INTERPRETING WITHIN THE WESTERN CAPE HEALTH CARE SECTOR: A DESCRIPTIVE OVERVIEW

Bernice Saulse

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Supervisor: Dr Harold M. Lesch
Cosupervisor: Prof. Ilse Feinauer

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DECLARATION

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

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ABSTRACT

Over the past decade many studies have shown that ad hoc interpreting services are still the norm for the health care sector in the South African context. The health care sector of South Africa, specifically in the Western Cape, is characterised by primarily Afrikaans- and English-speaking doctors, or medical practitioners in general, who do not understand Xhosa-speaking patients. In order to bridge this language gap, ad hoc interpreting services are employed, which are rendered by family members of a patient, nurses, or at times, even by porters or cleaners. As a result of the fact that these ad hoc interpreters lack training in interpreting theory and practice, they tend to distort communication, which impact negatively on the quality of the health care that the patient receives. This consequent lack of quality in health care can therefore directly be related to the quality of the interpreted utterances or product that the interpreter renders. Even though ad hoc interpreters are generally more used in the health care sector, some hospitals employ professionally trained interpreters to relieve the burden of a language barrier.

In 1996, due to the erratic nature of health care interpreting services and language barriers between medical practitioners and patients, the National Language Project trained 22 community interpreters to be placed in hospitals within the boundaries of the Western Cape. Three of these interpreters were placed at Tygerberg Hospital, three at Groote Schuur Hospital, and three at Red Cross War Memorial Children's Hospital. By 2008 none remained in Tygerberg Hospital, one was still employed by Groote Schuur Hospital, and two employed by Red Cross War Memorial Children's Hospital.

In 2007, Groote Schuur Hospital identified a need to train and place interpreters within the hospital, due to the language barrier between medical practitioners and patients, as well as to optimise health care. These trainees were formerly employed by the hospital in positions such as cleaners. Even though they were then professionally trained, they were still remunerated as cleaners, for example. In addition to the two interpreters employed at Red Cross War Memorial Children's Hospital, another interpreter was employed on a full-time basis. Some departments within the hospital make use of their own interpreters, who are not employed by the hospital. Tygerberg Hospital has one officially employed interpreter who is a nursing assistant by profession, and who has received no training in interpreting whatsoever.

The aim of this study was firstly to investigate interpreting practices within these three tertiary hospitals, and secondly to investigate the quality of the interpreted product delivered by the interpreters at these hospitals, whether on an ad hoc basis or as professionally trained interpreters.

The outcomes of the quality of the interpreted product, measured against a quality table, were compared with the attitudes of medical practitioners, interpreters and patients present in an interpreting session. This was done to determine whether the actual quality of the interpreted product took precedence over the attitudes of the role players, or vice versa.

OPSOMMING

Oor die afgelope dekade het ’n aantal studies aangedui dat ad hoc-tolkdienste steeds die norm vir die gesondheidsektor binne die Suid-Afrikaanse konteks is. Die Suid-Afrikaanse gesondheidsektor, veral in die Wes-Kaap, word hoofsaaklik gekenmerk deur Afrikaans- en Engelssprekende dokters, of mediese praktisyns oor die algemeen, wat nie hul Xhosa-sprekende pasiënte verstaan nie. Om hierdie taalgaping te oorbrug, word ad hoc-tolkdienste gebruik wat gelewer word deur ’n pasiënt se familielede, verpleegsters en soms selfs portiers of skoonmakers. Omdat hierdie ad hoc-tolke geen opleiding in tolkteorie en -praktyk ontvang het nie, is hulle geneig om kommunikasie te verdraai. Dit lei daartoe dat die gesondheidsorg wat die pasiënt kry, nie na wense is nie. Die gebrek aan kwaliteit van die gesondheidsorg wat die pasiënt ontvang, hou dus direk verband met die kwaliteit van die tolkuitinge of -produk wat die tolk lewer. Ten spyte daarvan dat ad hoc-tolke meer algemeen in die gesondheidsektor gebruik word, het sommige hospitale tolke aangestel wat professioneel opgelei is om die taalgaping te verminder.

As gevolg van die wisselvallige gehalte van tolking in die gesondheidsektor en taalgapings tussen mediese praktisyns en pasiënte, het die National Language Project (NLP) in 1996 22 gemeenskapstolke opgelei wat in hospitale binne die Wes-Kaap geplaas sou word. Drie van hierdie tolke is by die Tygerberg Hospitaal geplaas, drie by die Groote Schuur Hospitaal en drie by die Rooikruis Kinderhospitaal. In 2008 was daar nie meer een van hierdie tolke by die Tygerberg Hospitaal nie, een was steeds in diens by die Groote Schuur Hospitaal en twee by die Rooikruis Kinderhospitaal.

In 2007 het die Groote Schuur Hospitaal ’n behoefte geïdentifiseer om tolke op te lei en binne die hospitaal te plaas omdat daar ’n taalgaping was tussen mediese praktisyns en pasiënte, asook om gesondheidsorg te optimaliseer. Hierdie persone wat opleiding ontvang het, was voorheen in diens van die hospitaal as byvoorbeeld skoonmakers. Selfs nadat hulle professionele tolkopleiding ontvang het, het hulle steeds besoldiging as skoonmakers ontvang. Buiten die twee tolke wat by die Rooikruis Kinderhospitaal in diens is, is nog ’n tolk voltyds aangestel. Sommige departemente binne die hospitaal gebruik hul eie tolke wat nie deur die hospitaal aangestel is nie. Tygerberg Hospitaal het een amptelike tolk, wat eintlik ’n verpleegassistent is, en wat hoegenaamd geen tolkopleiding ontvang het nie.

Hierdie studie het dit ten doel om tolkpraktyk eerstens binne bogenoemde drie tersiêre hospitale te ondersoek, en tweedens om die kwaliteit van die tolkproduk by hierdie hospitale te ondersoek, hetsy die opleiding op ’n ad hoc- of professionele basis geskied het. Die kwaliteit van die tolkproduk, gemeet teen ’n kwaliteitstabel, is vergelyk met die sienswyses van die mediese praktisyns, tolke en pasiënte wat teenwoordig was in ’n tolksessie, om te bepaal of die kwaliteit van die tolkproduk voorkeur geniet het bo die sienswyses van die rolspelers, en omgekeerd.

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"*This is not about the language of the elite; it is about people in villages who put their sick in wheelbarrows to take them to a doctor who doesn't understand them. It's not only about the right to speak your own language; it's about life and death.*"

- Prof Russel Botman at the opening of the interpreting venue of the Stellenbosch University (2007) -

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CHAPTER 1

INTRODUCTION

1.1 Background

Over the past decade numerous South African researchers have indicated that the health care sector is characterised by disorganised interpreting practices, language barriers between patient and medical practitioner, and a consequent compromise on quality health care. The vision of the Department of Health is *"*Equal access to quality care*"*. However, this remains a vision: on ground-roots level patients are denied quality care due to a language barrier. Interpreting services can be rendered by both professionally trained interpreters and ad hoc interpreters. When either of these two types of interpreters is used in a consultation with the medical practitioner, the main aim will be to get the correct and relevant message across to both patient and medical practitioner. Whether that message gets across as intended, indicates the quality of the interpreted product.

1.2 Objectives

The main purpose of this study is therefore:

- To describe interpreting practice within the health care sector of the Western Cape with specific reference to the availability of interpreting services;
- To investigate the quality of the interpreting services at tertiary-level medical institutions within the Western Cape, namely Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital[1]; and
- To determine the attitudes of the participants in the interpreting session towards the interpreting product.

In addition, this study also aims to determine to what extent the quality of the interpreting product assists in quality health care.

[1] See Addendum I for letters of approval to conduct the research.

This study differs from that of Williams (2005) in that she focuses on the sociological aspect of health care interpreting, whereas this study focuses on the linguistic aspect of health care interpreting that is based on interpreting theory.

1.3 Overview of the Western Cape

The Western Cape is one of the nine provinces within the Republic of South Africa. Cape Town is the capital of the Western Cape and also the legislative capital of South Africa. This city is home to the Western Cape Provincial Parliament, which is responsible for promulgating laws to which the province should abide. These laws should be drafted within the parameters of the province as contained in the Constitution of South Africa.

The Western Cape province has approximately 4,2 million residents. According to statistics obtained from the 2001 census, the racial distribution within the province is as follows: Coloured (53,9%), Black African (26,7%), White (18,4%) and Indian/Asian (1,0%). Since the adoption of the new democratic constitution in 1996, South Africa has eleven official languages. The official languages within the Western Cape are Afrikaans, English and Xhosa. Although English is the main language generally used in business and governmental structures throughout the country, the majority of residents in the Western Cape is Afrikaans-speaking (Statistics South Africa). Within this province 2,5 million residents are Afrikaans home language and first language speakers. This constitutes 55,3% (or more than half) of the population of the Western Cape. Xhosa, spoken by 1,1 million residents in the Western Cape, represents the second largest language of this province and 23,7% of the Western Cape population. English is spoken by only 875 000 residents, which amounts to 19,3% of the Western Cape population (Statistics South Africa).

1.4 Legislation regarding Language

Since the Interim Constitution (1993) of a democratic South Africa came into effect, the two formerly official languages of the country, namely Afrikaans and English, were supplemented with nine more indigenous languages, making South Africa a truly multilingual and subsequently multicultural country. The reality is that South Africans communicate daily with fellow citizens who do not understand the language they speak. This creates a situation where fellow South Africans do not understand each other effectively. In other countries,

such as America, the citizens do not understand *foreigners* in their country (Pienaar, 2006). The constitution of South Africa required each provincial legislature to adopt their own constitution, not only to meet the specific needs of the province, but also to reflect the values contained in the national constitution. This led to the adoption of the Constitution of the Western Cape in 1998[2].

Clause 2(1) of the Western Cape constitution states that there should be "a progressive realisation of the equal status of Afrikaans, English and Xhosa". This constitution gave rise to the Western Cape Languages Act (Act 13 of 1998). Clause 4(2)(a) of this Act states that all residents of the Western Cape may use Afrikaans, English or Xhosa in any communication (situation) at any institution within the Western Cape Provincial Government, and they should be served in any of these three languages (Afrikaans, English or Xhosa) insofar it is possible for the specific institution to render their services in that specific language (Clause (2)(b)).

Government, whether provincial or national, is not the only official body in South Africa that has to regulate the equal treatment of all its official languages. The Pan South African Language Board (PanSALB) was established in 1995 (Act 59 of 1995 as amended) to "[create] conditions for the development and equal use and enjoyment of all the official South African languages". The values of PanSALB confirm their respect and equal treatment of all languages in South Africa, and nondiscrimination on the basis of language[3]. Whilst government should "regulate and monitor" the use of the official languages, whether in the entire country or a specific province, PanSALB should proactively promote and create conditions for the official languages to be developed and used.

Thus, a number of statutory bodies, laws and acts exist to ensure that all the official languages in the country (and specifically Afrikaans, English and Xhosa in the Western Cape) enjoy equal status and that citizens, regardless of the language they speak, be treated equally. However, the policy is a reflection of the ideal situation and is not always implemented in practice.

[2] http://wcpp.gov.za (19/02/2007)
[3] http://www.pansalb.org.za/pansalbhistory.html (18/01/2008)

1.5 Language Situation within the Health Care Sector

In the political dispensation prior to 1994, Afrikaans and English were the only two official languages of the Republic of South Africa. This led to the marginalisation of the African languages and speakers of those African languages. As a result, a large part of South Africans was therefore denied access to power and basic human rights in the legal, health care, education and economic sectors, as well as state bureaucracy[4]. In the new dispensation (after 1994) these imbalances across culture, language and race, had to be corrected. One method by means of which such gaps could be bridged in a multicultural society where linguistic and other rights should be maintained, is to employ interpreters, since they are integral in communication across linguistic and cultural barriers (Erasmus, 1999:vii).

With regard to the health care sector specifically, the majority of doctors do not speak African languages, and effective interpreting services have not been introduced to this domain (Ntshona, 1999:144). Over the past decade this situation has not changed. Where there are no proper interpreting services to facilitate communication between a health care provider and a patient, it will lead to a degree of miscommunication and disempowerment. The service rendered will only be a disadvantage for the patient because the patient's access to information and help is blocked effectively (Pienaar, 2006:44). Dr André Muller[5] suggested that "[i]f a doctor cannot speak to his or her patient, or the patient cannot properly convey their problem or medical history because of the language barrier, treatment [of a patient] could be compromised" (Cape Argus, 19 April 2004, pg. 6).

The Western Cape Department of Health is one of the largest departments in the province (Williams 2005:31). However, within the health care sector in the Western Cape, Xhosa-speaking patients are marginalised, even though the Western Cape Provincial Health Plan of 1996 states that "patients have the right to be addressed, at all provincial health facilities/services in any one of the three official languages of the province" (Ntshona, 1999:144). This Plan also stipulates that personnel who deal with the public directly will be appointed after consideration of their proficiency in the three official languages of the Western Cape.

[4] Kader Asmal's address at an Annual General Meeting of the National Language Project in June 1994.
[5] Senior Clinical Executive Officer at Tygerberg Hospital during the time that the hospital trained 25 interpreters in 2004, in association with the University of the Western Cape.

In 1993 and 1994 the now defunct National Language Project (NLP)[6] found that there was a communication crisis in the health services in the Western Cape (Ntshona, 1999:145). The providers of the health care services spoke only English and Afrikaans to the detriment of Xhosa-speaking patients who did not understand them (Ntshona, 1999:145-146). There were no professional interpreters employed. Subsequently, nurses or general assistants, and at times even relatives of the patients, were used as interpreters (Ntshona, 1999:146). This resulted in Xhosa being regarded as substandard and not as important as the other two languages (Crawford, 1994:6, as cited in Ntshona, 1999:146).

Therefore, by 1993 and 1994, it was evident that there was a language barrier between medical staff and patients within the Western Cape health care sector. These language barriers impact negatively on the quality of patient care (Schlemmer, 2005). Where language barriers exist, patient satisfaction reduces, return visits to medical facilities decrease and adherence to medication that has to be taken on a continuous basis shows a decline (Schlemmer & Mash, 2006:1084). Studies undertaken since 1994 such as Fisch (2001), Williams (2005), Pienaar (2006), Levin (2006), Schlemmer (2005) and Schlemmer & Mash, 2006) indicate that the situation has not changed. According to Williams (2005:80) there is a significant gap in communication in the public health facilities where more untrained interpreters are used, whereas a lesser gap is experienced in health facilities where officially trained interpreters are employed.

Literature has shown that making use of trained interpreters is more satisfactory than employing untrained interpreters or having no interpreters at all (Wood 1993, as cited in Schlemmer, 2005). The need for interpreters in health care is essential to assist the patient in understanding their problem, as well as allowing the doctor to appropriately manage and understand the patient (Fisch, 2001:114). During the 90's the NLP trained several liaison interpreters to work in the health care sector specifically (Ntshona, 1999:144), but this did not become the trend. South African governmental hospitals simply do not use interpreters, as said by Pienaar (2006:38), and interpreting is rendered by anyone who is bilingual and available. According to Lesch (2005, as cited in Schlemmer, 2005:3) "the situation has not changed dramatically if one looks at the statistics".

[6] A nongovernmental organisation (NGO) based in Cape Town.

1.6 Quality and Interpreting

At a congress in 1990 (*Die Burger*, 30 May 1990:2), Dr Hannah-Reeve Sanders[7] said that interpreting in health services is as important as interpreters within the legal practice. However, medical interpreters can take on many forms: from the nurse who is bilingual and has knowledge of medical terminology to the trained interpreter who has been skilled in theory of interpreting, as well as advocacy and cultural brokerage. But it is the untrained interpreter that one comes across most often (Gile, 1995:38).

To a nonspecialist observing the profession it may seem as if the quality of the interpreting service of the unqualified interpreter is not as good as that of the qualified interpreter. Also, the qualified interpreter may be remunerated at a higher rate than the unqualified interpreter, e.g. a nurse will not receive any payment for interpreting duties performed because it is often performed as an extension of her work. A higher remuneration implies a higher status. Professional interpreting differs from ad hoc interpreting in that it is a "[…] professional act of communication […] subjected to professional rules [and] particular rules relating to communication" (Gile, 1995:22). If there is ad hoc interpreting within an institution, it could have an enormous impact on the interpreting relationship. Nurses or cleaners, even family members, will each interpret a communication setting differently. For this reason, ad hoc interpreting services further complicates the position of health care interpreters and what is expected from them (Fisch, 2001:127).

Health care interpreting differs from other types of interpreting, since the participants come from different cultures and classes, and speak different languages. Consequently, health care interpreters should also be cultural brokers, mediators and explicators (Kaufert & Putsch, 1997:75, as cited in Angelelli, 2004:17). Interpreting takes place within a communication situation and based upon their differences the interpreter, patient and medical practitioner will each have their own viewpoint on the quality of the interpreting product (Gile, 1995:24,33). The unequal quality between the product of trained and untrained interpreters stems from power inequities which relate to gender, class, ethnicity and religion, and not necessarily from the communication situation (De Ridder, 1999, as cited in Fisch, 2001: 138).

[7]Head Director of Hospital and Health Services of the Cape Provincial Administration.

Notwithstanding the abovementioned, some underlying quality criteria exist that can be applied universally to the different participants. These criteria are **ideational clarity** (the message of the sender should be clear and understandable to the receiver), **linguistic acceptability** (the interpreter should use grammar which is acceptable for the situation and to other participants) and **terminological accuracy** (the interpreter should use the correct target language (TL) equivalent for medical terms in the source language (SL) (Gile, 1995:34). Even though these common criteria exist "…the actual assessment of quality depends inter alia on the specific needs of the [participants], and suggests that although common quality criteria do exist, actual overall quality assessment can vary significantly in any given context for this very reason" (Gile, 1995:38).

In order to reach these common criteria underlying the quality of the interpreting situation, the interpreters employed should receive proper training in interpreting theory and practice. Gile (1995:3) notes that when interpreters are properly trained their performance will be executed to the best of their abilities and their skills will develop at a faster pace. He also states that the theoretical components of interpreting have a strong explanatory power and can help an interpreter in understanding phenomena, difficulties and strategies in the interpreting situation (Gile, 1995:13). According to Komissarov (1985:208, as cited in Gile, 1995:13) "[i]t cannot be denied […] that [interpreting] theory is supposed, in the final analysis, to serve as a guide to [interpreting] practice".

Interpreting theory forms a basis and sets a standard to which interpreters should adhere. Even the most basic aspects of interpreting theory will cross the divide between trained and untrained. A doctor is not a doctor unless he/she has the imbedded universalistic rules or knowledge of how to practice medicine. Similarly, an interpreter who does not have the imbedded universal rules or knowledge of the interpreting practice is not an interpreter. However, this should not represent a one-sided analysis that only takes into account the qualities of the interpreter. Should the user of the interpreting service not understand the role of, or know what to expect from the interpreter, this would constitute a similar problem as having to deal with an untrained interpreter (Fisch, 2001).

Gile (1995:13) maintains that if interpreters are properly schooled in interpreting theory, those theoretical concepts and models could help them to prevent or overcome strategic errors. The theoretical concepts and models will also help interpreters to choose appropriate

strategies and tactics when they interpret in new situations, and can help them to refrain from using less professional and less efficient tactics when they are under pressure.[8]

1.7 Rationale of Study

Ad hoc or untrained interpreters are usually unequipped to optimise interpreting sessions for both the medical practitioner and patient. Besides their knowledge of the theory of interpreting, health care interpreters should possess certain qualities. In the case of liaison interpreters, interpreters should have a good knowledge and grasp of the target language (the language they interpret into) as well as the source language (the language they interpret from). They should also have sufficient knowledge on the subjects that they interpret. Lastly, interpreters should know how to interpret.[9] These basic traits set the norm for all interpreters: anything above the norm suggests an interpreter who is qualified; anything below the norm suggests the opposite, an interpreter who is unqualified.

In order to bridge the language gap in a specific health care situation, untrained interpreters would typically be used. The quality of these services would thus be questionable, since these ad hoc interpreters are not equipped with the necessary skills to perform optimally within an interpreting session.

The aim of this study is thus to describe the quality of the interpreted product as well as the interpreting service of health care interpreters within three tertiary-level hospitals within the public health sector of the Western Cape. These hospitals are Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital. The working languages of the interpreters, patients and medical practitioners included in this study will be Xhosa and English[10]. Interpreting theory is an integral part of interpreting practice and this study aims to investigate and describe differences in quality of the interpreted product between professional and ad hoc interpreters.

1.8 Field of Study

[8] Gile, 1995:13
[9] Traits that an interpreter should have, was extracted from Gile (1995:13).
[10] See Addendum II for consent form for interpreters, medical practitioners and patients to participate in this study.

There are three tertiary-level medical institutions in the greater Cape Town area that falls within the sphere of the Western Cape health sector. A tertiary-level medical institution is an academic and centralised hospital unit where the medical care is scientifically developed and researched, and health professionals involved in health care are trained accordingly (Williams, 2005:36).

1.9 Data Coding

The researcher used a coding system to simplify the data analysis. The hospitals were coded as follows: Tygerberg Hospital as TGH; Groote Schuur Hospital as GSH and Red Cross War Memorial Children's Hospital as RXH.

1.9.1 Tygerberg Hospital (TGH)

Tygerberg Hospital is linked to Stellenbosch University and is situated in the Parow area of the Tygerberg region (Williams, 2005:40). This hospital opened in 1976, and has 1 715 nurses and 536 doctors in its employment. In 2003, 55 446 patients were admitted to TGH and 588 334 outpatients were treated. Patients admitted to TGH stay at the hospital for an average of 6,64 days[11].

Staff members at TGH speak mainly Afrikaans; a small proportion speak English. The language preference of patients who visit TGH show similar trends. African staff members also speak African languages at times and the use of African languages are also evident among African patients (Williams, 2005:42).

1.9.2 Groote Schuur Hospital (GSH)

Groote Schuur Hospital, linked to the University of Cape Town, is situated in Observatory in Cape Town. This is mainly an English-speaking area (Williams, 2005:41). GSH has a total number of 1 377 nurses and 547 doctors, with 45 000 patients admitted during 2006/2007 (financial year) and 483 000 outpatients visiting the hospital[12].

[11] http://www.capegateway.gov.za/eng/your_gov/5987/pubs/public_info/T/96281 on 15/02/2007
[12] http://www.capegateway.gov.za/other/2008/4/fast_facts_gsh_nov07.pdf on 26/10/2009

It is estimated that GSH staff members speak English and Afrikaans in equal proportions, and a small proportion of African languages is evident. Among patients there is also a shared dominance between Afrikaans and English, and a large proportion of African or other languages (Williams, 2005:42).

1.9.3 Red Cross War Memorial Children's Hospital (RXH)

This hospital is the only specialised child health institution in South Africa, and is situated in the Rondebosch area (Williams, 2005:41). In 2003/2004, RXH admitted 19 710 patients and 216 000 outpatients visited this facility[13]. This hospital is linked academically to Stellenbosch University, the University of Cape Town and the Faculty of Dentistry of the University of the Western Cape.

At RXH the staff speak English and Afrikaans in equal proportions, while languages used by patients reflect great diversity. English, Afrikaans and Xhosa are used for communication on an equal basis (Williams, 2005:42).

1.10 Overview of Chapters

This study consists of five chapters: Chapter 1 deals with an overview of the study, while Chapter 2 gives an overview of the literature regarding interpreting, especially health care interpreting and the health care sector, both in a South African context and other parts of the world. The chapter includes a discussion on studies undertaken that determined the need for interpreters, as well as a look at the qualities that an interpreter should have. It contains definitions on health care interpreting, a discussion on the theory of interpreting quality and findings of other studies regarding interpreting and health care. It also focuses on the health care sector and interpreting services, with specific reference to the difference between the health care interpreting setting and other interpreting settings. Strategies as to how health care interpreters should vary their approach towards interpreting in a medical setting will also be discussed.

[13] http://www.capegateway.gov.za/eng/pubs/public_info/R/103416/1 on 15/02/2007

Chapter 3 focuses on the methodology and research design applied in this study, and also include a discussion on the nonlinguistic aspects regarding interpreting at the hospitals, which were either gathered through the questionnaires or personal observations by the researcher.

Chapter 4 deals with the findings of the research conducted in Chapter 3. In this chapter the researcher also analyses the quality of the interpreted product of the interpreters employed in this study. There will also be a discussion on the findings of this study pertaining to linguistic aspects, through personal observation and results from questionnaires. There will be an analysis of the quality of the interpreted product of the interpreters who formed part of this study. Excerpts of interpreting sessions will be transcribed and translated from Xhosa into English. These translated segments will then be analysed to determine to what extent the interpreter deviated from the original speaker.

Chapter 5 concludes the study with the main findings from the research. Here limitations of the study will be identified, and recommendations for further areas of study proposed.

CHAPTER 2

LITERATURE OVERVIEW

2.1 Introduction

The aim of this chapter is to provide an overview of the existing literature related to interpreting within the health care sector, within local and international contexts. This chapter will also define the term *quality* in interpreting and the criteria by means of which it (quality) can be measured. A number of generally used terms within the interpreting theory will be explained as they will be used throughout the study. The findings of previous studies that have been conducted on interpreting and health care within the South African context will also be discussed. This will clarify the difference between this study and previous research within this context, and will help identify those gaps in the other studies that this study aims to fill. This chapter will launch an investigation into studies that have been done on interpreting and health care outside the South African context.

The South African interpreting context does not differ significantly from the international scene. However, it is important to take subtle differences between the local and international health care sector into account. Different authors and their points of view will be compared in order to determine which aspects would be deemed fit to employ in this study.

2.2 Terminology

In order to understand the content of this study an explanation or definition of the key terms used throughout this research is provided. The term most generally used is that of *health care interpreting*. Health care interpreting should be distinguished from medical interpreting. Health care interpreting[14] takes place in any health care setting. This health care setting may include doctors' offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. The health care interpreting setting usually takes place in the form of an interview between a health care provider and a patient. The patient could also be

[14] The terminology of health care interpreting: A glossary of terms (NCIHC – The National Council on Interpreting in Health Care, 2001), hereafter named NCIHC.

accompanied by one or more family members. The health care provider could typically be a doctor or nurse.

Medical interpreting (NCIHC) is a type of interpreting that includes the setting in which health care interpreting usually takes place, as well as any other setting related to the medical profession. Medical interpreting is thus the overall term encompassing any interpreting that takes place in a medical setting, which may or may not include a patient. Health care interpreting, on the other hand, usually takes place with a patient present.

The interpreting in a health care setting is usually performed by a community or liaison interpreter, but in many instances also an ad hoc interpreter. A community interpreter and a liaison interpreter seem to be performing the same function. However, subtle differences do exist. *Liaison interpreting* (NCIHC) takes place when a person who speaks two languages (Language A and Language B) mediates in a conversation that takes place between two or more people who do not speak each other's language. Liaison interpreting can usually be found in all multilingual societies, such as South Africa where there are eleven official languages. This type of interpreting is usually performed by anyone who knows two or more languages. In certain instances it can even be performed by a family member or one of the parties involved in the interpreting setting.

The purpose of *community interpreting* (NCIHC) is to provide access to any public service to a person who does not speak the majority language spoken in that service. Both of these types of interpreting are *bi-directional* (NCIHC), meaning that interpreting takes place between two languages where each language functions as both the source language (SL) and target language (TL), e.g. doctor → English (*SL*) → interpreter → Xhosa (*TL*) → patient → Xhosa (*SL*) → interpreter → English (*TL*) → doctor, where English and Xhosa both function as SL and TL. In such a setting Xhosa would usually be Language A of the interpreter and English would be Language B. Language A (NCIHC) represents the language in which the interpreter has native proficiency in speaking and listening (usually the interpreter's mother tongue) and Language B (NCIHC) is the language in which the interpreter has full functional proficiency in speaking and listening.

The abovementioned types of interpreting can both be performed by either a professional interpreter or an ad hoc interpreter. A *professional interpreter* (NCIHC) is a person who has

been appropriately trained and with the appropriate experience to be able to interpret consistently and accurately and who adheres to a professional code of ethics. Such a person should also be skilled in advocacy and cultural brokerage. *Advocacy* (NCIHC) refers to any intervention not specifically related to the interpreting process, with the intention to further the interests of one of the parties for whom the interpreting is done. *Cultural brokerage* (NCIHC) refers to any action taken by the interpreter that provides cultural information in addition to the linguistic interpreting of the message. An *ad hoc interpreter* (NCIHC) refers to any person who is not trained in interpreting who is called upon to interpret, such as a family member, a bilingual staff member (nurse or cleaner) who is called from other duties, or a self-declared bilingual person present in a hospital (waiting room) who volunteers to interpret. If a person is *bilingual* (NCIHC)**,** that person has some degree of proficiency in at least two languages. A high level of bilingualism is the most basic qualification required by a competent interpreter, but by itself it does not ensure the ability to interpret.

