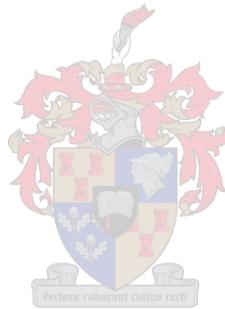


An exploratory study on telephone interpreting in the Western Cape healthcare sector

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Thesis presented in partial fulfilment of the requirements
for the degree of Master of Philosophy
at Stellenbosch University

Supervisor: Dr Harold M. Lesch
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PREAMBLE

DECLARATION

This thesis is submitted electronically and I declare that the entirety of the research and the reporting thereof is my own, original work. I also declare that I am the owner of the copyright thereof (unless explicitly stated otherwise) and that I have not previously submitted this thesis in its entirety or in part for obtaining any qualification.

April 2014

PREAMBLE

ABSTRACT

Communication in a global context is seriously hampered by language barriers. These barriers pose special challenges to service delivery, particularly in the healthcare sector. Onsite interpreting is considered most conducive to enable effective communication. In South Africa, however, it is not practical and financially viable to employ onsite interpreters for all the possible language combinations. Telephone interpreting is proposed as an alternative to onsite interpreting and Folio Online's InterTel service offers telephone interpreting in the Western Cape healthcare sector. This study gauges whether the InterTel service has the potential to contribute in any way to effective communication in the Western Cape healthcare sector.

In South Africa, language barriers do not only exist in communication with tourists or immigrants, but also among the country's own inhabitants. Furthermore, effective communication in the healthcare sector is particularly crucial. Miscommunication may lead to misdiagnosis and/or incorrect usage of medication, which in turn may result in death. The possible loss of life renders the issue of overcoming language barriers in the healthcare sector an important one.

The aim of the study is to argue descriptively about InterTel telephone interpreting service as a viable solution to the communication difficulties between healthcare practitioners and patients in the Western Cape healthcare sector. The research had to be narrowed down and instead the study descriptively argues whether InterTel service contributes to communication in the Western Cape healthcare sector. The researcher conducted an interview with the Folio InterTel project manager and sent out questionnaires to the Folio telephone interpreters. Five transcribed recordings of conversations between healthcare practitioners, patients and Folio telephone interpreters were analysed.

The findings of this study echo the findings of related studies reported in literature on telephone interpreting. The conclusion is that the Folio InterTel service makes a valuable contribution to more effective communication in Western Cape healthcare facilities.

PREAMBLE

OPSOMMING

Kommunikasie in 'n globale konteks word ernstig gekortwiek deur taalverskille. Hierdie verskille bied groot uitdagings vir die diensleweringsektor; meer spesifiek die gesondheidsorgsektor. Ter-plaatse tolking word beskou as mees bevorderlik vir betekenisvolle kommunikasie. In Suid Afrika is dit egter nie prakties en bekostigbaar om ter-plaatse tolke in diens te stel vir die groot verskeidenheid taalkombinasies nie en telefoontolking word as alternatief oorweeg. Folio Online bied die InterTel-telefoontolkingsdiens aan in die Weskaapse Gesondheidsektor. Hierdie ondersoek sal bepaal of die InterTel-diens die potensiaal het om effektiewe kommunikasie binne die Wes-Kaapse Gesondheidsektor te bevorder.

Taalgapings in Suid Afrika kom nie soseer voor in kommunikasie met toeriste of immigrante nie, maar eerder tussen die land se inwoners. Voldoende kommunikasie in die gesondheidsektor is van kardinale belang. Misverstande kan tot verkeerde diagnoses en/of die verkeerde gebruik van medisyne lei, wat in uiterste gevalle aanleiding mag gee tot die dood van 'n pasiënt. Hierdie moontlike noodlottige gevolge plaas taalgapings in die gesondheidsektor onder die soeklig.

Hierdie studie is 'n beskrywende argument wat ten doel het om te bepaal of Folio Online se InterTel-diens 'n lewensvatbare oplossing bied vir die kommunikasieprobleme tussen gesondheidspraktisyns en pasiënte in die Wes-Kaapse gesondheidsektor. Die navorsingsondersoek is gebaseer op 'n onderhoud met die Folio InterTel-projekbestuurder en vraelyste aan die onderskeie telefoontolke. Analises van vyf getranskribeerde opnames van gesprekke tussen gesondheidspraktisyns, pasiënte en Folio InterTel-telefoontolke vorm ook deel van die ondersoek.

Die bevindings van hierdie studie toon ooreenkomste met die bevindings van ander relevante studies soos opgeteken in die literatuur oor telefoontolking. Daar is bevind dat die InterTel-diens, soos gelewer aan die Wes-Kaapse Gesondheidsektor, wel 'n waardevolle bydra maak tot die bevordering van kommunikasie.

PREAMBLE

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PREAMBLE

TABLE OF CONTENTS

DECLARATION.....	i
ABSTRACT.....	ii
OPSOMMING.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	viii
LIST OF FIGURES.....	ix
CHAPTER 1: BACKGROUND AND PREPARATORY STUDY.....	1
1.1 Introduction	1
1.2 Overview of the language situation in the Western Cape	2
1.3 The need for interpreting in the healthcare sector	3
1.4 The need for telephone interpreting in the Western Cape health sector	6
1.5 Research statement and purpose of the study	7
1.6 Methodology	8
1.7 Overview of chapters	11
CHAPTER 2: LITERATURE OVERVIEW.....	12
2.1 Introduction	12
2.2 Defining interpreting	12
2.3 Interpreting categories	13
2.3.1 Healthcare interpreting	14
2.3.2 Community interpreting	15
2.3.3 Consecutive interpreting	16
2.4 A description of telephone interpreting	18
2.4.1. How telephone interpreting functions	19
2.4.2 Quality of telephone interpreting in light of the lack of visual stimuli	20
2.4.3 Concerns about confidentiality	22
2.4.4 Qualities of a model telephone interpreter	23

PREAMBLE

2.5 Advantages and disadvantages of telephone interpreting	24
2.5.1 Advantages of telephone interpreting	24
2.5.2 Disadvantages of telephone interpreting	29
2.6 Conclusion	32
CHAPTER 3: RESEARCH CONSIDERATIONS.....	33
3.1 Introduction	33
3.2 Folio InterTel	33
3.3 Hospitals included in the pilot phase of InterTel	37
3.3.1 Tygerberg Hospital	37
3.3.2 Karl Bremer Hospital	38
3.3.3 Swartland Hospital	39
3.3.4 Worcester Hospital	40
3.3.5 De Doorns clinic	41
3.4 Conclusion	42
CHAPTER 4: RESEARCH PROCEDURE AND DATA ANALYSIS.....	43
4.1 Introduction	43
4.2 Research design	43
4.3 Quantitative and qualitative approach	43
4.4 Selection of participants	44
4.5 Data collection instruments and method	46
4.5.1 Interview with InterTel project manager	46
4.5.2 Questionnaire for InterTel telephone interpreters	48
4.5.3 Recordings of interpreting sessions	49
4.6 Analysis of collected data	50
4.6.1 Discussion of interview with Folio InterTel project manager	50
4.6.2 Discussion of questionnaire presented to Folio telephone interpreters	58
4.6.3 Discussion of telephone interpreting sessions	63
4.7 Challenges encountered during the study	88
4.8 Conclusion	81

PREAMBLE

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS.....	82
5.1 Introduction	82
5.2 Findings of the study	82
5.3 Shortcomings of the study	85
5.4 Recommendations	87
REFERENCES.....	88
ADDENDA.....	95
Addendum A: Letters of approval	96
Western Cape Government Department of Health	97
Stellenbosch University Research Ethics Committee	98
Worcester Hospital	99
Folio Online	100
Addendum B: Interview	102
B1 Interview questions	103
B2 Transcription of interview	104
Addendum C: Questionnaires	109
C1 Questionnaire for interpreter	110
Addendum D: Transcribed interpreted sessions	114
D1 IsiXhosa interpreted session	115
D2 IsiXhosa interpreted session	120
D3 IsiXhosa interpreted session	127
D4 Sesotho interpreted session	130
D5 Sesotho interpreted session	131

PREAMBLE

LIST OF TABLES

Table 3.1: Language stats for Cape Town ¹	39
Table 3.2: Language stats for Swartland ²	40
Table 3.3: Language stats for Breede Valley ³	41

¹ This table has been generated by the Statistics South Africa's Time series data

² This table has been generated by the Statistics South Africa's Time series data

³ This table has been generated by the Statistics South Africa's Time series data

PREAMBLE

LIST OF FIGURES

Figure 4.1: Level of comfort interpreting over the telephone	51
Figure 4.2: Satisfaction with the interpreted product	53
Figure 4.3: Problems experienced with telephone interpreting	57
Figure 4.4: Number of calls from 2011 to 2013	58
Figure 4.5: The languages most often requested	59

CHAPTER ONE

BACKGROUND AND PREPARATORY STUDY

1.1 Introduction

This thesis explores the potential of telephone interpreting within the Western Cape healthcare sector. This should be seen against the background of the need for efficient communication and the impact of language barriers. A multilingual, multicultural context often gives rise to language barriers, since speakers of different languages are not always able to communicate efficiently and effectively with one another. Globalisation and the increased migration of people have exacerbated communication problems. This has resulted in the global need for interpreters. Kelly (2008:5) and Gracia-García (2002:2) ascribe this growing need in the USA to the influx of immigrants, with the consequent communication difficulties experienced in the public service sphere, including the legal and healthcare sectors.

The need for interpreters in South Africa is even more crucial, since the communication barriers exist not only between citizens and immigrants, but also among fellow South Africans. A high refugee population and the popularity of South Africa as a tourist destination exacerbate the problem (Folio Translation Consultants, 2013).

Impeded communication should be avoided, particularly in healthcare facilities, where impaired communication can be fatal: "In health care (and legal) settings, the consequences of not having interpreters can be tragic" (Gracia-García, 2002:2).

Telephone interpreting enables patients and healthcare practitioners to be connected to an off-site interpreter. This technique is as an inexpensive means of accessing a vast variety of languages at any given time.

1.2 An overview of the language situation in Western Cape healthcare sector

Both Schlemmer (2005) and Sause (2010), who conducted research on communication in the Western Cape healthcare sector, recognise that language barriers exist between some doctors and patients. Schlemmer's research was done from a sociological perspective and Sause's from an interpreting perspective. They established that these language barriers arise in cases where healthcare practitioners are either Afrikaans- or English-speaking and patients are not proficient in these languages. Given the number of language combinations in South Africa, situations where healthcare practitioners and patients do not speak the same language arise regularly. Except for some nurses, most South African healthcare practitioners are unable to speak any African languages (Drennan in Levin, 2006; Williams, 2006:42).

The Constitution of the Republic of South Africa recognises the importance of communication in one's own language. Section 6 of the Constitution (Act No. 108 of 1996) stipulates that 11 of the 25 languages spoken in South Africa hold official status. These languages are: isiNdebele, isiXhosa, isiZulu, siSwati, Sesotho, Sepedi, Setswana, Tshivenda, Xitsonga, English and Afrikaans (Department of Arts and Culture, 2002:5). The National Language Policy Framework was presented in 1998 to promote the statuses of previously marginalised languages. Thereafter, the Western Cape Language Policy, passed by the Provincial Parliament in 2004, paved the way for implementation (Department of Arts and Culture, 2002:5).

A key objective of the Western Cape Language Policy is to enhance the status and encourage the use of the official languages in the Western Cape and "to support the Batho Pele initiative of impartial service delivery by promoting equal access to public services and programmes by removing communication or language barriers" (Cape Gateway, 2005). This language policy implies that citizens have the right to communicate in Afrikaans, English and isiXhosa in the Western Cape healthcare sector, since these three languages are the official languages of the Western Cape. This policy does not enforce provision of healthcare services in other South African or foreign languages. However, it should be noted that proper healthcare services can be facilitated only through adequate communication. If a patient cannot speak the

language of the healthcare practitioner, he cannot obtain proper healthcare service, which potentially puts his life in danger. Access to communication in all South African languages, and any other languages spoken by immigrants and foreigners, is therefore vital.

Saulse (2010) established that effective interpreting services have not yet been implemented in the Western Cape healthcare sector. Furthermore, Schlemmer (2005) and Saulse (2010) contend that there is a lack of professionally trained interpreters in the Western Cape. Saulse's study confirmed that in 2010 the Groote Schuur and Red Cross War Memorial Children's hospitals employed four interpreters each, Tygerberg Hospital did not employ any interpreters and made use of a care worker for interpreting. Saulse also found that if on-site interpreters were not available, family members of patients or medical or cleaning staff would often be used to interpret for doctors and patients (Saulse, 2010).

According to Schlemmer (2005:3) the effect of language barriers can impact negatively on work efficiency and the quality of patient care. Language barriers can also result in cross-cultural misunderstandings. Ethical dilemmas may arise around obtaining consent and potentially breaching doctor-patient confidentiality. The inability of healthcare practitioners to obtain informed consent from patients, may also have legal repercussions for the healthcare facility (Schlemmer, 2005).

The likelihood of patients not properly comprehending the doctor's diagnosis, not attending follow-up consultations and not complying with prescription instructions, correlate with the incidence of language barriers (Schlemmer, 2005; Levin, 2006). Furthermore, language barriers often cause patients to feel disgruntled with the quality of healthcare (Schlemmer, 2005; Levin, 2006).

1.3 Need for interpreting in healthcare sector

The degree to which language barriers can influence the quality of healthcare, and the consequent need for interpreters, cannot be denied. According to Feinauer and Lesch (2013:125) "clear verbal communication is a necessary component of an

effective clinical encounter”. Schlemmer (2005:4) expands on this idea, stating: “A language barrier between patients and healthcare providers is one of the major obstacles to the provision of quality care to our culturally diverse population.” Schlemmer (2005:4) contends that impaired communication has a negative impact on the quality of healthcare that the patients receive, to the extent that patients may even be completely prevented from accessing the service (Pienaar 2006:35).

Untrained interpreters are often used in the healthcare sector (Kelly, 2008:27). Phelan (2001:34) states that patients “should be entitled to the professional services of an impartial interpreter”, as not all patients are comfortable with their family members having knowledge about their medical conditions.

With hampered communication or when an untrained interpreter is used, misdiagnosis is possible, which may result in the patient receiving unnecessary or wrongful medication, treatment or operations, or being unnecessarily referred to a specialist (Phelan, 2001:34). Misunderstandings are particularly likely in an intercultural context such as South Africa, as culture-specific references to ailments may not be understood by the other party. One example comes up in a study, done by Krige and Krige in 1943, on the Sotho-speaking Lovedu ethnic group. The Lovedu people will say “the snake is biting” when they have stomach ache (Green, 1999:92). A healthcare practitioner who is unfamiliar with this cultural reference to stomach ache may prescribe antiven. When receiving antivenin, there is a chance that the patient may have an anaphylaxis or get serum sickness, which both are potentially fatal. Antivenin should therefore not unnecessarily be administered to patients.

During a doctor-patient conversation, the doctor may pick up symptoms that the patient may think are unrelated to his medical condition. If communication is restricted, the patient is likely to try to communicate only the symptoms that he deems are most important. The patient needs to be able to speak freely in order for the doctor to gain all the information and make a proper diagnosis. The inability of healthcare practitioners to acquire information regarding a patient’s ailment and medical history can hinder the practitioner’s treatment of the patient and untreated conditions may result in the patient’s death (Muller in Sause, 2010).

In turn, doctors need to be able to convey information to their patients about their medical conditions; the severity thereof; how to use the prescribed medication and any other treatments needed. Deficient information can lead to the incorrect usage of prescribed medication, as well as failure to adhere to treatment and to attend follow-up consultations. All of these can put the patient's health at risk (Gracia-García, 2002:2; Schlemmer, 2005:4). Patients should understand the seriousness of their condition. Being diagnosed with a terminal or severe illness can be traumatic and communication is the only way in which doctors can put their patients at ease. On the other hand, it can be detrimental to a patient's wellbeing if he believes that he is terminally ill, when in reality he suffers from a curable ailment (Schlemmer, 2005:14).

Furthermore, lack of communication may strain the relationship between patient and healthcare practitioner (Gracia-García, 2002:2), which may lead to a breach in trust. In all medical issues it is of the utmost importance that the patient trusts the healthcare practitioner. Unobstructed communication between doctors and patients is therefore necessary in order for a doctor-patient relationship to develop (Gracia-García, 2002:3).

Ineffective communication does not only affect patients, but medical personnel as well. As mentioned, miscommunication may lead to misdiagnosis and even death, which may have legal implications for the hospital/clinic concerned (Schlemmer, 2005:13, 23). The hospital can also face legal repercussions if certain procedures are carried out without a patient's consent. Patients cannot give consent for treatment or operations if they do not understand what is said to them.

Moreover, communication is second nature to most people and experiencing difficulty to communicate may be tedious and stressful and may lead to the need for additional effort, for which medical personnel usually do not have the time or energy (Schlemmer, 2005:13). Inability to communicate with patients may leave medical practitioners feeling frustrated, inadequate or depressed, especially if this renders them unable to serve the patient properly. Work efficiency can also be hampered by ineffective communication (Schlemmer, 2005:13). Therefore, in an already stressful

environment in which staff is often overworked, language barriers should be minimised.

Consultations where interpreters are not present, take longer and are more expensive (Horn Berger in Schlemmer, 2005:5). However, it seems that when the decision to hire or not hire interpreters is made, the time-factor and cost associated with the use of an interpreter are decisive; even rated above the quality of doctor-patient communication. Furthermore, Schlemmer (2005:26) assesses that the cost of training and hiring interpreters is lower than the cost of misdirected resources, which are likely in cases where patients and medical staff are unable to understand each other.

1.4 Need for telephone interpreting in Western Cape health sector

Like in healthcare sectors across the world, bilingual persons not trained as interpreters, such as family members, nurses and cleaning staff, are generally used to perform healthcare interpreting in the US (Kelly, 2008:27). However, the use of relatives or friends to interpret is disapproved of by the law and interpreter associations (Gracia-García, 2002:3), and legislation was implemented in the US to ensure equal access to public services for the limited English proficient (LEP) population (Gracia-García, 2002:2). The legislation requires hospitals to provide interpreting services free of charge. Employing on-site interpreters, particularly low-incidence language interpreters, leads to an upsurge in expenses for healthcare facilities (Gracia-García, 2002:3). Despite legislation regarding the provision of free healthcare interpreting at hospitals, the interpreters employed at hospitals are normally few and far between and they are frequently overworked. Interpreters are therefore not readily available at all times and healthcare sector staff are in most cases not trained to assist LEP patients (Gracia-García, 2002:2).

Various recommendations have been made on how to deal with language barriers. Solutions presented by the US government are: "hiring bilingual staff who are trained and competent in the skill of interpreting; hiring trained and competent staff interpreters; contracting with an outside interpreter service; arranging formally for the

service of voluntary community interpreters who are trained and competent; and/or arranging/contracting for the use of a telephone language interpreter service” (Gracia-García, 2002:3-4). In the South African context with 25 different languages, hiring staff that are competent in all these languages will not be possible. Besides, relying on bilingual staff does not provide a problem-free solution, as these staff members will be unable to pay full attention to their official duties if they are called away to interpret. Having additional interpreting duties may result in these staff members becoming overburdened (Gracia-García, 2002:3).

The other option is to hire on-site interpreters. However, employing 25 on-site interpreters in order to cater for all South African citizens would be far too expensive for healthcare facilities. This figure does not even take into account interpreters needed to interpret for immigrants or foreigners. Furthermore, it would be difficult to employ such a high number of interpreters in all hospitals/clinics in the Western Cape, since the number of adequately trained healthcare interpreters in the region is limited (Schlemmer, 2005; Sause, 2010). For the same reason it would be difficult to find voluntary community interpreters.

Since it is not an option to employ on-site interpreters in all the official languages at hospitals/clinics in the Western Cape, telephone interpreting seems to present a plausible solution, as it is cost-effective and enables immediate access to numerous language interpreters.

1.5 Research statement and purpose of study

In a multilingual sphere such as hospital/clinic consulting or surgery rooms in South Africa, communication difficulties and subsequent misinterpretation are likely to occur. The need for adequately trained interpreters in the healthcare sector has been addressed by Angelelli (2004), Fisch (2001), Lesch (2007), Sause (2010), Schlemmer (2005) and Williams (2006). These authors indicate that making use of untrained interpreters is not ideal. However, due to a lack of availability of interpreters and financing, healthcare facilities often use cleaning staff or family members of patients to interpret instead of professional interpreters.

The need for an alternative to onsite interpreting is apparent. Telephone interpreting presents one option. In order to provide a telephone interpreting service for the healthcare sector in the Western Cape, Folio Online, based in Cape Town, added telephone interpreting to their services, and on the 11 October 2010, the Folio InterTel: The Telephone Interpreting Solution Project was launched. The pilot phase of Folio InterTel was implemented at various medical institutions, including Tygerberg and Karl Bremer hospitals (Cape Town), Swartland Hospital (Malmesbury), Worcester Hospital and De Doorns Clinic. Folio employed 32 interpreters of different languages, including the 11 official languages of South Africa, other languages spoken in Africa, and even Russian and Chinese. The interpreters received telephonic medical interpreting training through the Medical Interpreting and Translating Institute Online (MiTio) (Folio press release, 2010). Folio InterTel operates similarly to a call centre. The telephone interpreters log on to the system when they are available and calls from the hospitals or clinics are routed to them via the system (Folio press release, 2010).

The objective of this research study is to provide a descriptive overview of telephone interpreting in the Western Cape healthcare sector and to explore the functioning of Folio InterTel telephone interpreting.

In this study the researcher will define the term “telephone interpreting”, taking into consideration local and international sources. Information on Folio InterTel and how it works will be presented and the functioning of the service evaluated.

1.6 Methodology

The research will comprise of a literature review of telephone interpreting in healthcare situations. This will be done to explain and explore some theoretical notions on interpreting. To explore the potential of the InterTel telephone interpreting service in the Western Cape healthcare sector, the development and provision of services by Folio InterTel will be described.

Initially, the researcher wanted to explore whether the Folio InterTel service could function as an alternative to on-site interpreting and thus offer a potential solution to the communication barrier in the Western Cape healthcare sector.

The researcher intended to present questionnaires to patients, healthcare practitioners and interpreters who had experienced the Folio InterTel service. The questionnaires would be distributed to patients and healthcare practitioners at three facilities, namely Tygerberg, Karl Bremer and Worcester hospitals. These facilities were selected because they formed part of the pilot phase of the Folio InterTel project and indicated that they had implemented and used the InterTel service. The researcher intended to present the questionnaires to the patients and healthcare practitioners in a face-to-face situation and to obtain the services of an isiXhosa interpreter in case participants had trouble communicating in English or Afrikaans. Questionnaires would be presented to InterTel interpreters face-to-face.

The researcher drew up mix-method questionnaires (see Addendum C), including open-ended questions where participants could, for instance, explain the problems they had encountered with the service, and closed questions where, for example, the participants could rate the service on a five-point Likert-scale. This data would be used to establish whether the InterTel service functioned effectively and could be presented as an alternative to on-site interpreting.

The aim was to interview between 10 and 20 patients at each facility, as well as 10 hospital staff (However, this number would vary, depending on the number of staff employed at the hospitals). The questionnaire included 30 questions. Medical personnel and patients would be interviewed in order to determine the shortcomings and advantages of telephone interpreting in the health sector. The questionnaires were designed to take between 5 and 10 minutes to complete.

The researcher also intended to do observations at the facilities, in order to obtain an unbiased perspective on how the InterTel service functioned. The researcher hoped to observe, for instance, how often the healthcare practitioners had trouble communicating with their patients and whether they opted in these cases to contact InterTel. The researcher also hoped to see if telephones were readily available and

how long the process of contacting the interpreter would take. It would be possible to observe how long it took for the InterTel interpreter to pick up the phone. The researcher intended to gain an understanding of the positive and negative aspects of telephone interpreting by observing the interaction of patients and healthcare practitioners with the telephone interpreter.

Ethical clearance was obtained from the University of Stellenbosch and from the Western Cape Government Department of Health, as well as permission from Folio Online (see Addendum A) to conduct the research study.

Permission from Folio Online was granted to conduct research on the following:

- Folio Online and the Folio InterTel service;
- interviews with Folio Online telephone interpreters;
- Folio Online InterTel project manager and other staff;
- telephone calls; "... transcribe some of the telephone interpreting calls provided that no personal details of the patients or hospitals be disclosed" (Addendum A).

Of the facilities requested to provide clearance (Tygerberg, Karl Bremer, Swartland and Worcester hospitals), permission was only obtained from Worcester Hospital. During further communication with this facility, the medical superintendent indicated that the InterTel service was not used at this facility.

The intended research could therefore not be carried out (further discussed in 4.8). Nonetheless, the researcher still deemed the investigation of telephone interpreting in the Western Cape healthcare sector as important, given the limited research in this field. The direction of the study changed to an exploratory investigation into telephone interpreting in the Western Cape healthcare sector.

The empirical investigation was consequently scaled down to:

- questionnaires, with both open-ended and closed questions, presented to seven Folio InterTel telephone interpreters
- an interview with the InterTel project manager

- an analysis of telephone calls from healthcare facilities to Folio InterTel involving healthcare practitioners, patients and telephone interpreters.

At this stage, the questionnaires intended for the InterTel interpreters were presented to them. However, due to potential breach of confidentiality on behalf of Folio Online the questionnaires could not be administered to the interpreters face to face and was sent to the interpreters via email. A structured interview with open-ended questions was also conducted with the Folio InterTel project manager. Five telephone calls involving three isiXhosa and two Sesotho patients were requested from Folio Online. isiXhosa and Sesotho are two of the languages widely spoken in the area of the Western Cape that this research study focuses on. These telephone calls were transcribed and analysed in order to explore and understand doctor-patient communication as mediated by a telephone interpreter.

1.7 Overview of chapters

The research study comprises of four chapters and a conclusion. Chapter 1 offers an overview of the study. Concepts such as interpreting, healthcare interpreting and telephone interpreting are defined in Chapter 2. Telephone interpreting is discussed in terms of quality, confidentiality, and advantages and disadvantages. Chapter 3 includes the research context and an overview of the research context. Folio InterTel and the healthcare facilities that formed part of Folio InterTel's pilot phase are described. Tygerberg, Karl Bremer, Swartland and Worcester hospitals, as well as De Doorns Clinic, were included. The areas served by these healthcare facilities are also mentioned. In Chapter 4, which comprises of the research design and collection of data, the methods used during the study are described. The data obtained is then discussed. The conclusion presents the findings and shortcomings of the study. The problems and positive aspects of telephone interpreting are included. A few recommendations are made. Finally, observations and conclusions on whether or not telephone interpreting is a viable solution to the communication problem in the Western Cape healthcare sector are made.

CHAPTER TWO

LITERATURE OVERVIEW

2.1 Introduction

In this chapter, a literature overview regarding interpreting – telephone interpreting in particular – will be presented. Research on telephone interpreting seems to be limited compared to other fields of study. Kelly's publication *Telephone interpreting: A comprehensive guide to the profession* is the first published general guideline, including ethics and standards, for telephone interpreting (Kelly, 2008:28). Since literature on telephone interpreting is limited, this chapter will focus on the works of Hale (2007), Merlini and Favaron (2003), Gracia-García (2002) and Kelly (2008). A general introduction to interpreting will be given in which terms commonly used in the field will be defined. The focus of the chapter will be on telephone interpreting and topics such as the quality of telephone interpreting, particularly the absence of visual stimuli; concerns about confidentiality; and the advantages and disadvantages of telephone interpreting in comparison to on-site interpreting.

Note: The term "healthcare practitioner" may refer to a doctor, nurse or matron etc., while the term "healthcare facility" may refer to a hospital or a clinic.

2.2 Defining interpreting

Interpreting has been defined in many different ways (Hale, 2007; Phelan, 2001; Erasmus, 1999). These definitions have been influenced by the context in which interpreting is perceived. Hale (2007) describes it as "a branch of translation", but distinguishes it from translation by stating that it is "translation of the spoken word" rather than that of the written word (Hale, 2007:3). Interpreting will therefore be viewed as the action of producing an equivalent for the source language message in the target language. "Translation is a process by which a spoken or written utterance takes place in one language which is intended and presumed to convey the same meaning as a previously existing utterance in another language" (Rabin in Hale, 2007:4). Hale (2007:24) provides a similar definition, suggesting that interpreting is

the transferal of the original message to the intended listener in a manner that is concise and understandable.

When one moves away from the notion that interpreting has its roots in translation, the fact that interpretation is a means of communication comes to the fore. Interpreting can be viewed as a method of enabling communication between two parties who do not share a common language. This communication takes place through a third party, called the interpreter, who can speak both languages in question (Phelan, 2001:1; Hertzog and Reunbrouck in Erasmus, 1999:266). Hertog and Reunbrouck (in Erasmus, 1999:266) describe the act as one where the interpreter is “someone who will facilitate or mediate the communication, the transfer of meaning and intention”. The interpreter “translates orally what he or she hears into another language” (Phelan, 2001:6).

