LANGUAGE DISCORDANT HIV AND AIDS INTERACTIONS IN LESOTHO HEALTH CARE CENTRES

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DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Konosang Sobane

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ABSTRACT

This PhD study investigated the organisational structure of medical communicative facilities and the related communicative experiences of health care providers and patients in HIV and AIDS care centres where there is language discordance between physicians and patients. Such discordance refers specifically to communication in contexts where patients and health care providers speak a number of different, mostly mutually unintelligible first languages (L1s) and where speakers have varying levels of proficiency in a lingua franca such as English. This study considers key moments within the organisational communication structure to assess how well the structure meets its communicative aims.

The sites of care that provided empirical data in this study, were a public health clinic which is a division of a state hospital, and a privately run day care clinic both located near Maseru, the capital city of Lesotho. The participants were drawn from four categories, namely physicians, nurses, lay interpreters and patients. Data collection was done through semi-structured interviews, focus group discussions and direct observations of the study sites. The data was later transcribed interpreted and analysed according to insights gained from Organisation Theory on the one hand and Thematic Analysis and Qualitative Data Analysis on the other hand.

The most important result of the study is the recognition of organisational fragmentation of care into different units which helps to facilitate communication where patients and physicians show marked language discordance. Further results illuminate several challenges that are encountered by participants in mediating and making meaning where language diversity is such that physicians' linguistic repertoire does not match the repertoires of patients and local HCPs. The study highlights several institutional and interpersonal strategies that are used to overcome these challenges and to assure effective communication in the particular institutions. It also shows how some of these strategies fail to fully address the communicative challenges identified. The findings of this study suggest that in multilingual clinical contexts there is a need for more dedicated attention to interpreting practices, to the kinds of material distributed among patients and, more generally, to make consultative decisions on improved systems to put in place in order to facilitate communication related to quality health care.

OPSOMMING

Hierdie PhD-studie het die organisatoriese struktuur van mediese kommunikatiewe geleenthede en die verwante ervarings van beroepsmense in gesondheidsorg van pasiënte in HIV-versorgingsentra ondersoek, waar die taalvaardighede van dokters en pasiënte nie gesinchroniseer is nie. Die taaldissonansie verwys spesifiek na kommunikasie in kontekste waar pasiënte en beroepsmense in gesondheidsorg 'n verskeidenheid tale praat wat meestal onderling onverstaan-bare eerste tale (T1e) is van sprekers met ongelyke vlakke van vaardigheid in 'n lingua franca soos Engels. Die studie vestig aandag op sleutelmomente binne die struktuur van die kommunikasie van die organisasie om vas te stel hoe goed die bepaalde struktuur sy kommunikatiewe doelstellinge verwesenlik.

Die terreine van gesondheidsorg wat empiriese data vir hierdie navorsing voorsien het, was 'n openbare kliniek wat verbonde is aan 'n staatshospitaal, en 'n privaat dagsorgkliniek wat albei naby Maseru, die hoofstad van Lesotho, geleë is. Die deelnemers behoort aan vier kategorieë, naamlik dokters, verpleegpersoneel, leke-vertalers/-tolke en pasiënte. Data insameling is gedoen deur middel van semi-gestruktureerde onderhoude, fokus groepbesprekings and direkte waarrneming by die betrokke instansies. Die data is later getranskribeer, geinterpreteer en geanaliseer volgens insigte uit Organisasie Teorie aan die een kant en Tematiese Analise en Kwalitatiewe Data Analise aan die ander kant.

Die belangrikste bevinding van die studie is herkenning van die organisatoriese fragmentering van die sorg in verskillende eenhede wat help om kommunikasie te fasiliteer binne ‘n konteks waar pasiënte en dokters merkbare taaldissonansie vertoon. Verdere bevindinge werp lig op verskeie uitdagings wat deelnemers ervaar in die bemiddeling en skep van betekenis waar taaldiversiteit sodanig is dat die talige repertoires van die mediese praktisyns nie aangepas is by die talige repertoires van die pasiënte of plaaslike mediese beamptes nie. Die studie vestig aandag op verskeie institusionele en interpersoonlike strategieë wat gebruik word om uitdagings te oorkom en om effektiewe kommunikasie binne die betrokke instansies te verseker. Dit wys ook hoe sommige van hierdie strategieë misluk in die aanspreek van bepaalde kommunikatiewe uitdagings. Die bevindinge bevestig dat in die omgewing van ‘n veeltalige kliniek daar ‘n behoefte is aan meer toegewyde aandag aan tolkingspraktyke, aan die soort materiaal wat onder pasiënte versprei word, en in meer algemene terme, aan die neem van besluite gegrond op konsultasie sodat verbeterde stelsels geimplimenteer kan word om kommunikasie wat verband hou met goeie kwaliteit gesondheidsorg, te help bedien.

LIST OF ABBREVIATIONS

ABC:	Abstain Be faithful Condomise
AIDS:	Acquired Immunodeficiency syndrome
ART:	Antiretroviral treatment
ARV:	antiretroviral
CHAL:	Christian Health Association of Lesotho
HAART:	Highly Active antiretroviral Treatment
HC-A:	HC-A Wellness Centre
HC-B:	HC-B HIV AND AIDS Care Centre
HCP:	Health care providers
HIV:	Human Immunodeficiency Virus
L1:	First Language
L2:	Second language
MOHSW:	Ministry of Health and Social Welfare
NGO:	Non-Governmental Organisation
OPD:	Outpatient Department
OT:	Organisation Theory
QCA:	Qualitative Content Analysis
SPO:	Structure Process Outcome Model
TA:	Thematic Analysis
TB:	Tuberculosis
VCT:	Voluntary Testing and counselling

KEY TERMS

This section provides a list of key terms and how they are defined, understood and therefore used in this study.

Clinical staff - although the general definition of clinical staff is all staff that is medically trained and that participate in patient care (O'Connor, 2006:177), in this study the term is used loosely to refer only to all staff that are not physicians but are medically trained and provide patient care or participate in care. These include nurses, counsellors, pharmacists and laboratory assistants.

Language Discordance - in the health care setting, language discordance occurs when a patient has limited proficiency in the language(s) spoken by health care providers (John-Baptiste et al., 2004:221).

Linguistic repertoire - the total linguistic resources that a speaker possesses inclusive of the registers, dialect and styles. It is from this repertoire that a speaker usually makes a choice depending on the communicative situation s/he is in (Rodriques, 2000:201).

Multilingualism - the spatial presence or co-occurrence of two or more languages in a given community where the languages have a different social and historical status in a given speech situation (Moyer, 2011:1212). 'Multilingualism' can also refer to the knowledge a single speaker has of more than two languages, even at varying levels of proficiency and where the speaker typically uses the different languages for different functions in different domains.

Lingua franca - a language that is used for communication among speakers who have different mother tongues or L1s (Byram, 2000:357). The lingua franca typically facilitates communication where speakers of different, mutually unintelligible L1s would otherwise very limitedly be able to interact linguistically.

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CHAPTER 1

INTRODUCTION

1.0 INTRODUCTION

Recently, Lesotho has seen a growing number of health care facilities staffed by non-Sesotho speaking physicians. This study is interested in how medical discourses are organised and how staff and patients experience communication in public health care facilities where there is language discordance between the various participants in the discourse. These are contexts in which patients and health care providers speak different, mutually unintelligible L1s (L1s) and have varying levels of proficiency in a lingua franca such as English. Specifically, the study investigates how communication between health care providers and patients is structured and what the experiences of participants are in institutions that provide care, from voluntary testing for and counselling on HIV and AIDS through to the provision of anti-retroviral treatment and the care of AIDS patients.

A number of discourses with various role-players in the provision of HIV care in two HIV and AIDS care centres in Lesotho have been analysed with a view to gaining insight into these communicative structures and experiences within the selected two care institutions. The study relates to recent work on the provision of health care in multilingual contexts elsewhere where it has become clear that linguistic and communicative issues, in particular language discordance, have an impact on the effectiveness of communication and the quality of care. The sites of care chosen for collecting empirical data in this study are a public health clinic located in a hospital in Mapoteng about 72 km from the capital city of Lesotho, Maseru; and a day care clinic in Ha Senekane, a village about 40 km from Maseru.

1.1 BACKGROUND: THE HIV AND AIDS SITUATION IN LESOTHO

Research has shown that linguistic and communicative issues, including the structuring of communicative events in multilingual contexts, have an impact on the quality and effectiveness of care

of AIDS patients. In Lesotho where the prevalence of HIV is reportedly very high, communication in HIV and AIDS care becomes a central issue. Recent statistics show that Lesotho has the third highest adult prevalence of HIV and AIDS in the world, with a 23.6 % prevalence rate.[1] This pandemic is reported to cause an estimated 14, 000 deaths per year and has contribution to a reduction of life expectancy to 47 years in Lesotho.[2] This study was carried out in cognisance of these statistics and the negative effects that HIV and AIDS has on human and economic resources in Lesotho.

The prevailing HIV and AIDS situation in Lesotho has created a need for in-depth research on measures that can reduce the infection rate and guarantee the effectiveness of treatment. A great deal of scholarly work is being done to assess social, behavioural and medical circumstances under which the disease is spread and treated, however, little is available on the role of effective communication in HIV and AIDS education and treatment. Recent reports on Lesotho government measures to control the spread of the disease (see Makoae and Jubber, 2008; Cohen et al., 2009), refer to medical care programmes and educational campaigns as measures largely used by the government.

Care programmes and strategies that the Lesotho government has used to control the spread of HIV date back to the period prior to 2004, which is the year in which free ARV treatment was rolled out. According to Makoae and Jubber (2008:36) one of the strategies used was to provide a free "minimum package of care" which consisted of free treatment for opportunistic diseases such as TB, in order to reduce the rate at which HIV positive patients were hospitalised. This however did not change the situation, so home-based care was encouraged, which also did not bring any change to the infection rates. It should be noted that Makoae and Jubber (2008) report on a research study conducted from February to August 2004, while free ARV treatment was only rolled out in November 2004.[3]

On top of above-mentioned attempts, the Lesotho government embarked on several educational campaigns such as the ABC campaign (where ABC represents Abstain, Be faithful, Condomise) and the 'Know Your Status' Campaign. These campaigns were intended to create awareness about HIV and

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[1] Source: www.indexmundi.com. Accessed on 15/11/2012
[2] Source: www.unaids.org/en/Regionscountries/countries. Accessed on 15/11/2012
[3] Source: www.avert.org/aids-lesotho.htm. Accessed on 31/07/2012.

AIDS and ultimately change sexual behaviours in order to decrease the number of new infections and re-infections. The main objective of these campaigns is documented in the National HIV and AIDS Strategic Plan[4] document as to "modify behaviour that increases the risk of HIV infection [... by] getting behaviour change messages across effectively"[5].

Despite the success of the campaigns mentioned above, there was still a medical need to care for those already infected by HIV and at the stage that requires medical care and attention. In order to respond to that need, government engaged in the most significant medical intervention which was the rolling out of Anti-retroviral Treatment (ART) in November 2004. This was initially begun in some of the public health centres, with a gradual increase in the number of health care facilities and decentralisation of the treatment to primary health care level in 2004.

Even though studies on HIV and AIDS in Lesotho (see Makoae and Jubber, 2008; Cohen et al., 2009) provide a detailed account of these strategies and interventions, and also report on some of their successes and failures, they do not refer to specific communicative strategies and devices that are obviously central in achieving the aims of these strategies and interventions. This research will attend to this dearth in knowledge of linguistic communicative practices and intends to develop insight into the ways in which communication is structured in HIV and AIDS care and treatment in two treatment centres in Lesotho.

The gradual increase in the number of HIV and AIDS care centres has resulted in the current availability of HIV and AIDS treatment in most clinics and hospitals across the ten districts of Lesotho. Statistics from UNAIDS show that at present the ART coverage is estimated at 57%.[6] Although this is an improvement at the level of treatment, it presents an additional challenge to HIV care delivery, namely the strain on human resources - particularly, the professional health workers. According to Cohen et al. (2009:3) the country presently has just five doctors and 62 nurses per 100 000 people, with the majority of these doctors (80%) being expatriates from other parts of Africa. Although their recruitment has improved staffing in health facilities, it has also created a language discordant situation in which doctors

[4] Source: The Lesotho Government National HIV and AIDS Strategic Plan 2006-2011.
[5] Source: The Lesotho Government National HIV and AIDS Strategic Plan 2006-2011: 21.
[6] Source: www.unaids.org/en/Regionscountries/countries. Accessed on 15/11/2012

are neither familiar with Basotho culture nor proficient in the Sesotho language, yet many of the patients they have to treat do not speak English which is generally used as a lingua franca.

1.2 THE LANGUAGE SITUATION IN LESOTHO HEALTH CARE

Like many other African countries Lesotho has a diverse language landscape comprising of two majority languages and several minority languages. The constitution of Lesotho endorses Sesotho and English as official languages. Sesotho is a national language and an L1 for a majority of the population. Khati (1996:2) and Lewis (2009) agree that Sesotho is spoken by approximately 90 per cent of the population and is exclusively used as a language of instruction in public schools for the first three years of primary education. Due to the fact that it is spoken by a large portion of the population, Sesotho is widely used in the provision of many services such as legal, political and medical services.

English as a second official language is the language of education, used as a medium of instruction from the fourth year of primary education. In recent years the education fraternity has been more and more focussed on the importance of competence in English in facilitating communication with the outside world and obtaining employment (Legère et al. 2002:114). As a result, there are presently many English-medium primary and pre-primary schools where English is a medium of instruction from a very early age. Apart from the education sector, English is used for official interaction in domains like government, administration, courts and medical services.

Lesotho also has a diverse range of minority languages used by small population groups, with speakers concentrated in various regions of the country. Matsoso (2000), Lewis (2009) and Moloi and Matsau (2011) have documented that a considerable portion of the population living in the northern and eastern parts of the country, across the borders from South Africa, speak Nguni languages such as Xhosa, Zulu, Ndebele and Sephuthi as their mother tongue. Moloi and Matsau (2011:68) note that Xhosa is the most widely spoken of all these minority languages.

Apart from these minority languages, Lewis (2009) acknowledges the presence of several other immigrant languages that are not yet officially documented. These are languages that originate from countries such as France, India, China and Pakistan whose speakers migrated to Lesotho for economic and political reasons. Most of the speakers of these languages are in the business sector, where they

own and manage small businesses or large factories. Although these languages are not commonly used in Lesotho, they are used for in-group interaction among speakers of the same language.

Such immigrant languages are also found in the health sector, where there are many immigrant physicians. The language situation in the health care fraternity in particular, is shaped by the fact that there is a shortage of Basotho physicians, which has necessitated reliance on expatriates. The deployment of expatriate physicians in many health care centres has created multilingual centres in which there is language discordance between most physicians and their patients. This means that patients and physicians speak different, mutually unintelligible L1s. The patients' L1 is Sesotho, which is also the dominant language of the country, whereas the physicians are mostly L1 speakers of foreign, minority languages. Although English is used as a lingua franca, most patients have very limited proficiency in English and the situation seems to be the same for some physicians too, since some of them come from francophone countries where English is limitedly used.

The likely implications of this language discordance can be drawn from previous research on communication in health care in general (see Korthuis, 2008; Deumert, 2010; Moyer, 2011 for example), and in HIV and AIDS care in particular (see Stone, 2004 and Enriquez et al., 2008), which has documented the essence of communication in health care communicative difficulties that could arise where there is language discordance between physicians and patients. This body of work that includes the works of van den Brink-Muinen et al. (2000), Cioffi (2003) Meeuwesen et al. (2007), Korthuis (2008), Schouten et al. (2009) among others, underscores the importance of effective communication in health care. A detailed discussion of the findings of this body of literature is provided in *Chapter 3*. However it is noteworthy to mention that there is general agreement among these studies that mutual understanding between various parties in medical discourse requires exchange of information on the causes of illness, its therapeutic management and any other measures necessary for care, treatment and management of the condition.

Despite this apparent need for effective communication in health care, research has established that in language discordant consultations it is not always easy to attain effective communication. Scholars such as Harmsen et al. (2003), Meeuwesen et al. (2006), Ijadunola et al. (2007) who investigated particular communication experiences of physicians and patients in language-discordant health care provider-

patient interactions found that in the absence of compatible linguistic resources communication is less effective and often fraught with misunderstanding. For instance, Harmsen et al.'s (2003:104) main conclusion is that communication between Dutch speaking physicians and ethnic minority patients is less effective and is marred by misunderstandings that eventually lead to non-compliance with treatment. In another study, Meeuwesen et al. (2006:2415) established that linguistic incompatibility hinders physicians from building a good relationship with their patients. These findings suggest that communication in language discordant clinical interactions is challenging. Further problems are documented in Korthuis (2008:2046) who considers how race affects good transfer of information in medical consultations; and Schouten et al. (2009:468) who point out that good transfer of information enables the patient to make informed decisions about adherence to treatment. Rivadeneyra et al. (2000:473) and Wiener and Rivera (2004:93) have emphasised how language discordance impairs good physician-patient relationships since a patient's experience of empathy relies on good communication, which in turn co-determines his/her trust in the health care institution and improves the likelihood that he/she will keep return appointments.

While the above-mentioned research focussed on health care in general, in the treatment of HIV and AIDS specifically, Anthonissen and Meyer (2008) have noted that effective verbal communication is a prerequisite for effective treatment. The demand for good verbal communication is intensified by the nature of the illness where the treatment protocol dictates that the physician has to ascertain that the patient understands the chronic nature of the illness and the particular demands and risks of the medication currently available.

Based on this available literature, one could predict the same kind of difficulties in the Lesotho context where physicians do not have common linguistic resources nor shared cultural backgrounds with Basotho patients, yet they are bound to communicate in order for treatment to be successful. An example of an effect of this situation is that the lack of a shared language could make it difficult for the health care providers to adequately explain the seriousness of HIV infection and the steps that should be taken to manage it. They might not be able to discuss the contagious nature of the infection, also because that would entail discussing sexual behaviour, a topic that is tabooed in some cultures. It may be difficult to determine whether patients understand and are comfortable with the treatment. It is likely that patients may leave the consulting room without clearly understanding the treatment and the associated risks and

side effects, which in turn could affect their ability to adhere fully. Thus, with such a high risk of misunderstanding of the nature and causes of the disease, as well as the treatment and management thereof, there is an increased risk of impaired treatment. These insights and concerns rationalise the value of continued research into communication in health care. They call for research on how role-players (physicians, pharmacists, nurses, administrative officers and patients) manage language diversity and discordance in a way that will guarantee effective communication in view of adequate diagnosis and treatment.

The study is further rationalised by the fact that the bulk of above mentioned research has been done in first world contexts where the patients are from immigrant and refugee communities, speaking foreign, minority languages as L1s, and the physicians represent the dominant language community of the state that is responsible for providing health care. The opposite kinds of relations prevail in African and Southern African contexts. Although there is much social scientific interest in institutional medical discourse (see for example Drennan, 1999; Levin, 2006a,b; Robins, 2006; Kagee et al., 2007), scholarly work in the area of HIV and AIDS from a linguistic perspective is considerably less prevalent, more especially in the context of Lesotho.

The growing body of scholarly work on HIV and AIDS in Africa (see Kohi et al., 2008; Cohen et al., 2009) to date has not attended to communication in language-discordant provider-patient interactions in HIV and AIDS in Lesotho, in spite of the prevalence of the pandemic in this country. Thus there certainly is a need for primary research on the communicative experiences of health care providers and patients in language-discordant HIV and AIDS interactions in this region. Similarly, there is no available research that reports on the extent of language discordance amongst role players in HIV and AIDS care centres and the use of multilingual linguistic resources by health care providers and patients in Lesotho. The current research intends, on a limited scale, to fill these gaps by carefully following language-discordant provider-patient interactions in two HIV care centres in Lesotho, where the health care providers are speakers of minority languages.

1.3 STATEMENT OF THE PROBLEM

The focus of this study is on the organisation of communicative processes in particular multilingual HIV and AIDS care institutions in Lesotho. It considers how that organisation reflects the linguistic

diversity of the various participants (patients and service providers) in the clinics. The study firstly traces the HIV and AIDS care trajectory to empirically establish what communicative events and practices have been developed in this kind of care. By tracing this trajectory, the macro and micro structures within which bilingual and multilingual resources are used, are established. In addition to this, particular attention is paid to how the organisation of communication facilitates the effectiveness of communication. Through the communicative experiences of health care providers and patients, it identifies difficulties that may arise due to insufficient mutual intelligibility of participants' different languages, and how such difficulties are managed. It then establishes the kinds of communicative devices which participants use to account for successful communication in contexts like these, where participants do not share linguistic resources, nor have access to professional interpreting services. The study is therefore interested in knowledge about those places in the communicative process in the care centre where potential events of miscommunication occur, and whether possible miscommunication is recognised and addressed by means of regular interventions (e.g. interpreting, *lingua franca*, gesture or graphic illustration) or simply goes by unnoticed or unresolved.

1.4 RESEARCH QUESTIONS AND OBJECTIVES

1.4.1 Main Research Questions

The research seeks to answer the following two broad research questions: (i) How is health care communication in a multilingual HIV/AIDS testing, counselling and treatment institution organised and, given such organisation, (ii) how do different role players in these institutions report on their communication experiences with specific reference to how the organisational structure facilitates or limits the management of language diversity and use of multilingual linguistic resources at various points of the HIV/AIDS consultation?

Underlying these broad questions, the study seeks to respond to the following specific questions which address different components of the broad questions:

1.4.2 Specific Research Questions

i) What are the organisational structures of care and communication in multilingual HIV/AIDS care centres in Lesotho?
ii) What is the extent of language diversity in the two health care centres?
iii) What do participants report on their experience of communication in the process of giving and receiving care within the particular organisational structures?
iv) What threats to communicative success are posed by the organisational structures?
v) What are the multilingual resources and strategies that enable role players to counter these organisational threats to communicative success?

1.4.3 Objectives

In answering these research questions, the study is addressing the following objectives:

i) To establish how particular multilingual health care institutions organise the care and communicative process in testing, counselling and providing HIV and AIDS treatment.
ii) To gain insight into the extent of language diversity in the two health care centres.
iii) To gain empirical information on the experiences of role-players regarding the organisation of clinical interactions and the use of linguistic resources.
iv) To establish possible threats to communicative success that are posed by language diversity in HIV and AIDS care in the particular institutions and to report on possible reasons for communicative failure.
v) To determine how, within the framework of the organisational structure, the different role-players manage language diversity and use multilingual linguistic resources in communication structured to meet the requirements of HIV and AIDS care in each particular health care facility.
vi) To give a description of bilingual/multilingual communication within each institution that will account for achievement (or not) of communicative aims.

1.5 RESEARCH PARADIGM AND DESIGN

This is a qualitative research project. The general aim of the research is consistent with that of qualitative research which is to provide in-depth descriptions of phenomena by generating insiders' perspectives of the phenomena or practices being studied (see Mouton, 2001:148; Lambert and Loiselle, 2008:228). This study seeks to give an in-depth understanding (see Henning et al., 2004:3) of the organisational structure that directs communication practices in the selected health care centres. It will also give a detailed description and analysis of how the various role players manage language diversity at different contact points in the health, with data collected from role-players as insiders.

Because of the need for depth in data, the study adopted a case study research design. (See McGloin, 2008:46; Iwagabe and Gazzola, 2009:603)) Such a design allows for the generation of detailed descriptions of how the communicative processes in the two HIV and AIDS treatment clinics are organised. In health care research Anthony and Jack (2009:1172) have noted that case studies are currently gaining popularity due to their ability to provide in-depth descriptions of phenomena in their real life settings. See also Mills et al. (2008:1529), as well as other case studies on which this study was modelled, including Roberts and Volberding, 2000 in San Francisco; John-Baptiste et al., 2004 in North America; Collins and Slembrouck, 2006 in Ghent and Moyer, 2011 in Barcelona). Case studies on medical communication in in South Africa include Drennan, (1999) Anthonissen and Meyer (2008 and 2010) and Deumert (2010).

1.5.1 Case Description and Selection

The study used instrumental case selection, which Stake (1994:243) defines as case selection in which specific cases are selected from a pool of possible cases in order to explore a given research theme. In this case, two HIV and AIDS care centres were selected as cases, from a set of 24 possible HIV and AIDS care centres in Lesotho. Selection of the two cases, which will be named HC-A and HC-B respectively, was on the basis of three characteristics that distinguish them from other centres. Firstly, the health care professionals (HPCs) in these two health centres are mostly Sesotho L1 speakers, excepting for the doctors who are exclusively expatriates with very little or no Sesotho proficiency. Secondly, they are based in the rural areas where they serve a largely rural

patient base that often limitedly use English as a lingua franca. Lastly, the two health centres care exclusively for people living with HIV and AIDS, a situation which renders them as better resourced to provide information relating to communication in HIV and AIDS care. These two cases are therefore ideal for exploring the theme of multilingual communication in HIV and AIDS care.

The first health centre used in this study is HC-A, which is a public health facility established within a hospital run with state support, but under the auspices of the Christian Health Association of Lesotho (CHAL) is situated in Mapoteng. Although the hospital has been in existence for a long time, the public health clinic was only recently established (in 2001) as an HIV and AIDS treatment and care centre. This came about due to the hospital management's awareness that HIV positive patients need dedicated care that could not be provided by the regular service structures of the Out-Patient Division (OPD) of the hospital. At a later stage, considering the regular co-occurrence of the conditions, the clinic also started treating TB patients. The key function of the clinic is to facilitate provision of medical care for patients diagnosed with TB and/or HIV, and to liaise with the public in an effort to control the spread of communicable diseases through providing sound information and attempting to facilitate behavioural change that will assist in curbing distribution of these illnesses and improving the quality of life of those infected. The clinic staff follows up with patients to ensure the best possible adherence to the prescribed medication. According to the statistics obtained from the clinic reception, it currently serves about 1200 registered patients and registers around 100 new patients every month.

This centre is of particular interest to the current study because service providers in the centre have a variety of linguistic repertoires and cultural backgrounds. The physicians in the centre come from diverse African countries outside Lesotho. Also, the centre has an established interpreting practice meant to enhance communication among these physicians, other HCPs and patients.

The second research site, HC-B, is an HIV and AIDS care centre identified as a private health clinic which is run with the help of financial grants from foreign NGOs. The facility serves a rural community around Ha Senekane. It provides a complete programme of care that includes: voluntary counselling and testing (VCT), anti-retroviral treatment (ART), and treatment for

opportunistic diseases related to HIV-infection, counselling of patients and their caregivers. It also runs a feeding scheme for the patients. The centre started operating in 2007. In an interview a counsellor at the centre indicated that at present this clinic treats around 800 HIV positive patients of whom 500 are on ART. The anti-retroviral drugs (ARVs) are provided by the Ministry of Health and Social Welfare (MOHSW), and are distributed to patients free of charge through the District AIDS office in Teyateyaneng, a regional office about 40 km away from Maseru.

This centre is of interest to the current research project because there is only one physician who does not know the L1 of the majority of the patients. The patients are largely Basotho from a rural community who often limitedly speak English. Despite this discordance in linguistic profiles, the centre does not have an established interpreting service in place to facilitate communication.

The two clinics are different with respect to physical structure (buildings), number of patients (1200 in HC-A vs. 800 in HC-B) and of staff (see Table 1.1 below), and in that HC-A has interpreting services which HC-B does not. Nevertheless, they are similarly organised in terms of the diagnosis and treatment protocols that they follow. Around 2006, the prolific distribution of HIV and AIDS was addressed and several clinics such as the ones studied here were established across the country to address the pandemic. In order to guide and harmonise the treatment protocol WHO published guidelines for an integrated TB/HIV treatment, in 2004. Further guidelines were developed by institutions such as Doctors without Borders (*Medicine sans Frontiers*) who put forward suggestions as to the most efficient ways of providing care (see Cohen et al., 2009:2). These culminated in the development of the Lesotho national ART guidelines. HIV and AIDS care centres in this country are organised according to principles set out in such guidelines. This explains the similarity in organisational structure (see figure 1 on *p.97*) within these facilities that are run by different health care providers.

1.5.2 Participants

The population of this research consists of health care providers and patients in the two health centres studied. The following table shows the staff population in both centres from which a sample was drawn.

Table 1.1: Staff Population

Staff / Centre	Doctors	Nurses	Assistant nurses	Interpreters	Counsellors	Total
HC-A	10	34	43	3	3	93
HC-B	1	2	1	0	1	5

1.5.2.1 Participants' Descriptions and Selection Criteria

Data for this study was collected from five groups of participants. The first group consists of doctors, who work at HC-A Hospital and HC-B, who are not Sesotho L1 speakers and who use English as a lingua franca in the workplace. These doctors were found to have worked with HIV positive patients frequently enough to have first-hand knowledge and experience of the communicative practices that are employed where Sesotho patients communicate with non-Sesotho-speaking doctors.

The second group of participants consists of Basotho nurses who deal directly with HIV and AIDS patients and who are Sesotho L1 speakers with varying degrees of English proficiency. These nurses co-operate frequently with non-Sesotho-speaking doctors in their consultation with Sesotho-speaking patients. They are often tasked with facilitating communication between the doctors and patients. The third group consists of Sesotho L1 HIV and AIDS counsellors, who provide pre- and post-test counselling. They engage a great deal with patients during and before the start of treatment. The fourth group of participants consists of lay interpreters, who facilitate communication between non-Sesotho speaking doctors and Sesotho speaking patients in HC-A. The last group of participants are patients who are Sesotho L1 speakers with varying degrees of English proficiency, who are currently on ART and who get their treatment in one of the two centres. These patients live openly with their status and were therefore willing to discuss issues related to their health status and treatment.

The participants were selected through purposive selection, using a sample of two care facilities that are likely to represent the linguistic variety and communicative patterns typically found in HIV and AIDS treatment in Lesotho. While participants were screened and included on the basis

of convenience, availability and a set of inclusion criteria specific to this study, care was taken to make a selection that represents all the stakeholders in HIV and AIDS care from both health institutions. Senior staff at each institution assisted with the final selection of participants. Such insider-selection allowed volunteers to ask questions about the research project and what would be expected of them beforehand. This made it easy for them to make an informed decision about their participation in the study. It also made them feel less pressurised to take part if they did not wish to do so.

All the participants were informed about the objectives of the study. They were informed of what their participation would entail in terms of the process and its likely duration. All participants signed a consent form in accordance with ethical considerations stipulated for this particular research.

1.5.2.2 Participant Selection at HC-A

In HC-A, participant selection was done with the help of the centre Manager and the Matron. They volunteered to assist with the selection process because they knew the working schedule of the doctors, interpreters and nurses, and were therefore in the best position to identify possible participants. Prior to data collection they briefly prepared the participants about the nature of the study.

Due to the busy schedule of the doctors and because they do not work on appointment basis, the manager went to the consultation rooms of doctors who fit the selection criteria on the day of the researcher's visit. He made an arrangement for an interview with them according to their program for that day. In all five doctors were interviewed. Nurse participants were selected with the help of the Matron to fit their schedule of duties. Their selection was based on their availability on the day of the interview and the inclusion criteria mentioned in section 1.3.2.1. The selection of four nurses finally interviewed were two who work directly at HC-A, one who works at the TB section, who interacts very frequently with HIV positive patients, and one that works at the Out-Patient Department (OPD) where they frequently have to refer patients to HC-A. One of the two counsellors attached to HC-A was interviewed. She was selected because she had indicated her availability for participation in the study. All three lay interpreters were selected as participants,

two of whom work directly at HC-A, while the other one is at OPD, where he has encounters with HIV positive patients on a daily basis. One of the lay interpreters is a receptionist who also doubles as an interpreter.

The patient participants were selected with the assistance of one of the nurses at HC-A. While patients were in the waiting room at the reception of the centre, the nurse briefed them about the study objectives and asked whether they would volunteer for participation. Those who volunteered were then directed to the office in which interviews were done. A total of ten participants were selected and participated in the study.

The following table summarises the full sample of participants that were selected in HC-A:

Table 1.2: Sample in HC-A

Participant category	Number
Physicians	5
Nurses	4
Counsellors	1
Interpreters	3
Patients	10
Total	23

1.5.2.3 Participant Selection in HC-B

In HC-B participant selection was done with the help of a counsellor at the centre. Staff were informed about the study and they were encouraged to participate. The same counsellor scheduled interview appointments for staff, namely with one doctor, one nurse, and one counsellor.

In selecting patients the counsellor advised that interviews be held on Mondays, Tuesdays and Wednesdays because those are days when there are many patients in the centre and therefore the

probability of getting volunteers was higher on those days. The counsellor did a preliminary briefing and introduction of the study objectives to possible volunteers. Patients who were willing to participate were directed to an office in which the interviews were done. A total of eight patients were interviewed at this centre. The following table summarises the full sample of participants in HC-B:

Table 1.3: Sample in HC-B

Participant category	Number
Physicians	1
Nurses	1
Counsellors	1
Patients	8
Total	11

The tables show that the sample sizes in HC-A and HC-B are remarkably different in size. This is because the HC-B is a smaller centre than HC-A and correspondingly it has less staff. With no interpreters or administrative staff who interpret at HC-B, interpreting is done by the registered nurse.

1.5.3 Data Collection Methods, Procedures and Analysis

1.5.3.1 Data Collection Methods

Data was collected by using multiple data collection methods, a process that is called triangulation of methods (Lambert and Loiselle, 2008:230). The three methods I used were (i) direct observations that were recorded as field notes; (ii) semi-structured face to face interviews; and (iii) focus group discussions. Henning et al. (2004:100) note that data from such methods complement each other and fill the gaps that would have been left if methods were not triangulated. The

methods also help to capture different types of data thereby enriching detail in the description as is a requirement for a case study like this one (Henning et al., 2004:33).

Observations

The first phase of data collection was done to collect first hand data on the organisation of treatment and the accompanying communicative processes in the clinics. The different service points were visited to observe how each one of them contributes to the process of care in the clinic. The observations provided answers to the following questions about each service point:

1) What services are rendered by the point?
2) What are the communicative processes associated with the services?
3) What is the extent of language diversity among the conversants?
4) Who are the conversants?
5) What modes of communication are prevalent at this point?
6) What are the expected and practical outcomes at this point

The observations were coupled with taking pictures of the linguistic landscape relevant to issues of language diversity in each of the service centres. This was necessary because it recorded visibly the organisation of communication, and confirmed the multilingual nature of the health centres. This landscape consisted of pamphlets, pictures and posters of literature on HIV and AIDS. The observations were done across three days to ensure the researcher would experience typical actions and behaviours of role players without obstructing the daily working of the clinic. This was coupled with a few "on the spot" interviews for clarification of some of the observations

Semi-Structured Interviews

In the second phase, semi-structured interviews were conducted with participants representative of all role-players in the care centres. Open ended questions were used to elicit detailed explanations of participants' experiences in the clinic generally, and in language discordant provider-patient interactions specifically.

Although the questions were pre-formulated in a particular order, during the interviews there was flexibility on the order. This followed Knox and Bukard (2009:567) who note that an interview schedule is just a guide that should allow for creative follow-up until all the required information is obtained. The central themes of the prepared interview questions were related to the research questions given in *Section 1.4* above.

In interviews that lasted from 15 minutes to one hour participants were asked to describe how communication in consultations proceeds when care providers and patients do not share the same L1, and when it becomes apparent that either of the discourse partners does not have facilitative levels of proficiency in the local lingua franca. The intention was to get participants' perspectives on how mutual understanding is achieved in a context where such understanding is of critical importance, when there are insufficient shared language resources. Where lay or community interpreting were used, the participants were asked to describe how this proceeds. Where participants were aware of challenges in the management of language diversity in provider-patient interactions, they were asked to articulate those challenges.

Focus Group Discussions

A third phase of data collection made use of three focus group discussions in groups made up of five patients each. Here participants were asked to discuss their communicative experiences in consultation with doctors and nurses when they do not share a common L1. Focus group discussions were used to collect data that patients might withhold in individual interviews, but are able to say when placed in a group of people with similar health challenges. The focus group discussions were guided by the same schedule as was used in the interviews. This helped to restrict the discussions to issues related to management of language diversity and distribution of multilingual linguistic resources in multilingual contexts. The duration of the focus groups ranged from 30 minutes to one hour.

1.5.3.2 Ethical Considerations

This research was done in health care facilities under the jurisdiction of The Lesotho Ministry of Health and Social Welfare, therefore all the required protocols for obtaining ethical clearance from

this ministry were followed and clearance was obtained from the Director of Health Services in that ministry. Clearance was also obtained from the management of each of the two health care institutions and from the Ethics committee of Stellenbosch University.

During data collection, each participant was informed of the study objectives and their freedom to participate or to withdraw from the study. Participants were also guaranteed anonymity, although many indicated that they do not need to be anonymous. Prior to any participation, informed consent was obtained from each of the participants.

1.5.3.3 Data Preparation and Analysis

Observation Notes

Observations were done during visits to the study sites. At each site I followed the trajectory of care accompanied by one of the clinical staff in order to familiarise myself with how care and communication are organised. The aspects of interest were handwritten as notes. More data was handwritten during subsequent visits to the clinics, when interviewing participants. These handwritten observation notes were then typed and read repeatedly to familiarise myself with the content of the script. Deductive qualitative content analysis (QCA) was done to classify the data into the themes relevant to the research questions and objectives of the study (see S*ection 2.3*).

Interview and Focus Group Data

After data collection, the audio recorded data was transcribed using the Exmaralda transcription software. This software allows the transcriber to break the audio recording into manageable chunks, to rewind and fast track where necessary. Interviews with nurses, lay interpreters and patients were carried out in Sesotho, so they were translated from Sesotho to English as they are transcribed. The researcher (a Sesotho L1 speaker did the translation first, and then had it checked by an independent bilingual speaker of Sesotho as L1 and English as L2. As is suggested in Braun and Clarke (2006:87), the interview scripts were read several times to confirm accuracy and to gain familiarity with the content of the data, As the reading proceeded, notes on aspects of the data that are relevant to the research question were made.

After transcription and translation, the data were converted into Word format before they were uploaded into the Atlas-ti V5 Qualitative Data analysis programme in preparation for analysis. Atlas-ti was used for coding in a manner that would facilitate analysis in terms of Thematic Analysis (TA) and QCA successively (see *Section 2.3*). Such coding of the data assisted in systematically classifying data (Nuendorf, 2002:15). Firstly TA was done through open coding to label the content of the transcripts into themes. Theme identification in this case also involved interpretative work that considered the context in which the responses were made and the meanings that go beyond what is said. In that way both semantic and latent themes were incorporated in order to account for those experiences that are not explicitly articulated and yet have significance in the research.

When TA was completed deductive QCA was conducted. The aim of this part of the analysis was to classify the already identified themes into categories as directed by the research questions and objectives of the study and by literature on multilingual communication in health care. This deductive process helped to put aside content that is not helpful to the analysis and to recognise repetitions. Patterns were then identified in the themes and those were clustered into "code families" in preparation for discussion. The main "families" used in coding were: experiences, challenges, management strategies.

During the actual analysis, data from different groups of respondents was analysed separately to gain an understanding of the insight and experiences of each group. Then, the responses of the five groups of participants were compared to establish if there are any common themes or patterns that surface among all the groups. This was done to determine whether the role-players have similar or different experiences of linguistic diversity in clinical interactions about the treatment of HIV and AIDS in each particular health care centre. This also allowed for an in-depth description of bilingual/multilingual communication where participants have incompatible linguistic repertoires, thereby providing insights into how effective communication is achieved in these specific contexts. Finally, themes were reviewed and confirmed in order to prepare for report writing. This data formed the basis for a discussion of participants' experiences given in *Chapter 4*, based largely on the theory of multilingual health communication presented in *Chapter 2*.

1.6 THESIS STRUCTURE

The dissertation is structured as follows: ***Chapter 1*** contextualises the study and discusses the HIV and AIDS situation in Lesotho, and some of the interventions that the Ministry of health and social welfare in Lesotho have undertaken to combat the spread of the pandemic. It further looks into the language dispensation in Lesotho with relevance to the language distribution in the health fraternity. It highlights the extent of language discordance in this fraternity and some of the challenges that have been documented by past research in similar contexts. Then it lays out the study design with details of data collection processing and analysis. ***Chapter 2*** presents the theoretical and analytic framework composed of four different aspects. These are: Organisation Theory (OT) and how it has been applied to understand the organisation of communicative processes, Thematic Analysis (TA) and Qualitative Content Analysis (QCA) that were collectively used to systematically unpack the experiences of health care providers (HCPs) and patients in multilingual HIV and AIDS care. The chapter also sets out a discussion of existent body of research on Communication in health care and Multilingualism in health care as the primary contexts of the study is made. The discussion focuses on the role of communication in the effectiveness of care and the problems that have been found to occur where HCPs and patients speak mutually unintelligible languages. The data on the organisation of care process and therefore communicative units is presented in ***Chapter 3***. The trajectory of the process of care is traced and the communicative units are described in this chapter. The findings on the experiences of participants in multilingual HIV/AIDS are documented in ***Chapter 4***, where the challenges they encounter and the strategies and resources they use to overcome them are shown. The study draws conclusions from the data and literature and recommendations for further practice and research in ***Chapter 5.***

1. 7 CONCLUSION

The research intends to make a contribution to the body of research on medical discourses in linguistically diverse communities, and specifically to the growing body of scholarly work on health care communication in Africa. Since most research done in this field has been done outside of Africa, (see Roberts and Volberding, 1999; Angelelli, 2004 and Bischoff, Hudelson and Bovier, 2008) in settings where the doctor is part of a dominant culture, treating patients from the minority

culture, this research will bring an African perspective to this field and contribute a different scenario in which the doctor is part of the minority culture and the patient is from the majority (even if economically rather poorly resourced) culture. It will also add to the literature which describes resources that make successful communication possible in bilingual/multilingual contexts where participants often do not share similar language proficiencies.