Liaison interpreting or community interpreting is usually performed in the consecutive mode of interpreting. *Consecutive interpreting* (*Dictionary of Translation Studies* [DTS], 1997:27) takes place when the interpreter listens to a section of a speech delivered in the SL and makes notes. The speaker then pauses to allow the interpreter to render what has been said into the TL. When the section has been interpreted the speaker continues with the next section and the process continues until the entire speech has been delivered and interpreted into the TL. According to the *Dictionary of Translation Studies* (1997:157) the *source language (SL)* is the language of the speaker who is being interpreted (i.e. the language interpreted from) and the *target language (TL)* the language of the person receiving interpreting (i.e. the language interpreted into). The TL is thus the language into which an interpreter is interpreting at any given moment. Interpreting, specifically in the context of this particular study, is usually performed for patients with limited English proficiency. *Limited English proficiency* (LEP) (NCIHC) is a legal concept that refers to a level of English proficiency insufficient to ensure equal access to public services without an interpreter.

2.3 Studies on Interpreting in the Health Care Sector

2.3.1 South African Studies

A number of studies have been conducted on interpreting and health care, specifically in the Western Cape. In 2001 Fisch investigated the differences between trained and untrained interpreters. Her focus was mainly within the field of speech-language and hearing therapy. According to Fisch her study confirmed the need for interpreters in the health care sector. This need was determined in post-interview discussions with the informants (interpreters, caregivers and clinicians) employed in the study. Through the study she also determined a language barrier in hospitals (Fisch, 2001:112). The Xhosa-speaking patients do not understand the white clinicians, and therefore any person who is "bilingual" – nurses, cleaners, family members and even other patients – are used to fulfil the role of interpreters within the hospital setting.

Other studies also suggested that Xhosa-speaking patients seem to experience problems when they want to gain access to health services. Due to the fact that there are no trained interpreters available, clinicians seem to spend less time with these patients and only obtain minimal details from them (Fisch, 2001:113). The caregivers employed in Fisch's study felt that the needs of the patients had been met, because an interpreter was present, despite the level of training of the interpreter. In cases where an interpreter was not available the caregivers failed to understand what the clinician asked and said, because they could not understand him/her (Fisch, 2001:113). As a result of their limited English proficiency (LEP), doctors also struggled to understand the caregivers. Interpreters in health care are thus necessary in order for patients to understand their problem(s) as explained by the doctor, and for the doctor to understand the patient (Fisch, 2001:114). One of the trained interpreters who took part in Fisch's study felt that many Xhosa-speaking patients do not receive the help they need at hospitals, because they are not proficient enough in English to reach the point of understanding (Fisch, 2001:114). Fisch eventually found that all the participants in her study preferred trained to untrained interpreters. Negative consequences were evident when using untrained interpreters. This study serves as collateral for previous studies by finding that a need for full-time, trained interpreters within the health care sector still exists, in order for patients to receive the appropriate health care in the language of their choice (Fisch, 2001:117).

Another study exploring language barriers within the health care sector in the Western Cape was that of Williams (2005). Williams investigated language diversity in the public health sector within the Cape Unicity, specifically at Khayelitsha Site B Community Health Centre,

Hottentots Holland Hospital, Red Cross War Memorial Children's Hospital, Tygerberg Hospital and Groote Schuur Hospital (Williams, 2005:50). Williams (2005:78) compared the official language policy of the health care sector with the language policy of the five health institutions investigated in her study.

Williams (2005:iii) found that there was a significant gap between language policy and the implementation thereof within health care facilities. At Khayelitsha Site B Community Health Centre "there [was] no language policy for the facility", but respondents had some to no knowledge of the multilingual policy for the health care sector (Williams, 2005:51,52). At Hottentots Holland Hospital it could not be established whether the facility had an official language policy or not, but it was reported that the language policy of the facility was based on the language demography of the local environment, which was mainly Afrikaans and English. They tend to use whichever of the two languages the patients understand (Williams, 2005:52). At Red Cross War Memorial Children's Hospital the management of the facility either "did not know" whether they had an official language policy or not, and also mentioned that the language policy they use, was that of the Department of Health (Williams, 2005:54). At Tygerberg Hospital Williams assumed that the hospital did have an official language policy and that Afrikaans and English were used alongside the other nine official languages. Management, however, indicated that the language policy of the hospital stemmed from the Provincial Department of Health, and circulars and policies were generally communicated in English (Williams, 2005:55). At Groote Schuur Hospital the language policy was that "everything [was] done 'unofficially' in English" and that this particular policy had been in practice for approximately the past twelve years (Williams, 2005:57).

A gap between policy objectives and related practice was observed at all the health facilities included in the above study. This gap was significantly greater at Khayelitsha Site B Community Health Centre, Hottentots Holland Hospital and Groote Schuur Hospital where there were no professionally trained health care interpreters (Williams, 2005:78-79). English and Afrikaans were the languages most commonly used within these health care facilities, while English was viewed as the main language medium people understood and tended to converse in. However, with little or no interpreters employed, doctors were still inclined to make use of nurses, porters, other patients and family members to serve as ad hoc interpreters. Thus the patient who spoke Xhosa was under-serviced at the health facilities investigated in Williams's study (2005:79).

Williams (2005) also found that there was a significant language barrier within her field of study (five health care facilities located within the Western Cape, more specifically the Cape Unicity). According to Williams, individuals were predominantly English- and Afrikaans-speaking, with Xhosa-speakers being in the minority. This language gap seemed to be smaller when there were officially trained interpreters present in the health care facilities (Williams, 2005:80). This study also identified a seemingly positive experience related to the presence of an interpreter.

In 2006 Schlemmer and Mash conducted a study at the Hottentots Holland Hospital (HHH). HHH is a South African district hospital situated thirty kilometres from Cape Town in the Western Cape. At the time of the study, the hospital served patients who spoke Afrikaans, English and Xhosa. Staff members were fluent in Afrikaans and English and only a small percentage could speak Xhosa. This posed a problem, because there were no official interpreters at this hospital and the majority of the patients it served, spoke Xhosa (Schlemmer, 2005:3). Schlemmer and Mash (2006:1084) investigated the effects of the language barrier at HHH. They found that the language barrier interfered with working efficiently and caused uncertainty about the accuracy of interpretation which was enhanced by a lack of training. It further had a negative impact on the quality of patient care, it decreased satisfaction with the care they received and caused cross-cultural misunderstandings (Schlemmer & Mash, 2006:1085-1087). A language barrier can thus lead to significant problems, not only for the patients but for the staff as well.

In 2006 Levin did a study at Red Cross War Memorial Children's Hospital (RXH). RXH is a paediatric teaching hospital in Cape Town. Levin found that staff members at this hospital mainly used Afrikaans and English in their communication, while patients who frequented this hospital were mainly Xhosa-speaking. Levin (2006:1076) found that an interpreter (trained or untrained) was only used in 21% of the interviews. According to Levin (2006:1078 – 1079) parents experienced language difficulties, which could be divided into three main themes. The first theme identified these language difficulties as a barrier to health care for patients who speak Xhosa. This barrier leads to poor communication, which impacted negatively on parents and their children. In addition, the medical terminology posed a significant barrier to parents' understanding of what doctors said. Levin (2006:1079) suggested that interpreters should be more readily available, and doctors should be trained to make use of them. Parents at RXH did not have the use of interpreters and the consequent

language barrier caused problems in "understanding the doctors, making themselves understood, and asking questions" (Levin, 2006:1079). By providing interpreters for these parents, some of these problems could have been resolved (Levin, 2006:1079).

Although the abovementioned studies supported the fact that English and Afrikaans took dominance over Xhosa within the health care sector and that there was a need for trained interpreters to bridge the language barrier, this situation is not unique to the South African context. Many studies undertaken abroad suggest a similar phenomenon, with the only difference being the language combinations.

2.3.2 International Studies

According to Ku and Flores (2005:435) there are thousands of patients confronted with language barriers daily. This is mainly due to two reasons: they cannot communicate with their medical caregivers as a result of their LEP and/or untrained interpreters distort their communication (Ku & Flores, 2005:435). According to these authors language barriers can lead to inefficient care, because the doctors will not be able to understand LEP patients. In addition, ad hoc interpreters cause significant errors in interpreting. Patients who make use of ad hoc interpreters therefore tend to be less satisfied with their medical visits than when a qualified interpreter was used (Ku & Flores, 2005:436). This study also supported the fact that a positive impact was achieved when a qualified interpreter was used. Patients who made use of these qualified interpreters were usually highly satisfied with the care they received from the medical practitioners (Ku & Flores, 2005:436). The authors state that health care systems should prioritise the need to reduce language barriers, because this will "improve quality of care, reduce the risk of medical errors, and increase access to services" (Ku & Flores, 2005:442).

According to Chen (2006:808) two people from two different cultures who speak a language that is common or known to both of them does not necessarily imply that they will be able to understand each other fully. This could also be applied to the South African context: if a black patient, for example, speaks Xhosa but has sufficient knowledge of English to be able to communicate in it on a basic level, it does not guarantee understanding between the white doctor or medical practitioner who speaks English. Therefore, an interpreter is essential to facilitate both Xhosa and English to the extent that successful communication is achieved.

Chen (2006:811) states that a number of hospitals and health care institutions left it in the hands of patients and doctors to manage with untrained interpreters. This was not acceptable because "communication between a [doctor] and [his] patient is a delicate [situation]" (Chen, 2006:811). At times, there might be a small degree of miscommunication during a doctor-patient consultation, even though both patient and doctor may be native-tongue English speakers. Therefore, should a situation arise where the patient is not a native-tongue English speaker, miscommunication may worsen without a qualified interpreter present to clear the confusion (Chen, 2006:811). According to Chen (2006:812) many studies confirm that using untrained or ad hoc interpreters was "reliably unreliable". They were not fluent enough in English, they did not possess the linguistic skills to convert one language into another, and they did not have sufficient knowledge of medical terminology to render a complete and accurate interpreting product.

In my opinion, Chen makes an important observation with her statement that interpreters in the health care situation should receive equal treatment as interpreters within the judicial or legal setting. Governments (both in South Africa and in America) pay for legal interpreters and should therefore also pay for health care interpreters: "…using a trained medical interpreter is the right medicine" (Chen, 2006:813).

Jacobs, Shepard, Suaya and Stone (2004) conducted a study at four health centres that form part of a large Massachusetts health maintenance organisation (HMO). These health centres served approximately 122 00 patients. The study was conducted over a two-year period (1 June 1995 to 31 May 1997) and the patients served by the interpreters mainly spoke Spanish and Portuguese. The HMO members made use of the services of five full-time, trained interpreters. These interpreters were available 24 hours a day, either by telephone or during walk-in visits at the HMO.

The study conducted by Jacobs et al. found that people with LEP did not have a regular source of primary care, were not very likely to receive preventative care and were usually less satisfied with the care they received. This was almost always due to the fact that the majority of health care providers did not have interpreter services or the existing services were not adequate. Consequently, LEP patients did not receive the health care they needed, or did not receive quality health care. Jacobs et al. state that health care providers could not provide interpreter services, due to their great financial burden (Jacobs et al., 2004:866).

This study found that the delivery of health care to LEP patients would increase, should professional interpreter services be provided. The study also found that there was an increase in the cost of care, which was due to the provision of interpreter services. The number of patients who made use of the interpreter services showed an increase in visits to the physician, as well as in receiving prescription drugs. This showed that for a small increase in cost, interpreter services made primary and preventative services more accessible (Jacobs et al., 2004:868). In addition, more patients received preventative services, which suggested that LEP patients might decrease the cost of health care over time, should interpreter services be provided (Jacobs et al., 2004:868). The authors concluded their study by stating that millions of patients did not receive adequate health care, because they did not speak English or were not proficient enough to communicate in English. These LEP patients needed to communicate adequately with the health care providers in order to improve the quality of health care services (Jacobs et al., 2004:868).

2.4 Health Care Interpreting and Assumptions

In 1997 Prunč (as cited in Meyer, Apfelbaum, Pöchhacker & Bischoff, 2001:75) introduces the term *translational culture* which is the set of socially determined norms, conventions, expectations and values governing translational activity in a given society or institution (Meyer et al., 2001:75).

Within interpreting in the health care setting a number of doctors seem to suffer from what Meyer et al. (2001) calls the "glass half-empty or half-full syndrome". They tend to see the glass as being half-full, which means that they accept and use what they have at hand – be it an untrained, ad hoc interpreter or no interpreter at all and a patient with limited proficiency in a language – rather than to proactively try to improve the situation, which implies that the glass is rather half-empty and needs to be filled up (Meyer et al., 2001:74). This "glass half-full belief" could lead to doctors making a number of assumptions.

Doctors could make the assumption of *communication*, meaning that they may assume that communication with a patient with limited proficiency in a language is possible to take place without an interpreter. Having knowledge of a language may equal understanding of the message to doctors. Doctors could also make the assumption of *linguistic transfer* when they

call upon an ad hoc interpreter (i.e. someone who is bilingual) to fill gaps in the communicative event. In such a situation, doctors will not be likely to enquire whether the person knows how to interpret. They will merely assume this on account of the interpreter being bilingual (Meyer et al., 2001:74). Doctors may also hold the assumption of *understanding*[15]. The doctor may simply assume that the patient understands, even if this is not confirmed, when the patient does not seem to have any queries during the medical visit (Meyer et al., 2001:74).

These assumptions are a reflection of a naive translational culture. They challenge codes of practice of professional interpreting services which state (as one of its prerequisites) "that it takes a trained interpreter to enable communication between a client and a service provider who do not share a common language" (Meyer et al., 2001:75). However, in some instances a professional interpreter may be seen as someone who is "just translating," while the ad hoc interpreter provides explanations in order for the patient to understand more easily, uses the first-person form of address and is constantly monitoring understanding, thus "facilitating a satisfactory level of understanding" (Meyer et al., 2001:75). These standards of interpreting practice are not universally applicable, but are determined by the specific social environment. One can therefore ask whether the use of a professionally trained interpreter is preferable to an ad hoc interpreter in any given context, when it is in fact the doctor who chooses to manage on the patient's limited proficiency in a language (Meyer et al., 2001:75).

2.5 Quality and Interpreting

2.5.1 Factors determining Quality

When speaking about quality and interpreting, the most common criteria to consider are *accuracy*, *clarity* and *fidelity*. These criteria are usually associated with the product of interpreting. Each of the criteria determining quality relates to different aspects of the interpreting communication situation (Pöchhacker, 2002:97). For Gile (1995:34) there are two sides to these quality criteria. On the one side, *ideational clarity*, *linguistic acceptability*,

[15] Communication, linguistic transfer and understanding reflect more or less the process of interpreting from start to outcome in a broad sense.

terminological accuracy and *fidelity* exist and on the other *appropriate professional behaviour*.

One of the most basic and widely discussed components of interpreting quality is *fidelity* (Gile, 1995:49). In order to determine the principles or components of fidelity, one should not start with the interpreted product, but with the setting in which communication takes place (Gile, 1995:59). If successful communication is to be achieved, interpreters should lead the receiver along the same path of communication on which they followed the sender. The points of departure and arrival should therefore essentially be the same (Gile, 1995:59). The principles of fidelity are the *message (M), framing information (FI), linguistically induced information (LII) and personal information (PI)*[16] (Gile, 1995:59-62). "The minimum fidelity kernel should necessarily cover the message" (Gile, 1995:59). The golden rule of fidelity is that the message or the primary information should at all times be re-expressed in the TL (Gile, 1995:59).

The sender selects FI in order to facilitate the message received by the receiver. However, the receiver of the original message and that of the TL message may not have the same pre-existing knowledge and values. In order to ensure fidelity to the message of the sender to the TL receiver, some FI should be eliminated and some added. Selecting appropriate FI to transfer to the TL is, to a certain extent, a reflection of the personality of the sender (Gile, 1995:60). If the sender wants to ensure an image or idea beyond the message itself, the interpreter should use FI exactly similar to that of the sender. Nevertheless, the role of interpreting is to convey information in order to reach a certain goal, and the impact of that information with respect to the goal takes precedence over fidelity to the sender's "personality". If interpreters then feel that the FI of the sender is not appropriate for the TL receiver, they can change or adapt the FI until it is appropriate (Gile, 1995:61).

Unlike FI, senders do not choose LII out of their own free will. In the case of choosing FI the sender is presented with many options, of which they have to choose one. LII in the SL contains some elements which are redundant and some which are nonrelevant, but these are natural and a well-integrated part of the discourse. If this LII is carried over to the TL, the reformulation thereof could be awkward or even distort the original message (Gile, 1995:61).

[16] These principles are all related to the source text speech and represent elements that the interpreter may omit, choose to transfer as is or add to.

It is not always possible for interpreters to distinguish between the message and the LII. As a result, they interpret everything in order to avoid *not* interpreting everything. The result is TL speeches with more information than the SL speech. In such cases, the TL speech does not only contain LII from the SL speech, but also LII from the TL speech. Since interpreters tend to retain FI of the sender, the interpretations are usually longer than the SL speeches (Gile, 1995:61).

Personal information (PI) is simply a reflection of the personality of the sender expressed linguistically (Gile, 1995:62). The interpreter should thus follow the PI only if it does not affect the efficiency of the communication. If PI reflects a negative image of the sender, it should not be reflected in the TL (Gile, 1995:62).

When (the testing of) quality is approached, it can either be done by focussing on one or more aspects that determine quality, or on models that focus on a multidimensional form (Garzone, 2000:108). However, the first step is to identify which elements have to be analysed and thus what the focus would be to determine the quality of the interpreted product.

Shlesinger et al. (1997:128, as cited in Garzone, 2000:108) determine three levels in the analysis of the quality of the interpreted product. These three levels are the *intertextual level*, the *intratextual level* and the *instrumental level*. In the analyses of the interpreted speech, one compares the similarities and differences on the intertextual level between SL speech and TL speech, i.e. what the interpreter omitted or added, and whether such actions will eventually affect the outcome of the quality of the interpreted speech. The intratextual level refers to the interpreted speech as an unattached and independent product with reference to its acoustic, linguistic and logical aspects. This refers to the TL speech being unique and understandable, and that it provides in the needs of the TL receiver, similar to what the SL speech is to the SL receiver. The instrumental level refers to whether the TL speech is understandable enough to be viewed as an effective customer service. According to Garzone (2000:108) this model is more "coherent and effective than others". She states that this model eliminates terms like "equivalence" and "effectiveness" because these terms are too momentary and ambiguous – it has not yet been concretely defined. This proposed model looks at the original speech in relation to the interpreted speech, the interpreted speech in its own right, and the function of the interpreted speech. Within this model the SL speech is juxtaposed with the function of the TL speech.

In the case of simultaneous interpreting, the role of *intertextual consistency* cannot be discarded, because the speech of the original speaker is part of the same communicative event (Garzone, 2000:109). This differs from translations where the target text should almost always function as an independent text in the target culture. Therefore, the TL speech and the SL speech share the same function, or will always fulfil the same function. Therefore, in order to determine the quality of the interpreted speech, other factors such as "linguistic and encyclopaedic competence, technical skills, ability to work in a team, conference preparation" (all pertaining to the interpreter) and, amongst others, "textual [or] linguistic features, speaker's pronunciation and prosody and the degree of technicality" (all pertaining to the SL) should also be taken into account (Garzone, 2000:109). A number of other factors and situational variables also thus contribute to the quality of the interpreted product.

Another component in assessing the quality of interpreting is the *social status of the interpreter*. Interpreters can be divided into two categories. The one category includes the officially trained interpreter schooled in interpreting theory and practice in a formally recognised course in interpreting. This kind of interpreter has been specifically trained to work in a specialised area such as the legal, health care or governmental setting (i.e. national or provincial parliament). The other category consists of the untrained or (mostly) ad hoc interpreter. This type of interpreter can take on the form of a nurse, cleaner or sometimes even a family member of the patient – basically any person who is bilingual. This type of interpreter is usually not remunerated for services rendered as an interpreter while the trained interpreter is. It is also the ad hoc interpreter that society comes across most often. This tends to harm the status of interpreters in general, which negatively affects the assessment of the quality of the interpreted product: low(er) status means poor quality (Gile, 1995:38). If interpreters step into the interpreting communication setting and the other participants have a preconceived notion that the status of the interpreters is low, certain aspects of the interpreted product will remain unsatisfactory. For this reason, the quality of the interpreted product will be regarded as poor, whether or not the interpreter (trained or untrained) renders an interpreting product which is of high quality by any(one's) standards.

2.5.2 Role Players determining Quality

According to Gile (1995:31) there are four role players within an interpreting situation. These role players are the *sender, receiver, client* and *interpreter*. Whether the interpreting

product is of good quality or not, depends on each role player's views on the interpreting product. What may be a product of good quality to one role player may not necessarily be the case for another (Gile, 1995:33). For this reason, it can be deduced that the evaluation of the quality of the interpreting product is entirely subjective. Despite this apparent subjectivity, some common criteria should exist that each role player could extract from the interpreting product in order to determine the quality of the product. In cases where role players get all these common criteria from the interpreted product, it can consequently be said that the product is of high or good quality. However, role players do not view all of the criteria on an equal level.

Senders are in a good position to judge the quality of an interpreted product (Gile, 1995:35). They are usually aware that their speech is being interpreted and (if the consecutive mode of interpreting is used) are able to listen to the interpreted or TL speech. If senders understand the target language, they could also assess the quality of the interpreted product (Gile, 1995:35).

In a health care interpreting setting the receiver takes on the form of both doctor and patient, as neither understands one another's language sufficiently enough. Receivers (i.e. those that listen to the interpreter) are also in a good position to assess the quality of the interpreted speech, if they understand both source and target languages (Gile, 1995:36). However, this applies to short segments of speech only, because larger segments, such as the explanation of a medical procedure, tend to be more complicated and dense, and will contain a lot of information. In such cases, the receiver, who does not have an excellent command of the source language, will thus not be able to notice the errors that the interpreter makes (Gile, 1995:36). I am of the opinion that in a South African context, with specific reference to the health care sector in the Western Cape, where the doctors speak mostly Afrikaans and English and the patients mostly Xhosa, there would not be a need for an interpreter (it could be regarded as a wasteful effort) if the patient is in a position to understand English or Afrikaans. In interpreting, especially in a South African context, clients are not in a good position to assess the quality of the interpreted product because they seldom listen to the product. They can therefore only make conclusions based on feedback from the person who makes use of the interpreter, i.e. the receiver (Gile, 1995:36-37).

The interpreter is to some extent in a better position than both the sender and receiver, to assess the quality of the interpreted product (Gile, 1995:37). However, the interpreter may assess the quality of the interpreted product from a rather subjective viewpoint. In addition, the interpreter cannot always be exactly sure of what the motivations, aims or interests of the other participants are (Gile, 1995:37). The interpreter thus has a limited assessment capacity. Senders know what they want to say; they have absolute clarity about what they want to get across. This also applies to receivers. Interpreters, on the other hand, do not have this luxury.

In this study, the client refers to the hospitals where the need for interpreting services was assessed. Here, the client has little to no knowledge of interpreting and does not listen to the interpreted product. Should the client in this case wants to assess the quality of the interpreting service, it has to rely on the feedback from the three abovementioned role players (Gile, 1995:36-37).

The abovementioned analysis is a reflection of an ideal situation for quality assessment in interpreting. In reality, the quality of the interpreted product for each of the participants in the interpreting communication situation depends on the reason(s) for their participation in the communication situation and what they want to gain from it. Therefore, the information would have varying degrees of relevance to the different participants. They may only listen to or remember whatever they find relevant and choose to ignore the complete interpreted product. If what they *have heard* is in line with what they *wanted to hear*, chances are good that they will assess the interpreted product to be of high quality (Gile, 1995:37). According to Gile (1995:38) "the actual assessment of quality depends inter alia on the specific needs of the assessor, and suggests that although common quality criteria do exist, actual overall quality assessment can vary significantly in any given context …"

2.5.3 Unifying Concept of Quality

Garzone (2000:97) states that it is hard to determine the factors of quality because over the years the concept of quality has become "elusive". This problem with the term *quality* stems from the fact that the role players who take part in the interpreting situation have very different views on what quality means (Garzone, 2000:107). It is also difficult to test the quality of the interpreted product. According to Garzone (2000:107) it is methodologically

incorrect to analyse an oral text in its written form. The interpreted version when heard in auditory form may seem coherent, logic and understandable to the receiver, but when it is analysed in its written form it may be quite the opposite (Garzone, 2000:108).

Despite all these different variables that cannot be accounted for or applied to each and every interpreting situation, the literature on quality and interpreting seems to be unified in the notion that "sense consistency with (or 'fidelity' to) source language speech, accuracy and successful communication are the basic criteria one should look at when investigating quality in interpreting (Garzone, 2000:109). However, the extent and presence of these criteria may vary in relation to the role players who are present within the interpreting communication situation (Garzone, 2000:109). According to Garzone (2000:109) there is thus still a need for a universal principle that embodies and covers all the elements, which determine the quality of interpreting. When finding or determining such a principle one should not only take a look at the speeches or at the interpreting situation, but also at the interpreter's behaviour and choices as well as the expectations of the user.

Garzone (2000:110) suggests that the term *norms* should be applied to the quality of interpreting to standardise the variability of standard quality criteria. The variability is due to the different interpreting situations and the different role players involved in every situation. The same criteria cannot be applied to trained and untrained interpreters. This creates a need for a universal concept which can embody this variability. These norms are "internalised behavioural constraints" which guide or rule the specific behaviour or specific choices that an interpreter makes in a specific context in order to meet quality criteria. These quality criteria in turn depend on the specific sociocultural context and are therefore based on norms (Garzone, 2000:110). Interpreters thus share the same norms which generate similar behaviour in similar contexts; receivers have the same norms with regard to text-reception when they instinctively know what a good interpretation should be like and what they should expect from such an interpretation (Garzone, 2000:110). The norms relate to the traits that an interpreter should have (1.7). "The concept of quality in interpreting can thus be defined as a construct embodying the norms which are deemed appropriate to guarantee the intrinsic and extrinsic properties considered ideal for an interpretation performance in a given social, cultural and historical situation." (Garzone, 2000:110).

2.6 Comprehension as Outcome of Quality

Comprehension not only pertains to the knowledge of the language. Instead, it refers to a combination of knowledge of the language and extralinguistic knowledge. However, comprehension does not simply imply comprehension or noncomprehension (Gile, 1995:78). A higher level of both knowledge of the language and extralinguistic knowledge, leads to better comprehension. Therefore, should one component be weaker, the other would compensate (Gile, 1995:79).

However, it is not possible to fully comprehend anything simply on the grounds of knowledge of the language or extralinguistic knowledge (Gile, 1995:79). The content of the speech may be too difficult, it may deviate from generally accepted linguistic standards, or the level of knowledge of the language and extralinguistic knowledge of the receiver may not be high enough. Then it is necessary to analyse the discourse to a much greater extent with regard to comprehension than it would have been necessary in everyday situations (Gile, 1995:80). In order to fully comprehend, not only knowledge of the language and extralinguistic knowledge are deemed necessary, but also deliberate analysis (Gile, 1995:80).

2.7 Training Bilingual Staff Members as Interpreters

It is a reality in the South African context that the majority of interpreters used in the health care setting are ad hoc interpreters. These interpreters are usually bilingual and are therefore used to fill these positions. Sevilla Mátir and Willis (2005) are of the opinion that bilingual staff members specifically could be trained effectively to fulfil the role of interpreter. These authors suggest eight general rules according to which such bilingual staff members should be trained in order to distinguish them from mere ad hoc interpreters and cause them to move or progress more towards the area of trained interpreters (Sevilla Mátir et al. 2005:34). Chen (2006:812) also states that bilingual staff members might be a good alternative to ad hoc interpreters. However, in some instances the bilingual staff members may not be bilingually fluent in the necessary medical terminology and their interpreting skills may be questionable. The quality of their interpreting product would thus be questionable. Therefore, it should be borne in mind that the rules that Sevilla Mátir et al. suggest should not be substituted for

interpreting theory, and that the acquisition of these rules will not constitute bilingual staff members as trained interpreters.