Angelelli (2004) defines the act of interpreting from the point of view of an interpreter, focusing on the interpreter’s role. Angelelli (2004:1) describes interpreters as “vital agents between culture and languages” with the objective of facilitating communication, and co-constructing meaning together with the parties involved in the interpreting transaction (Wadensjö in Angelelli, 2004:18).

2.3 Interpreting categories

Not only are there numerous definitions for interpreting; there are numerous manners of categorising interpreting. These categories often overlap and boundaries may become blurry (Merlini and Favaron, 2003:206). Authors distinguish between two main categories of interpreting: simultaneous and consecutive interpreting. Hale (2007:10) subdivides simultaneous interpreting into simultaneous interpreting with the use of equipment and simultaneous interpreting in the form of whispering, also called *chuchotage*, which can be done without the use of equipment. Hale (2007:10) also subdivides consecutive interpreting into long consecutive and short consecutive (dialogue) interpreting. In the rendition of Hertog and Reunbrouck (in Erasmus, 1999:264-265) sight translation or sight interpretation is presented as a third category. Based on the interpreting situation/setting/context, one can discern

between conference and community interpreting (Merlini and Favaron, 2003:206; Hertog and Reunbrouck in Erasmus, 1999:266). Sometimes, business interpreting (Hale, 2007:28) and court interpreting (Phelan, 2001:20) are also included in this category. In addition to these types of interpreting, Phelan (2001:12-16), without discerning between categories, mentions telephone interpreting, sign language interpreting, television interpreting and videoconference interpreting.

Interpreting can be categorised in terms of the field in which it takes place. The field will be indicative of the content and terminology that will be used. Interpreting can also be categorised with reference to the user of the service, for instance the general public. Interpreting can thus be viewed as aimed at a particular community, which renders it community interpreting.

The focus of this study is on telephone interpreting in the healthcare sector, which takes place in the consecutive mode. In this study, healthcare interpreting is regarded as a subdivision of community interpreting. Therefore, the terms consecutive interpreting, healthcare interpreting, community interpreting and telephone interpreting will be discussed.

2.3.1 Consecutive interpreting

Healthcare interpreting, including telephone interpreting, is executed in the consecutive mode (Saulse, 2010:14). Consecutive interpreting is the interpretation of speech that has already been uttered. The interpreter starts speaking only once the speaker has stopped (Clausen, 2011:16). The speaker will then resume speaking and the relay continues. Kelly (2008:x) describes consecutive interpreting as “interpretation that is performed by the interpreter first listening to an utterance in one language and then rendering it into another language”. The lengths of speech segments that are interpreted vary. During long consecutive interpreting, the utterances may last five minutes; whereas during short consecutive interpreting the length of speech may be shorter (Hale, 2007:10). In contrast to simultaneous interpreting, a booth and headphones are not required during this mode of interpreting.

According to Phelan (2001:6), the first person singular is the form of grammatical person that should be used during interpreting, as the interpreter acts as a substitute for the speaker of the original utterance. By using the first person, communication between the parties will almost take the form of a “direct conversation”. However, Oviatt and Cohen (in Ozolins, 2011:38) have found that the use of the third person is prevalent in telephone interpreting transactions.

2.3.2 Healthcare interpreting

Healthcare interpreting is seen by some interpreting scholars as a specialised category on its own (Phelan, 2001:20). Others view it as a subcategory of community interpreting (Hale, 2007:30). Sause (2010:12-13) draws a clear distinction between medical and healthcare interpreting, because the patient is always present during healthcare interpreting, but not necessarily during medical interpreting. The parties involved in a healthcare interpreting transaction is a healthcare provider, such as a doctor or a nurse, and the patient, sometimes together with family members (Sause, 2010:12-13). Healthcare interpreting takes place in “doctors’ offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations” (Sause, 2010:12). Medical interpreting may include any of these settings, as well as any other setting related to the medical profession, like staff meetings, conferences, conventions and seminars (Sause, 2010:13).

Since the discussion between healthcare provider and patient is being interpreted, one can argue that healthcare interpreting is also liaison or dialogue interpreting, as the interpreting action is bi-directional (Sause, 2010:13). Furthermore, interpreting done at public hospitals and clinics renders healthcare interpreting part of public service interpreting. Interpreting in healthcare settings is more often than not done by volunteers, usually family members, nurses or cleaners. In these cases, healthcare interpreting can also be seen as *ad hoc* interpreting.

As with interpreting in general, the role of the interpreter during healthcare interpreting needs to be discussed. Some interpreting scholars suggest that the healthcare interpreter should be “invisible”. In that way, the interpreting transaction

will occur in such a way that communication between doctor and patient seems almost direct. If the interpreter does not intervene, it may improve the impartiality of the rendition. Potential legal implications can be avoided if the interpreter merely transfers what he has heard without adding anything on. The doctor-patient relationship may also be promoted if the interpreter remains invisible. In cases where the interpreter intervenes, back-and-forth communication between the interpreter and one party may result in the other party feeling left out or uncertain about what is being said, which can affect the doctor-patient relationship (Gracia-García, 2002:2).

Others propose that the interpreter should act as a cultural broker (Angelelli, 2004:17). As language and culture are interconnected, it can be assumed that, in most cases, the two parties speaking different languages have different cultural backgrounds. For communication to be understood, it is important to view it within context. Therefore, it is suggested that interpreters “should interpret in a way that conveys the cultural framework” (Saulse, 2010:29).

2.3.3 Community interpreting

In accordance with the various categories proposed for the division of interpreting and the multitude of definitions for interpreting, different authors will make use of different terms when describing community interpreting. Some use these terms as synonyms, while others assign altered definitions to them (Hale, 2007:28). Community interpreting is used either as a synonym for public service, community-based, *ad hoc*, contact, dialogue (Phelan, 2001:20), escort, cultural, liaison, medical, legal⁴, welfare, immigration, education, sign language, aboriginal (Hale, 2007:28), three-cornered (Gentile, Ozolins and Vasilakakos in Merlini and Favaron, 2003:206) and healthcare interpreting (Saulse, 2010:12) or as an umbrella term encompassing all these different types of interpreting.

For the purpose of this study, the term “community interpreting” will be used to refer to “any interpreting (paid or voluntary) where interpreters work in day-to-day life situations in the community” (Harris in Merlini and Favaron, 2003:207) and more

⁴ As mentioned, court or legal interpreting can be seen as a category on its own. However, several authors categorise it under community interpreting and it has subsequently been added to this list.

specifically, interpreting which “is provided face to face and over the phone in the spheres of health, social services, law and education” (Phelan, 2001:20). The term “community interpreting” is frequently used to describe any kind of interpreting that is not conference interpreting (Robert in Hale, 2007:28) and is therefore often defined in comparison to conference interpreting. One such definition indicates that community interpreting serves community members of one country, whereas conference interpreting usually caters for nationals from different countries (Hale, 2007:30). According to Mikkelsen (in Hale, 2007:29), the term “community interpreting” is derived from the group of people who will make use of this service, namely “residents of a community”.

To form a holistic picture of community interpreting, liaison and *ad hoc* interpreting will be discussed briefly, as these two terms are closely related to this form of interpreting. Liaison or bilateral interpreting is defined in a manner that sheds light on the language directionality in which this type of interpreting takes place: “*Liaison interpreting* is the name given to the genre of interpreting where the interpreting is performed in two language directions by the same person” (Gentile, Ozolins and Vasilakakos in Merlini and Favaron, 2003:206). In other words, the interpreter (or person who speaks two languages) interprets from the language spoken by one speaker into the language spoken by the other speaker (Phelan, 2001:12; Saulse, 2010:13). Hale (2007:10) calls this form of interpreting dialogue interpreting and explains the term as the interpreting of a dialogue between two parties, which takes place in situations such as interviews, consultations and hearings. Harris (in Hale, 2007:29) and Robert (in Merlini and Favaron, 2003:207) view liaison interpreting and escort interpreting as synonyms and use these terms to refer to the type of interpreting done when accompanying foreign nationals to business meetings.

Ad hoc and public service interpreting is mostly used interchangeably. Discussions on *ad hoc* or public service interpreting tend to highlight the status disparity between the parties participating in the interpreting transactions. In cases where *ad hoc* or public service interpreting is used to label the type of interpreting that takes place in situations where one party is a professional providing a public or social service, and the other making use of it (Merlini and Favaron, 2003:208). The term *ad hoc*

interpreting often carries the stigma of interpreting for “lower class” citizens. For example, an educated doctor at a clinic treats an immigrant from Zimbabwe, who works as a domestic worker and cannot afford medical care at a private hospital (Shackman in Merlini and Favaron, 2003:208). The fact that *ad hoc* interpreting generally refers to interpreting done by unpaid volunteers on a temporary basis, contributes to this stigma (Dueñas González et al, in Hale, 2007:28; Merlini and Favaron, 2003:214). *Ad hoc* interpreting can also imply interpreting performed by any individual who is not a trained interpreter, but who volunteers his services based on his ability to speak the two languages in question (Saulse, 2010:14).

2.4 A description of telephone interpreting

As mentioned, the focus of this study is telephone interpreting in the healthcare sector and consequently the modes of interpreting relating to healthcare have been described. In this section, telephone interpreting will be defined.

Telephone interpreting is “bilateral interpreting over the phone” (Phelan, 2001:13). Telephone interpreting is interpreting that is produced by an off-site interpreter via a telephone (Kelly, 2008). Heh & Qian (in Gracia-García, 2002:4) defines telephone interpreting as “... a real-time language service that enables speakers of different languages to communicate by telephone with the assistance of an interpreter via a three-way conference call.” Telephone interpreting can also be termed “remote interpreting/-ation, RIS (remote simultaneous interpreting), teleinterpreting, telephonic interpreting/-ation, TIS (telephonic interpreting services), OPI (over-the-phone interpreting/-ation)” (Niska in Gracia-García, 2002:4).

Telephone interpreting was used for the first time in Australia in 1973 as a free service that assisted immigrants in communicating in English during emergency situations (Kelly, 2008:5-6). As the service developed, it spread to other spheres. In America, telephone interpreting emerged in 1981 as a non-profit organisation in the police sector, but was soon used in other industries, such as the healthcare, finance, telecommunications and safety. Telephone interpreting subsequently evolved into a service run for profit (Kelly, 2008:5-6).

As telephone interpreting developed further, the need for quality assurance arose. Telephone interpreting companies started to implement training, testing and monitoring, in order to satisfy customers' demand for quality control and to measure and improve the quality of their service (Kelly, 2008:25-26). Today training and testing can be conducted internally or externally. Telephone interpreters are trained to implement a code of ethics and to uphold a set of professional standards (Kelly, 2008:27). Telephone interpreters are tested for language and interpreting skills, such as jargon proficiency, before being employed and once they are in service, monitoring or assessment is done by watching or listening to recordings of the interpreters (Kelly, 2008:26, 30).

The most significant distinction between telephone interpreting and face-to-face interpreting is that visual information, such as body language and facial expressions, are absent during over-the-phone interpreting (Gracia-García, 2002:4; Rosenberg, 2007:67). This form of interpreting is used in business, medical (particularly emergency) and court settings (Phelan, 2001:13). By means of telephone interpreting, a large number of interpreters in almost any location can be accessed from anywhere at any time (Phelan, 2001:13; Andres & Falk, 2009:16).

2.4.1 How telephone interpreting functions

The parties involved in a telephone interpreting transaction are the client, the LEP party, the agent and the telephone interpreter (Kelly, 2008; Heh & Qian in Gracia-García, 2002:4). In the case of telephone interpreting for the healthcare sector in the Western Cape healthcare sector, the healthcare facility or healthcare practitioner is the client and a telephone interpreting service, such as Folio InterTel, is the agent. The LEP would be a non-English- or non-Afrikaans-speaking patient.

There are two office settings for telephone interpreting: call centres and home offices (Kelly, 2008:23-4). Call centres either have operators, who simply put callers through to the interpreters, or have interpreters stationed at the centre. The latter option is normally elected to minimise the time it takes to connect the caller to the interpreter, particularly in emergency situations. Telephone interpreters can also work from

home. According to Kelly, American companies provide their at-home telephone interpreters with the required equipment, such as computers and telephone headsets. Additional training and other material, including terminology lists, are also provided to the interpreters, either in hardcopy or on the Web. Although telephone interpreters can be tested and trained via telephone or the Internet, some companies still organise seminars and group training for their interpreters.

Any phone can be used during telephone interpreting, as the phone can be placed on speakerphone or passed from one party to the other (Kelly, 2008:31). Dual receiver phones, which are user-friendlier as they have receivers for both parties, can also be used. Phones can be corded or cordless; fixed in different locations or carried around in cases or wheeled on trolleys; and can have a speed-dial function, which is normally preset to the interpreter's number (Kelly, 2008:31).

2.4.2 Quality of telephone interpreting: the lack of visual stimuli

The adequacy of telephone interpreting, particularly in comparison to face-to-face interpreting, is much debated (Gracia-García, 2002:4; Ozolins, 2011:37; Kelly, 2008:83). The adequacy of interpreting is important in the healthcare sector, as ineffective or incorrect interpreting can have bearing on the health of patients. For an interpreter to render a message completely and accurately in another language, he needs to understand the meaning thereof. According to Gracia-García (2002:5) experts suggest that accuracy can be achieved only if the interpreter has access to visual information. It is important to note that this is merely a suggestion and that empirical data proving the negative effect of a lack in visual information on the quality of the interpreted product, has not yet been provided (Kelly, 2008:83; Ozolins, 2011:42; Gracia-García, 2002:6). According to Gracia-García (2002:4-5) visual elements provide supplementary information that helps the listener to decode a message, as they are indicators of the emotion and attitude with which the message has been delivered. Visual information includes "the movement of the hands, body language, postures, facial expressions and eye contact". Without visual information, the telephone interpreter relies exclusively on the speaker's tone of voice, intonation and pauses in speech, which leaves room for misinterpretation (Gracia-García,

2002:5). Compensating for the lack of visual information, which plays a greater role in communication than the actual speech, involves a higher degree of concentration and may be stressful (Alic in Gracia-García, 2002:5).

Whilst Kelly (2008:83) agrees that non-verbal elements play a noteworthy role in communication, he points out that non-verbal elements may or may not be visual. Kelly (2008:83) questions the significance of visual stimuli during communication and suggests that interpreters have the ability to interpret non-verbal cues, such as “hesitation, inflection, tone of voice and vocal volume” adequately. Similar to blind interpreters, who depend on their other senses, telephone interpreters can be trained to compensate for the lack of visual information by improved listening skills and the ability to process auditory information adequately (Kelly, 2008:84; Ozolins, 2011:42).

Gracia-García (2002:6) concludes that due to a lack of empirical research, cost becomes the deciding factor when the supposed need for visual information is weighed up against the cost of on-site interpreters. Kelly (2008:87), recognising that there are both advantages and disadvantages to telephone interpreting, suggests that an empirical study be conducted in order to dismiss assumptions about telephone interpreting, as well as to provide information on which decisions regarding the use of telephone interpreting services can be made. Kelly (2008:87) acknowledges that there are situations in which on-site interpreting is more appropriate than telephone interpreting. This includes the following situations: when interpreting is done for a group of people; when only a telephone with a speakerphone option is available (in which case the sound quality is usually bad); when the patient is unable to communicate effectively via telephone, such as when the patient is a child or an elderly person, or either hearing or mentally impaired. However, Kelly (2008:87) points out that the inadequacy of telephone interpreting, as seen from the above-mentioned examples, relates more to “the needs of certain groups of speakers and equipment than to the telephonic medium itself”. Kelly (2008:84) also acknowledges the need for telephone interpreters to receive specialised training, particularly regarding techniques to make up for the lack of visual information. Ultimately both Kelly (2008:87) and Gracia-García (2002:6) affirm that no

matter the situation, the services of a qualified telephone interpreter is preferred over having to make do without one, or with an untrained on-site interpreter.

2.4.3 Concerns about confidentiality

Since healthcare interpreters deal with information about individuals' medical conditions and personal details, confidentiality is another concern. Patients may find it difficult to trust strangers and confide in them, especially when they cannot even see them. The patient has no form of proof that the telephone interpreter will keep the information discussed confidential. Hence concerns about telephone interpreters not providing confidentiality agreements arise.

It is the healthcare provider's responsibility to select a legitimate telephone interpreting service and to ensure that confidentiality forms part of the company's code of ethics and standards of practice. Healthcare providers should enquire about obtaining a copy of the interpreting service's code of ethics. It is also important to ensure that confidentiality agreements are signed by all telephone interpreters, including contractors, on a regular basis (Kelly, 2008:245). In addition, healthcare providers may want to look into insurance coverage (e.g. Errors and Omissions coverage and Crime Insurance and Professional Liability) of the interpreting service and confirm that it covers all employees, including contract interpreters (Kelly, 2008:245). This is necessary for both on-site and telephone interpreting. If a healthcare facility makes use of a service that upholds these policies, the healthcare providers can then put their patients at ease by guaranteeing that their personal information will be protected. The healthcare provider should inform the patient of the status of the interpreting service before the call to the interpreter is made. It may also be helpful if the interpreter informs the patient about the company's confidentiality policy when answering the call.

Some patients have fewer concerns regarding confidentiality when dealing with telephone interpreters. The argument is that since telephone interpreters do not know the identity of patients, they are able to adhere to a higher level of confidentiality (Gracia-García, 2002:10; Kelly, 2008:85). In cases where the language in question is

spoken only by a small community, patients often are afraid that the interpreter may know them or recognize them in public (Kelly, 2008:85). Gracia-García (2002:10) affirms: “The issue of **confidentiality** seems to be a strong point in favor of TI.”

2.4.4 Qualities of a model telephone interpreter

A model telephone interpreter is portrayed as someone who is trained and educated in telephone interpreting; fluent in the two languages in question and able to render a meaning in one language completely and accurately into another language (Kelly, 2008:35-37). If a person is bilingual, it does not necessarily imply that he is cut out to be an interpreter: “There is a common misconception that anyone who can speak two languages can work as an interpreter. In practice, even individuals who are fully fluent in two languages may not always be effective interpreters, even with training” (Kelly, 2008:27). Ideally, the person will have work experience, specifically in consecutive and community interpreting, and in customer and telephone services.

Versatility and adaptability in telephone interpreters are important, as they have to work in widely diverse situations (Kelly, 2008:35). For the same reason, an extensive vocabulary, as well as the ability to understand regional varieties in languages, will also be required. A willingness to learn will enable telephone interpreters to keep up with an ever-changing environment. A willingness to learn from others will allow telephone interpreters to be impartial instead of judgmental, especially when it comes to language varieties. They also need to be patient; not becoming frustrated when someone does not understand and they have to repeat.

A model telephone interpreter is able to communicate clearly and confidently over a phone, and can implement techniques such as inflection, tone, volume and pronunciation and can substitute visual clues with auditory ones (Kelly, 2008:36-47). In addition, he possesses exceptional memory, note-taking and listening skills, as he must be able to interpret long segments of speech when he is unable to request a pause. This may be the case when there are more than one person on the line, like when a speakerphone is used. A telephone interpreter must be able to think on his feet and Kelly (2008:44) states that a model interpreter should have “a willingness to

acknowledge that communication takes priority over textbook definitions of what is 'right' or 'wrong' for a given language".

2.5 Advantages and disadvantages of telephone interpreting

The advantages and disadvantages of telephone interpreting are often presented in literature on telephone interpreting, such as in Kelly's guidelines (2008), as well as in others studies, like the one by Gracia-García (2002). Although discussed separately, what seems to be disadvantages of telephone interpreting may also in some cases be seen as advantages.

2.5.1 Advantages of telephone interpreting

Telephone interpreting enables interpreters to interpret from any location at any time and thus almost any language spoken in the world is made accessible (Kelly, 2008; Andres & Falk, 2009:16). By means of a telephone interpreting service, communication is now borderless, convenient, faster and and less expensive (Gracia-García, 2002; Andres & Falk, 2009:9; Folio Translation Consultants, 2013). Instant access to the interpreter means that the connection time is literally only seconds (Kelly, 2008:16). Consequently, neither patient nor doctor has to waste time waiting. In the healthcare setting, particularly in emergency situations, time is life and immediate access to an interpreter is crucial (Gracia-García, 2002:4; 6). The time spent waiting for an interpreter can impact on the patient's health and even on his chances of survival.

Furthermore, unlike freelance interpreters, telephone interpreters do not have to be booked beforehand (Zietsman, 2011:1). In emergency situations, the healthcare provider does not necessarily know that an LEP patient will be coming in. Subsequently, an interpreter will not have been booked, and interpreters are rarely available on short notice. Even if they are, there may not be time to wait for the interpreter to travel to the hospital or wait for an interpreter who is busy somewhere else in the hospital. Doctors often have to make crucial decisions and if these decisions are made without the consent of the patient, legal implications for the

healthcare facility may result. In life or death situations where there is no time to wait for an interpreter, instant access to a telephone interpreter may save lives. Telephone interpreting makes access to interpreters simple and convenient. As Zietsman (2011:1) states: "Obtaining the services of a telephone interpreter is as easy as picking up the phone."

Compared to on-site interpreting, telephone interpreting is inexpensive. South African hospitals treat patients with diverse native tongues, and therefore a considerable number of interpreters will have to be employed (Gracia-García, 2002:7; Zietsman, 2011:1). Hiring freelance interpreters is not much cheaper either. Instead of per minute billing, as is the case with telephone interpreting, freelance interpreters, in addition to charging a basic tariff and travel costs, charge by the hour (Gracia-García, 2002:4; Zietsman, 2011:1). Folio InterTel, for example, charges for every five minutes. Using the service does not involve any hidden costs, the signing of a contract or paying a subscription fee (Zietsman, 2011:1).

Besides being a more cost-effective option for healthcare providers, telephone interpreting can also save patients money. Hospital visits are expensive and may be prolonged if doctor and patient are unable to communicate the necessary information, such as procedure details or medical history (Loutan in Gracia-García, 2002:7). Patients will save on travelling costs if they do not have to travel to hospital to meet an on-site interpreter (Gracia-García, 2002:7). Over-the-phone communication, such as scheduling an appointment or providing feedback on tests, can be done by means of telephone interpreting.

Telephone interpreting makes a vast variety of language combinations available (Phelan, 2001:13; Gracia-García, 2002:6; Kelly, 2008; Andres & Falk, 2009:16; Folio Translation Consultants, 2013). This is particularly important in a multilingual society such as South Africa. The American telephone interpreting company AT&T Language Line offers interpreting in 170 languages (Language Line Services, 2011) while Folio InterTel, a local telephone interpreting service, provides interpretation into over 37 African, West and East European and Asian languages (Folio Online, 2013). Since

telephone interpreting presents access to several different language interpreters, a larger number of LEP speakers can be served.

Telephone interpreting enables access to low-incidence languages (Gracia-García, 2002:4) and presents a solution for the seemingly unnecessary employment of low-incidence language interpreters. Healthcare facilities will benefit financially if they do not have to employ several on-site interpreters whose services are not often used. Furthermore, telephone interpreting does not limit low-incidence language interpreters to working for only one hospital/clinic, where they are employed as on-site interpreters. This is particularly advantageous in South Africa where trained interpreters are scarce (Schlemmer, 2005; Sause, 2010).

The availability and reliability of interpreters are to a large extent guaranteed when using telephone interpreting, which is not necessarily the case with employed on-site interpreters (Gracia-García, 2002:7; Zietsman, 2011:1). If the on-site interpreter is busy with another session, the patient will have to wait or come back at a later stage. With freelance interpreters there is no guarantee that they will show up, even if they have been booked beforehand. This is often the case in the South Africa where some healthcare facilities are located in distant rural areas where transport is not always reliable (Zietsman, 2011:1).

Telephone interpreting also ensures access to qualified interpreters as telephone interpreting companies source certified interpreters. For instance, Folio InterTel's recruitment process involves sourcing qualified interpreters. Even at hospitals where on-site interpreters are employed, untrained interpreters are often used, as on-site interpreters are not always immediately available (Pointon in Gracia-García, 2002:6). Sause (2010:iii) found that cleaning staff or family members are regularly used as interpreters at Western Cape hospitals and clinics.

On a sociological level telephone interpreting is beneficial to those in remote locations or those who are physically unable to obtain services, due to disability or illness (Kelly, 2008:4-5). In this way, telephone interpreting empowers patients who are unable to communicate in English (or Afrikaans) by enabling them to access a

variety of healthcare services that they will otherwise not be able to use (Kelly, 2008:6; Zietsman, 2011:1).

Absence of the interpreter from the consulting room has several advantages. The patient may benefit from not having to face the interpreter in person, as the patient may find it less embarrassing to talk about private matters over the phone (Gracia-García, 2002:9). The patient can also remain anonymous and will not have to fear the interpreter recognising him and disclosing information regarding his medical condition (Kelly, 2008:86). The patient may therefore feel that confidentiality is less likely to be breached. Furthermore, certain ethical dilemmas can be avoided if the interpreter does not know the identity of the patient. There is always a chance that the interpreter and patient may know each other, particularly if only a small community of people speaks the language in question. The interpreter may experience a conflict of interests between adhering to his confidentiality agreement and feeling obliged to inform family or community members that they are at risk of contracting a disease from the patient in question (Kelly, 2008:86).

Although the interpreter is cut off from visual information during telephone interpreting, this may somehow be advantageous. The interpreter may also benefit from not seeing the patient, as this will negate the possibility of becoming distracted by visual information such as a gruesome injury or physical disability (Kelly, 2008:85; Gracia-García, 2002:8). If the telephone interpreter does not know what the patient looks like, he will not show prejudice towards the patient, and his impartiality is unlikely to be compromised (Kelly, 2008:65). Furthermore, the patient, being unaware of the telephone interpreter's race, ethnicity, religion, disabilities and physical appearance, will be less inclined to discriminate against the interpreter. Consequently there is a smaller chance of the patient refusing to speak to the interpreter or showing scepticism towards the interpreter's abilities (Kelly, 2008:85). However, in South Africa race may not remain veiled, as the interpreter's accent may reveal his race to fellow South-Africans.

In a country like South Africa, with many races and ethnic groups, visual information may be interpreted incorrectly, due to cultural differences. Although interpreters are

expected to be bi-cultural, an interpreter may still be unaware of certain traditions. Misinterpretation of visual clues like body language, gestures etc. will be negated if the interpreter cannot see the patients. For instance, not looking someone in the eye is regarded as a sign of respect in some cultures, but in other cultures it may be interpreted as deceitfulness.

In addition, the culture and/or religion of the interpreter and patient can create moral predicaments. For instance, certain cultures dictate that it is unacceptable for a man to be present during a woman's medical examination, or for a married woman to speak to a man (Kelly, 2008:86; Gracia-García, 2002:9). Consequently, interpreting interactions involving the other sex may leave both the interpreter and patient feeling uncomfortable or may result in the interpreter having to decline the job offer (Kelly, 2008:86).

The telephone interpreter can distance himself emotionally from the situation and trauma if he cannot see the injured patient. The telephone interpreter can therefore remain composed, which could improve his ability to render the interpreting as competently as possible (Kelly, 2008:65; Gracia-García, 2002:8). The interpreter may be affected by seeing the patient suffer. Empathy with the patient may compromise impartiality. Furthermore, not all interpreters can handle seeing blood or graphic wounds. Feeling dizzy or traumatised may result in the interpreter being unable to interpret effectively (Kelly, 2008:86).

Another advantage is that the telephone interpreter's chance of contracting contagious diseases is decreased by not being in the patient's presence (Gracia-García, 2002:8). This may put the interpreter at ease, as he will fear that his health is jeopardised.

The interpreter can also avoid uncomfortable situations when he is not in the room. During on-site interpreting, the patient can easily feel more of a connection to the interpreter, and the doctor/nurse may therefore become excluded. Patients tend to confide in interpreters when the doctor leaves the room (Gracia-García, 2002:8). The telephone interpreter can avoid difficult situations where he has to choose between

being polite and sympathetic towards the patient or adhering to professional standards and ethical codes. It remains possible that the telephone interpreter and patient may establish a connection – the mere fact that the telephone interpreter is able to understand the patient may result in the patient feeling a sense of attachment.

2.5.2 Disadvantages of telephone interpreting

Criticism of telephone interpreting commonly questions the quality of the interpreted product, which lacks inclusion of information obtained from visual cues (Gracia-García, 2002:4; Kelly, 2008:83). According to Gracia-García (2002:4), experts deem a complete and accurate rendition impossible in the absence of non-verbal cues, which, according to them, play a greater role in communication than speech. As visual elements help structure meaning, there is a bigger scope for misinterpreting if these are unavailable (Gracia-García, 2002:5). It should be noted that empirical research on how the absence of visual information impacts on interpreting quality has not yet been conducted to date

(Kelly, 2008:83). Nonetheless, one can imagine that the absence of visual information demands a higher level of concentration and may cause the interpreter's job to be more stressful (AIIC in Gracia-García, 2002:5; Code for the use of new technologies in conference interpreting, 2000).

When the parties involved in the interpreting interaction are unable to see each other, they may find it more difficult to judge when a speech turn has ended and may end up speaking over each other. This, in turn, can complicate the telephone interpreter's interpreting task (Wadensjö in Ozolins, 2011:38). In addition, it may be a daunting task for the telephone interpreter to control turn-taking and the length of speech segments uttered by the speakers (Kelly, 2008:36; Gracia-García, 2002:14). In contrast to on-site interpreters, who can see who is talking and who have gestures and eye contact to their disposal to request the speakers to stop speaking, telephone interpreters can only use vocal cues to request a pause in speech. Since there are more than two speakers on the same telephone line, it is not guaranteed that the telephone interpreter's request will be heard.