CHAPTER 2

ORGANISATIONAL STRUCTURE AND COMMUNICATION IN HEALTH CARE INSTITUTIONS

2.0 INTRODUCTION

This chapter will give an overview of the literature on which this study draws. It will assist in gaining an understanding of the ways in which multilingual communication proceeds and is facilitated (or not) in the two health care institutions selected for this study, as well as of the communicative experiences of participants in multilingual health care centres. Specifically, literature will be introduced that topicalises how the process of care is organised in such institutions and what have been the experiences of participants in similar contexts elsewhere. The organisation of the care process has a bearing on the structure of communicative processes that are in focus in this study, and it reflects how institutions and all participants concerned respond to multilingualism. This chapter discusses pertinent aspects of organisational structure of institutions in general, and of health care institutions in particular. It discusses OT as a tool used to study organisational structure and as it is relevant specifically to health care institutions. The chapter also attends to QCA and TA that will jointly provide instruments for systematising and analysing the data collected in health care institutions for this project. The last part of the chapter discusses different aspects of multilingual health care communication as laid out in past research.

2.1 OVERALL STRUCTURE OF ORGANISATIONS

Literature on OT (see for example, Katzenbach and Smith, 1993, Robin, 1983 and Jaffe, 2001.) shows that an organisation is systemic structure consisting of individuals striving to achieve a common goal. Understanding organisational structure is important for this study, because the

study works with the assumption that the communicative events in which health care workers and patients engage, and through which health care is facilitated, are fundamentally dependent on the way in which the larger organisation is structured. The basic features in terms of which organisations are distinguished and categorised are their structure and size. Recent research indicates that because of changing market economies, which are sometimes accompanied by privatisation of previously state-owned institutions and commercialisation of different kinds of public services (including health care), organisational structures have also been changing (Willmott, 1995:29). The size of a particular organisation is considered to be a crucial element in describing how such an organisation is structured. According to Olden and McCaughrin (2007:7) insight into the structure and size of the organisation is a window through which management of workflow can be examined. It is through studying the organisational structure that one is able to predict the workflow and to see if there any problems (including communicative ones) hindering the workflow processes. This is useful in assessing the performance of an organisation. This position is consistent with Huang et al.'s. (2011:1104-5) observation that, by examining organisational structure, one gets insight into the allocation and division of power and responsibility in the organisation. One also gets insight into the grouping and coordinating of tasks within an organisation. This is because organisational structure is an important tool for facilitating task execution in any organisation (Zinn and Mor, 1998:354).

In an examination of the literature on OT, one finds a diverse range of aspects which are pertinent to a description of overall organisational structures and sizes. These aspects include the complexity of an organisational structure as it is manifested on a range of management levels, and the number of participants involved in the daily functions of an organisation (Huang et al., 2011:1104-05). One of the discussions of these key aspects of the overall organisational structures is found in the Structure, Process, and Outcome (SPO) model of organisational structure, first propounded by Donabedian (1988) and later used by Zinn and Mor (1998). This model groups elements of organisational structure into three categories namely the structure, process and outcome. These three components work together to influence the quality of service (or products) produced in an organisation.

In the SPO model the first component of organisational structure, which is the concept *structure,* refers to the professional and organisational resources that facilitate achievement of the organisational goal. This includes the staff, together with their skills and credentials that help them perform their designated tasks. It also includes all other facilities and resources like the infrastructure and inputs used in the daily operation of the organisation (Zinn and Mor, 1998:355). For example, in the case of a health care organisation such as a clinic, *structure* will comprise the clinic staff and their skills, the clinic infrastructure, the medication, equipment and tools used for patient care, which is the ultimate goal of a clinic.

The second component, *process,* refers to all the procedures followed in the execution of tasks in an organisation (Zinn and Mor, 1998:355). In a production organisation, such as a factory or an organisation that produces pharmaceutical products, this will include all the steps in the production processes, while in a service organisation like a health care organisation it refers to all the steps in service provision. Production and service provision processes entail a trajectory of communication that facilitates either production or service delivery, therefore the different steps found in this trajectory are an important part of these processes. In this study communicative process is used and understood similarly to Strain (1981: 55), who views it as a unit with a defined interpersonal purpose and clear function. It therefore refers specifically to any service point which serves a defined function in the care trajectory and therefore has specific communicative practices tailored by the demand that are related to its function.

Zinn and Mor (1998:355) exemplify the *process* component with a hospital as a service organisation, and show that in such a case the *process* will entail all the medical procedures carried out to and for a patient during the process of care. In the execution of these procedures, a patient also goes through different communicative units and engages in communicative encounters with a range of HCPS and administrative staff, therefore communication is an integral part of the process. Like the *structure,* the *process* is directly linked to the organisational goal in that it also works towards goal achievement. All these procedures and the associated communication are followed to achieve effective patient care.

The last component, which is the *outcome*, refers to the desired state of affairs that come as a result of the processes performed by all the relevant structures (Zinn and Mor, 1998:356). They show that in the case of a health care institution, the *outcome* will mean the results of the care process. This may include the improvement of health or quality of life, or negative response to the treatment and care process resulting in continued deterioration of health.

Zinn and Mor (1998:356) further show that these three components that encompass the overall structure of an organisation are intertwined and complement each other. A good overall structure results in proper processes and having proper processes promotes the quality of outcomes. This means that all three key features should be well coordinated to achieve the organisational goal. Understanding the structure therefore demands an understanding of the coordination processes as well. The *structure* and *process* components of the SPO model are of particular interest because they potentially shed light on the organisation of care and the relevant communicative processes within a health care facility, which is the focus of this study.

As has been mentioned earlier, the SPO model embeds in it a requirement of effective coordination of the daily activities and communication of an organisation for goal achievement purposes. In order to have insight into this kind of coordination and how it facilitates the effectiveness of communication, particularly in multilingual settings, it is imperative to understand the management structures which facilitate that coordination, inclusive of the roles and relationships of participants shaping the processes and communication trajectory of such an organisation. It is also important to understand the organisational culture because it influences the routines as well as the institutional communicative practices that members engage in while performing their daily activities.

2.1.1 Management Structure of Organisations

Management structures, which are embedded in the *structure* and *process* components of the SPO model, are a significant aspect of the organisational structure because they influence general processes in an organisation, including communicative processes, routines and practices that are inherent in the organisational structures. Barr (1995:355) and Schoen et al. (2009:6) note that the type of management structure in an organisation influences how communication is organised and

experienced by members and clients. This is consistent with Huang et al.'s (2011:1106) position that the direction of communication in an organisation is a result of role relationships among members of an organisation.

In order to further explain management structures and their relationships with the organisation of communicative processes, Huang et al. (2011:1103) developed a theory that provides a framework that can be used as a tool to study and understand organisational structures. In their theory, management structures are described along three dimensions, namely: relative flatness, centralisation and employee multi-functionality. These dimensions do not only reflect how tasks, power and responsibilities are allocated in an organisation, but they are also indicative of how communication is handled.

Huang et al. (2011:1105) show that some organisations have a management structure that can be described in terms of its relative flatness. They define the flatness of an organisation's management structure as the relative number of management levels in the hierarchy of power. If an organisation has several management levels its structure is perceived to be complex, while few management levels show that the structure is flat (simple). According to Huang et al. (2011:1106), the reason why multiple management levels are associated with complexity is that they create a requirement for an increased number of links in the communication channel. In these scenarios, the communicative process entails a number of units characteristic of the multiple levels of management. An example of this structure with multiple units and its implications for the communication process is seen in the discussions of Barr (1995:354) and Glickman et al. (2007:344) regarding the structure of large health care organisations (detailed discussion follows in subsequent sections). Huang (2011:1106) further show that the multiple levels also make it complicated to pass messages effectively across all levels. This complex management structure is a feature of many large organisations, with often several smaller units inherent within the organisation. They are of particular interest to this study in that they represent the structure of the HC-A and HC-B which are research sites for this study.

Apart from flatness, organisations' management structures can be described in terms of their level of centralisation (Huang et al., 2011:1106). According to Huang et al. (2011:1106) the

centralisation of an organisation's management refers to the organisation's hierarchical distribution of authority and decision-making across its different levels. The level of centralisation is indicative of the extent to which decision making is disseminated to lower levels of management. According to Huang et al. (2011:1106), in an organisation with this type of management structure, decisions are taken by top management and are communicated to the lower level employees whose responsibility it is to act upon or implement such decisions, with very minimal input. In a centralised organisation, Huang et al. (2011:1107) show that communication processes are organised to come from top management levels to lower levels, therefore the process is mostly unidirectional. Huang et al. (2011:1106) regards this type of management structure as "a traditional, control-oriented workforce management (which) emphasises positional authority". Glickman et al. (2007:344) show that this is not an ideal management structure for a health care organisation.

Management structures can also be described in terms of employee multi-functionality (Huang et al., 2011:1106) Employee multi-functionality refers to the ability of workers to perform a diverse range of tasks, with the help of the training that they have gone through in both formal and informal means. Huang et al. (2011:1106) show that because of training that affords them multiple skills, multifunctional employees are able to take on a wide range of tasks and responsibilities. Such flexibility provides them with opportunities to integrate and also participate in decision-making (Huang et al., 2011:1106). Because of the breadth of knowledge and their flexibility, these employees become valuable and relevant resources in the organisation.

In contrast with the unidirectional communication in centralised organisations, communication in organisations with multi-functional employees is multidirectional (Huang et al., 2011:1106). Huang et al. (2011:1106) further show that since the focus is on integration of different professionals and the coordination of their activities, communication processes move from one communicative unit to the other, depending on the demands of the services rendered at the time. This means that the direction of communication is not determined by top management but by the daily activities in an organisation. This allows communication processes to be organised and carried out routinely and successfully among different communicative units with very little, or no input from top management.

This aspect of management structures is important in this study because it facilitates an understanding of institutional responses to multilingualism. In multilingual health centres like the one studied here, management is responsible for making infrastructure available for the process of care. It is also responsible for controlling the extent of language diversity by deciding on recruitment of expatriate physicians. When such physicians are in place, decisions on how an institution responds to multilingualism by deployment of resources that facilitate communication between HCPs and patients is the prerogative of management.

2.1.2 Organisational Culture

Another aspect of the organisational structure that has an influence on the organisation of care and communication processes is the organisational culture. Samovar et al. (2012:11) defines culture as the rules for living and functioning in a certain society. These rules determine and influence how members behave in an organisation and how daily activities are carried out. Culture therefore provides a framework that explains some of the routines that are prevalent in an organisation. Culture therefore, has a bearing on the structure of communication processes because those form part of the daily activities of an organisation. Scholars who have worked on organisational structures, such as Hatch and Schultz (2002), Glickman et al. (2007) and Schultz (2012), have identified organisational culture as an integral part of organisational structure. Some of these theorists define organisational culture as:

i) "... tacit organizational understandings such as assumptions, beliefs and values that contextualize efforts to make meaning including internal self-definition (Hatch and Schultz, 2002:1017);
ii) "... the set of values, norms, guiding beliefs and understanding that is shared by members of an organisation ..." (Daft, 2004:361);
iii) "...the deeper level of basic values, assumptions and beliefs that are shared by members of an organisation ..." (Glickman et al., 2007:343).

These definitions agree that values and beliefs make up a significant component of the organisational culture. Hatch and Schultz (2002:343) add that organisational culture is mostly beyond the level of awareness so it is usually tacit. However, it becomes so entrenched in the lives

of members that even new members of the organisation learn it and it is passed on from generation to generation. In this study organisational culture is used to refer specifically to the routine activities in the care trajectory that are not medical, yet they seem significant for patient care, depending on the beliefs and values surrounding them.

There are several purposes served by culture in an organisation. One of them, according to Glickman et al. (2007:343), is to be "... a glue that holds the organisation together." This means that it is a unifying factor among members and among different sections. The fact that members share the same beliefs and values implies that they would be able to relate well with each other and to understand each other's behaviour. Organisational culture also provides a framework that serves as a guideline for employees to collaborate in working towards achievement of the organisational goal. Therefore, organisational culture influences the performance, commitment and work ethics of individual employees and of the organisation as a whole.

Another purpose of organisational culture is to position the organisation among other organisations (Schultz, 2012:105). Schultz (2012:105) also shows that culture is drawn on when an organisation engages in self-introspection and reflection in order to compare itself with other organisations in the same context. It allows the organisation to evaluate whether it conforms to the principles and norms of other organisations in their domain. Where it is necessary, it also provides a tool that the organisation can use to differentiate itself from others. This makes culture a very important component in the structure of any organisation.

In the present research an understanding of organisational culture is instrumental in understanding the significance of some of the routine activities that are governed by a particular set of beliefs among HCPs and patients in these clinics. The discussion was particularly relevant in that one of the health care centres studied is religiously affiliated.

2.1.3 Organisational / Institutional Communication

The above discussion of the components of the organisational structure and culture, presupposes the presence of members of an organisation as part of the structure. Due to the presence of people engaged in certain activities in an organisation, communication is inevitable. The significance of

communication in everyday life is acknowledged by Samovar et al. (2012:8) who view communication as a fundamental aspect of human life. Guffey and Almonte (2009:10) contextualise this notion to workplaces or organisations by regarding communication in organisations as a major consideration for everyone who enters an organisation.

The literature on communication reveals a diverse range of basic definitions of the term "communication". According to Littlejohn and Foss (2008:3), each author's definition depends largely on the objective of their definition. This is highlighted by Samovar et al. (2012:9) who also show that each definition of communication one finds in the literature is a reflection of its author's objective and the specific context from which s/he is writing.

Communication, according to Guffey et al. (2009:10), is the "transmission of meaning from one individual or group to another." In another definition, Wood (2012:3) defines communication as a "systemic process in which people interact to create and interpret meaning." These two definitions draw attention to meaning as a component of communication. The significance of meaning in communication is further emphasised by Wood (2012:4) who shows that meaning is the heart of communication, which means that it is the most fundamental aspect in communication.

This study adopts a definition of communication by Samovar et al. (2012:9) who emphasise intentionality and interaction as the main characteristics of communication. They show that these are the two most important variables in communication. Their explanation of this link between communication, intention and interaction is that communication is purposeful. People communicate to persuade, to inform and to serve many other purposes. This means that communication is undertaken with an intention of achieving a particular purpose and that intention is achieved through interaction (Samovar et al., 2012:11).

Given these conceptualisations of communication and the central role it plays in organisations, institutional communication becomes a crucial aspect in the study of any organisation. This is because communicative processes facilitate goal achievement and management actions in any organisation. The present study is interested in communication that has two characteristics, namely the fact that participants are multilingual and that the discourses belong to an institutional setting.

In this study an understanding of institutional communication sheds light on the organisation of communication and the related experiences of HCPs and patients. A clear understanding of these experiences along with the line of communication in these clinics requires an understanding of the dynamics of communication in institutions. The relevance of institutional communication in this study also stems from Drew and Sorjonen's (1997:92) opinion that communicative processes, and the various discourses that members engage in while communicating, reflect the role identities of such members in an organisation or an institution. This is because institutions attribute certain roles to their members and such institutional roles are usually reflected in what such members say, how they say it, and to whom. In order to successfully study these institutional interactions, one has to fully immerse oneself into such an institution (Sarangi and Roberts, 1999:3).

Drew and Heritage (1992:25) describe institutional communication as communication in which the institutional identities of interlocutors are reflected in the interaction and are made relevant to the ongoing discourse by the interactants. This definition is also subscribed to by Sarangi and Roberts (1999:5) who agree that the situation or context can therefore not be a definitional component of an institution because institutional communication can also happen outside the institution.

An important aspect of institutional communication is that it is understood to be the central way in which participants orient to their institutional identities (Jones et al., 2004:722). This sentiment is further shared by Geluykens and Kraft (2008:9), who also note that in an institutional interaction, at least one participant should be a member of the said institution and such a member should constitute his/her institutional identity by displaying professional knowledge when communicating (also see Sarangi and Roberts, 1999:61).

An interaction does not necessarily have to happen in an institutional physical space in order for it to be institutional. This view is shared by Sarangi and Roberts (1999:5) who use the example of health care communication. They point out that even when the interaction is happening away from a health care facility, it is institutional as long as participants' communication reflects their identities and roles in the institution. This explanation, therefore, accommodates HIV and AIDS care consultations done in patients' homes as institutional.

Institutional interactions have peculiar characteristics that differentiate them from ordinary conversations. Drew and Heritage (1992:22) identify goal orientation as one of the characteristics of these interactions. This means that the interactions constitute participants' tasks that are oriented towards the particular institution in which they happen. The tasks follow certain conventions that are peculiar to the institution. For instance, a medical interaction has a goal of addressing the patient's medical problem. The tasks that the provider and the patient will undertake and talk about will be oriented towards that goal and their communication will follow the conventions of the medical field.

Another characteristic of institutional interactions is that they have constraints or restrictions on the range of contributions that are permissible (Drew and Heritage 1992:22). This is supported by Geluykens and Kraft (2008:9) who point out that institutional interactions are guided by their own repertoires that are inclusive of the institutional jargons. In some cases, constraints are on particular discursive practices, with rigid constraints on participants' roles (Geluykens and Kraft, 2008:9).

Liebler and McConnel (2004:495) state that in health care, in particular, communication is regarded as an essential component of health care delivery. They explain this by showing that in health care it is pertinent to understand each other's ideas, so communication, particularly verbal, is very important. This is consistent with Rider and Keefer's (2006:624) comment that communication is a core clinical skill that has to be learned and taught. A detailed discussion on the role and significance of communication in health care is provided in *Chapter 3*.

Given these characteristics of organisations and the relevance of communication as a component of the structure, it can be argued that a comprehensive analysis of communication in an institution should encompass the institutional nature of settings where such communication is situated. Geluykens and Kraft (2008:8) show that such an analysis should entail a description of how the institution is enacted and constituted in the language use of the institution. It should also show how the institution shapes communication and the impact of that on both the members and the clients, who, in this case, are the participants in the study.

This discussion of the structure of an organisation illuminates the notion that in order to understand the structure of an organisation, it is important to identify the management structures and members

inherent in that organisation. It is also important to take into account the organisational culture that these participants draw on in their communication. This will provide insight into how these members organise communication among them and their clients, and within the different units in the organisation. This framework, which is true for corporate organisations/institutions, also serves as a framework for the structure of health care institutions and communication in them.

2.2 ORGANISATIONAL STRUCTURE OF LARGE HEALTH CARE INSTITUTIONS

The descriptions of organisational structures presented above have been used as a basis for describing structural aspects of health care organisations. Just as the structures of organisations are evolving (Willmott, 1995:29), the structures of health care institutions are also continually changing in terms of composition and size. According to Glickman et al. (2007:344), these changes in health care institutions became more profound in the 20th century with the need to respond to changing patient needs and demands. One of these needs and demands is identified by Schoen et al. (2009:1) as the prevalence of chronic illnesses. According to them, health care organisations that were originally meant to care for acute conditions suddenly found themselves confronted with patients with chronic illnesses. This altered the organisational goal from cure to ongoing prevention and management. When the goal changed the composition and size of health care institutions also had to change to a functional structure.

These functional structures that emerged have three basic characteristics. The first characteristic is segmentation of patient care across a range of functional sections (Glickman et al., 2007:344). This has also been articulated in an earlier work by Barr (1995:354) who observes that the provision of patient care which was traditionally carried out in the doctor's office with the help of just a few other workers had to be segmented among several sections and spread across a larger number of workers than the previous one. The sections are divided in accordance with specialisation areas, for example, various clinics such as the diabetes clinics and HIV/AIDS clinic. The notion of functional structuring and segmented patient care is also consistent with Beveren's (2003:92) description of a health care organisation as a collection of professional specialists who all contribute to the delivery of patient care, working in discrete sections.

The second characteristic is the key constituents responsible for patient care in a health care organisation. According to Barr (1995:354), the principal components of a health care organisation are technical aspects and human relationships. Barr (1995:354) further shows that the availability and quality of technical aspects is reflected in clinical outcomes, while personal relationships are reflected in patient satisfaction. For example, the availability of equipment and medicine as technical aspects potentially determines achievement of patient cure, so a patient getting cured will be a reflection of such availability. In the same manner the quality of the relationship between health care providers and patients, characterised by effective communication among other factors, determines the extent to which a patient is satisfied with care.

The third characteristic is a hierarchical management structure, with each of the different sections overseen by a manager who reports to higher management levels and ultimately to the hospital's Chief Executive Officer (Beveren, 2003:93; Glickman et al., 2007:345). In these structures, Glickman et al. (2007:342) shows that the role of senior management is to set the direction of the organisation, by producing ideas and ensuring implementation of such ideas. This implies that communication flows from the top to the bottom of the hierarchy.

While this hierarchical management structure seems to work well in corporate organisations, Glickman (2007:344) point out that in health care organisations this structure hinders the ability of service providers to develop innovative solutions about patient care. This is because decisions about care originate and are implemented at management level by people who know very little about care. As a result of this, delivery of quality care is negatively affected. In order to solve this problem, Schoen et al. (2009:6) show that some hospitals have resorted to involving physicians in top management position so that they can participate in decision-making about care.

On top of the structure, process and participants that constitute health care organisations, multilingual organisations also have resources that manage language diversity as part of their organisational structure. According to Collins and Slembrouck (2006:254) and Moyer (2011:1214) literary devices that are used to manage language diversity were found to be part of the organisation of multilingual health centres. In other studies such as Angelelli (2004) and Hsieh (2005) interpreters were found to be a crucial component of the structure of a multilingual health care

institution. The reason why there is emphasis of these aspects in these instances is that communication processes in these cases are different, and demand additional structures to be effective.

2.2.1 Individual Clients in Large Health care Institutions

Research has established that patients and staff in large health care institutions with complex structures have very little or no satisfaction (Barr, 1995; Drennan and Swartz, 2002; Schoen et al., 2009). In this study the size of an organisation is perceived along the complexity of the organisation, following Huang et al. (2011). This implies an organisation with a number of people employed in the organisation to serve a large client base. This distinction is necessary to be drawn in this study because the study collected data in two health clinics that differ in size. Their size and complexity of structure is pertinent for understanding the communicative practices entrenched in the two institutions.

In a study aimed at establishing the relationship between quality of care and the structure of a health care organisation, Barr (1995:353) notes that patients who are treated in large health care institutions reported more instances of dissatisfaction than those in small institutions. This is consistent with Schoen et al.'s (2009) findings in a survey of the experiences of chronically ill patients in eight different countries namely: Australia, Canada, France, Germany, The Netherlands, New Zealand, United Kingdom and the United States. They reported that patients across all these countries expressed dissatisfaction with care in large health care institutions because of their experiences of care in these institutions.

One of the experiences that patients report as their source of dissatisfaction is limited access to a single physician who is familiar with the patient's case (Barr, 1995:355). According to Barr (1995:355) patients reported that in large hospitals, they are not able to call and make an appointment with their personal physician and they cannot consult telephonically with a physician when there is a need because they see many different physicians in different consultation times. This is consistent with Schoen et al.'s (2009:5) finding which also record patients' dissatisfaction with not having access to a single physician. The patients in Schoen (2009:6) further reported that dealing with different physicians at different times deprives them of access to continuity of care

that would have been easily achieved if they were attended by the same physician, who is informed about their previous medical history, in all or most of their consultations.

Another experience that patients report is the poor coordination of care among the different types of professionals they have to consult in complex structured organisation (Barr, 1995:356). This was reflected in the fact that in some cases, records were not available at the scheduled times. This delayed care and in some cases prolonged the consultation because the patient and the doctor had to wait for the medical records to be provided. Schoen et al. (2009:7) also recorded the same experience among patients in the eight countries they studied and add that another indicator of poor coordination reported was unnecessary duplication of medical tests. This seemingly poor coordination of care can be attributed to the documented complexity of communication in an organisation that has different micro-structures in it (Glickman et al., 2007).

While the structural aspects of large health care organisations seemingly result in patient dissatisfaction, when these organisations are multilingual patient dissatisfaction is exacerbated. This is seen for example in a study by Deumert (2010), who investigates the role of multilingualism in health care, in three hospitals in Western Cape. Deumert (2010:58) reports prevalence of general dissatisfaction among patients, with the doctors' inability to communicate with them. The patients expressed their feeling of being robbed of adequate care because of inability to communicate directly with their doctors (Deumert, 2010:58).

These reports on the experiences of patients in large health care organisations show that organisational structure has influence on the how patients experience care. As health care organisations become complex in structure, and care is segmented into different units, patients satisfaction is lost in those structures. This means that organisation of care is an important aspect in achieving patient satisfaction.

2.2.2 Staff in Large Health Care Organisations

It is not only patients that are dissatisfied in large health care organisations but also staff. Barr (1995:357), comments that in general, working in a large organisation causes job dissatisfaction for all categories of workers. This includes physicians who work in large health care institutions.

The reason for this is that when one is working in a large institution, they lose their bureaucratic and clinical autonomy and become just one member of a big team. This deprives them of the sense of importance they would enjoy in a small organisation and therefore negatively impacts on their performance. In other studies, for example Drennan and Swartz (2002) and Mrayyan (2009), it was established that even nurses who work in large institutions are dissatisfied with their jobs, which explains why patient satisfaction is seemingly difficult to achieve in large health care organisations.

Feeling overworked is another experience that has been established among staff in large health care organisations. In a study carried out in an out-patient clinic in Vienna, Wodak (2006:685) established that because of the large numbers of patients that the doctor had to see, the doctors became frustrated and intolerant at some point. The doctor's questions such as *"They are still there waiting? How many more are there?"* show that the doctor is strained and cannot handle any more patients (Wodak, 2006:685).

The feeling of being overworked was also reported among nurses in the Lentegeur psychiatric hospital in the Western Cape (Drennan, 1999:11). According to Drennan (1999:9) this hospital caters for a large patient base in several townships around the Mitchells Plain and Khayelitsha area and care is segmented into a rehabilitation centre for mentally handicapped patients; and care for acute and chronic psychiatric illnesses. In reporting their experiences, Xhosa-speaking nurses in this hospital showed that they feel overworked because they perform many roles including doing ward rounds, interpreting and social work duties such as accompanying the patient home and interviewing relatives (Drennan, 1999:9). Their sense of dissatisfaction stems from the size of the hospital, characterised by its large patient base.

More staff dissatisfaction in large health care organisations is recorded in Deumert (2010:54-57). In this case, staff reported the feelings of helplessness, frustration, low morale and job dissatisfaction which are characteristic of general dissatisfaction. According to Deumert (2010:55) the source of this dissatisfaction is that the hospital structures do not have interpreters and they therefore cannot communicate with IsiXhosa speaking patients. The result of this is that doctors are not able to establish trust and rapport with their patients, yet that is required for effective history

taking and diagnosis (Deumert, 2010:56); they cannot do proper diagnoses because their diagnoses are based on symptoms that have clear physical manifestations only (Deumert, 2010:57-58) and therefore patients sometimes do not understand treatment and diagnosis (Deumert, 2010:58).

It is evident from the above discussion that the organisational structure in general, and the health care institutional structure in particular, is an important aspect if one needs to understand the experiences of patients and staff. This is because this structure influences staff satisfaction and performance, which in turn affects patient experiences of the overall care provided by an institution and their general satisfaction with such care. This relationship between the structure and experiences and staff that has been established in previous research (Barr, 1995; Schoen et al., 2009; Mrayyan, 2009) has formed the basis for the present study to firstly articulate its understanding of the structural organisation of the multilingual clinics studied, as a pathway for understanding the communicative processes that take place in the clinics and the communicative experiences of both health care providers and patients.

2.2.3 Multilingualism in Health Care Institutions

Due to recent migration processes many health care organisations are multilingual with staff and patients having a diverse range of linguistic resources. While in some multilingual health care organisations there is a common language that health care providers and patients can use to communicate, Bischoff et al. (2003:504) acknowledge that in others there is language discordance. Bischoff et al. (2003:504) define language discordance as a situation in which "health care provider and patient have no common language." This situation compels multilingual health care organisation to have measures that they use to facilitate communication between these health care providers and patients.

Most of the literature on multilingual health care, such as Bernard et al. (2006), Babitsch et al. (2008) Schouten et al. (2009) construct language discordant provider-patient interactions as problematic. In Bernard et al. (2006:357) the situation itself is constructed as the problem causing stress to health care providers. Other different studies identified patients' (Meeuwesen et al., 2006:2413) and doctors' (Schouten et al., 2009:469) interactional styles as the source of the

problems. Regardless of the perceived source of the problem, these studies show that there is need for a form of intervention in order to facilitate effective communication.

As a way of addressing communicative problems that arise in multilingual health care organisations, research has shown that some of these organisations have put particular structures in place. Some organisations such as a clinic in Ghent (Collins and Slembrouck, 2006:255) and another one in Barcelona (Moyer, 2011:1212) have devised literary materials to account for effective communication. Other organisations have established interpreting services in place (Angelelli, 2004; Hsieh, 2010). A detailed discussion of literature on multilingual health care interactions, their problems and interventions to make them successful is done in *Chapter 3* of this study.

The present study uses the SPO model to understand the structure of care and communication in the studied clinics. It analyses this process in terms of the components of this model and other aspect of the structure that can be explained by the culture, management structure or institutional communicative practices prevalent in each clinic. The different communicative units found in the process are explained in terms of their functionality, routine activities and participant identities found in them.

2.3 QUALITATIVE CONTENT ANALYSIS AND THEMATIC ANALYSIS

On top of studying the organisation of communication in the studied health centres, this study also investigated the experiences of stakeholders in these multilingual clinics, with a particular interest on the challenges posed by language diversity and the strategies and resources used to manage language diversity. In order to gain insight in what these experiences are, an analytic approach that integrates QCA and TA was used. This hybrid analytic framework was useful in that it helped in complete exploration of participant experiences as they appear in their narratives. In past research QCA and TA have been used successfully in health related research such as nursing research (Elo and Kyngäs, 2008), health communication (Parrot, 2004) and multilingual health communication (Cioffi, 2003), which is the broad field in which the present research is situated. Since the two approaches share the same principles (Joffe and Yardley, 2004:56), in some studies they have been

used separately while in some studies such as Deumert (2010), and Kristiansen, Hellzén and Asplund (2010) they have been combined.

2.3.1 Qualitative Content Analysis

A look at literature on the QCA approach yields different definitions, which are, however, in consensus that this is a systematic method of data analysis. The definitions of Mayring (2000), Patton (2002) and Hsieh and Shannon (2005) show this point of agreement although they emphasise diverse aspects of the approach. Mayring (2000:2) gives a general definition of qualitative content analysis situating it as a scientific approach. This approach is defined as "an empirical, methodological, controlled analysis of texts within their context of communication, following content analytic rules and step by step models ..." In another context Patton (2002:453) gives a more specific definition of this approach as "... any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings ..." this definition emphasises the same aspect as Hsieh and Shannon (2005:1278), who define qualitative content analysis as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" These two definitions embed in them the objective of this analytic approach, which is to interpret and make sense out of the data by classifying the main themes that arise from the data.

The main objective of QCA is to summarise the data rather than to report all the details (Nuendorf, 2002:15). Moretti et al. (2011:420) explains this summarising specifically as a way of interpreting data by looking for themes and patterns. They further show that in doing this interpretation, data is classified into themes or categories that have a similar meaning or similar patterns. The categories are derived from both the theoretical framework and the research question of the research project. Elo and Kyngäs (2008:108) show that this categorisation allows the researcher to condense a large amount of data into a few categories that can easily be discussed.

In the present study a deductive approach to QCA, in which themes were derived from past literature and the research question was used. QCA was used for its value in allowing the researcher to extract important aspects of the data, and to link such aspects to both the research

question and existing literature on multilingual health care. The synthesis of the research question, past research and data, was helpful in interpreting the data. This value is also attested to by Elo and Kyngäs (2008:108) who show that interpretations that are done in this manner can be used to reproduce inferences that are applicable to other situations. They can also enhance an understanding of those situations that are similar to the one represented in the data. These inferences can ultimately be used to guide the researcher to generate or build on existing knowledge about the phenomenon studied. They can also be used to guide decision makers to make practical decisions and take action where necessary (Elo and Kyngäs, 2008:108).

2.3.2 Thematic Analysis

The analytic framework also entailed a TA of interview transcripts. In describing TA, Braun and Clarke (2006:78) show that this is a text-driven approach to data analysis that seeks to identify and report patterns or themes within the data. This scope is further clarified in Fereday (2006:80), who adds that the themes are usually derived from the text itself and they are reflective of important descriptions of a particular phenomenon. Unlike in QCA where themes are derived from past literature and the research question, in TA themes come directly from the content of the text. It should be noted, however, that although these themes are not theory-driven, they are not necessarily abstract. Braun and Clarke (2006:85) show that these themes are related to the researcher's interest in a particular aspect of the data. This suggests that thematic analysis is a useful tool where the researcher aims to organise the data into themes.

A theme, according Joffe and Yardley (2004:57), is a specific pattern of meanings that are of interest to the researcher in the data being dealt with at the time. The idea of a theme as a pattern is consistent with an earlier definition by Boyatzis (1998:161) who views a theme not only as a pattern, but also as a tool that at minimum describes and organises possible observations and at maximum interprets aspects of the phenomenon. This means that a theme can be either descriptive or interpretative.

Given the significance of the concept theme in thematic analysis, Braun and Clarke (2006:83) provide a way in which a theme can be worked out. They show that a theme should be a pattern that captures an important aspect about the data. The importance of any aspect should be

determined by the research question, not necessarily by the frequency of occurrence in the data. This implies that identifying the theme requires the researcher's judgement based on the research question without necessarily quantifying the themes.

Literature on thematic analysis, for example, Joffe and Yardley (2004) and Braun and Clarke (2006) show several aspects that a researcher has to decide on, before carrying out this type of analysis. Braun and Clarke (2004:85) show that from the onset in the conceptualisation of the research project, a researcher has to make a decision on whether the analysis is intended to provide a rich thematic description of the whole data set, or a detailed description of a particular theme/s. In the former approach the themes identified, coded and analysed are a reflection of the content of the whole data set, while in the latter the theme/s are a reflection of a particular aspect often related to a specific research question or area of interest in the research (Braun and Clarke, 2006:85).

A researcher also has to decide if they will focus only on semantic, latent themes or both. According to Joffe and Yardley (2004:57) and Braun and Clarke (2006:86): describe semantic themes as themes derived from the surface explicit meanings. Braun and Clarke (2006:86) further show that if a researcher focuses on semantic themes s/he does not go beyond the semantic content of what the respondents are saying. The analysis process therefore progresses from the stage of organising data into patterns that reflect the semantic content, to the stage of attempting to theorise the significance of those patterns and their implications, often in relation to previous literature.

Latent themes, according to Braun and Clarke (2006:86), are identified by looking beyond the semantic content of the data and identifying underlying meanings that shape or inform such semantic content. In latent thematisation the analysis process involves an element of interpretative work. Braun and Clarke (2006:87) further point out that such interpretative work also entails an attempt to theorise the socio-cultural contexts and structural conditions in which the individual accounts have been produced. This therefore suggests the incorporation of implied and presupposed meanings in the analysis. Braun and Clarke (2006:87) comment that due to this inclusion of meaning in context, thematic analysis that focuses on latent themes overlaps with discourse analysis. Because of the value of these forms of thematisation in meaning interpretation

of qualitative data, Joffe and Yardley (2004:57) note that very often thematic analysis draws on both of them.

The value of TA in this study, which made it an ideal analytic framework, was its ability to allow the researcher to take into account the context of data in the analysis, and make latent themes part of the analysis. It also allowed the incorporation of aspects that would not have been covered by the literature or research question, yet were important in the study. This characteristic of TA is also acknowledged by Joffe and Yardley (2006:56) who note that TA allows the researcher to pay particular attention to qualitative aspects, such as drawing inferences from the data with relevance to the context in which the data was collected, or data discourses were produced. Due to this focus on qualitative aspects, the researcher is able to give a "rich and detailed, yet complex account of data" (Braun and Clarke, 2006:79).

An analytic process as has been outlined in different ways by different researchers. Braun and Clarke (2006:87-93) outlines the phases of TA starting from data preparation and initial familiarisation to producing the actual report. In the same manner Joffe and Yardley (2004:58-60) and Fereday (2006:84-90) provide their perception of the actual steps taken in thematic analysis. Although all these works present this process in a linear fashion, Braun and Clarke (2006:86) note that this process is not linear but recursive, which means that a researcher moves back and forth between steps or phases.

2.3.3 The Analytic Procedure

As it has been mentioned, the analytic procedure in these two approaches is systematic and objective, therefore it follows certain steps. However, Elo and Kyngäs (2008:113) caution researchers that this process does not progress in a linear fashion. In some cases there is a back and forth movement between some steps.

There is a consensus in literature that qualitative content analysis (Nuendorf, 2002; Hsieh and Shannon, 2005) and thematic analysis (Braun and Clarke, 2006:84) can be done either inductively or deductively. According to Elo and Kyngäs (2008:108) an inductive approach is used when there is little or no knowledge about the phenomenon studied. In these cases the research objective is to

generate a theory. This is consistent with Hsieh and Shannon's (2005:1282) observation which also adds that an inductive approach is best used where there is limited literature on the phenomenon and a new theory has to be grounded.

Because of the absence or limitations of former knowledge, an inductive approach moves from a specific level (specific categories) to the general (general theory) (Hsieh and Shannon, 2005; Elo and Kyngäs, 2008). Elo and Kyngäs (2008:109) further show that in this approach, categories are derived from the data itself with reference to the research question. This opinion is conceded to by Hsieh and Shannon (2005:1277) who note that researchers using the inductive approach avoid using preconceived categories and allow categories to emerge from the data. In this way, a theory is built on the basis of information that is gained directly from the data, not from preconceived ideas. Braun and Clarke (2006:84) call this a data-driven approach to data.

Conversely from the inductive approach, a deductive approach is used when there is an existing theory or body of knowledge on the studied phenomenon. According to Elo and Kyngäs (2008:109), since there is existing knowledge, a deductive approach is done generally to test the existing theory. Hsieh and Shannon (2005:1278) extends this explanation and adds that a deductive approach is used to validate aspects of the existing knowledge or to extend it by adding more information to it or refuting parts of such knowledge.

Categories and themes in a deductive approach are derived from former knowledge and past literature (Hsieh and Shannon, 2005:1278). Since there is already an existing theory, Elo and Kyngäs (2008:109) show that the process of analysis goes from the general level, which is at the theory level; to the specific level which is the specific categories developed from the theory. These two studies agree that although these two approaches are slightly different, the actual analytic process in both of them requires the same kind of preparation phase.

The steps in a QCA and TCA have been discussed in the works of Hsieh and Shannon (2005) and Elo and Kyngäs (2008) Fereday (2006). There is a consensus among these works that the process starts with data preparation. Hsieh and Shannon (2005:1279) advocate for the transformation of the verbal data into a written text that is analysable and "codable". This involves transcription of interviews and focus group data. The transcription and conventions are guided by the objective of

the study. When the data has been transcribed, the units of analysis are defined. Elo and Kyngäs (2008:106) show that the researcher has to decide what unit they are going to use for analysis, it could be the whole interview transcript or just part of it. This is the unit to which codes are going to be applied. When the unit has been identified, then the coding process starts and the data is divided into different themes guided by the research question. Hsieh and Shannon (2005:1276) note that the success of a qualitative content analysis process depends largely on the coding process, because this process allows the researchers/s to organise large quantities of data into few content categories that can be discussed as themes in the findings. This makes the coding process the most crucial aspect in qualitative content analysis.

2.3.4 Application to Health Communication Research

Qualitative Content Analysis and Thematic analysis have been widely used in health care communication research in general and in multilingual health care communication specifically. Studies that have applied it were carried out in European countries such as Belgium and France (Ajoulat et al., 2002); in Australia (Cioffi, 2003) and in Africa south of the Sahara (Deumert, 2010). All these studies use interviews and focus groups as the principal methods of data collection.

In a study aimed at exploring the communicative experiences of family care-givers of HIV infected patients in Belgium and France, Ajoulat et al. (2002:215) collected data through individual interviews and focus groups. In that study the content analysis steps included repeated reading of the transcribed interview scripts and indexing (coding) the data using thematic categories derived from the interview guides. These coding allowed the researchers to categorise the experiences, therefore the study yielded valuable insight into the difficulties that are experienced by these caregivers. One of those problems is that these care givers find it difficult to discuss the evolution of the disease and the prospect of death with their patients (Ajoulat et al., 2002:216-217).

Qualitative content analysis was also used in a study done in Austria by Dressler and Pils (2009). The main aim of this study was to establish how linguistic or cultural aspects influence communication between staff and migrant and ethnic minority patients in a post-accident rehabilitation centre. Data for this study was collected mainly through interviews (Dressler and

Pils, 2009:1182). An inductive content analysis was carried out and two main themes that emerged in the data were used as categories of aspects that influence communication. These themes were language aspects and cultural aspects (Dressler and Pils, 2009:1183-1185). These themes were then discussed in detail in the findings of the study.