- The first rule is that the interpreter should use the generic form of the language whenever possible. In a South African context this would mean that if the interpreter speaks a Western Cape dialect of Xhosa and the patient an Eastern Cape dialect, the interpreter should try to keep to a generally understandable form of Xhosa and try to eliminate dialectal discourse.
- The second rule is that the interpreter should try and prevent 'taking over' the role of the interviewer and remain a neutral participant.
- The third rule is that the interpreter should allow the patient, and not himself or herself, to lead the discussion.
- The fourth rule is to interpret everything. The patient may mention something, which may be in connection with the medical encounter, to the interpreter during an additional conversation when the interviewer is not present. Information contained in such a conversation should thus be relayed to the interviewer.
- The fifth rule is that the interpreter should be aware of culturally significant issues that affect patient care, and should interpret in a way that conveys the cultural framework. It is thus of importance that the interpreter should also be a cultural broker.
- The sixth rule is that the interpreter should meet the patient before the medical encounter. It is of utmost importance that the interpreter explains and clarifies his/her position or role to the patient in order for the patient to feel comfortable in revealing confidential information.
- The seventh rule is to develop a work plan for each patient between the interpreter and the physician.
- The eighth rule is that the interpreter should seek further education in the field. Sevilla Mátir et al. (2005:36) state that bilingual staff members can learn to practice a number of these rules even without having received formal training in interpreting. However, they should still participate in other educational programmes for further interpreter training.

2.8 Conclusion

Almost all of the studies conducted on interpreting within the South African health care sector found that the national language policy for health care is not implemented in practice. Despite the promotion of multilingualism by this policy, it is evidently clear that Afrikaans and English are the sole languages used for communication in health care settings, while Xhosa-speaking individuals who make use of these facilities have to be satisfied with no interpreters or ad hoc interpreters who are not qualified to successfully fulfil this role. Despite this, it seems as if these patients are grateful that there is at least someone who understands and can speak their language. The existence of a language barrier may be the cause of poor quality in health care, but it has not been investigated whether trained interpreters render an interpreted product that is of higher quality than the interpreted product obtained from an ad hoc or untrained interpreter. According to a number of scholars the interpreted product or the interpreter him-/herself has to adhere to ideational clarity, linguistic acceptability, terminological accuracy, fidelity and appropriate professional behaviour. But because the participants in the communication situation – sender, receiver, interpreter and client – all have different outcomes from the interpreting session, they will have different views on the quality of the interpreted product. Thus, to standardise these different outcomes Garzone (2000:110) suggests the use of the term *norms* to ensure the legitimacy of variability in quality criteria outcomes for each participant in the interpreting situation.

CHAPTER 3

EXTRALINGUISTIC SITUATION

3.1 Introduction

The overall aim of this chapter is to provide an overview of the research procedures employed in this study. This chapter will explain the research design, as well as the different research techniques that will be employed in this study. It will also explore the extralinguistic factors pertaining to the interpreting sessions and interpreting settings in the field of study as obtained through personal observations by the researcher or from the participant questionnaires during the interpreting sessions.

3.2 Research Design

Quality in interpreting was described as an elusive concept. Different scholars have different views on which aspects constitute quality in interpreting, and which to consider when the quality of the interpreted product is investigated (see 2.5). As a result of the elusiveness of the concept "quality" with regard to the product of interpreting, the researcher decided to employ a qualitative approach to test the quality of interpreting. The researcher identified the following aspects for testing the quality of the interpreted product:

- The attitudes of the medical practitioner, patient and interpreter towards the interpreted product; and
- Ideational clarity, linguistic acceptability, terminological accuracy, fidelity, and appropriate professional behaviour.

When testing the quality of the interpreted product, the ideational clarity, linguistic acceptability, terminological accuracy, fidelity, and appropriate professional behaviour all encompass intertextual, intratextual and instrumental levels[17] (Shlesinger et al. (1997:128, as cited in Garzone, 2000:108). As a result of the varying nature of aspects that need to be investigated when the quality of the interpreted product is determined, the researcher decided to employ a qualitative approach to test the quality of the interpreted product. On the one

[17] See 2.5.1

hand, one has the interpreted product itself, and on the other hand, the attitudes of the different role players towards the interpreted product.

This study represents a small-scale survey. This type of design was chosen because of the limited resources available, which impact on the size and scope of the survey (Punch, 1998:3). Punch (1998:22) states the following advantages in employing this type of research strategy:

- A small-scale survey model can be studied thoroughly and small-scale examples can be worked through more thoroughly in all its stages; and
- The results of small-scale surveys, which are well-conducted, could all accumulate to research-based knowledge.

3.3 Qualitative Research Approach

The five variables[18] mentioned previously (see 2.5.1) will be used to evaluate the quality of the interpreted product. With this approach the data is expressed in words (Punch, 1998:59). This research approach focuses on the "deductive testing of hypotheses and theories", and the aim of qualitative research is to "explor[e] a topic, and […] inductively generating hypotheses and theories" (Punch, 1998:240).

Thus the comparison of utterances employed in the product could be checked or verified against the attitudes of the different role players in the interpreting situation towards the quality of the interpreted product.

3.4 Measuring Instruments

Transcripts and audio-recordings were the main data sources employed in this study. Interpreting sessions which took place between medical practitioner, patient and interpreter, were audio-taped. This method of data capturing was chosen, because the five variables focus only on the *languages* used in the interpreting sessions, and not on *extralinguistic* factors. For this reason, the use of video tapes, in addition audio tapes, was decided against. The Revised Mistranslations Analysis Tool (RMAT), which was designed to analyse the

[18] The five variables are: ideational clarity, linguistic acceptability, terminological accuracy, fidelity, and appropriate professional behaviour.

utterances by the interpreter (Fisch, 2001), was used as starting point to test the five variables. Some elements of the RMAT were retained, some modified and new ones added to enhance the applicability of this tool in this study. The refined table for this study reads as follows:

Table 1: Analysing Interpreting Quality: A Table

	√	X
Ideational Clarity		
Same ideas as original speaker		
Idea clear for listener to understand		
Explain ideas clearly		
Accurately repeats what was said		
Examples given		
Linguistic Acceptability		
Standard variety of language		
Appropriate register		
Treat cultural words appropriately		
Explain words into culturally understandable language or euphemisms or vice versa (language into cultural euphemisms)		
Good language skills		
Terminological Accuracy		
Express medical terminology correctly in TL		
Explain medical terminology where necessary		
Know meaning of medical terminology		
Explain difficult terminology		
Explain difficult concept		
Fidelity		
TL utterance faithful to that of original speaker		
Is message in essence the same/ ideas the same as original speaker		
Was essential/ important information carried over to listener		
Appropriate Professional Behaviour		
Correct mode of interpreting		
Speech clear		
Speech audible		
Reasonable pace		
Professionally dressed		
Professional attitude towards process		
Interrupted speakers in a nonthreatening/polite way		
Displayed sympathy where needed		
High level of sophistication		
Unbiased		

3.5 Data Collection Method

These audio-taped interpreting sessions will be transcribed by a qualified interpreter with experience in health care interpreting. The expectation prior to conducting the study was that English or Afrikaans, spoken by the medical practitioner, would be the languages used in the majority of the interpreting sessions, and that Xhosa would be spoken by the patient. For these reasons, the transcriber and translator would be a Xhosa first-language speaker with proficiency in English.

The transcribed Xhosa sections will be translated into English. The two English segments will thus be compared and tested according to the five variables.

Semistructured interviews will be used to test or measure the attitudes of the medical practitioner, patient and interpreter towards the interpreted product, as well as towards the interpreter him-/herself. Data for the quantitative research will be collected by means of self-administered questionnaires[19], and more specifically by means of a variation of this method called "face-to-face" administration. This type of measurement instrument is most commonly used in quantitative surveys (Punch, 1998:4).

The basis of the questionnaire is similar for all participants, with only some questions reflecting a different approach in order to assess the different attitudes of each of the participants towards the interpreter and interpreted product. The questionnaire contains open-ended, as well as close-ended questions. Open-ended questions are questions "answered in the respondent's own words" (Sudman & Bradburn, 1989:149). This will enable the researcher to go more deeply into the area of research or interest and to explore the different aspects or opinions to(wards) the topic (Sudman & Bradburn, 1989:151). Open-ended questions do not have a choice of alternate replies, "and the answers have to be recorded in full". (Oppenheim, 1992:112).

3.6 Sampling Method

Fisch (2001) states that interpreting practices in South Africa, especially in the health care setting, is not structured enough and is quite "haphazard". It is from this statement that the

[19] See Addendum III for questionnaires for patients, medical practitioners and interpreters.

researcher decided to employ random sampling, and more specifically "convenience" or "accidental" sampling (Punch, 2003:36). Punch (2003:39) states that in practice many researchers are usually working on their own with limited resources and should thus use any sample which they are able to access, consequently chosen on a 'convenience' basis. Convenience sampling takes place in cases where events, situations or informants are close at hand (Punch, 1998:193). There are many sampling strategies but the important aspect to consider is that the research design should be valid (Punch, 1998:194). This study is thus employing the strategy of probability sampling with random selection (Punch, 1998:105).

3.7 Participants in this Study

The participants included in this study are the interpreter, patient and medical practitioner. The *interpreter* will include two types of interpreters. The first type is the ad hoc or untrained interpreter. This interpreter can take on many forms, e.g. nurse, cleaner or family member. For this particular study this type of interpreter will be requested to render interpreter services for a specific consultation, and will have to be present, willing and able to render such services when requested. The trained interpreter should be formally employed by the specific medical institution in the capacity as a health care interpreter. The specific interpreter will thus be requested to act as interpreter in specific consultations. The *medical practitioner* will be a doctor or any other medical staff member or specialist that will be present during a consultation, and who would not be able to fully understand the language of the patient. The medical practitioner can also be a social worker. For this reason, the services of an interpreter will be required. The *patient* would not be able to fully understand the language of the medical practitioner in a specific consultation, and would thus request an interpreter.

3.8 Languages Employed in this Study

It is expected that English and Xhosa will be the languages used in the interpreting sessions. The questionnaires for the medical practitioners as well as the interpreters will be drawn up in English, as it is expected that both groups will have sufficient proficiency in English to be able to answer the questions. Questionnaires for the patients will be in both Xhosa and

English, and the researcher will be assisted by a research assistant to pose questions in Xhosa to the patient if the patient is a native Xhosa speaker.

3.9 Data Collection

3.9.1 Groote Schuur Hospital (GSH)

The data collection process for this study commenced at this health care facility. At first, the researcher visited the hospital to establish whether interpreters were employed by the hospital and where they could be located. After several phone calls it became clear that the hospital had no employed interpreters.

The researcher then proceeded to the reception area of the outpatient area to enquire whether there were interpreters employed in the outpatient area. The response was also in the negative and it was said that most of the interpreting took place in the clinics, whereto the patients were referred after having visited the reception area. The researcher then was referred to the head of the outpatient department to enquire about how interpreting is handled within the department. However, the head was not available and the researcher was told by the secretary that the department indeed had an employed interpreter. The secretary then contacted the interpreter so that the researcher and research assistant could meet the interpreter, who was apparently not known by reception and administration.

Upon meeting the interpreter, she informed the researcher that there were three more interpreters employed within the boundaries of the hospital. The researcher then scheduled a meeting with the interpreters at the office of the head of the department. The researcher informed the person in charge of the interpreters of her intent and introduced the research assistant. The manager granted consent for the research to be conducted, and although the interpreters seemed somewhat sceptical at first, they agreed to take part in the research.

At that time, the researcher thought it best practice to rotate between the interpreters on a random basis in order to collect the data, especially the audio-taped interpreting sessions. In this way the researcher had ample time to inform the patient, as well as the medical practitioner of her intent and to gain their informed consent. This does not deviate from the

research design and remain examples of convenience or random sampling, because the interpreter did not know when and/or where an interpreting session would take place.

The aim of the research was to get five interpreting sessions at this specific hospital, and five corresponding questionnaires from each of the three participants. The fourth interpreter, who worked in the oncology ward, was excluded due to the sensitive nature of events in the specific ward. The possibility of interpreting sessions taking place without the presence of an official interpreter was also not excluded.

The data collection procedure was as follows:

- The researcher started with the interpreter who interpreted in the outpatient clinics;
- The researcher had to introduce herself to the sister in charge of the clinic and had to gain permission to conduct the research;
- The researcher would then enquire from the interpreter whether there were any patients in the waiting area of the clinics who would need interpreting. If there was a patient who needed interpreting, the research assistant informed the patient in Xhosa about the intent of the research, requested participation, and explained the content of the consent form. The interpreter was also requested to complete a consent form.
- If there were no patients who needed interpreting, the researcher would then proceed to the other interpreter, who worked in the outpatient clinics in another section of the hospital. The process explained above would then be repeated.
- If there were no patients in the outpatient clinics who needed interpreting, the researcher would proceed to the interpreter who worked in the occupational therapy department, but who also interpreted in the speech therapy department.
- The researcher had to explain the research methodology to the heads of these two departments who gave their permission to proceed with the research. The interpreting sessions in especially the occupational therapy department seemed more structured as the patients had appointments for work assessments on Mondays and Tuesdays. The interpreter could therefore easily establish which patients needed interpreting.
- For this reason, the researcher visited this interpreter on Mondays and Tuesdays.
- The researcher and research assistant also visited other clinics without the interpreter to establish whether there were any patients who needed an interpreter. At times, the researcher established that there were indeed patients who needed interpreting. However, the researcher did not inform the interpreter about these patients so that

there would be no interference with the natural proceedings of the interpreter's work, the research would not be jeopardised or no extra work would be handed out to the interpreter.

During the first visit to the hospital the researcher managed to get only one audio-taped interpreting session with corresponding questionnaires. The reasons were as follows:

- The interpreter would be in another part of the hospital and an interpreting session would take place with an interpreter in the clinics;
- The researcher would reach a specific clinic and the interpreter would inform the researcher that a session would be taking place, but the patient and the doctor would already be in the consultation room, which left the researcher no time to explain the research, confirmed participation and gained informed consent;
- According to the interpreter, at times there were no patients who needed interpreting at any of the clinics;
- In one instance the researcher enquired from patients in the waiting area of an outpatient clinic whether they needed interpreters. The interpreter intervened and told the researcher that none of the patients needed an interpreter, as she had already asked them. When the researcher and research assistant departed from the hospital for the day, they met the patient outside on his way home. The research assistant and the patient started a conversation and the patient relayed to the researcher that "that lady"[20] had interpreted for him.

The human resource manager of the hospital learned of the presence of the researcher on hospital grounds via the interpreters and requested a meeting with the researcher and research assistant. The aim of the meeting was to inform the researcher about the interpreters in the hospital. Present at that meeting was the human resource manager, his assistant and the person who designed and presented the course for these interpreters. The researcher continually assured the meeting that the research conducted was only for her own academic purposes, and was in no way an assessment of the interpreters themselves. There seemed to be scepticism among the parties, which was also later noticed with regard to the interpreters.

[20] Referring to the interpreter.

On the second visit to the hospital the researcher tried another approach to gain as much data as possible. On this second visit, the researcher had to gain permission from the sisters in charge of the clinics again. They complied and granted permission. Then the researcher learned from another sister that the head of the outpatient department had a problem with the presence of the researcher, and the researcher had to deliver a copy of the letter of approval from the CEO of the hospital to the office of the head of the outpatient department. Another sister in charge told the researcher that she had to have a stamp from the medical superintendent's office in order to proceed with the research. Upon visiting the office of the medical superintendent she was informed that no letters of approval were ever stamped, and that the letter of approval was signed by the chief medical superintendent herself. The researcher requested that the office stamped the letter to minimise further problems for the researcher in collecting the appropriate data. The office of the medical superintendent also told the researcher that if any sister in charge were to refuse permission, the researcher should refer her to the office of the medical superintendant.

At this point, the researcher decided to try and record some interpreting sessions, but also to hand out questionnaires to participants who have used an interpreter at this specific hospital on a prior visit.[21] The researcher also included patients who have acted as interpreters for other patients. This seemed to complicate the data collection as the researcher would be busy completing the questionnaire with a patient in the waiting room, who was then called into the consulting room. All the patients, with the exception of one or two, in the waiting areas of the clinics indicated that they had never used an interpreter before, or that it was their first visit to the hospital. The nursing staff informed the researcher that they and the doctors were very busy, and would therefore not have time to complete the questionnaires. These events resulted in less data collected than indicated in the original research design.

3.9.1.1 Personal Observations

Upon enquiry from the reception at the outpatients department, it became clear that Groote Schuur Hospital had no interpreters employed. The researcher was informed that the staff members at the different reception desks displayed the most basic knowledge of Xhosa only

[21] The researcher decided to exclude the interpreters, as they seemed even more apathetic towards the presence of the researcher and research assistant, and did not seem compliant at all.

to provide the patients with basic instructions. (From reception the patients were sent to the various clinics.) Clinics were operating during the morning and afternoon. Approximately 500 patients passed through the clinics in the morning, and approximately 200 in the afternoon. These statistics were received from an administrative assistant at the reception desk. Nowhere, or at no stage in this process was the language preference or usage of the patient determined. [During an incident at the reception desk, the receptionist told the patient to "take a seat over there". The patient looked confused and the receptionist said: "*Hlala pantsi"* (sit down). This indicated that this patient was indeed in need of an interpreter when in consultation with the doctor.]

Groote Schuur Hospital had four employed interpreters. One interpreter was trained with the National Language Project (NLP) and had been at the hospital since 1996. The other interpreters were trained by means of a six-day course presented over one month run by the hospital. They had been employed as clinical interpreters since June 2007. At the time of the research, the interpreters had been employed by the hospital for a period of one year. By the time that the researcher visited the hospital in May 2008, the interpreters had never been evaluated on performance. The researcher was told that the evaluation would still happen sometime in future. The researcher had to make it clear to the interpreters that the study was not an evaluation of their skills as interpreters, but rather an investigation of the complete interpreting services offered by the hospital. The interpreters were reluctant to take part in the study.

3.9.2 Tygerberg Hospital (TGH)

This was the second hospital the researcher visited. On the first visit to the hospital the researcher decided to make use of the amended method employed at GSH. The researcher decided to collect data from the outpatient clinics, as was the case at GSH. There seemed to be confusion among nursing, as well as administrative staff, whether the hospital had employed interpreters or not. After investigation by the researcher it was revealed that the hospital had no formal interpreters employed, and that the person who was assumed to be the interpreter was actually a Xhosa-speaking pastoral care worker who had been *placed* at the hospital, but not *employed* by it. This person helped out at times when an interpreter was

needed. The hospital employed interpreters from an agency[22] on a contractual basis. However, at that given moment, the contract had expired, and the hospital had no interpreters employed. For this reason, the researcher decided to follow the second approach by handing out questionnaires to all the Xhosa patients, as well as medical personnel who were willing to comply.

The researcher introduced herself to the sister in charge of the clinics, as well as to the head of the pharmacy and the speech therapy department, who gave permission to proceed with the research. The data collection procedure seemed to be more difficult at this hospital. As a result of the lack of employed interpreters, data collection had to be completely randomised and the researcher had to employ convenience sampling. The patients also indicated that they would not need an interpreter. In one instance an older woman was sitting with her daughter. The research assistant informed the patients about the study, and enquired whether the older woman would need an interpreter or if her daughter would interpret for her. The daughter replied that she would interpret for her mother. When the research assistant enquired whether they would like to form part of the study, the daughter surprisingly replied that they were bringing their child to the clinic, and that it was not her mother who was visiting the clinic.

The researcher could not gain easy access to the doctors. The nurses mentioned that the doctors were busy and would not be able to complete questionnaires. When the researcher asked whether they would have time to complete the questionnaires they said that they did not have the time, even though they did not seem very busy. The response rate among medical staff was thus very low.

The reasons for the low response rate at this hospital were the following:

- Patients indicated that they did not use an interpreter during a prior visit to the hospital and would not need an interpreter during the specific consultation;
- Nurses either indicated that they did not have time to complete the questionnaires, or that they did not need the services of an interpreter very often. Many indicated that they only needed an interpreter about once a month. They relied on their little Xhosa language knowledge to communicate with the patients. Patients indicated that they knew Afrikaans, and therefore could communicate with the nurses and doctors.

[22] The researcher thought the agency was a communication or translation agency, but it turned out to possibly be a nursing agency.

From this it could be deduced that no language barrier existed in this hospital.[23]

3.9.2.1 Personal Observations

As part of the process to gain permission from this hospital's management, the researcher visited the hospital. Upon request to meet the interpreter, the interpreter of the hospital was paged and came to meet the researcher. It turned out that this person was however not the interpreter of the hospital; it was a clerk who took on the position as interpreter for some time as the post for the new interpreter still had to be advertised. The clerk also indicated that the following day would be her last day as acting interpreter. When the person who managed the interpreters was contacted, the person confirmed that the position was still to be advertised and that no official interpreter was employed by the hospital at that point. The researcher deduced from this, that only one interpreter was needed for the entire Tygerberg Hospital, as one post was to be advertised and only one person was acting as interpreter in the meantime.

Upon visiting the hospital for data collection, the researcher was initially told that the hospital had an employed interpreter. The researcher and research assistant then attempted to find this interpreter within the bounds of the hospital. At one of the outpatient clinics, the researcher was informed that there was no interpreter. The reason given was that only a limited number of patients who visited this specific clinic needed interpreting; the statistics would probably show that only one patient per month needed interpreting. In a case such as this a nurse would usually fulfil the role as interpreter.

3.9.3 Red Cross War Memorial Children's Hospital (RXH)

On the first visit to the hospital, the researcher established that the hospital had two formally employed interpreters. Upon requesting permission for the research from the sister who was in charge of the unit that the interpreters worked for, the researcher had to gain permission from the heads of the units first, despite the fact that the CEO of the hospital had approved the research. The reason given was that provision in terms of time[24] had to be made for the research and research assistant. Only the head of the trauma unit responded to e-mails sent

[23] Will be discussed in further detail in Chapter 4.
[24] Time would be spent to complete the questionnaires within the busy schedule of the staff members.

by the researcher. A meeting was scheduled, and the head of the trauma unit granted permission to the researcher to conduct the research.

On the second visit to the hospital, the researcher visited the sister in charge of the medical emergency ward, in which the other interpreter worked. The sister in charge granted permission, without mentioning that permission had to be gained from the head of the unit. The researcher and research assistant also gained permission from the head of the outpatient clinics to proceed with the research.

At first, the interpreters displayed apathy towards the research. One interpreter retorted sharply when she was informed about the research and said that she was tired of people doing research and that nothing was being done about the situation.[25]

The other interpreter had a problem when the researcher mentioned that the interpreting sessions had to be taped. The interpreter said that she was tired of people coming and taking their voices overseas. She asked the researcher whether it was possible for herself and the research assistant to only sit in on a session and listen to what was being said. The researcher explained to the interpreter that she was in no way obliged to take part in the research, and if she decided to take part it had to be out of her own free will, and not because she felt sympathetic towards the researcher. The interpreter said that she had to think about it because she did not like the idea of the conversations being recorded. After a while she informed the researcher that she would participate in the research and during the period of data collection she proved to be quite helpful and informative.

As it seemed as if the interpreters covered the entire hospital without any problems, the researcher and research assistant went around the hospital trying to distribute as many questionnaires regarding interpreting experiences during prior visits to the hospital to as many patients as possible. However, the researcher and research assistant were mostly stationed in one specific area. One interpreter requested that the researcher and research assistant stationed themselves in an area where she could easily find them when there was an interpreting session taking place. The interpreters were also called on the intercom system if they were needed. Upon hearing the announcement for a specific interpreter, the researcher

[25] The researcher did not ask what situation she was referring to, as it was the researcher's main aim at that specific moment to try and convince the interpreter to form part of the research.

and research assistant could go to the area where the interpreter was stationed, in order to explain the research to the patient and doctor, and to obtain their informed consent.

Access to doctors to complete questionnaires was difficult. There was, for example, one doctor who had to oversee an entire section and who later then moved on to the clinics. One of the sisters in charge told the researcher that the doctors would not be very cooperative. She indicated to the researcher which doctors would probably be more helpful, and also pointed out the times when they were on duty. The researcher managed to get two doctors to complete the questionnaires, even though she had to collect the forms a few days after she handed them to the doctors. One doctor also misplaced his questionnaire, and the researcher had to furnish him with another, which she only collected almost a week later.

Upon visiting the physiotherapy department of the hospital, it turned out that this department used an interpreter, but that this interpreter was not employed by RXH. The researcher initially decided to include this interpreter in the study. The interpreter undertook to inform the researcher when an interpreting session would take place. This interpreter also functioned as an auxiliary social worker, so that her function within the department was twofold. The researcher decided that this interpreter would be excluded from the study as her roles would at times overlap: apart from interpreting for the physiotherapists who did not understand Xhosa, she also communicated to the patients in her own language.

Upon visiting the outpatient clinics the researcher discovered that one of the clinics used an interpreter on Wednesdays for specific patients, and that she was not employed by the hospital on a full-time basis. When the researcher visited this clinic on a Wednesday in order to collect data, about three patients indicated that they would use this specific interpreter. The research assistant explained the aim of the research, as well as the research process to the patient, and received their informed consent to conduct the research according to the original design. When one patient entered the doctor's consulting room and the researcher approached the doctor to gain informed consent, the doctor replied that she did "not feel comfortable about this", and that the researcher should gain permission from the head of the specific clinic to conduct the research. This discouraged the researcher as she visited this clinic with the specific aim to collect data from this specific interpreter. The researcher then went back to the office of the CEO of the hospital, to gain another letter of permission with the necessary authorisation to perform the research in any department without prior

permission from individual department heads. The researcher received the letter, which stated that doctors would only have to concede if they gave their consent, and that no further permission would be sought. When the researcher got back to that specific clinic, the patients had already been in consultation with the doctors.

The patients' response rate to the questionnaires were also not very high, as many of them indicated that they did not use an interpreter during a prior visit to the hospital, and that they would not need an interpreter during this specific consultation.

3.9.3.1 Personal Observations

At the first visit to the hospital, it became clear there were only two interpreters employed in the entire hospital. One interprets in the trauma unit and in the wards, and the other in the medical emergency unit.

The interpreters are allocated to specific stations, and usually are called to a consultation to interpret via a bleeper system. When the researcher visited the hospital, the bleeper system was not working and the interpreters had to be called through the intercom system. However, this arrangement posed a problem as the speakers were not all in a working condition throughout the hospital. When an interpreter was in an area where the speaker was not working, he/she was not able to respond and was thus not present where the need for an interpreter existed at that time.

Besides these two interpreters, it later became evident that there were two other full-time interpreters, of which one acted as an interpreter in the physiotherapy department. This interpreter was however not employed by the hospital.

The following table presents a visual presentation of the amount of data collected:

Table 2: Actual data collected

Hospital	Patient Questionnaire	Medical Practitioner Questionnaire	Interpreter Questionnaire	Taped interpreting session corresponding with questionnaire
GSH	3	3	1	1
RXH	7	3	1	2
TGH	5	1	1	0
Total	**15**	**7**	**3**	**3**

3.10 Results from Patient Questionnaires

3.10.1 Participants' Age Ranges

The ages of the patients who participated in this study ranged between 17 and 82 years. The majority of the patients were female. The ages of the medical practitioners (including doctors, nurses, a social worker and an occupational therapy student) ranged between 21 and 47 years. The interpreters were between 33 and 45 years of age. This indicated that the patients and interpreters seemed to be older than the medical practitioners.