Telephone interpreters may find it challenging to gauge how the interpretation was received (Code for the use of new technologies in conference interpreting, 2000). A person's facial expression usually gives away whether or not he understands what has been said. A telephone interpreter will have to resort to asking whether he has been understood.

Since the telephone interpreter is not in the same room as the parties involved, he may find the interpreting task more complicated. Not having the same frame of reference, places the telephone interpreter at a disadvantage (Rosenberg, 2007:75). It will be harder for the telephone interpreter to pick up on the atmosphere of the interpreting situation (Gracia-García, 2002:5) and act accordingly. Also, not knowing who the speakers are, makes it difficult to decide on the appropriate style and register to use (Gracia-García, 2002:13).

Many telephone interpreters feel less confident about their ability to interpret accurately, because they cannot see what is happening during the interpreting session (Gracia-García, 2002:13). According to Gracia-García's study (2002:4) interpreters tend to doubt their accuracy when interpreting over a telephone. They prefer to be present during the consultation, because they then feel in control of the situation.

Another consequence of not being present in the same room, is that the telephone interpreter may feel removed from what is happening and may become alienated (Code for the use of new technologies in conference interpreting, 2000) or marginalised (Wadensjö, 1999: 250). He also does not always share in the resolution of the situation, like when the patient is whisked off to the operating room, and may feel the need for closure. Since they are not at the hospital, telephone interpreters do not have access to therapists with whom they can discuss encounters (Gracia-García, 2002:14) and are left to deal with the traumatic experience on their own after the interpreting session.

Telephone interpreters are often thrown in at the deep end as they do not know what the situation will entail before they pick up the telephone (Gracia-García, 2002:14). It

is therefore not possible for them to prepare by doing research on the disease or reviewing terminology that is likely to be used. Furthermore, unlike other forms of interpreting, telephone interpreters do not have the opportunity to specialise in one discipline (Gracia-García, 2002:14). This means that they have to switch from one interpreting setting to another (e.g. from a general consultation to an emergency situation) without having the opportunity to prepare. This adds more stress. As a result of this large variety of interpreting settings, they have to deal with people from different walks of life each day (Kelly, 2008:35; Rosenberg, 2007:75). Rosenberg (2007:75) states: “Greater emphasis should be placed on the extra linguistic, situational demands being placed on interpreters who are suddenly being made available to a vast and heterogenous population of non-English speaking clients.”

Sound quality is another factor that can place telephone interpreters at a disadvantage. Poor sound quality may impair hearing and consequently impact on interpreting quality (Rosenberg, 2007:67). If the telephone interpreter is unable to hear the speaker, he will not be able to render the message accurately and completely. It can also place strain on and be stressful for the telephone interpreter if he cannot hear the other parties properly. Furthermore, having to ask for sentences or phrases to be repeated can become frustrating and tiring (Kelly, 2008:87). Although sound quality is crucial, Gracia-García (2002:11) found that healthcare venues are not always equipped to support telephone interpreting. For instance, institutions do not make use of dual-receiver phones, which yield the best sound quality. Telephone interpreting is often done by passing an ordinary telephone between the doctor and patient. This can be uncomfortable (Gracia-García, 2002:11) and the interpreter can be cut short if the telephone is taken from the listener before the interpreter has finished the rendition (Ozolins, 2011:39). Despite the poor sound quality of speakerphones, resulting from background noise and backchanneling, they are regularly used (Kelly, 2008:87; Ozolins, 2011:39).

There are other inconveniences related to telephone interpreting, such as the inability of the telephone interpreter to accompany the patient to another location like the X-ray room. Moreover, the interpreter will not be able to interpret visual movements, such as pointing to a body part, or the practitioner demonstrating an action.

The inability of telephone interpreters to provide proof of identity, certification and a signed confidentiality agreement, is an additional concern (Gracia-García, 2002:12). Patients and medical practitioners may not trust telephone interpreters, as they may feel that there is no guarantee for the quality of the interpreting service and no proof that the interpreter is qualified (Kelly, 2008:8).

2.6 Conclusion

The literature review entailed an overview of interpreting, with the focus on telephone interpreting. Based on the limited studies on telephone interpreting, further research should be conducted in this field. The review dealt with the following issues concerning telephone interpreting: the lack of visual elements; confidentiality and advantages and disadvantages. The effect of a lack of visual stimuli remains debatable, but it is yet to be proved that it impacts negatively on the quality of interpreting. The lack of visual elements may render the interpreter's task more challenging, but telephone interpreters may be able to adapt through training and experience. With regard to confidentiality, telephone interpreting can be both advantageous and disadvantageous to the patient. On the one hand, the patient may not be able to judge for himself that the telephone interpreter is reliable, and on the other hand, the patient can remain anonymous and therefore feel less exposed. Whether the patient feels more comfortable with the interpreter in the room than with a telephone interpreter, remains a personal preference. The major advantages of telephone interpreting are cost, speed, availability and reliability. Disadvantages, from the perspective of telephone interpreters, include the lack of visual elements, feeling marginalised and not having access to a therapist. The sound quality of equipment used during telephone interpreting can also adversely impact on the interpreting session.

In the following chapter, the telephone interpreting provider, Folio InterTel, will be discussed. The demographical details of the areas in which some of the healthcare facilities, serviced by Folio InterTel, are situated, will be discussed.

CHAPTER THREE

RESEARCH CONSIDERATIONS

3.1 Introduction

This chapter offers an overview of the Folio InterTel service: a description of InterTel; how InterTel originated; its pilot phase and how it functions. The chapter also provides information on the medical institutions that were included in the pilot phase: where they are situated; the number of healthcare practitioners and patients associated with the institutions and the main languages spoken by these persons. It should be noted that the data was subject to availability.

3.2 Folio InterTel

Folio InterTel is South Africa's first telephone interpreting service (Zietsman, 2011). It is a remote telephone interpreting service provided by the Folio Group. In 2012 InterTel, which is "geared towards medical interpreting" (Folio Online, 2012), served fifty hospitals and clinics in the Western Cape Province (Schenck & Viljoen, 2012:1). The Folio Group, situated in Cape Town, was established in 1988. Besides Folio InterTel, the Folio Group provides translation services to local clients via Folio Translation Consultants and to international clients via Folio Online (Schenck & Viljoen, 2012:1). Furthermore, in the field of medical interpreting, Folio is currently the market leader in Africa (Folio Online, 2011:4).

The number of interpreters working on a freelance basis at Folio InterTel varies between 130 and 150 (Viljoen, 2013). Folio InterTel offers interpretation into 37 different languages, which include African, Middle-Eastern, Asian and European languages (Folio Online, 2013). The South African languages include Afrikaans, Ndebele, Sepedi, Sesotho, Setswana, Siswati, Tsonga, Venda, isiXhosa and Zulu. Other African languages include Arabic, Bemba, Igbo, Lingala, Luo, Oromo, Shona, Somali, Swahili, Tonga, Tshiluba, Yoruba, Chichewa, Kirundi, Amharic and Malagasy. The Middle Eastern and Asian languages offered are Arabic, Lari,

Mandarin Chinese, Japanese and Thai. European languages include French, Italian, German, Portuguese, Russian and Spanish.

Philip Zietsman, founder and managing director of the Folio Group, saw the need in a multilingual South Africa for a telephone interpreting service, which would offer a convenient, cost-effective and reliable alternative to on-site interpreting (Zietsman, 2011). The idea of bringing telephone interpreting to the country was conceived in 2008. The reasons given for telephone interpreting to be considered are: it is less expensive; there are parts of South Africa where access to on-site interpreters is not guaranteed and it is not practically possible to have on-site interpreters in all the language combinations in South Africa, particularly not when the additional languages spoken by immigrants are also taken into account (Folio Translation Consultants, 2010 a).

In October 2010, the pilot phase was implemented at four hospitals and one clinic, namely Tygerberg and Karl Bremer hospitals (Cape Town); Swartland Hospital (Malmesbury); Worcester Hospital and De Doorns Clinic (Folio Online, 2010). The pilot phase was to run for three months (Folio Translation Consultants, 2010 b). Folio decided to implement the pilot phase at medical institutions (instead of at courts, police stations etc.) as the need for such a service in this sector was deemed most crucial. A language barrier between medical practitioner and patient could result in death (Folio Online, 2010).

The project manager then, Marli Viljoen, headed up the research and collaborated with the Department of Health of the Western Cape Provincial Government to have a budget approved (Folio Online, 2010). Viljoen recruited interpreters from Johannesburg and Cape Town. The recruitments were first-language-speakers from 32 different languages, including African, Asian and European languages (Folio Translation Consultants, 2010 b). The interpreters were trained through MiTio (Folio Translation Consultants, 2010 b). MiTio is an institution that has been accredited by the International Medical Interpreting Association (IMIA) and it offers an online diploma in medical interpreting (MiTio 2009). The coursework was supplemented by material specific to the South African context, like terminology regarding AIDS,

tuberculosis, malaria and malnutrition (Folio Translation Consultants, 2010 b). In addition, the training involved psychological, social and communication aspects (Folio Translation Consultants, 2010 b).

Folio recruits mother-tongue language professionals, most of whom have tertiary qualifications (Folio Translation Consultants, 2010 b). These interpreters interpret “into and from their mother-tongues” (Zietsman, 2011). After CV-applicants are selected, they are interviewed and tested. Successful candidates are placed on a probation period and the calls that they interpret are recorded and then monitored (Schenck & Viljoen, 2012:1). Folio interpreters continue to receive training (Folio Online, 2012). Since interpreter-training with a specific focus on medical interpreting is scarce, Folio provides workshops and reading material to its interpreters (Schenck & Viljoen, 2012:2). In 2012, Folio was looking into collaborating with a local university in order to provide formal training (Schenck & Viljoen, 2012:2). In addition, Folio is a member of the International Medical Interpreters’ Association (IMIA). The association, together with Folio, aims to set up telephone interpreting training programmes in South Africa (Folio Translation Consultants, 2010 a).

InterTel functions as a call centre. Each hospital and clinic has its own personal telephone number. When a call comes in from a healthcare facility, the number is registered on the InterTel system (Botha, 2013). Clients are directed by the voice prompts to select the language of their choice by keying in the corresponding language code (Botha, 2013). The list of language codes is usually printed out and available at the facility. Clients are connected to the interpreter within 30 seconds (Folio Online, 2010). The number that appears on the interpreter’s call identity is always the same; therefore the interpreters know that it is a Folio InterTel call (Botha, 2013).

Interpreters log on to the InterTel system when they are available (Folio Translation Consultants, 2010 b). The system indicates which interpreters are logged on. The project manager ensures that at least one interpreter for each language is logged on (Botha, 2013). When the interpreter becomes unavailable, he simply logs off. The InterTel system is set up in such a way that if it happens that all the interpreters for a

specific language are busy with calls (or not logged on) an incoming call will be directed to the Folio Online office. The project manager will then contact a Folio interpreter and request that he calls the healthcare facility back once he becomes available. The project manager can also request the healthcare facility to call back at a later stage in order to give her the time to organise an interpreter to log on. The latter option is preferred, as the call will then be recorded (Botha, 2013; King, 2013).

At present the InterTel system utilises 100 lines and can handle up to 50 phone calls simultaneously. Up to date, however, the highest number of concurrent calls was four (Botha, 2013). In order for the recording system to record all calls effectively, there needs to be an open line for every line in use. In other words, the number of lines divided by two, equals the number of concurrent calls that can be handled by the system. As InterTel expands, the number of lines will be increased (Botha, 2013). As already mentioned, all calls are recorded (Folio Translation Consultants, 2010 b). The customised system and applications created for InterTel are used to keep record of and monitor calls and their quality. The data is then used for future planning (Schenck & Viljoen, 2012:2).

The InterTel system is set up in such a way that if it happens that all the interpreters for a specific language are busy with calls, a new incoming call will be directed to the Folio Online office. The client will then be requested to call back or Folio will organise for an interpreter to call back the healthcare facility once he becomes available. However, the latter option is not preferred, as the call will then not be recorded (Botha, 2013).

The InterTel service can be used for business, medical or legal purposes by any client registered with Folio (Zietsman, 2011). Clients are billed per five minutes and invoiced at the end of the month (Zietsman, 2011). The Western Cape Healthcare Department pays for the InterTel services rendered to certain Western Cape healthcare facilities (Botha, 2014).

The equipment needed by the client is simply a speaker or a dual-handset phone or two phones on one line. Although it is not ideal, a single phone, passed from one

speaker to the other, can also be used (Zietsman, 2011). The interpreter ideally needs a phone with a headset, but a landline phone or cellular phone can also be used. The interpreters working for InterTel make use of landline phones or cellular +phones (Viljoen, 2013).

3.3 Hospitals included in pilot phase of InterTel

Four hospitals and one clinic in the Western Cape area were included in the pilot phase of Folio InterTel. A short description of each healthcare institution provides some information on the types of facilities at which the Folio InterTel service is offered, as well as an indication of the language situation in the Western Cape healthcare sector. The languages spoken by the healthcare practitioners and patients at these facilities, and the languages spoken in the areas in which the facilities are situated, are therefore indicated.

3.3.1 Tygerberg Hospital

Tygerberg Hospital, established in 1976, is a national central hospital with 1,310 beds (Western Cape Government, 2009/10). The hospital serves the Cape Town and Tygerberg sub-districts in the Cape Town Metropolitan Municipality, which has a population of 3 740 026 (Statistics South Africa, 2014). Between 2009 and 2010 over 90 747 patients were admitted to Tygerberg Hospital and 500 000 outpatients were treated at the facility. The 4031 personnel employed at the hospital included 873 medical and 1265 nursing staff members (Western Cape Government, 2009/10). Tygerberg Hospital is a teaching hospital and Stellenbosch University, the University of the Western Cape and the Cape Peninsula University of Technology are affiliated to the hospital (Western Cape Government, 2009/10).

The language spoken by the majority of the staff members is Afrikaans. English is spoken to a lesser degree, while African languages are spoken only by African staff members (Williams, 2006:42). The languages spoken by most patients are, in descending order, Afrikaans, English and isiXhosa (Williams, 2006:42). According to Saulse (2010:40) the hospital does not have an employed interpreter.

Interpreting at the hospital is a necessity, with problems mostly arising between Somali- and French-speaking patients and healthcare practitioners (Viljoen, 2012). Due to the size of the facility, the technicalities of the implementation of a service such as InterTel come into play, such as in which wards and consultation rooms the telephones may, or should be, installed (Viljoen, 2012).

3.3.2 Karl Bremer Hospital

Karl Bremer Hospital, established in 1956, is one of the Western Cape's oldest hospitals (Stellenbosch University, 2012). The large district hospital, with 372 beds, is situated in Bellville and also serves the Cape Town Metropolitan Municipality's Cape Town and Tygerberg sub-districts (Government notice, 2012:26). The Northern Suburbs and Cape Flats, including Elsie's River, Ravensmead, Belhar, the Delft/Blue Downs area, as well as Khayelitsha, form part of the hospital's feeder area (Lewis, 2005:64). There is a large Somali population residing in the nearby Bellville suburb. The fact that they speak Somali and French results in communication problems (Viljoen, 2012).

Since both Tygerberg and Karl Bremer hospitals serve the Cape Town Metropolitan Municipality, the languages spoken by the inhabitants of this municipality are presented in the table below.

TABLE 1: Language statistics for Cape Town⁵

Census 2011 by municipalities, language, gender and population group	
CPT: City of Cape Town	
Afrikaans	1 307 140
English	1 040 229
IsiNdebele	11 993
IsiXhosa	1 092 224
IsiZulu	19 699
Sepedi	6 168
Sesotho	35 979
Setswana	15 120
Sign language	15 162
SiSwati	2 294
Tshivenda	2 924
Xitsonga	7 242
Other	106 425

The table indicates that, in descending order, Afrikaans, isiXhosa, English and Sesotho are the languages spoken by most Capetonians. 35,69 % of the residents speak Afrikaans; 29,82% isiXhosa; 28,40% English and 0,98% Sesotho.

3.3.3 Swartland Hospital

Swartland Hospital is a small district hospital situated in Malmesbury in the West Coast District Municipality, which has a population of 113,762 (Statistics South Africa, 2014). The hospital serves the Swartland Local Municipality and has 85 beds (Government notice, 2012:28). As it is the only primary level hospital in the district, patients from clinics in Darling, Morreesburg, Malmesbury, Riebeek Kasteel, Riebeek West, Abbotsdale, Kalbaskraal, Chatsworth, Riverlands and Koringberg are referred to Swartland Hospital if need be (Stellenbosch University, 2012). Fewer than 20 personnel, including six doctors and six nurses, are employed at the hospital (Stellenbosch University, 2012). Between 100 and 180 patients are treated daily at the day hospital, and 40 at night (Stellenbosch University, 2012). French and Somali are the languages that are most problematic (Viljoen, 2012).

⁵ This table has been generated by the Statistics South Africa's Time series data (2013).

TABLE 2: Language statistics for Swartland⁶

Census 2011 by municipalities, language, gender and population group	
WC015: Swartland	
Afrikaans	86 669
English	4 894
IsiNdebele	159
IsiXhosa	9 278
IsiZulu	149
Sepedi	72
Sesotho	1 616
Setswana	492
Sign language	236
SiSwati	57
Tshivenda	64
Xitsonga	114
Other	935

According to the table, Afrikaans, isiXhosa, English and Sesotho (in descending order) are the most popular languages in the Swartland region. Of the residents living in the Swartland region 82,75% are Afrikaans-speaking, 8,86% are Xhosa-speaking, 4,67% are English-speaking and 1,54% are Sesotho-speaking.

3.3.4 Worcester Hospital

Worcester Hospital is a rural regional hospital in the Cape Winelands District Municipality, which has a population of 2 262 780 (Government notice, 2012:27). The hospital, which has an adequate number of staff and 322 beds, serves the farm community of the Breede Valley Local Municipality (Government notice, 2012:27; Viljoen, 2012). The municipality encompasses Matroosberg, Touws River, De Doorns, Rawsonville and Worcester (Stellenbosch University, 2012). Worcester Hospital serves as a referral centre for eight district hospitals and other healthcare facilities, including those in Ceres, Robertson, Montagu, Swellendam, Bredasdorp, Caledon and Hermanus (Worcester Hospital, 2001).

⁶ This table has been generated by the Statistics South Africa's Time series data (2013).

Staff at the hospital experience difficulties communicating properly with Somali-speaking patients (Viljoen, 2012).

TABLE 3: Language statistics for Breede Valley⁷

Census 2011 by municipalities, language, gender and population group	
WC025: Breede Valley	
Afrikaans	122 149
English	4 594
IsiNdebele	160
IsiXhosa	25 812
IsiZulu	219
Sepedi	130
Sesotho	4 272
Setswana	640
Sign language	512
SiSwati	42
Tshivenda	107
Xitsonga	133
Other	1 865

The order of the top four languages spoken in the Worcester and Breede Valley areas are the same as in Cape Town and Swartland: Afrikaans, isiXhosa, English and Sesotho. The table indicates that Afrikaans is spoken by an overwhelming 76,04% of the residents of the Worcester and Breede Valley areas. IsiXhosa is spoken by 16,07% of the residents, while English and Sesotho are spoken by almost the same number of residents – 2,86% and 2,66% respectively.

3.3.5 De Doorns Clinic

De Doorns Clinic is a small facility in the Cape Winelands District Municipality that serves farmworkers from the surrounding areas (Viljoen, 2012). The clinic has indicated problems with the following languages: Somali (Somalia), Shona (Zimbabwe), Chichewa (Malawi) and Mandarin (China). Due to the shortage of nurses, an interpreter is often not contacted, because time is always pressing (Viljoen, 2012).

⁷ This table has been generated by the Statistics South Africa's Time series data (2013).

3.4 Conclusion

To summarise, Folio InterTel is a telephone interpreting service provided by Folio Online. InterTel connects two speakers of different languages to an off-site interpreter via telephone. The service can be used in both the public and private sectors, in locations such as hospitals, courts and police stations, as well as during business meetings. However, due to the importance of adequate communication in the medical sector, the service was initially implemented in hospitals. InterTel enables patients and medical staff who do not speak the same language to communicate.

With regard to the healthcare facilities, a national central hospital, a regional hospital, two district hospitals and a clinic were selected to form part of the pilot phase of InterTel. Tygerberg and Karl Bremer hospitals both serve the Cape Town and Tygerberg sub-districts, where respectively almost equal percentages of residents speak Afrikaans, English and isiXhosa. However, the majority of staff members speak Afrikaans or English. isiXhosa is spoken only by African staff members. Swartland and Worcester hospitals serve the local municipalities Swartland and Breede Valley respectively, in which over 75% of the residents are Afrikaans-speaking. The rest of the residents speak mainly isiXhosa, English or Sesotho. French and Somali seem to be the languages that most frequently present language barriers. De Doorns Clinic also experiences problems with Somali, as well as with Shona, Chichewa and Mandarin.

The demographics reveal that the Western Cape is indeed multicultural and multilingual. The language profile of the communities in the Western Cape areas mentioned above indicates that at some point healthcare service providers will need an interpreter to ensure optimal service delivery. The Folio InterTel service presents a method through which the language barriers that arise between healthcare practitioners and patients can be addressed. Various languages are made accessible and intercultural communication becomes possible. Telephone interpreters are also readily available and a connection to a telephone interpreter can be established in under a minute.

CHAPTER 3

In the following chapter, the procedures followed in this research study are outlined.

CHAPTER FOUR

RESEARCH PROCEDURE AND DATA ANALYSIS

4.1 Introduction

The aim of the empirical research study is to examine the telephone interpreting service provided by Folio InterTel and to analyse its potential, especially regarding healthcare interpreting in the Western Cape. In this chapter the research procedures that were implemented during the study, the methods used to obtain data for the analysis and the empirical data obtained during the research study are discussed.

4.2 Research design

The study is regarded as an exploratory study as opposed to a descriptive study (Mouton & Marais, 1996:42). Exploratory studies are, according to Durrheim (2008:44) “used to make preliminary investigations into relatively unknown areas of research”. Since the field of telephone interpreting in South Africa has not yet been studied extensively, it can be considered a “relatively unknown research area” (Mouton & Marais, 1996:43) with the potential for exploration. The aim of exploratory studies, like this one, is to attempt to gather more information on a subject. Mouton and Marais (1996:43) state: “Because exploratory studies usually lead to insight and comprehension rather than the collection of accurate and replicable data, these studies frequently involve the use of in-depth interviews, the analysis of case studies, and the use of informants.”

4.3 Quantitative and qualitative approach

The two main methods of research are the quantitative approach and the qualitative approach. In this study, the researcher applied both approaches. Quantitative research employs the concept of measuring or counting. The term “quantify” means to “ascribe a quantity to a thing” (Preece, 1996:41). Qualitative research is based on qualifying, which is “to ascribe a quality, or to describe a thing” (Preece, 1996:41).

For this study, a qualitative approach was mostly used, mainly because of the small study population – there were a limited number of people with experience of the InterTel service. Although the InterTel service has been operational in several hospitals and clinics, the service has not been utilised by a significant number of people. Although it would be useful to obtain a large quantity of data for analysis to determine whether telephone interpreting is a solution to the communication problem in the Western Cape healthcare sector, the researcher deemed it valuable to deal with the limited quantity of data available, and to present it in a qualitative manner. Therefore, instead of questioning a large sample, the researcher attempted to extract in-depth data from individuals who have had experience with telephone interpreting. Data was obtained by a structured, open-ended interview with the Folio Intertel project manager; structured, mix-method questionnaires presented to some Intertel interpreters; and recordings of interpreting sessions involving healthcare practitioners, patients and Intertel interpreters. The information gathered during this research study was then used to gain a better understanding of telephone interpreting within the context of the Western Cape healthcare sector.

4.4 Selection of participants

Initially the researcher intended to present questionnaires to patients and healthcare practitioners. The questionnaires were to be distributed to participants at Tygerberg, Karl Bremer and Worcester hospitals. These facilities had indicated during correspondence with the researcher that they implemented and used the Folio InterTel service. These facilities were also in the attainable vicinity of the researcher. However, the researcher was unable to present these questionnaires to the healthcare practitioners and patients.

The researcher elected to interview the then project manager of Folio InterTel, Lauri King, as she was deemed to possess in depth insight into the InterTel project. King was responsible for quality assessment of the interpreted product, done by reviewing the recorded telephone calls between the interpreters and the patients and healthcare practitioners.

The researcher was not responsible for selecting the InterTel interpreters who participated in the research study. The researcher aimed to question as many InterTel interpreters as possible. However, due to the potential breach of the confidentiality agreement with Folio Online, the researcher was not allowed to question the InterTel interpreters in person. Instead questionnaires had to be sent to the interpreters electronically. The questionnaires were sent to the project manager, who distributed them to the interpreters via email. The interpreters who were willing to participate completed the questionnaires and sent their responses back to the project manager, who forwarded these to the researcher.

Although this method of selection may correlate to purposive sampling (specifically expertise sampling in the case of the interview, and convenience sampling in the case of the questionnaires) it cannot be regarded as such, as that would imply that one could deduce the same findings about a bigger population group. Purposive sampling is a form of non-probability sampling. Unlike probability sampling, non-probability sampling does not incorporate random selection processes (Durrheim & Painter, 2008:139). During purposive sampling samples are chosen based on the fact that they are easily accessible, or based on the researcher's judgement. According to Oliver (2006:45) purposive sampling is "a form of non-probability sampling in which decisions concerning the individuals to be included in the sample are taken by the researcher, based upon a variety of criteria which may include specialist knowledge of the research issue, or capacity and willingness to participate in the research".

The recordings of the interpreted sessions were selected at the discretion of Folio Online. The researcher requested access to three calls that involved isiXhosa patients and two that involved Sesotho patients. IsiXhosa and Sesotho are two of the eleven official languages of South Africa and are often requested by users of the InterTel service (indicated by King, 2013). The demographics of the Cape Town, Swartland, Worcester and Breede Valley regions, discussed in Chapter 3, show that of the African languages, isiXhosa and Sesotho are the top two most-spoken languages. Folio Online, that also transcribed and translated the recordings through

Folio Translation Consultants, sent the five recordings to the researcher electronically.

4.5 Data collection instruments and methods

The collection instruments utilised during the study were structured, mix-method questionnaires; a structured, open-ended interview; and data from recorded interpreting sessions (see Addenda B, C and D).

4.5.1 Questionnaire for InterTel telephone interpreters

Initially the aim of the study was to establish whether the InterTel service could function as an alternative for on-site interpreting in the Western Cape health sector. The researcher used a mixed-method survey design, which included both open-ended and closed questions, to gather the opinions of patients, healthcare practitioners and interpreters, who have used the InterTel service. The respondents had to comment on the functionality of telephone interpreting in the healthcare sector and the effectiveness of the InterTel service. The closed questions included ones where participants were asked to rate the service on a Likert scale. It should be noted that since the questionnaires could eventually only be distributed to InterTel interpreters; and moreover, a much smaller number of participants responded than anticipated. Therefore the views on the service reflected by the closed questions could not be generalised. The data could therefore not be used to establish whether the service was effective or not. The researcher still opts to include the responses of the participants to provide an idea of how the service was experienced.

Data could only be obtained through structured questionnaires sent to the interpreters by the InterTel project manager. Since the research design incorporates qualitative research methods, the study would benefit from open-ended interviews, conversations and observations. Open-ended interviews would offer the participants the opportunity to reveal their genuine perceptions (Preece, 1996:120) which may be useful in a qualitative study with a small sample. However, structured questionnaires are purposeful as the questions can be carefully constructed beforehand in such a

way that the researcher will be able to elicit all the information needed. Since participants are asked the same questions, the same stimulus is used across the board when obtaining the answers (Preece, 1996:120).

The majority of the questions incorporated in the questionnaires for the InterTel interpreters were open-ended questions, which allowed the respondents to provide any answer (Preece, 1996:120). The participants were asked to comment on the interpreting session or to list the problems that they had experienced with telephone interpreting. In addition, closed questions were included in the questionnaire, providing the respondents with already formulated answers from which to choose (Preece, 1996:120). The interpreters were, for example, asked to rate their language abilities or give their opinion about the InterTel service. The closed questions were presented in the form of tick boxes, listing values ranging from one to five (five being the highest value). The scale can be considered an ordinal scale, specifically an attitudinal scale, and in this case, a five-point Likert scale (Kumar, 2005:69). The Likert scale can be defined as a “summated rating scale used for measuring attitudes” (Garwood, 2006:162).

The questionnaire included basic questions relating to the participants’ personal details (age, gender and ethnicity) and language proficiency (regarding the participants’ second language). The questionnaire had a subdivision on interpreting qualification and ability. The next section dealt with how the interpreter would conduct an interpreting session and how they experienced sessions they had previously interpreted. The participants were asked about their general perspective on telephone interpreting and the InterTel service. Questions on the equipment used during telephone interpreting were also asked. The questionnaire left room for participants to comment on the problems they experienced with telephone interpreting. The participants were then asked to compare on-site to telephone interpreting. Finally, the participants were asked to provide general comments.

