testing areas are well resourced and the hygiene levels in common areas are very high.

The staff complement is adequate which results in a smooth patient experience and waiting times are considerably shorter than is the case at KwaZakhele. Staff morale is high and they are very motivated, which is a key factor for the achievement of PCC.

Overall the Provincial Hospital is superior in terms of facilities in every one of the areas discussed in terms of KwaZakhele. Consequently, as a facility it is much better prepared to create an environment of the achievement of PCC. Coupled to this is the fact that the Provincial Hospital is better able to address issues of language and cultural awareness, if only due to better staffing alternatives.

5.2 Language Policies at Centres

Chen has argued that: 'If there had not been any Tower of Babel - if there were only one language in the world today, then there would be no need and no place for the concept of language rights. (Chen 1998:45). While the Tower of Babel is metaphorical in the context of this research, in terms of language services in health care if there had not been the Tower of Babel – there would be no need for language services or language mediation. However, the issue of cultural is not as easily dismissed, assumes a monocultural context, there would still be issues pertinent to awareness of medical culture. However, in a multi-cultural context there are a number of levels and issues that come into play, as intimated above. Firstly, the need for effective language access. Secondly, the need for cultural awareness on

the part of the health care practitioners, and finally, the need for an awareness of the medical culture on the part of the patients. The critical importance for the service provider and his or her patient to be able to communicate through a common language has already been spelt out in the previous chapters.

In order to address the language situation in each of the centre's the analysis has been arranged around the key aspects of creating vibrant LAS for creating an environment that promotes PCC.

5.3 Interpretation

The Constitution of South Africa grants the right to interpretation services to the justice system only. The implicit assumption is that without interpretation, there would be miscarriage of justice. Of course, there is evidence to support the importance of having interpretation services in the justice system in multilingual Africa (Brock-Utne 2002). What is problematic, however, is that by providing for interpretation in the judicial domain only, to the exclusion of other public service domains, the constitution creates the impression that this type of language service is not merited in other domains. The logic is in all likelihood due to a perception that in other domains translated materials and casual interpretative structures will suffice. This is problematic when assessed against the role that LAS plays in the achievement of PCC.

The centres researched are not able to function effectively and administer even basic levels of health care without interpretation structures and activities. The centres are just one of the many contexts in the public services domain where interpretation is regularly required. Furthermore there are no official guidelines on interpretation at the research sites, resulting in a very ad hoc and unsatisfactory situation that undermines the effectiveness of the LAS. The interpretation that does occur is still offered through networks of support that exist between service providers and

patients, often with support from family members or friends of the patients concerned.

The terms interpretation and translation are often used interchangeably (Hatton 1992; Hatton & Webb 1993). However in the health care context it is not suitable to treat these as synonymous. When patients and health care practitioners engage in consultations there are many levels that may require translation; materials, contexts, processes, etc; while conversations, instructions, etc. may require interpretation, not to exclude some of the wider medical contexts. Consequently, these activities must be viewed and treated as distinct, especially if the health care is to meet the challenges of LAS and deliver PCC. In these circumstances, translation addresses the act of converting oral messages into another language, which is accessible to the recipient (patient), whilst translation refers to the conversion of written messages from one language into another that is also accessible (Haffner 1992; Valdes & Angelelli 2003). Consideration must also be given to the patients' languages skills in both the written and oral form when identifying the suitability of the relevant LAS that are applied.

For the purposes of the study, anyone who performs the task of interpreting or translation is referred to as an interpreter or translator, irrespective of whether or not they have received professional training or have been certificated. The reason for these 'loose' definitions, is that a strict definition of the type used by Perkins (Perkins 1999), as this would preclude anyone at either centre from being classified in the strictest sense. Perkins argues that within a health care environment interpreters are 'persons who have received some training in medical interpretation and the ethics of interpreting. This does not include friends or family members (particularly adolescents) unless they have received such training' (Perkins 1999:1). This definition does not apply satisfactorily to the centres under discussion, where it is common and necessary for anyone with the ability to speak the languages of the interlocutors to act as an interpreter. As Davidson observes, "in medical settings interpretation means something other than

'oral translation'; it is understood, by institutional insiders, that physicians interpret diseases and disease processes, which is the heart of medicine" (Davidson 2001:173). This indicates the complex nature that is characterised by the health care environment. It is for this reason that some medical practitioners talk of translation, which is wider and more encompassing, rather than interpretation.

The study of the Centres aimed to collect data on interpretation from patients' and service providers' perspectives, and how each of the two categories viewed interpretation as it was conducted at the research sites. To this end, relevant data was collected through patients' and service providers' questionnaires, complemented by interviews with key informants. Through these methods, the study aimed to develop insights into critical questions:

- Under what circumstances was interpretation required?
- Which linguistic groups are most in need of interpretation?
- Who provided the interpretation service?
- How effective/ineffective was the interpretation as a bridge to communication?

What this study has not done, however, is to conduct an analysis of interpreter-mediated communication between service providers and their patients. This approach has been undertaken by other studies that have followed the discourse analytic approach, for example, Davidson (2000, 2001) and Bolden (2000). In such studies, it is the interpreter-mediated communication itself that is the focus of the analysis.

The interpreter-mediated communication at the centres is important and this study offers an initial foundation upon which to develop such a study and this would be of extensive value for a future researcher.

5.4. Need and use of Interpreters

The inability on the part of a service provider to speak a patient's language represents a linguistic barrier and is a significant hurdle to the provision of high quality health care and PCC. The most effective way to remove such a barrier is through the creation of suitable interpretation structures and suitably qualified personnel. Any such efforts in this regard need to be applied and developed in a coherent and considered manner to avoid the interpretation itself contributing to the creation of further barriers.

An important aspect that needs to inform any introduction of interpretative activities is the existence of 'language concordant' interactions i.e. where the health care provider and the patient share the same language, but where the patient's command of the language is limited. 'Matching limited English proficient patients with physicians who speak their preferred language – also known as language concordance – can be challenging, but it has clear benefits (Kaiser Permanente 2009). This may strike as stating the obvious; however, the fact that the two parties share the same language does not necessarily result in a deeper understanding of the process. The scope for language concordance is not always as wide as would be required to ensure the provision of PCC at the respective centres; however, staff at the centres does attempt to ensure concordance wherever possible.

While concordance is a wide and significant topic within any public service domain, and warrants further research in the context of the centres under the study, this study aims to lay the foundation for this further study. The present focus is aiming to address, amongst other things, the degree to which language concordance and more specifically language-discordance occurs.

The existence of language concordance and discordance, points to the fact that interpretation is a complex issues, and while it can contribute to removal of communication barriers between parties who do not share a common or

colleagues. For example, a nurse or any other local member of staff (with suitable and appropriate language skills) is required to accompany expatriate doctors while they make their ward rounds. For instance, a patient attendant observed that in her department:

“We have a white doctor who doesn’t understand isiXhosa, I can speak several vernacular languages. So I go with her to interpret. I become a bridge between the two. So there are no difficulties because I interpret to both of them.” These circumstances are repeated across the centres whenever expatriate or English/Afrikaans speaking doctors are engaged with patients.

Whilst these anecdotal examples may lead to the conclusion that local health service providers face no linguistic barriers in their daily work, the evidence gathered by the study points in the opposite direction. Given that the most widely used language when dealing with patients is isiXhosa, local service providers who are conversant in isiXhosa find themselves, from time to time, requiring some form of interpretation to ensure that correct messages are conveyed and received. The situation becomes more complicated by the fact that some patients speak minority languages, such as isiHlubi and isiBhaca, which obviously present their own problems. Under these language conditions, isiXhosa speakers find their abilities inadequate to meet the demands of effective PCC for these patients, thus requiring interpretation support of some form or other.

Whenever a service provider was faced with a situation in which he or she had to serve a patient whose language he or she was not able to understand, the mostly frequently adopted language facilitation strategy was to seek interpretation. This result is consistent with the dominant view in the health communication literature that interpretation is the standard solution for overcoming language barriers (Bolden 2000, Candlin and Candlin 2003; Davidson 2001). The second most widely used strategy was for the service provider to switch to other language(s) in an attempt to find some possible

bridging language, the ability to communicate directly without the need for interpretation obviously has its own merits. Wherever possible the opportunity for language concordance must be the goal of all patient-health care professional consultations, i.e. communication without the use of interpreters. It is tempting to say interpretation should only be used when direct interaction is not possible, but this is not a simple rule to apply, the nature and quality of any direct exchange must be assessed against the benefits and patient comfort of being engaged in their MT. The study did investigate the degree to which the service providers at each centre felt that MT capabilities, in terms of their patient communication, were important. This returned a resounding positive from the vast majority respondents, which is indicative of the wide recognition of the role of effective language services within the sector.

It is significant to note that the overwhelming majority of the service providers held the view that it was important for them to share a common language with their patients. This is a sound solution for breaking language barriers. As a follow-up question, the service providers were asked to justify their responses. The main reason cited for this viewpoint was that if a service provider speaks the language of his or her patient, communication problems are minimised. At the same time, it was recognised that speaking a common language does not necessarily mean that communication problems between interlocutors can be eliminated completely. Most acknowledged that problems could still arise due to inadequate command of the target language or use of different variants of the same language.

Some service providers went on to elaborate on concerns that being able to speak the patient's language would assist in avoiding errors that may occur due to problems with effective interpretation. This points to the fact that those interpreters that can be mobilised and not adequately qualified to perform these delicate tasks. Inaccurate or incorrect interpretation can result from various reasons, from poor grasp of complex medical terminology to limited ability on the part of the patient to engage effectively

from an unfamiliar contextual framework. The ability to offer effective interpretation for subtleties and nuances so common in the health context could impact on the effectiveness of the communication. 'For example, whether a physician uses soothing, neutral, or harsh language in consultation may influence the course of treatment' (Gesler 1999:15), while the use of medical terminology and how the prosody is used can also have a significant impact on the effectiveness of any treatment regime. The demands that this can place on an interpreter can be extensive, and may require a high degree of training, which may be/is well beyond the resource availability for the Centres.

Another factor that can cause the interpretation activities to be less than ideal results from the tendency to leave out information or edit what either of the interlocutors has said. To quote one of the respondents, this occurs for example when an interpreter 'cannot say exactly what the patient is complaining about,' a point made by one of the nurses. A trainee English speaking technician who had no competence in the clinic's majority language, isiXhosa, was reliant on interpreters whenever he was required to engage with non-English speaking patients. From his experiences, he claimed that 'when you use interpreters, you cannot get exactly what the patient wanted to talk to you about.' Another form of faulty interpretation was to embellish what the patients were saying. One of the respondents observed that, 'if you speak the language of your patient, it makes it easier to solve your patient's problem because an interpreter can easily say what a patient hasn't said.'

Some studies have documented the existence of conflict between service providers and interpreters due to the fact that service providers, usually doctors, accuse 'the interpreter of censoring or inadequately translating the patient's reply' (Kaufert & Koolage 1984:285; see also Saohatse 1997, 1998, 2000; Crawford 1999). Thus, as stated above, the interpreters are acting as editors (see Crawford 1999; Bolden 2000). The view that interpreters can act as editors seriously questions the popularly held metaphor which

designates an interpreter's work as being "that of a 'voice box' or a 'translating machine'. According to this view, each utterance in language A is transformed by the interpreter into an equivalent in language B" (Bolden 2000:390). But as the service providers at the sites have observed, and research in other countries has also shown (e.g. Kaufert & Koolage 1984; Saohatse 1997; Crawford 1999; Bolden 2000; Davidson 2000, 2001), interpreters have a strong tendency to act as filters, exercising significant power over the substance of what is eventually communicated. In so doing, interpreters do not always convey an unaltered message, which can have serious implications in sensitive health care contexts, and militate against effective PCC.

Against this backdrop the study, in terms of the penchant for acting an editorial manner, explored the necessity for the interpreters to have a medical background to ensure that such actions were suitably sensitive to the health based context. The dominant view that emerged from the interviews with the various respondents was that, in order to be an effective interpreter at the Centres, a medical background allowed for more effective engagement with patients and made a contribution to the realisation of PCC.

When patients have the so-called 'straightforward medical problems' (Baker et al 1997) - such as a laceration or a sprained ankle - clinicians find little or no need for an interpreter, or a common language with the patient. This view was also advanced in the patient/hospital attendants' focus group discussion; in fact the group indicated that often accident victims arrive in an unconscious state or are simply too traumatised to speak. There is, therefore, no opportunity to have a clinical interview with such patients. Physical examinations and immediate action take precedence over any need to communicate with the patient.