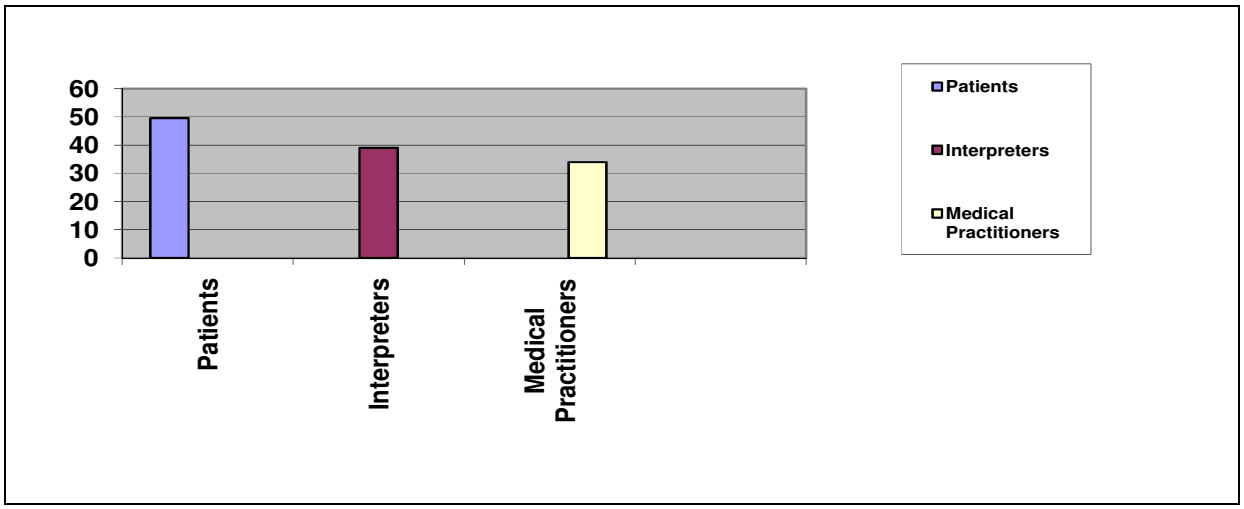

Figure 1: Average ages of participants

3.10.2 Participants' Geographical Location

All of the participants were residents of the Western Cape, although the majority of the patients originally hailed from the Eastern Cape.

The medical practitioners who formed part of this study represented both students who had been assigned to the hospital for one week and nurses who had been employed at a hospital for 25 years. Four of the medical practitioners were female, and three were male. The racial distribution of the medical practitioners was: white (three), coloured (three) and Indian (one).

3.10.3 Participants' Educational Level

The educational level of the patients ranged from having no formal education (never attended school) to standard 7 (grade 9). One participating interpreter passed grade 12 and one was busy studying towards grade 12. One interpreter had a qualification[26] from a nursing school. Those who acted as interpreters, had the following interpreter training: one, who was a nurse by profession, had no formal training as an interpreter; one had been trained by the National Language Project (NLP) and the other did a clinical interpreter training course (CITC) at GSH. The duration of the training presented by the NLP was one month, and the CITC was six days in total, but presented over one month. The aspects of these training courses are explained in 4.3.

3.10.4 Interpreter Availability

Nine out of the 16 patients (57%) indicated that there was always an interpreter available, and that the interpreter that interpreted for them displayed appropriate professional behaviour. If no interpreter was available, or if the patient had no family member to accompany him/her to the consultation to interpret, most of the patients asked a nurse or even a porter to interpret. Some patients would insist on an interpreter; others would try to speak on their own, and it was only at such instances that the doctor would request an interpreter. All 16 patients indicated that they need an interpreter every time they visited the hospital. The majority of the patients requested an interpreter from the doctor, i. e. in the consultation. The majority of the medical practitioners requested an interpreter before the consultation commenced, and they requested an interpreter from nursing staff or by using the phone switchboard or the bleeper system. The majority of the patients had not been given instructions as to how they could utilise the services of an interpreter. Three of the seven medical practitioners (43,%) indicated that there was always an interpreter available.

[26] The nature of the qualification was not disclosed on the questionnaire.

A nursing sister at Groote Schuur Hospital informed the researcher that the interpreter was supposed to interpret in all the clinics, but that she had never interpreted at that specific clinic since she was employed as an interpreter. Staff members of the clinic bleeped her, but she never responded, not even afterwards to ask whether she was still needed. As a result, the nursing sister, who was Xhosa-speaking, had to do the interpreting herself. She added that since they were short-staffed she did not have the time to interpret, and that she did not understand for what reason(s) the interpreter never came to interpret at that specific clinic. The researcher got the impression that the interpreter, who was assigned to interpret at all the clinics, only interpreted at two clinics.

The interpreter at TGH seemed idle during the second stage of the data collection, although there was one incident at a clinic for which an interpreter was needed. The patient could not converse in either Afrikaans or English. Upon realising this, the doctor requested one of the patients to interpret. However, none of the patients was willing to interpret. The patients told the researcher and research assistant that the doctor and patient did not speak a word to each other; the doctor simply read through the patient's file and treated her accordingly.

The following was said by one of the patients in the waiting room:

> "There is a special need of interpretation in hospitals especially I've been staying in Kraaifontein area. When I'm there I always see the patients ... who can't interpret and who can't speak to the doctors ... so they have to ask somebody ... so I think there is a problem for that because if the person ... can't talk to the doctor himself the doctor will give him a wrong medication because the doctor didn't understand what is the problem with that person."

3.10.5 The Need Frequency for Interpreters

The medical practitioners used interpreters daily, sometimes several times per day (RXH), once every second day (RXH), once or twice a week (GSH), or twice a day (RXH). The medical practitioner who used an interpreter twice a day did not make use of the official interpreter; he used anyone who could speak Xhosa. Five of the medical practitioners requested an interpreter before the consultation started, while two did not. Most of the medical practitioners request an interpreter through a member of the nursing staff, the bleeper

system, or the phone switchboard. All the medical practitioners felt that the interpreter they used, displayed appropriate professional behaviour and used the correct mode of interpreting. According to four of the medical practitioners an interpreter was not always available, despite the fact that the hospitals had employed interpreters.

Upon the question concerning the method the medical practitioners followed when there was no interpreter available, the responses on the questionnaire were as follows:

- I do it myself (TGH)
- Request nursing staff or reception staff if information is not too personal (RXH)
- Use nursing staff (RXH)
- Find someone who can speak the language, e.g. security guard, even other patients sometimes (RXH)
- Struggle (GSH)
- Ask staff members, ask other departments (GSH)

None of the medical practitioners ever received any instruction on how to utilise the services of an interpreter. Two of the medical practitioners indicated that they rephrased their questions when they did not understand what the interpreter said to them.

Twelve patients indicated that they requested an interpreter before the consultation started, and the majority of these patients requested an interpreter from the doctor. The doctor would usually ask a nurse or anyone who was Xhosa-speaking to interpret. It was evident that the only time an interpreter became part of a patient's hospital visit, was when the patient eventually saw the medical practitioner. From this observation, the administration of the interpreting services within the hospital was questionable. It was not established at any point prior to entering the medical practitioner's consultation room, whether the patient would need an interpreter. This might be due to the fact that time constraints are a primary factor: by the time the medical consultation occurred, any person who could speak and understand Xhosa was randomly used as ad hoc interpreter.

3.10.6 Problems

All the patients indicated that they never experienced any problems when they used an interpreter. In my opinion, the mere fact that interpreters were not readily available at times,

when patients needed them, constituted a problem in itself. The problems that the medical practitioners experienced were:

i. Patient does not trust the doctor or nurse [only the interpreter] (TGH)
i. Patient is unsure [whether] the procedure will go well (TGH)
ii. Frequently need to wait and reschedule interviews as interpreter unavailable (RXH)
iii. [Interpreter] nods off during sessions sometimes (RXH)
iv. Interpreter sometimes needed (GSH)
v. Prompting to relate what patient said (GSH)
vi. Waiting period, when interpreter is busy somewhere else (GSH)
vii. Shortage of staff, not enough interpreters (GSH)

The problems that the interpreters experienced were:

i. No problems (TGH)
ii. I don't have much problems, if there is a problem I know how to solve it (RXH)
iii. One interpreter for two or more clinics on one day, the solution is that we need more interpreters (GSH)

3.11 Conclusion

The aim of this chapter was to provide an overview of the research methodology employed in this study, and to discuss the sampling technique and data collection procedure. This chapter also aimed to explore the extralinguistic factors encountered during the data collection procedure, as well as the responses from the questionnaires completed by the role players in the interpreting session that related to the extralinguistic factors of the interpreting sessions and interpreting set-up within the field of study.

This study is qualitative in nature and the data was obtained from the questionnaires provided for patients, medical practitioners and interpreters. These verbal and written responses will provide an overall picture of the interpreting services, together with experiences during interpreting sessions, and personal observations made by the researcher in the process of data collection.

The data collection process at Groote Schuur Hospital, Red Cross War Memorial Children's Hospital and Tygerberg Hospital produced a number of problems. A low response rate to taped interpreting sessions was experienced, due to sessions being missed, no interpreters being available, nurses trying to communicate with patients in their own language and patients trying to communicate with medical staff in the language of the staff. The low response among medical practitioners seemed to be the result of mainly time constraints, together with a shortage of staff members. The low response rate of the patients was due to patients indicating that they did not need interpreters or never utilised the services of an interpreter during prior visits to a specific health care institution. The low response rate of interpreters was due to the limited number of formally employed interpreters, who had to serve a large population of medical practitioners and patients.

CHAPTER 4

LINGUISTIC SITUATION

4.1 Introduction

The aim of this chapter is to document the results pertaining to the linguistic aspects of the data collection process as explained in Chapter 3. These results will either have been obtained from personal observations by the researcher or research assistant during the data collection procedure or the results of the questionnaires completed by the role players in the interpreting sessions. Transcribed and translated sections from the taped interpreting sessions obtained during the data collection process mentioned in Chapter 3 will be discussed and analysed.

4.2 Participants' Language Proficiency

All the patients were proficient in Xhosa; they could read, write, speak and understand Xhosa, with very little proficiency in and understanding of English. The medical practitioners were mostly proficient in English and Afrikaans, with the exception of two who were proficient in French and Zulu respectively.

Table 3: Participants' Language Proficiency

Participant	Afrikaans	English	Xhosa	Zulu	French
Patients		x*	x		
Medical Practitioners	x	x		x	x
Interpreters	x	x	x		

* Limited English Proficiency (LEP)

From this table, the general statement can be made that direct understanding between doctor and patient would not be possible. The only language common between both parties was English, but the patients had limited proficiency in this language. Therefore, the only way to bridge the language gap would be to use an interpreter that was sufficiently competent in both English and Xhosa. The reason for the sufficient competency in English is two-fold. Firstly, the interpreter should be able to comprehend the English spoken by the doctor, who most

probably would assume that the interpreter was competent in English, and would therefore not adapt his/her speech to accommodate the interpreter. Secondly, complete comprehension of what the doctor said would require the interpreter to be sufficiently competent in English to relay the more "formal" English to a more simplified English, in order for the patient to follow the communication. Without the interpreter being competent to convert the technical language into a more simplified language, the message will either not get through to the patient or the wrong message will reach the patient.

4.3 Interpreter Training Programmes

4.3.1 National Language Project (NLP)

At the time of its inception in September 1996, a number of interpreting positions for the NLP were advertised. Of the 300 applicants who responded, 22 were selected. Criteria for the trainee interpreters included that applicants had to be mature Xhosa-speaking females who have attempted standard 9 (grade 11) or standard 10 (grade 12), and with a background in health or community work (Ntshona, 1999: 143 – 155).

Of the 22 trainee interpreters, 2 were promoted to coordinator and supervisor; the remaining 20 were placed in 10 health care institutions in the Cape Peninsula in the Western Cape. Three of these NLP interpreters were placed at Tygerberg Hospital, three at Red Cross War Memorial Children's Hospital and three at Groote Schuur Hospital. At the time of this study, none of the placed interpreters at Tygerberg Hospital was still employed; one was still employed at Groote Schuur Hospital, and two employed at Red Cross War Memorial Children's Hospital.

The following table gives a representation of the training programme of the NLP[27]:

Table 4: NLP

Aspect	Elements	Duration
Interpreting	What is a community interpreter?, Role of community interpreter, Interpreting and advocacy, Code of practice for community interpreting, How to handle terminology problems, Interpreting method	1 week

[27] For the complete course content of the NLP, see Addendum V.

Constitutional Affairs	SA Constitution, Reconstruction and Development Programme (RDP), Human rights, Concept of an ombudsman	1/2 days
Skills Development	Assertiveness, Advocacy, Mediation, Negotiation, Problem solving	1 week
Counselling and Cultural Affairs	Concept of counselling, Knowledge of the self, Verbal and non-verbal communication, Listening skills, Confidentiality	1 week
Health Information including Health Promotion	Introduction to the health module, The concept of health, National and Provincial Health Plan, Organisation of health services in the Western Cape, basic anatomy and physiology, Sociology, psychology and illness, Structure of a consultation between doctor and patient, Common medical problems, Role of health personnel in a health facility, Patients' rights, Introduction to health promotion	1 week
Ethical Issues	Concept of an informed consent, Confidentiality, Whose duty it is to break bad news to the patient	1/2 days
Administration	Orientation to NLP and health facilities, structures and administration, Reporting (verbal and written)	1 day
Practical Clinical Teaching and Seminars	Methods of facilitating: Short lectures, Group discussions, Assignments, Case studies, Role plays, Seminars, Clinical Orientation Visual aids: Videos, Overhead transparencies, Pictures, Clinical equipment Evaluation: Evaluation at the end of each day, A test at the end of the first month, An examination at the end of two months Certification: Certificates will be issued at the end of the course to candidates who have successfully completed the course.	4 weeks

4.3.2 Clinical Interpreter Training Course (CITC)

This course was presented during June 2007 at Groote Schuur Hospital. The course was presented as a pilot programme to employ interpreters at the hospital, as there was a great need for them. The interpreter position was advertised internally and three people, who were already employed by the hospital and worked as, among others, cleaners, were selected to attend the course for interpreter training. The only requirement for this course stated that applicants should be able to read and write. No pretesting of linguistic ability, linguistic transference or the ability to interpret formed part of the selection and recruitment process. The trainees were then subjected to interpreter training for six days, which was presented over one month. Practical interpreting constituted only one day of the entire course. The trainees were not subjected to any postcourse testing to assess whether theoretical knowledge had indeed been acquired during the course. One of the presenters of the course also mentioned that the course had to be presented "on their level", which meant that the theory had to be simplified to the level of understanding of the trainee interpreters, of whom some did not have a grade 12 qualification.

The aspects covered in this course included[28]:

Table 5: CITC

Aspect	Elements
Day 1	
A) Interpretation and Ethics	Definition, Types, Translation, Advocacy, Values, Ethical principles, Health and Human Rights
B) Interpreting in a health care setting	Code of conduct, Role and function of interpreter, Interpreting in various situations, Dealing with ethical issues, Dealing with difficult terminology
Day 2	
C) Language Skills	Multilingualism, Fluency, Colloquialism, Regional / cultural differences, Linguistics
D) Communication Skills	Process, Listening, Verbal and nonverbal communication, Writing skills
E) Self-management and Client Care	Self management, Time management, Record-keeping, Telephone etiquette, Client care, Batho Pele
Day 3	
F) Interpersonal Skills 1	Assertiveness, Conflict management, Interpersonal relationships
G) Practical / Role play	Clerking procedure, Admissions, Preparation for theatre, Discharge, Records
H) Feedback	Discussions, Role play
Day 4	
I) Intra and interpersonal skills 2	Counselling, Problem-solving and decision-making, Coping with emotions (E. I.)
J) Health Care 1	Introduction to health and basic health science (Anatomy and Physiology), Disease and illness, Common health problems, Medical terminology, Health services / organisations, WC, Health professionals' consultations with patients
K) Health Care 2	Introduction to health promotion, Lifestyle
Day 5	
L) Introduction to Anthropology	Culture, Belief systems
M) Introduction to Sociology	Sociology and health, Diversity management, Interpreting in a multicultural health care setting
N) **Assessment**	
Day 6	
O) Introduction to Medical Sociology	The multidisciplinary team
P) Practical	Visit to clinical area
Q) Portfolio	Revision of course requirements

4.3.3 Comparison of NLP and CITC

Both the NLP interpreter training course and the CITC were designed as a result of the language barrier between Afrikaans- and English-speaking medical staff on the one hand, and Xhosa-speaking patients on the other. This language barrier already existed as a problem prior to 1994, and remained a problem in 2008. The content of these two training courses

[28] For complete course content of the CITC, see Addendum V.

show a number of similarities, but also vast differences. The selection criteria of the NLP were much higher than that of the CITC, even though the interpreters had to fulfil the same role within the boundaries of the hospitals they had to render their services. The CITC continued over a period of six full days only, which was stretched over a period of one month. The NLP was presented over a two-month period. With regard to the CITC and the fact that the course content had to be simplified for the trainee interpreters, the researcher has some doubts as to whether the course content was not too condensed for the trainees; a high information density might have caused the trainee interpreters to forget some information. There was just too much information to assimilate during such a short space of time.

The interpreters trained by the NLP were referred to as *community interpreters*, while the CITC interpreters were called *clinical interpreters*. According to Ntshona (1999:145) community interpreting was chosen as the genre of interpreting for training, because the interpreters would have to represent the interests of the patients and assess the patients' needs in order to assist them in receiving the care they deserved. Therefore, although interpreters should remain neutral during the interpreting session (Shotsky-Faust & Drikery, 1986: 131, as cited in Ntshona, 1999:148 - 149), they should act in the best interest of the patient. Should they be devoted to the medical practitioner, it would suggest that they possessed medical information, which would enable them to be of assistance to the patient *from a medical point of view*. The medical diagnosis should be left to the doctor or nurse. The role of the interpreter should be to get the best possible information from the patient and to communicate that in the best possible way to the medical practitioner in order for the medical practitioner to make a diagnosis. By naming an interpreter in the health care setting a *clinical interpreter* suggests that the interpreter does indeed possess medical information, and is able to assist the medical practitioner on making a diagnosis, based on inherent knowledge.

This was apparently not the case as the following example illustrates: When a woman (who accompanied her daughter who was the patient) at Groote Schuur Hospital was asked whether she had used an interpreter at the specific hospital before, she replied that she had not, but that she felt that there should have been an interpreter to explain difficult terminology to her. Her daughter was diagnosed with lupus, and the doctor provided an explanation which she did not understand. If there were a Xhosa-speaking person who could explain the illness to her, then she might have been able to understand the concept better. When the interpreter, assigned to the clinic that specifically dealt with this disease, and who had been

working as interpreter for more than one year at the specific hospital, was asked what lupus was, she told the research assistant that the doctor and nurse should explain what the illness was; she also said that it was a disease similar to arthritis, and that many different forms of the illness existed. The expectation created by the term *clinical interpreter* and the fact that the interpreter was working at the clinic that specifically dealt with this illness, implied that the interpreter should at least know what lupus was, and should have been able to give a description of the illness.

When asked in the questionnaire which aspects were studied during interpreter training, the interpreters answered the following: communication, confidentiality, sickness (GSH) and counselling, and assertiveness (RXH). The interpreters at RXH and GSH were placed at the specific hospitals as a result of their interpreter training. The interpreter at TGH was placed as interpreter by the nursing agency that she worked for, with no formal training in interpreting, or no person teaching or informing her about any aspects of interpreting.

4.4 Bleeper System or Phone Switchboard

Interpreters employed at TGH, RXH and GSH made use of bleepers, on which they were contacted when they were needed to interpret. If the interpreter was needed in a certain area, the person who needed the interpreter or the nurse, for example, would call the radio room, which in turn would bleep the interpreter. The interpreter would then have to find a telephone and phone the area from where he/she was bleeped, and would then proceed to that specific area. In a hospital with such magnitude as the three tertiary hospitals involved in this study, and especially in the case of TGH, which has one interpreter only, this might seem a daunting task. During the data-collection process at TGH, the interpreter was called to interpret. The interpreter was stationed on the ground floor of the east wing of the building and was needed on the eighth floor of the west wing of the hospital. The interpreter then had to cross the ground floor to the west wing, from where she could take one of many general lifts, which also transported hospital staff, patients and visitors, to the eighth floor. When the interpreter reached the eighth floor and the ward that she had to interpret in, she was told that the doctor had already used a nurse to interpret, so she was no longer needed. On further investigation, it became evident that the nurse who was used as interpreter, quite often had to fulfil this role as substitute interpreter. When the research assistant spoke to her, he noticed

that she was not speaking Xhosa properly. When he asked her about it, she said that she was a Xitsonga first language speaker, and tried to speak and understand Xhosa.

There seemed to have been discrepancies regarding whose responsibility it was for getting the interpreter to where she was needed. The interpreter seemed to respond to the need and demand reactively, and did not establish this need and demand proactively. This means that the interpreter waited passively to be called. This idle mode is not conducive to the current ad hoc and erratic interpreting administration within the hospitals. Instead of the interpreters being headed by a nursing sister, who has no insight into linguistic professions and the interpreting situation, the interpreters should be headed by someone who is more inclined towards the language professions.

In addition it became evident that these interpreters had to perform menial administrative duties when they had no interpreting work. Since these interpreters were supposed to be "professionally trained", these additional duties immediately reduced their professionalism. If the interpreting services within hospitals were better regulated, these interpreters could have focused on the language situation within the hospitals in order to enhance the quality thereof. Instead, they were now performing duties that should have been assigned to someone who had been appointed to perform them. The interpreters should form part of the language organisation within the hospitals, and should be able to facilitate the translation of relevant documents. A patient at RXH mentioned that she once had to help an old woman fill out a form, which was only available in English, and which was very difficult to comprehend. The hospitals should make these forms, which at RXH were only available in English, available in all three official languages of the Western Cape. The skills of the interpreters should be at such a level that they could ensure this kind of service to patients.

This professionalism also relays to the educational level of the interpreters. According to Feinauer (2005) the term "professional" means that one should be able to assess the quality of one's own interpreting product and that one should be more than simply competent in the field of interpreting in any setting. In these specific interpreting settings, one should also have a good command of both source and target language, as well as knowledge of the specialised terminology used in a health care interpreting setting. Therefore, if interpreters are not very proficient in their second language (e.g. English), and the English-speaking medical practitioner notices this, the professionalism of the interpreter would immediately be

questioned. For this reason, trainees in the health care setting, who have to undergo a training course, should not be subjected to a course that is presented "on their level". Would such trainees ever be able to use the register of the medical practitioner? On the other hand, both doctors and nurses should try to use plain language to accommodate both patient and interpreter, and therefore increase the level of understanding (Lesch, 2007: 44).

The majority of the patients felt that the interpreter said everything that the doctor said, did not add or omit any information, and explained difficult terminology to them. If one explores the LEP of the patients, one can argue that the patients place their full trust in the interpreter to relay all information to them, because they do not fully understand what the doctor says in English, and because they see that as the role of the interpreter. This aspect is important to note when the quality of the interpreted product is evaluated. Ten patients indicated that they did not receive any instruction on how to utilise the services of an interpreter.

4.5 Problems

All of the patients indicated that they had never experienced any problems when they used an interpreter. In my opinion, the mere fact that no interpreter was available at times, while the need for an interpreter existed throughout visits to the hospital, constitutes a problem in itself. The problems that the medical practitioners experienced were:

i. Interpreting must be clear otherwise the patient does not understand the procedure (TGH)
ii. Sometimes the interpreter answers for the person based on information previously shared during interviews and does not relay the rephrased question to the person/interviewee (RXH)
iii. [The interpreter] communicates beyond questions asked by [medical practitioner] (RXH)
iv. The interpreters who have more medical experience (such as nurses) are the best [interpreters] (RXH)

4.6 Language Barriers

Patients were very reluctant to admit their need for an interpreter, that they had used an interpreter at a previous visit to the hospital, and that they did not understand the doctor or

nurse properly. This might stem from fear of stigmatisation borne from the belief that if you had no or not sufficient knowledge of English within the South African context you were regarded as "stupid".
The following instances of language barriers were observed in the hospitals:

(i) The researcher and the research assistant found a patient [29] in the reception area. The patient indicated that she had used an interpreter before at the hospital, but the interpreter worked as a cleaner. At this point, the patient had to go to another unit and did not have time to complete the questionnaire. While the patient was waiting in the unit to be tended to, a doctor asked the patient about her reason(s) for visiting the hospital. The patient replied that she wanted to have her baby tested. The doctor told the patient that RXH was not a walk-in hospital, and that she had to be referred to the hospital by her local clinic. He also told the patient that the next time she visited the hospital she had to go to her local clinic first. They should refer her to the hospital; she should not come to the hospital out of her own accord. The doctor then referred the patient to (clinic) S19. At first it was difficult for the researcher to grasp what the doctor tried to explain to the patient; the rate of his speech delivery was also fast. He did not try to slow down his speech to ensure that the patient indeed understood what he said.

When the researcher asked the doctor whether, in his opinion, the patient understood everything, he replied that the patient got the "gist of it", and that he would not be the final person to see her. He added that the interpreter was sitting around the corner, should he need her. Afterwards, the researcher and research assistant found the patient at the reception area. She looked confused and the research assistant had to direct the patient to S19.

(ii) A nurse asked a patient what was wrong with her baby. The patient then pointed to the baby's chest. The nurse asked "Is it his chest?" The patient replied: "Yes". The nurse asked: "What's wrong with his chest, is he coughing?", and made a coughing action by putting her hand in front of her mouth, without any coughing sound. The patient again said: "Yes". The nurse continued in Afrikaans: "Moenie vir alles *yes, yes* sê nie, moenie my kwaad maak nie, man!"[30] The nurse then called upon a Xhosa-speaking nurse to speak to the

[29] Whenever "patient" is used in relation to RXH, it refers to the parent or person accompanying the child, unless otherwise stated.
[30] "Don't say *yes, yes* to everything, don't make me angry!"

patient, because it was evident by the puzzled look on the patient's face, the delay in response, and the monosyllabic replies that the patient did not understand what the first nurse said.[31]

4.7 Untrained Interpreters

A nursing sister told the researcher that a mother was visiting the clinic with her child who had an abscess. It was getting late and the mother said that she had to go home to pick up her other children from the crèche. The sister asked the mother if she couldn't phone the crèche to ask if they could keep the children there for a while longer. The mother then replied that she did not know the number of the crèche. The sister asked if the mother's older son could not pick up the children from the crèche, but the mother replied that she did not know her son's contact number.

The sister then randomly found a Xhosa-speaking person to explain to the mother that she had to take her child and the letter of reference to the hospital, go home and tend to her other children, and then come back to the hospital so that the child could get treatment for the abscess. After some time the nursing staff noticed that the child was sitting in the waiting area alone; the mother had left. As a result, the doctors had no other choice than to admit the child to hospital.

When the mother returned the following day she told the nursing staff that she was the child's foster mother and that she went home to fetch the documents that proved this. The sister thought that the miscommunication occurred because the Xhosa-speaking person used as interpreter had not been trained how to interpret.

4.8 Tygerberg Hospital's "Interpreter", Ms X

At the next outpatient clinic that was visited, the researcher was told that the hospital had an interpreter. The interpreter was subsequently bleeped by a nursing sister. The interpreter did not call back for quite some time. When the researcher approached the nursing sister to ask

[31] The interpreter is not brought into the communication equation at any stage; it was expected that either patient or doctor would request an interpreter during the consultation process.

whether the interpreter was still going to show up, the nursing sister made a call and informed the researcher that this person was no longer the interpreter for the hospital, and worked for pastoral care. However, this person would at times render an interpreting service at times when it was truly necessary. The nursing staff was unable to direct the researcher to Ms X's office.

Next, the researcher went to the Human Resource (HR) department of the hospital to establish whether there were any interpreters employed at the hospital. The researcher was informed that no interpreters were employed at Tygerberg Hospital at that time (that was two months after the researcher visited the hospital for the first time and established that the post for an interpreter still had to be advertised). In the meantime, the hospital used the services of an agency to supply them with interpreters on a contract basis. However, this contract has expired, and no interpreters were available at the hospital at that moment. When the researcher mentioned that some staff members regarded Ms X, the pastoral care worker, as an interpreter, the HR staff was not aware of her and did not know where to find her.

In the researcher's effort to track down Ms X, the researcher asked one of the clerks at a reception desk at an outpatient clinic where she could find Ms X, the pastoral care worker. Neither the receptionist nor other staff members knew Ms X, but as soon as the researcher mentioned that Ms X was also the interpreter, they knew exactly to whom the researcher was referring and bleeped Ms X. Ms X then invited the researcher and the research assistant to her office.

It turned out that Ms X had been employed by her church to work at the hospital as a pastoral care worker. This implied that whenever a doctor had a difficult message to communicate to a patient, or needed help with a patient who did not want to comply with instructions, Ms X was called in. Her job was to comfort and care for the sick and needy; to provide care of a Christian nature. Ms X gave examples of what her work entailed:

- A patient once refused to take his medication. Ms X was called in to talk to the patient, and convince him to take his medication.
- A patient ridden with cancer was at such a stage that the illness had spread through the patient's body. There was nothing more that could be done for the patient. Ms X was then called in to inform the patient of the severity of his condition.