With regard to the data collection method followed, the researcher sent the questionnaire to the InterTel project manager via email on 5 June 2013. Four participants responded. On 8 July 2013 the researcher requested the project

manager to send out the questionnaire again, in the hope that more interpreters would volunteer to participate. Another three responded.

4.5.2 Interview with InterTel project manager

An extended, structured interview with open-ended questions was chosen to obtain data from the project manager of InterTel. The researcher opted for a structured interview, since the questions were sent to the respondent via email beforehand (see Addendum B1) in order for her to prepare for the interview. Preparation was necessary, as at the time of the interview, the project manager had been in that position for a relatively short period (five months) only. The structured interview also helped the researcher ensure that all the data would be collected. Although the researcher and interviewee had printed versions of the previously emailed questions at hand, the interview was conducted in a relaxed mode and the researcher amended or rephrased some of the questions during the interview to make them more conversational. The researcher also translated the questions into Afrikaans during the interview. (Both the researcher and interviewee are mother-tongue Afrikaans speakers.) This was done to put the interviewee at ease by creating an environment in which she felt free to discuss the topic openly. In addition, the questions were open-ended, which gave the respondent room to give a “free-ranging account” (Preece, 1996:120). This means that she could expand on her answers or include aspects that were not specifically asked. The interview was then transcribed and evaluated by the researcher.

The aim of interviewing the InterTel project manager, Lauri King, was to gather her perspective on the InterTel service. King was asked general questions about the InterTel service, such as the number of telephone interpreters employed; the number of healthcare facilities using the service; the number of calls they had received over the past three years; and which languages were most frequently requested. King was also asked to comment on the problems experienced with InterTel; whether she deemed telephone interpreting a viable alternative to on-site interpreting in the Western Cape healthcare sector; and to suggest improvements to the service.

The meeting was set up via email on 8 July 2013. This was also the day on which the researcher emailed a copy of the interview questions to King. The researcher met face to face with King on 30 July 2013 at the Folio Online offices in Pepper Street, Cape Town. The interview lasted for over an hour. The researcher recorded the interview in order to transcribe it at a later stage. The transcribed interview would be used for inclusion in this research study, as well as for a reference when analysing the interview.

4.5.3 Recordings of interpreting sessions

The research also included a discussion of recorded interpreting sessions. The calls involved an InterTel telephone interpreter, a healthcare practitioner and a patient. Folio Online recorded the calls for quality control purposes. The recordings were transcribed and translated by a qualified consultant from Folio Translation Consultants. Once the calls had been translated, the researcher was able to understand what both the health care practitioners and the patients were saying. The translated segments of what the healthcare practitioner and patient originally said and what the interpreter conveyed were compared. The discussion on these interpreted sessions focused on themes such as the lack of visual cues; the sound quality of the equipment used during interpreting sessions; preciseness of information conveyed by the interpreter; confidentiality issues and embarrassment; and the possibility of telephone interpreters feeling marginalised (see **2.4.4**).

The researcher requested five recordings (three calls involving isiXhosa patients and two involving Sesotho patients) from Folio Online on 1 August 2013. The recordings were sent to the researcher electronically. The researcher requested Folio Translation Consultants on 13 August 2013 to transcribe and translate the recordings verbatim into English. The researcher received the Sesotho translations and transcriptions electronically on 16 August 2013, and the isiXhosa translations and transcriptions on 18 August 2013 (see Addendum D).

In order to protect the rights of those involved and to prevent a breach of contract by any of the healthcare facilities or Folio Online, certain measures had to be taken.

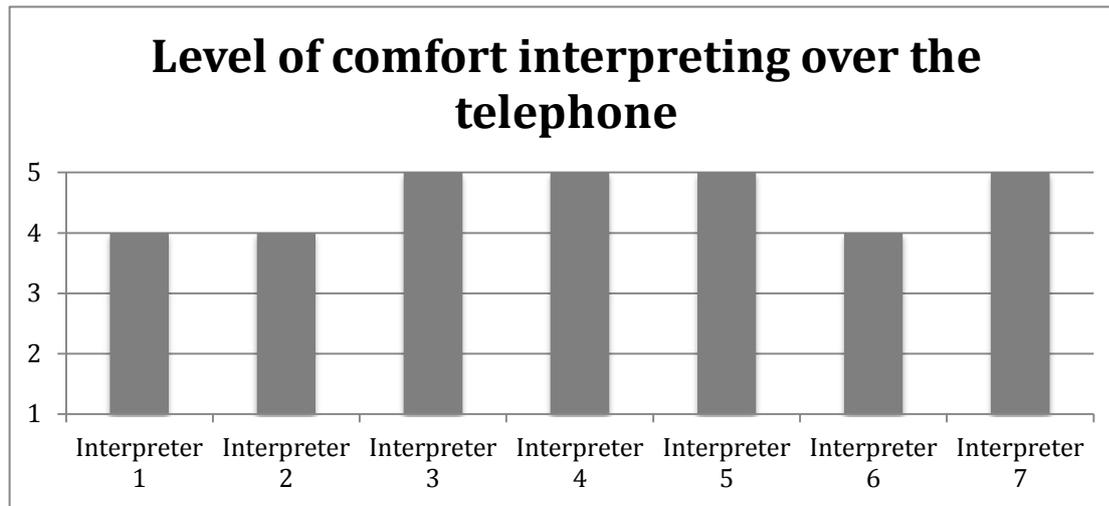
These included ensuring anonymity by substituting the names of healthcare facilities, healthcare practitioners, patients and interpreters with [...]. These measures were followed with the consent of Folio Online and Professor Hattingh, Dean of the Faculty of Arts and Social Sciences at Stellenbosch University.

4.6 Analysis of collected data

4.6.1 Discussion of questionnaire presented to Folio telephone interpreters

The seven participants who volunteered to complete the questionnaires were mother-tongue speakers of Sesotho, Zulu, Swahili, Luo, Chichewa, French and Portuguese. The interpreters interpreted from their mother-tongue into English and *vice versa*. In addition to interpreting from and into their mother-tongues, the Swahili interpreter interprets from French into English, the Luo interpreter from Acholi and Swahili into English and the French interpreter from Swahili and Lingala into English, and *vice versa*. Four of the seven interpreters held degrees or certificates in interpreting. Of the other three interpreters, one indicated that although he did not have a qualification in interpreting, he had 45 years of interpreting experience. With regard to their overall ability, as well as their comprehending, speaking, reading and writing abilities in their second language, the interpreters deemed that they were fully proficient, with all the interpreters rating their abilities five out of five, except for one interpreter, who rated himself four out of five. The interpreters had been practising as interpreters for between three and forty-five years and as telephone interpreters between one and four years.

The interpreters rated how comfortable they felt interpreting over the phone on a scale of one to five (five indicating the highest level of comfort).

FIGURE 1: Level of comfort interpreting over the telephone

With regard to training offered by Folio Online, the majority (five interpreters) reported to have received training in the past. It has to be stated that training seemed to be provided on an irregular basis. For example, one interpreter said that he had only attended training once and another said that he had attended two training sessions. According to the interpreters, interpreting material such as videos was made available. In addition, all medical interpreters were required to complete a MiTio course on medical interpreting.

Six of the seven interpreters stated that they rarely received telephone calls from the healthcare facilities. The Swahili interpreter commented that it was hard to say, as it depended on the needs of the patients. The Luo interpreter (who also interpreted into Acoli and Swahili) suggested that the reason could be that the need for the languages in which he interprets is low. The Portuguese interpreter said that there were very few Portuguese patients who could not speak English. The French interpreter (who also interpreted into Swahili and Lingala) indicated that he had received two calls in the previous two years. On the contrary, the Chichewa interpreter indicated that he received calls frequently. The number of calls varied, but he dealt with a minimum of one call per week.

The telephone interpreters were asked about their experiences during telephone interpreting sessions. Five of the seven participants answered that they would prefer

being in the room with the patient and healthcare practitioner. Reasons given included that it would make interpreting easier if it occurred face-to-face; that communication could be deduced from facial expression; that the interpreter would be able to identify the patient's gestures; and that being in the same room promotes the flow of communication. With regard to the latter, the interpreter said: "The physical presence is invaluable, as communication is more open and direct." One interpreter mentioned that he had done both on-site and telephone interpreting and while he did not have a preference, being on site was easier, as face-to-face communication was more comfortable. The interpreter who preferred not to be physically present during the interpreting session argued: "It's more comfortable on the phone, because you can say anything to a faceless voice without much embarrassment."

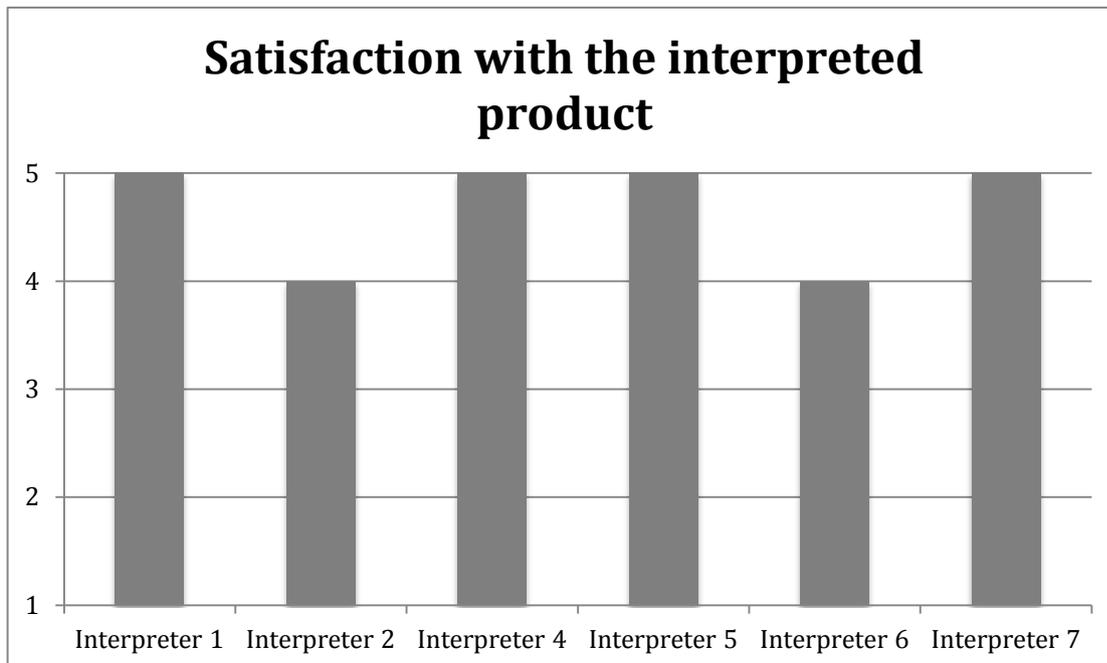
When specifically asked how it felt not being able to see the participants' facial expressions, one interpreter stated that he felt "perfectly comfortable", while another said that it did not make it particularly more difficult. One interpreter answered that he initially felt nervous about telephone interpreting, but that this feeling passed as he gained more experience. The other interpreters were not as comfortable with not being able to see the facial expressions of those involved in the interpreting session. One interpreter simply answered: "Bad sometimes." Another felt that there were some cues missing, but said that he used the information that he could obtain to interpret as best as he could. The last interpreter believed facial expressions complemented communication and made the exchange of communicated ideas quicker.

Telephone interpreters, similar to on-site interpreters, have to manage lengths of speech, as well as any segments of speech they cannot hear or understand. This task can be slightly challenging for telephone interpreters, who have to do this verbally. On-site interpreters can indicate that they have not understood by, for instance, their facial expressions or gesturing. Although the participants indicated that they understood what the patients and the healthcare practitioners said most of the time, they said that if there was a section of speech that they did not understand or hear properly, they would ask for clarification or repetition. One solution given by one

of the participants was to ask for a synonym. With regard to managing the lengths of speech, most of the interpreters could manage interpreting long sections of speech without requesting a break. Two of the interpreters said that they used summarising or phraseology, while another emphasised the fact that he did so “without interfering with the doctor’s duties”. A clever method of coping used by one of the interpreters was to set out rules to the healthcare practitioner before the start of the interpreting session.

The interpreters were asked to rate how satisfied they were with the interpreted product. The results were generally positive, as indicated on the graph⁸ below.

FIGURE 2: Satisfaction with the interpreted product



The attitudes the interpreters held towards telephone interpreting seemed to be positive. All but one of the interpreters recommended the use of telephone interpreting in the healthcare sector. The seventh interpreter answered: “Yes and no.”

⁸Only six of the seven participants answered this question. Interpreter 3 is not included in this graph.

Everyone responded overwhelmingly positively when asked whether they would recommend the use of the Folio InterTel service.

The equipment used can impact on the success of the interpreting session. During the interpreting sessions in which the participants were involved, a dual-handset phone, a speakerphone and a regular phone passed between the patient and healthcare practitioner, were used. The interpreter who interpreted in the session during which the dual-handset phone was used, said that he could hear the speakers most of the time. The speakerphone line was very static and therefore the interpreter in that session could not hear the speakers clearly. He was unsure whether the problem stemmed from the type of phone that was used or from the fact that the session was one of the pilot phase phone calls. He did not comment on whether the bad line impacted on his ability to interpret.

Three interpreters dealt with a regular phone being passed between the healthcare practitioner and patient. One participant said that although he could hear the speakers clearly, the passing of the phone impacted on his ability to interpret. Another interpreter said he could hear the speakers clearly. He mentioned that the phone being passed around “did not and will never impact on my own ability of interpreting the patient adequately”. It should be noted that this interpreter’s ability to remain unaffected by the type of equipment used could be attributed to his level of experience: 13 years as an interpreter and three years as a telephone interpreter. The third participant indicated that he could hear the speakers clearly, but that a speakerphone would have been preferable. He indicated that the speakerphone would make the communication set-up as “open as it can be under the circumstances” and that “hidden agendas are revealed!” It is often a concern that when, for instance, the healthcare practitioner and interpreter are speaking to each other over a normal phone, the patient is alienated from the conversation and would not know what is being discussed. Although the patient will not be able to understand what is being said, as he is unable to understand the language the healthcare practitioner speaks to the interpreter, he will at least feel included when a dual-handset or speakerphone is used.

The interpreters were asked whether they preferred on-site or telephone interpreting. Five of the seven interpreters preferred on-site interpreting, citing that it was easier; that facial expressions aided the interpreter; that the interpreter could gauge emotions and mood better; that being in the room facilitated interaction with those involved in the interpreting session and was more comfortable for the patient; and that it was more effective and more rewarding in the end. One interpreter simply stated: "On-site interpreting is much better than telephone interpreting." Other relevant quotes are listed below:

- "I have conducted on-site interpreting more than telephone interpreting. With on-site interpreting, as pointed out earlier, facial expressions help in conveying messages that may not be relayed during telephone interpreting. Also, I think the presence of the interpreter makes it easier for the client to be at ease with the whole interpreting exercise."
- "For the on-site interpreting is seemingly easy for the inexperienced interpreters. Because the interpreter is facing the patient, thereby he is able to understand the patient in his emotional feelings, etc. Whereas the telephonic interpreting appears to be a bit difficult in a way that the interpreter he is unable to comprehend totally the humour and mood and emotional feelings of the patient from distance."
- "On-site interpreting is much better than telephone interpreting, because you can interact with all the participants in the conversation."
- "I have conducted on-site interpreting and found the experience much more rewarding and effective in terms of the end results, as the interactions between the three parties to obtain the required results is easier to manage and progress from one stage to the next. It is more dynamic."

One interpreter stated that he had not experienced any problems with either on-site or telephone interpreting. He did not have a preference, but he did say that he thought on-site interpreting was easier, since it was faster and more comfortable for

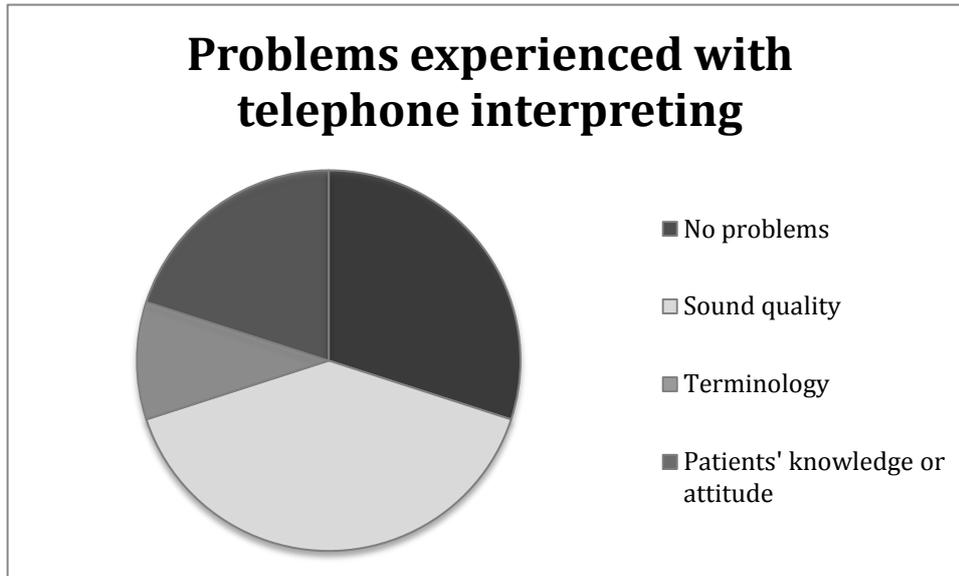
the patient. He said that during telephone interpreting trust was not established as easily as during on-site interpreting, and that it required of him to introduce himself “properly” and explain what his role would be.

The interpreter that preferred telephone interpreting attributed it to feeling more comfortable with this medium, particularly during medical interpreting. The interpreter reasoned that it was less embarrassing for both the interpreter and patient when the interpreter was not present.

Another interpreter who preferred on-site interpreting has been practising on-site and telephone interpreting for an equal length of time. The interpreter who indicated that he preferred telephone interpreting has interpreted for 18 years, of which only one year was over the phone. The researcher would nonetheless like to draw attention to a study done by Wadensjö. After doing extensive research, Wadensjö (1998: 248) found that “people seemed to prefer the type of interpreting they are used to”.

The interpreters were asked about the problems they experienced during telephone interpreting. Three of the seven interpreters indicated that they had not experienced any problems as yet. The problems that were experienced by the other interpreters across the board related to equipment, static on the line, the interpreter not hearing the participants clearly, the sound quality of long-distance calls being poor, the transmission of information being problematic and as a result, calls having been dropped. The latter was apparently resolved later. Another problem stemmed from the use of medical terminology. One interpreter mentioned that he found the terminology challenging, while another cited the “non-knowledge (ignorance) of the patient in the terminologies of the medical domain”. One interpreter also mentioned that patients projected a negative attitude when the interpreter did not hear what they said the first time around.

The problems experienced by the interpreters are presented in the pie chart below.

FIGURE 3: Problems experienced with telephone interpreting

It can be derived from their general comments that the interpreters realised the importance of telephone and medical interpreting, and that interpreting carefully and accurately is crucial, as misinterpretation can result in the death of a patient. The participants thought that telephone interpreters could benefit from more training. They perceived telephone interpreting as a growing phenomenon and would like to see the service implemented at private clinics and hospitals.

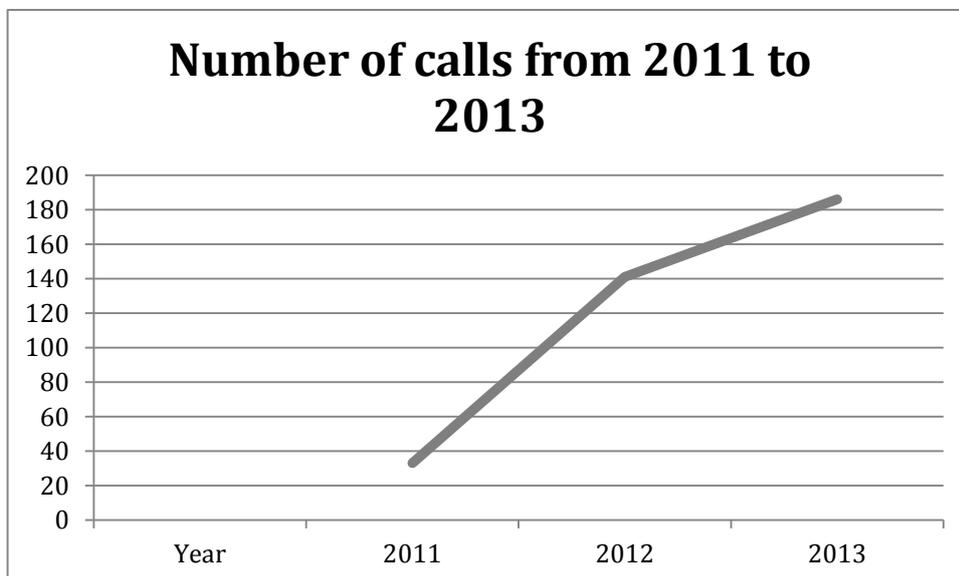
Although on-site interpreting was generally preferred over telephone interpreting, most telephone interpreters felt confident in their ability to interpret over the phone. Most of the interpreters felt that being in the same room and being able to see the participants' facial expressions, made interpreting easier. The biggest problem for telephone interpreters, namely poor sound quality, can easily be resolved by the healthcare facilities obtaining dual-handset phones. There is always room for more training, which can also help those interpreters who find medical terminology a challenge. It seems as if the InterTel service was working adequately. This raises the question of why the Sesotho, Swahili and Portuguese interpreters indicated that they received so few calls, whilst King indicated that these three languages were amongst the languages mostly requested.

4.6.2 Discussion of interview with Folio InterTel project manager⁹

Lauri King served as the InterTel project manager at Folio Online since early 2013. At the time of this study (2013) the InterTel service was available at approximately 50 healthcare facilities in the Western Cape and the company employed 100 telephone interpreters, of which 15 were usually logged into the system at any given time during working hours (from 9:00 to 18:00). Interpreting into 37 different languages, including European, Asian and African languages, was offered. The service recorded exponential growth since 2011, with not only the number of calls received increasing, but also the number of healthcare facilities requesting the service.

The following graph shows the growth in the number of calls received in 2011, 2012 and 2013. (Since the numbers for 2013 pertain to a six-month period only, they were amended pro rata for twelve months.) Thirty-three calls were received in 2011; 141 in 2012; and 93 in 2013 (until end of June).

FIGURE 4: Number of calls from 2011 to 2013¹⁰



According to King, the top three languages requested in descending order in the past three years were in descending order:

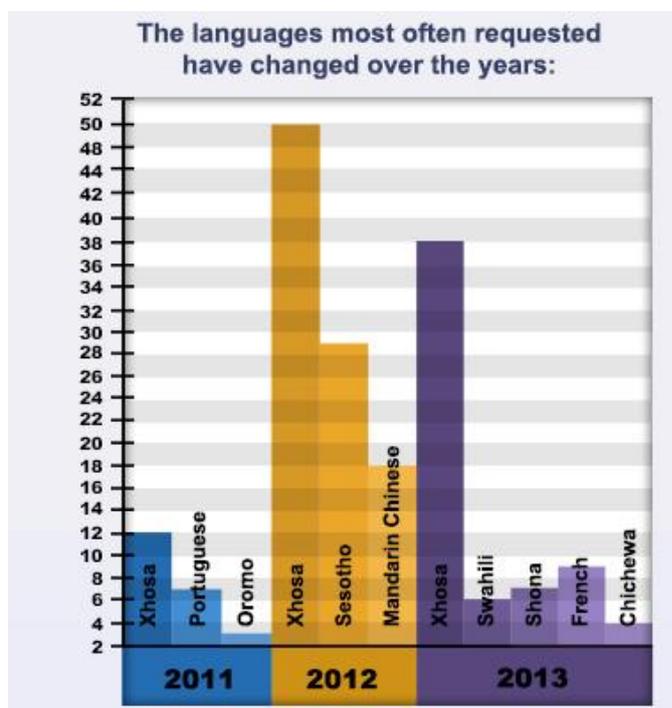
⁹See Addendum B for a transcription of the interview with the project manager.

¹⁰The number of calls for 2013 was calculated on a pro rata basis.

- 2011 – isiXhosa, Portuguese and Sesotho
- 2012 – isiXhosa, Sesotho and Mandarin
- 2013 (until end of June) – isiXhosa, Sesotho and Swahili

Although these are the statistics provided by King, the following graph supplied by Folio Translation Consultants indicates a different set of top three languages requested from 2011 to 2013. The reasons for the inconsistency is unknown.

FIGURE 5: The languages most often requested



(Folio Translation Consultants, 2013)

King attributes the high number of requests for isiXhosa to the fact that the service is implemented in the Western Cape, stating that if the service expands to, say, KwaZulu-Natal, the language requested most may well be Zulu. She states that language needs are regionally based.

The interpreters were recruited by means of referrals, tertiary institutions and advertising. The interpreters have interpreting qualifications, and most of them are also MiTio certified. King could not confirm if continuous training was being provided, but stated that in-house training was provided. She indicated that the interpreters

used either landlines or cellular phones. Although she was unable to confirm whether any other equipment such as headphones was used, she did state that a standard instruction to the interpreters was to move to a quiet area when taking a call.

Basic training on the service procedure was offered to hospital staff by the project manager herself. A briefing or presentation of the service would be given by King on site. According to King, these training sessions were provided on a regular basis, depending on necessity. The hospitals also often requested a training session.

During her five months at Folio Online, King claimed to have experienced only one problem with the InterTel service, namely technical glitches. This observation is in line with what the InterTel interpreters found (see Figure 6). According to King 20 calls could be handled by the system simultaneously. If it did happen that a language was requested for which there was no interpreter logged in (or interpreters were already on other calls) the call would go through to the project manager, or to another staff member in the Folio Online office. An available interpreter would be contacted. The interpreter would then either log in and take the call, or call the healthcare practitioner back. It was emphasised that this process was carried out as quickly as possible. King mentioned that only in the case of technical problems a call would be missed.

Facilitating the service presented challenges. Feedback from clients was rarely received. Occasionally, while listening to the calls recorded for quality control purposes, King would come across healthcare practitioners commending the interpreters on a job well done, or even stating that they would not have been able to have done it without the interpreters. However, she had never received feedback directly from hospital staff, even though the healthcare facilities were encouraged to do so. The lack of feedback from clients made improving the service difficult, observed King. For confidentiality reasons, she was not allowed any contact with patients. Although a subjective opinion, it is worth mentioning that King indicated that she could frequently hear in the patients' voices that they were relieved to be speaking to an interpreter who understood them and who could explain how they felt. King thought that overall the service was well received.

Another challenge regarding facilitation of the service became evident from communication with the healthcare facilities. The project manager usually communicated with the healthcare officials. According to King, communication often presented a problem. She rarely received responses to, for instance, emails, which exacerbated the difficulty of obtaining feedback on the service.

Reluctance to use the service presented another problem. King indicated that hospital staff were initially hesitant to use the service, but stated that once they used it, it was as though “doors opened for them”. She stated that the staff might not realise how simple the service was to use and that even the name “InterTel” might seem “exotic” and “strange” to them. This belief could render using the service a daunting prospect. Staff members might also be worried that, since the calls were being recorded and monitored, they might be caught making a mistake, such as using incorrect terminology or not following the correct procedure.

King indicated that Folio Online advertised the service on its social media platforms, such as Facebook, as well as on its website and in newsletters. The Western Cape Health Department was also in the early stage of launching a promotional campaign. Despite this, the researcher found in her interaction with hospital staff that very few people were in fact aware of the service. For example, the medical superintendent, the CEO, a secretary and the matron at Worcester Hospital were not aware of the InterTel service, while those who were did not know whether the service was being used.

For most of the calls dealt with by InterTel, telephone interpreting functioned adequately. Situations for which King recommends telephone interpreting not to be used, include those involving South African Sign Language (SASL) patients and patients whose mental state needs to be assessed. These recommendations are echoed by Kelly (2008:87). Upon asking whether the lack of visual aspects could be problematic, she responded that it was only in the aforementioned circumstances that visual elements were required.

King considered telephone interpreting a viable alternative to on-site interpreting and believed that the InterTel service was successful. Her opinion was that the InterTel service was cheaper and faster than on-site interpreting. Trying to get hold of an available interpreter to come out to a hospital could take hours, whereas through InterTel, one would be connected to an interpreter by simply pressing nine numbers. This could save lives.

King stated that confidentiality was also an aspect to take into account. Patients might feel more comfortable if the interpreter was not in the room. King projected that the InterTel service would show growth with regard to the number of telephone interpreters employed and healthcare facilities served. She also expected the service to spread to spheres outside that of healthcare.

King summarised the advantages of the InterTel service as follows: “Cost, speed and confidentiality.” She contended that InterTel, and telephone interpreting in general, promoted language and multilingualism. Telephone interpreting in a country with 11 official languages could play an important part in facilitating communication between people and bringing them together.

King proposed employing more interpreters as an improvement on the InterTel service. In this way the system would be as active as possible. Communication between all parties involved should be improved, and more training should be provided for hospital staff. During the training, healthcare practitioners should learn more about interpreting and be advised about the correct way of handling the process. In terms of growth, King suggested that InterTel had the potential to expand to other spheres. Moreover, by avoiding small mistakes such as inadequate communication with hospital officials, InterTel would improve their current service and would grow as a result.