Through processes such as x-raying, a patient's injuries may be identified and then treated, these are instances when communication is temporarily suspended. A service provider in the dentistry section, a dental therapist,

argued that communication is often superfluous as, for example, if a tooth is rotten, it is visible to the naked eye and can be removed with little or no exchange with the patient. There are many other examples in the context within which the centres deal with patients, from stab wounds, through accidents and other trauma conditions. It means that even if there is no common linguistic medium of communication between the therapist and the patient, the former will still be able to make a diagnosis and treatment prescription. A senior colleague of the dental therapist, however, dismissed this view, arguing that even when it is clear that a patient has a rotten tooth, some questions may still have to be asked by the therapist which the patient would be required to answer. For example, the patient's history, habits and other information would be essential to ensuring that the correct action is taken and post treatment factors are appropriate. Moreover, in the case of removing a tooth the patient's history could highlight any possible complications that could arise from any pain medication that could be administered. This cannot be adequately achieved without at least a basic exchange of information between the practitioner and patient. PCC can only be achieved when those contexts that do not involve an exchange between the health care provider and the patient are characterised by extreme trauma and/or cases with dire emergency needs.

On a visit to the physiotherapy department, the service providers were interviewed in terms of their experiences of the importance of communicating with patients either directly or through interpreters. Again the aim was to generate data on the relative importance of direct or interpreted communication with patients. This had the potential to generate a better understanding of the situation where physical malaise of the patients were easily identified, obviously, the scope for undertaking such action under conditions of trauma was not, and should not, be feasible. One of the physiotherapy patient attendants who were interviewed while attending to a patient who was engaged in physical exercises to address an injury, offered an informative example of the importance of direct, as

opposed to mediated communication, between a service provider and a patient. The patient attendant noted that although she could see that the patient's problem was either an injured arm or leg, she still had to ask the patient about how, where and when the injury was sustained. In addition, she also needed to know which areas of the injured arm or leg were most painful. She also stressed that during the required body exercises, she was required to take extra precautions to ensure that the patient did not sustain any further injuries, thus neutralising any treatment or at worst aggravating existing conditions. She would therefore, for example, ask the patient: Xa ndisenza ngolu hlobo, ingaba uva kabuhlungu? (When I do like this, do you feel some pain?) This represented the basic precautionary measures to ensure that the body-fitness exercises were not contributing to any further discomfort or potential injury. It was not possible for this practitioner to direct and supervise the physical treatment without suitable language concordance structures. However, this was achieved i.e. through her own knowledge or that of an interpreter. Simply communicating through gestures was highly undesirable in a context where further injuries are characteristic of any treatment regime; relying on signs/body language can be misleading and problematic. The role of intelligible verbal communication, therefore, remained paramount in physiotherapy. It is clear that in order to make suitable in-roads into the provision of PCC there needs to be a common language framework or structures that can address absence of suitable language concordance. Recognising this need for an effective and efficient language framework, opens the questions at the two centres: Who requires interpretation and/or when is interpretation required? Both service providers and patients at the research sites do have occasions when they need interpretation. Patients interact with two types of service providers, local service providers (speakers of the dominant indigenous languages) and non-indigenous language speakers or expatriates. This presents a fairly clear differentiation of who requires interpretation in terms of providing a suitable service; this would be the latter groups. For the expatriate staff, English tends to be their sole medium of interaction with patients and

language concordance with the patient. The third strategy was the use of gestures or signs. The following account given by an expatriate radiographer, a native speaker of English who was not able to speak any local language, offers testament to this strategy; 'often an examination can be carried out using signs, gestures and expressions. When further communication is needed, one of the department's patient attendants or other member of staff translates as required.' Responding to the question whether it was important for service providers to share a common language with patients, the radiographer was of the view that 'it is important though not always essential. The degree to which it is important will depend on the procedure being undertaken and how flexible the doctor/clinician is.' These are very important observations as they point to the fact that not all hospital procedures need verbal communication at the same level. In some cases, the lack of a common language between a service provider and his or her patient does not prevent the execution of certain procedures. What can suffer, however, is the quality of the procedures or treatment.

The study identified a further strategy that practitioners found useful, this is to make use of the patients' medical files, if such documentation was available, and consequently it mostly applied to in-patients. For example, one of the nurses said that when she failed to garner sufficient patient information from the subject due to lack of a common medium of linguistic communication, she would resort to reading the patient's records to generate sufficient understanding of the patient's medical history. Obviously, this is not possible when patients are newly arrived for treatment. They will require more attention that will be language intense as the practitioners endeavour to build an understanding of the patients existing medical condition and generate as comprehensive an understanding of the medical past as possible. However, it must be acknowledged that even when such records are available, they cannot be a substitute for actual service provider and patient interaction. Records, for example, cannot respond to questions regarding current health issues, speech still remains

the most direct and reliable means of communication between a service provider and his or her patient(s).

5.5 Translation activities at each centre

Nida quotes Richardson who observed that translation 'is probably the most complex type of evident in the history of the cosmos' (Nida 1993:1). Accepting this observation on face value, the situation of translation in a health context adds to the complexities given the gravity of the possible results of any errors of facts that axiomatically could be 'lost in translation'. Wong and Shen argue that when considering translation 'the three most important areas (are) language, culture and the translator's personal conditions' (Wong and Shen 1999:78). The authors continue and break each of these down in their respective components (Ibid:78-99):

- **Linguistics factors** - phonological, lexical, syntactic and textual;
- **Cultural factors** – culture-specific expressions, aesthetic differences, political interference, ethical influences, strategic orientation, and period style;
- **Personal factors** – personal competence, personal attitudes, aesthetic attitudes, attitude towards recipients, strategic attitudes, political and ethical attitudes, professional attitudes.

This list is presented here to offer a window into the minefield that characterises the challenges associated with effective translation in any environment. With the added loop associated with health care should allow for a greater understanding of the operational situation that confronts the centres in their drive to offer suitable PCC.

Translation and the rights it bestows are central to any suitable human rights contexts and, as Article 19 of the Universal Declaration on Human Rights states, everyone has the right to seek, receive and impart information regardless of frontiers.

In the centres health education posters are the customer approach to translation in terms of supporting the dissemination of information on health matters; this material is deemed health education literature. For this literature to be accessible, it must be in languages which are accessible to the patients and those who care for them outside of the centres. Given that the majority of the patients are more at ease with local languages, as opposed to English, translation into the local languages is a key tenet of the LAS in the Centres and, consequently, of the Centres' ability to supply PCC.

Through observations and other evidence gathered from the research data sources (questionnaires and interviews) and from key personnel, it is clear that translation is a much less common in terms of LAS than interpretation. The reality is that there is a near non-existence of translated materials at either site. In some cases, it is difficult to discern if the materials are a product of a translation exercise or not. This can only be ascertained when material in source and target language is simultaneously available. It can be argued that this situation has developed due to fact that English is seen as carrying a higher status function within the domain and any translation, no matter how effective, seen as inferior and thus avoided by patients. In terms of low status functional communication such as warnings or posters on symptoms and signs of diseases, isiXhosa or other local languages are used in a suitably translated manner. Even in the political dispensation in which the use of isiXhosa in official domains is prescribed, there is no suitable translation of material into isiXhosa or it has not been done to a satisfactory level at either centre. This situation could have arisen for a number of possible reasons, but the research seems to indicate that translation is more demanding than casual and ad hoc interpretation that is so common across the sites. The issue of costs cannot be discounted. In these circumstances, interpretation is to all intense and purposes provided free so neither Centre is required to hire professional interpreters. The same does not apply to translation. In order to have a document translated, a competent individual or institution has to be hired to undertake the assignment. Secondly, the

demand for interpretation is driven by real time requirements. For example, only when the patient is in site does it become clear whether or not there is a requirement for interpretation.

Developing effective and cost minimal translation activities requires extensive proactive activities such as needs analysis, patient demographic knowledge and/or patient requests for such material. Without a clear idea about the demand for translation, there is the danger of making translations that are in actual fact not required, representing a misallocation of limited resources for the provision of PCC. In addition, it can never be clear that people care to read the translated materials, especially in a South African context where there is a lack of a reading culture.

Another consideration regarding translation at both sites is the question associated with the question of which of the target languages that should form the framing reference for translation activities. Although theoretically, a linguistic pluralism type of language planning (Cobarrubias 1983) in a democratising multi-ethnic and multilingual society should ensure that public information is made available in as many languages as possible to ensure maximum diffusion of information, the reality is that this is often practically impossible. First, it is impossible to do efficiently on purely economic grounds. Secondly, the fact that significant numbers of mother tongue speakers of some of the minority languages do speak the dominant languages adds to the lack of economic viability in terms of translation into all official languages. Another constraint is that many of the languages lack a suitable level of standardisation both lexically and orthographically. This makes it important to adopt a standard dialect which all speakers would find easy to understand, otherwise there is a risk of an obscure or rarely used dialect acting as a barrier to the effectiveness of translated materials. It is against this background that we find a low volume of translations into isiXhosa at the Centres.

The scope for local Centre based action in terms of the development of the translation aspects of LAS need to be assessed in terms of the demand for translation services. As discussed above there needs to be a systematic approach that is firmly located on the need for any translation activities to ensure that resources are not misallocated. Further, it needs to be recognised that most of the materials that are available as translations are centrally commissioned (Department of Health) and not at provincial level, despite the fact that such structures are possibly more attuned to the needs at the coalface. Consequently, most of the translated literature comes from the Ministry of Health, whilst the other multi-lingual literature comes from both local and international health bodies such as the World Health Organisation.

Since the Provincial Hospital does not require a significant level of translation on a regular basis, it might seem that the best approach is to use the services of institutions such as the Centre for Language Studies or freelance translators whenever the demand arises. This is the strategy that is utilised for the translation of health care material into Malawian languages; however, these languages also exhibit a lack of standard health care terminology.

As Bandia (1998) has observed, freelance interpretation and translation can be lucrative, hence the observation by Englund (2001) that even those not specialized in language studies are attracted to the field driven by the potential for lucrative returns. It was argued earlier in this chapter that in order to be an effective medical interpreter, a professional must have fluency in the relevant language complemented by suitable medical knowledge. The same argument is applicable to the translation of health-related materials, skills in the relevant language is not sufficient on its own.

Some service providers suggested that one way of reducing the linguistic barriers at the research sites was to provide language courses to both local and expatriate staff. Such courses would improve the communicative ability

of the service providers as they discharge their duties. It is important that expatriate service providers be exposed to a language course that also features culture-based styles of communication. Sullivan (1991) stresses the importance of this linguistic and cultural knowledge. His word of advice is that:

'Health professionals, if they are to effectively communicate with their patients, must be fluent in more than one culture. We must carefully study African perspectives in a search for additional avenues for assistance, particularly in the training of African physicians. This requires sensitivity to cultural differences, and an awareness of appropriate language and behaviour in discussing health care practices' (Sullivan 1991:3).

Developing cultural awareness at the centres is a key element of promoting the LAS and by extension ensures the provision of PCC. However, again as with the issues surrounding interpretation and translation, it requires a coherent and systematic exercise that ensures that scarce resources are applied as effectively as possible. In the present context, the cultural awareness challenges carry a duality that can result in inefficient application of resources. This transpires from the need for cross cultural communication demands and the lack of familiarity with medical culture on the part of the patients. Consequently, it is important to reach a suitable and workable understanding of the base line for cultural awareness that is necessary to support the achievement of PCC.

As outline earlier, culture is a complex interaction between; amongst other things; customs, beliefs, values and viewpoints. 'Cultural belief systems interact with all aspects of information processing...and determine appropriate reactions to environment stimuli' (Seibert et al 2002:143). As any medical diagnosis is firmly located on the need to process information it is not surprising that '{k}nowledge of the patient's culture and sensitivity to its basic premises is imperative to quality treatment and recovery' (Ibid:143).

The complexity of culture and the interplay with the medical context makes the need for suitable cultural awareness on the part of health care professionals essential if any care is to be effectively patient centred. Seibert et al offer a checklist for the achievement of suitable cultural sensitivity and awareness within a health care environment (Ibid:144-145):

- **Communication method:** It is important to recognise the preferred method of communication and make all the necessary arrangements to ensure that this is the method used for consultations and other communication.
- **Language barriers:** Identify potential language barriers (verbal and nonverbal). List possible compensations.
- **Cultural identification:** Identify the patient's culture.
- **Beliefs:** Identify religious/spiritual beliefs.
- **Trust:** Does the patient and/or family appear to trust the caregivers? In these circumstances it is necessary to recognise verbal and non-verbal cues in order to promote feelings of trust on the part of the patient and their family.
- **Recovery:** Does the patient and/or family have misconceptions or unrealistic views about the caregivers, treatment, or recovery process?
- **Diet:** Address culture-specific dietary considerations.
- **Assessments:** Conduct assessments with cultural sensitivity in mind.
- **Health care provider bias:** It is important to acknowledge that all participants bring bias and prejudice to the interaction. We have biases and prejudices. Examine and recognise yours.