Ms X explained she was called an interpreter, because from time to time she interpreted for a doctor when he/she did not understand the patient, or the patient did not understand him/her. For this reason, anyone who needed an interpreter and knew of Ms X would bleep her whenever they needed an interpreter. Even though Ms X did not mind performing this duty, she did not get paid for performing the duties of an interpreter. The following represent some examples that Ms X gave about incidences where no interpreter was involved:

- A girl was sexually abused, and she had to relay what happened to her to a male (the medical practitioner) whose language she did not understand, who did not understand hers, and who was culturally different from her.
- A patient came to the hospital and complained that she felt unwell. It turned out that the patient took two pills once a day when she was supposed to take one a day. This miscommunication was possibly rooted in the instructions she received from the person who gave the medicine. This person did not consider the fact that the patient might not understand him/her.
- A doctor was asking a patient some questions; Ms X happened to be in the vicinity. The patient answered "yes" to all of the questions that the doctor asked. Ms X went up to the patient and asked him whether he understood what the doctor asked him, and also asked the doctor if he could not notice that the patient answered "yes" to every question he asked even though the question required a different type of answer.

Ms X mentioned that the hospital urgently needed interpreters. There were three interpreters, employed on a contract basis, but after their contract ended, they had to leave the hospital. At this time, staff members from the paediatric and psychiatric departments had a genuine need for interpreters. To prove that the hospital had no interpreters employed, Ms X phoned the radio room and asked them to call/bleep the interpreter. They told her that there were no interpreters and that they had to hand in their bleepers when they left the hospital.

Tygerberg Hospital thus had no interpreters employed. There was Ms X, who was presumed to be the interpreter. However, she took it upon herself to help her people. Ms X was not a trained interpreter, but she knew Afrikaans, English and Xhosa.

Upon return to TGH for data collection, the researcher and research assistant learnt that a new interpreter (not Ms X, who was the presumed interpreter) had been appointed. This new

interpreter was a nursing assistant by profession and had been working for a nursing agency as an assistant nurse. On several occasions, this person had to interpret for doctors at TGH, RXH and GSH. The new interpreter had no interpreter training. The staff members of only one section of an outpatient clinic that the researcher and research assistant visited were aware of this new interpreter. One administrative assistant, who was also aware of the presence of the interpreter, was under the impression that there was an interpreter assigned to every floor.

Most of the nurses indicated that they did not need often an interpreter; most of them indicated that an interpreter was needed more or less once a month. In one of the outpatient clinics the nurse said that she did the interpreting herself; in another outpatient clinic a nurse was used as an interpreter on a regular basis.

4.9 Interpreting Product against Participant Perceptions

According to Gile (1995:24,34) (see 1.6) the quality coin has two sides. The first is the participants' perceptions of the quality of the interpreted product and the second is the quality of the interpreted product itself, analysed according to the criteria that constitute interpreting quality. The transcribed sections[32] that will be discussed in this section had been analysed in accordance with the table for analysing interpreting quality, as explained in 3.4. The findings of this part of the research will be discussed below. However, it should be borne in mind that these findings cannot be generalised across the health care interpreting setting of the whole of the Western Cape, or even across the three hospitals in general. These findings are purely situational, and an in-depth study would be necessary to determine the overall quality.

4.10 Role players in the Interpreting Session

As mentioned in 2.5, four role players exist within an interpreting session. These role players are sender, receiver, client and interpreter. Within these interpreting sessions the medical practitioner[33] acts as both sender and receiver. The question that they put to the patient positions them as sender; the response they receive, positions them as receiver. The patient, patient's mother or patient's family member fulfil the role as receiver and sender too. The

[32] For complete transcribed sections of all the taped interpreting sessions, see Addendum IV.
[33] With reference to RXH, the medical practioner can also refer to the social worker.

question they receive from the medical practitioner or social worker puts them in the position as receiver, and their response to the question puts them in the position as receiver. The interpreter fulfils the role of interpreter, to get the message across between the sender and receiver. The client in the interpreting sessions would be the hospital or hospital management, as they commission the interpreter or interpreter services to fulfil the need for interpreting services.

For these interpreting sessions the interpreter would be in a good position to assess the quality of the interpreting sessions. As seen in Table 3, the interpreter had proficiency in both English and Xhosa – the working languages for these interpreting sessions.

The patient, patient's mother or patient's family member as sender and receiver was not in a position to assess the quality of the interpreting sessions as they have knowledge of Xhosa, but limited proficiency in speaking and understanding English. The medical practitioner as sender and receiver was also not in a position to assess the quality of the interpreting session, as they had knowledge of English, but no knowledge of Xhosa. The client may assume that the interpreting sessions were of good quality. They did not assess the interpreters, and did not receive feedback from any of the other role players.

Selected sections of interpreting sessions will now be discussed to determine the quality of the interpreted product (i) according to the quality table and (ii) according to the responses of the participants.

4.11 GSH

4.11.1 Participants and Seating Arrangement

The patient was an 82-year old woman, who spoke Xhosa as mother-tongue. She never attended school and could not speak, read, write or understand English. The medical practitioner was a 32-year old male doctor who had proficiency in English and French. The interpreter was a 45-year old female, proficient in Afrikaans, English and Xhosa, and trained by the CITC. The patient's daughter was also present at the interpreting session.

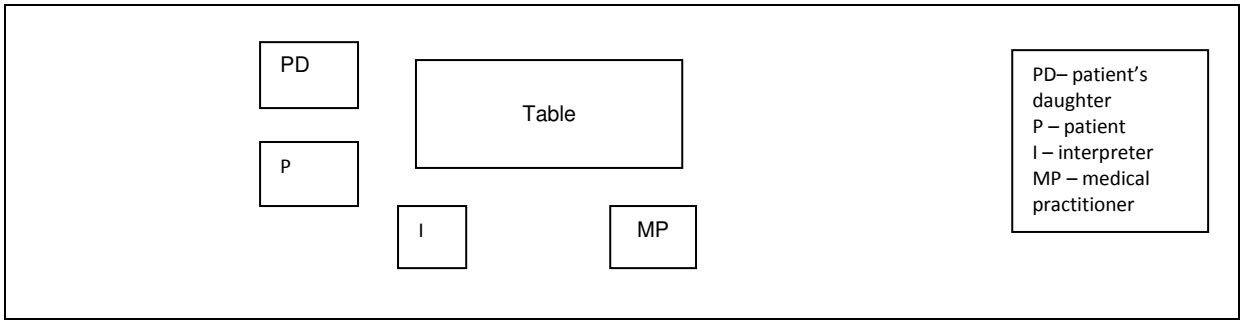

Figure 2: Seating arrangement GSH[34]

(A)

Doctor:	So she is there to make translating. I'm just going through the...history a bit errr
Interpreter:	Uthi uzakukhe afunde ugqirha kancinci.
	(He says he'll read a bit.)

None of the medical practitioners employed in this study had been thoroughly instructed on how to utilise the services of an interpreter. In section A it was clear that these services were of no importance to both doctor and interpreter, as the doctor did not explain the role of the interpreter properly. The interpreter did however explain her role to the patient before the session started. According to Sevilla Mátir et al. (2005) a work plan should exist between interpreter and doctor for each patient (see 2.7). This should be kept in mind when a bilingual person is used as an interpreter. For this reason, the doctor and interpreter should liaise beforehand on how the patient should be handled, and whether any aspects need to be taken into consideration during the interpreting session. In this specific session, the patient's situation, history, etc. were only known to the doctor; the interpreter was requested to simply interpret without having any knowledge of the patient's situation.

(B)

Doctor:	Yah, so how's mama doing?
Interpreter:	Umama uqhuba kanjani?
	(How is mama doing?)
Patient's daughter:	Malunga njani ke?
	(What do you mean?)
Interpreter:	She need explanation about how…

[34] The aim of the inclusion of the seating arrangement during the interpreting session is to provide a visual representation of the actual interpreting session, as there were no video or photographic equipment employed during the study. Also note that the ideal seating arrangement within a community interpreting setting should be triangular in nature.

Doctor:	Okay what I want to know is that I want to know how she's doing generally at home what is the situation like?
Interpreter:	Uthi ke ugqirha pha endlini ingaba impilo yakhe ihamba kanjani? *(The doctor asks at home, how is her health doing?)*

Once again, the doctor knew what he meant by this question, but without prior consultation with the interpreter she had no idea what was meant with this question, and therefore was unable to communicate the intended meaning to the patient's daughter. It would be a natural response from the patient's daughter to doubt the meaning of the question. Only afterwards, when the doctor realised the confusion, he explained what he really meant with the question. One could also argue that a question such as "How are you doing?" would refer to nothing other than a person's health in a medical setting such as this, and that the interpreter should have picked up on the extralinguistic factors that were coupled with this question.

(C)

Patient:	Yababhetele ngoku laa nto yokujikeleza kwengqondo. *(It is better now the condition of feeling dizzy)*
Interpreter:	The nauseous is much more better now.
Doctor:	Nauseous?
Interpreter:	Yes
Doctor:	Was she vomiting before?
Interpreter:	Ubugabha ngaphambili? *(Were you vomiting before?)*
Patient:	Bendingagabhi bekujikeleza ingqondo. *(I was not vomiting but feeling dizzy.)*
Interpreter:	She's says she was not vomiting but err err…
Doctor:	Are you saying nausea or dizziness which one is it?
Interpreter:	Dizziness
Doctor:	Not nausea?
Interpreter:	Not nausea yes

I am of the opinion that no interpreter is perfect, but that everyone strives to be, or should at least try to be. Gile (1995:13) mentioned (see 1.7) that an interpreter should have a good command of both the source language (SL), as well as the target language (TL). This last example illustrated that this was not the case: the interpreter either did not know the English equivalent ("dizzy) for the Xhosa word or she could not find the English equivalent "dizzy /

dizziness" immediately. Despite this, the interpreter did not once request the patient or doctor either to elaborate on the explanation, or even requested to have the word repeated that she was looking for. She probably simply used the word with the closest association ("nausea"), which in this case was not true. It was only when the patient repeated that she had experienced dizziness, that the interpreter realised her faux pas, and it became evident that she either did not know the word, or that she had completely forgotten it. This faux pas was on a lexical level only, as the researcher assumed that the interpreter understood what the patient was referring to, knew the concept, but could not access the correct term. The researcher also noticed that the interpreter was not equipped with a note-pad or even a dictionary – some of the required aids during a consecutive interpreting setting. Therefore, the only resources that she could rely on were the patient and doctor, but she did not utilise them when the need arose.

(D)

Doctor:	So what is the problem that she thinks the mother still has?
Interpreter:	Ucinga ukuba yintoni enye ingxaki umama anayo ngoku, esashiyekeleyo?
	(Do you think there is another problem your mother has that is left?)
Patient's daughter:	Okwangoku, ngumzimba ngoku oshiyekileyo obuhlungu, namadolo adumbile.
	(For now, it is the painful body and the swollen knees that are a problem)
Interpreter:	The knees are swollen and...
Doctor:	No about the confusion?
Interpreter:	Apha ke engqondweni ingaba ikhona into oyicingayo ukuba isekhona, esaseleyo?
	(In your brain, do you think that we have left something behind?)
Patient's daughter:	Yoh...ndiza kuyazela phi ke mna loo nto?
	(Oh, how am I going to know that?)

The conversation following this excerpt dealt with the patient's experiences regarding her confusion. Once again, the doctor should have explicated what he meant by his question. The difference in power between doctor and interpreter was evident during this interpreting session. The doctor did not seem to have enough confidence in the interpreter or in the abilities of the interpreter, and the interpreter seemed to be intimidated by the doctor.

(E)

Doctor:	Okay…does she hear any voices talking to her?
Interpreter:	Uyabeva abantu xa bethethayo mama?

	(Do you hear people when they are talking mama?)
Doctor:	When there are no people
Interpreter:	Xa kungekho bantu apha ecaleni kwakho.
	(When there are no people close to you.)
Patient:	Hayi iindlebe zam azinanto.
	(When I'm talking to a person.)
Interpreter:	Xa kungekho mntu?
	(When there's no person?)
Patient:	Ewe
	(Yes)
Interpreter:	She does hear the people talking even if they are not around.
Doctor:	So she still hears the voices?
Interpreter:	She still hear that.
Doctor:	Where does she hear them?
Interpreter:	Ubava xa besecalweni kwakho okanye ubeva xa bekude?
	(Do you hear when they are closer to you or when they are far?)
Patient's daughter:	Xa betheni sisi, xa bencokola okanye xa besecaleni kwakhe?
	(When they are doing what sister, when they are talking to themselves or what?)
Patient:	Hayi andinangxaki mna ndibeva kakuhle.
	(No I don't have a problem, I can hear them properly.)
Interpreter:	She don't have a problem, she do hear people when they are talking even when they are far and when they are near him.
Doctor:	No I'm talking about, you must understand what I'm talking about...I'm talking about the hallucinations when hearing voices but nobody is around.
Interpreter:	Okay…ukuba ngaba akukho mntu ecaleni kwakho, kukho abantu abathetha ngawe, abahlebayo manditsho uyabava.
	(Okay if there's nobody around and there are people who are talking about you, people who are gossiping, let me put it that way, can you hear them ?)
Patient:	Abantu bengekho aph'ecaleni kwam, hayi andiva.
	(I can't hear when people are talking being far away, no)
Interpreter:	She can't hear them.
Doctor :	Okay no hallucinations.
Patient:	Andilo gqirha kaloku anduzuva abantu.
	(I am not a traditional doctor, I won't hear people talking.)

This excerpt is confusing. From all appearances, one could think that the interpreter did not know what the word "hallucinations" meant, or the interpreter had difficulty in

communicating the concept to the patient from a cultural point of view. However, upon investigation it became clear that the interpreter did not know the meaning of the word. The message she conveyed to the patient had to do with hearing. Instead of asking the patient whether she was hearing voices ("in her head"), she asked the patient whether she could hear people gossiping about her. This represented a semantic error. In such cases, the doctor would not receive the information that reflected the true nature of his question, because it never reached the patient. Once again, the interpreter did not use the doctor as a resource to determine exactly what he wanted to know. Such a mistake, which seemed to be of no importance, compromised the care of the patient, as it could be deduced from the conversation that the doctor must have noticed the information regarding the hallucinations in the patient's file (history), and consequently asked the question(s).

4.11.2 Quality According to Role Players

According to the patient's daughter and patient (as the receiver) the doctor's message came across clearly. The interpreter was satisfied with the interpreting product. She felt that interpreting improved her knowledge and helped her bridge the gap between doctor and patient. According to the doctor (as sender) the interpreter expressed his message clearly to the patient.

The doctor felt that the message from the patient came across clearly, the doctor felt that the interpreter needed to be urged on since he (the doctor) had a huge workload, and probably did not have the time to wait for the interpreter to speak. Personal observations indicated that there were instances when the patient, the patient's daughter and interpreter were speaking among themselves, without including the doctor in the conversation. Because the doctor probably did not understand what was said and whether it was relevant, he had to urge the interpreter on. According to Sevilla Mátir et al. (2005:34) (see 2.7), one of the rules applied in the training of bilingual staff to become interpreters was that they had to interpret everything. However, in this instance the interpreter did not adhere to this rule.

4.11.3 Quality according to Table

An analysis of this session according to the quality table (Table 1 in 3.4), showed that despite the fact that the interpreter mostly displayed appropriate professional behaviour (except that she spoke in the third person to the doctor, but in the first person to the patient), she lacked good language skills and ideational clarity, terminological accuracy or fidelity was absent. For this reason, the interpreted product was of lesser quality. The interpreter compromised the position of the patient (whose collaborator she ought to have been), by (1) not realising that she made mistakes, and then (2) not trying to rectify them when she realised that she made them.

It seemed as though the message did not get through to the patient as receiver. The reason for this could be twofold. The medical practitioner, as sender of the message, failed to add framing information to the message for the interpreter to communicate to the receiver. The interpreter had no pre-existing knowledge of the situation, and therefore needed framing information to successfully convey the intended message of the medical practitioner to the patient. The interpreter also failed to identify the linguistically induced information in the message of the doctor. This meant that she could not convey the message to the patient, on the level the doctor intended it to be.

Evidently, there were enormous overall differences between SL and TL speeches (relating to the intertextual level), which definitely affected the quality of the interpreted product. The message sent by the doctor was not the message that reached (or was supposed to reach) the patient. On an intratextual level (interpreted product as independent product) and instrumental level (interpreted product as understandable) the interpreted product as such appeared to have been of good quality, but in relation to the SL speech it was in fact not.

4.12 RXH A

4.12.1 Participants and Seating Arrangement

The patient was a five-year old, female Xhosa first-language speaker. The medical practitioner was a 39-year old female social worker, who was proficient in Afrikaans and English. The interpreter was a female, Xhosa first-language speaker.

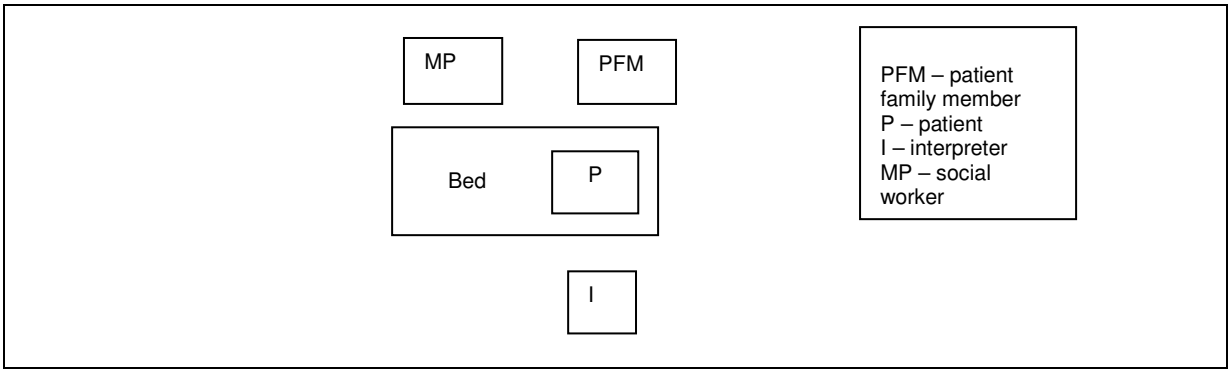

Figure 3: Seating arrangement RXH A

(A)

Social worker:	And do you remember sis'P?
Interpreter:	Usamkhumbula usis'P?
	(Do you still remember sis'P?)
Patient:	Yes
Social worker:	What's gonna happen is that my name is S and because I can not speak Xhosa, sis'P is gonna speak for me.
Interpreter:	Bendikuxelele mos ukuba igama lam ndinguNontlalontle, uS kodwa andikwazi ukuthetha isiXhosa, uP uza kunditolikela uS atolikele nawe neh? *(I have told you that my name is social worker S but I can't speak Xhosa, so P is here to help you and S.)*

Even though the social worker indicated on the questionnaire that she did not receive training on how to utilise the services of the interpreter, she introduced the interpreter again, even though the interpreter had worked with the specific patient on a prior occasion.

(B)

Interpreter:	Ndixelele ukwenzeka kwale ngozi ubuphi, ubusendlini kabani? *(Tell me when the accident happened, where were you, whose house were you in?)*
Patient:	Bendise...bendise...ndiye ndakhaph'itshomi yam, ke ngoku itshomi yam yahamba. Ndayibonisa iichips zam ke ngoku ndahamba ndaya kulo tshomi yam, ngoku xa ndikulo tshomi yam, ndagxothwa ngumama wayo. Ndabona umntu ophethe i-gun wandidubula ke ngoku ndafunqulwa ngusisi Nom... *(I was…was…and accompanied by friend and we went. I showed her my chips and we went to my friend's home, when we reached my friend's house, my friend's mother chased me out. I saw a man with a gun and he*

shot me and I was taken by sister Nom...)

Interpreter: I was at my home and I accompany my friend to her home. When I reach her home, my friend's mum chuck me out and lock the door, so when I was about to...when I was on my way going home I saw a man carrying a gun I ran, when I ran the gun, this man shoot at me.

The above excerpt illustrates a session during which the interpreter conveyed all the information to the social worker (with the exception of one or two items which could be explained by the fact that the interpreter had worked with the specific social worker on a prior occasion and knew what was relevant to the social worker). Given this, the essential message of what the social worker wanted to know, and what the patient communicated, reached both the social worker and patient, through the medium of the interpreter.

(C)

Social worker: The problem Y, Y is A's mom, every time you go there she close the door on you and then you can't get into her house.

Interpreter: Mamel'apha ke Y, umama kaA akakuthandi, qho xa usiya kulo A uyakugxothwa, so awuvumelekanga ukuba uphinde uye kuloA. Umama kaA yena usoloko ekugxotha ngalo lonke ixesha.

(Listen here Y, A's mother does not love you, every time you go her place you are chased out, so you are not allowed to go there at A's place. A's mother is always chasing you out.)

In this excerpt the interpreter was adding additional information to sympathise with the Patient: "...A's mother does not love you."

4.12.2 Quality According to Role Players

In this interpreting session the social worker (as sender) rated the interpreting product as (good) quality. She felt that the overall interpreting service rendered by this specific interpreter was good. The patient's mother (as receiver) felt the message from the social worker came across clearly. The social worker also indicated that the interpreter communicated beyond the immediate questions, and that the interpreter often answered for the patient based on shared information from previous interviews.

4.12.3 Quality According to Table

The analysis of this interpreting session according to the quality table clearly indicated that the interpreter did indeed display the appropriate professional behaviour, but also adhered to the criteria relevant to the interpreting session which were ideational clarity, linguistic acceptability and fidelity.

During the interpreting session (as seen from the excerpts above) the interpreter added substantial framing information to the message of the social worker, as well as to the message of the patient. Despite these additions, the message was still conveyed successfully to both sender and receiver. With regard to the intertextual level, it should be noted that the differences between SL and TL speeches, were not significant and did not affect the quality of the interpreting session negatively. On an intratextual level the TL speech was sufficient to act independently, and made sense. Therefore, it suffices to say that this interpreting session was an effective customer service on an instrumental level.

4.13 RXH B

4.13.1 Participants and Seating Arrangement

In the next session discussed here, the same interpreter and social worker as in 4.12 were present. This time the patient's mother was a 31-year old, Xhosa-speaking woman.[35]

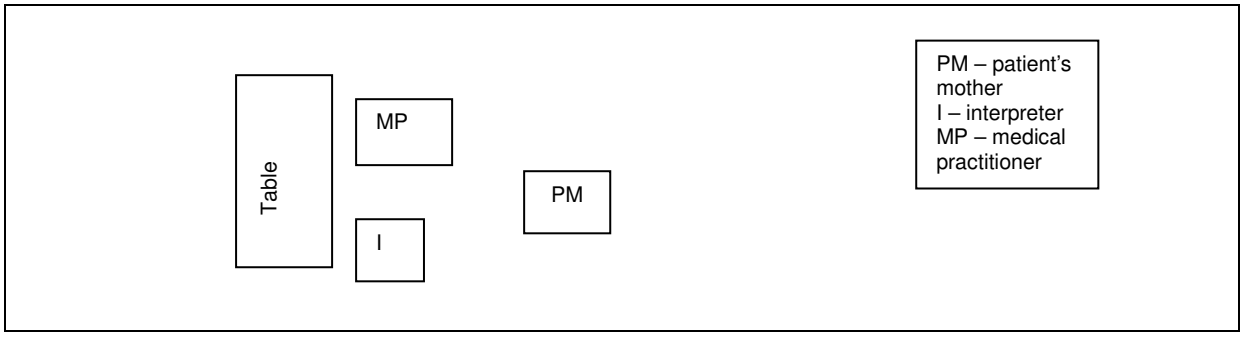

Figure 4: Seating arrangement RXH B

(A)

Social worker:	Okay then how long are you in the relationship?
Interpreter:	Ninexesha elingakanani nithandana phambi kokuba nitshate?

[35] The patient was nog present in the consultation.

	(How long were you in this relationship before you get married?)
Patient's mother:	Kaloku sasikhe sayeka, that's why ndingakwaziyo ukuyibala, sasikhe sayeka, saphinda sabuyelana.
	(*We had a break, that's why I do not know the exact period, we had a break, and we reconciled again)*
Interpreter:	We had a break...(to patient) Nibe ne...nohlukane phambi kokuba uA abekhona okanye emveni kokuba ekhona?
	(You have...did you break up before A was born or after?)
Patient's mother:	Emveni kokuba uA abekhona.
	(*After A was born)*
Interpreter:	After A was born, we split and then...we came together again. (to patient) Nibuyelene emva kwexesha elingakanani?
	(After how long did you reconcile?)
Patient's mother:	Inoba zinyanga ezimbini, iinyanga ezimbini ezinehafu, ndingatsho.
	(It may be two months, two months and a half, I can say so)
Interpreter:	Nohlukene?
	(Separated?)
Patient's mother:	Ewe, ndisengatsho, zange siyigqibe i-3 months.
	(Yes, I can say so, we did not even finish 3 months)
Interpreter:	Oh...we never even break for a long time, it was about two to three months and then we came together again.

This excerpt illustrates that the interpreter did not convey the question to the patient that the social worker wanted the patient to answer: the social worker wanted to know how long the patient was in the relationship. However, interpreter had her own conversation with the patient, and it seemed as if she forgot what the social worker had asked. Instead of trying to get the patient to answer the question, she herself lost track of the question and the patient's answer was clearly not what the social worker wanted. Consequently, she had to repeat herself (see the following excerpt). The interpreter wasted time by obtaining information, which was in all probability relevant to the social worker, but in essence not what she asked.

(B)

Social worker:	Okay, now from the beginning, from A, how long were you in a relationship?
Interpreter:	Phambi kokuba uA lo abekhona, nanithandane ixesha elingakanani?
	(Before A was born, how long were you in a relationship?)
Patient's mother:	Unyaka

	(A year)
Interpreter:	Kwaze kwabakho uA?
	(And then there was A?)
Patient's mother:	Ewe
	(Yes)
Interpreter:	UAyakha unangaphi ngoku?
	(How old is A now?)
Patient's mother:	3 years ngoku.
	(3 years now)
Interpreter:	Oh...we were in love for a year then...after that we got A and then we split for three months and then came together again.
Social worker:	So you were in the relationship for four years?
Interpreter:	Yes
Social worker:	and they are married for seven months?
Interpreter:	Yes seven months.

Here the interpreter was yet again not very clear in her questioning and answering. The social worker wanted to know the duration of the relationship. However, the interpreter requested this information from the patient by using the baby's birth as point of departure: "Before A was born, how long were you in the relationship?" As a result, the question that the social worker wanted to be answered did not correspond with the answer obtained form the patient. It was in actual fact a very simple question, which the interpreter complicated.

(C)

Social worker:	Is the baby on the milk supply for six months?
Interpreter:	Umntwana uyalufumana ubisi, iinyanga ezintandathu.
	(Does the baby get milk for six months?)
Patient's mother:	Hayi
	(No)
Interpreter:	No
Social worker:	I'm going to talk to the dietitian because your baby is malnutritioned, malnutrion means that your baby for a long time did not get enough proper food so the body can't build itself up, okay, that's why the baby is sick.
Interpreter:	Ndiza kuthetha no-dietitian yena mntu endizakuthi ndimcele ukuba umntwana makafumane ubisi eclinic ngoba kaloku umntwana

	akondlekanga, so kunyanzelekile ke ukuba umntwana makalufumane ubisi eclinic, siyavana?
	(I will talk to the dietitian the person that I will ask to give the baby milk from the clinic because the baby is malnourished, so it is a must that a child must get the milk from the clinic, do you understand?)
Patient's mother:	Ewe
	(Yes)

In this excerpt the social worker mentioned the concept 'malnutrition', and tried to explain it to the patient. However, the explanation was not correct. Instead of explaining the term, the interpreter provided a corrective measure, which was not mentioned by the social worker at all. The interpreter also did not equip herself with resources to help her with this error, and also did not try to remedy the situation.

4.13.2 Quality according to Role Players

The patient's mother (as receiver) felt that the message of the social worker came across clearly. The social worker (as sender) felt that the overall quality of the interpreting rendered by this specific interpreter was very good.

4.13.3 Quality according to Table

During the interpreting session, the interpreter adhered to appropriate professional behaviour, but failed to comply with ideational clarity, terminological accuracy and fidelity. Consequently, this interpreting product was not of good quality.