Overall, King’s perception of the InterTel service is positive. Apart from potential technical glitches, few problems existed within the service itself. It would seem as if the biggest issues concerned the facilitation of the service. These included

communication with the healthcare facilities and getting hospital personnel to use the service. These challenges, however, are surmountable.

4.6.3 Discussion of telephone interpreting sessions

The five recordings of telephone-interpreting sessions involving healthcare practitioners, patients and InterTel interpreters will now be discussed in order to provide information on the functioning of telephone interpreting in the healthcare sector. Three of the calls involved isiXhosa patients, while two involved Sesotho patients. Topics of discussion include the lack of visual cues and the sound quality of the equipment. Instances where the telephone interpreters added or left out information provided by the primary interlocutors will be examined. Confidentiality issues and embarrassment, and the possibility of telephone interpreters feeling marginalized, will also be discussed.

As mentioned, the most significant difference between on-site and telephone interpreting is the lack of visual cues (Gracia-García, 2002:4; Rosenberg, 2007:67). Visual elements, including facial expressions, eye contact, movements of the body and body language (Gracia-García, 2002:4-5) assist interpreters in decoding communication. Not only do the visual elements help the interpreter recognise the emotion or attitude with which the speaker conveys the message, they can also indicate to the interpreter when the speaker has finished his turn and whether the interpretation is understood. When the speaker speaks softly or in an accent unfamiliar to the interpreter, or when the sound quality over the telephone line is poor, seeing the speaker's mouth and facial expressions can help the interpreter decode the message. Wadensjö (1998:254) states: "... the more inarticulately primary interlocutors speak, and the poorer the sound quality of the audio equipment they use, the greater the interpreter's disadvantage in terms of not having access to non-verbal features accompanying talk in interaction."

Not knowing whether the interpretation is understood or whether the speaker has finished his turn can render the task of interpreting over the phone even more difficult. When interpreting takes place on-site, visual cues such as nodding or facial

expression can indicate that the primary interlocutor (the healthcare practitioner or patient) has heard or understood. Telephone interpreters have to rely on “verbal feedback tokens” (Wadensjö, 1998:257) such as “mm” or “ok”, or have to ask the interlocutor if he understands.

The following serves as an example of feedback given by the patient to the interpreter, indicating that the interlocutor heard or understood what the interpreter said (Addendum D2):

Interpreter: Ndi-alright nam akhonto. Uthetha no[...] ne, ndizawuzama ke ndithethe nawe nogqirha for uku-intaprita ne. So izinto ofuna ukundibuza, ungandibuza ndizawucacisa mna le nto ithethwa ngugqirha kuwe.¹¹

(I'm alright. You are speaking to [...], I'm going to try and speak to you and your doctor so that I can interpret. So if there are things you want to ask me you can ask, I will explain to you what the doctor is saying to you.)

Interlocutor: Ok (**interruption**)

Interpreter: Mamela ke mama, uthi ugqirha ne, wena mos umntana umzise kuba unoloyiko kuba umntana akakhuli kakuhle ne, andithi.

(Please listen mama, the doctor says you have brought your child because you fear that the child is not developing properly, isn't that so?)

Interlocutor: Ewe

(Yes)

Interpreter: Ewe, ugqirha uyavumelana nawe ke, uthi ewe umntana akakhuli kakuhle, kodwa ke uthe xa emjonga wafumanisa ukuba nangokwengqondo zikhona izinto wafumanisa ukuba usemva ne, ngokukhula kwakhe,

(Yes, the doctor agrees with you, he says the child is not developing properly, however when he looked at him he discovered that even mentally there are some things that are behind in his development.)

Interlocutor: Eh (**interruption**)

Interpreter: so into azawuyenza ke ngoku uzawujonga ukuthi yintoni na unobangela waloo nto.

(so what he's going to do is to look into what the cause is for all of this.)

¹¹ The transcriptions of the recordings have not been edited (for grammar, punctuation etc.) and have been used in their original form, as obtained from the Folio Translation Consultants.

Interlocutor: Ok

As the interpreter was speaking, the interlocutor spoke in the background giving feedback by saying either “ok” or “eh” (indicated by the word “interruption”). In both the interlocutor’s speaking turns, she acknowledged that she heard or understood by saying “yes” or “ok”.

The interpreter also asked the interlocutor if she understood on several occasions (Addendum D2):

Interpreter: Ukwenzela into yokubana bajonge kwesi skeni engqondweni yakhe ukuthi, njengangoku bebona ukuba usemva, akahambi, akaboni kakuhle, sizawujonga ke ngoku ukuba ziintoni ezinye izinto eziyimiphuma-ndlela apha uyaqonda apha emntwaneni. Then uzakuxelela ke ngoku iinkcukacha ezigcweleyo ngelo xesha. Uyayiva ke mama?

(So that they can look at the brain with the scan so they can see why he is behind, he is not walking; he is not seeing properly, we will look at other abnormalities in the child’s brain. Then he will tell you the full details then. Do you understand mama?)

Interlocutor: Ewe ndivile

(Yes, I hear you.)

Interpreter: Kodwa okwangoku uzakwenzela ke imali le yokukhubazeka komntana ukwazi ukuyifumana nayo. Uyayiva?

(But for now he is going to make an application so you can receive a disability grant for the child. Do you understand?)

Interlocutor: Ok

The lack of visual cues and not being able to see the other party or parties made it difficult to know whose turn it was to speak. In this example, there was much confusion as to who should be speaking (Addendum D3):

Sister: Can you please just ask her what happened please, thank you.

Interpreter: Hi sisi, Hello.

Sister: Hello

Interpreter: Hi, Uyandiva?

(Hi, Hello can you hear me?)

Sister: Speak speak speak No no no you speak, just speak speak.

Interpreter: Uyandiva?

(Can you hear me?)

Sister: [...]

Patient: [...]

Interpreter: Hello sisi uyandiva?

(Hello sisi, can you hear me?)

Patient: [...]

Interpreter: Uthini?

(What are you saying?)

Patient: [...]

Interpreter: Uyandiva?

(Can you hear me?)

Patient: Ha?

Interpreter: Hello, sabela kum, uyandiva?

(Hello, respond to me, can you hear me?)

Patient: Ewe ndiyakuva

Yes I can hear you.

The interpreter addressed the patient, but the sister answered. The sister might have thought that the interpreter was saying “hello”, because she wanted to establish if the sister was still on the line. The sister told the patient to “just speak”, but there was confusion as to whom she was addressing, as both the patient and interpreter could hear the sister at the same time, since a speakerphone was used. It took 28 seconds (00:51 to 01:19) to establish who was talking to whom and for the interpretation to begin. Considering that the call was only 3 minutes 19 seconds long, this took up almost one seventh of the conversation and hints at substantial time consumption.

Establishing whose turn it is to speak is much easier during on-site interpreting, as the speaker can simply turn to face the hearer or make eye-contact.

There are ways to avoid situations as the above. Using suitable equipment, such as dual-handset phones, can be helpful. In addition, if healthcare practitioners are trained in using telephone interpreting, they will be able to guide the patient as well as the interpreter. If healthcare interpreters are trained, they will advise the interpreter of clues that the interpreter is unable to see, such as when the patient is pointing to a body part where he is experiencing pain, or when the doctor is examining the patient. The interpreter needs to be aware of what is happening in the room to be able to understand the context of the conversation. The interpreter can misinterpret silence on the other end of the line as the line being dropped (Wadensjö, 1998:253) when meanwhile the doctor is only taking a patient's pulse.

There were two instances where the healthcare practitioner informed the interpreter of the situation in the room (addenda D5 and D2):

Doctor: Okay that is the first part, I'm giving the phone to her neh?

Doctor: Ok, mom is on the phone.

It could also be helpful if the telephone interpreter was trained to explain the telephone-interpreting process to the patient, such as this interpreter did (Addendum D2):

Interpreter: Ndi-alright nam akhonto. Uthetha no[...] ne, ndizawuzama ke ndithethe nawe nogqirha for uku-intaprita ne. So izinto ofuna ukundibuza, ungandibuza ndizawucacisa mna le nto ithethwa ngugqirha kuwe.

(I'm alright. You are speaking to [...], I'm going to try and speak to you and your doctor so that I can interpret. So if there are things you want to ask me you can ask, I will explain to you what the doctor is saying to you.)

In this case it was particularly valuable that the interpreter put the interlocutor (the mother of the patient) at ease by explaining the interpreting process as she was aware that the information was sensitive and possibly upsetting to the interlocutor.

Without visual cues, telephone interpreters have to rely a lot more on intonation and tone. Picking up on intonation and tone is not impossible, as is evident in this case (Addendum D2):

Interpreter: Awunambuzo ke mama?

(Do you have any questions mama?)

Interlocutor: A-a, eyi.

(No. Eyi [sigh])

Interpreter: Ok. Yintoni mama? Awuphethe...Uvakala ukhathazekile?

(Ok, what is it mama? You are not... You sound worried?)

Interlocutor: Owu, ndikhathazeke kakhulu sisi.

(Oh, I am really worried sisi.)

The telephone interpreter picked up on the sigh and the despondent tone of the interlocutor's voice. She subsequently asked the interlocutor if she was worried, and her deduction was right. The more experienced a telephone interpreter is, the more he will be able to use intonation and tone to assist him in decoding communication (Kelly, 2008:38).

During several interpretations the interpreter added information that was not articulated by the primary interlocutor. The reason for this could be that the interpreter was unsure whether the patient would understand. In the following case it seems as if the interpreter wanted to ensure that the patient really understood. The doctor told the interpreter to tell the mother of the patient that she needed to bring the child in a day before the child was scheduled to have a brain scan. The interpreter added an example of how the dates would work (Addendum D2):

Doctor: Ok that's right. When we do the scan, you must just tell her that when we do the scan they're gonna put the child to sleep so the child needs to come to the hospital the day before the scan. And we're going to admit the child for one night

Interpreter: Ok. Mama. Hello mama.

Interlocutor: Sisi.

CHAPTER 4

Interpreter: Uthi ugqirha ne, ngenxa.. uyayiva le nto oyithe.. inkxalabo yakho ne, but ke ngoku abakwazi ukukuxelela ngokuba ukuthi yintoni unobangela wazo zonke ezi zinto zenzekayo emntwaneni, ne.

(The doctor says, because..., he can hear what you're saying... your concern, but for now he cannot tell you what is the cause of all the things that are happening with the child.)

Interlocutor: Ewe sisi

(Yes sisi)

Interpreter: Into abazawuyenza ke bazawujonga, bazamfaka kwiskeni bazame ujonga uba yintoni unobangela apha kuye engqondweni, wento yonke engahambi kakuhle, uyaqonda?

(What they are going to do, they will check, they will put him in a scan so they can try and check the brain to see what the cause is, for everything that is not going well, do you understand?)

Interlocutor: Oh, ok.

Interpreter: But xa bezakwenza loo nto ke, kuzawufuneka umntana aze apha esibhedleleni, ngosuku..., let's say masithi umzekelo ne, uzawujongwa ngomso kwiskeni so wena kufuneka ke ngoku uze naye namhlanje, ngosuku oluphambi kolu bazamjonga ngalo

(But when they are about to do all that, you will have to bring the child to hospital on the day..., let's say for example, the child will be scanned tomorrow, you will have to bring him today, the day before the day of the procedure.)

In another example where the interpreter added information (Addendum D4), the sister told the interpreter that he must tell the patient that she needed a transfer letter from the previous clinic the patient attended. The interpreter did not only convey to the patient that the letter was needed, but also why the letter was needed. The sister said the following:

Sister: I just want you to explain to her that she must bring the transfer letter, because she's on ARVs and then she didn't bring anything so doctor says she needs a transfer letter and now she's telling me that she was at the taxi and then she forgot her stuff at the taxi. And now she was busy phoning them but they say they don't find her stuff, so it's missing but now the doctor says she must phone the clinic that she was attending and then just to get the transfer letter because they can't do anything without the transfer letter because they need to see all the information on that letter. So you can just explain to her that she must find a way to get it or she must give us the clinic number or something like that.

The interpreter greeted the patient and interpreted the sister's message as follows:

CHAPTER 4

Interpreter: Re teng. Wa utlwa sister o re o hloka transfer letter, lengolo le o fetisang ho tloha tleliniking eo o ne o ntse o e tsamaya ho tla moo ho bona. Wa utlwisisa?

(I'm fine. The sister says you need a transfer letter, a letter that transfers you from the clinic you used to visit to come here to this one. Do you understand?)

Patient: Ee

(Yes)

Interpreter: Ee, jwale o re ha ba kgone ho o thusa ntle le lengolo leno, eee....o tshwanetse o kgutlele ho ..ho...ho batho ba neng ba o thusa hore o fumane lengolo leno because lengolo leno le ngotswe information yohle e tshwanentseng hore ba e bale pele ba qala hore ba o thusa. Wa utlwisisa? Ba tshwanetse ho tseba hore na o no ntso fuwa meriana e feng, ba ke ke be ba qala fatshe. Wa bona?

(Yes, so now she is saying that they cannot help you without that letter, ...eemm...you need to go back to...to...to the people who were helping you so that you can get that letter because that letter has all the information that they should read before they start helping you. Do you understand? They need to know what medication you were being given, they cannot start from the beginning. You see?)

Ee, le taba ya pele akere ke ne ke le fuwe jwale ke ne ke ba bontshitse hore na dipidisi tse ke di sebedisang na ke difeng, ke di hlahisitse

(Yes, and the first thing is that I was given the letter and I showed them the pills that I am using, I took them out.)

Interpreter: No...o ba file dipidisi tseo?

(No...they gave you those pills?)

Patient: Ee ka di hlahisa

(Yes, I produced them.)

Interpreter: Wa bona leha o ba bontshitse dipidisi, lengolo le hlalosa ntho tse ngata ha le ngole dipidisi feela, wa utlwisisa? Le ngola treatment ya hao hore na e sebetsa ka tsela efeng, le Dr wa tseba hore na e ...ho ngotsweng mono, wena o ke ke wa utlwisisa ntho tse ngotsweng mono. So ba hloka lengolo leno, ntle le hore feela ba hloka dipidisi di feng, ba o fa dipidisi di feng, ba hloka le bopaki bono ba hore ba be le bona, wa bona ha ba ka o fa dintho ho...dintho tseo ba sena lengolo leo ba tla ba le bothata. Wa bona? Molao o hloka jwalo. Wa utlwisisa? Jwale ha o na nomoro ya tleliniki?

(You see even if you have shown them the pills, the letter explains a lot of information, it doesn't only have information about the pills, you understand? It has information about your treatment and how it works, and the doctor knows...what is written there, you would not understand what is written there. So they need that letter, besides knowing what pills you were given they need it as evidence that they should have. You see if they were to give you things, without the letter being present, they would be in trouble. You see? This is what the law requires. You understand? So do you not have a number for the clinic?)

In the next example it is not entirely clear why the interpreter included additional information (Addendum D5). The patient asked whether she had to take medication before or after meals. The interpreter posed this question to the doctor and the doctor answered:

Doctor: It doesn't matter, she can take it only with water.

Interpreter: A re ho wena ha ho na lebaka na o di nwa pele ho dijo kapa kamora dijo, ha ho na lebaka. Ha feela o di nwa. O di nwe ka nako e le nngwe. Ha o di nwa ka 7 o di nwe ka 7 mehlaena.

(She says that it doesn't matter when you take them whether it is before or after meals, it doesn't matter. As long as you take them. You should take them at the same time. If you take them at 7, take them at 7 everyday.)

Patient: Oh

(Okay)

Interpreter: Ha o di nwa mantsiboya ka 6 kapa 7 o di nwe ka 6 ka 7 o ska chenza dinako. Nako e tshwanang hoseng, nako e tshwanang mantsiboya. Ee, pele kapa kamora dijo

(If you take them at 6 or 7 in the evening, take them at 6 or 7 don't change the times. The same time in the morning, the same time in the evening. Yes, before or after meals.)

The interpreter added information about the times that the medication should be taken. He might have done so based on prior knowledge of how the medication should be taken. He might be assuming that the doctor left this out, and that it is important for the patient to know.

Other instances where the interpreter seemed to have added information based on assumptions are presented below (Addendum D1).

Patient: Sisi ndidliwa yinto apha esibindini apha esiswini.

(Sis, there is something eating at me (painful) in my liver, in my stomach.)

Interpreter: Utyiwa yintoni?

(What is eating at you?)

Patient: Ndidliwa yinto apha esibindini sesisu.

(Something is eating at my liver in the stomach.)

Interpreter: Esiswini?

(In the stomach?)

Patient: Ewe apha esiswini sisi, apha ndiyahambisa kakhulu

(Yes here in the stomach sis, my tummy is really running)

Interpreter: Oh ok. Ndizawu... Ok. Hi doctor can you hear me?

(Oh ok. I will...Ok.)

Sister: Yes, Yes, I'm Sister [...].

Interpreter: Ok um, he says that he has a very bad tummy bug, and it's causing him to go, to have diarrhoea

The interpreter assumed that the patient had a stomach bug, based on what he told her, namely that his stomach was running. Interpreters should be careful about making a diagnosis. She also left out that the patient said: "Something is eating at my liver." It could be possible that the interpreter perceived that that was a manner of speaking; however, leaving out information could also impact on the healthcare practitioner's ability to make an accurate diagnosis.

Other interpreters also left out information at times. In this example (Addendum D3) the sister gave instructions on how to use sputum bottles:

Sister: Today, like tonight, she must now, before she goes to bed, she must spit. Cough 1 cough, 1 spit is enough, she doesn't have to fill it up.

Interpreter: Oh, ok.

Sister: Ja, she must spit in number 1 tonight, and tomorrow morning when she wakes up, she must spit in the one that is marked number 2 irrespective, now the date will be of course a January date or another date. She must just spit for me hey number 1.

Interpreter: Ok

Sister: Tomorrow morning number 2 and then she must please bring it to the clinic tomorrow.

The interpreter interpreted it as follows:

Interpreter: Kuthiwa ke, kucelwa uze ukhohlelele kwesi sibhalwe 1 namhlanje ebusuku.

(The doctor says, she asks that you cough into the one written 1 tonight.)

Patient: Ok

Interpreter: Ukhohlele kwesi sibhalwe namba 2 ngomso kusasa.

(Then you must cough into the one written number 2 tomorrow morning.)

The instruction given by the sister was not conveyed fully. The interpreter only mentioned coughing, and not spitting. She also did not mention that it was not necessary to fill up the jar.

It should be noted that differences between what the interlocutor says and what is interpreted is not peculiar to telephone interpreting and can occur during on-site interpreting too. With on-site interpreting, however, the interpreter can ask for repetition through eye-contact or by simply turning to the healthcare practitioner and directing a question at him. With telephone interpreting, it is difficult for the interpreter to interrupt a section of speech by the patient. The interpreter will have to ask the patient to pass the phone to the healthcare practitioner or, in cases where a speakerphone is used, the interpreter will switch to the healthcare practitioner's language and start talking to him, which can cause confusion. Thus breaks in the flow of the conversation will possibly be more significant during telephone interpreting than during on-site interpreting.

Another factor that can affect interpreting is the sound quality of the equipment. In one instance the patient was unable to hear the interpreter and asked for repetition (Addendum D5). This was most likely due to poor sound quality.

Interpreter: Eeehhh ha ba ne bahlaha...

(So when they were born...)

Patient: Hmm? Ha ke utlwe?

(Hmm? I can't hear?)

Interpreter: Ba hlahile ka nako difeng, ba hlahile ka kgwedi di feng, ke hore...o no na le nako e kae ha o pepa, o no na le kgwedi tse kae ha o pepa?

(At what times were they born, which months were they born in, I mean...how far were you when you gave birth, how many months were you when you gave birth?)

Again, in the example below, the interpreter was unable to hear the patient and had to ask for repetition (Addendum D4). After having asked the same question for the third time, the interpreter told the patient that he was unable to hear her. The transcriber also indicated that the patient was “not clear, in all instances”. As the interpreter did not have a problem hearing the doctor, this was most likely due to the patient speaking too softly or due to her accent.

Interpreter: Ee, haeba ho na le batho ba jwalo, sheba nomoro tseno o kope e mong hore oeee a ka mpe a fumane nomoro eno. Wa utlwisisa? O hokae hona jwale?

(Yes, if there is someone like that, look for their number and ask them to please get you that number. You understand? Where are you now?)

Patient: Ke Kapa, Hobatseng [not clear, in all instances]

(In the Cape, at Hobatseng.)

Interpreter: Eh?

(Huh?)

Patient: Hobatseng, tleliniking

(at Hobatseng, at the clinic.)

Interpreter: Tleliniking e hokae?

(At the clinic where?)

Patient: Ke Hobatseng

(At Hobatseng)

Interpreter: Ai ha ke utlwe ... moo o sebetsang teng ke hokae?

(Ai...I can't hear...where do you work?)

Patient: Ke sebetsa hona Kapa mona

(I work here in the Cape.)

The sound quality of equipment is an aspect that does not come into play during on-site interpreting. In addition, if the interlocutor is speaking too softly during on-site

interpreting, it will most likely have less effect than during telephone interpreting, as it is usually more difficult to hear someone over the telephone. Having to ask for a repetition can disrupt the flow of the conversation or cause the interpreter to lose concentration (Wadensjö, 1998:251). As the communication is not taking place in a linear fashion – directly from healthcare practitioner to patient – it is vital for the conversation to progress as smoothly as possible.

As mentioned in **2.4.3 (Concerns about confidentiality)** confidentiality is another relevant aspect in an interpreting session. Wadensjö (1998:249) claims that telephone interpreting can have both advantages and disadvantages in this regard. Based on her research, she contends that some individuals prefer telephone interpreting, as the telephone interpreter will be less likely to identify them. People may also feel more comfortable talking about embarrassing ailments to someone over the phone. Wadensjö also mentions that people may think that the interpreter will be able to identify them in an on-site interpreting session, while they are unable to identify the interpreter.

Sensitive subjects arise regularly during medical interpreting. In one case the sister informed the interpreter that the patient was on an ARV wellness programme (Addendum D1). The interpreter could make an assumption about the patient's HIV status. Relaying this kind of information to a third party can make the patient feel uncomfortable, but as Wadensjö (1998:249) mentions, individual preference will determine which mode is favoured by each patient.

In one case where the patient's ailment (diarrhoea) could cause embarrassment, a female interpreter was interpreting for him (Addendum 1). The interpreter was told to ask the patient what his complaint was:

Patient: Ewe apha esiswini sisi, apha ndiyahambisa kakhulu

(Yes here in the stomach sis, my tummy is really running)

The interpreter related this to the sister:

CHAPTER 4

Interpreter: Ok um, he says that he has a very bad tummy bug, and it's causing him to uh, to go, to to have diarrhoea

The interpreter was evidently hesitant about how to phrase the patient's answer. She started off by saying "ok um". She then added "and it's causing him to uh, to go", but stopped mid-sentence and changed the sentence to "to have diarrhoea". She uses the vocal crutch "uh" and repeated "to" possibly because she could not find the right words. It would therefore seem as though she was uncomfortable with using the term "runny tummy".

Later on during the conversation, the interpreter once again hesitated when talking about the patient's bodily functions:

Sister: Ok, then you must ask him is there any blood in his stool, please

Interpreter: Uyakubuza ke ngoku ugqirha, xa uhambayo usi., xa uhambisayo uye ulibone na igazi?

(The doctor is now asking, when you go ... When your stomach is running do you ever see blood?)

The interpreter changed her sentence midway when asking the patient whether he had ever found blood in his stool when going to the toilet.

When she related the patient's answer to the sister, she hesitated again, pausing before and after the word "blood":

Interpreter: Um, he says yes he has seen ... blood ... in his stool.

Sister: He has seen it?

Interpreter: Ja he has seen blood in his stool.

Her hesitation caused the sister to repeat the question and the interpreter answered with more conviction.

The next case involves a male interpreter interpreting for an HIV-positive pregnant woman (Addendum D5). Questions about her menstrual cycle and her HIV status

arose. A woman could find it embarrassing to talk to a man about her bodily functions. In addition, in some African cultures, women are not allowed to talk about certain bodily functions, especially not to a male. The situation may not only be uncomfortable for the patient, but for the interpreter too. The doctor asked the interpreter to ask the patient what her HIV status was, so that the doctor could be sure that the patient understood. The interpreter phrased the question as follows:

Interpreter: Okay, ho thoe o entswe test ya HIV akere?

(Okay you did an HIV test right?)

Patient: Ee

(Yes)

Interpreter: Jwale ho thwe na o tseba status sa hao?

(Now they want to know if you know your status?)

Patient: Ee, kea tseba

(Yes I know it.)

He then told the doctor that the patient knew her status. The doctor then asked the interpreter if the patient knew that her status was positive. He told the doctor that he had not asked the patient, but the doctor insisted that he did so. He asked the patient, and his response to the doctor was this:

Interpreter: I didn't want to ask her about her status, but she she like,...you said I should ask, she says she knows that she's positive.

The interpreter was clearly uncomfortable with the ethical aspect of asking the patient her HIV status.

In the two cases above (addenda D1 and D5) the embarrassing and ethical situations that arose seemed to cause more uneasiness for the interpreters than for the patients. Perhaps these two patients preferred speaking about their conditions over the telephone.

The impact telephone interpreting has on interpreters should be considered. Wadensjö (1998:250) says that some telephone interpreters may feel “marginalised” and run the risk of “burn-out”. This is because they are left alone once the telephone interpreting session is over and have to deal with the emotions and feelings that arose during the interpreting session by themselves. Wadensjö (1998:250) recounts the feelings of an interpreter who dealt with psychiatric patients and traumatised refugees: “Being left alone, after having put down the receiver, she [the interpreter] had felt it hard to avoid taking patients’ traumatic stories to heart. Being on site and sharing the event more concretely with the professional care provider made her own feelings of sadness and desolation easier to understand and handle. Being physically there, she argued, means that interpreters can exchange a few words with the therapist after the session if they need to.”

In one case the interpreter had to inform the mother of the patient (an 11-month-old child) that the child was potentially disabled or had some degree of brain damage (Addendum D2). The interpreter had empathy with the interlocutor and asked her repeatedly whether she understood; had any more questions; or if there was anything else worrying her. Near the end of the consultation she asked the interlocutor:

Interpreter: Ok. Yintoni mama? Awuphethe...Uvakala ukhathazekile?

(Ok, what is it mama? You are not... You sound worried?)

Interlocutor: Owu, ndikhathazeke kakhulu sisi.

(Oh, I am really worried sisi.)

The interpreter might have felt affected by the interlocutor’s circumstances. She might also have felt the need for closure; however, she did not have access to a therapist and could not talk to the doctor about the situation afterwards. Being present physically could have made the interpreter feel that she was part of the situation as well as the solution. On the other hand, seeing the child could have been even more traumatic for the interpreter. Not being on-site could therefore help telephone interpreters to distance themselves from the situation and to manage their emotions.

In the session above (Addendum 2) the interpreter used her own initiative and asked the interlocutor if she had any questions or if there was anything worrying her. By doing so, she might have made the interlocutor feel that her voice was heard. Wadensjö (1998:257) citing Englund-Dimitrova, suggests that the interpreter can function as a “deputy listener”. Although this can be beneficial to the interlocutor, it can cause the interlocutor to relate rather to the interpreter than to the doctor. The same issue does however arise during on-site interpreting. It is important that a doctor-patient relationship is established in order for the patient to trust the doctor and confide in him (Gracia-García, 2002:3). Considering that the language barrier already affects the chances of a relationship being established between doctor and patient, it may negate the issue of the interpreter establishing a bond with the patient.

From these telephone recordings it is clear that the lack of visual elements remains the most significant problem during telephone interpreting. Although this cannot be completely negated, training healthcare practitioners in how to use telephone interpreting can compensate in part for the lack of visual cues. Not being able to hear the other parties involved in the interpreting session is another problem. Using proper equipment, preferably dual-handset phones, can ensure that optimum sound quality is achieved.

As seen from the calls discussed above, the interpreted product is not always exactly the same as the original message. Various possible reasons for this emerge from the study. Ensuring that telephone interpreters are experienced will be the best way of obtaining the best possible interpretation. It should also be emphasised during training that interpreters should not make assumptions or attempt a diagnosis. There are arguments for and against telephone interpreting when it comes to confidentiality. Whether an individual prefers on-site to telephone interpreting remains a personal issue.

Finally, there are again arguments for and against telephone interpreting with regard to the impact on the interpreter. Not being present can result in the telephone interpreter feeling less affected by the situation; however, it can also leave telephone interpreters with the need for closure.

4.7 Challenges encountered during study

Since research on the rather important topic of telephone interpreting in the Western Cape healthcare sector was restricted, the researcher decided to continue with the study despite the practical difficulties she had to overcome.

The first problem was the potentially small sample group. Although the InterTel service was available at over 50 Western Cape healthcare facilities, not many facilities actually utilised the service. This complicated the researcher's ability to recruit participants for this study.

Permission for access to the medical facilities presented another challenge. Despite being granted ethical clearance, the researcher could not access the healthcare facilities due to practical reasons and was therefore not able to interview healthcare practitioners and patients.