This list offers suitable starting point for developing the health care delivery frameworks in any environment that strives to minimize any culturally biased care. However, it must be recognised that in poorly resourced environments

it needs to at best represent a wish list around which any Continuing Professional Development (CPD) for staff can be designed and delivered. Finally, it is important to acknowledge that some level of cultural bias will always be present in cross cultural contexts, not least when there are secondary mediating factors such as that found in the medical field. This list could be integrated with the demands for LAS to create a two way structure for patients and health care workers alike that can be termed Cultural and Linguistic Appropriate Services (CLAS) (Office of Minority Health 2001). Where the patients enjoy access to suitable language services and the health care workers enjoy similar to cultural awareness. This study will aim to address in further detail in the conclusion building on the data gathered from the questionnaires and interviews.

The goal for researchers and exercises such as these is to gather data that can enhance and improve care and allow the health care facilities to meet their commitment to LAS and PCC, which by extension could generate CLAS. However, to achieve this it is imperative that suitable research activities are undertaken within appropriate research frameworks. This study has endeavoured to create a coherent platform built around relevant research parameters that will open a focus on the achievement of CLAS at the selected sites and identify the routes that could be taken to meet the demands in the face of numerous resource challenges.

5.6 Conclusion

This chapter has identified the research sites and they have been introduced in relation to an ethnographic approach, which has involved observations around language practices and how these relate back to language planning and translation issues.

CHAPTER 6

THE RESEARCH STRUCTURE

6.0 Introduction

This research has been conducted through a mix of questionnaires and interviews as collated in Appendix 1 at the end of this thesis. In this chapter results from these interviews will be covered to lay a coherent platform to build the suggested approach to enhancing the quality of care at the Centres.

6.1 Questionnaire

The questionnaire has been designed to generate a snap shot of the knowledge that diabetes patients have in terms of their condition and identify the sources of their information. This data will assist in framing further studies and data gathering. Examples of the questionnaires in English and isiXhosa can be viewed in Appendix 1. These questionnaires also explore personal data capture and attitudes towards language and health issues in the relevant health care facilities. The results analysed in relation to these questionnaires are presented below.

6.2 Questionnaire and Interviews

The research exercise has been built around the questionnaire and interviews. Questions are the essential component of both questionnaires and interviews. It is therefore particularly important to choose the right type of questions (*factual or concerning subjective experiences, open-ended or closed-ended*) and answer formats (*classic, rating scales, semantic differentials or ranking*). Attention must also be paid to *question order, proximity and avoiding bias*.

According to Frankfort-Nachmias and Nachmias, *factual questions* 'are designed to elicit objective information from the respondents regarding their

background, environment, habits, and the like' (Frankfort-Nachmias and Nachmias 1996:251). Background questions, such as gender or age for instance, are the most common factual questions and the information collected through them can be used to classify the respondents. Several background questions were included in the present study to generate this data but to develop structures for identifying issues that may have age and other demographic factors, and frame areas for further study.

Questions addressing subjective experiences refer to the beliefs, attitudes, feelings and opinions of the respondents. In the field of the social sciences, most questions of this kind concern attitudes. Due to their latent and multidimensional nature, attitudes are particularly difficult to measure. The difficulties a researcher is likely to encounter in an attitude survey are; the various degrees of relevance that the topic of an attitude might have for various respondents, the fact that some respondents might not be entirely aware of their own attitudes and the fact that a respondent might have a generally negative attitude towards something (e.g. abortion) and still express more positive attitudes towards it in specific situations (e.g. rape, incest or deformity of the foetus). For these reasons attitude measurement requires the analysis and scaling of several attitude statements.

Opinions, on the other hand, can be measured simply by assessing what proportion of the population agrees or disagrees with an opinion statement. Questions on both attitudes and opinions are usually more problematic than factual questions, because of their more subtle nature. Most questions in the present study focused on subjective experiences as they pertain to diabetes.

Frankfort-Nachmias and Nachmias (1996) also distinguish between *open-ended* and *closed ended*-questions. In *open-ended* questions, respondents are free to express themselves fully and in detail on a given topic. In spite of these advantages, open-ended questions are difficult to answer for the respondents and even more difficult to analyse for the researcher. A coding

frame must in fact be used to classify the answers and, in the process, the richness of detail which characterises open ended questions might be lost. A momentary lapse of memory or attention could also prevent the respondents from mentioning important points. Because of the fear that open-ended questions would discourage the respondents or allow for the discussion to go off-topic while relevant points are overlooked, very limited use has been made of this type of questioning.

In *closed-ended* questions, respondents can choose from a number of set answers. A strong pointing favour of this type of question is that they are easy to answer and analyse. A weak point is that they may introduce bias, either by presenting choices that otherwise would not have been considered or by excluding answers that the respondents might have chosen.

According to Lazarsfeld 1944 (cited in Frankfort-Nachmias & Nachmias 1996), closed ended questions are more appropriate than open-ended ones when the aim of the research is to elicit agreement or disagreement of the respondents on a specific point. Lazarsfeld also suggests that closed-ended questions, being less revealing and threatening, are more suitable for research on sensitive topics and contentious issues. For these reasons closed-ended questions seemed to be the most appropriate for the questionnaire. Open-ended questions, on the other hand, were used in the follow-up interviews to gain a deeper understanding of how attitudes were formed.

According to Frankfort-Nachmias and Nachmias (1996), answers to closed-ended questions can be structured in many different ways. The *classic form* is a set of questions among which the respondent can choose the one(s) he or she prefers. A distinction must be made between questions to which the respondent can mark only one answer and questions to which the respondent can mark more than one answer. In general, putting questions in a funnel sequence (from the one with a broader scope to the one with a narrower scope) helps respondents recall details more effectively.

Sometimes starting from broader questions is necessary to focus the attention of the respondents before asking more specific questions (see also Oppenheim 1966). A funnel-inverted order of questions, on the other hand, helps maintain the motivation of the respondents, because questions get progressively easier to answer as the focus gets broader (Frankfort-Nachmias & Nachmias 1996). *Proximity* among questions on related topics can also influence the responses. For this reason the order of questions in the questionnaire used have, to some extent, been randomised and questions on related topics have been separated. It is generally recommended (Oppenheim 1996; Frankfort-Nachmias & Nachmias 1996) that the first question should not be on a particularly sensitive topic and that it should be easy to understand and to answer. This favours the establishment of a rapport between the researcher/interviewer and respondent both in questionnaires and interviews.

Frankfort-Nachmias and Nachmias (1996) highlight the importance of *avoiding bias* in the wording of the questions. The researcher should avoid difficult words and leading questions. In the wording of the questions it is also important to avoid double-barrelled questions (i.e. asking two things at the same time), as they might confuse the respondents.

It should be borne in mind that it is generally easier for the respondents to agree than disagree with the position expressed by the researcher and to endorse socially acceptable values and norms.

Respondents also tend to give the same answer to different questions, regardless of the content, especially when the questions are close to each other, on the same topic and with the same response format. An example of this phenomenon, called *response set*, is a tendency to answer all 'strongly agree' (or all 'agree', 'don't know', 'disagree' and so on) in a matrix of Like type questions on a similar topic, irrespective of the content. It is also important to note that options which are presented first are more likely to be chosen.

Oppenheim (1966) emphasises the importance of good pilot work in both questionnaires and interviews to detect and eventually correct misunderstandings or bias in the wording of the questions and leading or inappropriate question order. According to this author, a question needs to be re-worded if respondents do not understand it, if it turns out to be a leading question or if it yields meaningless answers. In order to avoid wording errors while phrasing the question, the researcher needs to imagine how respondents would understand and answer the question and should bear in mind the way its answers are to be analysed. Once the questions are ready, they should be pilot-tested on a group of approximately 50 respondents (see Oppenheim 1966:28), and the composition of the pilot-test sample should be as similar as possible to that of the population as a whole. Questions borrowed from other surveys and details such as the layout and covering letter of a questionnaire should also be pilot tested and, if necessary, reviewed.

It is important to recognise the differences between interviews and questionnaires, Frankfort-Nachmias and Nachmias (1996) describe an interview as 'a face-to-face, interpersonal role situation in which an interviewer asks respondents questions designed to elicit answers pertinent to the research hypotheses. The questions, their wording, and their sequence define the structure of the interview'. According to Fontana and Frey (1994:361) 'the most common type of interviewing is the individual, face-to-face verbal interview, but it can also take the form of face-to-face group interviewing, mailed or self-administered questionnaires, and telephone surveys'.

In order to avoid confusion, in the present study the term *interview* refers only to an oral event opposed to a written questionnaire. Group and telephone interviewing have been rejected because of fear that respondents might influence each other in the first case and problems of cost and feasibility in the second case.

According to Frankfort-Nachmias and Nachmias (1996), the personal interview is a much more flexible tool and gives the researcher much more control over the research than the questionnaire. Interviews also have a higher response rate, as some respondents who would not take the trouble to fill in a questionnaire (for a number of reasons, including a lack of confidence in the language) are willing to be interviewed. Moreover, interviews allow the researcher to record additional information such as context and the immediate reaction of the respondents to the questions, which can be used in the subsequent analysis.

The disadvantages of interviews are that the analysis of the data is usually more complicated than for questionnaires, and they cannot guarantee anonymity. The gender and race of the interviewer can also generate assumptions regarding his or her expectations. Respondents might then try to fulfil these expectations. In addition, the very flexibility which is the interview's strongpoint can allow for the personal beliefs and attitudes of the interviewer to unconsciously influence the responses or their analysis (Frankfort-Nachmias & Nachmias 1996). With respect to the last point, Oppenheim (1966) seems to think that, in most cases, the risk of bias is worth taking, given the richness of information interviews can yield.

Fontana and Frey (1994) highlight the importance of the researcher/interviewer establishing rapport with and gaining the trust of respondents. This is necessary in order to understand their point of view, but it generally requires patience and hard work, especially if the research topic is a sensitive one. Mishler (1986) emphasises the difference between research interviewing and the daily practice of asking and answering questions. In particular this author warns against the set of assumptions that are perfectly legitimate (and in fact essential) in everyday conversation but cannot be taken for granted in research interviewing. It is commonly held (see Mishler 1986; Fontana & Frey 1994) that the interviewer should maintain a supportive attitude, encouraging the respondents to express themselves freely, but maintaining a neutral stand.

6.3. Research Findings

As discussed above the study made use of questionnaires, observation and interviews for data collection and analysis. The questionnaires were printed in two languages, back to back and the participants were given a choice between English and isiXhosa. The questionnaires were made available at the two health care centres that were identified above, namely, KwaZakhele Community Health Care Centre and Provincial Hospital. All participants were/are diabetes sufferers aged thirty years and older. Two hundred questionnaires were evenly distributed between the two health care centres, to be completed by diabetes patients. The use of the two language options was to ensure that patients were able to find the exercise as accessible as possible. The questionnaires were placed in a box in each site (100 per site), under the supervision of a health practitioner.

The research also included observation of consultations and the management of patients by health care practitioners; this allowed the researcher to gather first-hand experience and ethnographic information about the relevant issues to the consultation circumstances at both sites. These activities were complemented by individual interviews, aimed at gaining information from health practitioners and diabetes patients who participated in the study. Open-ended questions were used when interviews were conducted with health practitioners and patients in terms effectiveness of consultation and levels of satisfaction. All participants were assured of anonymity and confidentiality in terms of all information supplied.

Thereafter, the feedback from the two sites was compared and contrasted with the aim to gauge the effectiveness of communication and quality of translated texts and the accessibility for patients. In total 10% of the questionnaires were returned, which generates a small absolute number but does offer insight into the ineffectiveness of this approach and the need to focus on interviews with all stakeholders. Notwithstanding, the data collected through the questionnaires offers a very rudimentary picture of the

situation at each site and points to the framework around which future research action needs to be built. These offered complimentary structures when assessed against the data gathered through the interviews. Taken together the data collected offers a coherent platform upon which how effective CLAS and PCC strategies could be developed at both centres.