On the questionnaire the social worker indicated that this specific interpreter sometimes spoke for the patient. Such responses were based on previous information shared in the interview. The social worker also indicated that the interpreter communicated beyond the questions asked by the social worker at times. The latter may not pose a problem in some instances. However, when the information is not relevant to the situation or the question, it becomes a problem. In these instances, lots of time and energy are spent on information that will never be used, or is irrelevant.

The message of the social worker failed to get through to the patient. The interpreter added unnecessary framing information, which complicated and distorted the message of the social worker. In addition, the interpreter should have added framing information from time to time to *complement* the linguistically induced information by the social worker, and not to complicate the message.

An analysis on the intertextual level of the message, showed that a lot of information was added to the message, which constituted differences between SL and TL speeches. This jeopardised the quality of the interpreted product. The social worker almost had to answer her own question. On an intratextual level, the TL speech could not function as an independent speech in the TL, as it failed to make sense, and was too cumbersome. On an instrumental level, this interpreting session represented an uneffective customer service.

4.14 Conclusion

This chapter presented the findings of the data gathered as explained in Chapter 3. The analysis of the data was presented in two parts: the results from the questionnaires were discussed first; then an analysis of selected transcribed interpreting sessions followed. The patients were mostly Xhosa-speaking, the medical practitioners mostly Afrikaans- and English-speaking and the interpreters represented a combination of first-language Xhosa speakers, and speakers of Afrikaans and English. Most of the patients indicated that an interpreter was available to them when needed. These interpreters included family members, another patient, as well as professional interpreters employed by a specific hospital. Some doctors indicated that they preferred using a nurse to interpret, because of their medical knowledge, and their knowledge with regard to procedures and terminology.

Regarding the interpreting session and interpreting product itself, both the medical practitioners and patients indicated that the interpreter displayed appropriate professional behaviour, and that the message that they sent to the receiver or listener through the interpreter was indeed conveyed. These responses were taken into account when the transcribed interpreting sessions were analysed. Despite the fact that the medical practitioners and patients were of the opinion that the intended message was conveyed to the receiver, discrepancies were found in the interpreted product. It was revealed that due to the

interpreter's lack of knowledge or terminology, and/or the lack of sufficient target language (English) knowledge, some parts of the message from the medical practitioner to the patient were distorted, and the response that the medical practitioner received was not the response required. It could not be determined whether this distortion was due to a lack of knowledge regarding terminology, or because of a lack of (English) language knowledge.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The aim of this study was to investigate interpreting practices within the three tertiary hospitals in the Western Cape, namely Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital. The focus of this study was to investigate and describe the quality of interpreting services at these institutions and the intrinsic quality of the interpreted products at these institutions. The investigation was broadly conducted to determine whether the message of the doctor was successfully conveyed to the patient and vice versa and whether the interpreter was indeed equipped to ensure this successful transmission. The investigation was facilitated by randomly taped interpreting sessions, with the consent of the interpreter, medical practitioner and patient. After each interpreting session, questionnaires were completed with all three participants. Excerpts of these taped, transcribed and translated interpreting sessions were randomly chosen for discussion in Chapter 4.

Various factors, as described in Chapter 3, affected the data collecting process negatively, so that the amount of data finally collected, was less than what was expected. This could be due to the fact that the interpreters were stationed in specific parts of the hospital and other interpreting sessions could be happening elsewhere in the hospital that the interpreters were not aware of. It could also be because hospital staff is not aware of the interpreters at the hospital and interpreting sessions take place without the interpreters at the hospital being present. However, this did not seem to affect the research as such and participant attitudes could still be determined by the data obtained from the questionnaires, which were distributed to those who did use an interpreter at a specific hospital during prior occasions.

This study found that there was a shortage of professionally trained interpreters within the hospitals included in this study. Two or three interpreters, or at times only one, appointed interpreter were expected to render interpreting services within the boundaries of an entire hospital. This situation was not viable: when medical practitioners had to wait for the interpreter to reach the area where the interpreting was to take place, anyone who could speak

and understand Xhosa, was asked to perform the duty of interpreter. Medical practitioners preferred to use nurses as interpreters, because of their medical knowledge and knowledge of medical terminology and procedures. This, however, did not ensure proficient knowledge of both source and target language, in order to perform optimally in this position.

Gile (1995:34) identified five criteria according to which the quality of the interpreted product should be determined. The attitudes of the various role players within the interpreting situation should also be taken into account. It was found that an interpreted product may be of low quality, but that all three participants, namely the medical practitioner, interpreter and patient, still evaluated the interpreting product as being of good quality. The quality of the interpreted product was determined by measuring excerpts of the transcribed interpreting session against the quality criteria. The areas that were problematic, and therefore constituted a low quality of the interpreted product, included: lack of terminology, lack of sufficient vocabulary in both source and target languages, lack of resources to help solve a problem, as well as distortion of the original message by the interpreter and subsequently an irrelevant response to the question(s) from the medical practitioner. However, these problems regarding quality and interpreting should not be generalised to the entire population of interpreters in the Western Cape health care setting.

5.2 Training Programmes

The introduction of training programmes to equip potential interpreters with the necessary skills to act as professionally trained interpreters in hospitals, should be applauded. However, it defeats the object when anyone who can read, write and speak, are expected to be part of these training programmes. It should be borne in mind that interpreting is a language profession. To the researcher this implies that someone who is not proficient in both source and target language will not be a good interpreter. Should potential candidates for such a training programme be chosen, their level of proficiency in both source and target language, as well as their linguistic transference between these languages should be tested. It should be borne in mind that even though the community interpreter should try to get the correct information to and from the patient, the interpreter also has to communicate with the doctor on a linguistic level that is both acceptable and understandable to him/her as interpreter.

5.3 Findings of the Study

The data in this study showed the following:

(i) **Lack of interpreters:** During the time of this study there were too few professionally trained interpreters employed in the hospitals. No more than four interpreters (in some instances only one) were employed to serve the population of an entire hospital.

(ii) **The use of ad hoc interpreters:** It was evident from the questionnaires that even though hospitals had professional interpreters employed, any person who could speak and understand a language was requested to interpret. Doctors would prefer nurses as interpreters, because of their medical knowledge, and knowledge regarding medical terminology and procedures. However, their knowledge of source and target language, and their linguistic transference ability remained elusive.

(iii) **Interpreters were expected to perform administrative duties:** Whenever an interpreter did not have any interpreting to do, the interpreter had to perform the most basic administrative duties, such as answering phones. Interpreters were placed among nursing staff, and inside wards and clinics where they were expected to interpret. While interpreters were expected to perform administrative duties, a patient elsewhere in the hospital completing an admissions form that was only available in Afrikaans or English could have rather used the services of the interpreter.

(iv) **Outdated bleeper and intercom system for interpreters:** New calling systems should be introduced into the hospitals. The existing system posed two problems: Firstly, the method and mode by which interpreters were called were inefficient and time-consuming. Doctors did not want to wait for the interpreter, and secondly, the interpreters did not proactively try to determine where interpreting sessions would probably occur. Rather, they remained stationary until they were called. It was then that they were seen as being in "idle mode", and were requested to perform administrative duties.

(v) **Existing unorganised interpreting practice within the hospitals:** The visibility of the interpreters was lacking. At some hospitals few staff members at the reception

desks and the clinics and wards, were aware of the presence of available interpreters. This resulted in only a few who made use of the interpreters.

(vi) **The need of regulated interpreting practice within hospitals:** It appeared as if interpreters were forgotten about once they were placed at hospitals. They did not come into contact with other language practitioners, and seemed to work in isolation. They were rather far more absorbed into the medical system, while their language development was compromised or neglected. These interpreters should be subjected to continuous evaluation and training, in order to keep abreast with developments within the language sector. The researcher is of the opinion that these health care interpreters should resort either under the Western Cape Language Unit of the Department of Cultural Affairs and Sport, or the language unit within the Department of Health. This would contribute to the regulation and professionalism of interpreting and interpreters, better training, evaluation to establish areas which needed improvement, better (and just) remuneration and generally a position of more power.

(vii) **Lack of using resources:** Interpreters who did not use any dictionaries or who did not make any notes with regard to mistakes they might have made, risked making the same mistake(s) on other occasions. Interpreting should constantly be a learning process. If an interpreter makes a mistake without realising or documenting it, or keeping it in mind, chances are that the mistake will be repeated in future. Interpreters within the health care setting, as in any other language profession setting, should constantly develop themselves and try to improve their skills.

(viii) **Patients were of the opinion that interpreters were always available when they needed them:** The patients seemed to be too grateful to have someone who was able to facilitate communication between themselves and the doctor. Therefore, anyone able to facilitate communication, was seen as an interpreter, despite the fact that such interpreters may have delivered interpreting products that were of poor quality. The patients felt that there was always someone who could speak on their behalf.

(ix) **Medical practitioners not trained on how to use interpreters:** If the role of the interpreter were explained to the medical practitioners, and practitioners were

instructed how to best utilise the interpreter, the need to use nursing staff as interpreters would eventually diminish.

(x) **Quality and interpreting within a South African context:** Interpreting in the South African health care sector differs from health care interpreting in the international sector, because within the international context, LEP patients are mostly immigrants. In the Western Cape health care sector patients speak mostly Xhosa, which is one of the eleven official languages of the country. These patients are South African, and citizens are still marginalised in terms of health care. This study showed that the quality of the interpreting product differs in different situations. This depends on the context that interpreting takes place in, and is therefore difficult to evaluate.

5.4 Recommendations

On the basis of the findings of this study, it is recommended that an in-depth investigation should be conducted to examine the quality of the interpreting services – ad hoc and professional – at health care institutions within the Western Cape province. During such an investigation the effect of the quality (or lack of quality) of the interpreting product on effective health care for the LEP patient, should be established. Such a study should focus on the three official languages of the Western Cape: Afrikaans, English and Xhosa. This study could also be broadened to include interpreting services at health care institutions country-wide, and the inclusion of all eleven official languages in South Africa could be considered.

In addition, the feasibility to regulate health care interpreting practices within the province, and to integrating these health care interpreters into the greater language profession within the province, should also be investigated. Specialised training courses for health care interpreters should be available, and health care interpreters should continuously be exposed to training and current developments within the language sector.

This study specifically focused on interpreting between English and Xhosa, but research regarding the quality and availability of interpreting in languages spoken by immigrants from other parts of Africa, as well as the role of sign language within the South African health sector, should also be conducted. Hospitals should not only focus on providing interpreting

services to make health care accessible, but also on translation services to make written information accessible to patients. Within the Western Cape health care sector there is a dire need for intervention to bring all aspects of interpreting in line with internationally acceptable standards.

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ADDENDUM I

LETTERS OF APPROVAL

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Tel.: 808-4623
Navrae: Maryke Hunter-Hüsselmann

4 Maart 2008

Me B Saulse
Afrikaans en Nederlands
Universiteit van Stellenbosch
STELLENBOSCH
7602

Geagte me Saulse

AANSOEK VIR ETIESE BEOORDELING

Met verwysing na u aansoek in bovermelde verband, is dit vir my aangenaam om u mee te deel dat u projek *Interpreting within the Western Cape Health Care sector* (projeknommer 68/2007) deur Subkomitee A goedgekeur is met dien verstande dat:

1. Die navorser binne die prosedures en protokolle wat in die voorstel aangedui word, sal bly;
2. Die navorsing weer vir etiese klaring voorgelê sal word indien daar substantief van die bestaande voorstel afgewyk word
3. Die navorser binne die grense van enige toepaslike nasionale wetgewing, institusionele riglyne en die toepaslike standaarde van wetenskaplikheid wat binne hierdie veld van navorsing geld, sal bly.

Sterkte word u toegewens met u verdere navorsingsaktiwiteite.

(ME.) ME. M. HUNTER-HüSSELMANN
ns. SENIOR DIREKTEUR: NAVORSING (GEESTES- EN SOSIALE WETENSKAPPE)

G:\NAVORS\POEL\ANO-dokumente\GW koörd doks\Subkomitee A\Etiek\Briewe\2008\b-saulse.doc

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

23 April 2008

REC REF: 157/2008

Ms Bernice Saulse
111 Dermont Street
Stellenbosch
7600

Dear Ms Saulse

PROJECT TITLE: INTERPRETING WITHIN THE WESTERN CAPE HEALTH CARE SECTOR: A QUALITY SURVEY

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year till the 30th April 2009.

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

lemjedi

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

pp

lemjedi

Enquiries : Dr B Patel
Telephone : (021) 404-4256
Fax : (021) 404-4304
E-mail : bpatel@pgwc.gov.za
Reference : Research
Date : 7 March 2008

Departement van Gesondheid
Department of Health
ISebe IezeMoilo

Dear Ms B Sauise

RESEARCH: **INTERPRETING WITHIN THE WESTERN CAPE HEALTH CARE SECTOR: A QUALITY SURVEY**

Your recent letter to the hospital refers.

You are hereby granted permission to proceed with your research.

Please note the following:-

a) Your research may not interfere with normal patient care.
b) Hospital staff may not be asked to assist in the research.
c) No hospital consumables and stationery may be used.
d) Please introduce yourself to the person in charge of an area before commencing.

I would like to wish you every success with your project.

Yours truly

Patel

DR B PATEL
For CHIEF EXECUTIVE OFFICER

BP/em 07/03/08

GROOTE SCHUUR HOSPITAL
MEDICAL
28 JUL 2008
SUPERINTENDENT
GROOTE SCHUUR HOSPITAL

Groote Schuur Hospital
Private Bag,
Observatory, 7935
Telephone: 404-9111

Departement van Gesondheid

Department of Health

iSebe lezewMpilo

Verwysing: Reference: Isalathiso:	RESEARCH	Telefoon: Telephone: Ifowuni:	(021) 658 5383
Navrae: Enquiries:	Dr. T. Blake	Fax:	(021) 658 5166
Datum: Date:	19 May 2008		

Bernice Saulse
111 Dermont Street
Stellenbosch
7600

Dear Ms. Saulse

Research Study (REC REF): 157/2008: Interpreting within the Western Cape Health Care Sector: A Quality Survey

Thank you for the submitting your study documentation to Red Cross Children's Hospital

Approval is granted to you to conduct the above-mentioned study at Red Cross War Memorial Children's Hospital

Yours faithfully,

Dr. T. Blake
Senior Medical Superintendent

Red Cross War Memorial Children's Hospital
Klipfontein Road / Private Bag
RONDEBOSCH
7700 / 7704

Rooikruis Oorlogsgedenk Kinderhospitaal
Klipfonteinweg / Privaatsak
RONDEBOSCH
7700 / 7701

Departement van Gesondheid

Department of Health

iSebe lezewMpilo

Verwysing: Reference: Isalathiso:	RESEARCH	Telefoon: Telephone: Ifowuni:	(021) 658 5383
Navrae: Enquiries:	Dr. T. Blake	Fax:	(021) 658 5166
Datum: Date:	30 July 2008	Email:	Tblake@pgwc.gov.za

To Whom It May Concern:

Research Study (REC REF): 157/2008: Interpreting within the Western Cape Health Care Sector: A Quality Survey

Approval has been granted to Bernice Saulse to conduct the above-mentioned study at Red Cross War Memorial Children's Hospital.

Her research involves taping interpreting sessions and handing out questionnaires. Permission is granted to her to record the interpreting sessions provided that she has the informed consent of:

1. Patient
2. Interpreter
3. Doctor (If the doctor does not consent to his arrangement, then the specific session will not be recorded).

Yours faithfully,

Dr. T. Blake
Senior Medical Superintendent

Red Cross War Memorial Children's Hospital
Klipfontein Road / Private Bag
RONDEBOSCH
7700 / 7701

Rooikruis Oorlogsgedenk Kinderhospitaal
Klipfonteinweg / Privaatsak
RONDEBOSCH
7700 / 7701

RESEARCH PROJECTS

PROTOCOL NUMBER: ***68/2007***

Interpreting within the Western Cape health Care sector: A Quality Survey.

ETHICS REF:

Research conducted by: **Ms B Saulse**

NAME	APPROVED	SIGNATURE	COMMENT	DATE FORWARDED
Dr M Mukosi Clinical Executive	✓		Good of survey. It may benefit also Dept of Health	2008 -03- 27
R Thomson Clinical Executive	✓			27/3/08
Ms J Jooste Asst Director	✓		No monies involved.	31/3/08
Mr P J Wolfaardt Deputy Director	✓			31/3/08
Ms R Basson Dep Dir: Nursing	✓	RMBassa		2/4/08
Ms C Ford Dep Dir: Pharmacy	✓			9/4/08
Dr J H Groenewald Clinical Executive	✓			9/4/08
Dr T Carter ief Director	✓			11/4/08

Contact Details : Ms B Saulse (084 958 0248) / 13144014@sun.ac.za

Collected by : Posted on 15/4/08 to:

Date : Dermont III, Moltendstreet, Stellenbosch 7600.

/Research Projects voorblad desktop

LaBindeman

TERUG NA MEV L BINDEMAN , ADMIN
NADAT ALMAL GETEKEN HET.

ADDENDUM II

CONSENT FORM

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Interpreting and Health Care in the Western Cape: A Quality Survey

You, the respondent, are asked to participate in a research study conducted by candidate namely Bernice Saulse (B.A.; Postgrad. Dipl. Transl.), from the Department Afrikaans and Dutch at Stellenbosch University. The results of this research project will be contained in my MPhil thesis with the title as mentioned above. You were selected as a possible participant in this study because you are a patient **/ medical practitioner / interpreter** at a Western Cape Tertiary Hospital, and require the services of an interpreter **(patient and medical practitioner) / are used as an interpreter (interpreter)**.

1. PURPOSE OF THE STUDY

To measure the target text as delivered by the interpreter(s), ad hoc or professionally trained, at the hospitals concerned namely Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital.

2. PROCEDURES

You will be orally informed about the study and then asked whether you are willing to participate. If yes, you are requested to:

Proceed under normal circumstances;
Furthermore you are requested to speak clear and audible;
After the consultation you (namely medical practitioner, interpreter and patient) will be requested to complete questionnaires to the best of your ability and as truthfully and extensively as possible.

3. POTENTIAL RISKS AND DISCOMFORTS

As yet, I do not foresee any risk or discomfort, but will make provision for time risks involved during the answering of the questionnaires. The questionnaires are not extensive and it will not take up a lot of your time. In the case of African language speakers the researcher will have an African language speaker to assist her.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

If, after the completion of the research project, the researcher identifies interpreting products of poor quality, the appropriate authorities will be informed thereof, and will be informed of the potential hazards that interpreting of poor quality may cause. It is however up to them if they will want to rectify the problem, or not.

This study is a small survey and can therefore not be generalized to the interpreting society as a whole, but it can provide a picture of health care interpreting in Western Cape hospitals. On the basis of the result of the study it can be decided whether or not current appointed interpreters are fit for the job, or need more training.

5. PAYMENT FOR PARTICIPATION

No subjects in this study will receive payment, as they will first be selected, and should then be willing to volunteer to participate in the study.

6. CONFIDENTIALITY

Any information that is obtained during this study by the researcher will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of the data being solely in the possession of the researcher, and will be viewed and heard only by the transcriber and translator, who will not be allowed to make or keep any copies of the data.

The information (questionnaires, audio-taped interpreting texts) obtained during this study and the results of this study will only be published in the thesis of the researcher, and in possible future academic articles.

The participants have the right to edit the audio-taped interpreting texts, but not to the extent that it jeopardizes the research project.

The same rules for confidentiality in the actual research study will apply when the results are published.

7. PARTICIPATION AND WITHDRAWAL

You can decide whether to form part of this survey or not. If you volunteer to be part of this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still be part of the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:
Bernice Saulse at 084 958 0248, 13144014@sun.ac.za
Research supervisor Dr Harold M. Lesch at Tel: (021) 808 3573, E-mail: hlesch@sun.ac.za, Stellenbosch University, Faculty of Arts, Department Afrikaans and Dutch, Room 676, Arts Building
Head of Department Afrikaans and Dutch, and co-supervisor, Prof Ilse Feinauer at Tel: (021) 808 2162, E-mail: aef@sun.ac.za, Stellenbosch University, Faculty of Arts, Department Afrikaans and Dutch, Room 690, Arts Building

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Maryke Hunter-Hüsselman; Admin B, Room B3207; **Tel**: +27 (21) 808 4623; Fax: +27 (21) 808 4537, E-mail: mh3@sun.ac.za, at the Unit for Research Development.

SIGNATURE OF RESEARCH SUBJECT

The information above was described to [*the participant]* by Bernice Saulse or Research Assistant in [*Afrikaans/English/Xhosa]* and [*the participant is]* in command of this language or it was satisfactorily translated to [*/him/her*]. [*The participant]* was given the opportunity to ask questions and these questions were answered to *[his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

_____

Name of Subject/Participant

_____ _____

Signature of Subject/Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*of the participant]* and/or [his/her] representative _____ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/English/Xhosa/Other*] and *this conversation was translated into [Xhosa]* by _____[*Research Assistant].*

_____ _____

Signature of Investigator **Date**

ADDENDUM III

QUESTIONNAIRES

Questionnaire for Patient

Personal Information

1. Age

.....

2. Gender

M / **F**

3. Ethnicity

Coloured / **White** / **Black** / **Indian** / **Other (please specify)**

4. Area of residence

.....

Training

5. Highest scholastic/academic qualification

.....

6. Language proficiency

	Read	**Speak**	**Write**	**Understand**
.....				
.....				
.....				
.....				
.....				

Practice

7. Did the interpreter display appropriate professional behaviour (explain aspects to patient)

- **Dressed professionally** Y / N
- **Use the right mode of interpreting (alternate between speakers and give each speaker appropriate chance to speak)?** Y / N
- **If one speaker speaks for along time, did the interpreter interrupt in a manner that was appropriate and not rude?** Y / N

8. Is there always an interpreter available?

Y / **N**

9. What do you do when there is no interpreter available?

.....

.....

.....

10. How often do you need an interpreter?

.....

11. Do you request an interpreter before the consultation starts?

Y / **N**

12. Who do you request one from?

.....

Interpreting Session

13. Did you think that the interpreter said everything the doctor said or did he leave anything out or added anything?

.....

.....

14. Did the interpreter explain the terminology or difficult words to you?

Y / **N**

15. Did you fully understand what the interpreter said; do you think the message of the doctor came across clearly?

Y / **N**

.....

.....

16. If there are parts that you did not understand what were they, and what did you do about it, e.g. tell the interpreter, ask someone else to explain to you.

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

17. Have you received any instruction or training on how to work with/utilise the services of the interpreter?

Y / N

18. Did it seem as if the medical practitioner understood what you said, i.e. did the interpreter express your ideas or essence of your message clearly enough?

Y / N

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

Problems

19. Please name all the problems that you encountered during this specific interpreting session, as well as overall problems encountered during other interpreting sessions.

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(Patient Questionnaire in Xhosa)

Iphepha lemibuzo lesigulana

Ulwazi ngesigulana

1. Iminyaka

.....

2. Isini

.....

3. Uhlanga

Abantu bebala / **Abelungu** / **Abantu abantsundu** / **Amandiya** / **abanye (nceda balula)**

4. (a) Indawo osuka kuyo

.....

(b) Indawo ohlala kuyo

.....

Uqeqesho

5. Ibanga eliphezulu lesikolo / imfundo onayo

.....

6. Ubugcisa beelwimi onazo

Funda **Theta** **Bhala** **Qonda** / **yiva**

.....

.....

.....

.....

.....

Ukutolika

7. Ingaba itoliki ibonakalise ubuchule emsebenzini wayo?

- **Ebenxibe ngokufanelekileyo na?** Ewe / Hayi
- **Ebesebenzisa indlela elungileyo yokutolika (etshintshisana kakuhle phakathi kwezithethi kwaye enika isithethi ngasinye ithuba eliffanelekileyo lokuthetha)** Ewe / Hayi
- **Ukuba isithethi sithethe ithuba elide, ingaba itoliki ibi ngenelela ngendlela efanelekileyo nengekho krwada?** Ewe / Hayi

8. Ingaba iroliki isoloko ikhona?

Ewe / **Hayi**

9. Wenza njani xa ingekho itoliki?

.....

.....

.....

10. Ingaba uncedo lwetoliki nilufuna rhoqo?

.....

11. Ingaba uye ucele itoliki phambi kokuba uthethe nogqirha?

Ewe / **Hayi**

12. Uyicela kubani?

.....

Ngezesha lokutolika

13. Ucinga ukuba itoliki iyithethe yonke inkcaza kagqirrha, okanye iyishiyelele okanye kukho eyongezileyo?

.....

.....

14. Ingaba itoliki isicacisile isigama okanye amagama anzima kuwe?

Ewe / **Hayi**

15. Ingaba uyiqonde ngokupheleleyo na into etthethwe yitoliki, ucinga ukuba into ebithethwa ngugqirha icacile kuwe?

Ewe / **Hayi**

.....

.....

16. Ukuba bekukho izinto ongaziqondanga, zeziphi?, Wenze ntoni ngazo, umzekele, uxelele itoliki okanye omnye umntu ukuba akucacisele?

.....

.....

.....

.....

17. Ubukhe wafumana umyalelo okanye uqeqesho lokusebenzisana okanye usebenzise iinkonzo zetoliki?

Ewe /Hayi

18. Ingaba ngokwenkangeleko, ugqirha ukuqondile na okuthethileyo, into ethi ke, ingaba itoliki izacacise ngokucaceleyo izimvo zakho okanye umongo wencaza yakho kugqirha?

Ewe / **Hayi**

.....

.....

.....

Lingxaki

19. Nceda uxele iingxaki othe waqubisana nazo ngeli xesha bekutolikwa ngalo, nezinye iingxaki ongabe uqubisene nazo kwamanye amaxesha okutolika.

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Questionnaire for Medical Practitioner

Personal Information

1. Age

.....

2. Gender

Y / N

3. Ethnicity

Coloured / White / Black (please specify culture) / Indian / Other (please specify)

4. Area of residence

.....

Training

5. Language proficiency

	Read	**Speak**	**Write**	**Understand**
.....				
.....				
.....				
.....				
.....				

6. For how long have you practised medicine?

.....

7. How long have you been working at this specific institution?

.....

Practice

8. How long have you used the services of an interpreter, or on average per week for how many sessions do you need the services of an interpreter?

.....

9. Do you request an interpreter before the consultation starts?

Y / N

10. Who do you request one from?

.....

Interpreting Session

Did the interpreter display appropriate professional behaviour (explain aspects)

- **Dressed professionally?** Y / N
- **Use the right mode of interpreting (alternate between speakers and give each speaker appropriate chance to speak)?** Y / N
- **If one speaker speaks for along time, did the interpreter interrupt in a manner that was appropriate and not rude?** Y / N

11. Is there always an interpreter available?

Y / N

.....

.....

12. What do you do when there is no interpreter available?

.....

13. Have you received any instruction or training on how to work with/utilise the services of the interpreter?

Y / N

.....

.....

14. Did the interpreter speak clear and audible, and could you understand everything he said?

Y / N

15. If there are parts that you did not understand what were they, and what did you do about it, e.g. tell the interpreter

.....

.....

.....

.....

16. Did you think that the interpreter said everything the patient said or did he leave anything out or added anything?

.....

.....

.....

17. Did it seem as if the patient understood what you said, i.e. did the interpreter express your ideas or essence of your message clearly enough?

.....

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Problems

18. Please name all the problems that you encountered during the interpreting session, and other overall problems that you encountered during other interpreting sessions.

.....

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Questionnaire for Interpreter

Personal Information

1. Age

.....

2. Gender

M / **F**

3. Ethnicity

Coloured / **White** / **Black (please specify culture)** / **Indian** / **Other (please specify)**

4. Area of residence

.....

Training

5. Highest scholastic/academic qualification

.....

6. Language proficiency

	Read	**Speak**	**Write**	**Understand**
.....				
.....				
.....				
.....				
.....				

7. Do you have a formal qualification in interpreting?

Y / **N**

8. (a) If yes, what is the name of the qualification and how long was the training for?

Name .....

Duration .....

9. (b) If possible, please state all the elements of interpreting that you studied during your course

10. If no, please state how you came to fulfil the role as interpreter, and if you received any guidance as to how to fulfil this specific role?

.....

.....

.....

Practice

11. For how many years/how long have you been practising as an interpreter?

.....

Interpreting Session

12. For how long have you been practising as an interpreter at this specific institution?

.....

13. Have you interpreted for this specific medical practitioner before?

Y / **N**

14. Have you interpreted for this specific patient before?

Y / **N**

15. Did you understand everything the doctor said?

Y / **N**

16. Did you understand everything the patient said?

Y / **N**

17. What parts, if any, of the doctor's speech did you not understand?

.....