The researcher obtained ethical clearance from the University of Stellenbosch and the Western Cape Healthcare Department for the study. The researcher then contacted Tygerberg, Karl Bremer and Worcester hospitals. Afterwards, the researcher was informed that Tygerberg Hospital did not use the InterTel service. The researcher visited Karl Bremer Hospital on numerous occasions and submitted an application for permission to conduct research at the facility. Unfortunately, a response to the application has not yet been received. After having obtained permission to do research at Worcester Hospital, the researcher visited the facility. The researcher was then requested to submit another application for permission and was then told that the facility did not use the InterTel service. The questionnaires meant for the healthcare practitioners and patients are included in Addendum D, but as the researcher was unable to question healthcare practitioners and patients, these questionnaires were never completed, which subsequently invalidates a discussion on the responses.

A limited number of InterTel telephone interpreters completed the questionnaires sent to them. As the researcher could not contact them directly, there was no input the

researcher could make to encourage participation. Furthermore, since the researcher was unable to interview the telephone interpreters, she had to rely on the responses given to the questions. No open questions could be asked.

4.8 Conclusion

A qualitative approach to obtaining data was implemented and a structured interview and structured questionnaires were utilised. This provided an overview of perceptions about the InterTel service. The recordings of the telephone interpreting sessions were analysed to gain insight into how the InterTel service functioned.

The researcher gathered from the data collected, that those in the field of telephone interpreting generally feel positive about telephone interpreting and the InterTel service, and that they experienced only a few problems with the service. The few problems that were indicated stemmed from facilitating the service, as well as from the equipment used by the healthcare practitioners during telephone interpreting sessions. These problems are likely to be solvable. Another problem was the lack of visual elements during telephone interpreting, as indicated by some of the InterTel telephone interpreters. For this reason on-site interpreting is preferred over telephone interpreting. There were also instances where the lack of visual cues caused some confusion. The current InterTel project manager however maintains that the lack of visual elements is a minor matter. Based on the feedback from the InterTel interpreters and the recordings, the researcher does not fully agree with this statement. The researcher believes that with adequate training and experience it is indeed possible for a telephone interpreter to master interpreting without visual cues. Nonetheless, the researcher does not regard the lack of visual cues as insignificant and believes that this matter should be addressed to everybody's satisfaction. Telephone interpreters and healthcare practitioners should receive specialised training, focusing on coping without visual cues.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The aim of this exploratory study is to describe the InterTel telephone interpreting service and to explore the potential use of telephone interpreting in the Western Cape healthcare sector. Chapters 1 to 5 give account of the process the researcher followed.

Chapter 1 provides an introduction to telephone interpreting and the background of the study, followed by the statement of the research problem and the purpose of the study. The research problem is the lack of communication between healthcare practitioners and patients in the Western Cape healthcare sector. The purpose of the study is to describe and explore telephone interpreting within this setting.

A literature overview is presented in Chapter 2. Interpreting, telephone interpreting in particular, with the focus on the healthcare sector is discussed. Chapter 2 also provides an in-depth exploration of the following aspects regarding telephone interpreting: quality, confidentiality, and the advantages and disadvantages of this form of interpreting.

The research context is provided in Chapter 3. The Folio InterTel service and the healthcare facilities that formed part of the pilot phase of the service are discussed, followed by the research procedures, including the research design, and the sampling and data collection methods.

Chapter 4 provides a thorough analysis of the data.

5.2 Findings of study

There are arguments both for and against telephone interpreting, but context and situation determines whether the use of telephone interpreting is appropriate or

adequate. However, even when telephone interpreting seems adequate, there will always be restrictions (Gracia-García, 2002). Due to the considerable demand for interpreters and the inability of hospitals to employ permanent interpreters, the use of telephone interpreters in certain circumstances is inevitable. Therefore the focus should be on how to improve telephone interpreting and not on its viability (Gracia-García, 2002).

The study has established that the InterTel service seems to work adequately. The project manager and the InterTel telephone interpreters were approached in order to find out what their perceptions of the InterTel service were. All these participants viewed the InterTel service as adequate and recommended the use of the service in the Western Cape healthcare sector.

A few problems with the service were indicated. The quality of the telephone equipment used in the hospitals or clinics is suspect as the telephone interpreters could not hear the other parties involved in the interpreting session clearly. Another problem was the fact that telephone interpreters had no access to visual clues. Facilitating the InterTel service presented a serious problem. The InterTel project manager stated that communication between her and the healthcare facilities were poor. She also reported a reluctance on the side of the healthcare facilities to use the service. Although very few problems were experienced with InterTel service itself, healthcare facilities rarely utilised the service. Several healthcare facilities that were contacted indicated that they did not use the service and most of the InterTel interpreters stated that they rarely received calls.

Quality of the interpreted message and confidentiality assurance remain areas of concern. These aspects are discussed in Chapters 1 and 2.

Kelly (2008:25-26) states the need for quality control. The Folio InterTel project manager mentioned in an interview (2013) that their practice at Folio Online was to record the calls made to Folio InterTel telephone interpreters, for quality control purposes. The focus in Chapter 2 is on quality control with the emphasis on the lack of access to visual cues. Several InterTel interpreters indicated in their responses

CHAPTER 5

that the absence of visual elements during telephone interpreting rendered telephone interpreting more difficult than on-site interpreting. Since information that can usually be deduced from facial expressions and body language was lacking, it was more difficult to decode the message. Telephone interpreters are able to compensate, albeit partly, for the lack of visual stimuli by focusing on other aspects of communication, such as tone of voice and intonation. All the InterTel interpreters in the sample felt confident interpreting over the telephone. Most of them recommended the use of telephone interpreting in the healthcare sector and all of them recommended the use of the InterTel service. King also stated that telephone interpreting was adequate for the types of calls that InterTel dealt with and that the lacking visual elements would be problematic only in cases where sign language or mentally disabled patients were involved.

Confidentiality in a telephone interpreting situation can be problematic. Patients and healthcare practitioners may doubt that the information shared during interpreting sessions will remain confidential. As the parties involved cannot see the telephone interpreter, they may feel uncomfortable about sharing information with him. However, as one InterTel interpreter mentioned, not being able to see the parties involved, helped to reduce feelings of embarrassment. Patients may feel more comfortable speaking about certain bodily functions to someone they cannot see. The same goes for the interpreters who may feel less embarrassed when having to ask patients for personal information and conveying this to the doctor.

During this study it was found that research on telephone interpreting in the Western Cape, as well as in the rest of South Africa, was basically non-existent. Research on telephone interpreting is not limited only locally, but throughout the rest of the world. Kelly's general guideline to telephone interpreting is the first comprehensive publication of its kind.

The greatest problem with the InterTel service lies in the infrequency of its utilisation, seemingly due to poor facilitation and a lack of awareness and training; and not due to shortcomings in the service itself.

5.3 Shortcomings of study

The limited published material on telephone interpreting rendered it difficult to describe telephone interpreting in the South African context. Furthermore, the sample group was very limited. Unforeseen practical circumstances prevented the researcher from including valuable relevant information. These circumstances, discussed in Chapter 4, are: healthcare facilities were not using the InterTel service as much as expected and the researcher could not gain permission to interview healthcare practitioners and patients. Therefore the only perspectives on the functioning of the service that could be included, are those of the project manager and the InterTel telephone interpreters.

It would also have been useful to reach more InterTel interpreters and to interview them in person. However, due to confidentiality agreements, the project manager sent the questionnaires to the InterTel interpreters, and the researcher had to rely on the responses of those willing to participate in the study.

5.4 Recommendations

Training

In order for healthcare interpreters to perform optimally, they have to be trained. Training should be continuous and should include practice scenarios and broadening of vocabulary. As in any specialised field, knowledge of the terminology used in the healthcare sector is imperative. Since the interpreting content regards the medical condition of a patient, it is crucial for the interpreter to act impartially and professionally, and to be discreet at all times. Interpreters should be provided with guidelines on confidentiality, non-disclosure of information and the relevant codes of conduct and standards of practice (Kelly, 2008:254). It is vital for interpreters to implement the above-mentioned practices to create an environment in which the patient can trust the interpreter and by implication also the doctor; feel comfortable and build a doctor-patient relationship.

As the absence of visual elements remains one of the key concerns in telephone interpreting, telephone interpreters should be trained to interpret intonation, tone of voice and other speech clues to compensate for the lack of visual elements.

Hospital staff

Healthcare practitioners are unsure of how to use the service and may therefore shy away from the daunting prospect. Training will take the sting out, reveal how easy it is to use the service and boost staff confidence. The staff should be informed about the necessity to record calls to monitor quality, and be reassured that the recordings are not used to check up on them. In fact, only the project manager, who is unaffiliated to the hospitals or Healthcare Department, listens to the calls.

Training sessions can include roleplay in which various scenarios are simulated, eg. one where no interpreter is available; one where an on-site interpreter must be reached and one where the InterTel service is available. This might convince them of the simple effectiveness of a telephone interpreter.

Emotional and psychological support

InterTel can provide support groups facilitated by a counsellor, to help telephone interpreters cope with emotional stress and provide them with an opportunity to talk about traumatic experiences or situations. This may combat burn-out in telephone interpreters.

High quality equipment

Poor sound quality hinders effective communication and prevent the telephone interpreter from interpreting accurately. By implementing effective equipment at healthcare facilities, preferably dual-handset phones, optimum sound quality can be ensured.

Contact persons at healthcare facilities To solve the problem of poor communication between the InterTel project manager and the healthcare facilities, dedicated contact persons can be assigned to healthcare facilities. These persons should ideally be fully trained in using the service and should ensure that it is

implemented and used. Their feedback to the project manager can help improve the InterTel service.

Awareness campaigns

Awareness of the InterTel service can be created by launching an advertising campaign. This venture should be undertaken by the Healthcare Department. It will be beneficial to the campaign if the InterTel operating hours are extended.

5.5 Final comments

Although this study was not a comparative study on on-site and remote interpreting, the results of the study indicate that telephone interpreting is viewed as inferior to on-site interpreting. It is important to put this into a South African perspective. In this country it is not feasible to employ on-site interpreters for all the official languages, let alone for foreign languages. The reality is that if on-site interpreters are not available, which is usually the case, cleaning staff or family members are used as interpreters. In medical interpreting, one cannot afford the risk of using an untrained interpreter. The choice in the South African context therefore does not lie between on-site interpreters and telephone interpreters; the choice is no interpreter, an unqualified interpreter or a telephone interpreter. Having a qualified interpreter interpreting over the phone is far better than not having an interpreter at all.

If implemented correctly, the InterTel service can become a viable solution to the communication barriers between patients and healthcare practitioners not speaking the same language. InterTel has the potential to enable communication where it was previously impossible and to bring South Africans closer together.

This study paves the way for follow-up studies on this topic, specifically within South African context. There is room for an in-depth study on whether telephone interpreting can indeed offer a viable solution to the communication problems experienced between healthcare practitioners and patients in the Western Cape healthcare sector.

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ADDENDA

ADDENDA

ADDENDUM A

LETTERS OF APPROVAL

ADDENDUM A



Chief Directorate: Health Strategy and Support
Reference: Support for Research
Enquiries: Ms Charlene Roderick
Ph: 021-483 9341

13/03/2013
Ms Elois Brink
Student number: 14779250
Promoter: Dr. H.M. Lesch
Stellenbosch University
South Africa

Descriptive analysis of telephone interpreting services in the healthcare sector of the Western Cape

Dear Ms Brink

The Western Cape Government Department of Health hereby indicates in-principle support for the study you are proposing titled **Descriptive analysis of telephone interpreting services in the healthcare sector of the Western Cape**. We recognise that the study has the potential to address an important health challenge facing our population.

In giving our in-principle support, we indicate that our support is based on the understanding that

- (i) If and when you receive your ethics approval, you will provide us with your ethics approval reference number (by locally accredited committee) and proof of scientific review of your research proposal.
- (ii) You will submit the proposal to the health research sub-directorate as per the normal routes for permission (www.capecapeway.gov.za/eng/pubs/public_info/H/213781) so that the implementation of the study does not inconvenience the day to day functioning of our facilities.

We look forward to a good working relationship with you as you conduct your project.

I appreciate the time that you have taken to enquire and solicit our support.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tracey Naledi', written over a horizontal line.

Dr Tracey Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 13/03/2013

5th Floor, 8 Riebeeck Street, Cape Town, 8001
PO Box 2060, Cape Town, 8000

tel: +27 21 483 9341 fax: +27 21 483 6058 www.capecapeway.gov.za

ADDENDUM A



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

Approval Notice New Application

17-Apr-2013
BRINK, Eloise Karin

Protocol #: DESC_Brink2013

Title: Descriptive analysis of telephone interpreting services in the healthcare sector of the Western Cape

Dear Miss Eloise BRINK,

The **New Application** received on **09-Apr-2013**, was reviewed by members of **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **16-Apr-2013** and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **16-Apr-2013 -15-Apr-2014**

Standard provisions

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.

You may commence with your research with strict adherence to the abovementioned provisions and stipulations.

Please remember to use your **protocol number (DESC_Brink2013)** on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) number REC-050411-032.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant parties. For approvals from the Western Cape Education Department, contact Dr AT Wyngaard (awyngaar@pgwc.gov.za, Tel: 0214769272, Fax: 0865902282, <http://wced.wcape.gov.za>).

Institutional permission from academic institutions for students, staff & alumni. This institutional permission should be obtained before submitting an application for ethics clearance to the REC.

Please note that informed consent from participants can only be obtained after ethics approval has been granted. It is your responsibility as researcher to keep signed informed consent forms for inspection for the duration of the research.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218089183.

Included Documents:

Research proposal

Permission letters

REC Application

Consent forms

DESC form

Sincerely,

Susara Oberholzer
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

ADDENDUM A

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Reports to Sponsor. When you submit the required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

10. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

11. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

ADDENDUM A



STRATEGY & HEALTH SUPPORT

healthres@pgwc.gov.za
tel: +27 21 483 9907; fax: +27 21 483 9895
1st Floor, Norton Rose House., 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: 2013 RP 062
ENQUIRIES: Ms Charlene Roderick

Ms Elois Brink
Student Number : 14779250
Promoter: Dr H.M. Lesch
Stellenbosch University
Cape Town, South Africa.

For attention: Ms E. Brink

Re: Descriptive analysis of telephone interpreting services in the health care sector of the Western Cape.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted approval for your research at the Worcester Regional Hospital.

Please contact the following person to assist you with any further enquiries in accessing the above site:

Dr Elbie Vosloo

023-348 1210

Kindly ensure that the following are adhered to:

1. Arrangements are made with managers, provided that normal activities at requested facility are not disrupted;
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the Provincial Research Co-ordinator (healthresearch@pgwc.gov.za);
3. The reference of the above should be quoted in all future correspondence.

We look forward hearing from you.

Yours sincerely

A handwritten signature in black ink, appearing to read 'NT Naledi', written over a horizontal line.

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 12/6/13
CC Dr E. Vosloo

Worcester Regional Hospital

ADDENDUM A



The header section contains the Folio Online logo, which consists of two images: a woman on the left and a child on the right, with the text 'FOLIO ONLINE' in large, bold, blue letters between them. To the right of the logo is a list of services: Transcriptions, Interpreting, Chaperoning, Voice-overs, Teleconferences, Translations, Copywriting, Editing, Proofreading, and Localisation. Further right is a stylized blue tree logo. Below the logo and list is the contact information: Unit 2, 10 Pepper Street, Cape Town 8001. PO Box 16136, Vlaeberg 8018. Tel: +27 21 426 2727 Fax: +27 21 424 0162 www.folio-online.co.za

To: Department of Health

Re: Permission letter for Ms Eloise Brink

To whom it may concern:

We hereby give permission to Ms Eloise Brink to conduct research on Folio Online and the Folio InterTel telephone interpreting project for her Mphil thesis entitled *Descriptive analysis of telephone interpreting services in the healthcare sector of the Western Cape*.

We further give permission that she may conduct interviews with the Folio Online interpreters provided that these interviews, whether in person or telephonically, take place at the Folio Online offices, which reside at Unit 2, 10 Pepper Street, Cape Town.

She may also conduct interviews with the Folio Online InterTel project manager(s) as well as other Folio Online staff members. Ms Brink may also transcribe some of the telephone interpreting calls, provided that no personal details of the patient or the hospital be disclosed.

The above permissions are made with the understanding that the information will only be used for research purposes.

Kind Regards



Johan Botha
Director: International Clients
Folio Online
www.folio-online.co.za

ADDENDUM B

INTERVIEWS

INTERVIEW QUESTIONS FOR FOLIO INTERTEL PROJECT MANAGER

1. How was the hospitals/clinics chosen for the pilot phase of InterTel?
2. Which hospitals are now included?
3. Besides the healthcare sector, in which other spheres is the InterTel service implemented?
4. How many interpreters offer their services to InterTel?
5. How many languages are provided?
6. How are interpreters for all these languages recruited?
7. How many calls do you receive from hospitals/clinics in the Western Cape?
8. Which hospitals call in most?
9. Which languages are requested most?
10. What type of equipment do the interpreters use?
11. What type of training do you offer the interpreters?
12. Is any form of training offered on how to utilise the service at hospitals/clinics?
13. Do you know whether the InterTel service is promoted in any way?
14. How many calls can Folio handle at a time?
15. What happens when there are no interpreters available for the requested language?
16. To your knowledge, has it happened that a call has been missed?
17. Would you say that the InterTel service is successful?
18. Do you think the InterTel service (telephone interpreting) offers a viable alternative to onsite interpreting?
19. What problems have your company experienced with the service?
20. As the project manager, what difficulties have you had to overcome?
21. What suggestions would you make to improve the service?
22. What growth do you think the service will show in the next five years?

ADDENDUM B2

**INTERVIEW WITH LAURI KING, PROJECT MANAGER AT FOLIO ONLINE
(30 July 2013)**

Researcher: Hoe het julle die hospitale gekies wat deel was van die loodsprojek?

Lauri King: Dit was lukraak gedoen. Die gesondheidsdepartement het dit gekies en ons weet nie wat hul kriteria was vir dit nie.

Researcher: Daar is seker 'n baie lang lys van hospitale wat nou ingesluit is?

Lauri King: Ja, ek het dit ingesluit en toe sê Johan Botha [Director at Folio Online] ons moet net om seker te maak by die departement hoor of dit reg is dat ons die ingligting uitgee. Dit is min of meer 50 hospitale.

Researcher: Buiten die gesondheidssektor, is daar ander sferes waarin dit geïmplementeer is?

Lauri King: Ja, daar is verskeie informele tolksessies. Die een voorbeeld sal wees 'n huishulp. Dit word tog elders gebruik, maar die gesondheidsorg is tog ons grootste afdeling.

Researcher: Dink jy dit sal byvoorbeeld oorskuif na die howe toe?

Lauri King: Ja, definitief. Op die hierdie stadium is medies ons grootste kliënt, maar dit kan beslis op baie ander gebiede uitbrei.

Researcher: Hoeveel tolke het julle op die oomblik?

Lauri King: Dit was moeilik om te bepaal, maar ek sou sê so ongeveer 100. Nie almal is ewe aktief op die stelsel elke dag nie. Ons het so 15 ingeteken elke dag.

Researcher: Hoeveel tale verskaf julle?

Lauri King: 37

Researcher: En dit sluit Europese, Asiatiese en Afrika tale in?

Lauri King: Ja.

Researcher: Hoe het julle julle tolke gewerf?

Lauri King: Advertensies, verwysings van bestaande tolke of ons kontak ook instansies wat tolkkursusse aanbied.

Researcher: Moet hulle 'n sekere kwalifikasie hê of hoe werk dit?

Lauri King: Almal moet natuurlik 'n tolkkwalifikasie hê en dan het baie van die tolke ook MiTio sertifisering.

Researcher: Hoe gereeld kry julle oproepe van die hospitale af op hierdie stadium?

Lauri King: Dit was ook nogal moeilik. Omdat ek nog nuut is by Folio kan ek net uit my ervaring praat, maar ek het statistieke opgetrek en in 2011 was daar 33 oproepe. In 2012, 141 en in 2013, tot op datum, of tot einde Junie, was daar 93 oproepe. So jy kan duidelik sien dat dit groei.

Researcher: Watter hospitale bel die meeste in?

Lauri King: Ek is nou nie seker of ons mag sê nie. Ek gaan net by die departement hoor.

ADDENDUM B2

Researcher: Watter tale word meeste aangevra?

Lauri King: Xhosa. In 2011, was dit Xhosa, dan Portugees, en dan Sotho. In 2012: Xhosa, Sotho, en Mandaryns. En in 2013, tot einde Junie, was dit Xhosa, Sotho en Swahili. Xhosa is natuurlik die mees algemene een omdat dit in die Wes Kaap is. Ek dink as die stelsel sou uitbrei na KwaZulu-Natal toe sal Zulu meer algemeen wees. Ek dink dis baie streeksgebonde.

Researcher: Weet jy watter toestelle gebruik hul [the interpreters]?

Lauri King: Blykbaar verkies baie van hulle op die landlyne. Maar hoofsaaklik selfone en landlyne.

Researcher: Weet jy of hulle dan oorfone het of maak hulle seker hulle is in 'n stil gebied?

Lauri King: Hulle instruksie is om as hulle foon lui na 'n stil area te gaan.

Researcher: Ek het so bietjie opgelees oor die opleiding wat julle vir julle tolke bied. Dit is maar meestal deur MITio of hoe? Ontvang hul deurlopende opleiding of geskied dit slegs een keer?

Lauri King: Ek dink dit was deurlopend, maar ek het dit nog nie in my tyd hier gedoen nie. So ek is nie heeltemal seker of dit deurlopend is nie, ek weet net dis die aanlyn.

Researcher: Wat ek ook gelees het is dat hulle terminologielyste en sulke klas van goed ontvang? Ek weet nie of julle dit vir hulle stuur nie?

Lauri King: Ja, definitief. Daar is interne opleiding.

Researcher: Ek weet julle vorige projekbestuurder het op 'n tyd na die hospitale toe gegaan om opleiding aan die hospitaalpersoneel te bied.

Lauri King: Ja.

Researcher: Is dit nog iets wat julle nog oorweeg en doen?

Lauri King: Ja, definitief.

Researcher: So jy sal dit behartig en jy sal ingaan hospitaal toe en vir hulle wys?

Lauri King: Ja, aanbieding waar ons vir hulle wys hoe 'n oproep werk. Baie basies maar ja.

Researcher: En weet jy hoe gereeld julle dit omtrent sal doen?

Lauri King: Wel, dit is redelik gereeld. Dit is moeilik om presies te sê want jy gaan maar waar hulle dit nodig het. Hulle vra dit baie keer aan. Ek kan nou nie eintlik spesifiek sê nie.

Researcher: Weet jy of julle of dalk die gesondheidsdepartement die diens adverteer?

Lauri King: Ons adverteer op ons eie platforms soos Facebook, ons webwerf en nuusbriewe en ander sosiale media en ek weet die gesondheidsdepartement is ook nou op die vroeë stadium om 'n groot reklame veldtog te loots.

Researcher: Weet jy hoeveel oproepe julle op 'n slag kan hanteer op die oomblik want ek weet dit het stelselmatig gegroei?

Lauri King: Ek dink dit is 20, maar dit is ook iets wat ek net by ons tegniese outjie moet bevestig. Maar ek is amper seker dis 20.

Researcher: Ek dink dit was laas wat ek geweet het minder so dit het vermeerder.

Lauri King: Praat van vermeerder. Die hospitale kom ook by. Daar sal byvoorbeeld iemand wees wat vra soos Oudsthoorn, wat sê hulle sal dit graag dit wil gebruik.

ADDENDUM B2

Researcher: Wat gebeur as daar byvoorbeeld net een Swahili tolk ingeteken is en daar kom nog 'n oproep deur? En het dit al gebeur?

Lauri King: Dit het al gebeur dat daar nie iemand nie beskikbaar is nie, maar die oproep kom dadelik na my toe deur.

Researcher: En na ure?

Lauri King: Ons sisteem is net oop van 9h tot 18h.

Researcher: So die tolke is ook net ingeteken tussen daai tye?

Lauri King: Ja. So die oproep sal na my toe kom en dan is die proses om iemand te bel, 'n tolk in die hande kry wat beskikbaar is wat vinnig kan inteken of hy sal die dokter terug bel. En ons probeer dit natuurlik so gou as moontlik te doen.

Researcher: So dit gebeur soms maar die oproep word nooit gemis nie?

Lauri King: Tensy daar 'n tegniese probleem is. Daar is altyd iemand soos ek, die 'supervisor', anders sal dit by iemand in die kantoor uitkom.

Researcher: Het julle al ooit terugvoer van die kliënte gekry of iemand wat gereageer het op julle diens?

Lauri King: Dokters of?

Researcher: Ja, dokters of enige van julle kliënte wat vir julle terugvoer gegee het oor die diens.

Lauri King: Dit is nou iets wat ek hier gesê het is vir my 'n probleem is. Ek kry baie min terugvoer van mense af. Ek het al 'n paar dokters gehad wat vir die tolk gesê het (want ek luister na die oproepe vir gehalte beheer) ons sou dit nie sonder jou kon doen nie. En baie positief, baie positief, maar ek het self nog nie van die hospitaalpersoneel gehoor nie.

Researcher: Maar jy sou sê die meerderheid terugvoer is positief?

Lauri King: Ja, as hul dit eers gebruik het. Ek dink daar is definitief 'n huiwerigheid in die begin om dit te gebruik en ek dink as hulle dit eers gebruik het en gesien het hoe dit is dan is dit asof deure vir hulle oopgaan.

Researcher: Sou jy sê die diens is suksesvol?

Lauri King: Ja, definitief.

Researcher: Sou jy sê dat InterTel 'n uitvoerbare alternatief vir op-die-perseel tolke is?

Lauri King: Ek dink so ja. Al geval waar ons nogsteeds natuurlik op-die-perseel tolke verskaf is by 'n plek soos Valkenberg of SASL, maar dit het nou nie eintlik met InterTel te doen nie. Ek dink vir gewone hospitale is dit baie beter want dit is goedkoper, dis vinniger. Daai paar minute om iemand uit te bel om al die pad hospitaal toe te gaan. Dit kan ure vat om 'n beskikbare tolk te kry. Hier is iemand wat jy letterlik na nege nommers in die hande kan kry. Dit kan iemand se lewe beteken. Daai tyd wat jy spaar. En ek dink ook vertroulikheidskwessie. Dit is definitief iets om aan te dink. Hulle kan nie die tolk sien nie. So ek dink 'n pasiënt voel ook meer op sy gemak as wanneer daar iemand in die spreekkamer is.

Ek sou sê "cost, speed and confidentiality".

Researcher: So jy het nog nooit met 'n pasiënt gepraat wat dit vir jou gesê het nie?

Lauri King: Nee. Ek het nie rerig kontak met die pasiënte nie. Daar is 'n groot vertroulikheids kwessie. Hulle name word nie bekend gemaak nie. Die tolke se name word nie bekend gemaak nie. Hulle is

ADDENDUM B2

bewus daarvan dat iemand luister na die oproepe, die departement weet dit en so. Maar nee, ek het nie kontak met die pasiënte nie. Jy kan natuurlik hoor dit is vir hulle fantasties as daar iemand is wat kan verduidelik hoe hulle voel, iemand wat hulle verstaan. So dit kan jy hoor.

Researcher: So jy kan dit eintlik hoor in hoe hulle kommunikeer, hulle entoesiasme.

Lauri King: Natuurlik, ja. En ook, dit begin as 'n frustrasie en ek dink dan daai verligting

Researcher: Want dit is frustrerend om te probeer kommunikeer met iemand wat jou nie lekker verstaan nie?

Lauri King: Presies. Ek dink ook dat aangesien dit 'n pasiënt is, betrek dit mediese goed. Dis so sensitief. So dis nog 'n groter frustrasie as jy seer het en niemand kan verstaan nie. Niemand kan help nie.

Researcher: Hoe belangrik is die visuele aspekte wat verlore gaan tydens telefoontolking?

Lauri King: Ek dink nie. In 'n geval natuurlik met 'n SASL tolk, ja. Dit moet mos nou natuurlik in persoon geskied. En met Valkenberg pasiënte waar hulle eintlik die geestestoestand moet bepaal, daar is dit belangrik. Maar ek dink, in meeste gevalle, meeste oproepe wat ons kry, werk 'n telefoontolk uitstekend.

Researcher: Watter probleme waarvan jy weet het julle al ervaar met die diens?

Lauri King: Uhm.

Researcher: Dit kan enige iets wees soos dat mense dit nie wil gebruik nie.

Lauri King: Ja, ek dink dis 'n groot een. Dis weer een wat ek heeltemal weet hoe om te beantwoord nie want ek het nog nie baie probleme met dit ervaar nie.

Researcher: Jy kan dit ook sê. Want ek bedoel, jy is nou amper, hoe lank is jy nou al hier by Folio? Ses maande?

Lauri King: Vier of vyf maande.

Researcher: Maar ek bedoel in 'n vyf-maand periode, as iets drasties 'n probleem was sou jy daarvan geweet het.

Lauri King: Ja.

Researcher: So in 'n vyf-maande periode is daar niks drasties, niks tegniese probleme, of mense wat sê hulle gaan nie die diens gebruik nie.