Another study that employed qualitative content analysis is Cioffi (2003), who explored and described the experiences of nurses in communication with a culturally and linguistically diverse patient base in an acute care facility in Australia. The data collected through interviews was analysed through a process of transcription, repeated reading, data coding and categorisation into themes (Cioffi, 2003:301). The study yielded results on the strategies used by nurses to achieve communication and the categories of human resources such as bilingual health workers, who facilitate communication (Cioffi, 2003:301-305).

Other studies in health care communication research report on the use of Thematic Analysis. In one such study Attard and Coulson (2012:500) conducted a study aimed at gaining insight into positive or negative aspects of online communication about Parkinson's disease, by analysing messages from online forums. Attard and Coulson (2012:501) report that TA was data-driven and it allowed them to formulate in-depth description patterns. Attard and Coulson (2012:501) show that the process of analysis was characterised by repeated reading of messages, coding of patterns and establishing and assembling of themes. They did not go beyond the surface meanings of the text and therefore the analysis was semantic. Attard and Coulson (2012:501) further report that the study yielded three major themes prevalent in these discussions. Three of these were positive aspects and three were negative.

While some studies report to have used QCA and TA independently, in some studies the methods were integrated. Deumert (2010) conducted a study on the role of multilingualism in health care in three Western Cape hospitals. In this study Deumert (2010:54) integrated TCA and TA to report on experiences of staff and patients in these hospitals. In describing the analysis process Deumert (2010:54) shows that it involved full transcription of data and translation into English, where it was necessary. Then close readings of transcripts was done and themes were coded and classified. The data revealed useful insight on the organisation of care in South African health centres,

particularly the lack of established interpreting services and the experiences of stakeholders in health care (Deumert, 2010:56-58).

These studies show that QCA and TA are important tools in understanding health care communication in general. Because of its flexibility, it allows a researcher to interpret data on the semantic and latent level. It also provides a summarising tool that is helpful in managing data and eventually interpreting data. These characteristics are important in this study which deals with data that comes from three data sources where transcripts cannot be discussed individually. Its ability to go beyond the surface meanings of discourses is helpful in the interpretation of meanings form participants responses.

In this study, the analysis used an integration of TA and QCA. First TA was done to summarise each of the transcripts and to identify aspects that are of interest to the study in the texts. Such aspects were categorised and themes were derived. Then deductive QCA with a categorisation matrix made of codes developed from past literature was performed. The data were were assigned specific codes if they were semantically and pragmatically correspondent with the codes; meaning something that contrasts aspects of a code, or if they exemplified the code or some of the aspects embedded in such a code.

2.4 COMMUNICATION IN HEALTH CARE

Recent research on medical communication has widely acknowledged that there is a global increase in the mobility of medical professionals. Van De Poel and De Rycke (2011:70) observe that physicians increasingly relocate and work in places which have different L1s and cultural backgrounds from their own. As a result of this they are confronted with language discordant encounters in their professional environment. This has implications for the quality of communication with patients and colleagues. This section gives an exposition of past literature on communication in health care in general, and in HIV and AIDS settings in particular. It firstly discusses the relationship between the effectiveness of communication and quality of health care. Then it gives a review of literature on multilingualism and language diversity in health care settings. In this sub-section the discussion initially focuses on the challenges posed by multilingualism and language diversity. Then attention is directed towards the strategies and

resources that individuals and institutions have used to manage language diversity and overcome the challenges it poses in the past. Lastly, the section looks into communication issues in HIV and AIDS settings. Particular emphasis is on the barriers to communication and suggested ways of overcoming the barriers.

2.4.1 The Role of Communication in Health Care

The past two decades have seen a growing research interest in the field of health communication among medical and linguistic researchers. This comes as a result of the fact that practitioners and stakeholders in the health sector are increasingly acknowledging the significance of the role played by communication in health care. Earlier contributions of research in this field consist of diverse approaches such as are found in sociological and anthropological studies (see for example, Cicourel, 1983; Tannen and Wallat, 1986) and in sociolinguistic and discourse analytic studies (see Fisher and Todd, 1983). Later contributions to this field come from an intercultural and multilingual communication perspective (see for example, Rivadeneyra et al., 2000; Bernard et al., 2006; Hsieh, 2007; Deumert, 2010).

Research focusing on the role of communication in health care recognises the importance of effective communication in health care delivery in general. Van de Poel and Rycke (2011:71) cite communication as one of the factors that have a substantial influence on the quality of the physician-patient relationship, which in turn has implications for the quality of health care. This perceived value of communication in health care was proved in a study by Pendleton and Bochner (1983:677) who established that effective communication was used as a basis on which patients evaluated consultations. A sample of patients, asked to rate their clinical encounters in Pendleton and Bochner (1983:678), cited lack of good communication as a reason for them rating a consultation as a bad experience. Because of such previous bad experiences of communication, patients also associated follow-up consultations with increased stress and anxiety on their part, because they worry about how they will clarify matters with the provider. The same observation was made by Silverman et al. (1998:1) who observes that doctor-patient communication is a central component of clinical practice whose efficacy can help the realization of high quality health care. Other research, Lukoschek et al. (2003:204), views effective communication as the hallmark of a

successful doctor-patient interaction capable of leading to adequate treatment. This endorses the interrelationship between effective communication and positive health outcomes. It is also an acknowledgement of communication as a core clinical skill for a medical professional, which is why most medical schools have incorporated professional clinical communication in the syllabi as an integral part of the curriculum (Silverman et al., 1998:4; Harrington, 2004:8). While communication is important in health care in general, in the treatment of HIV and AIDS specifically it is even more crucial because patients have to be convinced to change behaviour and to take treatment meticulously (Hoeken and Swanepoel, 2008:1).

The significance of communication in a health consultation is reported to be evident from the onset of communication. This assertion is consistent with the observation of Ruusuvuori (2001) in a study that explored the coordination between patients' presentation of their complaint and the doctor's engagement in other activities during the consultation. In this study Ruusuvuori (2001:1096) observed that from the onset of the consultation it is mandatory for patients to be communicatively competent enough to present their medical history adequately because that paves the way for proper diagnosis and treatment. The same finding was made by Bharath-Kumar et al. (2009:448) who explored the role of multimedia and multimodal communication in HIV and AIDS consultations. They established that when an HIV positive patient arrives at a clinic, s/he passes through a series of consultation phases. From the beginning of these consultations, communication plays an important role in guiding, informing, encouraging and empowering the patient.

In order to substantiate the opinion that communication is an essential component in adequate health care delivery, researchers have identified several roles played by communication in a medical consultation. One of those roles is to solve and manage health problems as well as create therapeutic relationships (Van Den Brink-Muinen et al., 2000:115). On top of that, Lukoschek et al. (2003) adds that effective communication is also needed for patient education and to ensure patient compliance with treatment. This implies that when communication between a health care provider and patient is successful, positive health outcomes are likely to result.

2.4.2 Effective Communication and Achievement of Positive Health Outcomes

Previous research has linked effective communication (or lack of it) to several indicators of quality health care delivery and improved health outcomes as per the reports of experiences of both patients and doctors. For example, in an analysis of doctor-patient interactions, Gallagher et al. (2005) established that effectiveness of the doctor's communication, achieved through both verbal and non-verbal means, have an impact on patient satisfaction, understanding and compliance with treatment. This correlation was further was also found in a later study exploring patients' perspectives on doctor-patient relationships, where Shaw et al. (2009:118) found reports of a clear correlation between effective communication and improved self-care among patients with chronic illnesses.

In some studies effective communication during the consultation was associated with patients' adherence to treatment. According to Shaw et al. (2009), effective communication in a medical consultation is pertinent to shared decision-making which in turn guarantees compliance with proposed treatment. This is concede to by Lukoschek et al. (2003), in their study on patients' comprehension of medical treatment in New York Hospital, who noted that effective communication and patients' comprehension of health communication is one of the factors necessary to ensure patient compliance with treatment. When messages have been conveyed in a way that patients can easily comprehend, it becomes easy for them to understand and acknowledge the proposed treatment. Such patients are therefore more likely to adhere to the treatment than when they had not comprehended the message.

On top of ensuring adherence through understanding, Schouten et al. (2009) and Harrington (2004) show that effective communication gives rise to patient satisfaction which in turn results in accomplishing compliance and adherence to treatment. In explaining this relationship between effective communication, satisfaction and compliance, Rivadeneyra et al. (2000:470) show that where communication between doctors and patients is good, patient satisfaction tends to be enhanced. When patients are satisfied with the consultation, they usually comply with treatment and adhere to scheduled follow-up appointments.

2.4.3 Implications of Ineffective Communication on Health Care Delivery

In addition to establishing a link between effective communication and positive health outcomes, a large body of research in health sciences has provided insight into some of the adverse results of unsuccessful health communication. One of such results is lack of mutual understanding between practitioners and patients. In a study of general practitioners' interactional styles, Schouten et al. (2009:468) established that there was a relationship between ineffective doctor-patient interaction and patient's lack of understanding of diagnosis and treatment. In particular, they discovered that the physicians' communicative behaviour of ignoring patients' comments and rushing through the clinical consultation had a negative impact on the patients' understanding of vital content such as causes of the reported health complaint, diagnosis and treatment. They further discovered that patients' interpretation of the information on diagnosis and treatment differed markedly from that of doctors, which is a sign of lack of mutual understanding that would make it difficult for patients to adhere to treatment. Deumert (2010:4) concedes to this by noting that when patients were not adequately communicated to, they have a tendency to default on treatment and to do healer shopping (consulting a variety of healers both medical and traditional for the same problem).

Lack of effective communication has also been found to have a negative impact on doctors and their ability to deliver quality health care. This correlation was established by Deumert (2010:15) who reports that according to doctors, communication is a necessary tool for proper diagnosis. Where communication is ineffective doctors can only observe symptoms that have physical manifestations and those are often not sufficient to make a diagnosis.

Scholarly work has established that the degree of the need for communication is disease-specific. In commenting about medical consultations with patients that do not have detectable physical symptoms, Salmon (2000:109) shows that in such contexts, a proper diagnosis depends on the effectiveness of communication between a physician and a patient. This is because the physician cannot scrutinise the symptoms, nor detect their seriousness of the condition. He/she relies on the patients' explanation to arrive at a diagnosis and treatment plan. This is true of other ailments that very often do not have physical manifestations such as diabetes (Hampson et al., 1996) and HIV and AIDS (Anthonissen and Meyer, 2008; Watermeyer and Penn, 2009).

Another medical context where the importance of effective communication on diagnosis is clearer than in most medical contexts is in psychiatric care. Drennan and Swartz (2002) observed that since patients' accounts are crucial in psychiatric diagnosis, where there is a language barrier patients are likely to be misdiagnosed. For example, a patient who cannot adequately express himself/herself due to the language barrier may be mistaken to have symptoms of impaired intellectual ability. Such patients end up with a misdiagnosis and wrong prescription which can have dire health consequences.

2.4.4 Factors that Negatively Affect the Efficacy of Communication

Although it is apparent that communication is such a vital tool in medical consultations, sometimes it is not attainable due to factors that are at play among health care providers and patients. Linguistic and health science scholars have put forward several factors that account for lack of effective communication between patients and health care providers. According to Van Den Brink-Muinen et al. (2000), sometimes effective communication is hindered by cultural differences between providers and patients. Different cultures differ in their definitions of health problems, their causes, expression of the intensity of pain and treatment. When these differences are not well managed during the consultation, interlocutors are likely to misunderstand each other and consequently, the quality of care given will be negatively affected.

Another factor that adversely impacts on the quality of communication in health care is patients' level of education. In an assessment of the effectiveness of health information exchange, Lukoschek et al. (2003:205) found that low levels of education in patients was one of the barriers that hinder patients' comprehension of health information. They explain that due to the scientific nature of health care communication, patients with low levels of education may find it difficult to comprehend the information because it contains a lot of scientific terminology.

Effective communication has also been found to be affected by the agendas or purposes of the interlocutors involved. Meeuwesen et al. (2007) studied agenda setting and mutual understanding in health care interactions in Netherlands. They found that sometimes patients and doctors have conflicting agendas and expectations. When patients do not give a doctor a clue of their

expectations or agenda, doctors may wrongly assume that there is mutual understanding where there is none and thereby compromise the success of communication and health care delivery.

It is evident that in order for doctors to attain effective communication with their patients, they need competence in both medicine and communication. They require the skill and competence to structure their interactions in a way that makes it possible for patients to feel comfortable enough to provide the required information that will aid proper diagnosis. They also need to know the kind of questions to ask in particular points of the interaction and the institutional constraints and conventions that are relevant to their context. While the above literature provide ample background on some of the models, structures and sequences one finds in consultations, and recommendations of which models work best, very few studies are based on participants' perceptions or evaluation of these systematic structures and their efficiency (Robinson and Heritage, 2006). This is despite the fact that the concerned participants are the ones to best judge the suitability of a model. For example, patients should be the ones to best evaluate the suitability of a model or structures of questions. Moreover, most of these studies were done in the USA (see Robinson and Heritage, 2006; Heritage and Maynard, 2006) and Europe (see for example, Salmon, 2000; Meeuwesen et al., 2007), and there is a very limited insight (Anthonissen and Meyer, 2008) on clinical interactions in Sub-Saharan Africa in general, and Lesotho in particular. More research is therefore needed on role-players' perceptions of the systematic structures of clinical interactions in the Sub-Saharan region. There is also a need to know the structures prevalent in this region's medical interactions and the efficacy of such structures in order to eventually evaluate the efficacy of communication in these interactions.

On top of these factors, it has also been established that the mismatch of linguistic resources between health care providers and patients can have negative effects on communication (see Rivadeneyra, 2000; Elderkin-Thompson et al., 2001; Meeuwesen et al., 2007; Deumert, 2010). This mismatch comes as a result of the continued migration of speakers of different languages, who end up interacting with each other because they have to share public spaces like health institutions.

2.5 MULTILINGUAL COMMUNICATION IN HEALTH CARE

The growing trend of migration around the globe has been ascribed to various socio-economic and political factors. According to Apfelbaum and Meyer (2010:1) this increased migration has led to the norm of increased linguistic and ethnic diversity around the world. Because of continued mixing and interaction of people who speak different languages, the linguistic repertoires of both the migrants and the autochthonous populations are affected (Blommaert et al., 2005:198; House and Rehbein, 2004:5; Collins and Slembrouck, 2006:251). Blommaert et al. (2005:201) identifies three levels at which linguistic repertoires and resources are affected by the presence of an immigrant population in any speech community. Firstly, the linguistic repertoires of the immigrants are affected in that migrants are faced with the challenge of acquiring the autochthonous population's language; secondly, the autochthonous population is confronted with communicative practices formerly alien to them and thirdly, public institutions (such as medical institutions), have to deal with administrative issues involving people with diverse linguistic repertoires and operate in a way that successfully manages the language diversity.

This physical interaction between immigrants and the autochthonous populations, with different linguistic backgrounds, creates a need for them to communicate in different contexts and service encounters such as at courts, shops and health care centres. This need for communication is clarified by Brislin and Yoshida (1994:vii) who point out that regardless of the differences in linguistic repertoires, people have to communicatively interact when they exist in the same speech communities hence the existence of multilingual interactions.

2.5.1 Defining multilingualism

Linguistic researchers define multilingualism in many different ways. According to House and Rehbein (2004:5) multilingualism is a speech situation in which speakers use several languages to achieve their communicative purposes. The nature of multilingual encounters is further clarified by Moyer (2011:1212) who views them as language situations which entail the spatial presence or co-occurrence of two or more languages that have a different social and historical status in a given speech situation. These languages are used to achieve communicative purposes in multilingual communication, which occurs between interlocutors from different linguistic and cultural

backgrounds. Moyer (2011:1213) further shows that multilingualism is also a social practice that encompasses linguistic practices such as: the choice of which languages to use, in what spaces. It is therefore performed through writing and face to face interaction. Apfelbaum and Meyer (2011:4) refer to another dimension in multilingualism. They argue that multilingual communication is not only limited to interlocutors who do not share a language since sometimes even speakers of the same language can decide to use another language for different reasons, thereby rendering their encounter multilingual. Applied to the local context, this could refer to two Sesotho speakers who may decide or feel obliged to use English as a lingua franca due to the demands of their communicative event and the context or domain in which it takes place.

2.5.2 Multilingual Contexts

The general idea in all these definitions is that multilingualism entails a communicative event in which different languages are involved, together with the ways in which communication is carried out in such events. This implies that in order to understand multilingual communication, one has to also have an understanding of the statuses of the languages involved and how they are distributed in a given multilingual context.

The significance of context in understanding multilingual is also fore-grounded by Blommaert et al. (2005:203) who note that context has a bearing on communication. This is because context, which also includes the multilingual spaces in which such communication happens have a way of regulating the sociolinguistic factors that impact on communication.) In contextualising this to the current study, this implies that multilingual spaces (such as health care centres), would have institutional control over the sociolinguistic status of languages and therefore, on the distribution of such languages are used in communication around the centre. In an article examining how a health clinic in the Flemish city of Ghent responds to language diversity, Collins and Slembrouck (2006:260) subscribe to this idea by referring to a process in which languages are allocated to certain resources as scaling. They observe that a closer look into the distribution or scaling of languages in a health care centre provides insight into how such an institution manages language diversity. Collins and Slembrouck's (2006:260) observation of scaling issues came up with a language hierarchy showing which languages are mostly used and valued. This hierarchy is

consistent with Blommaert et al.'s (2005:214) observation that scaling emphasises non-equivalence and power. Language scaling is also seen in Drennan's (1999:10) study carried out in a psychiatric hospital in the Western Cape, where he established that English and Afrikaans are the main languages of communication in the centre, even though the hospital has many patients that are Xhosa speakers with no competency in either English or Afrikaans. Drennan (1999:11) shows that at the time of the study there was no official provision of interpreters for the Xhosa speakers. By scaling languages in this manner, the hospital as a multilingual space has assigned an institutional, official status and sociolinguistic value to the two languages thereby compromising the effectiveness of communication where Xhosa speakers are involved.

Multilingual spaces also have a bearing on the effectiveness of communication because their distribution of linguistic resources has an impact on the extent to which speakers are able to utilise their multilingual repertoires. According to Blommaert et al. (2005:196), the way a particular space distributes and organises linguistic resources can make multilingual speakers incapable of utilising their multilingual linguistic resources. This is because in distributing the languages; the speaker is likely to find that his/her linguistic resources are not used at all in that space or they are used in a way that is unfamiliar to them. This implies that such speakers still retain their multilingual repertoires but the efficacy of their communication is compromised by their incapacity to fully utilise such repertoires.

Along with having an effect on the effectiveness of communication, multilingual spaces also have an effect on the way speakers identify themselves in relation to other multilingual speakers and how they reflect their identity in a particular multilingual framework. This is conceded to by Blommaert et al. (2005:203) who argues that multilingual spaces affect speakers' identities constructed in language and therefore it affects their communication. To further explain the relation between multilingual spaces, language and participant identities, Kramsch and Whiteside (2008:661) show that in multilingual speakers position themselves in the interaction and show which identity they want to be associated with in the wider social context. Speakers therefore use their multilingual repertoires for different purposes and the choice of which language to use at a given space depends on the speaker's purpose at the time. Kramsch and Whiteside (2008:665) make an example of a participant who was competent in English but did not use it because she

wanted to show resistance to it in solidarity with Spanish speakers. Kramsch and Whiteside (2008:661) also found that another participant used a variety of languages in her communication depending on what her purpose was at the time. This speaker used Chinese as language of intimacy; Spanish as a marker of her stigma and non-assimilation and English as a way of distancing herself from Mexican newcomers. In this way this multilingual speaker shifts languages to constitute her identity and the effectiveness of her communication rests in being able to match her language choice with the right purpose for which it is intended to be used.

The seemingly widespread multilingual nature of different institutions and people has created a need for research on multilingualism. The primary goal of research on multilingualism, according to House and Rehbein (2004:5), is to enhance the quality of multilingual communication among speakers in order to ensure that communication serve the needs of both the speakers and the institutions in which the communication takes place. This kind of research achieves this goal by researching on a wide spectrum of parameters such as language use, participant roles and socio-political status of the languages involved in the interaction. House and Rehbein (2004:5) note that multilingual research should eventually provide insight into whether it is possible for speakers to understand each other in a multilingual setting and into the strategies they use to understand each other. This means that the major concern of research in multilingualism is the achievement of effective communication in multilingual speech contexts. In health care settings in particular, this type of research is important because the efficacy of communication has implications on the quality of health care provided.

2.5.3 Challenges Posed by Multilingualism in Health Care

Although effective communication is central to the attainment of positive health outcomes, several studies have shown that in multilingual contexts where there is language discordance between the health care provider and the patient it is not always attainable. To remedy the situation and yield good communication results, certain measures have to be taken (see for example Elderkin-Thompson et al., 2001; Harmsen et al., 2003; Babitsch et al., 2008; Deumert, 2010; Moyer, 2011). In multilingual health centres the staff faces a challenge of making language choices and developing strategies and mechanisms that will enhance communication and improve the quality

of health care delivery. Moyer (2011:1212) further notes that in these contexts, languages become scaled and some of them are valued more than others. Speakers of the valued languages become mediators and brokers of others (Moyer, 2011:1212). All these measures are a sign that where there is multilingualism there are decisions to be taken in order to enhance communication.

While several barriers such as low levels of education and cultural practices (Harmsen et al., 2003) are known to account for ineffective communication, there is a lot of research which has documented language discordant doctor-patient interactions as problematic. According to Elderkin-Thompson et al. (2001:1344), one of the problems in language discordant health care is that communication is limited to medical problems and allows very little room for patients' feelings, questions or explanations of the causes of the illness. In essence, this hinders patients from expressing their concerns and perceptions of the illness thereby being vulnerable to problems like misdiagnosis and poor medical care.

Further problems in language-discordant health care were reported in Bernard et al. (2006), in a study carried out in the University of Kentucky hospital where language discordance was found to bar the staff from performing their duties adequately, more especially from taking patients' history and diagnosis. This is consistent with the findings of Babitsch et al. (2008), in a study aimed at assessing the influence of gender and ethnicity on patient treatment in Germany. They found that German-speaking doctors experienced problems with one-third of the Turkish-speaking patients. Some of the problems identified were: patients' unwillingness to cooperate or communicate and inadequate comprehension.

It has also been established that when doctors and patients have incompatible linguistic repertoires, their behaviour in the consultation compromises the effectiveness of communication. Rivadeneyra et al. (2000) compared the interactional behaviour of English speaking doctors towards English speaking patients and Spanish speaking patients. In this study it was discovered that English speakers were more likely to receive a response from a doctor than their Spanish counterparts, while Spanish speakers were ignored. The same observations were made by Meeuwesen et al. (2007), who established that Western physicians show less affective behaviour to ethnic minority patients who have incompatible linguistic repertoires with them than to patients with the same L1

as their own. In another context, Schouten et al. (2009) report on Dutch doctors' frequent use of retractive behaviour when interacting with ethnic minority patients. Some of the elements of this behaviour that they recorded were that the doctors listened inattentively and ignored ethnic minority patients' questions and comments without responding to them. Doctors also demonstrated less socio-emotional exchange and less stimulation of patient participation than they did with Dutch patients. Moreover, they usually rushed through the consultation agenda without checking whether the patients understood or not (Schouten et al., 2009:469).

It should be acknowledged, however, that this seemingly negative behaviour towards patients who do not speak the doctor's language is not universal. For example, an analysis of Dutch doctors' verbal behaviour towards immigrant, non-Dutch speaking patients by Meeuwesen et al. (2006) revealed that although there was no exchange of socio-emotional talk, doctors listened very attentively to patients and spent a longer time making an effort to understand the immigrant patients than they did with Dutch speakers. They were also more empathic, asked for clarification more often and gave more medical advice (Meeuwesen et al., 2006:2413). According to Meeuwesen et al. (2006:2415), this behaviour marks the doctors' acknowledgement of the complexities surrounding language-discordant interactions and their attempt to accomplish effective communication in such contexts.

It is not only doctors whose behaviour has been found to compromise effective communication in language-discordant interactions, but also patients. For example, Rivadeneyra et al. (2000) found that because of the way doctors communicated with them, Spanish speakers contributed by making only a few comments through their interpreters, which made them doubly disadvantaged in health care. In another context, Meeuwesen et al. (2007) found that while doctors dominated the conversation, patients reacted very minimally by way of speaking. Even in Meeuwesen et al. (2006), where doctors handled the communication in a patient-centred manner, ethnic minority patients were still found to talk far less than their Dutch counterparts. Meeuwesen et al. (2006:2413) shows that in instances where they talked, ethnic minority patients' contributions were restricted to agreement with the doctor or acknowledgement of the doctors' comments, unlike Dutch speakers who very often disagreed with doctors. It can be deduced from this that, language-

discordant consultations are problematic regardless of the communicative styles or behaviour of doctors and patients.

2.5.4 Implications of Language Discordance on Health Care Delivery

The complexities in language-discordant health care negatively affect delivery of health care in many ways. The work of scholars (see Harmsen et al., 2003; Meeuwesen et al., 2006; Babitsch et al., 2008) who investigate communication experiences of doctors and patients in language-discordant health care provider-patient interactions, concede that communication between health care providers and patients who do not have compatible linguistic resources is usually less effective and often causes a set of problems for all stakeholders.

One of the problems caused by this scenario is that it hinders establishment of trust between patients and health care providers. According to Van de Poel and De Rycke (2011:71) medical professionals who do not speak the local language are at risk of being misinterpreted for being indecisive, insensitive or even rude. This makes it difficult for them to establish a trusting relationship with their clients and colleagues. The inability of these physicians to establish a trusting relationship with patients is further evident in Deumert (2010:56). That study reports that the Afrikaans/English speaking doctors interviewed reported on their inability to establish trust and rapport with IsiXhosa speaking patients. This is despite the fact that according to their training, these are the fundamental requirements for effective history taking and diagnosis. Without patients' trust it is difficult for doctors to get all the information pertaining to the health problem, and adequate health care is compromised.

The inability of health care providers to provide adequate services in language-discordant contexts has also been found to cause stress and anxiety for providers. Ulrey and Amason (2001:453) point out that the stress and anxiety staff experience in language-discordant settings is aggravated by the fact that on the one hand patients are too sick to concentrate on communication while providers are too pressed for time. This observation is shared by Bernard et al. (2006:357), who adds that on top of being a source of stress, language discordance is an impediment to good quality care. These observations are consistent with Dressler and Pils's (2009) findings of a study conducted in a post-accident rehabilitation centre, where they discovered that when dealing with patients who do not speak their language, staff became uncertain of whether patients understood the proposed therapy

and they found it challenging to explain the therapy. This created a feeling of helplessness and was stressful for staff.

In addition to that, language discordance has also been found to affect the accuracy of diagnoses. Drennan and Swartz (2002) attest to the fact that in cases where linguistic resources between doctors and patients are incompatible, doctors are hindered from making accurate diagnoses and they can end up misdiagnosing the patients. In a later study, Deumert (2010:58) concedes to this idea, adding that doctors cannot properly diagnose patients because they do not fully comprehend patients' accounts and can only access the symptoms that have clear physical manifestations, which they in some cases misinterpret.

Another negative consequence of language-discordant health care is that such consultations are fraught with lack of mutual understanding of the important aspects of the consultation. Meeuwesen et al. (2007:183) notes that mutual understanding is a prerequisite for quality health care delivery, though it is difficult to accomplish in language discordant settings. Moyer (2010:9) shares this view and comments that it is difficult to achieve mutual understanding where linguistic resources and language choices are limited. The effect of language discordance on mutual understanding is made further evident in a study investigating the levels of mutual understanding between ethnic minority mothers, who are not proficient in Dutch and Dutch-speaking doctors, where Harmsen et al. (2003:102) found gaps in mutual understanding in the very initial stages of symptom reporting. In particular, they discovered that in these language-discordant interactions characterised by less mutual understanding, there were instances in which on the one hand doctors failed to understand the health problems presented by a mother, while on the other hand mothers failed to understand the diagnosis and treatment plan recommended for her child. The results of this discrepancy have been found to be diminished understanding of the health condition in general (Deumert, 2010:15), and patients' misunderstanding of the risks and benefits of the proposed treatment. (Thompson et al., 2001:1344). This compromises delivery of quality health care and attainment of positive health outcomes.

The misunderstandings and lack of understanding in language discordant settings have been found to arise from several sources. In their study in which they were exploring issues that general practitioners

faced when they are dealing either patients that have a low proficiency in English, Roberts et al. (2005:468) discovered that a misunderstanding can be caused by a constellation of factors that include the participants' differences in word stress, intonation, vocabulary, grammar and lack of contextual knowledge. When there is an imbalance in any or all of these factors speakers find it difficult to comprehend what the other one is saying. In another study aimed at exploring how patients overcome misunderstandings, Moss and Roberts (2005:414) found out that in some cases misunderstandings are caused by interlocutors' lack of conventional knowledge about each other's world or by difficulties that are related to interlocutors' inability to process each other's verbal communication. Moss and Roberts (2005:414) further comment that these differences in stress and intonation can be found even where participants share a language, therefore where they appear along language discordance they are bound to cause communication problems.

The lack of mutual understanding stakeholders experience in language discordant settings has negative implications for patients' compliance to treatment. Wiener and Rivera (2004:93) show that in language discordant interactions patients reported less satisfaction and were therefore less compliant. This is supported in Babitsch (2008) who reports that the communication problems that were found between German doctors and Turkish patients were found to result in decreased compliance to treatment by Turkish patients. This is consistent with Rivadeneyra et al. (2000:470) who observed that Spanish speakers attended to by an English speaking doctor had poorer adherence rates, therefore poorer medical outcomes than English speakers. In another context Harmsen et al. (2003) found clear correlations between mutual understanding and compliance. The study established that ethnic minority patients had twice as much poor rates of compliance as the Dutch, which arose from their failure to understand the treatment protocol.

It clear from the studies discussed above that the ineffectiveness of communication has negative consequences on health outcomes. This is further proved in Bischoff et al. (2003:506), where it was established that when communication between asylum seekers was good, symptom detection was significantly higher, but if communication was poor the number of reported symptoms both physical and psychological was poor. According to the nurses in the study, this may have led to low referral rates to psychological care. However, in cases where interpreters were present, levels of symptom reporting improved and asylum seekers were also able to report psychological

symptoms that affect them like nervousness, sadness and traumatic events which affect their health status such as death.

2.5.5 Managing Language Diversity in Health Care

In cognisance of the increased level of language diversity due to widespread migration, and the effects of language diversity on effective communication in health care, health care institutions have to respond to such a language situation. This idea of the need to respond to language diversity is supported in the findings of Babitsch et al. (2008:7), where they show that there is a need for public institutions to introduce interventions that aid communication in language discordant interactions. The practical response to language diversity is also noted by Djite (2009:2) in a paper aimed at advocating for multilingualism to be seen as an evolving process not a static one. He shows that when there is language diversity, the state and public institution usually strive to manage the diversity in a way that will benefit those affected. The actions that the institution takes to do this are what Moyer (2011:1211) defines as multilingualism. These actions may include: the choice of institutional languages, the choice of information to be translated or even the pragmatic forms that are used in the institution. According to Moyer (2011:1211), it is important to look into these actions because they give an insight not only into how multilingualism is understood in the health institution and surrounding community, but also into how adequate health care is enhanced through effective communication.

Ideally, health care would be provided in one's own language in order to allow for mutual understanding between health care providers and their clients. However, time constraints, the extent of linguistic diversity and the often lacking resources in most health care institutions does not permit that. Van de Poel and Rycke (2011:71) note that ideally physicians would learn a local language, but in most cases they are so immersed in their professional work that they have no time to learn a language.

Even more pressing is the fact that medical communication is very scientific in nature and in some cases languages are not compatible in terminology. For example, in a study investigating the differences in definitions of common respiratory problems, carried out in the Red Cross Children's memorial Hospital in Cape Town, Levin (2006b:1080) found that there are not always IsiXhosa

equivalents for medical terms; and that the understanding of illness among Xhosa speakers often differs from that of the medical fraternity. This is true for most indigenous languages and therefore it creates challenges for health care delivery in the mother tongue. In order to work towards achieving communicative goals in a clinical consultations, where doctors and patients do not share a language, on the one hand interlocutors have to engage in the use of certain communicative strategies while on the other hand the concerned health care institutions also have to opt for other ways of managing language diversity without having to resort to the use of patients' mother tongue.

2.5.5.1 Communicative Strategies

Several researchers (see for example, Ruusuvuori, 2001; Dressler and Pils, 2009; Fatahi et al., 2010; Anthonissen, 2011) have established that in language discordant consultations speakers employ different communicative strategies, both verbal and non-verbal, in order to facilitate communication. In a study aimed at finding out how if there is a correlation between the way patients present their complaints and the direction of the doctor's gaze and body posture, Ruusuvuori's (2001) results confirmed that body posture and gaze are important aspects of communication in a medical consultation. The findings of this study show that usually when a doctor focuses their eyes at the patient, the patient becomes fluent but once the doctor shifts the gaze and looked at the medical records the patient would be dysfluent. The worth of non-verbal communication in multilingual clinical interactions is documented in Dressler and Pils's (2009) study of communication between providers and ethnic minority immigrant patients in an Austrian post-accident rehabilitation centre. This study established that nurses used nonverbal measures like speaking slowly and using bodily gestures to enhance communication. The use of body language and sign language was also observed in a later study by Fatahi et al. (2010), which explored the communicative experiences of nurse radiographers when interacting with non-Swedish patients. However, Dressler and Pils (2009) and Fatahi (2010) concur that body language does not adequately facilitate communication in multilingual clinical interactions. Dressler and Pils (2009:1188) note that body language, as a multilingual communicative strategy, was found to be inadequate because it accounted for very limited communication. The same observation was made by Fatahi et al. (2010:778) who found out that in cases where examinations were complex, the communicative demands were intense. Such examinations come with a demand for adequate

explanations by radiographers and therefore increased demand in verbal communication. These complex examinations therefore, could not be successfully carried out through the use of body and sign language.

Apart from the use of non-verbal communication, interlocutors (doctors and patients) have also been found to use different discourse strategies to manage language diversity in clinical interactions. One of the strategies that have been found to be used by doctors is to probe for detailed clarification from patients. This was observed by Meeuwesen et al. (2006) in their investigation of the verbal behaviour of Dutch doctors when interacting with immigrant patients. Doctors' managing of language diversity by probing for more information, through the use of questions was also observed by Robinson and Heritage (2006:283). This finding is consistent with that of Schouten et al. (2009:473), where it was established that in order to enhance mutual understanding, the doctors repeatedly probed for information and rephrase the question until the patient has provided adequate information. This observation is also further shared by Anthonissen (2010) in a study investigating how language diversity is managed in an HIV and AIDS clinic in South Africa. Anthonissen (2010:125) established that where there was a potential for misunderstanding, physicians asked follow-up questions and probed for more informative answers. This eventually yielded more explanations from patients and they were able to provide more explanations, and hence effective communication.

Apart from soliciting detailed information, probing in multilingual clinical interactions has been found to be used to check patients' understanding. Anthonissen (2010:137), found out that where the patient had limited proficiency in the language of the consultation, a doctor used question-answer sequences to solicit clarifications from patients and to check whether the patients follow the information in the consultation or not. The result of this was that potential misunderstandings were resolved.

Another strategy that doctors use to manage language diversity is to tone down the medical jargon in their communication with patients. Medical communication is very scientific in nature and as Anthonissen (2011:137) established, in a clinical consultation the doctor is a primary knower about both the language of the consultation and the disease. In order to enhance communication, the

doctor avoided the use of medical jargon. Her speech was therefore less technical and accommodated the proficiency of the patients (Anthonissen, 2010:126, 137).

It is not only doctors who initiate strategies of enhancing communication in language discordant consultations, but patients have also been found to play an active role in helping to achieve effective communication in multilingual clinical interactions. In a study aimed at exploring how patients with limited English and doctors overcome misunderstandings, Moss and Roberts et al. (2005:415) found that in cases where interlocutors seemed to have misunderstood each other due to differences in conventional knowledge about certain objects, the patient took the initiative to repair that misunderstanding by giving a detailed explanation with a concrete example. This resourcefulness of patients was also observed by Anthonissen (2010:127), who notes that a patient who was seemingly not proficient in the language of the consultation persistently utilised her limited linguistic resources until there was understanding between her and the doctor. Moss and Roberts (2005:415) therefore argue that even if patients have limited proficiency in the language of the consultation, they can produce effective explanations if doctors allow them to capitalise on their resourcefulness. This can ultimately shed light on their perspective of their illness, which is very crucial for diagnosis and treatment. Moss and Roberts (2005:415) however, note that these consultations can be quite lengthy and time is one resource that is lacking in health care institutions.

2.5.5.2 Literary and Training Materials

Research on multilingual health care has established several multilingual resources and strategies that are used by health care institutions, health care providers and patients to deal with language diversity and enhance communication in language discordant clinical consultations. Some health care institutions have been found to rely on the use of literary materials to enhance communication in multilingual settings. In a study aimed at finding out how language ideologies shape institutional responses to multilingualism, Collins and Slembrouck (2006:255) report on a multilingual instructional manual that was used by a medical clinic in Ghent to enhance communication between Dutch speaking health care providers and the immigrant non-Dutch speakers. Collins and Slembrouck (2006:254) shows that the literary manual was aimed at being a tool to support the

general practitioner when working with refugees, therefore it was simultaneously written in three languages namely, Dutch, Albanian Slovakian and Russian. This literary artefact was used as a translation manual in this clinic.

Although the producers of this literary artefact thought it would solve communication problems in this multilingual clinic, Collins and Slembrouck (2006:254) found that there are several problems with the use of this printed material and therefore it is very infrequently used and negatively evaluated by its purported users. One of the manual's negative evaluation point, given by medical practitioners is that: instead of eliciting short and clear responses to specific questions from the patients, the manual led to the production of more talk in the foreign language and created more confusion to the health care providers (Collins and Slembrouck, 2006:257). On top of this, the doctors also felt that in using the manual, they take too much time searching for the right page and therefore this prolongs the consultation unnecessarily, in a medical institution that is already very busy. On top of that, the manual was found to make wrong assumptions about the literacy abilities of patients. It disregards the fact that some of them are not literate enough to manage reading the manual, even if they go through it with the health practitioner.

The use of literary materials was also observed in a recent study by Moyer (2011), which investigates the way a public clinic in Barcelona incorporates multilingualism in its institutional communication. In this institution has two official languages namely Catalan and Spanish. However Moyer (20100:1211) shows that due to migration the health centre also takes care of speakers of other languages. Among the several strategies that were used to accommodate this multilingual patient base, was the production of written texts in the form of dictionaries in minority languages, word and phrase list and instructional manuals. According to Moyer (2011:1213), these literary materials are made to improve the conditions of service and shorten the consultations. However, Moyer (2011:1214) established that this strategy has its own problems. Firstly, the written materials embed the assumption that the patients are literate and that there are Catalan and Spanish equivalents of terms in minority languages, which is not the case. Secondly, in some cases translation was found to be flawed and the materials were difficult to use. This means that the literary materials are not always useful as a multilingual tool, because they are not designed in consultation with speakers of minority languages.

In another context Van de Poel and De Rycke (2011) report on the work of an international project team that developed a multilingual online training tool, called *Medics on the Move*. (MOM). According to Van de Poel and De Rycke (2011:71) this tool, was meant to provide guidance and support for medical doctors and it is accessible through computer workstations and web enabled mobile devices such as Smartphones, IPhones and Blackberry. They further report that because of its ease of accessibility, it allows users to use it on demand at any time.

Evaluation of this tool by all stakeholders showed that it is satisfactorily useful as the project had incorporated all their suggestions. (Van De Poel and De Rycke, 2011:80). The success of this tool is reportedly a result of two factors. Firstly, the toll was designed with close consultations with the users to establish their language needs. (Van de Poel and Rycke, 2011:73-76). Secondly, it is always readily available when users need it from the pre- to the post-medical encounter phase of the consultation.

A comparison of the three materials discussed above shows that in developing materials, it is imperative to establish the needs of the users. The development should be done in close consultation with them on a continuous basis. This ascertains that the final product addresses their problems and successfully guides them.

2.5.5.3 The Use of Interpreters to Enhance Communication

As another way of facilitating communication in consultations in some cases health care providers use different types of interpreters to aid effective communication. Research on medical interpreting, for example, Rosenberg et al. (2007) and Bezuidenhout (2008) refer to the use of both informal and professional interpreters. Although these two types of interpreters differ in qualifications, skills and knowledge, they both have been found to play an important role in enhancing communication in language discordant contexts. (Meeuwesen et al., 2009:203). The categories of people that have been found to be used as informal interpreters are family members or acquaintances (Meeuwesen et al., 2009:198), and in some cases patients' children, cleaners and nursing staff (Pöchhakker, 2000:115). These interpreters are in some cases referred to as *ad hoc* interpreters or community interpreters. They are not a formalised part of health care institution and therefore perform their role on the basis of need.

Researchers have established different conceptualisations of the role of an interpreter in a medical consultation. According to Dysart-Gale (2005:96), traditionally, interpreters were conceptualised as conduit, conveying messages without either adding or removing any elements of the interpreted message. This conduit model requires an interpreter to perform in a neutral manner without even providing clarifications or intervening in the interactions (Laws, 2008). In order to perform adequately, the interpreter is trained to use the first person singular and keeping the interaction dyadic, thereby minimising his/her presence in the interaction. This model in essence, requires the interpreter to be just the voice of the other participants without having any emotional attachment to his/her clients (Hsieh, 2007).