6.3.1 KwaZakhele Community Health Care Centre

As discussed in the previous chapter KwaZakhele Community Health Care Centre is situated in the township and caters for the diabetes patients who are predominately isiXhosa speakers. Observations at this centre generated a number of insights, for example, one of the health care practitioners assigned to the education of diabetes patients with regard to the condition, made extensive use of charts, booklets and pamphlets, translated in isiXhosa. Many of the patients showed little interest in knowing more about the disease, and in some cases they destroyed the translated health material, that is, pamphlets, and booklets. This action seemed to the researcher to be driven by an inability to read the material, consequently, rendering the information inaccessible. The health care practitioners' attempt to offer oral education, in isiXhosa; also seem to fall on deaf ears. This, in the researcher's observations, may be due to other more pressing concerns such as being attended to speedily or may have been a consequence of the socio-economic circumstances pertinent to people living in high levels of poverty. Another situation that was observed was that those diabetes patients who were also street hawkers were not interested in information about the disease as they need to return to their stands as quickly as possible. Further observations, indicated that many diabetes patients on receiving treatment are unclear with regard to the treatment regime, and the isiXhosa texts that were available were of very poor quality. Consequently, those diabetes patients who were literate in terms of written isiXhosa also experienced difficulty in accessing the relevant information.

The Centre presents a very challenging environment on days with high footfall; the atmosphere is characterised by continual crisis management, which is associated with a rise in the stress levels considerably between health care practitioners with the obvious impact on the quality of care. This places increased demands on doctors who, in turn, add pressure on any language access support structures. This is usually interpreters, who in this context tend to be the nurses who are then not always able to act immediately to support the doctor/patient discourse. This situation is further exacerbated by the fact that the nursing staff do not receive any extra remuneration for rendering of this translation service. Inevitably, professional activities suffered whilst the responsible members of staff were serving as interpreters and translators elsewhere within the facility. Further, the simple process of locating suitable translation personnel is a time-consuming exercise with the obvious impact on patient turnover rates.

Overcrowding represents another major problem, resulting in the health care practitioners being extremely overstretched and which leads to restricted individual attention, limited consultation time for patients, and pressures on availability of other staff for translation. So, for example, health care practitioners' battle to explain to the patient what is written on the medication and, as is often the case, is not conversant in isiXhosa. Coupled to a problem of understaffing, the situation is highly unsatisfactory, and places severe limitations for the Centre to achieve a suitable level of PCC, and, consequently the scope for CLAS. At the time of the observations there was regular communication breakdown between the doctor and a diabetes patient. Below is an example of the consultation between the health practitioner and the patient.

Doctor: Good morning!

Patient: Molo (greetings in isiXhosa for any time of the day)

Doctor: How can I help you?

Patient: Yhoo? Andiva? (Exclamation. I cannot hear you)

Doctor: (Again the doctor asks) How can I help you?

Patient: Ixamba... (diabetes)

In this example, the patient does not have a hearing problem, but rather is indicating to the doctor that they are unable to understanding what is being asked. Here language is acting as a barrier to communication.

The low return rate for questionnaires was due to the lack of literacy on the part of most of the patients at the Centre. Despite the availability of translated material it proved to be inaccessible, those who did have basic reading ability found the questions difficult to comprehend. While it is tempting to use this poor return rate to dismiss the validity of the exercise, it represents a finding in and of itself. A conclusion could be drawn that questionnaires, even in the lingua franca of the Centre are not an appropriate tool for generating data on the language status quo at the Centre.

The personal interviews were much more effective in generating data from this centre than the questionnaires. There was high response with the interviews from the respondents' side. This was because of the lack of confidence in the written language, lack of skills in writing and a preference for being interviewed. The respondents expressed themselves freely in the interview process, as the researcher was able to maintain a supportive environment. They were encouraged to speak freely in the language that they felt most comfortable using and consequently were more able to access the questions and offer suitable and appropriate answers. The researcher shared a common linguistic and cultural background creating a suitable bridge for expression and engagement with the material. For example, they would sometimes refer to diabetes as 'iswekile' or 'ixamba'.

For example, below is a typical interview at the Centre:

Researcher: What can you tell me about diabetes?

(Ungandixelela ntoni ngesifo seswekile?)

Respondent: Lixamba (a term for diabetes in that area)

Researcher: How long have you been suffering with diabetes?

(Lixesha elingakanani unesi sifo?)

Respondent: Kowu, ndiyayazi na? Kudala. (Cannot figure out, but long time)

Researcher: How many times do you visit the health care centre?

(Ulindwendwela kangaphi eli ziko lempilo?)

Respondent: Kanye enyangeni. (Once in a month's time)

Researcher: Tell me about the problems of diabetes.

(Khawundixelele ngeengxaki othi

uhlangabezane nazo ngeswekile)

Respondent: Andikwazi kuzilinda kwesi sifo. (Cannot control it)

Researcher: Are the diabetes campaigns effective?

(Ingaba imikhankaso ngesifo seswekile iyasebenza?)

Respondent: Kwabanye iyasebenza, kwabanye hayi. (To some it is effective to others ineffective)

Researcher: I see written information about diabetes. Do you read this?

(Ndibona okubhaliweyo ngeswelikile.Uyakufunda oku?)

Respondent: Ndiyazama, kodwa kunzima. (I try but it is difficult)

Researcher: Do you understand what is written?

(Uyakuqonda okubhaliweyo?)

Respondent: Ndiqonda ndingaqonda. (I understand some of it)

Researcher: Is the translation evoking your interest to read?

(Ingaba uguqulelo lwamagama kuyawudlwengula umdla wakho)

Respondents: Ewe kodwa kubhalwa maxawambi kakubi. (Yes, but it is sometimes poor translation)

Researcher: Is the language used familiar to you?

(Ingaba ulwimi olusetyenzisiweyo luqhelekile?)

Respondent: Amanye amagama ndiwaqhelile amanye matsha kum.

(I know some terms and words others are new to me)

This is typical of the interviews conducted at the Centre, and indicates that LAC at the centre has some way to go if it is to be the complementary structure for supporting PCC.

In summary the data gathering exercise at the Centre was ineffective when considering the use of questionnaires; however, the patients preference and openness of the interviews indicates that further research activities at the Centre need to build around face to face activities.

6.3.2 The Provincial Hospital Centre

The Provincial Hospital Centre is located in the central urban area, and is frequented by people from a higher income group and consequently with better levels of education. Patients using the centre tend to be living in the area and those working in that area. The entrance board was written in three languages, which are mostly spoken in the vicinity where the site is situated. The texts were clearly written, that they were visible enough for all patients to read. As to be expected this site generated better responses in terms of questionnaires as the patients enjoy higher levels of literacy. Even patients who have isiXhosa as a mother tongue were able to complete the English version.

The facility is better resourced, than KwaZakhele, with pleasant waiting areas and material available in English and isiXhosa and diabetes health provider or even a dietician offering education for those patients in the waiting area. Unlike the observed lack of interest amongst patients in learning more about the disease at the KwaZakhele Centre, at the Provincial Centre the patients are eager to receive more information about diabetes. This Centre also makes extensive use of visual information with colourful wall charts to offer more information about the disease. Patient turnover is also much higher than at the KwaZakhele Centre, with better equipment.

In the case of interviews most patients elected to be interviewed in English, including isiXhosa-speakers. The interviews were less time consuming, and required less probing on the part of the researcher.

Example of the typical interview carried out in Provincial hospital:

Researcher: What can you tell me about Diabetes?

Respondent: Diabetes is one of the chronic diseases... (The respondent went on in defining Diabetes and even provided causes, symptoms as well as cure)

6.3.3 Comparative Findings

The research exercise generated a number of insights into the status quo of language and language policy at both centres and offered a suitable platform upon which to build more activities and how the Centres could make inroads into CLAS and provision of PCC.

The new political dispensation of 1994 associated with the Constitution of 1996, heralded in a new era for all South Africans, the high levels of expectations on the part of the historically marginalised communities did not exclude the health care sector. The new government at the time inherited a massive task to improve the health system and health care for all South Africans. In order to meet these expectations the government had to address a health system designed for a minority now being required to meet the needs of all South Africans. Since the new dispensation, despite increased investments and improved social policies, the country has not been able to adequately address health disparities.

There are obvious problems that need to be addressed, after comparing the two sites where research was conducted, and analysing data. Initially the health facility practitioners in both facilities were uneasy with the presence of a researcher. This disquiet was dismissed after the goals and objectives of the research had been effectively communicated and the relevant documentation presented. The diabetes patients were also wary, some believing that the researcher might be a journalist; others at KwaZakhele thinking that there were possibilities of securing financial benefit, i.e. being paid to participate in a study. The existence of the language barrier is acute,

with illiteracy representing a key obstacle in the case of KwaZakhele. Their illiteracy denying them access to extensive information that appears in written form, with the consequent impact on the quality of the care they receive. Further, they are excluded from the health education that comes through posters, pamphlets, leaflets and other forms, which contain vital information. For instance the literature may carry information about signs and symptoms of diseases, diabetes in this case, modes of disease spread, prevention and cure. Such information is important for every citizen to use in the maintenance of his or her good health. If a patient is denied access to such vital information due to illiteracy, then he or she is unable to access information that would have enabled him or her to enjoy the right to health.

At the Provincial Hospital, the researcher was informed that there was no language policy to cater for effective communication. Despite the absence of official guidelines, the health facility still offers ad hoc interpretation through networks of support that exists between service providers and clients. The absence of a staff language bank is also a problem. There is, however, a list of staff members' and the languages they can competently speak or read or write.

From the data gathered there is prima facie evidence that a number of diabetes patients suffering from chronic diseases are not receiving adequate care, not because they are ignorant or they cannot control their conditions, but because they cannot read or understand the translated texts provided for them at the health care facilities. Some of the respondents were unable to read and could not therefore access any written or translated texts. Therefore it makes it difficult for the patients to fully comprehend and follow the prescriptions or to control this chronic disease.

The findings of this research exercise points to the need to narrow the gap associated with language barriers as this will promote the achievement of PCC. Effective communication in health care facilities is a necessary but insufficient condition for the achievement of PCC. Cultural sensitivities are

also required; the goal should be to ensure the provision of CLAS. The government is indeed presently trying to improve the health care system, for example translation is receiving more attention. Furthermore, more funding is being made available to address the scourge of HIV/AIDS. Health care practitioners also indicated that there was a bias towards HIV/AIDS that was skewed against other chronic and equally debilitating illnesses such as diabetes. And, it is possible to argue that the treatment offered for HIV/AIDS is more politically sensitive and is advantaged by more readily available provision of translated materials in contrast to other chronic illnesses such as diabetes, where translated material continues to be of a poor and ineffective quality.

6.4 Quality of Translated Texts

The health care interviewees all acknowledged the government's intentions to improve the quality and provision of health care; recognising efforts aimed at production of suitable translated texts and health care materials. The main concerns expressed were associated with the high costs, and the ability of translators to offer translation of texts of a sufficiently high quality for effective communication.

6.4.1 Examples of poorly translated material

Example 1

ENGLISH: Inject into the stomach at a 90 degrees angle or 45 degrees angle if thin.

ISIXHOSA: Hlaba esiswini kwi- angle engu 90 degrees okanye engu 45 degrees ukuba awutyebanga.

ENGLISH: Rotate the injection site/area.

ISIXHOSA: Sukuphinda uhlabe kwindawo enye.

ENGLISH: Rotate the insulin injection within the injection site/area for every injection.

ISIXHOSA: Yitshintshe roqo indawo ohlaba kuyo

ENGLISH: Inject into the leg at a 90 degrees angle or 45 degrees angle if thin.

ISIXHOSA: Hlaba esiswini okanye ethangeni kwi angle engu 90 degrees okanye engu 45 degrees ukuba awutyebanga

The spelling with some of the translated words is incorrect. For example, "roqo" should be written as "rhoqo".

There is mixing of languages. The translator did not look for proper words for translation. For example, "degrees".

Example 2:

Ukutya ngokusempilweni

- Ukutya okutyayo kudala *i-glucose* esegazini lakho. Ukuba unesifo se-*diabetes*, kufuneka uqwalasele ukuba utya ntoni, kangakanani, kunye nokuba utya ntoni.
- Yenza ukutya okune-*starch* kube ngundoqo kuninzi lwezidlo
- Yitya iimbotyi, *i-peas*, *i-lentils*, ibotolo yamandongomane, iimbotyi ezisenkonxeni, nokutya okune-*soya*.
- Inkukhu, intlanzi, inyama, amaqanda, okunye ubisi, zingatyiwa yonke imihla.

The above words written in Italics are not translated. English words are used because medical terms are in English and there is no terminology for such terms in isiXhosa.

Even the spelling with translated words is wrong. For example, “ibotolo”.