Lauri King: Nee.

Researcher: En jy het gesê dis nogals 'n probleem dat jy nie direkte terugvoer kry nie?

Lauri King: Ja dit is my persoonlike probleem. Dis maar net, ek kry nie baie terugvoer op e-posse nie. Ek kry nie terugvoer oor die stelsel nie. Hoe hulle dit ervaar nie. Of daar enige tekortkominge is of probleme is nie. Sal graag daarop wil verbeter.

Researcher: En hoe bedoel jy as jy nie terugvoer kry op e-posse nie. Kontak jy hulle soms?

Laur King: Ja, die hospitale nou. Die kommunikasiebeamptes. Dis nie almal nie. Ek wil nou nie iemand in die moeilikheid laat kom nie. Ons sê altyd as daar enige iets positief of negatief is dat hulle ons moet laat weet. Ons kan daaraan werk of daarop verbeter.

Researcher: As jy praat met hulle, met wie praat jy gewoonlik?

ADDENDUM B2

Lauri King: Die kommunikasiebeamptes.

Researcher: Wat dink jy is redes hoekom mense dit nie gebruik nie? Of so gereeld gebruik nie soos wat jy sou wou gehad het as dit so is.

Laur King: Soos ek sê ek dink nie hulle besef hoe eenvoudig dit is nie. Ek dink hulle hoor hierdie InterTel stelsel en dit klink eksoties en vreemd. En hulle besef nie dit is net twee fone wat jy nodig het nie. Ek dink ook miskien die feit dat ek hulle opneem of nou vir gehaltebeheer luister. Alhoewel dit absoluut vertroulik geskied en niks persoonlike inligting word uitgegee nie.

Researcher: Dink jy dit is omdat die personeel is bang dat hulle die vertroulikheidsooreenkoms met die pasiënt sal breuk?

Laur King: Nee. Ons praat nou van die hospitaalepersoneel, die suster, of verpleegster of dokter wat bel. Ek dink hulle dink hulle sê dalk iets verkeerd of doen iets verkeerd.

Researcher: So is hulle bang hulle gaan in die moeilikheid kom omdat hulle dalk nie die tegniese terme gebruik nie?

Laur King: Presies.

Researcher: Hoe dink jy kan die diens verbeter? Maar dit hoef nie noodwendig die diens te wees nie, net die implementering of die gebruik daarvan of in die algemeen.

Lauri King: Ek dink definitief die werwing van meer tolke. Dit kan altyd net goed doen. Ons wil natuurlik hê die stelsel moet so aktief wees soos wat hy kan wees. Ek dink kommunikasie tussen al die betrokke partye moet beter wees. Meer opleiding vir die hospitaelpersoneel. Met hierdie opleiding, moet ook van tolking leer. Wat is die moets en die moenies.

Researcher: Jy bedoel spesifiek die hospitaelpersoneel?

Laur King: Ja.

Researcher: Watse groei dink jy sal dit toon in die volgende vyf jaar?

Lauri King: Ek dink in nog meer sferes. Medies is net een komponent van dit, daar is nog soveel meer waarin dit kan uitbrei. So ek sou sê definitief uitbreiding en ek dink ook verbetering op die bestaande, soos die klein foutjies, die kommunikasie wat moet verbeter.

Researcher: Wat dink jy is die positiewe aspekte van InterTel of telefoontolking oor die algemeen?

Lauri King: Oor die algemeen, sou ek sê dat dit definitief taal en veeltaligheid bevorder. Ek meen in 'n land waar ons 11 amptelike tale het is tolking die enigste opsie. Nie die enigste opsie nie, maar 'n baie belangrike deel in die fasilitering van kommunikasie tussen mense.

ADDENDUM C

QUESTIONNAIRES

ADDENDUM C1

QUESTIONNAIRE FOR INTERPRETER

<u>No.</u>

Questionnaire for InterTel interpreter

Personal information

Age

Gender

M	F
---	---

Ethnicity

Black	Coloured	Indian	White	Other (specify)
-------	----------	--------	-------	-----------------

Language

1. What is your mother tongue language?

.....

2. Which language do you interpret into?

.....

3. On a scale from 1 to 5 (5 being the highest), how proficient are your second language?

1	2	3	4	5
---	---	---	---	---

3.1 Understanding

1	2	3	4	5
---	---	---	---	---

3.2 Speaking

1	2	3	4	5
---	---	---	---	---

3.3 Reading

1	2	3	4	5
---	---	---	---	---

3.4 Writing

1	2	3	4	5
---	---	---	---	---

4. Do you have a qualification in interpreting? If not, what is your highest academic qualification?

.....

5. If you are a qualified interpreter, what is your qualification and from where was it obtained?

.....

ADDENDUM C1

6. For how long have you been practising as an interpreter?
.....

7. For how long have you been practising as a telephone interpreter?
.....

General

8. On a scale from 1 to 5 (5 being the highest), how comfortable do you feel interpreting over the phone?

1	2	3	4	5
---	---	---	---	---

9. Have you been trained to use Folio's InterTel service? If so, how often do you receive training?
.....

10. How many times a week do you receive calls from healthcare facilities needing interpreting services?
.....

Interpreting session

11. Did you explain to the patient/medical practitioner how the InterTel service works?
.....

12. Would you have preferred being in the room with the patient and the medical practitioner? Please explain why or why not:
.....

13. How did you feel about not being able to see the patient/medical practitioner's facial expressions?
.....

14. Were there gestures or physical actions performed during the consultation that the patient/medical practitioner informed you about?
.....

15. How did you go about conveying these actions?
.....

16. Did you understand everything the patient said? If not, please explain what parts of the patient's speech you did not understand.
.....

17. Did you understand everything the medical practitioner said? If not, please explain what parts of the medical practitioner's speech you did not understand.
.....

ADDENDUM C1

18. What did you do with the parts of speech that you did not understand (e.g. asked for them to be repeated/left them out)?

.....

19. How do you manage the lengths of the parts of speech (e.g. do you verbally request a break)?

.....

20. On a scale of 1 to 5 (5 being the highest), how satisfied were you with the interpreted product? Which aspects contributed to your perception?

1	2	3	4	5
---	---	---	---	---

Folio InterTel service

21. Would you recommend the use of telephone interpreting in the healthcare sector?

.....

22. Would you recommend the use of Folio's InterTel service?

.....

Technical aspects and equipment

23. What type of phone equipment was used (dual handset, speakerphone, normal phone passed between the medical practitioner and the patient)?

.....

24. If the interpreting was done by passing the phone between the medical practitioner and the patient, did it impact on your ability to adequately interpret?

.....

25. Could you hear the patient/medical practitioner clearly? If not, please explain why:

.....

26. Do you have any comments regarding the phone equipment used?

.....

Problems

27. Please name all the problems you have experienced with telephone interpreting:

.....
.....

28. If you have conducted onsite interpreting, please compare onsite to telephone interpreting?

.....
.....

ADDENDUM C1

Comments

.....

.....

ADDENDUM D

TRANSCRIBED INTERPRETED SESSIONS

ADDENDUM D1

IsiXhosa INTERPRETED SESSION

Interpreter: Interpreter Hello

Sister: Hello

Interpreter: Hi

Sister: Hi, I'm Sister [...] phoning from [...] Clinic

Interpreter: Ok no problem

Sister: I have a patient here who really needs an interpreter. I just want to find out from the patient what is his complaints. He's sitting right here next to me, you're on speaker phone.

Interpreter: Ok, hello. Hi uyandiva?

Hi, can you hear me?

Patient: Hello

Interpreter: Hi , uyaphila?

Hi, are you well?

Patient: Ndiyaphila sisi akhonto kunjani kuwe?

I am well sis, how are you?

Interpreter: Ndiyaphila nam. Ugqirha uyabuz' uba yintoni ingxaki, angakunceda ngantoni?

I am also well. The doctor is asking what the problem, how can he help you?

Patient: Sisi ndidliwa yinto apha esibindini apha esiswini.

Sis, there is something eating at me (painful) in my liver, in my stomach.

Interpreter: Utyiwa yintoni?

What is eating at you?

Patient: Ndidliwa yinto apha esibindini sesisu.

Something is eating at my liver in the stomach.

Interpreter: Esiswini?

In the stomach?

Patient: Ewe apha esiswini sisi, apha ndiyahambisa kakhulu

Yes here in the stomach sis, my tummy is really running

ADDENDUM D1

Interpreter: Oh ok. Ndizawu... Ok. Hi doctor can you hear me?

Oh ok. I will...Ok.

Sister: Yes, Yes, I'm Sister [...].

Interpreter: Ok um, he says that he has a very bad tummy bug, and it's causing him to uh, to go, to to have diarrhoea

Sister: Ok. And, when did it start?

Interpreter: Kuthwa ikuqale nini bhuti?

He says when did it start, brother?

Patient: Indiqale, ngolwe..., izol' welinye, ngolwesi

It started, on..., the day before yesterday, on

Interpreter: Em, he said, um, ngolwesingaphi?

Em, he said, um, on what day?

Interpreter: Oh. He said it started on Friday

Sister:and how often has he gone to the bathroom?

Interpreter: Kuthwa ke ngoku uquqa kangakanani e...

Sister *He says now, how often do you go to...*

Sister: In a 24 hour period

Interpreter: Kuthwa ngosuku uquqa kangakanani endlini yangasese?

He says in a day how often do you go to the toilet?

Patient: Yhu, khandilale namhlanje sisi. Kwanamhlanje! Oko andilali ubusuku obu. Ndimana ndisity'ezinto izinto ezinqamlayo zinqamla(mumbling)

Gees, I haven't slept today sis. Even today! Since since I have not been sleeping at night. I have been taking things to stop the runs and it stops (mumbling)

Interpreter: Owu Ok. He says that he hasn't he didn't sleep well and he hasn't been sleeping well he's been going to the loo a lot.

Sister: Ok. Just tell me, ask him whether he is on ARV's

Interpreter: Kuyabuzwa ke ngugqirha ukuba usela iiARVs na?

The doctor is asking if you are taking ARVs?

ADDENDUM D1

Patient: Hayi bendingekazisebenzisi zona.

No I am not using them yet.

Interpreter: He says he hasn't used ARVs yet

Sister: He hasn't started yet?

Interpreter: No he hasn't.

Sister: Ok, then you must ask him is there any blood in his stool, please

Interpreter: Uyakubuza ke ngoku ugqirha, xa uhambayo usi., xa uhambisayo uye ulibone na igazi?

The doctor is now asking, when you go When your stomach is running do you ever see blood?

Patient: Ndikhe ndazijonga. Ndikhe ndalifumana apha ezintsukwini.

I have looked. I have found some in the past couple of days.

Interpreter: Ukhe walifumana?

You found it?

Patient: Ewe bendimana ndiy' ethoyilethi, qha ndabon' uba mandikhe ndiphuma apha , ndingayi toyilethi, ndayibona ukuba heyi ndihambisa kakhulu kakubi

Yes, I've been going to the toilet, but I thought let me not going out, let me not go to the toilet, then I saw my tummy is really running in a bad way

Interpreter: Um, he says yes he has seen ... blood ... in his stool.

Sister: He has seen it?

Interpreter: Ja he has seen blood in his stool.

Sister: Ok. And now you must tell him he is on the ARV wellness programme. He hasn't pitched up for the appointment dates that were scheduled for him. So the last time that he was at the clinic it was 27/09/11. He never came back to collect his cotramoxizol that he's supposed to come and collect on the 2 monthly basis. So I am going to draw the blood. I'll do a CD4 of him today and he must come back in a week's time to come and collect the results. And then I will treat him for the diarrhoea.

Interpreter: Oh Ok. Uthi ugqirha uzakutsal' igazi lakho ke ngoku then azojong' iCD4 count yakho. Ucel' ubuye kwiveki, inoba ke kwiveki ezayo ngolwesithathu, ubuye ngolwesithathu kule veki izayo uzakuxelela iziphumo zakho zokuba igazi lakho liye laphuma lisithini , but okwangoku uzakube ekunika amayeza okunceda olu tyatyazo lakho.

The doctor says he is going to draw your blood now and then check your CD4 count. He asks that you come back in a week, possibly next week Wednesday, you must come back on Wednesday

ADDENDUM D1

next week, he will tell you the results, what your blood is saying, but for now he will give you medicines for you diarrhoea.

Patient: Owu, into eyenzekayo ke sisi, selitsaliwe igazi ngoku ngoku ngabanye oosisi.

Oh, what has happened sis, the blood has been drawn already, just now by those other ladies.

Interpreter: Andiva?

Pardon?

Patient: Lisand' ukutsalwa igazi kum ngoku ngomnye usista.

My blood has just been drawn by another sister.

Interpreter: Owu. Ndizawukhe ndimxelele ke ndive ukuba uthini

Ok. I will tell him that and hear what he's got to say.

Patient: Kangangokuba ndiphelelwe ngamandla apha sister andiwo amandla kwala okuhamba.

So much so I have no strength sister, I don't even have strength to move.

Interpreter: He says that he's already had a nurse that has taken his blood.

Sister: Ja I can see now that in the folder it's written and the dates for follow up is 12/02

Interpreter: Are you going to be taking another blood sam...?

Sister: No no no, I see the sister has taken the blood, the reason for that is our laboratory services switch up at 1 o'clock, I think that they took out the file, draw the blood and now it's seen by me.

Interpreter: Oh ok, uthi akazophinda alitsale ke igazi. Ucel' ubuye next week uzojonga iziphumo.

Oh ok, he says he won't draw blood again. He asks that you come back next week to check your results.

Patient: Ok ke sisi

Ok sis.

Interpreter: Uza kunceda ke kodwa ngale ngxaki onayo okwangoku. Uzubuye kule veki izayo ke bhuti.

However he is going to help you with your current problem. You must please come back next week brother.

Patient: Enkosi

Thank you

ADDENDUM D1

Sister: Ok. And then the last thing that I want you to tell him is that he must stop using alcohol because, I could understand that he been drinking alcohol and smoking is not good for his lungs, especially at this moment.

Interpreter: Uthi ke ugqirha ucela ukhe uyeke u, ungabuseli utywala okanye izinto ezinotywala ngoku. And also uba uyatshaya ucela uyeke ukutshaya because icuba ali...(mumble) amaphaphu akho ngakumbi ngeli xesha empilweni yakho

The doctor said you must please stop em, not drink alcohol or things with alcohol now. And also if you smoke he asks that you stop smoking because tobacco does not ... (mumble) your lungs especially this time in your health.

Sister: Thank you very much

Interpreter: It's a pleasure.

IsiXhosa INTERPRETED SESSION

Interpreter: Interpreter hello

Doctor: Hi, is that Xhosa interpretation

Interpreter: Yes sir.

Doctor: Hi. Ok I'm doctor [...]. I've got a mother who's sitting next to me. She's called [...], the boy, she's called, she's Mr. [...].

Interpreter: Ok

Doctor: Ok. She came here, She's got a 11 month old girl and she brought the child here because she is worried about the child's development.

Interpreter: Ok.

Doctor: Ok. What I'd like you to tell her is that I agree with her that the child has, is delayed, is behind.

Interpreter: Is the child 11 months of age

Doctor: That's right. He's called [...]. That's the child's name.

Interpreter: Ok, ok.

Doctor: I would like you to tell her that he is behind and I'm also worried about the fact that he's not seeing well.

Interpreter: Ok

Doctor: And then I what I want to do is I'm going to, I'm not sure why the child is delayed but I'm going to book another scan of the brain.

Interpreter: Ok, are you specifically talking about the child's development or there are brain problems with him?

Doctor: Ja, I'm talking about the child's development I think the child is behind because there is something wrong with the brain.

Interpreter: Alright, ok, ok.

Doctor: Ok. Do you want to go ahead?

Interpreter: Can I speak with. Yes I can.

Doctor: Ok, mom is on the phone.

Interpreter: Alright. Molo mama.

ADDENDUM D2

Hello mama.

Interlocutor: Ewe

Yes

Interpreter: Unjani?

How are you?

Interlocutor: Ndiphilile kunjani?

I am well, how are you?

Interpreter: Ndi-alright nam akhonto. Uthetha no[...] ne, ndizawuzama ke ndithethe nawe nogqirha for uku-intaprita ne. So izinto ofuna ukundibuza, ungandibuza ndizawucacisa mna le nto ithethwa ngugqirha kuwe.

I'm alright. You are speaking to [...], I'm going to try and speak to you and your doctor so that I can interpret. So if there are things you want to ask me you can ask, I will explain to you what the doctor is saying to you.

Interlocutore: Ok

Interpreter: Mamela ke mama, uthi ugqirha ne, wena mos umntana umzise kuba unoloyiko kuba umntana akakhuli kakuhle ne, andithi.

Please listen mama, the doctor says you have brought your child because you fear that the child is not developing properly, isn't that so?

Interlocutor: Ewe

Yes

Interpreter: Ewe, ugqirha uyavumelana nawe ke, uthi ewe umntana akakhuli kakuhle, kodwa ke uthe xa emjonga wafumanisa ukuba nangokwengqondo zikhona izinto wafumanisa ukuba usemva ne, ngokukhula kwakhe,

Yes, the doctor agrees with you, he says the child is not developing properly, however when he looked at him he discovered that even mentally there are some things that are behind in his development,

Interlocutor: Eh

Interpreter: so into azawuyenza ke ngoku uzawujonga ukuthi yintoni na unobangela waloo nto.

so what he's going to do is to look into what the cause is for all of this.

Interlocutor: Ok

Interpreter: Ukhona omnye umbuzo onawo?

ADDENDUM D2

Do you have another question?

Interlocutor: Ha-a, andinawo.

No, I don't.

Interpreter: Ayikho nenye into oxhalabe ngayo ngaphandle kwale ayithethayo?

Is there nothing else that worries you besides what he spoke about?

Interlocutor: Ikhona into endixhalabisayo le nto angakwazi nokuthini, akakwazi nokuhamba, akakwazi nokuthini.

There is something that worries me, the fact that he can't do anything, he can't even walk, he can't do anything.

Interpreter: Ewe, yile nto esithi kaloku inoba ikhona into echaphazela ingqondo. Bamba, kodwa ndizawulantuka ndizawumbuza ukuba yintoni unobangela waloo nto ne.

Yes, that's why he says maybe there is something that affects the brain. Please hold, I will ask him what the cause is for all of that.

Interlocutor: Ok sisi.

Interpreter: Ok ke. Hi doc.

Doctor: Hi, thanks for that. Tell her I'm gonna, I can't tell what's wrong at the moment, because I need to, we need to do the scan first.

Interpreter: Ok. And another thing that she said she's worried about is the fact that the ... is not even walking and all that. I just explained to her that probably the cause you won't know exactly you'll have to do the scan.

Doctor. Ok that's right. When we do the scan, you must just tell her that when we do the scan they're gonna put the child to sleep so the child needs to come to the hospital the day before the scan. And we're going to admit the child for one night

Interpreter: Ok. Mama. Hello mama.

Interlocutor: Sisi.

Interpreter: Uthi ugqirha ne, ngenxa.. uyayiva le nto oyithe.. inkxalabo yakho ne, but ke ngoku abakwazi ukukuxelela ngokuba ukuthi yintoni unobangela wazo zonke ezi zinto zenzekayo emntwaneni, ne.

The doctor says, because..., he can hear what you're saying... your concern, but for now he cannot tell you what is the cause of all the things that are happening with the child.

Interlocutor: Ewe sisi

Yes sisi

ADDENDUM D2

Interpreter: Into abazawuyenza ke bazawujonga, bazamfaka kwiskeni bazame ujonga uba yintoni unobangela apha kuye engqondweni, wento yonke engahambi kakuhle, uyaqonda?

What they are going to do, they will check, they will put him in a scan so they can try and check the brain to see what the cause is, for everything that is not going well, do you understand?

Interlocutor: Oh, ok.

Interpreter: But xa bezakwenza loo nto ke, kuzawufuneka umntana aze apha esibhedleleni, ngosuku..., let's say masithi umzekelo ne, uzawujongwa ngomso kwiskeni so wena kufuneka ke ngoku uze naye namhlanje, ngosuku oluphambi kolu bazamjonga ngalo

But when they are about to do all that, you will have to bring the child to hospital on the day..., let's say for example, the child will be scanned tomorrow, you will have to bring him today, the day before the day of the procedure.

Interlocutore: Oh, ndizawusikelwa idate?

Oh, they will set a date for me?

Interpreter: Bazamnika idate ewe.

Yes they will give him a date.

Interlocutor: Ok

Interpreter: Uyayiva? But bazamlalisa umntana xa bejonga loo nto so funeka aze ngosuku oluphambi kwala date uzayinikwa.

Do you understand? But they will put the child to sleep when they check him so he needs to come the day before the date they give him.

Interlocutor: Ok.

Interpreter: Uyayiva

Do you understand?

Interlocutor: Xa izawuba ngomso, namhlanje

When it's going to be tomorrow, then today/

Interpreter: Ewe senza umzekelo, if mhlawumbi kuthwa ingomso wena uzakuya naye namhlanje.

Yes we're making an example, if maybe they say tomorrow the you will go today.

Interlocutor: Ok

Interpreter: Uyayiva ke ma?

Do you understand mama?

ADDENDUM D2

Interlocutor: Owu ndiyakuva

Oh, I hear you.

Interpreter: Ok ke ma. Hi doc

Doctor: Hi, just one more thing, also because the child is behind, I mean the child at the moment is getting a care support grant. Because the child is so behind, I'm going to also, because the child can't see properly, I'm going to apply so long for a disability grant. I'm gonna fill in the form, mom has brought her ID, I'm going to send her to a social worker just because mom is entitled to get more money.

Interpreter: Ok.

Doctor: Ok?

Interpreter: Ok doc. Mamela ke, uthi ugqirha umntana ikhona imali mos ayifumanayo ne?

Ok doc. Please listen, the doctor says your child is getting some money, isn't that so?

Interlocutor: Ewe ikhona.

Yes there is.

Interpreter: Uthi ke ngoku, ngenxa yentobana uthe xa ejonga kukhona nezinye izinto, uyeva? ezingaqhelekanga apha emntaneni nazibonayo, umzekelo, akaboni kakuhle ne.

He says, because when he looks there are other unusual things that he sees in the child, for example, the child cannot see properly.

Interlocutor: Oh, ok

Interpreter: So int' azawuyenza ke ngoku for ukwangeza kule mali ayifumanayo ne, uzakongeza, uzawufilisha amaphepha, afak' iiforms okanye abhale iinkcukacha ezandileyo ne?

So what he's going to do now in order to add on the money you're receiving, he will add..., he will complete papers, submit forms or write further details, you hear?

Interlocutor: Ok

Interpreter: For umntana afumane imali yokukhubazeka

So that the child can receive a disability grant.

Interlocutor: So ngolo hlobo ukhubazekile?

So that means the child is disabled?

Interpreter: Ewe, kodwa ke akakwazi ukuthi ukhubazeke yintoni unobangela uyayiva? Bazawukwazi ukuxelela into egcweleyo xa benze esa skeni. Uyayiva ma?

ADDENDUM D2

Yes, but he cannot say why he is disabled do you understand? They will be able to tell you everything after the y do the scan. Do you understand mama?

Interlocutor: Ok. Ngoku ukuhamba oku akasoza ahambe kona?

Ok. So he will never walk again?

Interpreter: Ngawume ke ndizawubuza kugqirha andinalwazi mna. Ne!

Please wait, I will ask the doctor as I do not have that knowledge. OK!

Interlocutor: Ok sisi.

Interpreter: Ok, Hi doc.

Doctor: Thank you for helping.

Interpreter: She started to asked something.

Doctor: Sure?

Interpreter: She was just saying, because of everything does that mean that the child has a disability? That is one question. And then the second question was, because of this bad experience that they have with the child, does it mean that the child will not be able to walk for life.

Doctor: I think the first question, yes the child does have a disability. I can see child development is behind and he can't see properly.

Interpreter: Ok

Doctor: That's why I'm applying for the grant. The second question I will be able to answer after we've done the scan.

Interpreter: Ok. So will you give the date of the scan today?

Doctor: That's right. We will. That's right we will. And then she must come in the day before.

Interpreter: I'll explain to her. Ok. Ok. Mama!

Interlocutor: Sisi

Interpreter: Mamela, uthi ugqirha ne, ewe umntana ukhubazekile ngenxa yokuba engaboni kakuhle. Uyaqonda? Maar ke ngoku baza kunika idate for iskeni ne? Uze ke wena ke, ungalibali ukuza usuku oluphambi kwala date. Uyaqonda?

Please listen, the doctor says, yes the child is disabled because he cannot see properly. Do you understand? But now they are going to give you the date for the scan, ok? Then you must come, don't forget to come the day before that date. Do you understand?

Interlocutor: Ok

ADDENDUM D2

Interpreter: Ukwenzela into yokubana bajonge kwesi skeni engqondweni yakhe ukuthi, njengangoku bebona ukuba usemva, akahambi, akaboni kakuhle, sizawujonga ke ngoku ukuba ziintoni ezinye izinto eziyimiphuma-ndlela apha uyaqonda apha emntwaneni. Then uzakuxelela ke ngoku iinkcukacha ezigcweleyo ngelo xesha. Uyayiva ke mama?

So that they can look at the brain with the scan so they can see why he is behind, he is not walking; he is not seeing properly, we will look at other abnormalities in the child's brain. Then he will tell you the full details then. Do you understand mama?

Interlocutor: Ewe ndivile

Yes, I hear you.

Interpreter: Kodwa okwangoku uzakwenzela ke imali le yokukhubazeka komntana ukwazi ukuyifumana nayo. Uyayiva?

But for now he is going to make an application so you can receive a disability grant for the child. Do you understand?

Interlocutor: Ok

Interpreter: Awunambuzo ke mama?

Do you have any questions mama?

Interlocutor: A-a, eyi.

No. Eyi (sigh)

Interpreter: Ok. Yintoni mama? Awuphethe...Uvakala ukhathazekile?

Ok, what is it mama? You are not... You sound worried?

Interlocutor: Owu, ndikhathazeke kakhulu sisi.

Oh, I am really worried sisi.

Interpreter: Ewe ne! Kodwa ke into azawuyenza, uza kuthumela nakonoontlalo-ntle, uyaqonda

Yes, I see. What he is also going to do is send you to social workers, do you understand?

Interlocutor: Ok

Interpreter: Ok ke ma.

Doctor: Ok, thanks for helping.

Interpreter: Ok doc. Thank you so much, keep well.

Doctor: Ok, thanks.

ADDENDUM D3

IsiXhosa INTERPRETED SESSION

Interpreter: Interpreter Hello.

Sister: Hello

Interpreter: Hi

Sister: Good morning. I am Sister [...] from [...] Clinic. I've got a Xhosa speaking patient here. I've asked her about her treatment, she's on TB treatment with me.

Interpreter: Ok

Sister: I gave her sputum jars in January that she was supposed to bring for me

Interpreter: Bring?

Sister: Bring back to the clinic on the 7th yes. But I don't see any results now in her file, now I'm asking her did you bring your sputum jars back but now she doesn't understand what I'm saying. Now she said something about lungs or something, maybe she said she was at the lung something I'm not sure.

Sister: Can you please just ask her what happened please, thank you.

Interpreter: Hi sisi, Hello.

Sister: Hello

Interpreter: Hi, Uyandiva?

Hi, Hello can you hear me?

Sister: Speak speak speak No no no you speak, just speak speak.

Interpreter: Uyandiva?

Can you hear me?

Sister: [...]

Patient: [...]

Interpreter: Hello sisi uyandiva?

Hello sisi, can you hear me?

Patient: [...]

Interpreter: Uthini?

What are you saying?

ADDENDUM D3

Patient: [...]

Interpreter: Uyandiva?

Can you hear me?

Patient: Ha?

Interpreter: Hello, sabela kum, uyandiva?

Hello, respond to me, can you hear me?

Patient: Ewe ndiyakuva

Yes I can hear you.

Interpreter: Ok, uuu..nesi, ugqirha wakho uyakubuz' ba, ii..., eza bhotilana bekunike zona zokuba ugalele izikhohlela kuzo uye wa, uye weza nazo?

Ok, the nurse..., your doctor is asking you, those little bottles she gave to you so that you can put sputum in, did you bring them with?

Patient: A-a, into eyenzikileyo ndiye ndathi ngala veki ekufanele ndibe apha ngayo ndavela ndaya emngcwabeni kabhuti oswelekile, kwacac' uba itranspoti le ekufuneka sibuye ngayo inengxaki njeng'ba ,sifike namhlanje kusasa njeng'ba ndi-apha ngoku.

No. What happened is that the week I was supposed to be here, I went to my brother's funeral instead. There was a problem with the transport that was supposed to get us back, so we only arrived today. That's why I'm here now.

Interpreter: Awabiseza nazo na?

And did you bring them?

Patient: Andabiseza nazo ke ngoku kuba kaloku andizisebenzisanga.

No I didn't bring them because I didn't use them.

Some voice mumbled something)

Interpreter: Oh, ok. Eh, hi doctor!

Sister: Yes I'm listening, thank you.

Interpreter: She says she didn't bring them cause she didn't use them. She couldn't bring them on the day that you asked her to.

Sister: Yes. But what

Interpreter: So she didn't. She's keeping them at home, she hasn't used them yet.