The concept of the conduit interpreter corresponds to Angelelli's (2004) concept of invisible interpreter. Angelelli (2004:7) shows that invisible interpreters are not considered to be actively participatory in the interaction. Their role is that of a language switching operator expected to convey messages without additions, omissions and therefore no incorporation of cultural values in the interaction on their part.

Research on the role of medical interpreters (Drennan and Swartz, 2002; Angelelli, 2004; Hsieh, 2007; Deumert, 2010) concur that these interpreters practically engage in their work in ways that go beyond the conduit role. In a study exploring the role of interpreters in Midwestern US, Hsieh (2007:936) discovered that in some cases they are co-diagnosticians, meaning that they play an active role in the diagnosis and treatment of the patients for which they interpret. In performing this co-diagnostician role, interpreters overlap with providers in that they give advice that has not been given by providers. Hsieh (2007:928) further shows that the co-diagnostician behaviour is identifiable by three criteria namely: operating beyond the conduit role and assuming responsibilities typically associated with doctors such as assuming the providers' communicative goals by initiating information-seeking on behalf of a provider independently of the provider (Hsieh, 2007:930); deciding whether information has medical value and editing or discarding one they do not value from the interpretation (Hsieh, 2007:927); and volunteering medical information (Hsieh, 2007:934). The idea that medical interpreters go beyond the conduit performance is also supported by Angelelli (2004) who explored the role of invisible interpreters in the medical setting. According to this study, the visibility of the interpreter is measured by the degree of participation

in the interaction. Angelleli (2004:88) found that interpreters usually display an array of either minor or major visibility in contrast with invisibility (conduit) performances. In displaying minor visibility, the interpreters participate during conversational openings by introducing themselves to participants as helpers; and in closings where they close with their own remarks not provided by doctors. Since these lines are the interpreters' constructions, they have total control over that part of the discourse (Angelleli, 2004:88).

In most cases, interpreters were found to display major visibility in the consultations (Angelelli, 2004:88). During the body of the interaction, interpreters were found to produce their own lines and manage the flow of the conversation by managing overlaps. They were also found to volunteer explanations where they deem it necessary and demand clarity and responses on behalf of patients where patients do not do so. By so doing they became active contributors to the conversation because they added significantly to the interlocutors' messages (Angelelli, 2004:97). These interpreters obviously perform in a manner that is totally deviant from the conduit model of interpretation.

Various reasons have been given to explain interpreters' deviation from the conduit role. According to Deumert (2010:57), informal interpreters' lack of training and having shared linguistic resources with patients make them feel responsible for the welfare of their clients. As a result, they sometimes redefine their roles to those of educators and reshape messages in attempt to be polite and give hope to the patient. More reasons are found in Hsieh (2006:723), who shows that interpreters find it difficult not show emotions. On top of that, they feel that they need to advocate for the patients and ask questions where they feel that the patient has not asked the right questions.

Hsieh (2006:723) further shows that in some cases interpreters cannot avoid being active contributors because either providers or patients direct certain questions to him/her as a confidante. This leaves him/her with the responsibility to respond to the question and therefore become one of the contributors. Participants direct questions to the interpreter in cases where their cultural background bars them from understanding each other. The interpreter in such contexts becomes the facilitator of understanding not just language.

Research on medical interpreting (Drennan and Swarts, 2002; Hsieh, 2005; Dressler and Pils, 2009) has discovered that in most regions there are no formally trained medical interpreters therefore medical institutions use untrained informal interpreters. Dressler and Pils's (2009) research, conducted in post accident rehabilitation centre in Austria, and Deumert's (2010) research, carried out in three hospitals around the Cape Peninsula, established that there was no formal interpreting in both contexts, therefore, bilingual support staff such as kitchen staff, cleaners, security personnel or in some cases even family members were used as interpreters. Drennan and Swarts (2002) add nurses and other patients to this list of informal interpreters while Green et al. (2005:2107) found that in London, there are bilingual youth who act as health care interpreters.

While there is a general consensus on the need for interpreters in language discordant settings, the use of informal untrained interpreters has been associated with several problems. Deumert (2010) observe that unprofessional interpreting practice is marred by questions of quality which seriously affect health care outcomes such as history taking, diagnosis, patient education and informed consent. Dressler and Pils (2009) found one of the main problems in unprofessional interpreting to be the fact that these interpreters are untrained, therefore, their interpretation is usually flawed with mistakes because they are not aware of the institutional implications of certain linguistic constructions (Bührig and Meyer, 2004:51). Specific mistakes are found in Elderkin-Thompson et al. (2001), who show that ad hoc interpreters were found to usually misinterpret questions. In another study (Bührig and Meyer, 2004:48), it is reported that ad hoc interpreters were found to alter doctors' utterances in a way that changed the communicative purposes of such utterances without realising it because they were ignorant of the communicative force of those linguistic constructions. For example, Bührig and Meyer (2004:51) found that when explaining the medical procedure that would be done on a patient, doctors use they construction "they want to" in order to communicate it as a planning phase to which the patient can give opinions. However, interpreters were found to change the doctor's modalities from "they want to" to "they will" thereby altering the communicative function of the utterance. By using "they will", the interpreter makes the procedure sound finalised and does not give a patient an opportunity to participate in decision-making. Ad hoc interpreters were also found to make mistakes in other aspects such as translating

medical terms because there is no direct equivalent in the target language, the use of deictic expressions and personal pronouns (Bührig and Meyer, 2004:52-55).

Other complications were observed in London where Green et al. (2005:2104) found that many health care professionals reported dissatisfaction with the use of children as ad hoc interpreters because they do not have enough sophistication to deal with health problems such as maternity issues. The use of nurse interpreters was also found to be problematic in that they were found to usually censor the information and provide information they thought the physician needed. These omissions and editing usually led to misdiagnosis (Elderkin-Thompson et al., 2001:1350).

More problems regarding unprofessional interpreters are mentioned by Fatahi et al. (2010) who shows that it is inappropriate to use friends or relatives to interpret, because they are too emotionally involved to be impartial; and they can find the hospital situation stressful, which could hinder quality interpretation. Using bilingual staff as interpreters is also problematic in that their involvement as interpreters causes interruptions to the general workflow of the concerned medical institution because these people are employed to do other jobs that they have to neglect in favour of interpreting (Fatahi et al., 2010). In addition to this, Dressler and Pils (2009) points out that these staff members are sometimes unavailable or off–duty when they are needed to interpret because interpreting does not fall within their terms of reference.

Although there are problems associated with the use of informal interpreters, researchers concede that interpreted medical interactions are characterised by positive health outcomes. Fatahi et al. (2010:776) observes that in a clinical interaction mediated by an interpreter with linguistic competence, quality style of interpreting and awareness of culture, positive health outcomes are achievable. This implies that not using interpreters when they are obviously needed, compromises the quality of health care. Wiener and Rivera (2004:94) for instance shows that when there are no medical interpreters, patients lack understanding of the medical encounter in general, therefore they are less satisfied and less compliant than in interpreted consultations. In another context, Drennan and Swarts (2002:1858) established that when interpreters are not used in psychiatric health institutions, psychosocial assessment is compromised and there are high chances of misdiagnosis and faulty prescriptions.

Despite the obvious worth of interpreted consultations, some researchers have established that in some cases health care providers do not use interpreters (trained or untrained) even when they are necessary. This is reported in the findings of Wiener and Rivera (2004) who report that physicians were reluctant to use interpreters because they felt that the triadic nature of interpreted consultations violates doctor-patient confidentiality, compromises patients' trust and unnecessarily prolongs consultations, while in Dresler and Pils (2009:1184) physicians argued that interpreters increase the cost health care. The idea of length and cost is also found in Fatahi et al. (2005) who argues that interpreted consultations are long due to the fact that finding the right words takes time; and trained interpreters in Sweden are rare and expensive. These findings also correspond with those of Drennan and Swarts (2002:1857) who found that even where it was obvious that a patient had limited proficiency and therefore required an interpreter, the provider opted rather to have the patient communicating limitedly than to use an interpreter. In consultations where interpreters had been used, the file did not mention or even acknowledge the interpreter which would mean that the interpreter was not an absolute necessity.

In other cases interpreters were used but the experience was not conducive to improved health outcomes because it culminated in conflicting role performances by doctors and interpreters. Hsieh (2010) discusses these conflicts that are seemingly caused by differences between physician and interpreter training. According to Hsieh (2010:156) the interpreters' style of using specialised speech practices used to reinforce a dyadic interaction and stay invisible such as the use of a first person style, simultaneous interpreting and nonverbal behaviours like avoiding eye contact with the participants, which are meant to stop the patient from focusing on the interpreter, were perceived as disruptive and disrespectful by some doctors. In some cases doctors also complained of instances where interpreters asked for more information that the provider requested or initiated comments that were not said by the provider thereby overstepping the medical expertise and boundaries (Hsieh, 2010:157). In these cases then the interaction ended with lack of cooperation between the interpreter and physician, which clearly compromised patient care.

Other challenges in interpreted consultations are caused by the medical domain itself and the communicative styles and behaviours of both doctors and patients. In a study carried out in London, Green et al. (2005) found one of the challenges faced by youth interpreters to be the

deficiency of medical terms in their mother tongue therefore rendering interpreting difficult. Doctors complicated matters by using words that are not available in Bangladeshi or Vietnamese. In some cases the doctors interrupted the interpretation by using disapproving verbal gestures. The patients were also found to be disruptive to the flow of the conversation because they either argued with or whispered to the interpreter in the middle of the interpretation. All these behaviours compromise the quality of the interpretation and therefore the quality of health care.

However, there are other interpreted consultations that have been found to be successful. According to Hsieh (2010) the success of an interpreted medical encounter depends on the participants' ability to understand each other's goals and to be cognisant of each other's needs in the communication. In a study aimed at assessing the accuracy of interpretations in a US hospital, Elderkin-Thompson et al. (2001) found that in successful encounters, physician and interpreter worked slowly to understand the patients' opening comments. The physician also frequently explained his/her perception of the problem thereby allowing the interpreter to confirm with the patient whether the patient has been understood. The physician and interpreter were emphatic and the interpreter use minimal editing. The success of the interpretation also resulted from the physicians use simple sentence that were easily interpreted and understood by patients, while the interpreter avoided multiple questions (Elderkin-Thompson et al., 2001:1350).

2.6 COMMUNICATION IN HIV AND AIDS CARE

While language discordant clinical interactions already pose communicative challenges, when such interactions are on HIV and AIDS the challenges are likely to be intensified because of the increased communication demands. According to Airhihenbuwa (2000:5), the communication demands in HIV and AIDS care are different from those in the treatment of other diseases because HIV and AIDS care emphasises prevention and self-care. This creates a demand for providers and patients to communicative effectively in order to help each other in controlling the pandemic. It also creates the need to periodically, critically evaluate communication approaches and strategies about HIV and AIDS. This view is shared by Anthonissen and Meyer (2008) who observe that in HIV and AIDS care communication is needed to monitor patients understanding of the disease and their ability to follow a rigid treatment protocol. On top of that, in some instances HIV and AIDS

does not have explicit physiological manifestations therefore, in order for providers to give adequate treatment and care, there has to be effective, communication between them and their patients (Anthonissen and Meyer, 2008:2).

2.6.1 Adherence Communication

Successful management of HIV depends largely on patient adherence to treatment, which in turn is governed by patient understanding of the condition and treatment thereof. Research on communication on HIV and AIDS (Roberts and Volberding, 1999; Barford et al., 2006; Bharath-Kumarr et al., 2009) has established a correlation between adherence and success of treatment. In fact Dahab, Charalambous, Hamilton, Fielding, Kielmann, Churchyard, and Grant (2008:2) regard adherence as the strongest predictor of treatment success, which makes it crucial for health care providers to discuss adherence with patients who are on ART.

The correlation between adherence and positive treatment outcomes is further evidenced in the study of Roberts and Volberding (1999:477-478). In this study, the physicians interviewed are reported to agree that good provider-patient communication about expected treatment outcomes and side effects is believed to positively impact on patient adherence. These physicians subscribed to the notion that patients who get enough information about their treatment and feel that they are listened to, have a tendency to adhere to the proposed treatment, while those who received inadequate information and do not understand during the consultation are likely not to adhere. This implies that adherence communication improves the compliance of patients with ART; therefore spending time on adherence communication is a good investment (Roberts and Volberding, 1999:479).

In cognisance of the significance of adherence communication in HIV and AIDS care, Roberts and Volberding (1999) report on a model through which communication between health care providers and patients can be enhanced to improve and guarantee patients' sustained adherence to treatment. According to Roberts and Volberding (1999:1772), this adherence communication model has three stages. The first stage is the "readiness evaluation stage, in which providers and patients discuss patients' willingness to begin therapy. This is followed by the "initiation stage" where providers discuss with patients the potential barriers they may face in adhering to their regimens as well as

characteristics that may contribute to their success. The final stage is the "maintenance stage," where providers and patients communicate about the efficacy of the anti-retroviral treatment regimens, in order to change patients' therapies per need. Roberts and Volberding (1999:1772) add that this model can guarantee effective adherence communication between providers and patients. However, they note that the success of this model depends on the providers' willingness to play a role in adherence communication.

The success of adherence communication can also be achieved by adjusting physicians' communicative styles. This is seen in a study intended to explore communication patterns and difficulties among physicians who work on patients' adherence to treatment in Copenhagen and San Francisco by Barford et al. (2006), who reports on how physicians enhanced adherence communication with their patients. These physicians were found to create a friendly, trusting atmosphere with their patients. This was done by using informal body language, slang, passing jokes and asking about private matters prior to asking about adherence. Then adherence questions were popped without warning. The question styles used were either open ended such as "How are u doing with the medication?" or suggestive such as "How many doses have u missed?" This way of communication was found to make patients be honest about their adherence or lack of it; therefore it guaranteed effective communication on adherence (Barford et al., 2006:8).

Even though there is general agreement (Roberts and Volberding, 1999; Barford et al., 2006; Bharath-Kumarr et al., 2009) about the necessity of adherence communication in HIV and AIDS care, in practice such communication is not always achieved in clinical consultations. This observation is shared by Barford et al. (2006:4) who show that adherence communication and joint decision-making about treatment were rare in that study. This is supported in Bharath-Kumar et al. (2009:449) who observe that adherence communication and individualised client education is inadequate in most African settings.

The most common barrier to adherence communication identified by Roberts and Volberding (1999:480) and Barford et al. (2006:4) is inadequate time. Physicians in the studied health facilities are usually expected to consult many patients at any given day. They therefore prefer to keep the consultation as short as they can in order to accommodate other patients. This rules out the

possibility of adequately engaging in adherence communication because it demands a lot of time. On top of that, the health centres do not have enough financial resources to employ enough adherence counsellors to cover all patients. This hampers the success of adherence communication and impacts negatively on patients' adherence to treatment (Bharath-Kumarr et al., 2009:449).

Adherence communication has also been found to be hampered by the fact that patients sometimes present acute health problems to the physician (Roberts and Volberding, 1999:480). In such cases the physician is usually overwhelmed by the acute problems and the topics of the consultation are structured around the presented acute problems to the exclusion of adherence communication in the consultation. In other cases (Barford, 2006:7) the physicians excluded adherence communication because they felt it will be awkward to ask the patients about adherence since the patients looks believable and does not show any signs of potential non-adherence. This implies that the patients leave the health care centre without having been made aware of the consequences of non-adherence.

Adherence communication is not the only HIV and AIDS related communication that has challenges, even communicating about the disease in general is problematic. This can be seen in the fact that effective communication is difficult to achieve in HIV and AIDS consultations, despite its well-known significance in HIV and AIDS care. This observation is shared by Anthonissen and Meyer (2008:1) in their analysis of HIV and AIDS consultations in the Western Cape Province where they report an impression of some communication dilemmas among doctors and patients. These challenges and dilemmas stem from the fact that a discussion on HIV and AIDS entails some topics that people find difficult to talk about (Curtis and Patrick, 1997; Ajoulat et al., 2002).

2.6.2 Difficult Topics to be Discussed

One of the topics people find difficult to engage in is the prospect of death (Ajoulat et al., 2002:213). This topic, according to Ajoulat (2002:217) and Ijadunola (2007:80) is uncomfortable and difficult to discuss for both health care providers and patients alike because it is a disturbing topic for all role-players. In their analysis of the communicative difficulties experienced by health care providers and family care-givers of people living with HIV and AIDS, Ajoulat et al. (2002:219) found that both health care providers and care-givers prefer not to discuss death with

the patient because they believe that if they do not talk about death, the patients will fight and struggle against the disease. This finding is consistent with one in an earlier study by Curtis and Patrick (1997:737-738) where it was revealed that both physicians and patients find it uncomfortable to talk about death in HIV and AIDS consultations. The main reason providers gave is that they feel that by talking about the prospect of death, they are taking away patients' hope of fighting the disease, which will in turn have negative implications for patients' adherence to treatment. In another study carried out in Zimbabwe, De Baets et al. (2008:483) found that HIV and AIDS positive parents prefer their status not to be disclosed to their children just to protect the children from a discussion on the prospect of death. The fear discussion of death from all role-players is therefore likely to pose communication challenges in HIV and AIDS clinical consultations.

Sexuality is another topic embedded in HIV and AIDS discussions that providers and patients find difficult to discuss (Ajoulat et al., 2002:217). This observation is supported in Helleve et al. (2009:197) who note that communicating about sexuality and sexual behaviour in general is out of the norm and it goes against most cultures, particularly if such discussions are cross-generational. This situation poses a dilemma for providers and patients in HIV and AIDS consultations, where there is a need to discuss sexual behaviour and suggest sexual behavioural change to curb re-infection and further transmission of the virus (Ajoulat, 2002:217).

Another barrier to communication in HIV and AIDS consultations is the stigmatisation that is associated with the disease. Observations made by Curtis and Patrick (1997) in America; and Ijadunola (2007:77) in Nigeria show that the disease bears a social stigma which makes people reluctant to open up about their status or to be associated with HIV positive people because they do not want to be isolated by the community or to be socially discriminated against. According to Kohi et al. (2006:404), this stigma and discrimination against people living with HIV and AIDS results from lack of understanding about the disease.

The stigma and discrimination against people living with HIV and AIDS continues to happen despite increased awareness about the disease (Ijadunola et al., 2007:78). In a study carried out across Malawi, Lesotho, Swaziland, Tanzania and South Africa, Kohi et al. (2006) established that

the stigmatisation towards people living with HIV and AIDS in these countries results in violation of such patients' human rights. For example, they report on cases where such patients are denied access to certain medical procedures and are verbally abused by medical staff because health care workers presume such patients to be already on the way to death or because they are judged as sinners. Kohi et al. (2006:408).

If people living with HIV and AIDS are negatively perceived by health care workers, it is likely that communication problems will arise and the quality of health care will be compromised. This is seen in Ijadunola (2007:80) where 29% of physicians admitted that they had a negative attitude towards people living with HIV and AIDS, therefore they would consider giving them an early discharge from hospital to protect other patients. These physicians also admitted that contrary to their patients' expectations, they do not communicate to patients about matters related to treatment options, living positively and treatment side effects. This compromises patients' adherence to treatment.

Language discordance adds another challenge to HIV and AIDS care communication. This attested to by Stone (2004:402), who notes that in language discordant HIV and AIDS consultations minority language speakers are usually less satisfied because they have trouble comprehending the doctor's message and they also feel that they are not listened to. They therefore experience problems trying to adhere to the treatment due to lack of understanding and being less involved in decision-making about treatment options. This is consistent with Enriquez et al. (2008:296) who report that because of the language barrier, Hispanics in the US have a high prevalence of HIV and AIDS and they also record low adherence rates because of prior of lack of understanding of their treatment regimens and how they work. It should be noted that however, that in another study in the US Korthuis (2008:2049) found that communication health care providers and HIV positive Latino minority patients was rated higher than that for whites. These minority patients reported that their physicians explained things in a way they understand and their physicians also spent an optimal amount of time with them in consultations. However, Korthuis (2008:2051) concludes that this observation changed when they changed the hospital profile, which suggests that it is not generalizable.

In order to enhance communication in language discordant HIV and AIDS consultations, Stone (2004:402) suggest that more time should be spent on attentive listening to HIV and AIDS patients and providers should enhance patient understanding by enquiring about patients' comprehension. An additional strategy is suggested by Stone (2004:403) and Enriquez et al. (2008:298), who advocate for the use of bilingual health care teams. Enriquez et al. (2008:299) report that the introduction of a bilingual/bicultural medical team for Hispanic/Latino adults who received care in an HIV care clinic in the US resulted in the increase in the number of outpatient visits and a decrease in patients' viral loads. In addition to that, consultations became shorter and there was lesser demand for interpreters. This further resulted in patients' improved understanding of HIV treatment, adherence and increased patients trust of the health care system.

2.7 CONCLUSION

The literature overview shows that provider-patient interactions, regardless of linguistic diversity, demand more care in their planning and performance than ordinary conversations do. It has indicated what the value of OT may be in understanding where in the process of diagnosing and treating HIV and AIDS, difficulties are likely to be encountered. In addition, it has indicated what the frameworks of TA and QCA can contribute to an investigation of multilingual experiences in health care. The relations between various participants in the clinic demand that HCP-patient discourses be structured in a way that is conducive to patient understanding and be handled in a manner that is sensitive to cultural difference. These demands seem to be intensified in consultations where there is language discordance between providers and patients, particularly if such consultations are about HIV and AIDS care. The literature dealt with in chapter 2, however, does not account for scenarios where doctors are speakers of a minority language and treating speakers of a majority language. The literature is also scant in accounting for communication in the treatment of diseases such as HIV and AIDS that are stigmatised and culturally not easy to communicate about. These gaps in knowledge have formed the basis and justification for the present study.

CHAPTER 3

ORGANISATION OF COMMUNICATION IN HIV AND AIDS CARE CENTRES

3.0 INTRODUCTION

This study investigates the communicative experiences of health care providers and patients in health care centres where they operate with a variety of linguistic resources which are often dissimilar and not mutually intelligible. This chapter addresses the first objective of this study which is to establish how particular multilingual health care institutions organise the care process and the coinciding communicative processes in testing, counselling and providing HIV/AIDS treatment (see sections 1.4.2 and 1.4.3). The chapter presents findings on the organisational structure of the care and communicative processes in the two care centres. This structure is interpreted on the basis of OT literature discussed in Chapter 2. The results presented in this section are based on data collected through observations of the trajectory of care and communication in the two clinics. Interviews and focus group discussions contributed in confirming such observations. Literature about the clinics in terms of information pamphlets was also collected during these observations. Observations were recorded as field notes which were used in the analyses. In the analysis aspects of the organisational framework were scrutinised and assigned to two broad categories derived from SPO components detailed by Zin and Mor (1998). These were the structure (S) and process (P). When all the aspects were classified, two main processes were identified as recurrent in the overall organisation. These were the care process and the communicative process.

3.1 HC-A AND HC-B AS ORGANISATIONS

Observations of the overall organisation of care and communication in the two clinics reflect typical characteristics of organisations as detailed in the literature on OT discussed in *Chapter 2*. According to Jaffe (2001:19), the first aspect that characterises an organisation is that it should have a clear goal that it is meant to achieve. Observation results from the two clinics showed that the clinics have a clear medical goal articulated in the Lesotho National ART guidelines as "to halt the progression of the HIV and AIDS epidemic, to increase the number of people who receive the care and treatment they need and to improve the quality of care available".[7] In both clinics, also based purely on the establishment of and allocation of resources to the clinics, it was clear that there is a specific organisational structure tailored by both the resources available and a particular goal intended to be achieved.

3.1.1 Organisational Goal

A look at literature from the two health care institutions, in the form of informational pamphlets, clarifies the basic goal of each of the centres namely specifically to offer patient care. On the one hand, information from a pamphlet about HC-A shows one of the core goals of this centre as to "provide continuum chronic care for People Living with HIV, AIDS patients and TB patients issuing treatment, such as ARVs, TB treatment and treatment for other opportunistic infections" (*unpublished pamphlet, produced by clinic*). On the other hand a pamphlet about HC-B states its main goal as to "offer day care and treatment for people living with HIV". These extracts from informational pamphlets show that each of the centres has a specific medical goal. The goals are related and they are relevant to what is determined by the Lesotho National ART guidelines. Although the goals do not explicitly state communication as a component of care, it goes without saying that in order for care to be achieved, there has to be effective communication among HCPs and patients. This goal is acknowledged by interview data of the HCPs who participated in this

[7] Lesotho National ART guidelines. p.10.

study in that they often explicitly refer to patient care as their core business, and otherwise implicitly allude to patient care as the core of the work they do.

Besides care of the physical aspect of illness to the clinics are also organised to take care of patients' psychological welfare. Interviews with physicians D1 and D2 acknowledge the aspect of psychological care as a component of HIV and AIDS treatment. Observation of the trajectory patients follow in the clinics confirmed that these two aspects of patient care are addressed directly in the structural organisation of the two clinics. The psychological welfare of patients is taken care of primarily by the counselling units, whereas medical care and treatment is done collectively in the physician's consultation and in interaction with the pharmacy.

It is apparent that patient care is multifaceted and to achieve such a multifaceted goal, a clinical structure has to be equally segmented, with different individual elements working together to achieve the common goal. This is consistent with the perception of an organisation as documented in the works of Katzenbach and Smith (1993:41), Robin (1983:33) and Jaffe (2001:19) as shown in Chapter 2.

In order to ensure adequate patient care, HCP participants reported that in their execution of their primary task they make sure that patient understanding and patient satisfaction has been achieved. The significance of patient understanding as, introduced in sections 2.6.1 and 2.6.2, is documented in Schouten et al. (2009:468) and Deumert (2010:4) who established a relationship between lack of patient understanding and patients' defaulting on treatment. In the same way, physicians who participated in this study mentioned patient understanding as an important consideration in achieving their goal of sufficient patient care.

Along with patient understanding, physicians also mentioned patient satisfaction as an important goal. This quest for patient satisfaction is in line with previous studies such as Rivadeneyra et al. (200:470) who have associated patient satisfaction with good adherence to treatment and therefore positive health outcomes. When physicians in these two health care centres express concern for organisational goals that their patients understand their condition and the treatment thereof, and

should be satisfied with their experience at the clinics, they are in fact also showing concern for adherence to medical protocols in the treatment provided.

From this discussion of the organisational goals of the two health care centres it becomes apparent that they have the characteristics of organisations as set out in OT. The members of these organisations are aware of the primary goal and its manifestations in the treatment of both psychological and physical health problems. They therefore have developed strategies that realise the goal, and they have a set of indicators for the evaluation of whether the goal has been achieved or not. Patient understanding and satisfaction are two such indicators.

The core tool that the two clinics use to achieve their goals is communication. The relationship between effective communication and adequate patient care as well as positive health outcomes has been attested in past research such as Harrington (2004:9). There is a proven correlation between effective communication in medical consultation and patient satisfaction. Observation of communicative practices in the two clinics and participants' descriptions of their experiences show that communication is a very important aspect in HIV care in both of the sites of this study. In what follows the organisational structure of the two clinics and how this functions to achieve effective communication aimed at adequate patient care, will be set out.

3.1.2 The Structural Organisation

The overall organisation of the two clinics reveals that two of the three components of Zin and Mor's (1998) SPO model discussed in section 2.1 recurred in the data. Aspects that this model classified as *structure* are described in terms of the unit in the consultation process, the participants involved in each such a unit, the linguistic and communicative resources available for use in each unit. The *process* element includes the complete medical care trajectory through which patients progress from their entry into each clinic through to their exit either as HIV-negative or as HIV-positive and then moving through various stages of treatment; the communicative processes and communicative content associated with the care trajectory are included in the process. The *outcome* component in these institutions would refer to the treatment outcomes. However, as clinical responses to treatment were not included in what this research addressed, the treatment outcomes are not organisationally assessed here. The *structure* and *process* components are

important in that they are a reflection of both the institutional responses to language diversity and the communicative events that evolve out of the organisation.

Zin and Mor (1998:355) describe the structure of an organisation as an aspect that consists of the staff, their skills and credentials together with all other facilities and resources like the infrastructure and inputs used in the daily operation of the organisation. An analysis of the filed notes and descriptions of clinical staff yielded a division of the overall organisation into three structural phases of the consultation process. These phases are: the pre-consultation phase, which is a phase that prepares for the physician's consultation; the physician's consultation, which is the central service point where patient history is evaluated, diagnosis is made and treatment recommendations are made. It is also at this point where it is decided whether a patient should start ART or not. Then there is the post-consultation phase, which prepares patients for care at home. Here the patient is taught about behavioural change and proper use of, and adherence to, medication. Each of these phases has different consultation points that mark the services rendered at each point. The results show that these consultation phases vary in terms of the communicative and care goals, participants found in them, the linguistic resources available for use and prevalent modes of communication.

3.1.2.1 The Pre-Consultation Phase

In the field notes on my observations and in clinical staff's description of this phase of the consultation, a recurrent theme was the organisation of the care centre into different service points. The service points identified from these descriptions and observations as part of the pre-consultation phase are the reception, the testing unit and the history-taking room. While all patients go through the reception and history-taking room, testing is only done for first-visit patients in the clinic. From the reception, first-visit patients are directed to the counselling and testing centre, where they will be counselled, tested and counselled again, while subsequent-visit patients are directed from the reception to the history-taking room.

The pre-consultation units jointly serve as information-giving points on entry into the clinic. The medical purpose of the pre-consultation phase at reception is to prepare patients for the

introductory councelling and tests and for the medical consultation. At the reception the main goal of communicative activities is to gather basic information about the patient, to register new patients, to organise patients' files in preparation for consultation with the physician, to give basic information on procedures that patients have to follow, and to give directions on where they should go in moving from one unit to the next. At this point patients are also given printed, visual and multi-media educational information on HIV, AIDS and TB.

More information exchange is done in the testing unit and history-taking room, where a specific intention is to give HIV, AIDS and TB education on a one-to-one basis. An important function in pre-consultation phase is to collect bio-physical information about the patient. In essence, it can be said that the pre-consultation phase is an information resource division of the clinic. It is a vital component of the care process, particularly considering that here there is much communication between L1 speakers of Sesotho, but at a later stage when patients meet the physicians, they limitedly share linguistic resources.

Apart from composition into different service points, the pre-consultation phase can also be described in terms of the participants who are engaged in care and communication. Zin and Mor (1998:355) show that as part of the structure, participants who work in the organisation are described in terms of their skills and credentials that are relevant to their daily tasks. Services at the pre-consultation phase are rendered by nurses and administrative staff.

Another structural feature that is descriptive of this phase is the linguistic resources available for communication. The nurses, administrative staff and patients are mostly L1 speakers of Sesotho and L2 speakers of English. Sesotho is therefore the language that is predominantly used in this phase. This is an interesting feature of these multilingual clinics, because it marks how the organisation into different units is functional for both medical care and communication. The fact that information dissemination at this initial stage is done in the patients' mother tongue has positive implications for patient understanding of their condition.

Given the fact that this phase is an information dissemination section of the two clinics, mode of communication becomes a crucial aspect in the description of its structure. Information is delivered in three modes namely the verbal, printed and audio-visual mode. Direct observations made during site visits revealed that themes addresssed verbally between staff and patients in this education phase are how HIV and TB are transmitted, how further infections can be avoided, how to live positively with HIV, and how to engage in safe sexual conduct.

The second mode is the printed mode of communication. The researcher observed printed pamphlets and posters that patients get in the clinics, and also, in interviews and focus groups, heard how participants refer to these. The printed material are a salient part of the linguistic landscape of the two clinics. From the entrance of the clinics all the way through one finds several manifestations of this mode of communication, which assumes literate patients. Pamphlets, posters and notices that target a patient-audience carry messages with directions, procedures, and the causes, symptoms and treatment of HIV and AIDS.

The third mode of communication typically used, is the audio-visual mode. According to nurses' accounts of the communicative practices in the clinic, sometimes HIV and AIDS related information is circulated through videos that patients watch in the reception area. These videos are educational movies that primarily warn people about risky sexual behaviour. According to the nurses these videos are in Sesotho. The videos are an asset to health care providers because of their ability to address sexual health information in an explicit manner which cannot be done by the nurses in face-to-face interactions. This audio-visual mode of communication was operative only in the reception area while the conversational and literary modes were used throughout the whole consultation process as will be seen in later discussions.

In general the pre-consultation phase is a useful resource in a multilingual clinic like the two studied. The information-giving function of this phase may remove potential misunderstandings or communication gaps that could crop up in the later language discordant communicative events where patients and physicians meet. This phase also serves as a foundational phase where patients are equipped with information that would benefit them with regard to self care. Although the principal goal of this structural part of the organisation of the clinic is to harmonise care, it also

facilitates communication processes that are organised according to that central goal. Here shared linguistic resources between HCPs and patients are invoked. There is a distinct difference in forms of communication in this phase and those required in the later phase when patients and HCPs such as nurses meet in consultation with the physicians who are not L1 speakers of Sesotho.

3.1.2.2 The Physician's Consultation.

The physician's consultation can be described as the peak of the medical care process in the organisation. In the physicians' consultation the main purpose of communication is to make decisions about the clinical stage of a patient and recommend treatment. Communication at this consultation point is characterised by detailed accounts of the health complaint by the patient. These accounts are solicited by the HCP, who is reported to probe until sufficiently detailed explanations are given. These explanations are later analysed together with the information compiled in a patient file, in order to ascertain a diagnosis and suggest a proper treatment plan. If the patient's information suggests that the CD4 count is low, ART is recommended and the patient goes to the post-consultation phase of the consultation.

According to participants' descriptions most consultations between patient and physician involve three parties namely the physician, patient and an interpreter – who may be formally or informally engaged. In HC-A interpreters may be any one of three categories of staff functioning as bilingual lay interpreters, namely interpreters nurses and the receptionist. If no appointed interpreter or bilingual nurse is available, the receptionist is called in as informal interpreter. In HC-B a nurse is present duirng the consultation, also to assist with interpreting. Although the interpreting services function mainly as a communicative bridge between physicians and patients, who in most cases have incompatible linguistic resources, experiences of some of the participants show that sometimes even patients who can speak and understand English prefer to use interpreting services.

It is at this point of the organisational process that language discordance between patients and physicians is prevalent. This is because physicians in both clinics are not LI Sesotho speakers. English is therefore predominantly used for interaction, with traces of Sesotho where a physician has some proficiency in that language.

The mode of delivery of communication at this phase was observed to be predominantly conversational, therefore verbal. However, physician's reports also show that in cases where they feel that their patients do not understand them they often draw pictures to enhance their descriptions. This means that the visual and textual mode of communication among participants sometimes becomes a feature of this phase.

3.1.2.3 The Post-consultation Phase

The physician's consultation is followed by the post-consultation phase. This phase of the consultation consists of the Pre-HAART (Highly Active Anti-Retroviral Treatment) counselling unit and the pharmacy. This phase is generally meant to equip patients with knowledge to prepare them for self-care when at home. At the counselling unit patients are taught by a professional councellor or designated nurse about the pros and cons of ART. They are also taught about the benefits of good adherence and safe sexual behaviour. This phase is therefore characterised by intensive information-giving by the counsellors and nurses. Patients contribute by asking questions and soliciting further explanations where necessary. Post-consultation patients will meet an L1 Sesotho speking nurse who palys a pharmacist role and dispenses the medication.

Since services at this point are given by nurses and counsellors who are Sesotho speakers, the organisational framework of communication is not very different from that in the pre-consultation phase. In general it can be said that communicative processes in these two phases have similar characteristics in terms of the number of participants involved in the consultation and the linguistic resources that are used. The only difference is that at this point there is intensive counselling that takes place in order to prepare patients for life-long treatment.

Observations show that an important aspect of the structure is the fact that both clinics have staff ranging from administrative staff, health care providers and, in the case of HC-A, interpreters. Because of language diversity in the clinics, clinical staff also doubles as interpreters facilitating communication between physicians and patients. The availability of different cadres of staff with diverse qualifications and experiences is helpful in the attainment of overall care since HIV and AIDS care has different components.

A closer look at the staff roles shows an element of employee multi-functionality as explained by Huang et al. (2011) and referred to in section 2.1 The staff in the two clinics, perform at least two other functions, in addition to their normal duty, namely transmitting information and interpreting. This ability to perform multiple tasks requires the staff to be flexible to meet patient needs. The following table shows the extent of employee multi-functionality in the two health care centres:

Table 3.1: Employee Multi-functionality

Staff categories	Secondary duties
Physicians	Counselling
Nurses	Interpreting Counselling Information transmission Pharmacists Co-diagnosticians
Counsellors	Interpreting
Receptionist	Interpreting

This table shows that each cadre of staff performs at least one other function. The table shows that nurses perform more duties than the other categories of staff. In particular, nurses in HC-A and B explained that sometimes they become co-diagnosticians. This co-diagnostician role has been observed in a previous study by Hsieh (2007:932) who noted that interpreters did not explicitly state this but in describing their duties it became apparent that they participated in examining physical symptoms, identifying the specific illness and suggesting treatment.

Some of the nurses in the two clinics reported having in some cases participated in diagnostic roles and prescribing treatment, which in fact was altering the physician's prescription. Unlike interpreters in Hsieh's (2007) study who worked in collaboration with physicians, these nurses reportedly performed such diagnostic tasks by themselves, in fact even refuting what the

physicians have said or prescribed. *Excerpt 1 and 2* below were taken from descriptions of the experiences of some of the nurses in HC-A and B respectively

Excerpt 1

1.	**N2:**	Aee rona ha re na stress. Ha re bona hore ngaka ne re itse
		No, we dont have stress. When we realise that we had said
2.		Tje tje le tje ha a utloe rea ichenchela re mo chenchela Regimen
		something and the physician does not agree, we change the regimen
3.		re ngola ho nepahetseng ... Haeba mohlomong ke re o sa le ka
		we write the correct one. Say for example the patient is already at
4.		qetellong ka litlhareng, ha ke bona hore fela tje tje ke ngola li lipi a
		the end at the pharmacy, when I realise something I write slips for
3.		ee labong ke tlo ba sure hore ke reaction ea nevirapine ke mo fa
		the lab,to be sure it's a reaction to Nevirapine, I prescribe and dispense
4.		lithare oa tsamaea re na le tokelo ea ho etsa joalo
		medication, she/he goes ...

(N2 in HC-A)

Excerpt 2

1.	ua fumana hore joale ha a sa ngotse, 'm'e oa ka mona ka
	you find that when he has already written, the lady at the
2.	pharmacing o tla re: "mm joale le ngotse le le babeli, batho ba
	pharmacy will say : "mm, now both of you have written, two
3.	babeli ba se ba ngoletse motho a le mong lithlare? mm joale hee
	people writing a prescription for one person? Mm. Then I would
4.	ke ee be ke ngotse ha kere le nna? joale he ebe kea ka mane ka ho
	Have written too you see? Then I go to him
3.	eena ka mane ke re: "ak'u ngole hee ka handwriting ea hau e"
	and say: "write here with your handwriting",
4.	lenngoe. u ngole lithlare tsena tse ke li ngo tseng mona.
	you write the medication I have written here.

> 7. he never refuses because he knows that he does not hear the
> 8. language properly.
>
> **(N5 in HC-B)**

These nurses report on their taking on diagnostic roles and reasons why they do so. In these excerpts the nurses cite the physicians' incompetence in the language of the consultation as the reason why they end up taking on the role of a diagnostician. They therefore report to look at the prescription the physician has made for the patient and alter it according to what they think is the appropriate prescription. They then dispense medication according to their own prescription and seemingly ignore the physician's decision. While in HC-B the nurse reported to have sought the physician's endorsement of her prescription, in HC-A the nurse apparently did not do that. The nurse probably relies on her training and experience in HIV care in taking up a diagnostic role, although this is highly unconventional and goes against all accepted protocol. The two nurses who reported that they do this, have two common characteristics though they work in different clinics. Firstly, they are both older than the other nurses in their establishments. Secondly, they have worked in these clinics longer than their counterparts. The ability of the nurses to act multi-functionally is probably a result of communication processes that are far from optimal. They assume a role outside of their, most likely due to their perception that the physician has misunderstood the patient or the interpreter and that they need to act correctively. In *Chapter 5* I shall offer suggestions as to how this can perhaps be remedied.

This description of the structure of the clinics highlights three features that are pertinent to the organisation of health care communication and instrumental in accounting for largely effective communication in these multilingual contexts. Firstly, the division of the process into three phases ensures that patients get enough information in their mother tongue to supplement what they get in the physician's consultation. In this way, even communication gaps that would emerge in the physician's consultation due to language discordance are filled by such additional information. Secondly, the use of multimodal communication in the pre- and post consultation phases accounts for effective communication in that this approach accommodates all patient groups in information dissemination. Lastly, the inclusion of formally appointed or lay interpreters ensures a fairly high

level of achievement of communicative goals in the consultation with the physician where there would otherwise be greater threats to communication due to language discordance.

3.1.3 The Care and Communicative Process

The process component of the organisation of the two clinics was constituted of two basic processes that complement each other**.** The first one is the care process which is the main goal for which the two clinics were established. As mentioned in Chapter 1, the care process is tailored according to the specifications of the Lesotho National ART guidelines guided by WHO directives. The second one is the communicative process which facilitates the care process although it is not a main reason why care is organised as it is. These two complimentary processes work together towards the achievement of the primary care goals of the clinics.