- Okunya ukutya okuneswekile kungatyiwa ngamaxesha athile
- Yitya isidlo sakusasa
- Utye isidlo sasemini
- Utye isidlo sangokuhlwa
- Ungasela amanzi acocekileyo
- Ukuba usela utywala ungadlulisi kumlinganiselo omnye ukuya kwezibini
- Sela amanzi abandayo okanye iziselo ezibandayo
- Sebenzisa ipilisi okanye imigutyana

Looking at the above sentences, one, or rather a diabetes patient, can be confused. One cannot attach the actual meaning of the sentence. One has to read the sentence many times to really comprehend what is being conveyed.

Borrowed words are used, for example, “ipilisi”.

Example 3:

Diabetes Education

(The above heading “Diabetes Education”, is not translated into isiXhosa).

ENGLISH: Always keep your feet clean

ISIXHOSA: Gcina *inyawo* zakho zicocekile rhoqo

ENGLISH: Dry feet well especially between your toes

ISIXHOSA: Zisule zome *inyawo* zakho ngakumbi phakathi *kwenzwane*

From the above examples, the words written in italics were supposed to be written in plural form. For example, “inyawo” should be “iinyawo” and “kwenzwane” should be “kweenzwane”.

ENGLISH: Home care

ISIXHOSA: Ukuzinonelela ekhaya

ENGLISH: Check under your feet regularly

ISIXHOSA: Zihlole ngaphantsi *kwenyawo* rhoqo

ENGLISH: If you can't see under your feet, check with a mirror...

ISIXHOSA: Ukuba awuziboni ngaphantsi *kwenyawo*, sebenzisa isipili.

ENGLISH: ... or get someone to check for you

ISIXHOSA: okanye ucele omnye umntu akujonge

ENGLISH: Medical care

ISIXHOSA: Unyango

ENGLISH: Never cut corns or use sharp objects on your feet

ISIXHOSA: Ukuzisika ngokwakho *i-corns* okanye usebenzise izinto ezibukhali *kwinyawo* zakho

ENGLISH: Get help from the clinic or doctor

ISIXHOSA: Funa uncedo kwikliniki okanye kugqirha *wakho*

Again the translator did not take into consideration the plurals, for example, he wrote “kwinyawo” instead of “kwiinyawo”.

Medical terminology for isiXhosa is scarce. The translator used “corns” in both languages.

Example 4:

Foot Care

(The above topic “foot care”, is not translated into isiXhosa.)

ENGLISH: Avoid long boots

ISIXHOSA: Sukunxiba *i-boots* ezinde (Musa ukunxiba iibhutsi ezinde)

ENGLISH: Avoid tight socks

ISIXHOSA: Sukunxiba *ikawusi* ezikuqinisileyo (Musa ukunxiba iikawusi ezikubambayo)

ENGLISH: Avoid high shoes with no support

ISIXHOSA: Sukunxiba izihlangu ezichophileyo (Musa ukunxiba izihlangu ezichophileyo ezingenazixhathisi)

ENGLISH: Wear well fitted shoes

ISIXHOSA: Nxiba izihlangu ezikulinganayo (Nxiba izihlangu ezikulingana kakuhle)

ENGLISH: Avoid extreme heat

ISIXHOSA: Suka ngasemlilweni oshushu kakhulu (Lumkela ubushushu obugqithisileyo)

ENGLISH: Never put your feet near open heat

ISIXHOSA: Sukusondeza *inyawo* zakho emlilweni (Ungaze usondeze iinyawo zakho kwindawo enobushushu obuvulekileyo)

ENGLISH: Never walk barefoot

ISIXHOSA: Nxiba izihlangu rhoqo (Ungaze uhambe ngeenyawo)

It is clear that on occasions the translated texts do not convey the intended and relevant information. Therefore, despite the best intention in terms of the application of language policy and activities to promote access to information the result is less than satisfactory. However, despite this outcome it is encouraging to see some evidence of the recognition of the need to provide materials in the patients' mother tongues. The predominance of patients who have limited English proficiency (LEP) makes this an essential strategy, but does point to the pressing need to improve the translation skills infrastructure.

As discussed above patients who have LEP are at a disadvantage in terms of the quality and effectiveness of the care that they receive. This language barrier 'affects LEP patients' access to services, their ability to give informed consent for medical treatment, and their compliance with drug regimens and follow-up' (Cornelio 2004:14). Cornelio also observes that there is growing evidence that these patients 'are at greater risk of medical error or misdiagnosis if they are not provided with an interpreter, are less likely to use preventative care services, and are more likely to use emergency rooms than English speakers...and are often dissatisfied with the quality of translated material they are given' (Ibid).

In contexts like the KwaZakhele Centre this creates an ominous feedback loop, where the majority of patients have LEP and, accepting Cornelio's observations make more use of services than their English speaking counterparts, thus placing more demands on the limited resources at the Centre. These points to the fact that there may be scope for arguing that there is a skewed perspective on the short versus long term economic costs associated with translation activities.

Fundamentally the problems can be sublimated to the wider issues associated with cross cultural communication between people from different cultures (depicted by languages) and then the secondary mix of medical and non-medical cultures. This dual layer of cultural mediation can and does contribute to a number of challenges. These need to be addressed if PCC is to be achieved and central to this are suitable CLAS.

According to the U.S. Department of Health and Human Services (Office of Minority Health 2001), effective CLAS can be characterised in 14 standards. (Note -The terms in brackets are allocated to support the model that will be developed in chapter 8):

Standard 1 (Cultural beliefs): Health care organizations should ensure that patients/consumers receive care that compatible with their cultural health beliefs and practices and preferred language.

Standard 2 (Diverse staffing): Health care organizations should implement strategies to recruit a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3 (Continuous Professional Development –CPD): Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4 (Language Capacity): Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 (Language Access): Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 (Language appropriate): Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 (Translation): Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8 (Goals and Objectives): Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9 (Continuous Quality Improvement - CQI): Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10 (Information Management): Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11 (Community Demographics): Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12 (Collaborative Activities): Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13 (Conflict Resolution Awareness): Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14 (Transparency) : Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

These standards are reproduced here in detail as they offer a sort of gold standard for effective health care services, and by extension the provision of PCC. While the standards pertain to well resourced health care across the USA, they transfer very well to the South African context. Further, it can be argued that the legislation in terms of language policy and goals within South Africa health care makes these standards implicit, at least as objectives for provision of care.

6.6 Conclusion

For each of the standards a term has been allocated which will be used in Chapter eight to develop a training and development framework for supporting the creation of an infrastructure for provision of CLAS. It can be argued that these standards are beyond the reach and resource base of the centres under review, however, against the research conducted at the centres, this study aims to develop a training and capacity building exercise that will use these standards as reference. These will be developed in chapter eight as part of the conclusion to this initial study. The chapter that follows further explores health care challenges and communication in relation to South Africa.

CHAPTER 7

CHALLENGES FACING HEALTHCARE PROVISION IN SOUTH AFRICA

7.0 Introduction

In this chapter the researcher will further present challenges that face the health care sector as elicited from the ethnographic data gathered from the respective research sites, as well as available documentation that is relevant to the discussion. This information will be presented from both the perspective of the health care practitioner and the patient.

7.1 Challenges

The subject of communication in health care has been a serious study during the last 50 years. At the beginning of the 21st century it is now established in the curriculum of every training institute for healthcare professionals at every level. Evidence is that healthcare requires a conscious and informed effort of communication which is the personal and professional responsibility of health care providers, including nurses, doctors, therapists and pharmacists and ancillary staff and managers. Some of the difficulties for patients when addressing communicating with health care professionals could include the following concerns. These were identified during interviews with patients and practitioners at the centres:

- **Inferiority.** Patients commonly feel themselves to be in a position of weakness during consultation. This may be due to the strangeness of the context, lack of awareness of process or a result of the healthcare professional's manner or communication.
- **Anxiety.** Many of the patients interviewed expressed as sense of anxiety, this was generated through a complex mix of factors, from lack of awareness of procedures, poor language skills, etc.
- **Conflicting information.** Apart from friends, family and the media, patients encounter mixed messages from many different healthcare

professionals. These messages could lead to confusion which can undermine the quality and effectiveness of care.

Through observation a number of problems were identified at each centre to differing degrees, with the KwaZakhele situation being considerably more challenged than the Provincial centre. These problems included, amongst others;

- Under-use and overuse of services;
- Avoidable errors;
- Lack of suitable resources;
- Inadequate diagnosis and treatment;
- Inefficient use of resources base;
- Poor record keeping and information management;
- Inadequate referral systems;
- Lack of regard for human dignity;
- Shortage of suitable medication;

These problems are included here in a very crude manner to ensure that the operational realities are recognised and the limitations that these may present for achieving high levels of PCC and allow scope for CLAS. Many of these problems need to be addressed at a national level through suitable policy frameworks that will address the overall quality across the health care sector.

This study has highlighted how the existence of the language barrier coupled with parsimonious language access services diminishes the quality of health care for individuals with limited English proficiency. In the South African context, and at the centres specifically, the patients are mostly people who speak a language other than English when at home. They have

very limited ability to understand English at best, and consequently are most likely not to understand the requirements attached to the medication prescribed to them. Moreover, these patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Therefore language difficulties and inadequate funding of language services are major barriers to patients accessing health care.

Before 1994, the South African health system was based on the Apartheid government's discrimination policies, which was characterised by geographical and racial disparity, resulting in fragmentation and duplications and deregulation of the health sector. In seeking to fully segregate all the aspects of South African society, the Government developed the so-called 'ethnic homelands'.

Established as semiautonomous and administrative entities, each of the homelands was charged with the provision of health and other public services. There were 14 health departments across South Africa, including one for each homeland, acting separately. Poorly organised, inefficiently managed, many of the homeland health services struggled to provide adequate medical and public health care. Later, ethnic based departments of health and separate health services for each racial group (African, Coloured, Indian and White) were established. The proliferation of public sector services, hopelessly unequal, resulted in grossly inefficient and costly structures and health care facilities. The racial fragmentation and politicisation of health services perpetuated discrimination in health care access. Furthermore, differential expenditure on health services based on a self-serving racial/ethnic ideology, rather than needs, exacerbated the existing health disparities.

With the advent of the post-Apartheid era a National Health Plan was conceptualised and presented to the public in 1994. The National Health Plan envisioned the fundamental restructuring of the national health system. Specifically, it sought to: eliminate the fragmentation and duplication of

services by integrating all the health services under a single Ministry of Health; to decentralise the organization and management of health services through a well-coordinated district health system; and to make comprehensive, community-based health care accessible to all South Africans by establishing primary health centres. Immediately following the election of the Government of National Unity in 1994, a range of pro-equity policies and programmes were initiated throughout the public sector, many of which were elements of the Reconstruction and Development Programmes (RDP).

In addition to dynamic building programmes for primary health facilities, RDP also introduced free maternal and child health care and later free primary for all; comprehensive extension of social welfare grants to previously disadvantaged populations; and a national school nutrition programme. Under the direction of the National Department of Health, a team of officials from each of the nine newly-established provinces drafted a detailed implementation strategy for the development of the decentralized, district-based health system. The committee's report entitled 'A policy for the development of the district health system for South Africa' anticipated the drafting of the 'White Paper on the Transformation of the Health System', formally endorsed by Parliament in 1997 (Department of Health 1997).

The objectives of the White Paper in terms of the provision of health care were, that:

- the health sector must contribute to promoting equality and developing a unitary health system (**Equality**);
- the health system must be centred on the district and utilize the approach of the primary health care (**Community Centric**);
- Government, NGOs and private sector must find ways to work to a common objective (**Coherence**);

- the national, provincial and district levels should act in a complimentary manner (**Co-operation**) ;
- a package of basic service, essential and free of charge, will be available to the whole population at the first contract level (**Accessible**).

For the purposes of this research exercise and the development of a suitable model for each of the centres, a catch all term is associated with each objective, from the White Paper, delivering a summary for the Paper's objectives as: 'Equality, Coherence, Co-operation, Accessibility and Community Centric'. This will be a paradigm we will come back to later.

These objectives are commendable and essential if the quality of health care enjoyed by the majority of South Africa's population was to be improved. However, efforts to decentralise and build the district-based primary health care system presented many challenges, including that associated with a lack of a suitable human capital infrastructure. Further, as would be expected national transformation proceeded at a faster pace than that found at local and provincial level.

The status quo at the two centres that were the subject of the research study varied in terms of these objectives. However, it can be argued that these objectives are nationally driven imperatives and the operational realities at the coalface represented by the centre must be informed by local realities, with reference to the national priorities.