.....

.....

18. What did you do with those parts (also how did you interpret them), e.g. ask the doctor to repeat / omitted them?

.....

.....

.....

19. What parts, if any, of the patient's speech did you not understand?

.....

.....

.....

20. What did you do with those parts (also how did you interpret them)?

.....

.....

.....

21. Before the interpreting session started, did you inform the medical practitioner and patient about your role and purpose, as well as the process of interpreting?

Y / N

22. Do you think that would've had an influence on the interpreting session or not?

.....

Role of interpreter

23. Do you think that in your role as interpreter you should be the ally of the doctor or patient or remain neutral?

.....

24. Do you view yourself as a professional who plays an important role in the communication process or not? Reasons for this.

Y / N

.....

.....

.....

Problems

25. Were you satisfied with the interpreted product, and if not, what specifically were you not satisfied with?

Y / N

.....

.....

.....

26. Name all the problems that you have encountered during this interpreting session, and overall problems that you encounter during all the sessions that you interpret in.

.....

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ADDENDUM IV

TRANSCRIBED INTERPRETING SESSIONS

GSH A 1

Doctor (D) –	So she is there to make translating. I'm just going through the....history a bit errr
Interpreter (I) –	Uthi uzakukhe afunde ugqirha kancinci.
	(He says he'll read a bit)
D –	How old is mama?
I –	Mingaphi iminyaka yakho mama?
	(How may years do you have mama?)
Patient's Daughter (PD) –	Ngoka 1926
	(She was born in 1926)
I –	She is 1926
D –	She was born in 1926, so she is 82 neh?
PD –	Yes
D –	Yah, so how's mama doing?
I –	Umama uqhuba kanjani?
	(How is mama doing?)
P –	Malunga njani ke?
	(What do you mean?)
I –	She need explanation about how…
D –	Okay what I want to know is that I want to know how she's doing generally at home what is the situation like.
I –	Uthi ke ugqirha pha endlini ingaba impilo yakhe ihamba kanjani?
	(The doctor asks at home, how is her health doing?)
PD –	Ubhetele ngoku
	(She is better now.)
D –	In what way is she better?
I –	Uthi ugqirha ubhetele kangakanani?
	(The doctor asks how better is she?)
P –	Yababhetele ngoku.... a
PD –	U ..u ..u...
I –	Myeke umama azithethele.
	(Let mama speak for herself.)
P –	Yababhetele ngoku laa nto yokujikeleza kwengqondo.
	(It is better now the condition of feeling dizzy)
I –	The nauseous is much more better now.
D –	Nauseous?
I –	Yes
D –	Was she vomiting before?
I –	Ubugabha ngaphambili?
P –	Bendingagabhi bekujikeleza ingqondo.
	(I was not vomiting but feeling dizzy.)
I –	She's says she was not vomitting but err err …
D –	Are you saying nausea or dizziness which one is?
I –	Dizziness
D –	Not nausea?
I –	Not nausea yes
D –	So when is the dizziness stopped?
I –	Ingqondo ukujikeleza iyeke nini mama?
	(When did the dizziness stop?)
P –	Inoba kule nyanga iphelileyo

(I think last month)

I – It stopped last month.

D – Last month?

I – Yes

D – And eh ... from the daughter, at home, how is the functioning?

I – Kuwe ke sisi umbona eqhuba njani?
(To you sisi how do you view her?)

PD – Ubhetele akasafani nela xesha langaphambili kuba ngoku akasabethi, akasathethi kodwa ke uyaqaqanjelwa zindawo zakhe ezimqaqambelayo.
(She is better than before because she is no longer violent, she is not talking but she's at pains.)

I – She's much better now because she's not hitting the people and not talking but the pains are still there.

D – So will she say she's still confused?

I – Xa ucinga wena kuba umbona ingaba ingqondo yakhe isa...isa...inako ukuphazamiseka kancinci ?
(Do you still think that her brain is...is....is still a little bit disturbed?)

PD – Ewe ayikabi right ncam ncam.
(Yes it is still not okay.)

I – She's not complete.

D – Oh she's not completely, and what are the things that she would do that are called normal?

I – Uthi ugqirha ucinga ukuba ungenza kanjani ukuze umbone ukuba uright, ungula mntu umaziyo ?
(Doctor asks how are you going to do to see her that she is better?)

PD – Ebeqhele ukunikwa iipilisi kaloku so ke ngoku aye abebhetele, sibone ke ngoku aye abe-right right, ziipilisi iinto ezimncedayo abe right. Andiyazi ke ngoku enye into enokumenza aberight.
(She used to get some tablets that make her better, it is the tablets that make her feel better. I don't know now what can make her better.)

I – When she gets tablets she gets much better but we do not know now what can make her better than the tablets but when she drinks the tablets she gets much better.

D – Oh which tablets has she been drinking that make her feel better?

I – Uthi ugqirha zeziphi ezi pilisi?
(The doctor wants to know the tablets?)

D – Oh these tablets are making her feel better?

PD – Ewe nezinye ezincinci, so andiyazi ke ngoku.
(Yes and the small ones, I don't know now.)

I – Yes and the other ones that are small.

MP – Okay, which tablets that you drink, did you bring them?

I – Kha uze nazo ke ezo.
(Show them to us)

PD – Yo hayi ke asizanga nazo, ziphelile.
(We didn't come with them, they are finished.)

I – It is finished, she didn't drink them.

D – And eh...is it the tablets that the doctor gave her when she started ?

I – Zipilisi awayezinikwe ngugqirha ngoku wayeqala ezi?
(It is the tablets that the doctor gave her on her first stages?)

PD – Ziipilisi ezi awaye zinikwe ngugqirha apha e-Grooter Schuur kwacaba

akayeki, ezi uzifumene eBrooklyn ezi zincinci zimhlophe, so ezi uzifumene eBrooklyn.

(These are the tablets that she got here in Groot Schuur and she didn't get any better, and she got these small tablets in Brooklyn Hospital.)

I – These tablets, she get it in Brooklyn hospital and the small one she get it here when she started to come here.

D – And and... she is not violent any more?

I – Akasalwi ngoku?

(Is she still fighting?)

PD – Mm-mm

(No)

I – No

D – Can she do the work at home?

I – Ukhona umsebenzi awenzayo endlini?

(Is she working at home?)

PD – Mm-mm, akasebenzi.

(No she's not working)

D – And when she's sleeping, she sleeps or she's half asleep?

I – Ulala kanjani umama?

(How does mama sleep?)

P – Ndilala kakuhle

(I sleep well.)

I – She sleeps well.

D – And what about getting lost when she's going out, does she go out by herself?

I – Uyaziphumela ngaphandle yedwa?

(Does mama go out alone?)

P – Ewe

(Yes)

I – Uyaziphumela ngaphandle yedwa **(asking patient's daughter)** Kwindawo enjani ke? *(In what kind of place?)* Ukuphuma nje endlini *(Just to go outside.)*

PD – Ewe uyaziphumela.

(Yes goes out alone.)

I – She does go out

D – Where does she go, she doesn't get lost?

I – Akalahleki xa ephume phandle?

(Is she not getting lost when she gets out?)

PD – Mm-mm

(No)

I – No she does not get lost.

PD – Akalahleki ngoku, wayelahleka ngokuya.

(She is not getting lost now, but before she was getting lost)

D – Where does she go, how far does she go out?

I – Uhamba kangakanani xa aphumileyo?

D – To the shop?

I – Uyaya eshop?

(Do you go to the shop?)

PD – Ewe uyaya, uyaya nakubamelwane?

(Yes she does go, she even goes to the neighbours.)

D – Okay, and eh..can she bath and dress herself ?

I – Angahlamba okanye azinxibise ?

(Can she bath or dresses herself ?)

PD – Uyazihlamba azinxibise ngokwakhe.

(She washes herself and dress herself)

I – She bath herself, she dress herself.

D – Can she cook?

PD – Ewe uyaziphekela

(Yes, she cooks for herself.)

I – She pek, I mean she cook herself.

D – She does not need help with cooking?

I – Akafuni kuncediswa ekuphekeni?

(Does she need some help with cooking?)

PD – Hayi

(No)

I – No she does not need help.

D – Could she do these things before?

I – Ubezenza ezi zinto ngaphambili?

(Was she doing these things before?)

PD – Hayi

(No)

D – So what is the problem that she thinks the mother still has?

I – Ucinga ukuba yintoni enye ingxaki umama anayo ngoku, esashiyekeleyo?

(Do you think there is another problem your mother has that is left?

PD – Okwangoku, ngumzimba ngoku oshiyekileyo obuhlungu, namadolo adumbile.

(For now, it is the painful body and the swollen knees that are a problem)

I – The knees are swollen and...

D – No about the confusion?

I – Apha ke engqondweni ingaba ikhona into oyicingayo ukuba isekhona, esaseleyo?

(In your brain, do you think that we have left something behind?)

PD – Yoooh...ndiza kuyazela phi ke mna loo nto?

(Oh, how am I going to know that?)

P – Ayikho

(There is nothing)

I – She doesn't have any problem left.

PD – Uz'uthi awunanto unganikwa pilisi.

(Do not say you have nothing, because you will not tablets/treatment)

P – Ndizongazinikwa ngoku, ndithi ndiligeza ngoku ndingelilo.

(Am I not going to get them? must I say I'm mad whereas I'm not)

D – What does she say?

I – No she is fighting, saying she is not confused any more now.

D – She doesn't mess up her panties?

I – Akazichameli?

(Does she mess up her panties?)

PD – Hayi akazichameli ngoku, wayezichamela ngokuya wayegula kakhulu.

(No she does not mess up her panties, she was doing that when shen she was sick.)

I – She is not messing now, she was messing before.

D – When did she notice that things were getting worse with the mother?

I – Sorry?

D – When was the real problem, how long was that?

I – Zeziphi izinto ubuqonda ukuba umama ebehleli engazenzi kakuhle?

(What are the things that mama was not doing right before ?)

PD – Engazenzi kakuhle ?
(Not doing right ?)

I – Ewe
(Yes)

PD – Hayi bo umntu xa ebetha abantu, awumboni ukuba akakho right?
(No people, if a person is violent, beating people, can't you see that she's not right?)
Ndizakuthini, hayi andiyazi mna le nto, kaloku ukuqala kwakhe uye watshintsha, wangumntu obetha abantu, umntu ohamba apha esithubeni, ke ngoku ndiza kuthini ke mna.
(*What am I going to say, I don't know this question, but my mother changed and started beating people and was wandering the whole area .)*

I – Before she was beating the people and shouting the people and not talking right, the right thing.

D – When was that?

I – Bekunini ngoko?
(When was that?)

PD – Ufuna unyaka awayeqale ngawo okanye ufuna into yangoku?
(Do you want the year that she started or you want the condition now ?)

I – Ndifuna ukuqala kwakhe .
(I want the time when she started?)

PD – Wayeqale ngo 88.
(She started in 1988)

I – She started in 1988.

D – From 1988 until now?

I – Uqala ngo-88 kude kube ngoku ?
(Starting from 1988 until now ?)

PD – Ewe, ubane eyeka mhlawumbi after two years aphinde aphinde.
(Yes,she would stop for two years and start again.)

I – She would be sick and after two years she would start again.

D – So she started in 88?

I – Yes 88, she just get for two years and she starts again.

D – Okay now, how often has she been on and off?

I – Yenzeka kangaphi le nto yakhe yokubana iphela iphinde ibuye?
(How many times does this on and off happen?)

PD – Ukwenzeka ngaphi, mhlawumbi enyakeni?
(How often,maybe in a year)

I – Ewe
(Yes)

PD – Unyaka sisi, ngoDisemba ukuba akaqalisanga kunyaka olandelayo ngoApril uyaqalisa.
(A year sister, on December if not the following year on April, she starts.)

I – If she didn't get mad by December by April she starts.

D – Every year between December and April?

I – Eleke nyaka?
(Every year?)

PD – Ewe eleke nyaka.
(Yes every year.)

I – Yes each year.

D – So since 1988 she was doing like that?

I – Ukususela ngo 1988 uzokutsho ngoku ebesenza ngolo hlobo?
(Was she doing like that from 1988?)

PD – Oh andiyazi ukuba ndiza kuyikhumbula njani kuba ndandimncinci.
(Oh I don't know how am I to remember this because I was still young.)

I – I don't recall this because I was still young.

D – But she says 1988?

PD – Ewe but ndandi na-15 ngoko.
(Yes, but I was 15 years then.)

I – She says that she was only 15 years and could not remember.

D – Okay but you notice that there was something not right with her?

I – Uyakwazi ukuba ubone umahluko ukuba akakho right ngoku?
(Can you notice the difference that she is not okay now?)

PD – Ewe
(Yes)

I – She noticed that her mother was not the same as before.

D – Okay...does she hear any voices talking to her?

I – Uyabeva abantu xa bethethayo mama?
(Do you hear people when they are talking mama?)

D – When there are no people

I – Xa kungekho bantu apha ecaleni kwakho.
(When there are no people close to you.)

P – Hayi iindlebe zam azinanto.
(When I'm talking to a person.)

I – Xa kungekho mntu?
(When there's no person?)

P – Ewe
(Yes)

I – She does hear the people talking even if they are not around.

D – So she still hear the voices?

I – She still hear that.

D – Where does she hear them?

I – Ubava xa besecalweni kwakho okanye ubeva xa bekude?
(Do you hear when they are closer to you or when they are far?)

PD – Xa betheni sisi, xa bencokola okanye xa besecaleni kwakhe ?
(When they are doing what sisi, when they are talking to themselves or what ?)

P – Hayi andinangxaki mna ndibeva kakuhle.
(No I don't have a problem, I can hear them properly.)

I – She don't have a problem, she do hear people when are talking even when they are far and when are near him.

D – No I'm talking about, you must understand what I'm talking about...I'm talking about the hallucinations when hearing voices but nobody is around.

I – Okay...ukuba ngaba akukho mntu ecaleni kwakho, kukho abantu abathetha ngawe, abahlebayo manditsho uyabava.
(Okay if there's nobody around and there are people who are talking about you, people who are gossiping ,let me put it that way, can you hear them ?)

P – Abantu bengekho aph'ecaleni kwam, hayi andiva.
(I can't hear when people are talking being far away, no)

I – She can't hear them.

D – Okay no hallucinations.

P – Andilo gqirha kaloku anduzuva abantu.

(I am not a traditional doctor, I won't hear people talking.)

(laughter in room)

D – What is she saying?

I – She says she...she's she is not an African doctor.

D – She's not an African doctor, okay...so African doctors hear that?

I – Yes

D – Does she smoke?

I – Uyatshaya?

(Do you smoke?)

P – Ndiyatshaya isneyifu.

(I am smoking snuff)

I – She smokes snuff

D – How many in a day?

I – Zingaphi ozitshayayo ngemini?

(How many do you smoke a day?)

P – Yoooh hayi ke ngoku, iyaphela iveki nditshaya esinye.

(Oh no...it took me a week to finish one)

I – I'm using one in a week.

D – One what, a packet or what?

P – Packet

D – How many years you smoke?

I – Mingaphi iminyaka utshaya?

(How many years smoking?)

P – Mihlanu

(Five)

I – It's five years.

D – Not more than five years?

I – Not ngaphezulu kweminyaka emihlanu?

(Not more than five years ?)

P – Hayi

(No)

D – Does she drink alcohol?

I – Uyabusela utywala?

(Do you drink?)

P – Hayi

(No)

D – Okay what I want to do now, it's just to examine her, can she take the jacket off, I just want to listen to her heart.

I – Kufuneka ukhulule ke ngoku uza kuxilongwa ngugqirha.

(You must take off your jacket, the doctor wants to examine you)

D – Okay before she does that, she must just sit, I'll ask her for the last time.

I – Uza kuku buza ke ngoku okokugqibela.

(He'll ask you now for the last time.)

D – Can you tell me where you are today?

I – Uyazazi ukuba uphi namhlanje?

(Do you know where you are today?)

P – Ndiyazazi ukuba ndilapha kwagqirha?

(I know I'm here at the hospital)

I – She knows that she is here in the hospital.

D – What's the name of the hospital?

I – Ngubani igama le-hospital?

(Who is the name of the hospital?)

P – I-hospital andiyazi, ndiyakhohlwa mna ligama.

(I don't know the name of the hospital, I forget.)

D – Does she...eh...know the date today?

I – Uyayazi ukuba ngumhla wesingaphi namhlanje?

(Do you know today's date?)

P – Andifundanga nje?

(I'm illiterate/I didn't go school.)

I – She never go to school, she know nothing about that.

D – She doesn't know the date, which year it is?

I – No

D – Mhmm...ask her

I – Akayazi i-date umama?

(Does mama know the date?)

PD – Hayi akayazi, into ayaziyo yeyoba kungomvulo qha namhlanje.

No, what she knows is that it is Monday today.)

D – The day, ask her.

I – Kungolwesingaphi namhlanje mama?

(Which day is it today?)

P – Namhlanje kungolwesibini, hayi suka mna ndidiniwe ngoku.

(It is Tuesday, and I'm tired now of being asked too much.)

I – She says it's Tuesday today and is also tired of asking too many questions.

D – I have to tell her to remember three things, can she remember for me?

I – Uthi ubangaba ugqirha angakuxelela izinto ezintathu, ungazikhumbula?

(The doctor asks if you can remember three things that he'll tell you, can you remember?)

P – Ewe ndingazazi

(Yes I will know them.)

I – Yes she can remember

D – Potato, bean and sky.

P – Ndiyazazi nje iitapile.

(I know potatoes.)

I – Uthi zitsho kaloku.

(He asks you to name them.)

P – Iimbotyi, izulu kunye ne...e...ne...e

(Beans, sky and… eh…and eh…..eh)

I – Kunye nepotato

(And potato)

P – Ndiyazazi maan ezo nto

(I know those things man)

D – Then ask her this, does she know the month we are at?

I – Uthi uyayazi yeyiphi le nyanga sikuyo?

(He asks you the month we are in?)

P – Andiyazi

(*I don't know.)*

I – She does not know.

P – Andiyazi, andifundanga.

(I don't know, I am illiterate)

I – She don't know the months, because she's never been to school.

D – She don't know the months. Can she tell me the day of the week?

I – Uthi ungamxelela ukuba kungolwesingaphi namhlanje?

(Can you tell him which day it is today.)

P – Kungolwesibini.

(It is Tuesday.)

I – It is on Tuesday.

D – Okay, but she must say Monday, Tuesday...up to Friday.

I – Uthi ke ugqirha kufuneka ubale uqale ngoMvulo uyoma ngoLwesihlanu.

(You must count from Monday to Friday.)

P – KungoMvulo up to Friday.

I – Monday, Tues...up to Friday.

D – What about Saturday and Sunday?

I – UMgqibelo neCawa yena?

(What about Saturday and Sunday?)

D – Now what I want you to do is to tell me the days of the week in the reverse order, Sunday, Saturday...going back to Monday.

I – Uqala ngecawa ukwehla uyoma ngoMvulo.

(Starting from Sunday, backwards and Saturday up to Monday.)

P – NgeCawa, ngoMgqibelo...err

(It is Sunday, Sartuday…err…err..err)

I – She's struggling

D – Okay what are the three things I have told you, can you remember?

I – Usazikhumbula ezazinto zintathu bendikuxelele zona?

(Do you still remenber the three things I have told you?)

P – Iimbotyi, iitapile...err...err...

(Beans, sky and… err…and err…..err)

I – It's beans, potatoes, she can't remember the third one.

D – Who is the president of the country?

I – Ngubani umphathi weli lizwe, uthi ugqirha ngubani umphathi weli lizwe?

(Who is the president of this country?)

P – Ndiza kumazelaphi umphathi weli lizwe?

(How will I know the president of this country?)

PD – Lo naniyo kumvotela yayingu bani?

(Who were you voting for, when you went to the polls?)

P – Ngubani na lo mfana ngoku, khawumchaze, ndizakumazelaphi?

(Who is this young chap, tell me please, how will I know?)

I – She does not know him.

D – I want you to do this for me

I – Funeka wenze le nto athi ugqirha yenze

(You must do what the doctor tells you to do.)

D – Keep doing it

I – Yenza nangokwakho

(Do it on your own)

D – Faster

I – Qhubekeka uyenze, yenza ngokukhawuleza.

(Continue to do it, do it faster)

D – Okay now, you can take off the jacket now and get on the bed.

I – Uthi ungakhwela ke ngoku ebhedini.

(He says you can get on the bed.)

D – How many tablets do you take a day?

I – Zingaphi iipilisi oziselayo ngemini?

(How many tablets do you take a day?)

P – Zimbini

(Two)

I – Two

D – Two okay. Lie on your back.

I – Lala ngomqolo mama

(Lie on your back)

D – Open your mouth

I – Khamisa mama

(Open your mouth mama)

D – Alright. Okay.

I – Yeka ke mama

(Stop mama)

D – Open your eyes

I – Vula amehlo mama

Oopen your eyes mama.)

D – Is she losing weight?

I – Wehlile egazini?

(Has she lost weight?)

PD – Ewe

(Yes)

D – Does not eat?

PD – Ewe

(Yes)

I – She does eat

D – She does eat, okay. Breathe with your mouth

I – Phefumla mama ngaphandle

(Exhale)

D – She never had stroke?

I – Zange axhuzule?

(Was she ever epileptic?)

PD – Hayi

(No)

D – Okay she must stand up for me

I – Phakama ke mama, usondele apha ngaku gqirha.

(Stand up mama and come nearer to the doctor)

D – Stand up for me

I – Phakama mama

(Stand up mama)

D – Err...I want her to close her eyes.

I – Uthi ugqirha ucela uvale amehlo.

(The doctor asks you to close your eyes.)

D – Sit

I – Hlala phantsi

(Sit down)

D – Can you feel where the thumb is?

I – Mxelele ukuba ubhontsi lo wenze njani?

(Tell him how is the thumb?)

D – Tell me mama

I –	Mxelele, uthi ufuna ukuqonda ukuba wenze njani na ?
	(Tell him, he wants to know if she feels the thumb)
D –	Is the thumb up or down?
I –	Uthi xela ukuba umile okanye ulele.
	(Tell the doctor if the thumb is up or down)
P –	Umile, ulele
I –	Standing, sleeping
D –	And now
I –	Ngoku mama wenze njani?
	(Now mama, how is the thumb?)
P –	Andiwuboni
	(I don't see it)
I –	She says that she does not see it.
D –	If she does not know she must say so
I –	*Mama xa ungawazi, vele nje utsho wena.*
	(If you don't know say so mama.)
P –	I do not know.
D –	Okay does she feel anything when I'm touching her?
I –	Ingaba ikhona into oyivayo, njengokuba ugqirha akubambayo?
	(Do you feel anything when the doctor touches you?)
P –	Ewe ndiyayiva, kubuhlungu apha.
	(Yes I can feel, it's a bit painful here)
D –	Okay, I'm coming now.
I –	Uyabuya ugqirha
	(Doctor is coming)
P –	Ndiyaqala ukufumana ugqirha obuza kangaka.
	(This is my first time to get a doctor who asks so many questions.)

GSH A 2

Interpreter (I) –	Uvile ke sisi?
	(Did you hear sister?)
Patient (P) –	Mhm
	(Yes)
Doctor (D)–	Is she okay with it?
P –	Izakwenzeka nini ke le nto?
	(When is it going to be done this thing?)
I –	When are you going to do that?
D –	They need today, she's going to be taken up to the ward.
I –	Iza kwenziwa namhlanje, kuza kufuneka asiwe ewadini.
	(It is going to be done today, she has to be taken to the ward)
Patient's daughter (PD) –	Uyalaliswa?
	(Will she be admitted?)
I –	Are you gonna admit her?
D –	No no no, they are not admitting her, just to do the procedures and she goes home.
I –	Uza kwenziwa le nto qha, then agoduke.
	(She will be done only this thing and go home.)
P –	Ndiza kuthini na ngoku, ndidiniwe nje?
	(What will I do now, I'm tired?)
I –	Which ward is that?
P –	It's E 7
I –	Kuse E7
	(It's E7)
D –	I'm gonna get somebody to take you there.
I –	Ndiza kufuna umntu oza kunisa kwela cala
	(I'll organise a person to take you to that side.)
D –	Or maybe the other thing I can bring him here. It might be easier.
I –	Okanye ke angamthatha aze naye, azokumenzela apha.
	(Or he can fetch him to do her here.)
D –	She has to wait here until she gets better.
I –	Azokwenzelwa apha?
	(Can she be done here?)
PD –	Ewe
	Yyes)
I –	It will be very much...if she can get here.
D –	Okay that's fine, that's fine.
P –	Izakwenziwa nini na le nto?
	(When is it going to be done this thing?)
D –	Yes I'm finished, I'll just go and fetch. I'll be in a rush.

RXH A

Social worker (SW) –	You married seven months, neh? Are you married by court, you sign or only traditional.
Interpreter (I) –	Nitshate mtshato mni, nitshate ecourt okanye nitshate ecaweni okanye nitshate isiXhosa?
	(What kind of marriage do you have, did you go to court or in the church or you married traditionally?)
Patient's mother (PM) –	At Home Affairs
SW –	and
I –	Oh...Home Affairs that's fine.
SW –	Do you have more children?
PM –	Yes
SW –	What are their names?
PM –	Igama lakhe?
	(His name?)
I –	Yes
PM –	Ayakha
	(It's A)
SW –	How old is A?
PM –	3 years
SW –	Err...err a girl or a boy?
PM –	Boy
SW –	Where does he live?
PM –	EmaXhoseni
I –	*Err...in the Eastern Cape*
SW –	Okay…Who is looking after him?
I –	Ngubani omjongayo pha e-Eastern Cape?
	(Who is looking after him in the Eastern Cape?)
PM –	Ngumam'am
	(My mom)
I –	My mom
SW –	Do you...is this the only child you have or you have more children?
I –	Kuphela ko-A onaye okanye unabo abanye abantwana?
	(*Is A the only child you have or you have other children*)
PM –	Kuphela kwakhe nguye nalo ulapha esibhedlele.
	(It is the only one and the one here at hospital)
I –	It's A and this one who is in the hospital.
SW –	And S? Does the father have any other children?
I –	Utata unabo abantwana ngaphandle?
	(Does the father have children outside?)
PM –	Hayi akanabo
	(No, he does not have)
I –	No
SW –	N is not A's father?
PM –	Yes
SW –	Okay then how long are you in the relationship?
I –	Ninexesha elingakanani nithandana phambi kokuba nitshate?
	(How long were you in this relationship before you get married?)
PM –	Kaloku sasikhe sayeka, that's why ndingakwaziyo ukuyibala, sasikhe sayeka, saphinda sabuyelana.
	(*We had a break, that's why I do not know the exact period,we had a break, and we reconciled again)*

I – We had a break...**(to patient)** nibe ne...nohlukane phambi kokuba uA abekhona okanye emveni kokuba ekhona?
(You have...did you break up before A was born or after?)

PM – Emveni kokuba uA abekhona.
(*After A was born)*

I – After A was born, we split and then...we came together again. **(to patient)** Nibuyelene emva kwexesha elingakanani?
(After how long did you reconcile?)

PM – Inoba zinyanga ezimbini, iinyanga ezimbini ezinehafu, ndingatsho.
(It may be two months, two months and a half, I can say so)

I – Nohlukene?
(Separated?)

PM – Ewe, ndisengatsho, zange siyigqibe i-3 months.
(Yes, I can say so, we did not even finish 3 months)

I – Oh...we never even break for a long time, it was about two to three months and then we came together again.

SW – Okay, now from the beginning, from A, how long were you in a relationship?

I – Phambi kokuba uA lo abekhona, nanithandane ixesha elingakanani?
(Before A was born, how long were you in a relationship?)

PM – Unyaka
(A year)

I – Kwaze kwabakho uAyakha?
(and then there was A?)

PM – Ewe
Yyes)

I – UAyakha unangaphi ngoku?
(How old is A now?)

PM – 3 years ngoku.
(3 years now)

I – Oh...we were in-love for a year then...after that we got Ayakha and then we split for three months and then came together again.

SW – So you were in the relationship for four years?

I – Yes

SW – and they are married for seven months?

I – Yes seven months.

SW – How do you live..., the house you live in, what kind of a house, is it a brick house or a shack?

PM – Shack

SW – And how many rooms in the shack?

PM – One

SW – Do you have a bedroom and a split kitchen or it is a one room and the other side you have is a kitchen?