3.1.3.1 The Care Process.

Direct observations made during site visits and participants' description of the process of care in the centres reveal an organisational structure and care process that is consistent with Barr's (1995:354) and Glickman et al.'s (2007:344) description of health care organisations. This body of literature describes health care organisations as constituted of care that is segmented across a range of sections that form the overall structure of the health care institution. The organisation of the two clinics studied here as and the different service points, each staffed by relevant professionals offering a service that constitutes part of the overall care process, is schematically represented in Figure 1 below

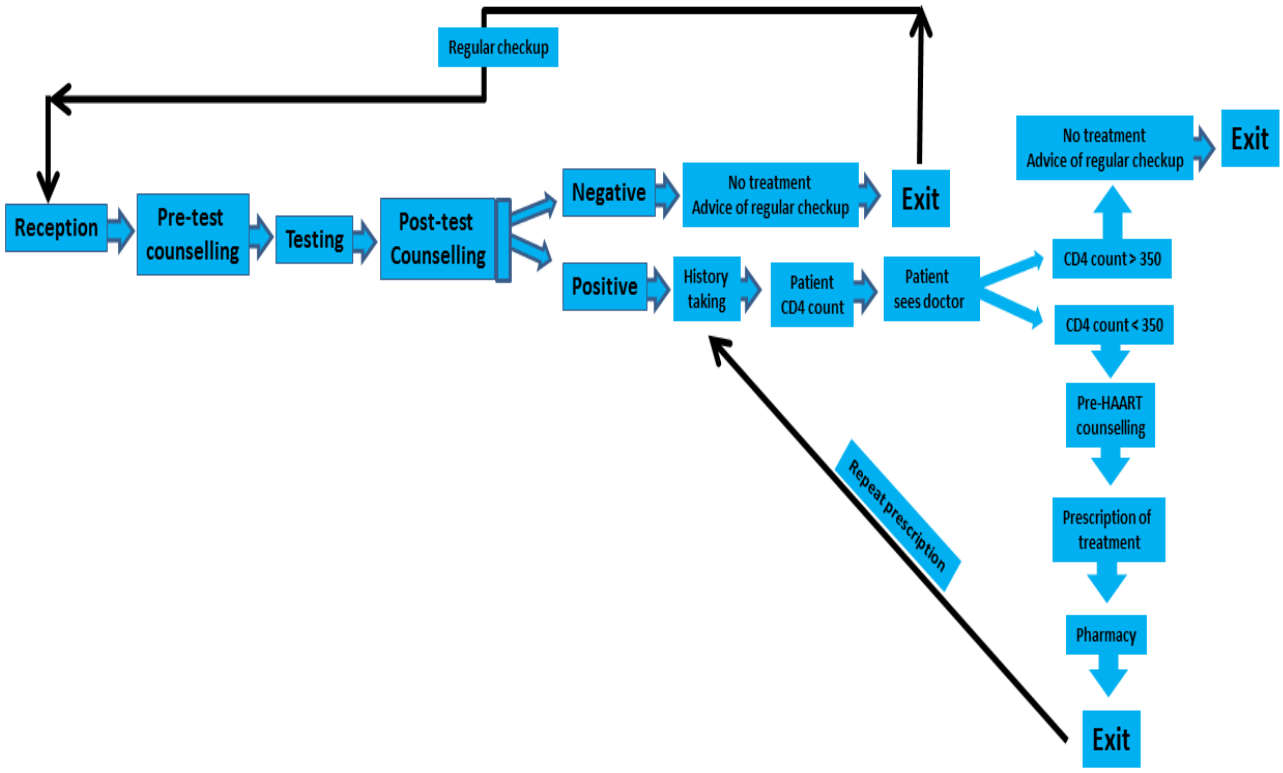

Figure 1: A Representation of the Organisation of Care at HC-A and HC-B

Figure 1 shows the complete process that patients go through, starting from the point of arrival at their first visit to the clinic, through each of the stages of care, whether they test HIV-negative and then exit without treatment, or test HIV-positive and then are taken into the system as a person with a chronic disease who will return regularly for continued medical care. Patients who come to HC-A come in two ways: (i) through referral from the OPD or other satellite clinics which they visited with a medical complaint and where concerns may have been raised, or (ii) through a process of voluntary visits with a view to being tested for HIV, in response to popular advice on the sensibility of early detection and "knowing your status".[8] Testing is always preceded and followed by counselling, either to encourage safe behaviour in the case of a negative test outcome,

[8] "Know your status" campaign was enshrined in the Lesotho National Strategic HIV and AIDS policy 2006-2011. Its purpose was to encourage widespread testing and counselling for HIV.

or to provide information and support in the event of a positive test outcome. In HC-B all patients come voluntarily for testing, as this clinic is not part of a network that would otherwise see the patients and refer them to this facility. In both clinics the patients' first point of communication is at reception, where they are registered by an administrative officer who directs them as to where they have to go.

First, patients will be directed to a health care provider (HCP), in most cases a professional HIV-counsellor with the relevant academic training, or a nurse who has had in-service training, for pre-test counselling before they are tested for HIV and given their results and advice on what the next steps should be. The test is done by the counsellor or nurse who did the pre-test counselling and the results come out immediately.

If a patient tests negative, s/he is given advice on how to remain negative by being given instruction on responsible sexual conduct and other measures that can protect him or her from being infected. The patient then exits the clinic with a recommendation to come for regular testing. When that patient comes for subsequent testing, the process begins at the reception again.

If a patient tests HIV positive, s/he goes to the history-taking room where his/her medical history is taken by a nurse on duty at that time. Then the patient will go to have his/her viral load tested and CD4 Count. If the CD4 Count is higher than 350, s/he is given counselling on how to live positively with HIV and will exit the clinic with a recommendation to come for regular check up, and to return in the event of any worrying medical condition such as a persistent cough or vomiting. When a patient comes back for subsequent check-ups, s/he starts at reception again, will be directed straight to the history taking room and will continue with the process from there. Eventually s/he is either given advice on care and will exit, or s/he is referred to a physician for attention to his/her specific symptoms.

Patients with a CD4 Count of less than 350 go to the physician's consultation room, where they are seen by a physician who in all cases is not a L1 speaker of Sesotho, and who may in some cases have limited or no proficiency in that language. Communicative events at this point are mostly in English, with an interpreter in some cases but not others. This is unless patients and physicians share some Sesotho. At this point the physician further scrutinises patients' medical

history and decides on a diagnosis. After diagnosis a treatment plan is suggested and medication is prescribed. The treatment plan is suggested in accordance with the standard treatment protocol in Lesotho, which was revised in 2007. The protocol states that a patient with a CD4 count of <350 needs to be put on ARV treatment (Cohen et al., 2009:5).

When a decision to put a patient on medication has been made, patients have to go for pre-treatment counselling which is done by a professional counsellor. Since at this point services are once again given by Sesotho speaking clinical staffs, communicative events are in Sesotho. In HC-A this form of counselling is called Pre-HAART (pre-Highly Active Antiretroviral Treatment) counselling whereas in HC-B it is called adherence counselling. This terminology is drawn from an interview with a nurse (**N1 at HC-A**) for HC-A and from the information brochure from HC-B .Although the labelling is different, attention to the information discussed with patients at this stage shows that they are of the same kind, with counselling focussed on diet sexual behaviour and empowering patients to live with a positive attitude towards HIV.

After this counselling, patients proceed to the pharmacy where they encounter a pharmacist who dispenses the medication and will ensure that the patient is informed on how and when to take the medication. In HC-A after having received their medication, patients exit the clinic, in most cases with a specific follow-up appointment arranged. The appointment entails a specific time and date in order to facilitate easier communication for follow-up visits at the reception, as opposed to first-visit patients. In HC-B patients are given advice as to their next visit to the clinic in the same way as appointments are arranged in HC-A, and then they proceed to get a free healthy lunch before they exit the clinic.

For subsequent visits the process of care starts at the reception again. Patients already on ART will go for CD4 Count testing, which is a laboratory test. In HC-A the test is done is done by a medical laboratory attendant in the hospital and the results are accessed on the same day, whereas in HC-B, the blood samples are taken to the district hospital about 30 km away, and patients come back for results at their next appointment. After the results have been interpreted, patients go through counselling with a professional counsellor, or trained nurse, and then proceed to the pharmacy where the medication is dispensed.

Patients who come for follow up appointments can be divided into two groups. The first group consists of those who come for the routine check-up after 3, 6 or 9 months, depending on their risk factors. They are tested and then exit the clinic without seeing the physician. The second group are patients who have concerning physical symptoms and who are seen by a physician.

The range of services provided by nurses are listed by N1 at HC-A as ones including taking the weight of patients, selecting those who need to see the physician, showing them into the physician's consultation room, directing those who need to go for x-rays, those who need to collect medication, and those who need to go to pre-HAART counselling.

Another feature of the care process established through observations is the presence of daily lectures called Health Talks. These talks are done prior to the physician's consultation by a nurse. They equip patients with knowledge even before they see the physician. The purpose of these talks is that they are educational lectures about HIV and AIDS in general. The educational nature of these talks is also proved by the fact that in the interpreter directly refers to them as "education

3.1.3.2 Communicative Process

The communicative processes in the clinics reflect their attempt to respond to and manage language diversity in a way that will enhance positive health outcomes. The various modes of communication mentioned above have apparently developed according to the features of each phase of the consultation; therefore, a particular mode becomes a characteristic of communication in that phase.

In the pre-consultation phase, communicative processes are organised in such a way that there is very little one-on-one verbal exchange between the patients and the service providers. At the reception point, the receptionist practically engages more with the patient files and cards than with the patient. The little interaction that does happen, is when a patient is asked a few administrative questions on issues such as his/herbiography. The next two points located in the pre-consultation phase are the testing unit and history-taking room. At these points also, participants report that not much verbal exchange ensues although the nurse on duty does a physical examination. The physical examination done at this point is reported to be *baseline*, such as measuring the patient's

temperature, weight and administering urine tests whose results will be written on the patient card and shown to the physician. These results form a basis for diagnosis and treatment. The pre-consultation phase is marked largely by Sesotho communication among L1 Sesotho patients and L1 Sesotho HCPs.

The consultation phase is the point where there is much verbal exchange among the physician, interpreter and patient. This is the point at which decisions on treatment and the readiness of the patient to start treatment are taken. The same is true of the post-consultation phase where the logistics of treatment and self-care are discussed between the HCPs and patients.

Another distinctive feature of the communicative process relates to participants' speaking roles in each communicative event. In the pre-consultation phase, communication is primarily between clinical staff and patients. These conversations are in Sesotho and therefore overwhelmingly dyadic. Despite the fact that there is a notice at the reception area which advises patients to bring along someone else as a “buddy” when they come for testing and other services, many patients still come alone, thereby rendering these interactions dyadic. Even so, there are rare cases when patients bring someone along. This finding is substantiated by the fact that out of the 10 patients that were interviewed for this study, only one reported to have been accompanied by a community health worker on their first visit. The particular patient explained that she was accompanied in this way because the health worker already knew about her sickness. The health care worker's presence therefore posed no threat to confidentiality. In this case then, the whole consultation process, inclusive of the pre-consultation phase where nurses and patients have compatible linguistic resources, was triadic.

The conversational roles in the pre-consultation phase are similar with those in the post consultation phase because the participant categories are similar.

However, the consultation phase differs from the others in terms of speaking roles. Interactions in this phase are mostly triadic. In HC-A participants report that interpreting services are always available in consultation rooms to facilitate communication between the physician and the patient, while in HC-B such services are solicited where there is a needAlthough the different categories of staff view their interpreting roles differently, there is consensus in that all believe they play an

important role in enhancing the quality of communication between physicians and patients.The organisation of the communicative process in the consultation room in terms of the number of participants in the interaction and speaking roles they perform is largely a result of the linguistic resources shared and the extent of language diversity at this point.

3.1.3.3 Hot Spots in the Communicative Process

Considering the data which I received from HCPs at various levels of appointment as well as patients (Ps) registered at the two centres, it became clear that there are certain service points that can be identified as communicative "hot spots" within the process of care. In this study, the term "communicative hot spots" refers to those places in the care process where communicative challenges are likely to be more manifest, and where there is a more profound demand for communicative success than in others. I considered specifically two factors that render a service point a hot spot. Firstly, it could be the communicative content that is topicalised in the spoken exchange at such a point. Secondly, it could be the extent of language diversity in the service point. This will be discussed in detail in the forthcoming sections.

3.1.3.3.1 Communicative Hot Spots in Terms of Communicative Content

Individual interviews with some of the HCPs identified the counselling unit and the history taking room as hot spots in terms of communicative content. Some of the nurses and counsellors show that in the counselling unit and the history taking room patients have to engage in conversations that entail sexual behaviour, which they seem reluctant to discuss. This reluctance becomes exacerbated where there is age and gender discordance between the HCP and the patient, particularly where young female health care providers interact with older male patients. *Excerpts 3 and 4* on the following page indicate the impressions given by two HCPs, namely a nurse and a counsellor at HC-A, regarding their experiences in such contexts.

The responses in these two excepts highlight the fact that some married men show resistance to the use of condoms. In articulating their resistance, they refer to the HCP's age, a strategy which could imply that the nurse or counsellor knows less because she is younger than the patient is. These men's understanding is that when they have paid the bride price for their wives it is not

necessary to have protected sex even when they are HIV positive. Their attitude to condoms comes out strongly in *Excerpt 4* where the patient is reported to have repeatedly referred to a condom as *nthoeno* ("that thing"), thereby avoiding to even say the word. This communicative behaviour in interactions about sexuality and sexual behaviour is consistent with the findings of Aujoulat et al. (2002:216-217) and Helleve et al. (2009:197) who identify this topic as a problematic one for patients and HCPs in HIV and AIDS care. They established that this is because sexuality and sexual behaviour are generally private information and in very many communities it is taboo to talk about them, particularly if such discussions are cross-generational as in the case presented in *Excerpt 3* below.

Excerpt 3

1. **U tla** fumana hore ke bua le ntate e moholo oa boemo bo holimo ke tlo mo khothaletsa
   You find that I speak to an elderly man of a high status and I am going to encourage him
2. hore a sebelise khohlopo ka makhetlo ohle hahae. Ntate e moholo oa Mosotho
   to use a condom every time at his home. An elderly Mosotho man
3. o tla ba mpolella: "khomong tsa ntate? Ae kannete!! ke sebelisa khohlopo joang?
   will tell me: " with my father's cattle? No!! How do I use a condom?
4. Ntate o nts'itse likhomo mona ke tlamehile ho kena feela. Joale ke tlameha ke mo
   My father paid bride price (so) here I have to just go in unprotected!" Then I have to
3. bontse na khohlopo e thusang boemong bofe leha e le "khomong tsa ntate" joalo.
   show him how a condom helps, even though his father his father has paid bride price.

(N1 at HC-A)

Excerpt 4

1. Bo ntate ... ke bona be kee ke utloe ba re: "ae ngoanaka ke le mokana
   Men ... are the ones I usually hear saying: "no, my child, at my age
2. esale ke sa sebelise nthoeno. 'Na ke lula le mosali enoa oa ka, ha ke utloe na
   I have never used that thing [condom – KS]. I stay with my wife, I don't
3. mosali ea nyetsoeng ka likhomo tsa ntate? ebe ke tlo sebelisa nthoeo?
   understand (why) with the woman for which my father paid bride price? I (should) use that thing?
4. Ha ke tsebe le hore e sebelisoa joang nthoeno."
   I don't even know how that thing is used.

(C1 at HC-A)

This perception of condom use marks the patients' lack of understanding about safe sex as a component of HIV treatment. The implication is that HCPs have to engage in lengthy conversations to clearly explain the nature of HIV infection, the possibilities and dangers of re-infection and the implications on treatment. The HCP attempts to ultimately convince patients to use condoms. This is one reason why the counselling unit becomes a communicative hot spot. The information discussed here should clearly be understood by patients because it has implications on how they will conduct themselves and how they will adhere to treatment plans, but it is not easy to talk about.

3.1.3.3.2 Communicative Hot Spots in Terms of Linguistic Diversity

Findings of this study show the physician's consultation as a point where linguistic diversity is more pronounced than other points. This is because of the extent of language diversity among physicians and the fact that in both health centres there is language discordance between physicians, patients and other HCPs. Observation of linguistic resources in HC-A and HC-B shows that physicians have a diverse range of linguistic repertoires, most of which they do not use in consultations because their patients speak either Sesotho only or English and Sesotho.

Further observation of communicative practices in the consultation room in both health care centres allows the identification of three types of communicative events, marked by the distribution of linguistic resources in them. In the first type of events physicians and patients do not have any compatible resource to carry out communication between them. Because of this, they communicate through the help of an interpreter. This is a characteristic of most consultations in both HC-A and HC-B because both clinics are staffed exclusively by non-Sesotho speaking physicians. Interpreting services are offered by different cadres of clinical staff and the deployment of these interpreting facilities varies from clinic to clinic.

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from clinic to clinic. HC-A has put in place formalised and established interpreting services where appointed staff are always available in consultation rooms to offer interpreting services. A nurse is called in to facilitate communication only in cases where there seems to be communication breakdown, or when the two parties struggle to comprehend each other's message.

In the second type of communicative event, physicians and patients share either limited Sesotho or limited English. In these events the interactants get by with limited available Sesotho, English or in some cases a mixture of both languages, without an interpreter. This becomes possible only where patient cases are not complex and are easily understandable to physicians. In order to make this possible, some physicians have taken an initiative to learn Sesotho, together with English for those who originate from francophone countries. They report that they do this because they believe that talking in the patient's language is the best option for providing adequate care.

The third type of communicative events is a kind in which physicians and patients have enough competence in either English or Sesotho to have a successful consultation regardless of the complexity of the presented patient's problem. In such cases participants use either Sesotho or English as a lingua franca depending on in which language they are both competent and comfortable. In these cases, interpreters are invited only when there are communicative challenges caused for example by the use of scientific terms.

Despite attempts in all the three types of communicative events to have effective communication, challenges still occur as it will be seen in a discussion of experiences of each group of participants in *Chapter 4*. These challenges are consistent with previous research in contexts like these, for example Meeuwesen et al. (2007), which documents such communicative events as problematic. It is because of these potential problems that the physician's consultation is viewed as a communicative hot spot.

3.2 HC-A AND HC-B AS HEALTH CARE ORGANISATIONS

Observations of the two health centres show that they have the structure of large health care organisations similar to those discussed in the works of Barr (1995), Glickman et al. (2007) and Schoen et al. (2009). Glickman et al. (2007:344) note that from the beginning of the 20th century

the structure of health care organisations seemed to change to accommodate growing patient numbers and the diversity of chronic illnesses. Literature from the two centres also shows that they have evolved to accommodate the nature of the HIV care they now give. On the one hand HC-A was formed as a part of the public health sector of a large hospital, when it became apparent that HIV positive patients need extra care that could not be provided adequately if they were treated in the hospital with other patients. On the other hand, HC-B was formed initially to provide only testing and counselling services, but ultimately it became clear that there is a need to disseminate ARVs, so that change was effected. This shows that the structure of health care organisations evolve with the needs of patients.

Another aspect of the structure of contemporary health care organisations is that patient care is segmented. Glickman et al. (2007:344) acknowledges the division of patient care into several functional divisions. These divisions are segmented in accordance with the specialisation of services they render (Barr, 1995:35). Each of the divisions is staffed by a collection of specialists who work together towards patient care (Beveren, 2003:92). HC-A and HC-B have the same structuring in that the process of care as illustrated in Figure 1 has been divided into phases and, as has been mentioned, each of the consultation points within these is staffed by professionals, for example, the counselling unit is staffed by professional counsellors.

Literature on OT has established that health care organisations have a hierarchical management structure, with clear-cut roles for all levels of management (Beveren, 2003:93; Glickman et al., 2007:345). Observations of the operations in HC-A and HC-B show that HC-A has a management structure that is composed of several levels because it is part of a large hospital, while HC-B does not have such a well-defined management structure. Of particular importance is that the top management of the two institutions is made of health care professionals, a physician in HC-A and a registered nurse in HC-B. According to Glickman (2007:344) and Schoen et al. (2009:6), this is an important feature because it ensures that decision-making is left in the hands of people who are professionals in medicine.

Human relations among staff members play an important role in HIV care. The value of good human relations is acknowledged in literature on OT such as Barr (1995:354) and health care

communication such as Meeuwesen et al. (2006:2415) and Schouten et al. (2009). These works concur that it is vital to have good relationships among health care providers and patients in order for adequate care to be achieved. The quality of a relationship can be assessed by the quality and effectiveness of communication among the concerned parties.

My obesrvations and interviews show that generally patients are satisfied with the communicative process. Even where there are challenges there are strategeis by which the challenges may be overcome and care is given successfully. The remarkable challenges that patients reported will be discussed in *Chapter 4* in detail.

3.3 CONCLUSION

The above discussion of the organisational features of the two health care institutions of this study shows that the communicative practices and management of linguistic diversity are largely determined by this organisation. In particular, the organisation of the centres provides insight into how the overall process of care accommodates the language diversity in the particular community. The actual measures incorporated in the structure to respond to language diversity are made evident by looking at the organisational features. Although this organisation helps to facilitate communicationin these centres, participants still experience communicative challenges as it will be seen in the forthcoming chapter.

CHAPTER 4

COMMUNICATIVE EXPERIENCES AND MANAGEMENT OF LANGUAGE DIVERSITY

4.0 INTRODUCTION

This chapter presents a description, analysis and interpretation of the experiences of staff and patients in the two health care centres studied. The results respond to questions (ii) to (v) set out in section 1.4.2 of this study. These results were drawn from interview and focus group data that were entered into an atlas-ti transcription program which helped to classify material for analysis in terms of TA and QCA. Firstly, TA was applied to the transcripts in order to identify themes that are prevalent in each transcript. After this identification, the coded themes were further classified through deductive QCA into three basic categories that were derived from the research questions and from previous studies on multilingual health care. The categories identified for content analysis were (i) the extent of language diversity, (ii) participant challenges in the communicative process, and (iii) strategies and resources for managing language diversity. The discussion in this chapter has been structured in accordance with this classification.

4.1 THE EXTENT OF LANGUAGE DIVERSITY IN HC-A AND HC-B

This section responds to research question two of this study which is articulated thus: *What is the extent of language diversity in the two health care centres?* This question will assist in assessing the degree of risk of miscommunication in the particular context that may be ascribed to language discordance. There is no doubt that the institutions studied, and the encounters that occur in them, are multilingual. This is interesting because Lesotho is a state where an overwhelming majority of the population are L1 speakers of Sesotho, so that the multilingualism of the health care facility needs to be explained. A significantly large number of doctors are foreigners whose proficiency in Sesotho is limited. They need to rely on English as a lingua franca in communication with other staff members and with patients. Calling the communicative events in the clinic multilingual is

consistent with House and Rehbein's (2004:5) and Moyer's (2011:121) description of a multilingual speech situation as one in which speakers use more than one language to achieve communicative goals. In these cases Sesotho and English are the two languages that are most widely used.

A survey of the linguistic repertoires of the participants showed that in both clinics, physicians are the ones who have more diverse linguistic repertoires than other participants mainly because they are mobile people who originate from a wide range of countries and have had to adapt to language communities other than their L1 communities. Their biographic information shows that they come from the African countries of Congo, Madagascar, Uganda and Zimbabwe, and from a European country, namely Germany. Most are proficient in at least their own L1 (e.g. French, Luganda, Shona) and English; although some do have basic levels of Sesotho they cannot use it fluently in professional communication. Other HCPs, specifically the nursing staff and administrative officers are largely L1 speakers of Sesotho, with at least intermediate levels of English L2 proficiency. Such HCPs could use both Sesotho and English in professional communication. In general terms, many patients are also Sesotho-English bilinguals, but often with lower levels of proficiency in English than the HCPs have.

Further scrutinising of physicians' responses about their linguistic repertoires[9] revealed two clusters of language competencies among them. The first cluster consists of speakers who are competent in their own L1 and other languages spoken in their respective countries of origin as first or second languages (e.g. Luganda and Kiswahili). The second cluster consists of speakers of two local languages, namely Sesotho (which is a national and official language in Lesotho) and English (which is an official language used as a lingua franca in most public and official domains in the country).

An indication of the range of languages that are spoken by physicians is given in Table 4.1 below.

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[9] The term linguistic repertoire in this study is used narrowly to refer to the languages that participants can speak. No information was asked about the languages they recognise, though they cannot speak, nor the dialects and registers of each language.

Table 4.1: Physicians' Linguistic Repertoires[10]

Physician's Country of origin	Languages spoken (total no of languages in the person's repertoire)
Dr 1: Congo (HC-A)	French, Swahili, English, etc. (± 10)
Dr 2: Congo(HC-A)	French, Swahili, Lingala, English (4)
Dr 3: Madagascar(HC-A)	Malagasy, French, English, etc. (7)
Dr 4:Uganda(HC-A)	English, Kiswahili, Luganda, etc. (± 7)
Dr 5: Zimbabwe(HC-A)	English, Shona and Ndebele (3)
Dr 6:German(HC-B)	English, German, Somali, French (4)

The profile gained from Table 4.1 gives a good impression of the super-diversity of the linguistic repertoires of physicians in the consultation rooms. According to the physicians' responses about their linguistic profiles, they speak a total of more than 30 languages among them.

The extent of language diversity among physicians is in stark contrast with that among patients and other staff in that physicians' linguistic backgrounds reflects a larger range of languages spoken than the background of both patients and other staff members. The table in the forthcoming page illustrates the linguistic repertoires of clinical and administrative staff as well as patients as provided by the participants themselves. This table show a presence of four languages among the sample of patients and non-physician staff. All staff members are bilingual speakers of Sesotho and English except one lay interpreter, who reported being able to speak Ndebele and Afrikaans in addition to Sesotho and English.

[10] This information is based on the physician's reports. There is therefore no additional information on either how these languages were acquired, or the proficiency level that the physicians have in each language. Proficiency levels were observed (not measured) only for English and Sesotho, as they were the active languages in the consultation.

Table 4.2: Linguistic Repertoires of Clinical Staff, Administrative Staff and Patients

Staff Category (no in sample) and Institution	Languages Spoken
Nurses (6) 5 from HC-A, 1 from HC-B	Sesotho and English
Lay interpreters (2) HC-A	Sesotho, English, Afrikaans, Ndebele
Receptionist (1) HC-A	Sesotho English
Patients (15) 10 from HC-A, 5 from HC-B	Sesotho and English

Although data from the two clinics is put together here, it is noteworthy to mention that there is more language diversity in HC-A than in HC-B, because of the size difference between the two sites. Since in HC-B there is only one physician, he is the only person with a linguistic background that is different from the rest of the staff and patients who are mostly bilingual speakers of English and Sesotho. There seems to be more diversity among physicians than among patients and other levels of HCP staff.

4.1.1 Language Scaling

A look at participants' descriptions of language use in the consultation process yielded some degree of language scaling that happens in the two clinics. Language scaling is described in Blommaert et al. (2005:212) as institutional organisation of languages in a hierarchical order as a response to language diversity. Blommaert et al. (2005:212) shows that this "hierarchisation" is done on the basis of the value of the various languages in a given context. The scaling in the two clinics is not necessarily a written policy, but a practical way in which languages are distributed in terms of how they are used. This three tiered language hierarchy obtained from participants'

reports of language use in the clinics is presented in the diagram below and it was found to be the same for both health care centres:

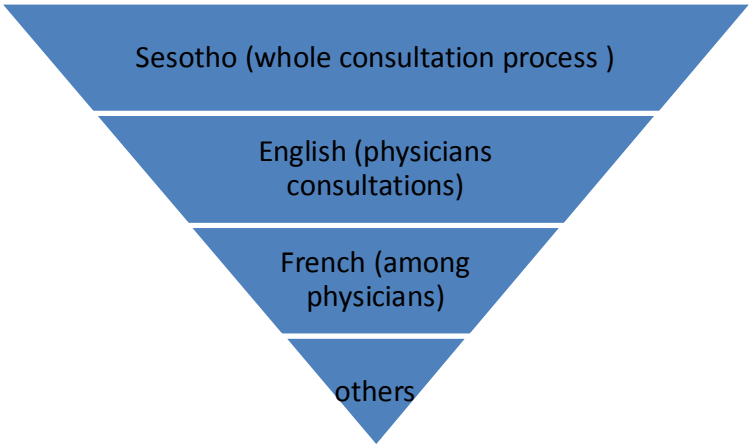

Figure 2: Scaling

The illustration above shows the way languages are distributed in terms of dominance. Sesotho is a significant heritage language in Lesotho in general, and in these two health clinics in particular, therefore it is the most predominantly used language. English is predominantly used in physicians' consultations because of the prevailing language discordance between physicians and patients. French is used by physicians among themselves because most of them are L2 speakers of the language.

4.1.1.1 Sesotho as a Dominant Language in the Health Care Centres.

The dominant status of Sesotho in the country has determined the language situation in the studied medical institutions. Since it is spoken by a majority of patients in the clinic, all the physicians report that they have had to learn, or are in the process of learning the language. This is because physicians view proficiency in Sesotho as an ultimate solution to all the challenges caused by language discordance between them and their patients.

Physicians' attitude to learning Sesotho comes out clearly in one of the physician's comments in *Excerpt 3 Chapter 3*. In his comment the physician sees learning Sesotho as *"the only way to sort*

*out this thing [language discordance – **KS]"*** This shows that the speaker does view language discordance as a communicative problem that has an effect on the quality of care he can give. The suggested solution to the difficulties in this case is that HCPs should learn the patients' L1. He intensifies this need by saying: *"there is no option",* thereby emphasising that process as obligatory in the situation.

An examination of physicians' responses to interview questions regarding their linguistic repertoires reveals that all the physicians who participated in this study acknowledge the need to speak Sesotho because they all list Sesotho as a component of their linguistic repertoires. Their self-rating of proficiency in this language reveals two proficiency levels. The first proficiency level is where physicians report knowing a bit of Sesotho. This is how some of these physicians expressed their level of proficiency:

Excerpt 5

1. **D1:** I have got few Sesotho's term … medical terms. I start in
2. Sesotho, even if they have headache, fever I say it in Sesotho, so
3. I can say I understand a little Sesotho.
4. **D5:** ... maybe to talk is eh ... it's a problem, but I can understand
5. a little Sesotho.

(Ds at HC-A)

At this proficiency level physicians' competencies in Sesotho are limited to only a few vocabulary items and common phrases. Direct observations made during conversations with these physicians confirm that they are able to verbalize at least greeting exchanges in Sesotho. Their limited vocabulary, which they are able to use in some parts of a conversation, is mainly restricted to body parts and minor ailments. Because of their limited vocabulary and understanding of complex Sesotho sentences, they cannot hold a full consultation with a patient in Sesotho.

On a second, more advanced level, other physicians rated their proficiency as adequate to have a Sesotho conversation with a patient. They report that they solicit help only when it gets complicated. Physicians in the following two examples (D2 and D3) rate their proficiency this way:

Excerpt 6

1. **D2**: I know Sesotho half ... because is not yet fully (sic) ... but I can
2. communicate sometimes with my patient, halfway when I'm stuck I
3. ask the interpreter to come.
4. **D3**: Sesotho? That one I'm not so fluent with it, but I can
5. communicate with a patient correctly and I call the interpreter if it is difficult.

(Ds at HC-A)

These physicians have a level of communicative competence sufficient to hold a consultation with their patients. Respondents in this category further reported that when medical problems are not complex, when there are visible physical symptoms, such as oral thrush, and when the patient's history is already articulated well in the patient card, they are able to complete the consultation without the help of an interpreter.

However, when it comes to communication about HIV related ailments, treatment and counselling, physicians report that the information is too complex to be done with the Sesotho vocabulary they have. This is because very often HIV positive patients' medical problems arise from or are connected to social problems that need to be understood before proper counselling and treatment are recommended.

It is apparent from the accounts of all physicians in HC-A and the one in HC-B that they can only limitedly use Sesotho in their interaction with patients. Even the ones who reported the ability to engage in a consultation show that there comes a point in that consultation where their linguistic resources become inadequate and they are bound to solicit interpreting services from other Sesotho speaking colleagues. This becomes clear in the following explanation by a physician in HC-B.

Excerpt 7

1. **D3**: first of all I start with the people that eh ... could to talk
2. some words I can understand especially if they have physical
3. symptoms so if they show me what kind of ... let's say a rash for
4. example, so I can see where
5. they have it so I can see their disease so sometimes it's quite

6. simple t if I see the people are talking and especially
7. they have other problems, for example depression and for
8. how long, and other problems then I need of course the help of
9. other colleagues

D3 at HC-B

This physician makes it clear that his Sesotho proficiency can only extend to patient problems that are not complex; and that for more complex problems he needs help from colleagues. These physicians' proficiency levels in Sesotho become particularly interesting because they operate in a situation in which Sesotho is the dominant language in the two centres. It is the L1 of an overwhelming majority of the patients physicians have to treat, as well as of administrative staff, such as receptionists, and interpreters, and of clinical staff, such as nurses, all of whom they regularly interact with in the professional domain. The local and administrative staff therefore usually mediates between physicians and patients, thus leaving Sesotho as the language that features most prominently in communication at the different consultation points in the two health care centres.

Apart from being used for communication at different consultation points, the use of Sesotho is also seen in different information-giving literary artefacts that one finds posted on the walls of the clinics in the form of posters and information notices to patients and staff. The content of the messages in posters is mostly on behavioural change, warning people against irresponsible sexual behaviour. The notices, on the other hand, are generally information bulletins concerning the procedures to be followed in the clinic and the day-to-day operation of the clinic. The following pictures taken from HC-A and HC-B respectively illustrate the types of posters and notices one finds in these health care centres:

Figure 3: Aspects of the Linguistic Landscape of HC-A and HC-B

The first picture is a poster creating awareness about HIV and AIDS and encouraging people to test for HIV, while the second picture is a notice that explains treatment protocol with three message contents. The first message is to make patients aware that those with a CD4 less than 350 have to start ARVs. The second part informs patients that they have to be counselled three times before starting treatment and lastly, that patients are supposed to bring along a carer to support them and help them listen. The information is presented in Sesotho because they are primarily addressed at patients whose L1 is Sesotho.

The use of Sesotho was also observed in the "Health talk" which is a daily lecture that is given to patients about HIV and TB in general. Some of the information about these two diseases is delivered through audio-visual materials and those are in Sesotho too. Thus overall, it can be said that Sesotho is the most dominant medium of communication in the two health care centres. It is spoken by a majority of patients and staff and is used predominantly around the clinic. However, because of the fact that most physicians cannot speak Sesotho, it cannot be used exclusively in the

consultation, hence the use of English, with interpreting services intermittently engaged, in the physicians' consultation rooms.

4.1.1.2 English as a Second Language in the Two Health Care Centres

English is the second most predominantly used language in the two health care centres. It is also the language used in consultation with physicians because, as has been mentioned before, patients are mostly speakers of Sesotho, while physicians have very limited communicative capacity in Sesotho.

My survey of competencies and patterns of interaction further shows that, in responding to the question about their linguistic repertoires, all the six physicians in both health care centres, that were interviewed list English as one of the languages they speak. Different to their reporting on knowledge of Sesotho, physicians did not remark on their level of proficiency in English, nor did they rate their proficiency in English. However, their proficiency in English became apparent during interviews with them and other clinical staff.

Observation during interviews with the physician in HC-B showed that he is fluent in English. Unlike in HC-B, some of the physicians in HC-A were reported by nurses and interpreters to have limited to inadequate English proficiency. For example this is how one of the clinical staff described such low proficiency and the challenge it holds for them:

Excerpt 8

1.	**N1**:	Re na le bothata ba hore lingaka, hangata mona mosebetsing *We have a problem that physicians here at my workplace we*
2.		oa ka re sebetsa ka batho ba tsoang DRC kapa ba tsoang bo Malawi. *we work with physicians that come from DRC or Malawi.*
3.		o fumana hore ba tla ba tseba French le puo e 'ngoe ba sa tsebe *they come knowing French and another language,*
4.		Sekhooa so, e tla be le hona ba learnang Sekhooa e le hona *English so, it's only now that they learn English and*
5.		ba learnang Sesotho. Le sekhooa sena seo ke *that they learn Sesotho. Even that English that I am*

6.	u joetsang sona e le bothata ho se ngola le ho se undastanda *telling you about it's a problem to write and understand it*
7.	Ke nna ke tla tlameha ... empa he ha ke tla ke e bua ka li term *I am the one who has to ... but when I come with this terminology*
8.	tsena tsa healtheng ke hona a e utloang. Ehlile e ba bothata hangata *of health, its then that she/he understands. It is often a problem*
9.	lingaka ha li qala ho fihla ts'ebetsong hore litla li tseba French *when physicians initially start work, that they just speak French*
10.	li sa tsebe sekhooa *and not know English.*

(N1 at HC-A)

This perception of some physicians' low level of competence in English as a problem is characteristic of the descriptions given by most of the support clinical staff in HC-A. They also find this low level problematic because it demands extra work from the nurses and interpreters in order to ensure that there is understanding between the physician and the patient in a consultation.

It was further established that although English is the language of the consultation, most of the patients treated in the two health care centres also have low levels of proficiency or no proficiency at all in the language. Out of the 10 patients who participated in this study in HC-A, only two reported having some English proficiency, while in HC-B only 1 out of 5 reported having some English proficiency. These statistics are further supported by the receptionist in HC-A who reported that she knows almost all the patients who attend this clinic, and that there is a very limited number of their patients who have enough English proficiency to carry out a lengthy conversation, and thus be conversationally involved in a consultation where the physician does not speak Sesotho.

An examination of patients' accounts of their English proficiency and descriptions of clinical staff reveals three categories of proficiency among patients. The first category consists of patients who report having no knowledge of English at all. These patients report that they cannot understand or speak any English, as is expressed by a patient in the following case:

Excerpt 9

1. **Res**: U tseba ho bua puo tse kae?
   How many languages can you speak?
2. **P2**: ke ipuela ena eaka ea sesotho fela
   I speak this one of mine, Sesotho only.
3. **Res:** Ea sesotho fela?
   Just Sesotho?
4. **P2:** eea.
   yes.

(P2 at HC-A)

Because of their inability to speak and understand English, these patients cannot communicate directly with physicians, therefore in their consultations there is a demand for mediation.

In the second level are patients who report to know a little English. They speak a little and they can understand parts of the conversation between the physician and the interpreter, though they cannot be involved in a full consultation with a non-Sesotho speaking physician. The following exemplifies how these patients report on their proficiency level in English.

Excerpt 10

1. **Res:** Leha o sa se tloaela feela u oa se bua hanyane
   Even though you are not used to it, you do speak it a little,
2. akere?
   not so?
3. **P7:** eea
   yes
4. **Res:** so o no ntso utloa ha ntse ba bua le ngaka
   So you were able to hear (*understand*) *what the physician*
5. hore na ntse ba reng?
   was saying (*through the interpreter?*
6. **P7:** eea 'me
   Yes madam

(P7 at HC-A)

The third category consists of those patients that are competent enough to have a conversation with a physician with very little help from the interpreter. Reference to this group's proficiency is found in the data collected among physicians, nurses and the interpreters. The presence of such patients is further substantiated by the fact that in the sample of patient-participants for this study, two in HC-A were confirmed to have a relatively high proficiency in the language.

Although it would be expected that patients who are competent in English would want to communicate directly with physicians, data about their communicative practices reveals that these patients usually demonstrate two contrasting language preferences in the consultation room. The first group of English proficient patients prefers to speak English in the consultation room. Their language preference and the reasons for their language choices are summed up in *excerpt 20* below taken from descriptions of the experiences of two physicians in consultations with such patients.

Excerpt 11

D4: ... adults who know English, they don't want even an interpreter, because an interpreter is an inconvenience, It's a breach of their confidentiality …"

D1: … patients, when they come into the consulting room, they prefer only to be free, only with the physicians so that they can say to the translate (sic) please I can speak English ...

(Ds at HC-A)

The physicians who reported such experiences indicate that such patients prefer to maintain physician-patient confidentiality in their consultations with physicians. It is therefore the need for privacy that drives their choice of language in the consultation room.

Unlike the English proficient patients discussed above, the second group of patients are those who prefer to use Sesotho in consultations and therefore make use of interpreting services despite being suitably competent in English. The data shows several possible reasons (to be discussed below) why these patients make this choice. Some of such reasons are articulated by the patients themselves while others are articulated by health care providers.

The excerpt in the forthcoming page contains three extracts from three different patients showing some of the reasons that patients gave for why they opt/ed not to talk directly in English to their physicians.

In that excerpt P1 attributes her choice to the fact that she had been ill and, by implication, therefore less inclined to speak a language that she was not used to speaking. P3 motivated her choice of relying on an interpreter to herself sometimes simply being lazy. This suggests that speaking in a foreign language requires a bit of extra effort that patients feel they are not up to when they are sick. This means that under the circumstances of being ill, patients may not want to spend energy on looking for the right words to use in a language they do not use regularly. Then they feel that it is better to use the language they speak on a daily basis. This choice seems to be made easy by the availability of an interpreter who is reported to be helpful.