7.2 Developing Effective Structures

Patients, diabetes patients in this case, cannot benefit if there are language barriers. Language problems can hinder multiple aspects of healthcare, including; access, health status, use of health services, and health outcomes. 'However linguistic incompatibilities are not the only factors influencing healthcare. A patient's health beliefs and practices arise from a

combination of normative cultural values together with personal experience and perceptions' (Angelelli 2004:19). Angelelli continues and notes that 'even if the healthcare provider and the patient share the same language, the difference in their cultural norms can lead to miscommunications and misunderstandings' (Ibid). It should be recalled from early chapters that language is socially determined; the society makes up the language of its people; in this regard South Africa is very culturally diverse and embraces a number of language groups. It is important to improve delivery of public health and healthcare services and to encourage social norms that ensure quality health care provision with the obvious impact on quality of life within all communities across South Africa. Central to achieving this improvement is the need to improve the levels of health literacy across the sector. As discussed earlier in this study, health literacy is a wide and encompassing concept which includes; self-management, health knowledge, and vocabulary range, ability to assimilate new concepts, attitude and motivation. Nutbeam and Kickbush, (Nutbeam and Kickbush 2000:183-184) observe that the benefits of effective health literacy are:

- That health literate individuals enjoy enhanced decision-making
- Able to make best use of health services
- Adopt healthy lifestyles
- Take an active role in addressing the social determinants of health
- Have better access to health information
- Have more knowledge about health and more awareness of options for treatment.

Against this backdrop a high level of health literacy allows a population to act in a manner that is appropriate in terms of decisions for improving health and well-being (Parker 2000). Health literacy is believed to be a major factor in promoting health and access to healthcare in public settings such as clinics.

An ideal situation is that health information should be made available to all South Africans in all official languages with adequately translated materials.

The government should aim to support the effective introduction of language policies at all levels and in all sectors, in particular health and education sectors. This could be better achieved through policies that aim to develop African languages in order for them to be more widely used in all domains.

7.3 Developing Policy

Before embarking on describing a specific strategy for the level of the centres it is beneficial to address the wider national issue within the health care sector in general, as this is the wider framing of the debate which by definition is pertinent to the centres under research.

The White Paper of 1997 (Department of Health) offers a suitable framing environment to lay the foundation of a strategy for the Centres which would complement the wider national agenda. Further, assessing the health care national agenda against the *Batho Pele* principles will create a logical and coherent structure for capacity building models for the centres. This will also, by extension, enhance the quality of the health care at both centres and promote the achievement of PCC and delivery of CLAS.

In order to work towards a model intended to achieve the White Paper's objectives, the framing allocated for this study namely: Equality, Coherence, Co-operation, Accessibility and Community Centric, will be referenced against each of the *Batho Pele* principles.

White Paper Objectives	<i>Batho Pele</i> Principles
Community Centric/Co-operation	Consultation
Coherence/Co-operation	Setting Services Standards
Accessibility/Community Centric/Co-operation/Equality	Increasing Access
Accessibility/Community Centric/Equality	Ensuring Courtesy
Accessibility/Community Centric/Co-operation/ Equality	Providing Information
Equality/Community Centric	Redress
Equality/Community Centric	Openness and Transparency
Accessibility/Community Centric	Value for Money

The allocation is not a strict or detailed analysis but acts as to demonstrate the obvious, and to be expected relationship between the objectives for the health care sector and the national principles for service delivery, *Batho Pele*.

Taking these principles and objectives as a referential paradigm it is possible to develop collection of goal statements that should be characteristic of effective health care across South Africa. This approach will support the development of a capacity enhancing programme for health care staff at Centres, such as those that this study has investigated. Some examples will be developed below, with some focus on language and transition issues, again the White Paper framing terms are applied:

- **Health care capacity should be matched to the health needs of the population (Community Centric)** – there is a need to reduce excess capacity, avoid waste and reduce costs, as well as increase capacity in other areas to ensure access for under-served populations, and ensure that the care provided across the health care system is appropriate and of the highest possible quality. The concept of capacity has the potential to be categorized according to a number of variables. However, in this context the term refers to resources both physical and human, and all those resources necessary to ensure the delivery of PCC and provision of CLAS.

- **All stakeholders should co-ordinate translation activities (Accessibility/Equality)** – Access to information and knowledge pertinent to the medical context and experience is essential to ensuring accessibility and equality of health care received. Further, the health care professionals must ensure that their communication is fully understood by patients who have a different mother tongue. Improved planning for which translation services are to be provided at which levels could make significant contributions to the achievement of PCC and provision of CLAS.

- **Increasing capacity will increase use (accessibility)** - With more services and resources available, it is likely that many people who are in dire need of health care services are more likely to make use of these extended services. Such extension is, therefore, a necessary but not sufficient condition for achievement of the accessibility objective. Expanding the services needs to be part of a coherent and co-operative (both White Paper objectives) exercise between stakeholders to ensure that other suitable prerequisites are in place. These would include language access, translation (language and medical) and suitable pre and post care structures. This can help to extend the delivery of health care services to previously under-served populations.

- **Tackling inadequate health care capacity, particularly in rural areas (accessibility/community centric/co-operation/equality) -** Amongst one of the most insidious outcomes of the Apartheid era health care system was the wide disparity between rural and urban health care facilities. As a result of the high concentration of people from non-White communities being located in rural areas, there were few suitable facilities that could take up the cudgels after the 1994 dispensation. This has resulted in very poor and inadequate facilities and, when coupled to the fact that most if not all patients have LEP, the situation in these areas is dire. The situation witnessed through this study at KwaZakhele is playing out across the country at numerous health care centres in townships and, a priori, likely to be considerably worse at rural centres. At a very simplistic level, for example, good quality care cannot be provided without high-quality doctors, but in many rural areas there are too few doctors. One approach is to limit new private medical practices in areas where there is already an oversupply of doctors, using the “certificate of need” procedure contained in the National Health Act, i.e. Act 61 of 2003.
- **Increased patients’ participation and the dignity afforded to them (accessibility/equality) –** As discussed throughout this research report promoting patient engagement through all possible routes will by extension enhance the quality of their experience and the dignity associated with their health care experience. There is an obvious link between receiving CLAS and the overall dignity associated with a health care experience.
- **Informing patients and involving them in decision –making (accessibility/community centric/coherence/equality) -** Active participation by patients in their care can improve its effectiveness and the level of satisfaction, making inroads into the goal of PCC. Furthermore, by participating in the decision making processes patients are able to embrace a sense of control and recognise their

responsibilities in terms of the effectiveness of their own care. Active participation requires communication.

- **Enabling patients to care for themselves (Coherence/Community Centric)** – Empowering individuals with the skills and tools to take care of their own health they is especially important for individuals with chronic illness or disability. Enabling users to assess their health and reduce unnecessary health care service and costs.

These are by no means an exhaustive list, training and development exercise could include the development of more statements of this nature. Such an activity would support the creation of dynamic vision statements for the Centres and similar facilities.

The White Paper when viewed in conjunction with the *Batho Pele* principles offers a vibrant and fertile foundation for assessing and developing the health care structures across South Africa. Further, through this methodology the Centres can develop their services and approach the delivery of PCC and the provision of CLAS.

7.4 Effective Communication in Health Care

The achievement of both the White Paper objectives and the *Batho Pele* principles require all stakeholders to embrace the real challenges at the health delivery coalface. Consequently, the key objectives as per the terminology used above, the achievement of PCC is built around co-operation and coherence on the part of the relevant structures and stakeholders. The complex nature of PCC and the provision of CLAS, requires effective co-operation and coherence and a communication between all nodes within the health care sector. The nature and challenges associated with effective interdisciplinary communication represent a key consideration within the sector.

Developing the coherence and co-operation requires a comprehensive recognition by all parties of 'the importance of communication to delivering

quality care' (QualityFocus 2008:1). This importance is evidenced by the observation 'that 70 to 80 percent of medical errors can be attributed to interpersonal factors' (Ibid). The QualityFocus report identifies four areas of communication within a health care context (Ibid):

- Staff communication
- Interdisciplinary communication
- Provider-to-provider communication
- Provider-to-patient communication

The QualityFocus report continues and includes focus areas for each of the communication channels. Using these areas it is possible to initiate an integrated framework for effective communication in South African health care facilities, which can dovetail effectively with the White Paper objectives and *Batho Pele* principles. Using this methodology will allow the relevant stakeholder groups at the Centres in question to identify suitable strategies that are sympathetic to the resource availabilities at the coalface of provision.

Accordingly, to effectively address the quality of communication within the health care context, through each of the channels, key sub-areas require attention, in the case of staff communication; these would be leadership, education and empowerment. For interdisciplinary communication, essential attention needs to be given to cooperation, coordination, collaboration and standardization. While in the cases of provider-to-provider and provider-to-patient, a mix of coordination, cooperation, with patients the need for simplification and coordination is highlighted; both required an element of follow-up (Ibid).

Extracting from some of the QualityFocus communication frameworks can potential deliver a communicative training matrix that can act as a referential structure for capacity building activities to promote PCC and ensure the

provision of CLAS. Below an attempt is made to construct such a table with possible outcomes of training and development at centres. It would require further development and consultation with relevant stakeholders but offers a suitable foundation for further work.

QualityFocus Channel	Focus Area	Centre based training (potential outcomes/topics)
Staff Communication	Leadership Empowerment	<ul style="list-style-type: none"> • Leadership at Centres should engage with national health policies • Develop all health care providers understanding of their role – through discussions and engagement

Interdisciplinary communication	Cooperation Coordination Collaboration Standardization	<ul style="list-style-type: none"> • Assist all stakeholders to understand roles and areas for coordination and collaboration • Create a framework for effective standardization of the quality of health care • Standardization of PCC and provision of CLAS.
Provider-to-provider communication	Cooperation Coordination Follow-up	<ul style="list-style-type: none"> • Develop inter-provider (Centre) cooperation • Create environments for effective coordination • Establish coherent structures for effective follow-up and post consultation care
Provider-to-patient	Identification Simplification Coordination Follow-up	<ul style="list-style-type: none"> • Develop cultural and linguistic awareness structures • Ensure information is communicated in a simplistic manner • Establish channels that assist in the achievement of PCC • Create coherent follow-up activities that enhance the quality of health care

The table attempts to start the dialogue necessary for effective training and development work within the Centres under research. The model has potential resonance beyond KwaZahkhele and the Provincial Hospital, and will be given more attention as part of the conclusion in the form of training and development recommendations.

7.5 Health Care in South Africa: The Health Care Charter

The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education, and the provision of housing, clean water, sanitation and electricity. In addition, reductions in the levels of violence and malnutrition, and promotion of healthy lifestyles should be addressed, and with this the provision of accessible health care services in line with the White Paper and other health care policies.

South African legislation makes it a human right for all people to be entitled to optimal health care, and it is the responsibility of the state to provide the conditions necessary for the achievement of this level of care. Health and healthcare, like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of political and economic conditions or other factors.

The African National Congress, as the contemporary party of government, is committed to the promotion of health through prevention and education. The primary health care (PHC) approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community development, and is based on full community participation in the planning provision, controlling and monitoring of services. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities. The key objective for the achievement of this goal is a single comprehensive, equitable and integrated national health system (NHS) as the South African government's overall vision for the health care

sector. 'The most significant challenge facing the South African health system is to provide an equitable distribution of resources between the public and private health care sectors, urban and rural areas, and across and within provinces relative to the population served by each' (Chetty 2007:20).

In order to promote the equalisation of health care, the government enacted The Medical Schemes Act (Department of Health 1998). This act sought to:

- Promote non-discriminatory access to private health funding
- Put medical schemes on a more sound financial footing
- Improve scheme governance in interests of members
- Improve consumer protection through enhanced regulatory oversight.

While this act made significant inroads into the inequitable nature of health care between public and private provision, the government went further and 'initiated a process to develop a Health Care Charter' (Chetty 2007:23) with four pillars (Department of Health- Health Charter:1):

- Access to health services
- Equity in health care
- Quality of Health Services
- Broad based black economic empowerment

The document observes that the four pillars 'acknowledge the urgent need to effect transformation of the national health-system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa' (ibid). This charter builds on the foundation of the White Paper and attempts to integrate the *Batho Pele* principles.

In terms of access the charter identifies the challenges to be (Ibid:13):

- information relating to health and health services options to all patients, providers and employers in order to promote informed decision- making;
- information designed to address the particular needs of vulnerable groups, including people living in rural and under-serviced areas, and the illiterate;
- information relating to the purchase of health insurance products (i.e. value for money, richness of benefits); and
- information relating to quality of care (i.e. appropriateness, necessity, cost-effectiveness)

With regard to access, the Charter is less than explicit on the matter of language. This could be argued to be an oversight but is more likely a consequence of the assumption that the national language policy is sufficient to address the issues associated with language. The basic research undertaken in this study indicates that this part of the charter should be more explicit regarding language within the health care sector.