Sister: Oh, she hasn't used it yet.

ADDENDUM D3

Interpreter: Yes

Sister: So can you please tell her that, as I told her, because we need them specifically..... we mark, like the few sputum jars, we mark sputum jar number 1,

Interpreter: Yes?

Sister: Today, like tonight, she must now, before she goes to bed, she must spit. Cough 1 cough, 1 spit is enough, she doesn't have to fill it up.

Interpreter: Oh, ok.

Sister: Ja, she must spit in number 1 tonight, and tomorrow morning when she wakes up, she must spit in the one that is marked number 2 irrespective, now the date will be of course a January date or another date. She must just spit for me hey number 1.

Interpreter: Ok

Sister: Tomorrow morning number 2 and then she must please bring it to the clinic tomorrow.

Interpreter: Ok I'll let her know. Hi sisi.

Patient: Yes

Interpreter: Kuthiwa ke, kucelwa uze ukhohlelele kwesi sibhalwe 1 namhlanje ebusuku.

The doctor says, she asks that you cough into the one written 1 tonight.

Patient: Ok

Interpreter: Ukhohlele kwesi sibhalwe namba 2 ngomso kusasa.

Then you must cough into the one written number 2 tomorrow morning.

Patient: Ewe

Yes

Interpreter: Uze nazo apho ekliniki okanye kwagqirha ngomso ke.

You must then bring them to the clinic or the doctor's tomorrow.

Patient: Ok

Interpreter: Um, she understands that and she'll bring it tomorrow.

Sister: Thank you very much hey.

Interpreter: It's a pleasure, ok bye.

ADDENDUM D4

Sesotho ITERPRETED SESSION

Interpreter: Hello?

Sister: Hello [...] speaking from [...] Clinic. I just want an Interpreter for this Patient who doesn't understand English, she only speaks Sotho.

Interpreter: Okay

Sister: I just want you to explain to her that she must bring the transfer letter, because she's on ARVs and then she didn't bring anything so doctor says she needs a transfer letter and now she's telling me that she was at the taxi and then she forgot her stuff at the taxi. And now she was busy phoning them but they say they don't find her stuff, so it's missing but now the doctor says she must phone the clinic that she was attending and then just to get the transfer letter because they can't do anything without the transfer letter because they need to see all the information on that letter. So you can just explain to her that she must find a way to get it or she must give us the clinic number or something like that.

Interpreter: Clinic number? Okay...

Sister: Mmmm

Interpreter: Hello, mme le kae?

Hello madam, how are you?

Patient: Re teng le kae?

I'm fine thanks and you?

Interpreter: Re teng. Wa utlwa sister o re o hloka transfer letter, lengolo le o fetisang ho tloha tleliniking eo o ne o ntse o e tsamaya ho tla moo ho bona. Wa utlwisisa?

I'm fine. The sister says you need a transfer letter, a letter that transfers you from the clinic you used to visit to come here to this one. Do you understand?

Patient: Ee

Yes

Interpreter: Ee, jwale o re ha ba kgone ho o thusa ntle le lengolo leno, eee....o tshwanetse o kgutlele ho ..ho...ho batho ba neng ba o thusa hore o fumane lengolo leno because lengolo leno le ngotswe information yohle e tshwanentseng hore ba e bale pele ba qala hore ba o thusa. Wa utlwisisa? Ba tshwanetse ho tseba hore na o no ntso fuwa meriana e feng, ba ke ke be ba qala fatshe. Wa bona?

Yes, so now she is saying that they cannot help you without that letter,eemm...you need to go back to...to...to the people who were helping you so that you can get that letter because that letter has all the information that they should read before they start helping you. Do you understand? They need to know what medication you were being given, they cannot start from the beginning. You see?

ADDENDUM D4

Patient: Ee, le taba ya pele akere ke ne ke le fuwe jwale ke ne ke ba bontshitse hore na dipidisi tse ke di sebedisang na ke difeng, ke di hlahisitse

Yes, and the first thing is that I was given the letter and I showed them the pills that I am using, I took them out.

Interpreter: No...o ba file dipidisi tseo?

No...they gave you those pills?

Patient: Ee ka di hlahisa

Yes, I produced them.

Interpreter: Wa bona leha o ba bontshitse dipidisi, lengolo le hlalosa ntho tse ngata ha le ngole dipidisi feela, wa utlwisisa? Le ngola treatment ya hao hore na e sebetsa ka tsela efeng, le Dr wa tseba hore na e ...ho ngotsweng mono, wena o ke ke wa utlwisisa ntho tse ngotsweng mono. So ba hloka lengolo leno, ntle le hore feela ba hloka dipidisi di feng, ba o fa dipidisi di feng, ba hloka le bopaki bono ba hore ba be le bona, wa bona ha ba ka o fa dintho ho...dintho tseo ba sena lengolo leo ba tla ba le bothata. Wa bona? Molao o hloka jwalo. Wa utlwisisa? Jwale ha o na nomoro ya tleliniki?

You see even if you have shown them the pills, the letter explains a lot of information, it doesn't only have information about the pills, you understand? It has information about your treatment and how it works, and the doctor knows...what is written there, you would not understand what is written there. So they need that letter, besides knowing what pills you were given they need it as evidence that they should have. You see if they were to give you things, without the letter being present, they would be in trouble. You see? This is what the law requires. You understand? So do you not have a number for the clinic?

Patient: Ntate?

Sir?

Interpreter: Haeba o na le nomoro ya tleliniki o ba fe yona. Ha o na yona?

If you have the clinic number, give it to them. Do you not have it?

Patient: Oh nomoro ya tleniki?

oh, the clinic number?

Interpreter: Ee

Yes.

Patient: Ha ke na yona kannete hobane ke ne ke di nka Steke, ke ne ke nkile le lengolo leo Steke di lahlehile ka koloing

I really don't have it because I took it from Steke, I took the letter from Steke and they got lost in the taxi.

ADDENDUM D4

Interpreter: Ha ho na motho ya nang le nomoro ya tleliniki eo o ka mo founelang?

Is there no one who has the clinic number that you can call?

Patient: A-e kannete, ha a yo kannete, ha ke na yona ntate

No really, there is no one really, I don't have it sir.

Interpreter: Ah...o tla tshwanela hore o lo le lata ausi, wa bona hore o entse bomadimabe?

Ah...you will have to go and get it sister, you see that this is unfortunate?

Patient: Oya ntate

Yes, sir

Interpreter: Okay mo fe

Okay, please give her the phone.

Sister: Hello?

Interpreter: Hi sister, she doesn't have any of those things that you need so I've told her that she'll have to go back and get to them

Sister: She doesn't have anything? But we need those things she must find out...mmm

Interpreter: I've just said that to her, she doesn't even have the clinic number...so she's gonna have to go back and get them...

Sister: Then she must phone her sister, the family that is staying close by the clinic someone who is staying close by the clinic then they can go and ask there...

Interpreter: Ya I... I already asked her about that, she is saying no...She's saying...

Sister: What is saying? She doesn't even have a family...staying that side?

Interpreter: Mmm, ya ya...ya i think so...ya

Sister: She doesn't have a family?

Interpreter: Ya

Sister: A friend...nothing?

Interpreter: Ehhhh...let me just ask her about family because I just asked her if she doesn't have a way of getting there but let me just....

Sister: A friend, or family who can go to the clinic....to find out where is the clinic and then ...there and there... so that we can do the follow up, if we can get the clinic number then we can do the follow up on our own...

ADDENDUM D4

Interpreter: Okay, eh...let me just get that one sister

Sister: Alright

Patient: Hello?

Interpreter: Ausi? Ho thwe na ha ho na le motho eo o ka mo founelang, motswalle kapa mang kapa mang feela ya tsebang tlelinike eno feela, hore a fumane phone number ya bona ke phetho. Bona ba tla ba mo founela, ba tla ba founela tleliniking ho fapana le hore wena o palame jwale o tsamaye. Wa utlwisisa?

Sister? They want to know if there no one that you can call, a friend or anyone who can go to the clinic, to get the phone number, that's it. They will call, they will call the clinic instead of you having to go all that way. You understand?

Patient: Oh

Yes

Interpreter: Ha ba yo batho ba jwalo?

Is there no one like that?

Patient: Ke sa tlo sheba dinomoro tsa bona, ha ke di tsebe

I will look for their number, I don't know it.

Interpreter: Ee, haeba ho na le batho ba jwalo, sheba nomoro tseno o kope e mong hore oeee a ka mpe a fumane nomoro eno. Wa utlwisisa? O hokae hona jwale?

Yes, if there is someone like that, look for their number and ask them to please get you that number. You understand? Where are you now?

Patient: Ke Kapa, Hobatseng (not clear, in all instances)

In the Cape, at Hobatseng.

Interpreter: Eh?

Huh?

Patient: Hobatseng, tleliniking

at Hobatseng, at the clinic.

Interpreter: Tleliniking e hokae?

At the clinic where?

Patient: Ke Hobatseng

At Hobatseng

ADDENDUM D4

Interpreter: Ai ha ke utlwe ... moo o sebetsang teng ke hokae?

Ai...I can't hear...where do you work?

Patient: Ke sebetsa hona Kapa mona

I work here in the Cape.

Interpreter: Tleliniki eo o neng o e tsamaya e hokae?

Where is the clinic that you used to go to?

Patient: Ke ne ke e tsamaya Steke, ke ne ke sebetsa Steke pele

I used to go to Steke, I used to work in Steke before.

Interpreter: Iyo Steke! Hole hakana?

Oh Steke! So far away?

Patient: Ke ne ke tloha Ketane (not clear)

I went there from Ketane.

Interpreter: Ee kea utlwisisa. But haeba o no tsamaya Steke, hona le batho bao o ba tsebang ba dulang Steke akere?

Okay I understand. But if you used to go to the clinic at Steke, there are people that you know that live in Steke right?

Patient: O mong feela motho eo ke mo tsebang, jwale ke ena e ntseng ke re ke tlo sheba nomoro ya hae, ke tla mmotsa hore na wa e tseba na

There is only one person that I know and that is the person whose number I'm saying I will look for, I will ask him/her if she knows it.

Interpreter: Oh okay, e shebe hee kgaitsemi ya ka, o tsebe ho fa bo-sister hobane ha ba e fumana ba tla tseba ho o thusa ba tla tseba.

Oh okay, please look for it my sister, so that you can give it to the nurses because when they get it they will be able to help you.

Patient: Ooya ntate.

Yes sir.

Interpreter: Okay, mo fe hee

Okay please give her.

Sister: Hello?

ADDENDUM D4

Interpreter: Hello sister, eh ya she gonna... ya she says there's one person that she knows in Sterkspruit that can try and and ehh...get the number for her but she still gonna search for her number, I think on the cellphone

Sister: Mmm... does she going to do it today or when? Because she must...

Interpreter: Ya she must do it now, now

Sister: Mmm now she's gonna do it now of who?

Interpreter: Ya....eh I told her when she gets the number she must phone that person of if she doesn't have the money she must go and get airtime and then make sure that she gets the number so that you can help her, you see it's her problem...not more than yours...you see

Sister: Mmm...okay, okay thank you

Interpreter: Okay thanks sister bye

Sister: Bye

ADDENDUM D5

Sesotho interpreted session

Interpreter: Hello

Doctor: Good morning sir, I've got a Sotho speaker here at the clinic and we cannot speak to her, she's here to do her antenatal booking so we would like to ask her a few questions and maybe inform her about the treatment process now...

Interpreter: Okay

Doctor: Her name is [...] neh?

Interpreter: Okay

Doctor: She's here because she's pregnant

Interpreter: Mmh

Doctor: So we want to know from her...can I ... are you gonna write out all the questions and just give me feedback? Because it's going to take longer if we do it one by one, because it's a whole list.

Interpreter: Okay okay I'll write them down...yes

Doctor: Okay

Interpreter: Yes?

Doctor: I want to know how many times is this now the pregnancy. Is it second, third, fourth child?

Interpreter: Okay

Doctor: And then I want to know if she has she had any miscarriages?

Interpreter: Okay

Doctor: And then I want to know the babies that she had, in which year they were born

Interpreter: Okay

Doctor: Were they born in the full 9 months, or were they small or big?

Interpreter: Okay

Doctor: Did she have any problems during those pregnancies?

Interpreter: Okay, did she have?

Doctor: Any problems, any sicknesses during those pregnancies...

Interpreter: Okay

Doctor: Then, does anyone in her family or in her house now have TB or sugar?

ADDENDUM D5

Interpreter: TB or sugar

Doctor: Yes, and then what was the last menstrual date, like when was the last time to see her period?

Interpreter: last menstrual...ok

Doctor: And then if she has a choice, if she would like to breastfeed or bottle feed

Interpreter: Okay

Doctor: And then if she finishes this pregnancy, is she ready to do a sterilisation or is she going to use injection for prevention?

Interpreter: Okay that's fine

Doctor: Okay that is the first part, I'm giving the phone to her neh?

Interpreter: ...or injection or sterilisation...

Patient: Hello? Ke [...]

Hello? It's [...].

Interpreter: Hello, ausi [...], ok sister o batla ho tseba hore na o na le...o bile.. na o imme makgetlo a makae?

Hello ausi [...], ok the sister wants to know how many times you have been pregnant.

Patient: Makgetlo a makae..ke imme makgetlo a makae?

How many times...how many times have I been pregnant?

Interpreter: Ee

Yes

Patient: Ke imme makgetlo a makae?

How many times have I been pregnant?

Interpreter: Ee

Yes

Patient: ka January

In January

Interpreter: A-e bophelong ba hao

No, in your life

ADDENDUM D5

Patient: Bophelong ba ka?

In my life?

Interpreter: Mm

mm

Patient: Esale ke ima?

Since I got pregnant?

Interpreter: O imme makgetlo a makae hore na o bile le bana kapa o...?

How many times have you been pregnant, have you had children ... or...

Patient: Oohh oo a mabedi

Oh! Twice.

Interpreter: A mabedi?

Twice?

Patient: Ee

Yes

Interpreter: Makgetlo a mabedi, two. Bana ba phetseng ba ba kae?

Two times, two.. How many children lived?

Patient: Ba babedi

Two

Interpreter: Ba teng?

Are they there?

Patient: Ee ba teng.

Yes they are.

Interpreter: Okay

Interpreter: Okay, eh...ha u ka ba wa senyhelwa haesale?

Okay, have you ever had a miscarriage?

Patient: E-e

No

ADDENDUM D5

Interpreter: Okay. ke ba lemo dife?

Okay, which year were they born?

Patient: E mong ke wa 2005

One was born in 2005

Interpreter: Kwa?

Interpreter: When?

Patient: O lemo ke wa...di hlano, enwa e mong o lemo di pedi.

She/he is...she/he is 5, the other one is 2.

Interpreter: Okay wa ... o re ke wa 2005?

Okay ... you say 2005?

Patient: Ee

Yes

Interpreter: E mong o lemo di pedi?

The other one is 2 years old?

Patient: Ee

Yes

Interpreter: E mong ke wa 2000 and...2011?

The other one was born in 2000 and... 2011?

Patient: Ee

Yes

Interpreter: Eeehhh ha ba ne ba hlaha...

So when they were born...

Patient: Hmm? Ha ke utlwe?

Hmm? I can't hear?

Interpreter: Ba hlahile ka nako difeng, ba hlahile ka kgwedi di feng, ke hore...o no na le nako e kae ha o pepa, o no na le kgwedi tse kae ha o pepa?

At what times were they born, which months were they born in, I mean...how far were you when you gave birth, how many months were you when you gave birth?

ADDENDUM D5

Patient: Aa enwa e mong o moholo, o hlahile pele ho enwa

No, this other one is older, she/he was born before this one...

Interpreter: A-e butle, ha o le moimana o pepile ka kgwedi ya bokae ho eo ya moholo?

No wait, when you were pregnant at which month of your pregnancy did you give birth to the elder one?

Patient: Hmm kea lebala a tseba

Mmm I can't remember

Interpreter: Okay o mo pepile ka nako? Haa hlaha pele ho nako?

Okay, did you give birth on time/full term? Was he/she not born before time?

Patient: A-e haa hlaha pele ho nako.

No, he/she was not born before time/premature.

Interpreter: Ba hlahile ka nako ba le babedi?

Were they both born at full term?

Patient: Ee

Yes

Interpreter: And then ehhh...ba ne ba le baholo kapa ba ne ba le banyane?

And then...were they big or small?

Patient: Ba ne ba le banyane

They were small

Interpreter: Ba ne ba le ka tlase ho boima bo lebelletsweng?

Were they smaller than the expected weight?

Patient: Eee ene bana ba hantle feela, ke hore bane ba lekane hantle feela

No they were just fine, I mean, there were just the right size.

Interpreter: Ba ne ba lekane? Normal?

They were just the right size, normal?

Patient: Ee

Yes

ADDENDUM D5

Interpreter: Okay, okay o la ba le mathata ha o imme?

Okay, did you have any problems while you were pregnant?

Patient: Ha ke etsang? Ha ke...

When I did what?

Interpreter: Ha o ntso le moimana o la ka ba le mathata?

While you were pregnant, did you have any problems?

Patient: Ee ha ke le moimana ke ile ka ba le mathata ka enwa e monyenyanane enwa ka robaha leotong

Yes, when I was pregnant I had problems with the smaller one, I broke my leg.

Interpreter: Oh feela? Eseng mathata a boimana?

Oh that's it? Not pregnancy problems?

Patient: A-e

No

Interpreter: Okay hona le batho ba nang le tswekere kapa TB lapeng la hao?

Okay, are there people with sugar or TB at your house?

Patient: Ee, mme wa ka o na le high blood eseng TB

Yes, my mother has high blood, not TB.

Interpreter: A-e eseng high blood, tswekere kapa TB, hadiyo bobedi ba tsona?

No, not high blood, sugar or TB, both are not there?

Patient: Ee

Yes

Interpreter: O qetetse ho ya matsatsing neng?

When last did you go on your periods?

Patient: ka January

In January

Interpreter: ka January

In January

Patient: Ee

ADDENDUM D5

Yes

Interpreter: Date ha o e tsebe?

You don't know the date?

Patient: A-e date ha ke e tsebe

No, I don't know the date.

Interpreter: Ha o ba le ngwana o batla ho mo nyantsha kapa o batla ho mo fa tami?

When you have your child do you want to breastfeed or give him/her the bottle?

Patient: Ke batla ho mo fa tami

I want to give him/her the bottle

Interpreter: Okay, then ha o batla ho thibela pelehi kamora moo o tla batla ho hlaba ente kapa o tla batla ho ho etsa, ho kgaotsa ho hang, o tla batla opareishene e thibelang ho hang, e qetang ho hang?

Okay then, when you want to prevent pregnancy after this will you want to use the injection or will you want to stop completely, will you want an operation that prevents it completely, which stops it fully?

Patient: Ke tla batla ho hlaba ente

I will want the injection.

Interpreter: Okay o tla batla ho hlaba ente?

Okay, you will want the injection?

Patient: Ee

yes

Interpreter: Okay oko mo fe eona hee ausi.

Okay, please give her the phone.

Patient: Okay

Doctor: Hello?

Interpreter: Okay she's had 2 pregnancies and she delivered 2 kids, normal...

Doctor: Full nine months?

Interpreter: Sorry?

ADDENDUM D5

Doctor: Full 9 nine months?

Interpreter: Full terms ya and there were no miscarriages, and the one was born 2005 the small one 2011, and uhh...

Doctor: any problems during the pregnancy?

Interpreter: they were normal size, full term okay... and only during the second pregnancy, did she... it was not pregnancy related, she broke her leg...and she hasn't had any pregnancy problems like I said. And in her family there is nobody with sugar or TB problems, only high blood, her mother has high blood. And then ehhh she last had her menstrual period in January, she's not sure of the date and then when she gets the baby she would like to bottle feed and then she would like to use the injection for prevention...

Doctor: Okay that's the first part, thank you very much. The second part is, someone talked to her yesterday and in some way explained to her about HIV and AIDS and they informed her about her status and I would like to know if she understands and what she is telling you about her status. Because we now know the status but I'm not sure if she knows.

Interpreter: Okay, okay, whether she knows? Just that? Just that?

Doctor: Yes, I want to be sure if she knows.

Patient: Abuti?

Yes brother?

Interpreter: Okay, ho thoe o entswe test ya HIV akere?

Okay you did an HIV test right?

Patient: Ee

Yes

Interpreter: Jwale ho thwe na o tseba status sa hao?

Now they want to know if you know your status?

Patient: Ee, kea tseba

Yes I know it.

Interpreter: Wa tseba?

You know it?

Patient: Ee

Yes

ADDENDUM D5

Interpreter: Okay, oko mo fe

Okay give her

Patient: Ke mo fe?

Should I give her?

Interpreter: Ee

Yes

Doctor: Hello?

Interpreter: Yes she says she knows about it

Doctor: That she's HIV positive?

Interpreter: Well I didn't ask...

Doctor: Well I want to know

Interpreter: Okay let me ask her again

Patient: Abuti

Yes brother?

Interpreter: Ho thwe na wa tseba hore o HIV positive kapa tjhe?

They are asking if you know whether you are HIV positive or not?

Patient: Ke etsang?

I'm what?

Interpreter: Ho thwe o wa tseba hore na o positive kapa o negative?

They are asking if you know whether you are positive or negative?

Patient: Ee, ke HIV, ke na le yona nthweo, hana ho thoe keng?

Yes...HIV, I have that thing, what's it called again?

Interpreter: Positive?

Positive?

Patient: Ee

Yes

Interpreter: Okay, oko mo fe

ADDENDUM D5

Okay, please give her

Patient: Ke mo ne?

Should I give her?

Interpreter: Ya

Yes

Doctor: Hello

Interpreter: I didn't want to ask her about her status, but she she like,...you said I should ask, she says she knows that she's positive.

Doctor: Okay, well now the problem is now that she's HIV positive, I gave her a packet of tablets yesterday and this is to prevent the baby from getting the virus from her

Interpreter: Yes

Doctor: So I would like her to make sure that she takes that treatment tablets every day until the pregnancy is finished, in the morning and in the evening, so can you please tell her that?

Interpreter: Okay

Patient: Abuti?

Yes brother?

Interpreter: Ok wa utlwa ho thwe hobane jwale ka ho imme, hore ngwana a tla ska fumana HIV a tla hlahe a sena yona o tshwanetse ho nwa dipidisi tseno hoseng le...mantsiboya

Ok you hear they say as you are pregnant, in order for the baby not to get HIV, for him/her to be born without it you have to take those pills in the morning and evening.

Patient: Ha ke qeta ho ja?

After I eat?

Interpreter: Eh?

huh?

Patient: Kamora dijo kapa pele ho tsona?

After meals or before them?

Interpreter: Eh...ke tla mmotsa, ke tla mmotsa mono, feela o tshwanetse hore o di nwe hoseng le mantsiboya ho fihlela o qetile treatment eno

Okay I will ask her, but you must take them morning and evening until you finish the treatment.

ADDENDUM D5

Patient: Okay

Okay

Interpreter: Ako mo fe hape moo ke mmoitse

Please give her the phone so I can ask her.

Interpreter: Sister she wants to know if it's before or after meals

Doctor: It doesn't matter, she can take it only with water.

Interpreter: Okay

Doctor: The other thing is today we are going to draw the blood, the sister already took the blood, the blood that we draw is for CD4 count. Okay?

Interpreter: Okay

Doctor: If the CD4 count is low, you must tell her we maybe going to refer her to start the treatment, for HIV the ARVs. So the sister will give her an appointment date to come back next week, to check to come and check the results. Okay?

Patient: A reng?

What did she say?

Interpreter: A re ho wena ha ho na lebaka na o di nwa pele ho dijo kapa kamora dijo, ha ho na lebaka. Ha feela o di nwa. O di nwe ka nako e le nngwe. Ha o di nwa ka 7 o di nwe ka 7 mehlaena.

She says that it doesn't matter when you take them whether it is before or after meals, it doesn't matter. As long as you take them. You should take them at the same time. If you take them at 7, take them at 7 everyday.

Patient: Oh

Okay

Interpreter: Ha o di nwa mantsiboya ka 6 kapa 7 o di nwe ka 6 ka 7 o ska chenza dinako. Nako e tshwanang hoseng, nako e tshwanang mantsiboya. Ee, pele kapa kamora dijo

If you take them at 6 or 7 in the evening, take them at 6 or 7 don't change the times. The same time in the morning, the same time in the evening. Yes, before or after meals.

Patient: Oh

Okay

Interpreter: Ee, jwale o hutswe madi kajeno?

Yes, so you had blood drawn today?

ADDENDUM D5

Patient: Ee

Yes

Interpreter: Jwale madi ano a tlo etswa ntho eo ho thweng ke CD4 count.

Ok so a CD4 count will be done on that blood.

Patient: Ee

Yes

Interpreter: Kamora yona ba tla sheba haeba CD4 count ya hao ele tlaase ba tla o fetisa hore o lo fumana treatment ya... ya... ya... ya...ya HIV

After that they will check and if your CD4 count is low they will refer you to get treatment for...for...for...for HIV

Patient: Oh

Oh

Interpreter: Ee, mo fe yona hee

Yes, please give it to them

Patient: Oh

Oh

Doctor: Hello

Interpreter: Hello sis, I've explained to her

Doctor: Okay then the last thing. The sister is going to give her a book neh? A pregnancy book, antenatal book. If she gets any bleeding or she starts the onset of labour, the pains and stuff like that she must take the book and go straight to Stellenbosch Hospital.

Interpreter: Okay

Interpreter: Ausi? Eehh ok Diresults ba tlo o fa tsona next week akere?

Sister? Eehh oka, they will give you the results next week okay?

Patient: Oh

Oh

Interpreter: Jwale o tlo fuwa buka, hona le buka e ba tlo o fa yona ya ho tsamaya tleliniking. Jwale ha o ka bona ho ba le madi a tswang, ha o ka bona madi kapa nthoe e nngwe e o belaetsang o nke buka eo o ee tlelinikeng ya Stellenbosch hang hang.

ADDENDUM D5

Now you will be given a book, there is a book that they will give you for visiting the clinic. So when you see some blood coming out, if you see the blood or any other suspicious thing you should take the book and go to the Stellenbosch clinic at once.

Patient: Stellenbosch? Jwale ke tle tleliniking la bo kae?

Stellenbosch? So on which day should I come to the clinic?

Interpreter: Ee, ke tla mo botsa. A ko mo fe ke mo botse

Yes, I will ask her. Please give her the phone so I can ask her.

Doctor: Hello?

Interpreter: Sister I've explained to her and she wants to know what day she must come to the clinic

Doctor: The book that sister is going to give her now, tell her I'm going to show her now, the sister will write the date there. Ok? And then, tell her that we do not agree with the date that she is giving us for the period, because according to us she's already almost 6 and a half months pregnant and we think this baby might come around the 18th of July.

Interpreter: Okay

Doctor: Neh? She will deliver around the 18th of July, so we don't think that her date is correct.

Interpreter: Okay,

Patient: Abuti?

Brother?

Interpreter: Ausi? ho mmmm..thwe ke o jwetse hore letsatsi la hore o tla tla neng le tla ngolwa bukeng eo ya hao. Ha u qeta tsatsing lena o tla tseba na o tla neng hape. Hape nthwengwe eo ho thweng ke o jwetse ke hore letsatsi le o faneng ka lona la hore na o qetetse neng ho ba le diperiod tsa hao ho thwe le bonahala le fosahetse hobane ho thwe ngwana o bonahala a lebelletswe hore a kanna hlaha ka li 18 tsa July.

Sister? She says I should tell you that the day for you to come will be written in your book. When you finish today you will know when you are coming again. And another thing that I have to tell you is that the day that you gave as the last day you had your period seems to be wrong because they say the child appears to be expected to be born on the 18th of July.

Patient: Li 18 tsa July? Tjo

The 18th of July? Wow.

Interpreter: Ee, so date eo o buwang ka yona ho bonahala e le morao, kea kgolwa ho la ba le diperiod tse ding tse o sa hlokomelang hore ha o ba le tsona.

ADDENDUM D5

Yes, so the date that you mentioned seems to be behind, maybe there were periods that you did not realise you had.

Patient: Mmmm...eee

Mmmm...yes

Interpreter: Ako mo fe...

Please give her.

Doctor: Hello?

Interpreter: Sister you said the July isn't it?

Doctor: Yes, 17 July.

Interpreter: Okay I told her. I told her.

Doctor: Now can you please ask her if she has any questions other than what we already told her.

Interpreter: All right. Ho thwe na o na le dipotso tse ding hape ausi

Interpreter: All right. They are asking if you have any other questions sister.

Patient: Dipotso?

Patient: Questions?

Interpreter: Ee, na ho na le letho le o batlang ho le tseba ho fapana ...kantle ho dintho tse re buileng ka tsona

Interpreter: Yes, is there anything that you want to know besides...besides the things that we spoke about.

Patient: A-e

Patient: No

Interpreter: Ha ho na letho?

Interpreter: There is nothing?

Patient: Ee

Patient: Yes

Interpreter: Okay, ako mo fe.

Interpreter: Okay, please give her.

Doctor: Okay that's it thank you my friend.

ADDENDUM D5

Interpreter: Okay thanks sister

Doctor: Bye bye

Interpreter: Bye

terpreter: Bye