Excerpt 12

1. **P3**: ke ne ke kula joale sekhooa joalokaha motho o sa se tloaela
   I was sick and English one is not used to,
2. hakaalo o utloa a o thusa...
   that much, so I found her helpful ...
3. **P7**: aee ka nako e nngoe ke ba botsoa feela ebe ke itholela feela
   No sometimes I just get lazy and just keep quiet.
4. **P4**: batho bana ba mofuta oane o mots'o o hlahang koana bana le
   these kind of black people from "there" sometimes have a way of talking
   hore ka nako e ngoe ba tebe ...
   deep language

(Ps at HC-A)

P1 attributes her choice to the fact that she had been ill and, by implication, therefore less inclined to speak a language that she was not used to speaking. P3 motivated her choice of relying on an interpreter to herself sometimes simply being lazy. This suggests that speaking in a foreign language requires a bit of extra effort that patients feel they are not up to when they are sick. This means that under the circumstances of being ill, patients may not want to spend energy on looking for the right words to use in a language they do not use regularly. Then they feel that it is better to

use the language they speak on a daily basis. This choice seems to be made easy by the availability of an interpreter who is reported to be helpful.

The third reason that patients give, is the complexity of the English spoken by the foreign physicians as articulated by P7 above. This patient identifies two potential problems with the way these physicians speak. Firstly, he refers to the physicians as being "batho bana ba mofuta oane o mots'o o hlahang koana", that is, as "black people from over there" by which the doctors are "othered" even if they are "black like us". Thus the physicians are removed in terms of "distance", meaning that they are of foreign origin and so do not share local knowledge. This also indirectly referred to the physicians' foreign accent, which makes it difficult for the patient to understand when they speak. Secondly, he describes the physician's language as "*deep language",* refers to the complexity of their vocabulary and sentence constructions even in talking English. The attribute "deep" is used to signify use of relatively sophisticated language, thus, the use of Standard English, and of medical jargon which would make it difficult for patients to comprehend the speech of the physicians in consultation.

Apart from the reasons provided by patients for not speaking English directly to physicians, health care providers also gave their opinions on what they think would make patients reluctant to communicate directly to HCPs even when the patients have some proficiency in English. Although health care providers report that they have never asked patients to explain this language preference, their opinion is that this is caused by lack of confidence in using the language. This means that patients are not confident in their command of English therefore they become reluctant to express themselves in that language.

In summary, it transpired that although patients' choice not to use English may have been driven by several factors as mentioned here it was largely a result of the organisation of communicative events that allowed them to have access to interpreting services. They are aware that if they are not at using English there are interpreting services to facilitate communication between them and their physicians. These language choices have a bearing on how communication is structured in the two health care centres and how it is experienced by different participants.

4.2 PARTICIPANT EXPERIENCES

The extent of language diversity discussed in the section is a significant feature of the studied context given the relation between communication and health care. It becomes important to establish how the different groups of participants involved in the care process experience this diversity and to have insight into how communication proceeds under the circumstances. This section is related to the third question of this study which is: *how do participants experience both the care and communication as provided for by the organisational structures?* This section focuses on how each group of participants experience both the organisation of the two clinics and language diversity. The experiences of patients, physicians and nurses are discussed here, while those of interpreters will be dealt with in the subsequent section on *threats to communicative success* because most of what they reported is problems.

4.2.1 Patients' Experiences

In these two health care centres patients are part of the organisational communicative process in the following flow of events: (i) entry at reception, (ii) pre-test-counselling, testing and post-test counselling related to a diagnosis of HIV-positive, (iii) history taking, checking CD4 count, (iv) consultation with a doctor – also regarding possible ART, (v) prescription of treatment, instructions on how to use the medication and information on the possible effects and side-effects of the medication, (vi) encounter with pharmacist in collecting the medication. In relating their experiences, patients commented on the three major phases of the consultation, namely on the interaction with administrative staff and nurses in the pre-consultation stages (i) to (iii), on the interaction with doctors and interpreters in the consultation stages (iv) to (v), and on the interaction with nursing staff and the pharmacist in the post-consultation stages (v) to (vi). Considering that administrative staff and nurses would be L1 speakers of Sesotho, and thus would have the same linguistic background as the patients, it is not surprising that patient comments were largely centred on experiences in the physician's consultation room.

A QCA of patients' descriptions of their experiences reflects the reception area as the most commented on service point in the pre-consultation phase. They make no comment about the pre-test counselling point. This is noteworthy considering that the pre-test counselling point is a

significant unit because that is where they are emotionally and psychologically prepared for the blood test results; and the first point where a nurse diagnoses HIV status of patients.

Patients' explanations show that most of them are appreciative and value the information they get at this point. For most of them they acknowledge that most of the information is new knowledge about HIV and AIDS and TB in general. Although the information is reportedly disseminated through the literary, verbal and audio-visual modes, literary materials and health talks are the ones that feature most in patient explanations and audio-visual materials are only mentioned in passing by some of the patients. This is because patients are report to be given health talks and literary materials more often than they watch videos.

Comments about the literary materials refer to information leaflets, notices and booklets that patients are given at the clinics. These literary artefacts are bilingual, written either in Sesotho or in English and at times published in both these languages. The use of multilingual literary materials as communicative tools in multilingual clinics has been investigated and topicalised in research on multilingual health communication research in general by Collins and Slembrouck (2006) and Moyer (2011). More specific research by Saal (2004), Feinauer and Luttig (2005) and Swanepoel (2005) specifically refer to different booklets used for HIV AND AIDS campaign in South Africa. All these studies (discussed in chapter 2) recognise the existence of different literary artefacts in health care communication, in the same way as patients in HC-A and HC-B refer to such materials.

Patients reported that upon being given these literary materials, they are never asked about their literacy or competence in English. Even for those who have access to the written Sesotho, the English parts of texts can be communicatively disruptive. A patient who cannot read or cannot comprehend English is likely to experience problems understanding the information. This could mean the HCPs or the institution itself assumes that all patients are able to read and write. Such an institutional assumption was also observed in Moyer (2011:1214) who established that a health care institution's implementation of a translation manual was premised on patients being literate, which made it an inappropriate resource for illiterate and limitedly-literate patients.

An analysis of the patient comments revealed four different ways in which patients deal with the literary materials provided at the clinics. Patients who are literate and proficient in English and

Sesotho read the information and understand it well. However, patients with low literacy levels or low proficiency in English handle the materials differently. Many do not directly acknowledge their discomfort with printed material. They will explain their reluctance to engage with such material in one of the ways represented in the excerpt below.

Excerpt 13

1. **P9**: Kannete ha ke batle ho qala maka ka nako enngoe kea
   Well I don't want to lie, sometimes I just pass by
2. iphetela ha ke li bale
   and don't read them
3. hobane ke ee be ke tatile ke lula hole, so ke ee be ke
   because I usually am in a hurry because
4. tatetse ho fihla mona ka nako!!
   I stay far, so I am usually hurried to get here in time.
5. **P1**: ke li nka fela kea hae koana le tsona kannete e be
   I just take them I go home with them honestly, and
6. se ntse ke ichebela lits'oantso fela ha lits'oantso li le
   look at the pictures if there are pictures
7. teng mono
   there.
8. **P5**: kea sheba ebe ke bala moo nka khonang mo ho ngotsoeng ka
   No I just look and read only where I can where it's written in
9. Sesotho.
   Sesotho.

(Ps at HC-A)

According to these patient reports, when confronted with these literary materials some just pass them without reading them at all (P9) – perhaps with the excuse that they do not have the time to read, others just look at the illustrations (P1), while a third group will select the parts written in Sesotho because they are the ones they can read (P7). These patients also admitted that because of the ways they handle these materials, they do not access the information written in English at all.

Although in some cases patients acknowledge that they cannot read the materials, in evaluating the usefulness of the materials some of them rate these literary materials as useful because they

remind them of what they were taught in health talks. This means that the materials complement the information given in health talks. This positive evaluation is contrary to that of the observed evaluation of literary materials in Collins and Slembrouck (2006) and Moyer (2011), which was negative. In Collins and Slembrouck (2006:257-9) medical practitioners said the negative aspects of the manual (such as for example, the fact that it elicits restricted contributions and that it is too technical to use for most of them) are so intensive that the manual actually causes confusion instead of helping to facilitate good communication. In Moyer (2011:1214) the users observed that the translations in the manual were flawed and the manuals were difficult to use.

Another point of contrast is that, unlike in the studies of Collins and Slembrouck (2006) and Moyer (2011) where the manuals were intended to be used as tools for facilitating communication, the literary materials in the case of HC-A and HC-B are used only as a complementing component of communicating information about HIV and AIDS. As a result, if patients cannot access information in them, those gaps get filled by other modes of communication at other service points. Patients' inability to access information in these literary artefacts does therefore, according to their own attestation, not constitute a communicative problem with any significant effect on the diagnosis and treatment available to them.

Another organisational aspect that patients comment on in this initial phase is the health talks. All the patients interviewed evaluated the talks positively. Their experience is that these talks are very informative and are given in a sympathetic way, so that both in what is said and how it is communicated, the talks appear to meet their aims.

Patients state two reasons why they like these talks. Firstly, the talks are done in Sesotho (thus in the L1 of the hearers) and patients report that it makes them easy to understand. Secondly, the information patients get from these talks is important for their health and for the well-being of the people around them. Through this information patients report being able to protect others from infection and they are also able to know when others start developing signs that require them to see a doctor and they advise them accordingly.

In general it can be said patients' experiences of the pre-consultation phase are positive. This is because the pre-consultation phase serves to give patients much needed information and education about how to live with HIV and TB. What makes this phase even more appreciated by patients is that the phase is staffed by Sesotho speaking personnel and that language concordance makes it easy to communicate effectively. Even though part of the information is given in English, in the form of literary materials, much more is given by videos and in verbal mode, so that they still feel informed enough. Some of the patients, however, feel that the information would be more valuable if it were taught also to people in the villages. This indicates that such patients appreciate the worth of this information so much that they foresee its positive contribution on the well-being of communities beyond the health facility boundaries.

Another aspect that is found among patients experiences of the organisation is the prevalence of interpreted consultations. Although elsewhere in the data health care providers mention some unmediated physician-patient interactions, a majority of patients who participated in this study, particularly in HC-A said that their consultations were interpreted. In HC-A this interpretation is standard practice and is therefore done regardless of whether patients had limited proficiency in English or no English proficiency at all.

The physicians become the first point where interpreters are needed because this is where patients first encounter a non-Sesotho speaking HCP. It is also a point in which communication is critical because it is where major decisions about patient treatment are taken and it is crucial that participants understand each other. Interpreters therefore become an important human resource to facilitate communication.

Patients in HC-A report that in their experience interpreters are always present in the consultation room and these interpreters carry out the task without asking the patient whether they require the service or give consent to such mediation, or not. This means that in this clinic, organisationally, interpreters are an institutionalised part of the structure of the language discordant interactions that unfold between physicians and their patients. They structurally serve as an institutional response to the situation of language diversity. Contrary to this triadic set up of communicative events in HC-A, in HC-B there are no interpreters, but a nurse usually performs an interpreting role when

needed. Thus physicians and patients in this private clinic that serves rural communities, get by with Sesotho (often mixed with code-switching between English and Sesotho) even if the physician speaks and understands the language only limitedly.

The data shows that when patients in HC-A describe their experiences in the consultation with the physicians, they focus primarily on their experiences with the interpreters and only comment limitedly about their interaction and relationship with physicians. Patients generally display submissiveness on the presence of interpreters in consultations. They seem to have accepted that interpreters are part of the clinic system. This is seen, for example, in the following comment by one of the patients.

Excerpt 14

1. **P4:** Ache enoa ea ntseng a ntranslatela ... ka lebaka la hore
   Well, this one who was translating for me ... because
2. che ke motho ke tlile moo e le hore ke tlile moo ke nahanang
   I am human and I have come where I think
3. hore ke tlile ts'epong moo ke tla thusoa ka utloa ke
   there is trust and where I think I will be helped, I
4. amohetse taba tsohle.
   accepted everything.

(P4 at HC-A)

The phrase "ka utloa ke amohetse taba tsohle" (*I accepted everything*) displays the patients' feeling of powerlessness in deciding whether to have or not have an interpreter. The source of such powerlessness is to be found in the institutional power relations between the health care provider and patients, where the health care provider has more institutional power than the patient. The powerlessness also comes from the fact that the patient needs help and therefore feels he has to submit to everything in the institution.

4.2.2 Physicians' Experiences

Physicians' responses were found to be in relation to their consultation with patients and they made no comments about the other phases of the consultation**.** There are two types of consultation that

they refer to. On the one hand there are consultations which physicians carry out directly with patients without the help of an interpreter. The language used in these consultations is either the physicians' limited available Sesotho vocabulary for interacting with patients who are not proficient in English; or English, which is also often limited, for interacting with patients who are proficient in English. On the other hand there are consultations that are mediated by interpreters who are there to facilitate communication. The role of interpreters in medical consultations has been noted also in the studies of Angelelli (2004), Hsieh (2007) and Deumert (2010). A detailed discussion of these studies is made *in Chapter 2* of this study.

This study established that interpreted consultations are prevalent in both centres. However, the centres differ in the way in which interpreting services are deployed. In HC-A physicians report that an interpreter is always present at the consultation room ready to render services. In contrast in HC-B a nurse maybe called on as community interpreter, but only when there is a problem. These reports corroborate information that has been given by patients and some of the nurses as it will be seen in Excerpt *24* below which shows how the nurse (N5) and physician (D6) at HC-B articulate the utilisation of interpreting services.

Excerpt 15

1. **N5:** ee mm, nka mpa ka mo tolokela feela haeba a na le bothata
   no, I only interpret when he encounters a problem because
2. hobane o sa ntsa se tseba-tseba Sesotho.
   he has now learnt a bit of Sesotho.
3. **D6:** **f**irst of all I start with the people that eh ... could to talk some
4. words I can understand especially if they have physical symptoms
5. if they show me what kind of ... let's say a rash for example, so I
6. can see where they have it so I can see their disease, so sometimes
7. it's quite simple, but if I see the people are talking and especially
8. have other problems, for example, depression and for how long and
9. other problems then I need of course the help of some colleagues.

(N and D at HC-B)

The comments in the above excerpt highlight the fact that interpreting in HC-B is on a "needs basis". The physician explains that he only seeks assistance when patients report health problems that do not have clear physical symptoms.

The data from interviews with physicians clearly show two categories of interpreters found in the two health care organisations. The first category is of interpreting personnel who are not in any way trained in medicine. They interpreters are lay personnel appointed only for interpreting. This category also includes bilingual administrative staff who in some cases are called on to interpret if lay interpreters are either too occupied or absent from duty. This category of interpreters is found only in HC-A. Two of the doctors in HC-A describe them in the following way in *excerpt 16 below*:

Excerpt 16

1.	**D4:**	translators these are non-health personnel
2.		usually who translate for us, we just hire them, maybe
3.		school kids who are waiting for the results, then they
4.		need to do something so they come and translate for us so you are asking questions, they will be translating.
5.	**D5**:	yes we have students, we have eh, ... even the one
6.		who are not ... eh ... what can I say? eh mmmm ...
7.		they are paramedical, its mean (sic): no nurse no
8.		eh ... eh ... it's no work (sic) in the health department,
9.		but it's just there just to help to translate

(Ds in HC-A)

The second category of interpreters consists of medically trained nurses who know the community language (Sesotho) as well as the lingua franca, and alternate between their nursing duties and interpreting services when they are needed. This group is found in both HC-A and HC-B. In HC-A the data shows that nurses interpret when lay interpreters are not available, or if they have had to accompany a patient to the physicians consulting rooms and so are at hand in any case. In HC-B a nurse interprets when requested by the physician.

Data from physicians in both centres show that they prefer interpretation to be done by nurses rather than by lay personnel and administrative officers. The reason they provide is that medical personnel know how to convey medical information better than lay personnel. Therefore physicians feel that their interpreting is more accurate and reliable than that of lay personnel.

Physicians' descriptions of non-interpreter mediated consultations show that these happen mostly if patients present problems that have physical manifestations and that are not complex. Previously, physician in HC-B gave examples of cases where an attempt to have an unmediated consultation becomes difficult due to the complexity of patients' problem. While physicians seem to prefer this type of consultation because it gives them an opportunity to interact directly with patients, patients who have been involved in these consultations report that such consultations are not helpful for them. In the following excerpt, some of the patients in HC-B articulate their experiences of non-interpreter mediated consultations.

Excerpt 17

1. **P11**: ha ke fihla ke fihlile ka mo fa bukana, o e shebile, a e
   When I arrived I gave him my card, he looked at it, an
2. sheba, ha a qeta ho e sheba ha a re letho o ngotse feela
   after looking at it he said nothing, he just wrote
3. a beha file a re ke tsamaee ka be tsamaea ha hona ntho
   then put back he file and said I should go, and I went,
4. eo ba e ngotseng ka mono, kannete eena re na le
   they wrote nothing there, honestly we have a problem
5. bothata ha hona ntho eo re e buang kannete.
   with him we talk nothing with him.

(P11 at HC-B)

In this excerpt the patient emphasises lack of communication with the use of expressions such as: *he just wrote, he wrote nothing, we talk nothing*. The repeated use of *nothing* even with the contradiction between *he wrote* and *he wrote nothing*, shows that the patient feels that she cannot communicate with this physician. This is reported to bar these patients from explaining their problems to their physician. These patients therefore report their problems to one of the nurses

who speak their language after the consultation. This generally means that non-interpreter mediated consultations are communicatively problematic in these situations.

These physician experiences already begin to mark the fact that communication where participants are linguistically diverse is somewhat problematic. The experiences show indication that there is a need to manage language diversity among all concerned in order to facilitate effective communication.

4.2.3 Nurses' Experiences

According to data drawn from nurses in both HC-A and HC-B, nurses have their clinical duties such as taking patients' weight, blood pressure and testing for HIV. Their interaction with physicians comes when they have to discuss a patient's case and care, and when they have to interpret because the interpreters are all occupied. Their involvement as interpreters is therefore an institutional strategy to manage language diversity and curb potential breakdowns in communication. However, previous studies, for example, Dressler and Pils (2009:1184) and Fatahi (2010:776) have established that using staff such as nurses as interpreters is undesirable because it brings an added workload to their schedule. These studies also noted that such staff members do not consider interpreting as their duty so sometimes they are unavailable to interpret.

It should be noted that in Lesotho clinics nurses are bilingual Sesotho-English speakers with their L1 as Sesotho, and their L2 English skills being above the average. Due to the fact that in secondary school as well as during their training, the Language-of-Education would have been English, it is reasonable to assume not only respectable levels of English as a lingua franca, but also the ability to work in a medical practice context through the medium of English. Thus, although nurses have no training as professional interpreters, they are not unsuitable as community interpreters. Even so, not all nurses are willing to take on the interpreting assignments that come their way.

The negative perceptions nursing staff articulate regarding their involvement as interpreters in clinical consultations were found to be expressed both implicitly and explicitly in both health care centres that were studied. These nurses were found to generally consider the extent of language diversity, specifically language discordant clinical consultations as challenging for them. One of

the objections they report is that they do not feel that it is their duty to do interpreting. In the data some of the nurses are vague about interpreting as an added task to their job description, while others mention it explicitly. For example, in making reference to this role, some of the nurses point out that they become interpreters "ka nako eno" (*at that time*). This implies that it is not part of their duty but a role they perform occasionally, at a particular point in time when the need arises. Some of the nurses clearly stipulated their exasperation at the idea of having to take on an interpreting role. The following from interviews with nurses N5 and N2 illustrates a position generally expressed at both HC-A and HC-B:

Excerpt 18

1. **N5:** che o ua bona le eena hore kea teneha ke ho be sa le ke mo tolokella.
   he is also aware that I get annoyed with always interpreting for him
2. **Res:** uena u tenehelang ke ho toloka?
   and why do you get annoyed?
3. **N5:** ache ha ke no qeta, ke mosebetsi oa tsatsi le leng le leleng joale? Ae!
   oh no! I will never finish, then it becomes a daily routine? No, I won't!
4. nako e 'ngoe eba o sa sobokella feela hore
   sometimes he just passes information by, regardless
5. na ua utloisisa o ua utloisisa kapa ha a utloisise ...
   of whether he undertstands or not ...

(N5 at HC-B)

Excerpt 19

1. **N2:** ... Na ha nke be ke transleitele ngaka hobane ke hle ke re nna
   I never translate for the physician, because I always say my
2. mosebetsi oaka hase ho transleitela ngaka, ke hane.
   job is not to translate for a physician, I usually refuse.
3. Hoa ka ke hore fela mohlomong haeba ngaka e entse ntho
   mine is just to probably when the physician has done something
4. Eo ke nang le liquiry ke tla ea ke re 'm'e o hlokometse hore
   That I have a query with, I go and say have you realised that
5. Moo ho tje ho tje kapa le eena aee Mahase tje le tje le tje.
   here it's like this and this or she also says X,is this and this

6.		Hantle reee be re solva litaba tsa bokuli not necessarily *Actually it's when we solve a patient's problem not necessarily*
7.		Hore keo mo transleitela *to translate for her/him.*
8.	**Res:**	tsa ho transleita oo hane hobaneng? *Why do you refuse to translate?*
9.	**N2:**	aee tsa o trensleita ha ke li etse ke hore a person of my *No, translation I don't do. Imagine a person of my*
10.		calibre? ke ee sekolong nako e kale-kale ke tlo tla ke *calibre? After so many years of studying I act as a*
11.		transleitela ngaka? Nna? Aee *translator for a physician? Me? No!!*
12.		ke tla be ke re "Nna nke be ka o transleitela 'nana, ha o tlile o sa *I usually say "I will never translate little girl, you came here*
13.		tsebe Sesotho o tlo ithutela moo, ke taba ea hao. Joale o tla ba nke *without Sesotho proficiency coming to learn here. It's your problem. Then*
14.		eo a ka mo grabang hore ooe o ko tlo tla ntolokela mona joale *she grabs just anybody and says: please come and translate*
15.		lintho li ba worse ... *and things become worse ...*

(N2 at HC-A)

The interview excerpt contains four crucial elements that summarise the nurses' perceptions of their interpreting role. Firstly, there is an indication of N2's understanding of what constitutes the role of a nurse, which is to "solva litaba tsa mokuli" (*to solve a patient's problem*) *in line 4*. This means that nurses identify themselves as actors in the clinical consultation, helping patients specifically with medical care. They do not see the communicative part of the consultation as an extension of this responsibility, as they clearly stipulate that "mosebetsi oa ka ha se ho transleitela ngaka" (*my job is not to translate for physicians*). This position is similarly articulated by a nurse in HC-B (*N5 at HC-B*) *in excerpt 18 above***,** said that "kea teneha ke ho be sale ke mo tolokella ... ha ke na qeta (mosebetsi oa ka)" (I *get annoyed with interpreting for him ... I will never finish* (*my work*)) *in lines 1 and 3*. This indicates that nurses perceive interpreting as an added chore in the way that it has been explained by Dressler and Pils (2009) and Fatahi (2010).

Thirdly the excerpt contains an indication of how the physician deals with the refusal, namely by turning to some other person who may be available – "o tla ba nke eo a ka mo grabbang" *in line 14 excerpt 19*. The physician in HC-B, faced with a similar problem of not having an interpreter available, is reported to "sobokella feela" (*just pass information by*) *line 4 excerpt 19 above*. The fact that there is no institutional mechanism either to co-opt designated interpreters or to manage the ways in which nurses should or should not assist in interpreting certainly presents a challenge. That a nurse can refuse or articulate reluctance to interpret in both health care centres indicates and indirect acknowledgement by the institutions that interpreting by nursing staff is "nice-to-have" but not an obligatory part of their role.

Fourthly, N2 gives reasons why she finds the interpreting role an annoying one, namely that, it does not suitably recognise her qualifications. The comments of N2 about qualifications in line 9-11 above also show that they regard themselves more qualified than an interpreting job. This is true in their context because in Lesotho interpreters are usually people with a high school certificate, or awaiting results for COSC, as it is the case with interpreters in HC-A. In referring to her qualifications, N2 is directly comparing herself to these interpreters. It should be noted that in other contexts interpreting is a qualified job and a skill in demand, therefore so highly valued that nurses would appreciate performing the role. For example Meyer et al. (2010:165) notes that in the USA interpreters are qualified and some of their skills are that they: "... are aware of cultural differences, and are able to use specialised terminology, are able to use different interpreting modes ..." This means that in such cases interpreting is a specialised job, while its not in Lesotho.

Nurses experiences, like those of physicians and patients also indicate that there challenges in the communicative process. This is not surprising considering the fact that literature on health care communication, composed of studies done across the world reports that language discordant health are challenging. The challenges established in the current study are presented in the forthcoming section.

4.3 THREATS TO COMMUNICATIVE SUCCESS

Data from all groups of participants shows that they all experience certain communicative related challenges arising from both the organisational framework of the two clinics and language

diversity. These challenges were probed by the third question of this study, related to objective (iii), both of which focus on: *threats to communicative success*. In this section the challenges experienced by each group are presented, starting with those of patients since they are the clients in health care provision.

4.3.1 Patients' Challenges

The findings show that patients' challenges are experienced mainly in the physician's consultation**.** Although all patients accept that language diversity demands some form of participation by interpreters in the consultation, the data shows conflicting opinions among patients regarding the quality of the interpretation. Some patients expressed content with the accuracy of the interpretation, while others were not satisfied. Patients who indicated uncertainty about the accuracy with which interpreters conveyed their messages, said that they do not know whether interpreters pass on their messages and those of physicians with accuracy and completeness. However, they relied on individually devised indicators that they believe had helped them to decide, and mentioned what they read as evidence that interpreters were probably passing on their messages accurately. Patients P5 and P6 gave the following examples:

Excerpt 20

1.	**P5**:	kea itjoetsa hore o ntsa fetisa tsona hobane ha kere ke na le *I tell myself that she is because even when I say there is*
2.		ntho mona (o supa setono) ke tla utloa doctor a sa ke hlobole *something here* (*points to behind*) *I hear Doctor say I should undress,*
3.		a bone ... ha ne ke hlalositse litlhare li mpha mathata *so she can check ...when I had explained that medication gives me problems*
4.		ne ke bone a sa li chencha a mpha mofuta o mong o fapaneng. *I saw him/her changing and giving me a different type of medication.*
5.	**P6:**	ke hobane ke la ka ea x-rayeng ea bua ntho e ne se ntse ke e *It's because I went for an x-ray and it said what I already*
6.		tseba eaba kea bona hore motho enoa o ntsa bua tsona kamora *knew, that proved to me that this person is mediating properly, after*
7.		mono ntho e la nkholisa ho feta sepetlele sena ke la ka joetsoa *and after that what made me believe even more, I was told*

8.	nthoe ne se ntse ke e joetsitsoe mosebetsing: hore ke na le ntho *what I had already been told at work, that I have*
9.	ka sefubeng. *chest problems.*
	(Ps at HC-A)

Patient (P5) was convinced of the accuracy of the interpretation by the fact that the physician wanted to see the symptom she had talked about. Patient (P6) came to the clinic to confirm what he already knew on the basis of a visit to another clinic. When that information was confirmed he was convinced that the interpretation was accurate. This shows that overall these patients are content with the interpreting services they get, even though the situation does not allow them to rate the accuracy of such interpreting objectively.

Another group of patients report upfront to have reservations about interpreting accuracy and that they would therefore have liked to communicate directly with physicians. These patients' discontentment arises from the feeling that they had that interpreters had not given the physician sufficient descriptions of their problems. They would have successfully done so if they had been able to speak directly to the physician. P1 and P7 commented about the issue in this:

Excerpt 21

1.	**P1**: Ka nako e nngoe ke ee ke bone joalo ka motho *Sometimes as someone who*
2.	ea sa tsebeng ke ee bone eka hona le a mang ao a a *doesn't know, I feel like there are words she*
3.	koentseng ... ke ee bone ... ke ee utloe eka ha a hlalosa *omitted ... I feel ... that she has not explained*
4.	tse ling, ke sa tsebeng hore na ke ho hloka tsebo *others* (*problems*), *I don't know whether its*
5.	kapa che ... ke belaela hore ekare hona le nqae *because I don't know the language or not but*
6.	engoe moo a sa chong. *I feel like there are things she omitted*
7.	**P7:** ache ke ile ka utloa ke phuthulohile empa e se hakaalo *well, I was free, though it was to a limited extent*

8. hobane ke utloisisa hore ekare ha nna ke mo hlalosetsa
because my understanding was that if I was the one

9. kea kholoa nka hlalosa hantle haholoanyane.
explaining I believe I would do it better and more sufficiently.
(Ps at HC-A)

These excerpts give a representation of patients' comments opinions about the interpreters' performance. The patients felt that there had been omissions in the information that had been passed on. The expressions: "kea kholoa nka hlalosa ... haholoanyane" (*I believe I would do it ... more sufficiently*), and ..." ke ee utloe eka ha hlalosa tse ling (*I feel that she has not explained others*) indicate a perception that the interpreters' explanations are inadequate and some elements of the patient's problem/s have been omitted. These are the reasons that these patients give for their preference for communicating directly with the physicians, which they cannot do given the incompatibility of linguistics resources between them and their physicians.

Patients' reports also show that they experience challenges in non-interpreter mediated consultations too due to the language barrier between them and physicians. This is despite the fact that physicians see this type of consultations as ideal. The barrier can be attributed not only to different levels of English proficiency and different levels of knowledge regarding the medical jargon, but also to communicative styles that make it difficult for patients to communicate with the physician. Patients reported three reasons that made it challenging to communicate with physicians. The first is the complexity of the English spoken by physicians as reported by a patient in Excerpt 12 above – "batho bana ba mofuta oane o mots'o o hlahang koana bana le hore ka nako e ngoe ba tebe" (*these kind of black people from "there" sometimes have a way of talking deep language*), where vocabulary and sophisticated sentence constructions are mentioned. Patients sometimes find that physicians talk in complicated English that they cannot understand.

The second reason is the accents of physicians, which are reported to be unfamiliar to patients. As mentioned before, most of the physicians, particularly in HC-A come from Francophone countries. Their English accents are therefore unfamiliar to Sesotho L1 speakers, who already have limited proficiency in English. For example, in talking about these accents a patient P7 comments in the

way presented in excerpt 22 below. In that excerpt, this patient shows that physicians pronounce words in a way that "u batla u sa utloe" (you really cannot hear (understand)). When patients cannot comprehend what physicians are saying, it would be difficult for communication to be effective.

Excerpt 22

1.	**P7:**	ka nako e 'ngoe bo-ntate baa ba lingaka le bo 'me *Sometimes these gentlemen who are physians, and ladies*
2.		tsela eo ba buang ka teng ba pronounsang, o batla *the way they talk and pronounce, u really*
3.		sa ba utloe hantle ... *don't hear* (*understand them*)

(P7 at HC-A)

A third factor that emerged from the interviews with physicians is that they tend to talk fast. Interestingly, patients did not mention this, but some of the physicians identified it as a potential hindrance to patients' direct communication with them. Patients are reported to say that some physicians talk too fast for them to understand, so they prefer to have an interpreter to assist them.

These challenges affect the patients' ability to communicate effectively with their physicians because when they cannot adequately comprehend what physicians are saying, it becomes difficult to express themselves too, hence the use of interpreters. The implication is that in the absence of a shared language, patients feel that they are deprived of an opportunity to explain their problems adequately to their physicians. As a result, they feel that they would be forced to leave out explanation of parts of their problem s because they do not know how to say them, thereby rendering their explanations inadequate. These patients therefore feel that interpreters are a very important aspect of the consultation because they are able to fill the communicative gaps between patients and physicians.

4.3.2 Physicians' Challenges

The study established that it is not only patients that experience language discordance as problematic. Physicians also report that they find the situation challenging. The data reflects that

the challenges that physicians generally comment on fall into three main categories. The first category is one where physician-patient relationships feature. The second category is related to cases where there are interpreters involved or in interpreted consultations in general. The third category is of challenges that are related to the content of the topics discussed.

4.3.2.1 Physician-Patient Relationships

The results show that language discordance between physicians and patients is one of the factors that potentially limit the effectiveness of communication in a clinical interaction in that language discordance does not allow direct communication between a physician and a patient. This has a negative impact on the physician-patient relationship, which is a crucial element in the achievement of positive health outcomes.

All physicians who participated in this study acknowledged that it is challenging to treat a patient with whom one does not share any linguistic resources. Physicians' accounts show that if there is no linguistic compatibility between them and their patients, they feel uncomfortable and it is difficult to establish rapport and trust with the patient. This is because it is difficult to engage enough to build a relationship.

The value of a good relationship characterised by good communication between physicians and patients has been established in previous studies such as Rivadeneyra et al. (2000: 470) and Lucoshek et al. (2003:204). These studies established that communication is a core aspect in a clinical consultation. Other studies, for example Schouten (2009:469) found that where there is language discordance between physicians and patients both parties develop communicative styles that are not conducive to effective communication. This means that communication is compromised. The physicians in this study echo the sentiments present in previous literature, indicating that when they do not share a language with their patients they are unable to build a relationship.

The fact that mutual linguistic resources help in building relationships between physicians and patients is attested to by physicians in this study. They give accounts of their experiences of patients' positive reactions when they speak Sesotho in a consultation, by articulating several

indicators of patients' appreciation. To exemplify this, one of the physicians expresses the experience in *Excerpt 23 below:*

Excerpt 23

1. **D2**: They give you the information that you want
2. from them ... they will be happy yes even free to
3. ask you questions, to tell you their complaints you
4. know most of the time some of them are afraid even
5. to tell you what they are feeling, yes, but if you are
6. talking on the language the relationship is becoming
7. tight now it's no longer a physician and patient
8. but it's friends now."

(D at HC-A)

This physician's account shows that the ability to speak directly to patients in their L1 has a positive impact on the quality of interactions. This positive impact is characterised by patient behaviours such as them providing required information; showing happiness; asking questions and so on. The positive behaviour ultimately leads to the rapport, trust and good physician-patient relationship that are requirements for a satisfactory quality of patient care. It also affords patients the opportunity to freely articulate their problems.

4.3.2.2 Interpreted Consultations

Medically trained staff, such as nurses, is a preferred option of interpreters by physicians, as reported earlier. However, the data shows that even with this option physicians still experience some challenges. The first challenge that appears in the data has to do with the role performance of interpreters. This performance has also been identified in research previously done elsewhere, for example Angelelli (2004:88) and Hsieh (2007:927). In these studies interpreters were found to go beyond their interpreting role, giving additional explanations and instructions, thereby assuming the roles of physicians by either increasing the interpreted information or censoring it.

In HC-A physicians reported that they have experienced cases where it seems that the interpreter is giving more information than has been given either by the physician or by a patient. In that way the interpreter is acting in a way consistent with Angelleli's (2004:88) critique of interpreting

behaviour that is characterized by the interpreters being active contributors to the conversation – rather than them being "invisible" and simply transmitting what has been said, no more and no less. By so doing, they run the risk of misinforming or even misguiding patients. In these settings, physicians report that they feel undermined by interpreters. While this opinion recurred in the data from physicians in HC-A, in HC-B the physician reported that he never had such experiences or even thought about the possibility, because he has trust in the nurse-interpreter as a colleague.

Another challenge prevalent in the data from physicians in HC-A refers to the cultural barriers. Physicians report that there is some content that interpreters are not able to pass on to patients because it is culturally taboo. A physician in HC-A expresses this challenge in the following way:

Excerpt 24

D4: but sometimes they are ... you know Basothos, they have got their own culture. Myself I am a doctor, there are certain things that I want to say but them, they may be shy to say them or it's taboo to say so you'd feel that No, this thing was not ... you can feel it if something was not ... that the patient was not given the info.

(D4 at HC-A)

This means that interpreters find it difficult to verbalise certain pieces of information due to their specific cultural restrictions. In interviews with physicians, some of them cited sexuality and sexual behaviours as one of the topics that interpreters find difficult to convey. This becomes a problem in these clinics, particularly because the treatment of HIV and AIDS entails discussing patient's sexual behaviour.

This situation creates a sense of helplessness among physicians. Physicians expressed their helplessness due to not knowing what interpreters are saying to patients. They cannot ascertain whether their message is conveyed accurately or not, or whether the patients' messages are conveyed accurately to them. One of the physicians explained such uncertainty in this way:

Excerpt 25

1. **D4:** Sometimes you feel that what you have said has not been
2. said ... but to confirm it how do you do it? You can't ...
3. you try ... but you don't know their language. You can't
4. yah, you can't confirm that ..."

(D4 at HC-A)

This points to the fact that the physicians sometimes feel left out in the communicative event. They cannot guarantee the communicative content, quantity or even quality of the interaction that is passed on to their patients. In that way the interpreter is the one that communicatively controls the consultation.

4.3.2.3 Challenges Associated with Message Content

Apart from the above mentioned problems that are clearly caused by language discordance and the organisational aspects meant to respond to it, this study established patients' reluctance to conversationally engage in sex related discourses becomes an additional challenge for physicians. Their accounts show that at the point where sex or sexuality becomes a topical issue in the consultation, patients shy away from expressing themselves. This is how some of the physicians describe patients' communicative conduct at such points:

Excerpt 26

1. **D5**: Yes, some are comfortable some are like shame..feel shame,
2. even when you have a box of condom there when you propose
3. them (sic), particularly the men they... *(physically imitates a shy person)*
4. **D2**: Especially if it's a village patient, those that are 12, 14,
5. 15, somewhere there, they will always rolling (sic) around and
6. even covering the eyes when you start to talk about it *(sex)*

(D2 and D5 in HC-A)

This reluctance on the side of patients is reportedly a challenge for physicians and HCPs in general. This is because it has implications for the completeness of patient history, more especially since information on sexual behaviour is crucial for a discussion of treatment and adherence.

4.3.3 Nurses' Challenges

The nurses in this study report no challenges associated with their nursing duties. The challenges they seem to have are associated with their interpreting role. The first challenge has been reported earlier is the fact that they do not like the interpreting role as it is not part of their terms of reference.

The second challenge observed in their report is their dissatisfaction over working in an environment where physicians are assisted by lay interpreters. As mentioned earlier, these are staff without training in interpreting or medicine, and who are recruited simply because of their bilingual proficiency. The fact that these lay interpreters are neither trained as health nor communication specialists is reportedly evident in the quality of their interpreting. Nurses report that there is information that these interpreters cannot convey due to lack of knowledge of medical conditions and the jargon used in the field. The following excerpt presents an illustration of one such piece of information drawn from interviews with nurse, N2 in HC-A.

Excerpt 27

1. N2: Hona tjena ha ke o fa mohlala ho no be ho thoe na fatigue
Now, for example, they were asking what fatigue is,

2. ke'ng, ngaka a sa e utloisise eaba enoa ea lay le eena o hloloa
the physician did not understand that, and this lay also failed

3. ho lokolisa hantle hore na fatigue ke'ng but ha e ne e le
to explain what fatigue is, but if it was me I would know

4. nna ne ke tla tseba hore na fatigue keng Kapa ha e ne e le
what fatigue is, or if it was

5. nurse assistant o na tla tseba hore na Fatigue keng
a nurse assistant he/she would know what fatigue is.

(N2 at HC-A)

The lay interpreter's failure here is related to his limited English vocabulary. His knowledge of an English term often used in medical consultation, namely 'fatigue' is reported in this case to have impeded the **communication** between physician and patient. Such lack of understanding would have been avoided if the interpreter had a higher level of English proficiency, or had been a

medically trained person. They therefore feel that the job would be best done by someone with basic training in medicine.

4.3.4 Interpreters' Challenges

As the previous sections have indicated, there are two types of interpreters found in HC-A, while HC-B does not have interpreters as part of their staff but uses nurses for that purposes. In HC-A the first category is one of lay-interpreters and the second one is made up of administrative staff, such as a receptionist frequently called on when the lay interpreters are not available. The experiences reported in this section are those of members of these two groups who play an interpreting role in HC-A and of the nurses that perform an interpreting role in both centres. Just like physicians, patients and nurses these interpreters report that they experience facilitating communication in these instances as challenging. The data drawn from interviews with these interpreters reflect a prevalence of challenges that fall into two categories namely language related obstacles and communicative style related obstacles.

4.3.4.1 Language-related Barriers

One of the challenges that interpreters report is one of a vocabulary mismatch between the two languages used in the consultation room, which are English and Sesotho. This means that there are some words that do not have an exact lexical equivalent in the other language. This makes it difficult for them to convey some of the information, and especially so in the scenarios in HC-A where the physicians have limited English proficiency, so that they can also not always offer an alternative. An example of such an expression that does not have a lexical equivalent, is given below:

Excerpt 28

1.	**I2:**	Ka nako e nngoe u tla utloa mokuli a re lehlaba le ile la *Sometimes a patient reports that sharpa pain is felt*
2.		re nyebelele e be ua ipotsa u tlo reng, nyebelele? nyebelele *[a Sesotho term that indicates intense pain that feels like it's moving swiftly - KS] then you wonder what you will say.*
3.		Ua utloa o leka ho ho bonts'a matla hore na le joang. *She/he is trying to show the intensity of the pain.*

4.	Ka nako e nngoe ha o re *If you just say:*
5.	feela, sharp pain, but eena ha re nyebelele ke nthoe fetang ... *sharp pain, but* nyebelele *is more than that.*
	(I2 at HC-A)

As this example illustrates, the word "nyebelele" is difficult to translate into English, particularly given the fact that it has to be translated for a physician who knows very little English and less Sesotho. Interpreters reported that in cases like this they consult nurses with a hope that either there is a scientific term to explain the problem, or nurses know better English and will assist. In some cases a solution is found, while in other cases nurses will just indicate that there is no translation for the term.