Specifically, in terms of access the Charter states 'sustainability of the national health system is dependent upon its efficient use, management and generation of resources including financial, human, technological, scientific, clinical, managerial, infrastructural and resources in the area of materials and equipment and research and development' (Ibid:14). The Charter then focuses on the specifics of human resources and finance, again with no direct reference to issues of language and culture. In the multi-cultural contexts within which health care is delivered this is an oversight at best or a serious omission at worst. However, when the Charter addresses access solutions, the need to ensure that that language and cultural issues are addressed is implied, where improving access will require, inter alia, 'the provision of information designed to address the particular needs of vulnerable groups, including people living in rural and under serviced areas and the illiterate' (Ibid:28). While this is

encouraging for those engaged in the challenges associated with language barriers and the provision of CLAS.

Similar omissions can be found throughout the document; however, it can be argued that language and culture issues are implied, since it is not possible to provide quality, equitable and empowering health care without addressing these barriers and challenges. The Charter can be seen to be acting as the framing document for the sector as a whole, addressing the macro issues associated with sector. It is incumbent on the health care professionals, practitioners and other stakeholders to recognise that the achievement of PCC and provision of suitable CLAS is a logical extension of the Charter documents statements.

The Charter does offer the requisite gateways for building CLAS provision and a detailed analysis of the document would offer ample evidence of this contention. However, such an analysis is beyond this initial research study. Such further research will be extremely beneficial in terms of developing the next iteration of the Charter, to ensure that language and culture are more integral to the Health Care Charter. For the present purposes it will assist the final analysis of this study to take some examples from each of the key sections to support the present interpretation of the Charter. For each of the key areas the charter offers a number of solutions, for each of the examples an attempt will be made to bridge this into the area of provision of CLAS, this will offer a framing context for the next chapter.

- **Access** – ‘Developing indicators within 6 months of the finalisation of the Charter to measure improved/increased access, in order to track the extent of progress made, and evaluate the sustainability and quality of such access’ (Ibid 29). This call to the profession opened the opportunity for language practitioners to introduce suitable metrics along the lines that will be suggested in the next chapter.
- **Equity** – ‘Putting in place programmes that result in the broader representation of black persons in the workplace’ (Ibid:30). Once again this solution will increase the number of people who are likely to be

skilled in the languages of the majority of patients in the respective centres. Therefore, by extension this will promote the need for PCC and provision of CLAS.

- **Quality** – ‘The implementation of benchmarked quality assurance programmes that include a quality monitoring system and the measurement of health outcomes’ (Ibid:31). This solution offers an opportunity for language practitioners to develop, as suggested above and as will be attempted in the next chapter, a cultural and language access measurement environment.
- **Broad Based Black Economic Empowerment** – Solutions in this area are predominately focused on issues of ownership, which will not have a direct impact on the issues of language and culture. However, it could be argued that a change in ownership structures may have an impact on the nature of the sector in terms of its ability to address the needs of all language and cultural groups. Some may feel that this is a benign interpretation as any ownerships restructuring will be driven by economic variables, associated with efficiency and profitability, variables that do not always sit comfortably with challenges associated with language barriers and cultural awareness.

7.6 Conclusion

The Charter is an excellent framing document for the sector but it falls well short of suitability addressing in an overt fashion the issues associated with language barriers and cultural awareness that are key to the effectiveness of the sector, and by extension the provision of PCC.

CHAPTER 8

CONCLUSION

8.0 Introduction

In the final part of this thesis a way forward will be suggested in the hope that it will contribute to more effective communication strategies being implemented within the health care sector.

8.1 Building CLAS in South African Health Care – a Proposal

Against the backdrop of this study and the analysis, this final chapter will attempt to create a suitable bridging framework between documents like the White Paper, The Health Charter and *Batho Pele* principles, in terms of policy and the coalface realities that the basic research has generated. The approach will aim to create a fertile environment that will support the delivery of PCC and that this provision is characterised by culturally and linguistic appropriate services (CLAS).

The model will be built around the context of the two Centres but with a bias towards the situation at the KwaZakhele Centre. The logic for this bias is that this Centre faces considerably more challenges than those experienced by the Provincial Centre. Consequently, any model that works in the KwaZakhele context will resonate with Centres across South Africa, which would include the Provincial Centre.

South Africa is a very complex country, with a history fraught with inequalities; these continue to plague many domains, health care and education sectors being riddled with inequalities. The new political dispensation of 1994 onwards has made some in-roads into the inequalities but much still needs to be done. The challenges can be loosely categorized as:

- **Facilities and infrastructure** – the inequality of facilities and infrastructure continues to be one of the most insidious legacies of the Apartheid era.
- **Human Resources** – skills and skills development is a major area of concern for all sectors of South African society.
- **Cultural and Language** – the cultural and linguistic diversity characteristic of South Africa make this a key area that needs to be addressed in service delivery. While there is wide language policy frameworks the coalface realities do not always reflect the vision of enabling legislation.
- **Finance** – In any public service environment finances are and always will be an issue, in the South African context the skewed historical investment agendas have made this a highly contested area.
- **Service Quality** – The other areas are necessary but not sufficient conditions for the delivery of quality services. Developing a coherent and collaborative quality service delivery infrastructure requires a comprehensive system built on measurement and effectiveness founded on service level agreements

It could be argued that having culture and language as a separate category alongside the other obvious challenges, is disingenuous and serving the interest of the study, rather than being substantive enough to stand-alone. However, the reason for taking this approach is that the language and cultural barriers that many people from historically marginalised backgrounds experience make this an appropriate strategic approach. The obvious potential outcome of this strategy is to ensure that issues associated with culture and language is brought to the fore in terms of debates around service delivery. This would militate against the need for language practitioners having to take the fight to the policy makers in different sectors. For example, as has been demonstrated above with the

Health Charter would have been more explicit in regard to this area and it would not require language practitioners to find those statements that give credence to the need for cultural and language awareness.

The research at the two centres has demonstrated that the status quo in terms of delivery of health care services does not meet the diverse objectives and quality standards outlined in various policy statements. In terms of rudimentary comparative analysis from the research questionnaires and observations, basic data points to very different levels of quality of delivery between the two centres. However, as pointed out above the journey from the status quo to PCC and the provision of CLAS will be similar for both centres and for other Centres immaterial of their existing delivery status.

Developing a route map for the Centres from existing delivery to robust provision of CLAS necessitates a suitable framing environment. In chapter 6 the standards associated with CLAS as identified by the US Department of Health were introduced and a catch all term was allocated for each to support the development of a model, the table below offers a summary of this earlier exercise, with additional context summary for each in terms of locating these within the health care sector in South Africa. This latter exercise will be applied to the centres that have been investigated under the study.

US Department – CLAS standards	Paradigm allocated for model development and context locator.
<p>Standard 1 - Health care organizations should ensure that patients/consumers receive care that compatible with their cultural health beliefs and practices and preferred language</p>	<p>Cultural beliefs – The centres should develop awareness of cultural beliefs and attitudes of all patients they treat and serve.</p>

<p>Standard 2 - Health care organizations should implement strategies to recruit a diverse staff and leadership that are representative of the demographic characteristics of the service area.</p>	<p>Diverse staffing – Centres should aim to have a staffing policy that represents the diversity of the patient groups that they serve.</p>
<p>Standard 3 - Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery</p>	<p>Continuous Professional Development –CPD – CPD activities should include on-going and appropriate training that highlights the cultural and linguistic challenges faced by practitioners at the centres.</p>
<p>Standard 4 - Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation</p>	<p>Language capacity – The centres should endeavour to develop the language capacity within the Centres to support all language groups that patients represent.</p>
<p>Standard 5 - Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</p>	<p>Language access – patients at the centres should have robust language appropriate access through all phases of their contact with health care practitioners and other service personnel.</p>
<p>Standard 6 - Health care organizations must assure the</p>	<p>Language appropriate – language capacity and access imply language</p>

<p>competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff.</p>	<p>appropriate, however, for the development of PCC health care experiences the issue of language appropriateness must be recognised.</p>
<p>Standard 7 - Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.</p>	<p>Translation – The centres must ensure that the materials that are made available to the patients, are of a suitable quality and promote the delivery of effective PCC.</p>

<p>Standard 8 - Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services</p>	<p>Goals and Objectives – Centres should create coherent and measurable goals and objectives for the provision of cultural and linguistic appropriate services. These should assist in identification of training and development needs and measurement of effectiveness of the service delivery.</p>
<p>Standard 9 - Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations</p>	<p>Continuous Quality Improvement – CQI – The development of CQI structures flows logically out of the development of goals and objectives. Through suitable CQI environments the quality of the services can be assessed and improved on an on-going basis.</p>

<p>Standard 11 - Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area</p>	<p>Community Demographics – similarly to the need to maintain patient data the role and importance of community data is key to the Centre’s effectiveness in terms of achievement of its community responsiveness goals.</p>
<p>Standard 12 - Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities</p>	<p>Collaborative Activities – the Centres should endeavour to build suitable partnerships that mobilise the relevant stakeholders to meet the challenges associated with the delivery of CLAS and PCC. Effective collaboration can mitigate effectively against limited resources that is characteristic of the Centre’s operating environments, although much more pronounced at KwaZakhele.</p>
<p>Standard 13 - Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.</p>	<p>Conflict Resolution Awareness – given the demands on the respective Centres, the scope for conflict exists, again much more likely at the KwaZakhele site. Therefore, the achievement of effective CLAS and PCC requires a structured approach any conflicts that may emerge. This is an area that can best be addressed through the collaborative approach listed in the previous standard.</p>

<p>Standard 14 - Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information</p>	<p>Transparency – the need for transparency is key to embrace and developing the relationships that the Centres carry with their patients and the wider community. As Centres embark on promoting CLAS and the achievement of PCC, sharing the information and progress will greatly promote the Centres reputation.</p>
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These standards and their localised synonyms open a key debate regarding the measurement of the effectiveness of the provision of CLAS within each Centre. These standards can act as serving a vision for the provision of PCC built around suitable cultural and linguistic awareness, acting as a sort of gold standard. However, for them to be more than 'good ideas' a vibrant training and development infrastructures needs to be complemented by assessment criteria.

Developing a suitable measurement framework for CLAS presents a number of challenges and is prone to being politically hijacked for purposes that may not serve the achievement of effective PCC. This study has endeavoured to take a brief snapshot, via questionnaires and interviews to assess the status quo at the two Centres and lay a coherent foundation for the development of coalface structures to support the improvement in the qualify and experience of health care. This has show that developing a set of standards along the lines outlined above will serve the stakeholder groups and offer patients a greatly improved service.

In order to develop the provision of CLAS at the Centres it is necessary for the various stakeholders to identify key focus areas to lay the foundation upon which the various standards can be built and developed. The

development process for CLAS in the United States context once again offers a suitable referential framework. According to the Office's recommendation the following steps could be followed (Office of Minority Health:xvii-):

- Develop a consensus on core cultural competencies for health care staff and develop and validate measures for assessing these competencies
- Conduct and disseminate research to connect cultural competency behaviour to specific health outcomes
- Support and increase efforts to expand pool of health care professionals from diverse communities
- Develop a consensus on curricula standards and evaluative tools for cultural competency training
- Cultural competency training should be substantively integrated into health professions education and training at all levels, both academic and functional

In terms of the language aspect of CLAS, the recommendations in terms of laying a suitable foundation, the Department recommends:

- Collect and disseminate information on model programmes and strategies of implementing language assistance service
- Support direct and indirect financing of language assistance services at all levels of health services delivery
- Support the development of national standards for medical and community interpreter training, skills assessment, certification and codes of ethics
- Develop national standards or guidelines for the translation of health-related materials

- Develop standard language or templates for key documents

The report also generates guidance in terms of the organizational support structures that need to be developed to promote the provision of CLAS. These include:

- Develop model implementation plan and toolkit for CLAS that includes model strategies, policies, and a phase-in timetable with checklists and measurable short-and long-term process goals.
- Expand the availability of centralized information on CLAS model programmes and practices, with contacts, detailed resource information, and bibliographic references.
- Survey and disseminate information about model strategies to involve ethnic communities in the development and oversight of CLAS service
- Conduct a critical review of current organizational self-assessment tools, and define baseline and ongoing organizational self-assessment processes for cultural and linguistic competence
- Develop standard tools or processes for health care organizations to measure performance, satisfaction, and access related to CLAS
- Federal, state, and accreditation agencies should develop and require standardized, uniform data sets related to the race, ethnicity, and language of their patients/consumers
- Develop best practices or methods to help health care organizations integrate race, ethnicity, and language data components into their data collection processes
- Develop a guide to help health care organizations incorporate race, ethnicity, and language variables into routine outcomes analyses
- Develop a framework or process for maintaining a culture-sensitive community profile and needs assessment

- Develop guidance for the human resources, legal and ethics staff or committees of health care organizations on the impact and management of cross-cultural ethics issues
- Develop reporting guidelines to help organizations share information with the public about efforts to implement the CLAS standards

Finally, the report offers some general recommendations for establishing CLAS standards:

- Raise awareness about and promote the adoption of the CLAS standards
- Support the development and dissemination of resources and technical assistance on CLAS implementation
- Support assessments, evaluations, and oversight on implementation of the CLAS standards

There are many challenges associated with developing effective CLAS and PCC environments in the Centres that have been investigated; however, the opportunities to create a vibrant and effective health care experience can be served by the embrace of the areas covered above. Recognising that the resource challenges are extensive, developing the proposed model, on the back of further research has the potential to greatly enhance the quality and standard of health care at clinics in South Africa.