This challenge of terminology mismatch between languages was also observed in the studies of Levin (2006a) and Levin (2006b) where health communication was carried out in Xhosa and English. Levin (2006a:1079), for example, pointed out that very often one English word can mean several different things in Xhosa, and when quizzed further for clarification English-speaking physicians usually cannot explain which of the possible meanings are activated in the context. In other cases, Levin (2006b:1081) shows that English has only the generic term, whereas the patient's ailment need more specific information than that. Levin (2006b:1081-82) gives an example of the Xhosa word "isifuba" (chest). This word is a general term that patients' parents would use to mean either the anatomical chest, a number of signs and symptoms signifying chest disease, or a specific chest illness. It is apparent that in cases like this, interpreters would encounter a problem of knowing which meaning is being communicated.

4.3.4.2 Communicative Styles of Physicians and Patients

Data from interpreting staff demonstrates that sometimes the work of interpreters is made difficult by certain physicians' and patients' communicative styles, or by practices that develop as a result of language discordance. One of those styles is brevity in explanations. This brevity reportedly compromises patient understanding and leaves added responsibilities for interpreters. Since these physicians either have a limited vocabulary in English, or they find that one technical term should

be sufficient, they do not give enough details to patients. This brevity of information is articulated in the following interpreters' recollections of instances they experienced, where they felt that information provided to patients was insufficient or too brief.

Excerpt 29

1. **I3:** lingaka tsena ... ha li tsebe Sekhooa hantle, o itsebela li
   these doctors ... don't know English, they just know
2. abbreviation feela a ba fihla a re feela ho mokuli: PV
   abbreviations, he/she just said to a patient :PV
3. discharge, a sa reng PV a re LMP? Mokuli ha utloisise le
   discharge, or apart from that LMP? The patient doesn't
4. ha eka ba eaba a tsebang Sekhooa ...
   even if it's an English proficient one
5. **I2:** ka nako e nngoe physician o tla ba re feela ho mokuli: qala
   sometimes the physician would just say to a patient start
6. Pre-HAART. U ts'oanetse u joetse mokuli u bo mo bolelle
   pre-HAART. Then you have to tell the patient, tell
7. hobaneng a lokela ho e qala. Le hore na ke'ng?
   him/her why s/he has to start it and what it is.

(Is at HC-A)

While in the context recalled by **I2** and **I3** in *Excerpt 29*, the inadequacy of detail was ascribed to the use of abbreviations, in other cases interpreters report on inadequacy of detail due to cursory explanations to patients. In clarifying such situations, an interpreter in HC-A recalled several encounters between physicians and patients, where physicians were interpreting laboratory test results and would not explain the results to the patient thereby leaving the interpreter with the responsibility of producing an explanation.

Besides brevity in verbal explanations as reported above, the data also indicates that some of the give very brief written records of patients' histories. This written patient history is important not only for patients but for other health care providers (nurses, other physicians) who are going to take part in the treatment of such a patient in the future. If a patient's history is not articulated

sufficiently and precisely, the patients' problem may not be understood properly and care is compromised.

The findings suggest that it is not only physicians' communication styles that pose a threat to communicative success, patients also have ways of communicating that exacerbate the situation for interpreters. The patients' communicative style that emerges as problematic for interpreters is their long-winded explanations, often providing detail than is necessary and so making it difficult to distinguish between relevant and less relevant information. For example, patients are reported to provide extended descriptions of their problems, including the health problems they had a long time ago. This reportedly prolongs the consultation and may cause the physician to lose track of the actual problem that needs attention. For interpreters it calls for more involvement because, over the task in interpreting, it requires them to filter the information and guide the physician to the present problem.

In addition to too much detail on some matters, the previously mentioned patients' reluctance to openly communicate about sexuality or sexual behaviour poses a threat too. This reluctance is also attested to by physicians and some of the patients themselves. Their accounts show that some patients just avoid talking about the topic saying they are sexually inactive. This leaves the interpreter with the added responsibility to probe for more information in order to help the physician do a proper assessment and suggest treatment where necessary.

According to these experiences, language discordant clinical interactions are a big responsibility for interpreters. On top of interpreting they are faced with the task of making sure that physicians and patients understand each other. Where there are communicative gaps they fill them and where there is too much information they have to filter the information. These interpreters are therefore demonstrating an interpreting behaviour commensurate with what are referred to as visible interpreters (Angelelli, 2004:88) and non-conduit interpreters (Hsieh, 2007:927), interpreters who are found to actively participate by producing their own lines to the information they are expected to interpret.

4.4 STRATEGIES OF MANAGING LANGUAGE DIVERSITY

As it has been reflected in the previous discussions, all groups of participants report that they experience challenges in language discordant interactions. The physician's consultation has been singled out as the point that presents the most stumbling blocks. This is related to the fact that where language discordance is more manifest than other areas. Regardless of these challenges, all parties concerned have an interest in the success of communication. This section discusses the strategies that have been developed by the institutions and the different groups of participants. The section therefore answers the first question of this study which is: What are the multilingual resources and strategies that enable role players to counter these organisational threats to communicative success? Data classification of the strategies done through QCA yielded two types of strategies that are used to manage language diversity. The first type consists of strategies that are organisational, that is they arise from the institutional organisation of the health care centre and the consultation. The second type will be called interpersonal strategies. These are strategies that each group of stakeholders report to have used in their own management of language diversity.

4.4.1 Organisational Strategies

Organisational strategies to manage language diversity in health care have been reported in past research such as Collins and Slembrouck (2006), Babitsch et al. (2008) and Moyer (2011). All these studies established that where there is language diversity, medical organisations become aware that communication is likely to be challenging, and they respond by introducing measures to avert the hazards. According to Moyer (2011:1211) these strategies become a reflection of how a medical organisation understands multilingualism and the role that communication plays in health care.

Observations of the care and communicative processes and practices in HC-A and HC-B disclosed an occurrence of organisational features that do enhance the effectiveness of communication in these multilingual clinics. The first organisational feature that was observed was the fact that the care process is divided into different sections staffed by different professionals such as nurses and counsellors. The second organisational feature is the way in which the consultation with the physician is structured as a communicative event.

In relation to the first organisational feature, this study established that the fragmentation of the care process into different sections assures that different professionals are able to perform different components of the care process competently using the L1 of the patient. As figure 1 (chapter 5) illustrates, the care process in the two health centres takes place across ten different service points, (also see section 4.2). Of all these stages, nine are committed to giving education, health care services, outcomes of tests and treatment by administrative, counselling and clinical staff, with varying skills and experiences, who all have linguistic resources compatible with those of the patients. At virtually every stage there is an educational component, which as has been noted by Watermeyer and Penn (2009:212), is a crucial component of successful HIV and AIDS patient care, especially in language discordant contexts.

The HIV and AIDS education in the two multilingual clinics of this study was found to have two features that account for its success and effectiveness, namely the use of different communicative modes, and the use of Sesotho L1 professionals in most of the stages that patients pass through in the clinic. Regarding the different modes of communication that are used to disseminate the information, nursing staff in both clinics made reference to the use of printed, verbal and audio-visual modes. These modes appeal differently to different individuals and groups of patients and by using them concurrently all these groups are met. In evaluating the value of care given at the clinic, a nurse made the following comment about one of the videos giving HIV and AIDS education that patients usually watch in the reception area. This is reflected in *Excerpt 30* below. The description given by nursing sister N2 highlights the fact that the video affords nursing staff the opportunity to convey information that has to do with sexual organs, which they would otherwise be too embarrassed to convey in direct verbal communication because it is tabooed in the Basotho culture. The video therefore fills the communicative gap that culture would otherwise have generated.

Excerpt 30[11]

1.	**N2:** e bua ka sesotho e ne eona na e tla hle e toboketse e bue *It's in Sesotho and it usually talk explicitly, it says things as*

[11] "Thing" in this excerpt refers to a man's sexual organ and it is considered a less derogatory term in Lesotho.

2.	ntho e le joalo. Ebile hangata kee bone eka ha lia etsoa hae *as they are. In fact I think they were no produced here, they*
3.	mona li entsoe South Africa, li tla be li e bitsa ntho eno li toboketsa, *were produced in South Africa, they call things as they are,*
4.	Lesotho e le Lesotho ntho ea ntate e le ntho ea ntate e bitsa e le joalo. *Lesotho as Lesotho, a man's thing as it is.*
5.	Re tla be ntse re shebanang fela qetellong ea letsatsi *We would just be looking at each other, at the end of the day*
6.	ebe kea botsa: "molaetsa na o fetile hantle? lipotso li teng?" *I ask: "did the message clearly pass? Questions?"*

(N2 at HC-A)

Regarding the facilitation of HIV and AIDS education in these organisations by Sesotho speakers, the advantages of introducing new patients to the clinic through medium of their L1 are evident. Since patients get this education in their L1, by the time they get to the physician's consultation room where there is language discordance, they are already well enough informed and their care is not unduly threatened by communicative challenges. In *Excerpt 31* below, one of the patients in HC-A expresses the effectiveness of this education.

Excerpt 31

1.	**Res:**	ha ho ko be ho etsahale hore ho be le lintho *Doesn't it happen that sometimes you feel like there are*
2.		tseo o utloang eka tsena ke batla tlhaloso e batlang e le *more explanations you need about your medication?*
3.		ngatanyana litabeng tse amanang le litlhare?
4.	**P2:**	ke hore oa tseba ke ile ka tsoa se ke *you I went out of the counselling unit so*
5.		rutehile haholo ka tlhabollong hoo nka ka rutang ba *educated that I felt like I am capable of being the one who*
6.		bang ka taba ea litlhare *teaches others about medication.*

(P2 at HC-A)

Here patient P2 reflects that the education they get is informative and empowering enough for them. This implies that the patient feels capable of managing her condition and her adherence to treatment, regardless of the communicative challenges that could have transpired in consultation with the physician. The fragmentation of the care process therefore helps to manage language diversity in that it makes available information that would otherwise be independent on the physician's ability to communicate more and more thoroughly in the consultation.

The second organisational feature that was found to be useful in managing language diversity is the organisation of the physician's consultation as a communicative event with two aspects in it. The first aspect that health care providers refer to quite regularly is the interrogation aspect, given in the form of question-answer sequences. This is the communicative style by means of which the information about a patient's health problem is solicited and the patient gives an explanation. Another aspect of the consultation is the physical examination where physical symptoms are observed. Information from these two sources is combined to help in making a diagnostic and treatment decision. These two components are important in that they complement each other in terms of information. Content that cannot be articulated accurately due to language discordance can be picked up in the physical examination, thereby rendering this organisational feature a crucial aspect in managing language diversity.

Furthermore, both these health care institutions were found to make different forms of literature available to patients as another step in empowering patients with knowledge about their disease. As mentioned in earlier sections this literature is found either in the form of posters around the clinic or as pamphlets distributed to patients. The value of this literature is that it also acts as an educative tool, providing patients with information that would otherwise be given to them by a physician only. It therefore is another tool that fills the information gap that would be left by a language discordant clinical interaction.

It is apparent from the above discussion that the two health care centres are organised in a way that the physician's consultation is surrounded by complementary communicative events that inform and educate patients about their condition. While this may not look like a direct strategy to manage language diversity, indirectly it translates into managing language diversity because it averts the

potential misunderstandings and communicative inadequacies that patients would be confronted with if their consultation was solely a language discordant physician's consultation.

4.4.2 Interpersonal Strategies

Apart from strategies that arise out of the health care organisation, this study established that different groups of participants have ways in which they manage language diversity and find ways of achieving communicative success in consultations. Most of the strategies discussed below were suggested by physicians and nurses. Interestingly the strategies reported by patients were very similar to the ones reported by interpreters.

4.4.2.1 Patient Strategies

Although patients reported that most of the time communication between them and physicians goes through smoothly, there are a few cases when they have felt that the physician does not understand them and they make an extra effort to be understood. The need for patients to be understood is underscored by previous have researchers such as (Ruusuovori, 2001:1096) who has indicated that the success of a consultation is very much dependent on patients' ability to communicate the health problems accurately and in a way that is understandable to the physician.

Two strategies were found in patients' reports. The first strategy was found to be used when patients need to be understood. They report that they use a non-verbal strategy of pointing to the area of the body that is ailing and show the physician where the problem is. Obviously, this strategy accounts for limited communication because it can only be useful in cases where the health problem has physical manifestations. This limitation of non-verbal communication was confirmed in Dressler and Pils (2009:1188) and Fatahi et al. (2010:778) who noted that when the health problem is complex, nonverbal communication cannot be a useful communicative strategy.

The second strategy was to solicit assurance from the interpreter that the information has been passed accurately. In these cases patients reported that they also ask the interpreter to elaborate more, so the explanation is intensified to make them understand better. This is sees in *excerpt 39* in the forthcoming page where one of the patients gives an example of how in some cases as patients they show persistence in their asking for more clarity. The patient's persistence is

characterised by the use of the expression "ke ee ke tlatse lerata" (I usually make noise), which means that she calls for attention until her quest is attended to. This indicates that patients do make an effort for communication to be successful in these consultations.

Excerpt 32

1. Res: ha u le ka ngakeng ho na le nthoe o sa e ultoisiseng u etsa joang?
   when you are in a consultation and there is something you don't understand what do you do?
2. P5: ke re ho enoa a tolokang, bua hantle ke utloe na u ntso reng, u ntso reng joale?
   I say to the interpreter, talk properly so I can hear what you are saying, what are you saying now?
3. Ke ha ke utloa eka karabo tsa hae ha li nkhotsofatse, ke ee ke tlatse lerata ke re na
   That is when I feel that the response does no satisfy me. I usually make noise and say,
4. u buile taba tsa ka hantle?
   have you detailed my problems adequately?

(P5 at HC-A)

4.4.2.2 Physicians' Strategies

In a physician's consultation the physician is responsible for diagnosis and treatment. This makes the doctor communicatively responsible for ensuring that mutual understanding between him/her and the patient. The importance of mutual understanding in HIV and AIDS care, particularly ensuring that the patient understands the nature of the illness, has been highlighted in past research by Watermeyer and Penn (2009:207). They note that because of the urgency of HIV and the complications that are associated with non-adherence, it is imperative that patients understand their condition and the treatment available.

In order to account for effective communication and patient understanding, physicians reported that they always check patient understanding at different points of the communicative event and explain more if necessary. This is how a physician in HC-A explains their way of checking patient understanding.

Excerpt 33

1. **D2:** … the method that we usually use. I think the
2. one for communications, is …
3. I think we always ask what did they understand
4. for them to explain in their own terms …

(D2 at HC-A)

This physician does not only acknowledge checking patient understanding but he also provides the method they use which is: *asking a patient to tell what they understand*. This method is consistent with the one that was found to be used by pharmacists in Watermeyer and Penn (2009:207) which they term *demonstration of understanding*. They found that this method is more effective than just asking the patient whether they have understood or not. Although in the present study the effectiveness of the method was not evaluated, the fact that it was referred to by at least four physicians and most of the clinical staff and interpreters allows a conclusion that it is a strategy that is used frequently and that participants find it effective.

Another strategy that physicians were found to use is visual illustrations. They report that they usually take a piece of paper and draw a sketch for the patient. In these illustrations physician report that they draw an anatomy of the organ that has a problem and explain where exactly the problem is, then they show how the medication is going to help. According to these physicians the illustrations usually do shed light and help to explain the problem in a way they cannot do verbally due to the limitations of their linguistic competence.

Apart from illustrations, physicians also reportedly use non-verbal communication, especially in cases where a patient has an opportunistic disease or infection that has visible physical manifestations. A physician in HC-B expresses the use of this type of communication in this way:

Excerpt 34

1. **D3:** ehm ... how can I say it?
2. If the people I can see ...l et's say we have nonverbal
3. communication also so its ... non-verbal
4. communication is quite international ...

(D3 at HC-B)

According to this physician, non-verbal communication, such as pointing to the problematic area, is generally understood by everybody, which makes it a useful communicative tool where speakers do not share a language. However, in other contexts where this was found to be used in language discordant health related communicative events such as Austria (Dresler and Pils, 2009) and Sweden (Fatahi, 2010), this mode of communication was found to be lacking in some respects. Dresler and Pils (2009:1183) reported a deficiency in terms of the mode accounting for very little communication and therefore being unable to cover the wide aspects of the rehabilitation process. For example, the psychological aspect of treatment was reported impossible in 50% of the cases. In the same manner Fatahi (2010:777-778) recorded that the mode becomes inadequate where treatment requires detailed communication, for example where a patient has to be instructed to periodically hold breath, or where expected side effects have to be communicated to a patient. In the case of physicians in HC-A and HC-B, it was reported that when the same situations arise and interactions become too complex for non-verbal communication, interpreters are called in to assist.

4.4.2.3 Nurses' Strategies

In accounts of their experiences, nurses reported that they have a responsibility to make sure that a patient leaves the centre with the right diagnosis medication and understanding of how the medication has to be used. Therefore, in the consultation room (even when they are not officially called on to interpret) they allegedly engage in lengthy explanations until the physician and the patient have understood each other. These explanations are usually their own initiative and do not come from either the physician or the patient.

Apart from lengthy and detailed explanations, nurses reported that they manage language diversity by reducing and shaping patient explanations so that they become more understandable to the physician. This is because in some cases patients give very long and incoherent versions of their problem, dating back from a long time ago and this makes it difficult for the physician to address the current problem.

Although in some cases nurses are part of the consultation and are able to spot potential communicative problems, they report that in some cases they are not part of the consultation and they spot a communication breakdown only when a patient comes out of the consultation room.

These communication failures are said to arise not only from language diversity but also from the fact that physicians are not familiar with the Lesotho guidelines of HIV care. In such cases, nurses spot the problem when they look at the prescription. When they feel that there has been a communication breakdown and that the prescribed medication is wrong, the nurses report that they change the prescription. This is mentioned in the account of N2 and N5 in *Excerpt 15 and 16* respectively.

These accounts show a visible role overlap between nurses and physicians, where some nurses take the role of physicians. The nurses do not only change patient's prescription (*line 2*), they also send patients to the laboratory for certain tests, they read and interpret the results, then diagnose, prescribe and dispense medication without consultation with a physician (*line 4-6*). Unlike N2 who does not consult at all, Nurse N5 reports minimal consultation with a physician. Although she does not seek an opinion, she at least makes the physician aware that the medication has been changed.

4.4.2.4 Interpreters' and Patients' Strategies

In a consultation, interpreters are responsible for facilitating communication. It is their responsibility to see to it that the two parties namely, physicians and patients understand each other. Therefore, when they feel that communicative success is threatened, interpreters report that they intensify the explanations, elaborating on what the physician says. This means that they stop interpreting and produce unsolicited explanations to the party that seems to have a problem of understanding. In some cases these explanations are verbal, consisting of examples made by interpreters, while in other cases they use illustrations that appeal to a party's sense of sight and therefore aid them to visualise the problem.

Apart from these explanations, interpreters reported that in some cases they solicit non-verbal communication, particularly from patients if possible. If a patient has brought a complaint that has physical manifestations, they ask the patients to point to the problematic area. This allows the physician to see where the problem is and work towards diagnosis and treatment suggestion.

Interpreters also report that they consult the nurses where they feel that they cannot explain further. The reason is that they feel that nurses are medically better qualified than they are and would

therefore know what the right explanation would be. These strategies used by interpreters were also found among patients. When they feel that the physician has not elaborated enough, patients report that they consult nurses who speak their own language and seek clarity form them. For example, a patient in HC-B explains how they handle the inability to explain to the physician:

Excerpt 35

1.	**Res:**	... ha o tla ngakeng o tla o na le mathata ao o batlang ho a hlalosa *... when you consult a physician with a problem you want to*
2.		joale ha u khone ho hlalosa joale oa tsamaea? o khutlela hae *explain but you cant't, do you go back, you go back home* ka
3.		oona a ntsa le joalo? *as you are?*
4.	**P 11:**	ache nna ha nke be ke khutle ke etsa bonnete ba hore ke *Well I never come back, I make sure that I*
5.		kopane le batho bano ba le babeli. Mohlala, hona joale ke na le *consult both of them. For example, now I have*
6.		bothata bona noo ke sa tsebeng na ke eng ene ne ke batla *this problem that I don't know what it is, and I want*
7.		ho fumana thuso, ke entse hore ke kopanne le 'me X (mooki) *to get help, I consulted Mrs X (nurse),*
8.		a etse ka hohle hore tle ke fumane thuso. *so that she can do everything to make sure that I get help.*
9.	**P12:**	eea 'M'e. *Yes Ma'm*

(Ps at HC-B)

This excerpt presents two different ways in which patients deal with challenges that are posed by language diversity and incompatibility. Patient *P12* just goes back home without seeking more help, but *P11* consults a nurse and explains her problem more elaborately so that she can get help.

4.5 CONCLUSION

It is clear from the above discussion that these two clinics are multilingual contexts in the way literature has explained this concept. The type of multilingualism that prevails in HC-A is particularly interesting because some of the doctors have limited proficiency in Sesotho and in

English which is a lingua franca. This brings further complications in a context that is already communicatively challenging in terms of the cognitive and contextual disparities that exist between patients and physicians. Although participants have reportedly developed ways in which they can counter these challenges, the fact that they report the existence of challenges means that the strategies do not work address these challenges comprehensively, thereby leaving both the institutions and participants to come up with further strategies that will effectively manage language diversity.

CHAPTER 5

DISCUSSION, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

The main research question that this study sought to answer, as articulated in section 1.4.1, was related first to how health care communication is organised in a multilingual HIV and AIDS care institution and second to how different role players in these institutions report on their communication experiences within such an organisational structure. This two-pronged question embeds three issues that were given extensive attention in this study namely, (i) the organisation of care and the corresponding communicative processes, (ii) participant experiences or multilingual communication within these structures, and (iii) communicative resources used to manage language diversity. This chapter will discuss the findings of the study in terms of the objectives set in section 1.4.3, relating these to aspects highlighted in the literature overview in Chapter 2. It will also present the conclusions drawn from these findings. Possible theoretical and clinical practice implications of this study will be laid out in the last part of the chapter.

5.1 ORGANISATIONAL FRAMEWORK OF CARE AND COMMUNICATION

The findings related to the first objective of this study which is *to establish how particular multilingual health care institutions organise the care and communicative process in testing, counselling and providing HIV and AIDS treatment* are addressed in this section. There were specifically two aspects of the organisation of the care process that were found to be instrumental in facilitating communication in these multilingual contexts. The first is the division of the care process into a series of consecutive units where different HCPs attend to different phases of the testing and care of patients; the second is the use of different modes of communication for information dissemination.

The data shows that the care and accompanying communicative processes in the two clinics are organised in largely similar fashion, and that their structure is oriented towards the achievement of the primary organisational goal of good quality medical care. The similarity in the organisational structure is explained by the adherence of the institutions to stipulations of the Lesotho National ART guidelines which direct how HIV care should be structured across the whole country. The ultimate goal which this organisation is intended to achieve is adequate care of patients diagnosed with a chronic disease of extensive proportions. Scholars who have done work on communication in HIV and AIDS in other contexts (cf. Roberts and Volberding, 1999; Anthonissen and Meyer, 2008; Swanepoel, 2005; Barfod et al, 2006; Watermeyer and Penn, 2009) have noted that a key element that determines successful treatment of HIV is the soliciting of patient adherence. This means that adequate patient care can only be fully attained where patients understand the nature of the illness and the importance of adherence. Facilitating adherence is therefore an implied goal of this organisation.

Further scrutiny of the actual organisation of the care process and the activities and goals of each service point suggests that HIV care has two basic components. The first one is the educational component meant to help patients understand the condition, how it is contracted and how it can best be avoided, and also how the infection can be managed and treated. The second component of HIV-treatment is medical care meant to address physical problems related to the patient's HIV status. In order to ensure that patients fully understand the nature of their condition, the treatment, after-care and required adherence behaviour, the health care centres are tasked with disseminating a lot of information to patients. This entails a need for attention to the quality of the various modes and means of communication at the respective service points.

An important feature that was found to facilitate this dissemination of information and communication between patients and HCPs is decentralisation of the task. The division of the care process into easily manageable care units has been schematically given in figure 1 on p. 96. These communicative units are complimentary in that the information given at one point becomes helpful at subsequent points, and in self-care after the patient has left the health care centre. My perception here is that such segmentation of care is particularly helpful in centres of this nature where physicians and patients limitedly share a language.

This is illustrated in both HC-A and HC-B where L1 Sesotho HCPs are strategically deployed at points where patients meet them before and after the consultation with physicians, particularly in sections such as the counselling unit where intensive and successful spoken communication is imperative. Here patients get important information in their L1. Sesotho speaking staff are also available to assist in facilitating communication in the consultation rooms where language discordance is prevalent. This is meant to take care of communicative challenges where they are likely to assist and attempt to enhance patient understanding of both the process of care and treatment. An important finding here is that the mediation of Sesotho L1 staff is not unproblematic, but that eventually there may be less miscommunication than one would anticipate in the circumstances.

Another structural aspect that was found to facilitate information dissemination is the availability of multimedia information materials to patients in three modes in order to cater for the needs of all patients. There is abundant use of audio- and visual materials (video-recorded and printed) in the two clinics, with a noted heavy reliance on the verbal, printed materials. HCP's view these printed materials as instrumental in intensifying education outside the consultation room and before patients arrive at the consultation with a physician. Reports of the patients themselves put less value on these printed materials. The limited literacy practices of the community outside of the clinics possibly explains this patient position. Patients' comments are corroborated by research done elsewhere (see eg. Feinauer, 2005; Swanepoel, 2005).

Patients' comments about the printed materials make it apparent that most of them do not read the literary materials they get from the clinics. In spite of such explicit negative valuation of the materials, the practice of distributing limitedly accessible printed information continues. This suggests that there is no effective communication between HCPs and patients about the usefulness of these materials. In fact there seems to be no point at which the clients are systematically consulted for their opinion on what the best methods for information dissemination would be. Collins and Slembrouck (2006) and Moyer (2011) have reported on similar limits in user-friendliness of printed materials elsewhere. The situation is reportedly different in the MOM project reported by Van De Poel and De Rycke (2011), where the tool was successful because clients were continuously consulted in its development.

On the basis of the above-mentioned findings, this study maintains that fragmentation of the care process into different units is instrumental for both adequate care as well as effective communication, although the latter was not a primary concern in setting up the organisation. Similarly, even considering the shortcomings, dissemination of information in different modes is important because it caters for patients of all interests and communicative competencies. My suggestion eventually would be that the institutions should periodically consult their patient base to establish which modes are received well, so that they can intensify provision of the needed and best received modes of communication. The current practice of substantial provision of reading materials without consultation with patients is a waste of resources.

5.2 PARTICIPANT EXPERIENCES OF CARE AND LANGUAGE DIVERSITY

The data on this topic was used to achieve the second and third objective of this study which were *to gain insight into the extent of language diversity in the two health care centres; and to gain empirical information on the experiences of multilingual role-players regarding the organisation of multilingual clinical interactions and the use of linguistic resources*. Two matters were found to be interesting regarding the extent of language diversity and participants' accounts of their experiences.

The first matter of interest is the kind of multilingualism in HC-A and HC-B where the linguistic repertoires of the physicians are far more extensive than is useful to them within the context of the clinic. They can use at most three of the languages they know in their interaction with patients and with other HCPs. This is particularly interesting because in Lesotho there is wide use of two languages, Sesotho and English, but such elaborate multilingualism as the physicians exhibit, is rare. In HC-A some of the doctors have limited proficiency in English which in most cases functions as the lingua franca. This creates a unique speech context in which both patients and local HCPs have to find communicative mechanisms for dealing with physicians' limited competencies in both Sesotho and English.

The second matter of interest is related to participants' account of their experiences. The different participant groups reported differing trends in that patients generally seemed to be satisfied with care while the HCPs reported discontentment at different levels. For example, patients reported

satisfaction with the whole process of care. They appreciated the segmentation of care and the deployment of Sesotho speaking personnel as service providers and interpreters. The experiences of HCPs were almost the opposite.

Unlike patients, physicians were much more upfront in expressing a range of reservations and difficulties they experience during consultations where there is language discordance and where they are directly involved as care givers. Their sources of dissatisfaction include the inability to build a one-on-one relationship with their patients, and their discontent with interpreted consultations due to negative experiences they had had of such mediation.

Similar to the physicians, nurses' reports show a general feeling of dissatisfaction with the care process, and particularly with the fact that they are called on to do interpreting. This dissatisfaction seems to have created a degree of conflict between the nurses and physicians. The conflict was characterised by role conflict in which some of the nurses go beyond their brief, assuming the role of the physician, as (e.g.) where one actually changed the prescribed medication of a patient without consulting the physician. Although none of these parties clearly voiced this dilemma as outright conflict, it was very pronounced in their tones and reference terms when talking about each other. Physicians would for example use phrases such as *those ones,* to refer to the nurses and at one point a nurse referred to a physician as "nnana" (*little girl*) which is an unfriendly and slightly disrespectful way of referring to a colleague.

The experiences of interpreters who are not nursing staff are not very different from those of the nurses in that they also expressed frustration about the physicians' limited proficiency in English. Besides the limited English proficiency of physicians and patients interpreters reported different communicative styles that leave interpreters with an added responsibility of explaining more, selecting or filtering the important and relevant information from what is provided by the physicians. Interpreters expressed the difficulties related to the fact that there is sometimes a vocabulary mismatch between English and Sesotho and that they then get stuck with in trying to find the correct rendering of terms and other language conventions. In such cases they resort to consultation with a nurse.

In relation to participant experiences, this study concludes that the ability of HCPs to articulate their reservations while patients are appreciative of everything and rarely question what happens could be a manifestation of institutional powers and is therefore a feature of the institutional organisation. An observation of the institutional identities of the two parties place physicians as members of the institution with professional knowledge as explained by Sarangi and Roberts (1999:5). Patients, in contrast, regard themselves as outsiders in the institution with lesser knowledge about the system. They therefore cannot freely voice their dissatisfaction of the process and the system as a whole because they feel it is not their place due to their lack of knowledge of the system. In analysing this part of patients' communicative behaviour, certainly one has to consider how vulnerable the patients generally are, how limited their care resources would have been without the intervention of foreign support, and then to appreciate that for many compromised communication appears to be a blip rather than a disabling hurdle in the larger organisation of HIV treatment at these clinics.

The study would like to suggest that staff satisfaction is as important as patient satisfaction in patient care. The fact that all the HCPs report to be dissatisfied with the way in which interpreting is organised, suggests that there is likelihood that patient care will be compromised. It also suggests a need for better training concerning the particular challenges of multilingual communication. In particular, the fact that nurses sometimes prescribe and dispense medication to patients without consulting doctors, raises a red flag about patient safety in these contexts. Although there are no reports of compromised patient health, the situation needs attention.

5.3 COMMUNICATIVE CHALLENGES.

The fourth objective of this study is *to establish possible threats to communicative success that are posed by language diversity in HIV and AIDS care in the particular institutions and to report on possible reasons for communicative failure.* This study established that all participant groups made reference to challenges that they encounter in the process of care. Most of the challenges were reported to be encountered in the consultation with physicians where the medical aspect of care to HIV-positive patients is provided. At this point of the consultation, most challenges were attributed to language discordance among physicians, patients and other HCPs. This finding is

consistent with the results of several past researchers who investigated various aspects of communication in language discordant settings and agree that they are communicatively challenging. Most of these studies concentrated on general communicative aspects of the medical consultation, such as the characteristics and communicative styles of patients and physicians (Rivadeneyra, 2000; Harmsen et al., 2003; Schouten et al., 2009); relational aspects between doctor and patient (Meeuwesen et al., 2006 and 2007); and resources used to account for more or less effective communication (Elderkin-Thompson et al., 2001; Collins and Slembrouck, 2006; Moyer, 2011).

A conclusion related to this one is that although language discordance is a major challenge, the there are other difficulties that are not necessarily related to the linguistic differences between participants. Miscommunication and limited agreement are also experienced in interactions where there are participants who share the same L1, but with different levels of knowledge, different levels of linguistic sophistication, different educational and socio-economic backgrounds, and the like. Such challenges include patients' reluctance to communicate about topics that are related to sexual behaviour; and physicians and patients' communicative styles. This suggests that language discordance is just one aspect that negatively affects physician-patient communication. This observation is consistent with the works of Ashton et al. (2003:147) and Street, Gordon and Haidet (2007:587) who note that physician-patient communication is a product of multiple factors such as contextual factors. Ashton et al (2003:147) show that sometimes the difference between the physician and patient explanatory models of the sickness can affect the effectiveness of communication. Street et al (2007:587) cite the difference in demographic characteristics of physicians and patients as the some of the factors that affect communication. This implies that the success of physician-patient communication cannot be gauged by language discordance alone.

5.4 ACCOUNTING FOR COMMUNICATIVE SUCCESS

The fifth objective of this study which is *to determine how within the framework of the organisational structure the different role-players manage language diversity and use multilingual linguistic resources in communication structured to meet the requirements of HIV/AIDS care in each particular health care facility*. The study found several management strategies and resources

used by individuals and introduced by the institutions. On the one hand, institutions manage language diversity by putting in place interpreting facilities and multimedia resources to manage language diversity. On the other hand, HCPs and patients employ certain interpersonal and communicative strategies to improve communication across the consultation. These institutional responses to language diversity as well as participants' actions seem to be based on particular facts that are held as common knowledge by participants and health care institutions. Firstly, it is acknowledged that in HIV and AIDS care communicative success is a pertinent issue because the physicians' decisions regarding treatment can only be taken if they are well informed on psycho-social circumstances of the patient – more than just clinical information gained from a physical examination, is required. This importance of communication in the field of HIV and AIDS treatment is emphasised by Watermeyer and Penn (2009:206) who note further that successful and appropriate communication appears to promote adherence which will ensure the best possible treatment outcomes. The second fact that seems to be generally acknowledged is that language discordant provider-patient interactions are communicatively challenging. This is an opinion that is also acknowledged by previous researchers on communication health care, for example Bischoff et al. (2003) and Schouten et al. (2009).

Among HCPs and patients there is a general opinion that the best strategy is for physicians to learn a local language in order to communicate directly with patients. This opinion disregards two crucial facts. Firstly this study and others have established that even where HCPs and patients are speakers of the same language, the disparity of their cognitive and contextual backgrounds still poses communicative challenges. Secondly it has been established that because of the pressure of the work they do, physicians have very limited time to learn a new language. (cf. Van de Poel and Rycke. 2011:71). It will not be easy for the physicians in these circumstances to learn Sesotho formally given their workloads.

The study therefore concludes that since communicative challenges are still prevalent despite attempts by both institutions and all the participants involved, considered measures need to be introduced in order to successfully manage language diversity in clinics. This problem should be approached with optimum consideration of all the factors that account for ineffective communication in order to come up with an appropriate set of actions for each context.

5.5 IMPLICATIONS FOR THEORY, PRACTICE AND RECOMMENDATIONS FOR FUTURE RESEARCH

Theoretically, this study extends the contextualisation of language discordance in health care in two ways. Firstly it stretches the context from the much researched and emphasised one in which physicians are speakers of a dominant language treating minority group patients. The studies of (e.g.) Harmsen et al. (2003), Schouten et al. (2009) and Moyer (2011) successfully discuss the challenges of language discordance and the interventions that could help overcome these challenges. These studies however, do not address contexts such as Southern African ones where often physicians are minority language speakers, not patients. This study foregrounds this area of research and highlights some of the pertinent challenges that HCPs and patients in these encounters experience and their ways of overcoming them.

The study also extends the current conceptualisation of multilingual health care which is viewed as care given in a context where there is incompatibility of linguistic resources, but physicians and interpreters have shared competence in at least one language. Here, often, the lingua franca is an L2 for all participants. This study corroborates the Blommaert et al. (2005:199) notion of 'truncated multilingualism', which they define as "linguistic competencies organised topically on the basis of specific domains". Some of the physicians in this study were limitedly competent in English, and knew only medically related terms. The working definition of 'multilingualism' in studies such as this one has to keep in mind that it does not only involve full competencies, but also truncated and domain specific ones.

In connection with implications for practices in HIV and AIDS care, the present study highlights the value of multi-modal messages in HIV and AIDS care. Nevertheless, periodical research on patients' needs and preferred modes would be ideal to ensure that the kinds of materials introduced to patients are useful. For example, the videos are shown occasionally, yet informal interviews with patients showed that patients like them and understood them better than written materials.

Another useful resource, whose effectiveness needs to be enhanced, is interpreting services. Health care clinics need to make sure that these services are established and are offered by staff with at least minimal training in medical interpreting. Furthermore, pertinent aspects of translation and

interpreting should be incorporated into the training (even in-service training) of staff at various levels of the Ministry of Health and Social Welfare in Lesotho. In cases where there are community interpreters already performing these functions, they should be given certificated in-service training. This will improve their status and thus also the appreciation of their contribution to care. If nurses are to be used, they should be trained similarly in interpreting. It would help if they could be informed upon appointment that they will need to perform interpreting roles, and some token of appreciation should be given to them as an incentive so that they do not feel disgruntled and overworked by performing interpreting duties.

There is also a dire need for an orientation programme for new physicians in the country, particularly expatriates. This programme should include the basics of the Basotho customs, values and beliefs as well as an introductory language course, because these have a bearing on doctor-patient relationships. The orientation will ensure that physicians have at least a minimal understanding of what frames the Basotho patients' explanatory models of different ailments. In these days when multilingualism is very common, the medical fraternity needs to be alerted to the importance of applied linguistic insights as a component of medical care.

This study has illuminated the significance of linguistic issues, not only in medical care in general, but in HIV and AIDS care in particular. It is therefore recommended that research in this area should be intensified to provide practical guidelines to the HCPs on how to approach communication in these contexts. The study also identified a need for a clear language policy with regard to the incorporation of non-Sesotho speaking physicians in HIV and AIDS care. At the moment every health care centre arranges its own communicative measures depending on available resources and there is no clear policy on procedures that have to be followed. While this study constitutes only a basic part of this, it is necessary to engage in large scale projects that would allow collection of data from a more diverse range of clinics in order to get a more general picture of what linguistic issues are prevalent and what communicative interventions are appropriate, if not imperative, in HIV AND AIDS care. Such research can inform policy formulation, and so enter the protocol of organisations that currently have developed their own structures, but could do with more official support.

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APPENDIX A

Permission Letter from the Ministry of Health and Social Welfare, Lesotho

JD 61/2010

LESOTHO

Ministry of Health and
Social Welfare
PO Box 514
Maseru 100

Date: 14 January 2011

Konosoang Sobane
Academia 23/103
Stellenbosch 7602

Dear K. Sobane,

Re: Language Discordant Doctor-Patient Interactions in Lesotho HIV/AIDS Care Centres: An Applied Linguistics Study

Thank you for resubmitting the above mentioned protocol. The Ministry of Health and Social Welfare Research and Ethics Committee having reviewed your protocol hereby authorizes you to conduct this study among the specified population. The study is authorized with the understanding that the protocol will be followed as stated. Departure from the stipulated protocol will constitute a breach of the permission.

We are looking forward to have a progress report and final report at the end of your study.

Best regards,

Dr. M. M. Moteetee
Director General of
Health Services and Chairperson Research and
Ethics Committee

APPENDIX B

Ethical Clearance from Stellenbosch University

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

3 March 2011

Tel.: 021 - 808-9183
Enquiries: Sidney Engelbrecht
Email: sidney@sun.ac.za

Ms K Sobane
Department of General Linguistics
University of Stellenbosch
STELLENBOSCH
7600

Reference: 501/2011

Ms K Sobane

APPLICATION FOR ETHICAL CLEARANCE

With regards to your application, I would like to inform you that the project, *Language Discordant Healthcare Provider-Patient Interactions in a Lesotho HIV/AIDS Care Centre: An Applied Linguistic Study*, has been approved on condition that:

1. The researcher/s remain within the procedures and protocols indicated in the proposal.
2. The researcher/s stay within the boundaries of applicable national legislation, institutional guidelines, and applicable standards of scientific rigor that are followed within this field of study and that
3. Any substantive changes to this research project should be brought to the attention of the Ethics Committee with a view to obtain ethical clearance for it.
4. The researcher/s implements the suggestions made by the mentioned by the Research Ethics Committee (Human Research) in order to reduce any ethical risks which may arise during the research.

We wish you success with your research activities.

DIE UNIVERSITEIT VAN STELLENBOSCH
3 MAR 2011
THE UNIVERSITY OF STELLENBOSCH

Best regards

MR SF ENGELBRECHT
Secretary: Research Ethics Committee: Human Research (Non-Health)

Afdeling Navorsingsontwikkeling • Division for Research Development
Privaatsak/Private Bag X1 • Matieland 7602 • Suid-Afrika/South Africa
Tel: +27 21 808 9184 • Faks/Fax: +27 21 808 4537
www.sun.ac.za/research

APPENDIX C

Permission Letter from HC-A Wellness Centre

Maluti Adventist Hospital
AND SCHOOL OF NURSING
A SEVENTH-DAY ADVENTIST INSTITUTION
LESOTHO

Private Bag X019
Ficksburg OFS
9730

Tel: (00266) 22540203
Fax: (00266) 22540230

P O Box 11
Mapoteng 250
Lesotho

14th March 2011

Dear Madam

Re: Language Discordant Doctor – Patient Interactions in Lesotho HIV/AIDS Care Centres: Applied Linguistics Study

Please be informed that the Maluti Adventist Administration that sat on the 14th March 2011 has considered your request to do the above mentioned study.

The anticipation is that you will take necessary precautions and confidentiality with regard to the patient's records and information.

Secondly we expect that you'll furnish the hospital's management with the necessary findings that will help improve the welfare of this hospital's patients/clients.

Yours faithfully

Robert 'Neko
Project manager, Wellness Centre

"NOT TO BE MINISTERED UNTO, BUT TO MINISTER"

APPENDIX D

Permission Letter from HC-B Wellness Centre

Paballong HIV/AIDS Care Centre
PO Box 1839,
Maseru 100,
LESOTHO
Tel: 00266 5250 7000

Ref: Res/04/2010

Dear Ms K. Sobane

Re: Language Discordant Provider-Patient Interaction in HIV/AIDS Care Centers in Lesotho: An Applied Linguistic Study

I would like to inform you that the management of Paballong HIV/AIDS Care Centre has granted you permission to conduct the above-mentioned study. It is hoped that you will adhere to all ethical principles as discussed in the face to face meeting. The expectation to furnish the centre with a report also still stands.

We look forward to working with you.

S.Lesoli
Senior Counsellor

APPENDIX E

Interview Guide for Health care Providers

INTERVIEW SCHEDULE FOR HEALTH CARE PROVIDERS

Note: For nurses the interviews were conducted in Sesotho therefore the schedule was translated. For doctors the interviews were conducted in English.

a) The doctors and nurses will be asked open-ended questions that are meant to elicit information on the following:

i) The particular languages that each participant knows and uses – with a self-assessment of their own proficiency in each.
ii) Their communicative experiences and practices when attending to patients whose L1 is Sesotho.
iii) The challenges posed by language discordance or incompatibility in such consultations.
iv) The strategies and resources they use to ensure patient understanding despite language discordance.
v) The possibility of using translators or interpreters in dealing with Sesotho L1 patients who have clear difficulty in following the *lingua franca* (English)
vi) Potential "hot spots" where multilingual communication appears to be either particularly hazardous, or particularly uncomplicated.

b) The following are some of the specific questions that will be asked:

i) How do you decide which language will be used in your consultation with a specific patient (or are all consultations by default conducted in English)?
ii) Do you sometimes make use of an interpreter (translator)?
If yes, who is available to provide such translation services?
iii) Do patients themselves ever ask for interpreting assistance – or bring along a friend or family member as an interpreter?

iv) Are there circumstances under which you choose to refer a patient to another practitioner or to a nurse for information that you feel can better be communicated by a L1 speaker of Sesotho?

v) Do you find that patients have a specific preference for using either English or Sesotho in their consultations at the Centre?

vi) Considering that in the prevention and treatment of HIV and AIDS much depends on lifestyle decisions of patients – do you in your consultation discuss such matters and in which language?

vii) How do you evaluate whether patients (or Sesotho L1 colleagues) have understood you or not?

viii) When it seems they have not understood you, what resources do you use to aid communication between you and these patients or colleagues?

ix) Do you explain ARV treatment to patients themselves, or do you refer them to nurses or counsellors for the detail of the relatively complicated regimen?

x) Do you find patients with limited English proficiency reluctant to ask or answer questions, or is that not a difficulty?

xi) Do you find that there are language barriers between Sesotho L1 nurses and doctors / nurses who are speakers of other L1s?

xii) Do you find that L1 communication would be the best in certain "hot spots" in the Centre, and that there should be some kind of official provision of language support at these points in the care programme?

Note: some of these questions arose from the general discussion

APPENDIX F

Interview Guide for Patients

INTERVIEW SCHEDULE FOR PATIENTS

Note: The interviews were conducted in Sesotho therefore this schedule was translated.

a) The interview will be guided by questions which are aimed at eliciting information on:

i) The L1 of the patient, and his/her proficiency in English and any other languages.

ii) Patients' communication related experiences when being attended to by doctors with limited proficiency in Sesotho.

iii) Patients' communication related experiences when being attended to by nurses who do (or do not) share their L1-proficiency in Sesotho.

iv) The challenges they encounter when communicating with these doctors and nurses, and how the challenges are addressed and overcome.

v) The effects of such challenges on the patient's participation in the care programme.

vi) The possibility of specific "hot spots" where bilingual or multilingual communicative encounters in HC-A appear to be problematic, or in other cases, particularly unproblematic.

b) Examples of specific questions will be:

i) What language is most used in your communication with doctors and nurses in the HC-A Wellness Centre?

ii) Do you have a specific preference for communication in Sesotho when you visit the Centre, or is it all the same to you when communication is through medium of English?

iii) Do you feel more at ease with a doctor who can speak Sesotho, or does the language of the doctor make no difference?

iv) Do you feel more at ease with a nurse who can speak Sesotho, or does the language of the nurse make no difference?

v) Have you ever had the experience that you do not understand a doctor or nurse when they are speaking to you in English?

vi) If a doctor (or nurse) does not speak Sesotho and you do not quite understand what they are telling you (or asking you) – would you ask him/her to explain more carefully? Or would you wait till after the consultation and ask somebody else for clarification?

vii) Have you ever asked for a translator to assist in a consultation with a foreign doctor or nurse?

viii) If yes, did that make a difference to your experience?

ix) Has a doctor or nurse ever called in a translator to assist in a consultation with you?

x) If yes, did you feel that such translation was helpful, or would you have preferred to get by without such a facilitator?

xi) Are there specific sections in the Centre (e.g. in the administration, in the x-ray section, at the pharmacy, in consultation with doctors or nurses) where the communication is particularly easy and efficiently conducted?

xii) Are there specific sections in the Centre (e.g. in the administration, in the x-ray section, at the pharmacy, in consultation with doctors or nurses) where the communication is particularly difficult (even hazardous)?

Note: some of the questions arose from the general discussion.

APPENDIX G

Informed Consent Form for Patients

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STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH FORM A

Working Title: Language Discordant Health care Provider-Patient Interactions in HIV/AIDS Care Centre: An Applied Linguistics Study.

You are asked to participate in a research study conducted by Ms Konosoang Sobane (BA, BA Hons, MA), from the Department of General Linguistics at Stellenbosch University. The results of this study will be reported in a PhD thesis and published research articles. You were selected as a possible participant in this study because you are a Sesotho L1 speaker who gets treatment at the HC-A Wellness Centre where there are many health care providers who do not have Sesotho as their L1.

1. PURPOSE OF THE STUDY

The purpose of this study is to investigate how health care providers (doctors and nurses) with different L1s, communicate in providing health care to Sesotho L1 patients in the HIV/AIDS programme. I am interested in the experiences of patients as well as health care providers regarding the role of language in giving and receiving treatment.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

i) to be interviewed face-to-face about your communication-related experiences when being attended to by doctors and nurses at the HC-A Wellness Centre, in a 30-minute face-to-face interview with Ms Sobane, in Sesotho;
ii) to participate in a one hour discussion with other HIV positive people who get treatment in HC-A, where the topic will be communication-related experiences participants have with doctors and nurses in the Centre.
iii) to participate in a follow-up interview of about 30 minutes, if further clarification is required.

Note that the interviews and the discussion groups will be audio-recorded for the purposes of the research only.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks or discomforts.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not benefit directly from you participation, however since the study is going to investigate communicative strategies among health care providers and patients with different L1s, the outcomes of the study may lead to better practices, and so indirectly benefit you.

5. PAYMENT FOR PARTICIPATION

You will not get payment for participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will not be disclosed without your permission. Confidentiality will be maintained by means of keeping recordings in a computer that has a password known only by the

researcher and the supervisors. Also, in writing up the research your name will be changed, so that you are not personally identifiable.

You have the right to listen to the audio tape recordings. You also have the right to withdraw the recordings from the study.

When the results are reported and published, your identity will continue to be protected in that no personal information will be used at any stage afterwards.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact

Researcher's Name: Ms Konosoang Sobane

Telephone 0710264597/62779777

Email address: 16399307@sun.ac.za

Supervisor: Prof. Christine Anthonissen

Fax Code: 0027 021 808 2009

Email address: ca5@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

If you have questions regarding your rights as a research subject, you may contact the Division for Research Development at Stellenbosch University:

Ms Maléne Fouché

tel. 021 808 4622
e-mail: mfouche@sun.ac.za

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Ms Konosoang Sobane in Sesotho and I am in command of this language. I was given the opportunity to ask questions and these questions were answered my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant or Legal Representative **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant*]. [*He*/*she*] was encouraged and given time to ask me any questions. This conversation was conducted in Sesotho and no translator was used.

_____ _____

Signature of Investigator **Date**

APPENDIX H

Informed Consent Form for Health care Providers

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STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH FORM C

Working Title: Language Discordant Health care Provider-Patient Interactions in a Lesotho HIV/AIDS Care Centre: An Applied Linguistics Study.

You are asked to participate in a research study conducted by Ms Konosoang Sobane (BA, BA Hons, MA), from the Department of General Linguistics at Stellenbosch University. The results of this study will be reported in a PhD thesis and published research articles. You were selected as a possible participant in this study because you are a doctor who works at HC-A where a majority of patients are L1 speakers of Sesotho, a language which is not your L1.

1. PURPOSE OF THE STUDY

The purpose of this study is to investigate how health care providers (doctors and nurses) with different L1s, communicate in the provision of health care to Sesotho L1 patients especially those who are on ARVs. I am interested in the experiences of patients as well as health care providers regarding the role of language in giving and receiving treatment.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

i) to be interviewed face-to-face about your communication-related experiences when attending to patients in the HC-A Wellness Centre where the patients and most nurses are L1 speakers of Sesotho. The interview will be conducted in English by Ms Sobane, and will last approximately 30 minutes;

ii) to participate in a follow-up interview of about 30 minutes, if further clarification is required.

Note that the interviews will be audio-recorded for the purposes of the research only.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks or discomforts.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not benefit directly from you participation, however since the study is going to investigate communicative strategies among health care providers and patients with different L1s, the outcomes of the study may lead to better practices, and so indirectly benefit you.

5. PAYMENT FOR PARTICIPATION

You will not get payment for participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will not be disclosed without your permission. Confidentiality will be maintained by means of keeping recordings in a computer that has a password known only by the researcher and the supervisors. Also, in writing up the research your name will be changed, so that you are not personally identifiable.

You have the right to listen to the audio tape recordings. You also have the right to withdraw the recordings from the study.
When the results are reported and published, your identity will continue to be protected in that no personal information will be used at any stage afterwards.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact

Researcher's Name: Ms Konosoang Sobane
Telephone 0710264597/62779777
Email address: 16399307@sun.ac.za

Supervisor: Prof. Christine Anthonissen
Fax Code: 0027 021 808 2009
Email address: ca5@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

If you have questions regarding your rights as a research subject, you may contact the Division for Research Development at Stellenbosch University:
Ms Maléne Fouché

tel. 021 808 4622
e-mail: mfouche@sun.ac.za

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Ms Konosoang Sobane in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered my satisfaction.
I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant or Legal Representative **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant*]. [*He*/*she*] was encouraged and given time to ask me any questions. This conversation was conducted in English and no translator was used.

_____ _____

Signature of Investigator **Date**

APPENDIX I: SAMPLE OF TRANSCRIPT

Meta Information

Project name Language Discordant HIV/AIDS interactions
Referenced file C:\Users\connie\Documents\the data\Interpreters\Mampho\DVT_A007-
Comment

Speakertable

I1	**Sex**	f
	Languages used	sot
	L1	sot
	L2	eng
	Comment	

[1]

	0 [00:00.0]		
RES [SOT]	Ke tla kopa u ntlhalosetse lemo tsa hau na li oela pakeng tsa tse kae le tse kae ha		
RES [ENG]	Iwould like you to tell me your age range it doesnt need to be a definite one		
[2]	..	1 [00:10.0]	2 [00:12.0]
RES [SOT]	ke batle le age a definite		oh ha ke
RES [ENG]			oh its
I1 [ENG]		oh I don't mind you knowing it, I am 32 years	
I1 [SOT]		oh ha ke na bothata le ha u li tseba ke 32 years	
[3]	..		3 [00:22.0]
RES [SOT]	re batho ba bang ba be le mathata (laughs)		(sighs)u na le nako e kae u sebetsa

RES [ENG]	because some people have a problem(laughs)			(sighs) how long have you been
[4]	..	4 [00:24.0]	5 [00:24.0]	6 [00:31.3]
RES [SOT]	koano?	u na le nako e kae u sebetsa koano	Ho tloha	2006? aa ue na u
RES [ENG]	working here	how long have you been working here?		20006? well you
I1 [ENG]			from 2006	

[5]

	..	7 [00:38.2]		8 [00:40.2]
RES [SOT]	so le mokaubere	u bua puo tse kae?		
RES [ENG]	have been here for some time.	how many languages do you speak?		
I1 [ENG]				Sesotho and
I1 [SOT]				Sesotho and

[6]	..	9 [00:42.2]	10 [00:44.2]	11 [00:44.2]	12 [00:48.2]
RES [SOT]		tse peli feela		U sebetsa eng setsing koano?	
RES [ENG]		just two?		what is your job at the centre?	
I1 [ENG]	English		yes		I work as an
I1 [SOT]	English		eea mme		ke sebetsa ke le

[7]	..	13 [00:50.2]	14 [00:52.2]		15 [00:53.9]
RES [SOT]		u le interpreter?	u koetliselitsoe mosebetsi oa bo interpreter		kapa u
RES [ENG]		as an interpreter?	were you trained as an interpreter		or you
I1 [ENG]	interpreter				
I1 [SOT]	interpreter				

[8]	..	16 [00:55.9]		17 [00:59.9]
RES [SOT]	ithutile ona mosebetsing mo o?			ha u fihla u
RES [ENG]	learned it on the job?			When you arrived here
I1 [ENG]		I learned it on the job		
I1 [SOT]		ke ithutile hona mosebet-sing mona		

[9]	..
RES [SOT]	fihlile u tsoa kae, u tloha sekolong directly kapa ho no na le moo u la ka sebetsa

[10]	..	18 [01:05.4]	19 [01:11.9]
RES [SOT]	teng teng?		Ha re
RES [ENG]			Let us
I1 [ENG]		I came directly from school, I had never worked before	
I1 [SOT]		ne ke tsoa sekolong directly, ho no se na moo ke la ka se betsa	

[11]	..
RES [SOT]	shebane le oona mosebetsi ona oa hau he, haholoholo u sebetsa le bakuli ba
RES [ENG]	focus on your job, you work a lot with HIV/AIDS patients?

[12]

	..	20 [01:21.8]	21 [01:23.8]	22 [01:23.8]
RES [SOT]	HIV/AIDS/		le ba TB?	ke rata ho tseba hore, lee decide joang hore
RES [ENG]			and TB?	I want to know how do you decide that the
I1 [ENG]		..and TB		
I1 [SOT]		Le ba TB		

[13]	..	23 [01:34.5]
RES [SOT]	mokuli o batla ho tolokeloa? lee bone joang ha a batla ho tolokeloa?	
RES [ENG]	patient needs an interpreter?	
I1 [ENG]		for us to se e

I1 [SOT]		hore re bo ne

[14] ..

I1 [ENG]	that the patients needs an interpreter, some of them will say when they come in
I1 [SOT]	hore mokuli u hloka ho tolokeloa, ba bang ba ipolela ha a kena feela hore ke kopa

[15] ..

I1 [ENG]	that please interprete for me, some will not say and they start talking, when you
I1 [SOT]	u tlo toloke mme, ba bang u tla thola o tla bua-bua u bone eka ua utloisisa ha u

[16] .. 24 [01:53.0]

RES [SOT]		oh, ele hore u lula u le teng ka
RES [ENG]		oh, so you are always in the
I1 [ENG]	realise that they don't understand you come in.	
I1 [SOT]	bona hore ha a utloisise u so kenella.	

[17] .. 25 [01:53.9] 26 [01:54.0]

RES [SOT]	mono ka ngakeng?		u emetse ba batlang ho tolokeloa le ba sa batleng ho
RES [ENG]	Consultation room		regardless of whether they need or do not need an
I1 [ENG]		yes	
I1 [SOT]		e	

[18] .. 27 [01:58.9] 28 [01:59.0]

RES [SOT]	tolokeloa?		ha ho ko bo etsahale mokuli e mong are "ha ke batle toloko ke
RES [ENG]	interpret		
I1 [ENG]		yes	do you find that some patients will say "I don't need an interpreter? so please go out
I1 [SOT]		e	

[19] .. 29 [02:03.7] 30 [02:05.3]

RES [SOT]	kopa u tsoe"		ha ho bo etsahale hore
RES [ENG]	interpreter "		do you find that some

I1 [ENG]		in a rare cases ea etsahala... (inaudible te xt)		
I1 [SOT]		in rare cases it happens		
[20]	..			
RES [SOT]	mokuli e mong a fihle a tsoere ngoana hae kapa mokhotsi oa hae a re " ae ke tla			
RES [ENG]	patients will come with their children or friends and say " this person will			
[21]	..		31 [02:13.2]	32 [02:15.2]
RES [SOT]	tolokeloa ke motho enoa uena tsa maea" ?			ha re bue ka
RES [ENG]	interprete for me"?			let us focus our
I1 [ENG]			no, it never hap pens	
I1 [SOT]			no, ha ke etsaha le	
[22]	..			
RES [SOT]	botoloki bona ba rona he, u fetisetsa melaetsa ea mokuli ho ngaka le ngaka ho			
RES [ENG]	attention on interpretation then, you pass the patients' messages to the doctor and			
[23]	..	33 [02:25.4]	34 [02:25.9]	
RES [SOT]	mokuli?		mme le bua ka lefu le ka hare moo ho senang lintho tseo l e ka	
RES [ENG]	vice vers a?		.and you talk about an internal disease without visible	
I1 [ENG]		yes ma'm		
I1 [SOT]		eea mme		
[24]	..		35 [02:31.9]	
RES [SOT]	li supang.....		u ee u sebelise matsapa afe ho bona hore	
RES [ENG]	symptoms that can be pointed to		what strategies do you use to ensure that the	
I1 [ENG]		yes		
I1 [SOT]		eea mme		
[25]	..		36 [02:34.5]	
RES [SOT]	molaetsa o fihlile hantle ho mok uli?			
RES [ENG]	message has passed well to the p atients?			
I1 [ENG]			we ask them to show the doctor,	

I1 [SOT]	re re a bontse, ngaka a bone, ka nako
[26]	..
I1 [ENG]	sometimes our doctors are not proficient enough in English, even if you say
I1 [SOT]	E nngoe a supe ka nako e nngoe ha ke re le lingaka tsa rona tse re sebetsang le
[27]	..
I1 [ENG]	something they will not understand so the patients points and shows them or they
I1 [SOT]	tsona ha li tsebe le sekhooa hantle, le ha u ka re bua ntho ha utloe hantle, mokuli
[28]	.. 37 [02:51.3]
RES [SOT]	ha re bua ka HIV, taba tsa HIV li
RES [ENG]	when you talk about HIV, which
I1 [ENG]	should undress and show them,
I1 [SOT]	ahla supe a mo bontse kapa a hla phetle a bo ne
[29]	.. 38 [02:53.6]
RES [SOT]	le maling koa joale o supa joang?
RES [ENG]	is internal, in the blood, how do they point?
I1 [ENG]	Often when talking about HIV you
I1 [SOT]	HIV ha ke re hangata ha re bua ka
[30]	..
I1 [ENG]	talk of things like cd4 count, its just explained you don't have to see it.
I1 [SOT]	eona re tla bere bua ka bo CD 4 count e tla be le nthoe hlalosoang feela e sa
[31]	.. 39 [03:03.9] 40 [03:09.2]
RES [SOT]	oh so le qeteletse teng le hlalosa feela ha ho ko bo
RES [ENG]	oh, so you just explain do you find that
I1 [ENG]	yes yes we just explain
I1 [SOT]	hlokoeng ho bonoa. e e re hlalosa feela
[32]	..
RES [SOT]	etsahale hore ebe mokuli oa lona ha utloisise hantle ka nako e nngoe kapa ke qale
RES [ENG]	sometimes a patient does not understand or let me first start by saying how do
[33]	..
RES [SOT]	pele ka hore: u bona joang ha mokuli a utloisistse litaba tse ntse le mo joetsa
RES [ENG]	you realise that the patient has understood what you and the doctor are telling
[34]	.. 41 [03:19.2] 42 [03:23.0]
RES [SOT]	tsona kamoo le ngaka: u mmona
RES [ENG]	him/her? how do you

I1 [ENG]	I see them satisfied when they have understo od
I1 [SOT]	ke mmona ha a khotsofetese hore o utloisitse

[35]

	..	43 [03:24.6]	44 [03:23.4]
RES [SOT]	kang ha a khotsofetse?		o tla cho ho re o khotsofetse, ha le ke be le
RES [ENG]	see they are satisfied?		they will say, do you encounter t hose that did
I1 [ENG]		they will say	yes they will say
I1 [SOT]		o tla cho	e o tla cho

[36]	..	45 [03:29.7]	
RES [SOT]	kopane le ba sa utloisiseng?		
RES [ENG]	not understand?		
I1 [ENG]		there are those that I sometimes go to the nurse and	
I1 [SOT]		ba ntse ba le teng be ka nako e nngoe ke ee ke fetele	

[37]	..
I1 [ENG]	say" please explain for me in another way here here, I think I didn't explain
I1 [SOT]	ho mme nese ke re "aku nthlasetse hape ka tsela e nngoe kea kholoa ha kea

	..	46 [03:35.1]	47 [03:40.2]
RES [SOT]		oo, u thusoa ke mme nese ha ho le joalo?	ngaka eena ha ho bo
RES [ENG]		ok you are helped by a nurse in t hese cases?	and does it happen
I1 [ENG]	adequately"	yes, yes	
I1 [SOT]	hlalosa hantle"	e, e	

[39]	..	48 [03:43.6]
RES [SOT]	etsahale hore a ska utloisisa na u ntso reng?	
RES [ENG]	that sometimes the doctor does not understand what you are saying?	
I1 [ENG]		it happens.
I1 [SOT]		hoa etsa hala.

[40]	49 [03:44.7]	50 [03:44.7]
RES [SOT]	ebe u etsa joang?	
RES [ENG]	and what d you do?	
I1 [ENG]		I sometimes perhaps show her what I am talking about.
I1 [SOT]		ke etsa ka tsela tsa ho mo bontsa hore na mohlomomg ke bua

[41]	..	51 [03:52.6]	52 [03:54.6]
RES [SOT]		oo,	mosebetsing ona oona ona oa lona ha ho bo etsahale hore u utloang
RES [ENG]		ok	in your work, are there concepts that you find it difficult to
I1 [ENG]		yes	
I1 [SOT]	kang	ee	

[42]	..
RES [SOT]	li le thata ho li toloka, mohlomomg ekaba ho li fetolela Sesothong kapa ho li
RES [ENG]	interprete be it into Sesotho or English
I1 [ENG]	or English
I1 [SOT]	kapa Sekhooeng

[43]	..	53 [04:08.5]
RES [SOT]	fetolela Sekhooeng?	
RES [ENG]		
I1 [ENG]		yes, some scientific words more especially medical terms do
I1 [SOT]		e bo mantsoe a mang a li science haholo ona a a li medical, a

[44]	..	54 [04:14.8]
RES [SOT]		joale u etse

RES [ENG]	and what do
I1 [ENG]	not have a Sesotho equivalent so you dont know what you will s ay
I1 [SOT]	mang ha a na Sesotho ha u tsebe na u tla reng

[45] .. 55 [04:14.8]

RES [SOT]	joang ha ho le joalo?
RES [ENG]	you do in such cases ?
I1 [ENG]	that is where I ask for help form the nurses and they too
I1 [SOT]	ke hona mane moo ketla nne ke kope thuso ho bo mme

[46] ..

I1 [ENG]	will say " it does not have a Sesotho equivalent, when its like that its like that"
I1 [SOT]	nese le boana ba tla nne ba cho ba re " ae ha e na Sesotho ha e le tjena, feela he

[47] .. 56 [04:24.7]

RES [SOT]	ele hore ha e se na lentsoe la Sesotho ba
RES [ENG]	oh so if it does not have a Sesotho
I1 [ENG]	but they explain a little biit more dee per.
I1 [SOT]	ba tla ke ba hlalose ka botebonyana.

[48]

.. 57 [04:32.9]

RES [SOT]	hlalosa ba pharapharalla hore mokuli a tsebe ho utloisisa? ha ho na lintho tsa
RES [ENG]	equivalet they elaborate more for the patient to understand? are there any cultura l
I1 [ENG]	yes, yes, elaborate more...
I1 [SOT]	e, e ba pharapharalla...

[49] ..

RES [SOT]	bochaba ba rona tse u oo bone li u thatafaletsa ho toloka ekaba lilemo tsa mokuli
RES [ENG]	factors that make interpreting difficult, be it the age or the fact that the patient is

[50] ..

RES [SOT]	oa hau kapa taba hore mokuli oa hau ke ntate, joale Sesothong ha rea tloaela ho

RES [ENG]	a man and in Sesotho we are not used to talking....	
[51]	..	58 [04:49.9]
RES [SOT]	bua..	
RES [ENG]		...
I1 [ENG]		...just plainly with them, it happens but you will feel that you are ashamed,
I1 [SOT]		....ka bophara feela tjena, hoa etsahala feela he u utloe ho re ke tlamehile ho
[52]	..	
RES [ENG]		
I1 [ENG]	although you have to say it but you feel that :I am ashamed, because of how I	
I1 [SOT]	cho feela, feela u ultoe hore ke soabile ho latela kholiso ea ka	

[53]

	..	59 [04:55.1]
RES [SOT]	(laughs) joale u etsang ha u soabile? kapa u so bonahala mahlong	
RES [ENG]	(laughs) and what do you do when you are ashamed?or you just show	
I1 [ENG]	was raised.	
I1 [SOT]		
[54]	..	60 [05:02.1]
RES [SOT]	feela hore che ke soabile?	u sko bo bone ba tsitsipa na?
RES [ENG]	by the look on your face that you are ashamed	and dont they become a bit
I1 [ENG]	yes just the look	
I1 [SOT]	e mahlong feela	
[55]	..	61 [05:03.5]
RES [SOT]		
RES [ENG]	uncomfortable	
I1 [ENG]	yes, more especially if our female doctor asks to see and the	

I1 [SOT]	e bo haholo ha mme ngaka a ka re: "ere ke bone" joale e le mokuli
[56]	..
I1 [ENG]	patient is male, you find that they don't like it, then you have to eplain to them:
I1 [SOT]	oa ntate o fumana kannete ha khotsofale joale ebe u tla mo hlalosetsa hore: "joale
[57]	..
I1 [ENG]	"but now she says whe will not be able to give you medication because she did
I1 [SOT]	u re o tla sitoa ho u fa litlhare hobane joale ha a bona u hloka ho bona," ba bang
[58]	..
I1 [ENG]	not see, she needs to see" some will even say that: " no I am not satisfied, it only
I1 [SOT]	a ba cho hore: "ache ae ha ke khotsofala, hoja e ne le ua ntate, kannete ha ke
[59]	.. 62 [05:23.3]
RES [SOT]	ha khotsoafalle ho treatoa ke oa mme ?
RES [ENG]	he is not satisfied to be treated by a
I1 [ENG]	it was a male doctor. I am truly dissatisfied"
I1 [SOT]	khotsofale:.
[60]	.. 63 [05:25.3]
RES [SOT]	
RES [ENG]	female?
I1 [ENG]	yes, yes, but if its the women to a male doctor they will say: " no no, such
I1 [SOT]	e e le teng ha e le ba bo mme ngaka e le monna) ba tla re "ee moshanyana
[61] **I1 [SOT]**	a mokaa ka uena a nno re ke hlobole ke hloelle betheng, ke kakalle? ae ngoa naka
[62]	.. 64 [05:34.1]
RES [SOT]	(laughs)joale le e ba etse joang ha ba le
RES [ENG]	(laughs)and what do you do when they are
I1 [ENG]	just undress for my husband o nly?
I1 [SOT]	ke hlobolela monnaka feela.
[63]	.. 65 [05:41.3]
RES [SOT]	hlooho li thata joalo?
RES [ENG]	that stubborn?
I1 [ENG]	some would understand that the doctor will not be able to
I1 [SOT]	ba bang ba nne ba utloisise hore ngaka u re a kebe a khona

[64]

	..
I1 [ENG]	help, some will continue to be stubborn yet they are told that it will not be
I1 [SOT]	hore a mo etse, ba bang u tla ngangabala feela a ntsa utloa hore ha ho na
[65]	..
I1 [ENG]	possible to treat them eithout having seen, they would just say:" it does not
I1 [SOT]	khonahala hore a treatoe ntle le hore ho bonoe, u tla ngangabala feela are: " ha ho
[66]	.. 66 [05:53.1]
RES [SOT]	.. tsang joale batho ba Molimo re sa bona
RES [ENG]	.."for what now by God's grace when we have
I1 [ENG]	matter, just give me the medicines
I1 [SOT]	nata ba ae mpheng litlhare feela
[67]	.. 67 [05:55.1]
RES [SOT]	letho? melaetsa ena ea treatment ea HIV/AIDS le lit aba tsena kaofela
RES [ENG]	not seen anything? these messages about HIV/AIDS, its treatmen t and other
[68]	..
RES [SOT]	tse amanang le eona ,le e fetisa ka ho bua le bakuli feela kapa hona le lintho tse
RES [ENG]	matters related to it, do you pass them by just talking to th e patients, or there are
[69]	.. 68 [06:11.7]
RES [SOT]	ling tseo le ba thusang ka tsona hore ba utloisise tsa lona hantle?
RES [ENG]	other resources that you use to help t hem understand better?
I1 [ENG]	there are
I1 [SOT]	hona le
[70]	.. 69 [06:15.8]
RES [SOT]	oo le ba fa eona ba le
RES [ENG]	oo do you give it to them as

I1 [ENG]	pamphlets, and I also give them some e ducation					
I1 [SOT]	lipamphlet, talks	che u tla nno be fe u ba rute	le	health		
[71]	..	70 [06:22.2]		71 [06:23.5]		
RES [SOT]	sehlopha kapa ka bo nngoe?			oo, li pamphlet tse tse le li sebelis ang,		
RES [ENG]	a group or individua lly?			ok, are these pamphlets you use w ritten		
I1 [ENG]		as a group				
I1 [SOT]		ba le sehlopha				
[72]	..		72 [06:25.4]			
RES [SOT]	li ngotsoe ka Sesotho kapa ka sekh ooa?					
RES [ENG]	in Sesotho or English?					
I1 [ENG]			some are in English, some are in Sesot ho			
I1 [SOT]			tse ling li ngotsoe ka Sesotho tse ling k a			
[73]	..	73 [06:29.4]			74 [06:31.6]	
RES [SOT]	ebe le etsa oang, ha motho a sa tsebe sekhooa					
RES [ENG]	and what do you do if he patiient does not know English?					
I1 [ENG]					they take a	
I1 [SOT]	Sekhooa				o tla nka eas	
[74]	..	75 [06:33.3]				
RES [SOT]	oo e ntse e le pamphlet e le ngoe e ngotsoe ka Sesotho le sekhooa?					
RES [ENG]	oo, its the same information written in Sesotho and English					
I1 [ENG]	Sesotho one				yes	
I1 [SOT]	Sesoho				e e	
[75]	76 [06:35.4]				77 [06:40.8]	
RES [SOT]	ha le ke be le thulane le ba reng ka nako e nngoe ha ke tsebe ho bala?					
RES [ENG]	don't you sometimes encounter those that would say: I cannot r ead?"					
I1 [ENG]					they are	
I1 [SOT]					ba teng	

[76]	.. 78 [06:41.5]		79 [06:43.5]	80 [06:45.0]
RES [SOT]		ebe le etsa joang?		oo
RES [ENG]		and what do you do?		ok
I1 [ENG]	there		we just explain what is being talked abiut there	yah
I1 [SOT]			o tla hlalosetsoa feela na ho buuoa kang mono	e ba
[77]	..			
I1 [ENG]	they are there, even when they sign consent, one will say:" I cannot write"			
I1 [SOT]	teng leha ba tsoanetse ho signa consen e mong o tla re "nna ha ke tsebe ho			
[78]	..			
I1 [ENG]	whenthey have to sign c onsent forms so they can start ARV, one would say" I			
I1 [SOT]	ngola", ha a lokela ho signa consent form form a qale li ARV, o tla re: " nna ha			
[79]	..		81 [06:53.7]	
RES [SOT]			ha ba se ba fumane li ARV, ha le ke be le kopaneng le bao e	
RES [ENG]			when they have started on ARVs do you find that some of	
I1 [ENG]	cannot write"			
I1 [SOT]	ke tsebe ho ngola"			
[80]	..			82 [07:04.7]
RES [SOT]	leng hore o defaulta treatment ha a noa lithlare hantle			
RES [ENG]	them default on treatment and do not use medication properly?			
I1 [ENG]				they are many of
I1 [SOT]				ba bangata ba
[81]		.. 83 [07:04.8]	84 [07:08.8]	
RES [SOT]			ba re mabaka a bona eebe a fe?	
RES [ENG]			what reasons do the y give?	

I1 [ENG]	them who def ault, many!	some of them its the
I1 [SOT]	defaultang ha holo!	ba babang eba li side

[82] .. 85 [07:14.8]

RES [SOT]		lee be le sa
RES [ENG]		and wou ld
I1 [ENG]	treament side effects you find that the treatment ch anges their shapes	
I1 [SOT]	effects tsa lithlare o fiumane hore li ba sentse lisha pe	

[83] .. 86 [07:15.5]

RES [SOT]	ba hlalosetsa hore ho tla ba joalo?	
RES [ENG]	you have explained to them that it will b e like that?	
I1 [ENG]		we would have explained
I1 [SOT]		ntse ba hlaloselitsoe

[84] 87 [07:19.5]

I1 [ENG]	before a patient starts on ARVs they go for counselling and they are c ounselled
I1 [SOT]	mokuli a kere pele a li qala o ea counselling, ua counselloa a joetsoe h ore ho tla

[85] ..

I1 [ENG]	about the side effects but when they come they are like a shock, its lie they did
I1 [SOT]	ba le side effects, empa ha li fihla li fihla e le nthoe kareng ke shock e kare o na

[86] .. 88 [07:32.5] 89 [07:33.7]

RES [SOT]		ke li side effects le eng hap e?	
RES [ENG]		it's side effects and what el se?	
I1 [ENG]	not know they will be t here.		its side effects and
I1 [SOT]	sa lebella hore li tla ba t eng.		ke li side effects le

[87]	.. 90 [07:42.7]	
RES [SOT]		o hloka a suppotruoe
RES [ENG]		who has to support
I1 [ENG]	family support, some do not have support in the fa mily	
I1 [SOT]	support ka lapeng, ba bang ha ba na eona support ka lapeng.	
[88] **RES [ENG]**	them? should there be someone assisting them with taking the p ills?	
I1 [ENG]		yes, they
I1 [SOT]		e, a ntsa m o
[89]	..	
I1 [ENG]	need someone to help because they are too strong one needs the support of	
I1 [SOT]	thusa ho li noa ha qeta ha kere its a strong medication, u hloka support ka hore	
[90]	..	
I1 [ENG]	someone who will every morning say" take your medication properly,	
I1 [SOT]	motho eno a nna u tsehetse hoseng ho hong le ho hong a nna re a tla ba ntsa re no	
[91]	.. 92 [08:02.1]	
RES [SOT]		joale ha motho a
RES [ENG]		so when there is
I1 [ENG]	persevere," because they are very strong"	
I1 [SOT]	noe litlare tsa ha hantle nno tsoele pele hobane li strong h aholo.	
[92]	.. 93 [08:03.2]	
RES [SOT]	sa sapotoe ka nako enngoe o kh athala matla?	
RES [ENG]	support someone the patient los es hope?	
I1 [ENG]		yes, and they stop, I was took them
I1 [SOT]		e ebe se ba tlohela, se ke ke li noe
[93]	..	
I1 [ENG]	for 28 days when I had pricked myself with a needle, in the consultation room we	
I1 [SOT]	28 days ke iprickile ka nale, ha ke re kamoo ha re toloke feela re thusa le ngaka	

[94]	..
I1 [ENG]	don't just interprete we also help the doctor with other tasks, so I pricked myself
I1 [SOT]	ka mesebtsi e meng ea e etsang, joale ke iprickile ka li noa 28 days, ka fila hore
[95]	..
I1 [ENG]	and I had to take them for 28 days. I felt what they feel. We used to shout at them
I1 [SOT]	na ba utloang, ne re tloaetse hore ha ba lofile litlhare ebe re tla ba omanya"
[96]	..
I1 [ENG]	when they have defaulted: why did u not take your medication? bla bal bla, that
I1 [SOT]	hobane u lofile litlthare, nye nye nye, ene be ke qetetse ho tloha hona mohlang
[97]	..
I1 [ENG]	was the last time I did it. These days I talk to the calmly and comfort them
I1 [SOT]	ono ke mo joetsa hantle kea mo khothatsa ke re "u nno tsoele pele"

APPENDIX J: SAMPLE OF ATLAS TI CODE OUTPUT

```
HU:  New Hermeneutic Unit
Edited by: Super
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Codes-quotations list
Code-Filter: All
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Code: adherence {1-0}

```
P 1: mampho.docx - 1:23 [hore o defaulta treatment..]  (351:418)
(Super)

RES [ENG]  How many of them default on treatment and do not use
medication properly?
I1 [ENG] they are many
I1 [SOT]  ba bangata ba
[81]                                ..
RES [SOT]  ba re mabaka a bona eebe a fe?
RES [ENG]  what reasons do they give?
I1 [ENG]  some of them it's the treatment side effects you find
               that the treatment changes their shapes
I1 [SOT]       ba babang eba li side effects tsa lithlare o fumane
               hore  li ba sentse lishape
[82]                                ..   85 [07:14.8]
RES [SOT]                           lee be le sa ba hlalosetsa hore
ho tla ba joalo
RES [ENG]  Wouldn't you have explained to them that it will be
like that?
I1 [ENG]  we would have explained
I1 [SOT] ntse ba hlaloselitsoe
[84]                                87 [07:19.5]
I1 [ENG]  before a patient starts on ARVs they go for counselling
          and they are counselled
I1 [SOT]  mokuli a kere pele a li qala o ea counselling, ua
          counselloa a joetsoe hore ho tla
[85]                                ..
I1 [ENG]  about the side effects but when they come they are like
          a shock, its lie they did
I1 [SOT]                            ba le side effects, empa ha li
          fihla li fihla e le nthoe kareng ke shock e kare o na
[86]                                ..   88 [07:32.5]   89
[07:33.7]
RES [SOT]  ke li side effects le eng hape?
RES [ENG] it's side effects and what else?
```

I1 [ENG] family support, some do not have support in the family
I1 [SOT] support ka lapeng, ba bang ha ba na eona support ka lapeng.
[88] RES [ENG]

Code: Challenge: age discordance {1-0}

P 1: mampho.docx - 1:19 [e e le teng ha e le ba bo mme ..] (269:272) (Super)
Codes: [Challenge: age discordance]

e e le teng ha e le ba bo mme ngaka e le monna) ba tla re "ee moshanyana
[61] I1 [SOT] a mokaa ka uena a nno re ke hlobole ke hloelle betheng, ke kakalle? ae ngoanaka
[62] .. 64 [05:34.1]
RES [SOT]

Code: Challenge: gender discordance {1-0}

P 1: mampho.docx - 1:18 [yes, more especially if our fe..] (249:256) (Super)
Codes: [Challenge: gender discordance]

yes, more especially if our female doctor asks to see and the
I1 [SOT] e bo haholo ha mme ngaka a ka re: "ere ke bone" joale e le mokuli
[56] ..
I1 [ENG] patient is male, you find that they don't like it, then you have to explain to them:
I1 [SOT] oa ntate o fumana kannete ha khotsofale joale ebe u tla mo hlalosetsa hore: "joale
[57] ..
I1 [ENG] "but now she says whe will not be able to give you medication because she did
I1 [SOT] u re o tla sitoa ho u fa litlhare hobane joale ha a bona u hloka ho bona
---

Code: Challenge: language mismatch {1-0}

P 1: mampho.docx - 1:15 [ot have a Sesotho equivalent s..] (199:204) (Super)
Codes: [Challenge: language mismatch]

Some do not have a Sesotho equivalent so you dont know what you will say
I1 [SOT] a mang ha a na Sesotho ha u tsebe na u tla reng
[45] .. 55 [04:14.8]

Code: Challenge: literacy {1-0}

P 1: mampho.docx - 1:22 [I1 [ENG] they are there, even ..] (339:348) (Super)
Codes: [Challenge: literacy]

I1 [ENG] they are there, even when they sign consent, one will say:" I cannot write"
I1 [SOT] teng leha ba tsoanetse ho signa consent e mong o tla re "nna ha ke tsebe ho ngola", ha a lokela ho signa consent form a qale li ARV

Code: Challenge: scientific language {1-0}

P 1: mampho.docx - 1:14 [e bo mantsoe a mang a li scien..] (195:197) (Super)
Codes: [Challenge: scientific language]

I1 [SOT] e bo mantsoe a mang a li science haholo ona a a li medical, a mang ha a na Sesotho ha u tsebe na u tla reng
[44] .. 54 [04:14.8]
yes, some scientific words more especially medical terms do not have a Sesotho equivalent so you dont know what you will say

Code: Demographics: Age {1-0}

P 1: mampho.docx - 1:1 [h I don't mind you knowing it,..] (14:14) (Super)
Codes: [Demographics: Age]

I don't mind you knowing it, I am 32 years