APPENDIX 1

Structure of questionnaire

Patient Questionnaire (English)

Part 1: Personal data

Gender: (circle the correct answer) Male Female

Age:

Marital status:

Status of employment:

Residing in a rural or urban area:

Home language:

Provide a tick for your answer	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>	<i>Do not know</i>
1. Diabetes can affect anybody, young and old					
2. It affects rich and poor					
3. Diabetes is a genetic disease. That means it appears in some families					
4. Overweight, inactive people are at greater risk of getting diabetes.					

Part 2: Attitudes towards Diabetes information

Provide a tick for your answer	Strongly Agree	Agree	Neutral	Strongly Disagree
5. Diabetes information is confusing				
6. Diabetes information is not readily available				
7. Diabetes information is too scientific				
8. I am tired of hearing about Diabetes				

Part 3: Knowledge of diabetes

(You have a choice to answer the following)

9. Why are you here at the clinic and how often do you come?
10. What is diabetes all about?
11. What are the signs and causes of Diabetes?
12. How long have you been suffering from Diabetes?

Provide a tick for your answer	Strongly Agree	Agree	Neutral	Strongly Disagree	Disagree	Don't know
13. The rapid diabetes test (which gives results in 15-20minutes) is reliable						
14. Certain things ego viruses or stress can cause diabetes to start in people who are at risk.						
15. Personal hygiene has nothing to do with diabetes						

<p>16. A blood test will show whether one has diabetes.</p>						
<p>17. When there is a large amount of blood sugar in the blood, it spills over into urine</p>						
<p>18. Some people incorrectly believe that sugar causes diabetes.</p>						
<p>19. Good nutrition is important.</p>						

20. Salt and alcohol intake should be kept to a minimum.						
21. Another sign of diabetes is loss of weight.						

Please tick the correct answer

22. The diabetes test checks for the presence of:

a) The sugar

b) Glucose

c) Insulin

23. It is required by law in South Africa for everyone taking diabetes test to get counselling

Yes

No

don't know

24. If someone's diabetes test result shows no sign of it, it means:

- a) The person will never be Diabetic
- b) The person is very healthy
- c) The person must take treatment to prevent Diabetes

25. It is important to test for diabetes

- a) Because it is the right thing to do
- b) Because most people are doing it
- c) So that I can protect myself from infection
- d) So that I can change my lifestyle

Provide a tick for you answer	Truth	False
26. Overweight, and inactive people are always diabetic		
27. Elderly people cannot use insulin properly.		

Please tick the correct answer

28. When must one start taking treatment of diabetes

- a) Immediately after one has tested that he or she has Diabetes
- b) When one loses weight

c) As soon as one finds out that he or she has increased trips to the toilet

29. Under what conditions does Diabetes become resistant to treatment:

- a) If one stops and then restarts the treatment
- b) If the person has itchiness and skin infections
- c) If the person takes the diabetes treatment for a long time

Part 4: Diabetes information sources

Provide a tick for your answer	Always	Often	Sometimes	Seldom	Never
30. I visit Chronic diseases (diabetes) websites					
31. I read printed material (such as pamphlets, books and newspaper articles) on diabetes					
32. I watch diabetes related TV programmes					
33. I listen to diabetes related programmes on radio					

34. I attend workshops and seminars on diabetes					
35. I talk about diabetes					

Part 5: General

36. If you could ask one question on diabetes, what would it be?

.....
.....
.....
.....

Thank you for your time!

Part 6: Invitation to take part again

Thank you for filling in this questionnaire. Please note that another research regarding diabetes will be conducted at a later stage. Should you be interested in taking part, please provide your contact details below:

Email address:or Cell number:.....

6.1.1.2 Patient Questionnaire (isiXhosa)

Iphepha lemibuzo ngomguli

Ihlelo loku-1: linkcukaca ngomguli

1.

Ubuni (yenza isangqa kwimpendulo efanelekileyo) Indoda Umfazi

Iminyaka:

Imo yomtshato (ingaba utshatile?):

Imo yempangelo (ingaba uyaphangela?):

Uhlala edolophini okanye ezilalini?:

Ulwimi lwasekhaya:

<u>Beka uphawu kwimpendulo yakho</u>	<u>Rhoqo</u>	<u>Futhi</u>	<u>Ngamanye</u> <u>amaxesha</u>	<u>Nakanye</u>	<u>Andiyazi</u>
2. <u>Isifo seswekile singahlasela</u> <u>ngumntu omtsha nomdala</u>					
3. <u>Sihlasela izityebi</u> <u>namahlwempu</u>					
4. <u>Isifo seswekile sisifo sofuzo.</u> <u>Oko kukuthi sibakho kwamanye</u> <u>amakhaya</u>					
5. <u>Abantu abatyebileyo</u> <u>nabadangeleyo ngamaxhoba</u> <u>amakhulu okufumana isifo</u> <u>seswekile</u>					

Ihlelo lesi-2: Ubume ngolwazi malunga nesifo seswekile

<u>Beka uphawu kwimpendulo yakho</u>	<u>Ndiyavumelana ngamandla</u>	<u>Ndiyavumelana</u>	<u>Ndiphakathi</u>	<u>Andivumelani ngamandla</u>	<u>Andivumelani</u>
6. <u>Luyabhida ulwazi ngesifo seswekile</u>					
7. <u>Ulwazi ngesifo seswekile alufumaneki ngokuchanelekileyo</u>					
8. <u>Ulwazi ngesifo seswekile lunobunzulu-lwazi ngokumandla</u>					
9. <u>Ndidiniwe ngokuva ngesifo seswekile</u>					

Ihlelo lesi-3: Ulwazi ngesifo seswekile

(Unelungelo lokuphendula oku kulandelayo)

10. Kutheni ulapha kwiziko lezempilo, kwaye uza kangaphi apha?
11. Singantoni isifo seswekile?
12. Zeziphi iimpawu nezinto ezidala iswekile?
13. Lixesha elingakanani ukhathazwa sisifo seswekile?

<u>Beka uphawu kwimpendulo yakho</u>	<u>Ndiyavumelana ngamandla</u>	<u>Ndiyavumelana</u>	<u>Ndiphakathi</u>	<u>Andivumelani ngamandla</u>	<u>Andivumelani</u>	<u>Andiyazi</u>
14. <u>Ithembekile indlela ekhawulezileyo yokukhangela iswekile (enikezela iziphumo ngemizuzu eli 15-20)</u>						

<u>Beka uphawu kwimpendulo yakho</u>	<u>Ndiyavumelana ngamandla</u>	<u>Ndiyavumelana</u>	<u>Ndiphakathi</u>	<u>Andivumelani ngamandla</u>	<u>Andivumelani</u>	<u>Andiyazi</u>
5. <u>Ezinye izinto ezinjenge ntsholongwane noxinzelelo zibangela isifo seswekile kubantu abaninzi abasebungcuph ekweni</u>						
6. <u>Ucoceko lomntu alunanto yakwenza nesifo seswekile</u>						
7. <u>Uvavanyo-gazi lungabonisa ukuba ubani unesifo seswekile</u>						

8. <u>Ukuba kukho</u> <u>isixa esikhulu</u> <u>seswekile</u> <u>egazini,</u> <u>siyakuchithakela</u> <u>kumchamo</u>						
9. <u>Abanye</u> <u>abantu</u> <u>banenkolelo</u> <u>egwenxa yokuba</u> <u>iswekile yenza</u> <u>isifo seswekile.</u>						
10. <u>Ukutya</u> <u>okunezondlo</u> <u>kubalulekile</u>						
21. <u>Ukuthatyath</u> <u>wa kwetyuwa</u> <u>notywala</u> <u>kufuneka</u> <u>kugcinwe</u> <u>kwizinga</u> <u>elisezantsi</u>						

22. <u>Olunye uphawu lesifo seswekile kukuwohla komzimba</u>						
--	--	--	--	--	--	--

23. Uhlolo lwesifo seswekile lukhangela ubukho be:

a) swekile

b) glukhosi

c) insulini

24. Ngokomthetho wase Mzantsi Afrika kufuneka wonke ubani othabathe uvavanyo lwesifo seswekile afumane iingcebiso

Ewe Hayi Andiyazi

25. Ukuba iziphumo zovavanyo lomntu othile alubonakalisi mpawu zayo, oko kuthetha ukuba:

d) Umntu akasayi kuba naso isifo seswekile

e) Umntu usempilweni kakhulu, ungumqaba-qaba

f) Umntu makatye amayeza ukuzikhusela kwisifo seswekile

26. Kubalulekile ukuvavanyela isifo seswekile
- e) Kuba iyinto elungileyo
- f) Kuba abantu abaninzi bayayenza lo nto
- g) Ukwenzela ndizikhusele ekosulelekeni
- h) Ukwenzela nditshintshe indlela endiphila ngayo

<u>Beka uphawu kwimpendulo yako</u>	<u>Inyani</u>	<u>Inkolelo</u>
27. <u>Abantu abatyebileyo, nabadangeleyo basoloko benesifo seswekile</u>		
28. <u>Abantu abadala abakwazi kuyisebenzisa kakuhle i-insulini</u>		

29. Kufuneka aqale nini ubani ukuthabatha amayeza esifo seswekile
- d) Kwakamsinya nje ubani evavanywe ukuba unesifo seswekile
- e) Xa ubani ewohla emzimbeni
- f) Ngokukhawuleza ubani akufumanisa ukuba izihlandlo zokuya kwakhe kwindlu yangasese kwangezelekile
30. Ngaphantsi kwezphi imeko isifo seswekile sisalana namayeza:
- d) Xa ubani ethe wayeka aze aphinde aqalise ukutya amayeza
- e) Xa umntu ebabelwa okanye enesosulelo kwisikhumba
- f) Xa umntu esitya amayeza eswekile ixesha elide

Ihlelo 4: lindlela ezikhethekileyo ezimbhaxa zokufumana ulwazi ngeswekile

<u>Beka uphawu kwimpendulo yakho</u>	<u>Rhoqo</u>	<u>Futhi</u>	<u>Ngamanye amaxesha</u>	<u>Mana</u>	<u>Nakanye</u>
31. <u>Ndindwendwela i-websayithi yezifo ezinganyangekiyo (isifo seswekile)</u>					

<p>32. <u>Ndifunda</u> <u>okubhaliweyo (okunje</u> <u>ngamapece-pece,</u> <u>iincwadi, iziqingatha</u> <u>kumaphepha-ndaba</u></p>					
<p>33. <u>Ndibukela</u> <u>kumabona-kude</u> <u>iinkqubo</u> <u>ngokungamene</u> <u>nesifo seswekile</u></p>					
<p>34. <u>Ndimamela</u> <u>inkqubo eziphathelele</u> <u>kwisifo seswekile</u></p>					
<p>35. <u>Ndiya kwiindibano</u> <u>nemihlangano</u> <u>malunga nesifo</u> <u>seswekile</u></p>					
<p>36. <u>Ndiyathetha</u> <u>ngesifo seswekile</u></p>					

Ihlelo 5: Okuqhelekileyo

37. Ukuba unokubuza umbuzo ubemnye malunga nesifo seswekile, ingaba ngowuphi?

.....
.....
.....
.....

Enkosi ngexesha lakho!

Ihlelo lesi-6: Isimemo sokuthabatha inxaxheba kwakhona

Enkosi ngokugcwalisa ngeempendulo kule mibuzo. Qaphela ke ukuba olunye uphando malunga nesifo seswekile lakuqhutywa ngethuba elingephi. Ukuba unomdla wokuthabatha inxaxheba, nceda unikezele imininingwane yakho yonxulumano apha ngezantsi:

Idilesi ye I-meyile:okanye inombolo kanomyayi wakho:.....

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