I – Kulo mkhukhu wakho uhlala kuwo, ngamagumbi amangaphi, unegumbi lokulala, unelokutyela, unelekhitshi okanye ?
(How many rooms in your shack that you live in, do you have a bedroom, a dining room, a kitchen or what ?)

PM – Ndinelantuka...ndinegumbi eliyi-one, kukho ibhedi kwelinye icala nekhitshi kwelinye icala.
(I have a... I have one room, there's a bed on this other side and a kitchen on the other one.)

I – It's only one room with its bed on the other side, on the other side it's part of the kitchen.

SW – Okay who all sleep here?

I – Ngoobani abalala kweligumbi?
(*Who are the people who sleep in this room?)*

PM – Ndim nomyeni wam nomntwana wam qha.
(It is me, my husband and my child only.)

I – It's myself, my husband and my child.

SW – Tell me...the income into the family, are you getting grant?

I – Ndicel'ukwazi ukuba uyayifumana na indodla yabantwana?
(I want to know if you do get the child support grant?)

PM – Ewe, ndiyayifumana.
(Yes I get it)

I – Yes I do get the grant

SW – For what child?

I – Owuphi?
(Which one)

PM – Bobabini
(Both of them)

I – Both of them

SW – Oh...do you send the money down for A?

I – Uyamthumelela uA imali?
(Do you send the money for A?)

PM – Ewe
(Yes)

I – Yes I do

SW – Okay and S?

I – US yena uhlala nawe?
(Is S staying with you?)

PM – Ewe uhlala nam
(Yes, he is staying with me)

I – S stays with us.

SW – So that is R210 plus...how much is your husband getting every week?

I – Umyeni wakho wamkela malini, wamkela ngeveki, okanye nge fortnight?
(How much does your husband earn, is he paid weekly or on fortnight?)

PM – Wamkela ngenyanga
(He is paid on a monthly basis)

I – He is a monthly payer. So wamkela malini?
(So how much is he paid?)

PM – R2000

I – It's about R2000

SW – And you don't do anything else for the other income, nowhere else you get the money.

I – Wena, malunga noba uncedise apha ekhaya, akukho nto uyenzayo,awuthengisi,awuthini?
(And you for assisting at home, is there anything that you do, are you not selling,you are doing nothing?)

PM – Hayi akhonto ndiyenzayo, nam bendikhe ndafumana, qha ibiyinyanga eyi-one kwaza kwagula umntwana, ndayeka ke ngoku.
(No there's nothing that I'm doing, I had a job for a month and when my child got sick I had to stop working.)

I – No there is nothing that I'm doing, although there was a part-time job that I do get but it was only

	one month and then my child became sick, so I had to drop.
SW –	Who looks after the baby in the day?
I –	Xa uthe wafumana umsebenzi, waphangela, ngubani umntu ojonga emva kosana?
	(When you got a job and work, who is the person who looks after the child?)
PM –	Ndimsa ecreche xa iphuma, ayokuthathwa ngusister womyeni wam.
	(I send my child to the creche and when it closes my sister in-law takes him)
I –	I took my child to the creche and then later on my sister in-law fetches the child.
SW –	I'm talking about now, neh, before you start to work.
I –	Ngoku phambi kokuba uphangele.
	(Now, before you start to work)
PM –	Andiva
	(I don't understand)
I –	Ngoku phambi kokuba uphangele.
	(Now before you start to work)
SW –	Your baby is now a year old, your baby is a year old, right? So did your sister-in-law look after the baby when you had to go and work?
I –	Njengokuba umntwan'akho enonyaka omnye ephangela, u-sister-in-law ebejonga emva komntwana wakho?
	(As your baby is a year old, was your sister in-law looking after your child?)
PM –	Ewe ebejonga emv...
	(Yes she was looking…)
I –	Sister-in-law looks after my baby.
SW –	And then you are not working, who looks after the baby?
I –	Xa ungaphangeli ngubani, ngubani omjongayo umntwana?
	(When you are not working, who is looking the baby?)
PM –	Ujongwa ndim
	(I look after him)
I –	I'm looking after my child.
SW –	What is the aunt's name?
I –	Ngubani igama lendodakazi?
	(What is the name of the sister- in-law?)
PM –	NguNokwakha
	(It is N)
I –	It's N
SW –	Where does she live?
I –	Uhlala phi uN?
	(Where does Nlive?)
PM –	Uhlala ePhillipi
I –	She stays in Phillipi
SW –	Also near to you or not?
I –	Ukufutshane kuwe okanye akakufutshananga?
	(Is she nearer to you or not)
PM –	Ukufutshane
	(She is nearer)
I –	She is very near to me
SW –	Did the doctor speak to you about what is wrong with the baby?
I –	Ugqirha uye wathetha nawe ukuba yintoni erongo ngomntwan'akho?
	(Did the doctor talk to you about what is wrong with your child?)
PM –	Hayi
	(No)

I –	No
SW –	It's not my job, neh, to tell you what is medically wrong with the child, that's something that the doctors must do.
I –	Ayingomsebenzi wam ukuba ndikuxelele ngento erongo emntaneni, yinto ebekumele ukuba ugqirha uyayenza kuwe. (*it is not my job to tell you about what is wrong with the child, it's something that the doctor must do to you.)*
SW –	But I can tell you that the doctors are very worried about the baby's weight.
I –	Naxa kunjalo ndinga kuxelela ukuba oogqirha bakhathazekile yindlela ahle ngayo umntwana. *(Even though it is so, I can tell you the doctors are worried with the weight loss of the child.)*
SW –	They feel that the baby's growth is not the same with the baby's age.
I –	Baqaphela ukuba ukukhula kwakhe akungqamananga nobudala bakhe. *(They noticed that his growth is not on the same level with his age)*
SW –	They feel that maybe he's not getting enough food.
I –	Babona ukuba umntwana akafumani kutya kwaneleyo *(They feel that the baby does not get enough food)*
SW –	So what is the problem, is the problem with food at home?
I –	Ndicela undixelele ukuba unengxaki yokutya ekhaya? *(May you please tell me if there's a food problem at home)*
PM –	Ewe kuba umyeni wam ebesanda kuphangela, akukudalanga ephangela. *(Yes I had a problem because my husband recently got a job, it's not long that my husband has been working.)*
I –	Yes, I've got a problem because my husband was not working for a long time he just got a job recently.
SW –	How long did he get a job, how long ago?
I –	Unexesha elingakanani ephangela? *(How long has he been working?)*
PM –	Uneenyanga ezimbini *(It's been two months)*
SW –	So how did you survive before that?
I –	Phambi koko beniphila yintoni? *(Before that what were you living with?)*
PM –	Ubebana ebamba komnye umsebenzi, abane ebambe aphinde ayeke. *(He used to get piece jobs that would not last long enough)*
I –	My husband was getting piece jobs which they were not lasting
SW –	Now that you have your money every month, are you able to eat every day?
I –	Njengokuba ufumana imali rhoqo ngenyanga uyakwazi ke ukuba nitye ngokufanelekileyo? *(Now that you get money monthly, do you manage to have enough food?)*
PM –	Ewe ndiyakwazi *(Yes I am able)*
I –	Yes we do
SW –	Are there any days of the week that you don't have food/.. interruption
PM –	Yes
SW –	Are there any days that you don't have milk for the baby?
I –	Zikhona na ezinye iintsuku apho unokuthi umntwana akabinalo ubisi? *(Are there any days where you would say a baby has no milk?)*
PM –	Ewe zikhona *(Yes, there are)*

SW – Even though the husband is working now?

I – Nangoku umyeni esebenza?
(*Even now that the husband is working)*

PM – Ewe zibakhona.

I – Yes there are days that we don't have enough food

SW – Which days?

I – Zeziphi?
(Which are they?)

PM – Xa mhlawumbi kuza kuphela inyanga
(Maybe towards the end of the month.)

I – Towards the end of the month, when there's no money at all

SW – Is the baby on the milk supply for six months?

I – Umntwana uyalufumana ubisi, iinyanga ezintandathu.
(Does the baby get milk for six months?)

PM – Hayi
(No)

I – No

SW – I'm going to talk to the dietitian because your baby is malnutritioned, malnutrion means that your baby for a long time did not get enough proper food so the body can't build itself up, okay, that's why the baby is sick.

I – Ndiza kuthetha no-dietitian yena mntu endizakuthi ndimcele ukuba umntwana makafumane ubisi eclinic ngoba kaloku umntwana akondlekanga, so kunyanzelekile ke ukuba umntwana makalufumane ubisi eclinic, siyavana?
(I will talk to the dietitian the person that I will ask to give the baby milk fromthe clinic because the baby is malnourished, so it is a must that a child must get the milk from the clinic, do you understand?)

PM – Ewe
(Yes)

I – Okay

SW – So that you can get milk from the clinic until the baby's weight is right.

I – Ndiza kuzama ke ukuba umntwana afumane ubisi de umntwana amimitheke.
(I will try so that the baby gets milk until he regains the weight.)

SW – Now is there anyway that you cannot find a job...to keep the family going?

I – Err...umntwana wakho ngoku ubukhula, uthe dlandlu ngoku noko, ingaba ayikho na indlela yokuba ungafumana umsebenzi ukwazi ukuncedisa umyeni wakho ukuze nikwazi ukondla abantwana?
(Err…your baby now is a little bit old,he's older now, is there no way that you can find a job to assist your husband so that you can feed your child?)

PM – Ingakhona
(It can be possible)

I – Yes I can try my best.

SW – Okay because R2000 is not a lot of money but it's not really a lot of money because you have to take away the money for travelling that he needs to go to work with and whatever money is left it must go for electric, eh.....food and having a baby is expensive and the baby food is really expensive. So if you can get a job say 4 or 3 times a week and then you can still care for your baby and your sister-in-law and you can help the family, because it's a lot, I mean your husband cannot get a job that pay him a lot/more. Lucky you have a husband who is working and can keep a job but a security job is not paying well.

I – Ukwimo engathi xa ujongile ubone ukuba le mali yamkelwa ngumyeni wakho i-R2000 ininzi gqitha, kanti ke ayininzanga kuba kaloku kufuneka umyeni wakho akhuphe i...travelling

allowance, imali yokukhwela, abhatale amanye amatyalanyana, eshiyekileyo ke ngoku ibe yile nithenga ngayo igrocery. Ewe yona ungacinga ukuba yenza umahluko, kodwa ifike ibethe xa kuza kuphela inyanga, ngoba kaloku umntwana akabinalo ubisi.

(You are in a situation where you'll look at the money your husband is paying as sufficient,you'll think that R2000 is a lot of money, but it is not because your husband needs to deduct money for the transport to work, pay some debts and then the rest is for the grocery. Yes you may think that it makes a difference,but it becomes a problem towards the end of the month, because the baby has no milk.)

SW – Okay mama?

PM – Okay

SW – You can talk to the doctor and tell him what you told me and then I'll talk to you soon again, but I'll talk to you on Monday.

I – Ndiza kuphinda ndibuye ndizokuthetha nawe, ndisafuna ukuthetha nogqirha, ndibonisane naye ngemeko yakho, wena ke ndiza kubuya ndithethe nawe ngoMvulo.

(*I will come again and talk to you, but I want to talk to the doctor about your situation and I will talk to you on Monday.)*

PM – Okay

RXH B

Social worker (SW) –	Y how are you doing today?
Interpreter (I)–	Y uphila njani namhlanje?
	(Y how are you today?)
SW –	Y you know I spoke with your mom this morning, neh?
I –	Y ndithethe nomama wakho namhlanje, yazi?
	(Y I spoke with your mother today, you know.)
SW –	Okay Y?
I –	Uyakhumbula?
	(Do you remember?)
SW –	And do you remember sis'P?
I –	Usamkhumbula usis'P?
	(Do you still remember sis'P?)
Patient (P) –	Yes
SW –	What's gonna happen is that my name is S and because I can not speak Xhosa, sis'P is gonna speak for me.
I –	Bendikuxelele moss ukuba igama lam ndinguNontlalontle, uS kodwa andikwazi ukuthetha isiXhosa, uP uza kunditolikela uS atolikele nawe neh?
	(I have told you that my name is social worker S but I can't speak Xhosa, so P is here to help you and S.)
SW –	There are some important things that I want to talk to you about?
I –	Ndinezinto ezibalulekileyo endifuna ukuthetha ngazo nawe, va?
	(I have important things that I want to talk with you, do you understand?)
SW –	Now first for mother, please tell the mother that I have phoned the EMDC that's in charge of the school, that the school falls under, and I spoke with Y with regard to T, with regard to her son, I spoke with her this morning.
I –	Eh usakhumbula ukuba kusasa siye sathetha ngoThabo neh, uthi ke uNontlalo ufowunele i-EMDC eh ...eh ...malunga noba uza kuthini.
	(You remember that we spoke about T, the social worker says she had phoned the EMDC about what you'll do)
SW –	Yolanda is a school social worker.
I –	UYo kuNotlalontle wesasikolo.
	(Yo is the social worker of that school.)
SW –	And she is in Mbasa School.
I –	And enguNontlalontle nje unguNotlalontle naphaya eMbasa esikolweni.
	(And she is also a social worker at Mbasa School.)
SW –	Now I have explained the problems that you have with T.
I –	Ndimchazele uY ingxaki emalunga noT.
	(I have explained to Y the problem about T.)
SW –	And basically what is going to happen is that she gonna fax some things through to Miss D M.
I –	Into oza kuyenza zikhona izinto azakuzithumela ngefax ku Miss D M.
	(What she'll do is to fax some things to Miss D .)
SW –	She's a teacher at the school.
I –	Ungutishala phaya esikolweni.
	(She is a teacher there at school.)
SW –	She's in charge of all the correspondance of the social workers and the EMDC
I –	UMiss D lo nguye ophethe icandelo le i-EMDC nguye ophethe neetishala eziphantsi ko-EMDC.
	(Ms D is the who is responsible for the EMDC section and she is also in charge of the teachers under the EMDC.)

SW – So you understand Ms D neh?

I – Uyamqonda uMiss D neh?
(you understand Ms D okay?)

I – I know Ms D

SW – Okay, now...err Y is gonna phone us, she waiting for the response from Ms D. But what you can do in a week's time

I – UY uza kundifowunela xa ethe wabe udibene no Ms D kodwa ukuba ngaba kuphela iveki engakhange akwenze oko wena uze uzixhamle uye pha esikolweni malunga nale nto kaT.
(Y will call me after she met Ms D but if it is over a week and there's no phone call, you must go to school about T's issue.)

Patient's mother (PM) – Oh...uza kufowunela mna?
(Oh...is she going to call me?)

I – Hayi uza kufowunela uNotlalontle.
(No she'll call the social worker)

SW – Because it's not your job to take T to a special school, this goes through the school, it's the school that makes the recommendations.

I – Ayilo xanduva lwakho into yoba mawuhambe uyokukhangela isikolo khon'ukuze uT afumane isikolo, sisikolo esiyiMbasa nootishala esifanele ukuba bakhangelela uT isikolo esifanelekileyo nanje ngomntwana ingqondo yakhe ocothayo esikolweni.
(It is not your responsibility to look for the school for T, it is the school Mbasa and its teachers that is responsible to look for a school best suited for Ts slow paced brain at school.)

SW – Alright? Yonela I'm gonna talk to you now.

I – Ndiza kuthetha nawe ke ngoku M (nickname for patient) neh?
(I'll talk to you now M (nickname for patient) okay?)

SW – Okay. Yonela tell me when this accident happened to you where were you?

I – Ndixelele ukwenzeka kwale ngozi ubuphi, ubusendlini kabani?
(Tell me when the accident happen, where were you, whose house were you in?)

P – Bendise...bendise...ndiye ndakhaph'itshomi yam, ke ngoku itshomi yam yahamba.
Ndayibonisa iichips zam ke ngoku ndahamba ndaya kulo tshomi yam, ngoku xa ndikulo tshomi yam, ndagxothwa ngumama wayo. Ndabona umntu ophethe i-gun wandidubula
ke ngoku ndafunqulwa ngusisi Nom...
(I was...was...and accompanied by friend and we went. I showed her my chips and we went to my friend's home, when we reached my friend's house, my mother's friend chased me out. I saw a man with a gun and he shot me and I was taken by sisi.

I – I was at my home and I accompany my friend to her home. When I reach her home, my friend's mum chuck me out and lock the door, so when I was about to...when I was on my way going home I saw a man carrying a gun I ran, when I ran the gun, this man shoot at me.

SW – Okay, now let's start with you, you were playing at your house, is that right?

I – Ubudlala kowenu wena neh?
(You were playing at your house, neh?)

P – Ewe besidlala netshomi yam, sidlala isikolo, ukugqiba kwethu netshomi yam yagoduka.
(Yes we were playing school with my friend and after that my friend went home.)

I – Yes we were playing with my friend at my home, after we finished she went home.

SW – What's your friend's name?

I – Ngubani igama letshomi yakho?
(What is the name of your friend?)

P – NguA

I – My friend's name is A.

SW – Are you and A best friends?

I – UAnita lo nizitshomi ezithandanayo, uA udlala kokwenu qho?

(Are you best friends with A, does A always play at your home?

P – Yes

SW – Okay, is this the first time that you go to A's house?

I – Ibikokokuqala wena usiya kulo A?

(Was it the first time you go to A's place?)

P – Mna bendiphuma ngapha esikolweni ndaphuma ngapha ngakulo A, ndathi uA makandikhaphe wandikhapha, ndakhulula ke mna ke impahla yesikolo.

(I was from school and I passed by A's house, I asked her to accompany me and she did and I took off my school uniform.)

I – I was from school and I came from A's side and err...so A I asked her to accompany me to my place to take off the uniform, which A did that.

SW – The problem Y, Y is A's mom, every time you go there she close the door on you and then you can't get into her house.

I – Mamel'apha ke Y, umama kaA akakuthandi, qho xa usiya kulo A uyakugxothwa, so awuvumelekanga ukuba uphinde uye kuloA. Umama kaA yena usoloko ekugxotha ngalo lonke ixesha.

(Listen here Y, A's mother does not love you, every time you go her place you are chased out, so you are not allowed to go there at A's place. A's mother is always chasing you out.)

SW – The first thing you do is to tell your mom that you are going out.

I – Enye ingxaki ngoku kufuneka xa uhamba uxelele umama, uthi mama ndiyahamba ndihamba nobani, angakukhangeli angakwazi nokuba uyephi.

(Another problem now is that you need to report to your mom, and say mama I'm going with so and so, so that your mother may not be worried about your whereabouts.)

SW – You go to your friend's house and now you are alone in this accident.

I – Uhambe netshomi yakho ngoku wenzakele ngenxa yokuba ugxothwe ngumama wayo wafunyanwa yimbumbulu.

(You went out with your friend and now you are injured because your friend's mother chased you away and a bullet got you.)

SW – Is it true Y that when you go with Anita to her house, you can't get into her house?

I – Kuyinyani ukuba wena kuloAnita, awukwazi kungena umama kaAnita uyakugxotha avale ucango?

(Is it true that at As place, you can not get inside, A's mother chases you out and closes the door?)

P – Ewe

(Yes)

I – Yes

SW – So every time you get to her house, you put yourself in danger neh?

I – Qho xa uye kuloA uyabona ukuba wena ubasengozini, ngoba kaloku uyakugxotha avale ucango?

(Everytime you go to As house, you are in danger, because A's mother is chasing you out and close the door.)

SW – The area that you live in is not a safe place.

I – Ingingqi ohlala kuyo, uyayibona ukuba yingingqi engekho lucwangweni kwaphela.

(The area that you live in can you see that it is not in order at all?)

SW – And it's not safe for you as a young girl.

I – Le ngingqi yakho ayikho lucwangcweni ingekho naselucwangcweni loumntwana ongangawe.

(This area is not in order and it's not in order for a girl of your age.)

SW – How old are you.

I – Mingaphi iminyaka yakho?

(*How old are you?)*

P – Five

SW – Oh five. It's not safe for you as a five year old to be walking up and down the street and your mommy doesn't know you.

I – Uyabona ke laa ngingqi yakho ayikho tu eluzolweni and ayimnandanga ayintlanga into yokuba uvele uphume endlini uhambe umama engakwazi ukuba uyephi.
(You see you area is not at peace at all, it is not right, it is not nice to just go out without telling the mother.)

SW – You are very lucky, you could have been dead.

I – Unethamsanqa elibi wena ngoba ngowufile ngoku.
(You are very lucky because you could have been dead.)

SW – Remember I spoke to your momy and I must speak to her about this also, she needs to know where are you at all the time.

I – Ndithethile nomama wakho ndamxelela okokuba nanjengomzali wakho ngalo lonke ixesha wena makakwazi ukuba uphi, uyaphi, okubalulekileyo kufuneka udlale apha phambi kwam.
(I spoke to your mom and tell her that as a parent, at all times she must know the place you are at, where you are going, what is important is that you must play not far from me.)

SW – Should your mother, if anything happens to you then we gonna question her.

I – Ngumama wakho, nguye ekufuneka ejongene nobomi bakho, yilento ke kufuneka ungaveli uphele emehlweni ungaziwa ukuba uphi, ngoba xa kuphinde kwenzeka enye ingozi, thina siza kubeka ityala kuye apha esibhedlele, neh?
(It is your mother who is responsible for your life, that's why you must not just vanish and not know your whereabouts because if anything happens to you, we are going to blame her here in the hospital.)

SW – So you are playing, from school you are playing inside the house or you're playing outside the house or in the backyard, alright?

I – Ubuya esikolweni udlala apha ekhaya, ubuya esikolweni udlal'aphe yadini okanye udlala apha emva eyadini, ungemki uye kulo tshomi wakho apho ugxothwa khona.
(From school you play in the house, you come back and play in the yard or you play at the back in the yard and don't go to your friend where they are chasing you out.)

SW – Your friends can come and play to your house but you don't go to their house, neh? Especially you don't go to A because you know you don't go to her house.

I – Iitshomi zakho mazizokudlala apha ekhaya, uyeva? Ngakumbi uA, uA makazokudlala apha kokwenu wena ungayi kulo A, because uyagxothwa, okay?
(Your friends must come and play at your house, okay? Especially A, she must come and play at your place and you don't go to A's place because you are not welcome, okay?)

SW – Anita can come to your house but you don't go to her house.

I – UA makazokudlala apha kowenu, wena awuyi kuloA, siyevana?
(A must come and play here and you don't go there, do you understand?)

SW – I'm very serious about this Yonela neh, otherwise you gonna land to big trouble, okay?

I – Ndiyithetha yonke le nto ngoba andikwazi ukukuvumela ukuba uye kuloAnita, kufuneka usoloko usekhaya, uyeva?
(I'm speaking to you because I can't allow you to go to Anita's place, you must always be at home, do you hear me?)

SW – No running around, neh?

I – Ungabi ubaleka apha esithubeni siyevana?
(Don't run around the place, can you hear me?)

SW – And you need to, anywhere you go, you must first tell mommy, okay? You tell mommy and your mother must give you permission because your mother must know you anytime.

I – Xa ufuna ukuhamba kufuneka uqale kumama, mama ndingaya na endaweni ethile, ndingahamba na nobani, kufuneka umama ekwazile ungavele nje uphele emehlweni ngoku umama angakwazi ukuba uphi, xa ebuzwa athi hayi ubulapha phambi kwendlu, siyevana?

(If you want to go you need to start with mama, mama may I go to a certain place, may I go with so and so. Your mother must know and don't just disappear and mother does not know you and when she is asked and say, no you were playing in front of the house, do you understand?)

SW – Okay mama you understand, this is serious if you don't look after the child you gonna end into deep trouble, okay, you need to know where your daughter is, she's only five years old, okay?

I – Mama kaY ndiyithetha le nto ndisentlungwini, kunyanzelekile ukuba umntwna usoloko umazi ukuba ubheka, uphi, uyaphi makangahambi engakhange athethe nawe ngoba ukuba awumkhangeli emva kwakhe uza kuba sengxakini.

(Y's mom, I am talking this in pain and it is a must that you know a child's way, where is she, where is she going, she must not go without without talking to you because if you do not look after her, you will be in trouble.)

SW – Because if you can not keep under control, I'm gonna talk to the social worker and they gonna come to your house and they gonna investigate how and who is looking after your child, okay?

I – Ukuba ngaba awuyithatheli ngqalelo le nto ndiyithethayo ndiza kufowunela ooNontlalontle abajikeleza iCrossroads, abayakuhlola ikhaya lakho ukuba likhaya elinjani babuye bandichazele ukuba likhaya elinjani, athathwe ke ngoku umntwana ayokugcinwa kwikhaya labantwna ekufuneka benonophelwe.

(*If you don't take note of what I'm talking about, I'll phone the social workers who are doing rounds in the Crossroads area and will do investigations into your home and report to me about their findings of your home.Your child will be taken and be placed in the places of safety, where she'll be taken great care of.)*

SW – If they find out that you are not watching her properly that she run arounds the street they are going to finalise this report

I – Ukuba bathe xa befika bafumanisa ukuba ungumzali ongakhathaliyo, ungumzali othi xa ubuzwa ngomntwana kufumaniseke ukuba awuhoyanga, lo mntwana uza kususwa ayokubekwa kwikhaya labantwana.

(If they found out that you are careless about the child, your child will be taken from you and be placed in a children's home.)

SW – You are single mommy, you are working hard everyday you go out early in the morning to work and provide for your child.

I – Ungumama ongatshatanga, osebenza kanzima osebenzela abantwana kuba ufuna ikamva eliqaqambileyo ngabo, ngoko ke kufuneka ubene nkathalo ngabo.

(You are a mother who is not married, who is working hard for the bright future of your kids therefore you need to be careful about them.)

SW – Okay it will not be a nice thing if they can take away your child from you because there's nobody who watch them in the afternoon when you are at work.

I – Ayuba yinto entle ke leyo xa aba Nontlalontle benokufika, bafike bebona ukuba elo khaya alikhathali, bamsuse kuwe, iya kuba buhlungu intliziyo yakho.

(It won't be a nice thing if these social workers arrive and find out that this home does not care and remove her from you, your heart will be painful.)

SW – Okay mama, any questions?

I – Ikhona imibuzo onayo?

(Do you have any questions?)

PM – Hayi andinayo, ndibulela ngale niyenzileyo

(No I do not have questions, I thank you for what you have done for me .)

I – I don't have any questions, I thank you for what you have done.

SW – I want you to talk to your child anytime.

I – Ndiyafuna ukuthetha naye umntwana wakho ngalo lonke ixesha, uthethe naye kungenjalo uyakugcwalelwa zizandla ungayazi ukuba mawumthini.

(I want you to talk to your child anytime because you will get into trouble.)

ADDENDUM V

TRAINING COURSES

Clinical Interpreter Training Course (CITC)

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
TIME TABLE

FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 1 31/07/2007		
TIME	**TUESDAY**	
	TOPIC	**FAC.**
08h00	**Introduction** Welcome Introductions Ice-breaker Orientation to the course	**NN/PP**
09h30	**TEA**	
10h00	**Interpretation & Ethics** Definition Types Translation Advocacy Values Ethical Principles Health and Human Rights	**PP**
13h00	**LUNCH**	
14h00	**Interpreting in a health care setting** Code of Conduct Role and Function of the Interpreter Interpreting in various situations Dealing with ethical issues Dealing with difficult Terminology	**PP**
16h00	**END OF DAY**	

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
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FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 2 01/08/2007		
TIME	**WEDNESDAY**	
	TOPIC	**FAC.**
08h00	**Language Skills** Multi-lingualism Fluency Colloquialism Regional / Cultural Differences Linguistics	**NN**
09h30	**TEA**	
10h00	**Communication Skills** Process Listening Verbal & Non-verbal Communication Writing Skills	**NN**
13h00	**LUNCH**	
14h00	**Self-management and Client Care** Self management Time management Record-keeping Telephone Etiquette Client Care Batho Pele	**NN**
16h00	**END OF DAY**	

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
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FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 3 02/08/2007		
TIME	**THURSDAY**	
	TOPIC	**FAC.**
08h00	**Interpersonal Skills 1.** Assertiveness Conflict Management Interpersonal Relationships	**PP**
09h30	**TEA**	
10h00	**Practica/ Role Play** Clerking Procedure Admissions Preparation for Theatre Discharge Records	**PP/NN**
13h00	**LUNCH**	
14h00	**Feedback** Discussions Role Play	**PP/NN**
16h00	**END OF DAY**	

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
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FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 4 08/08/2007		
TIME	**WEDNESDAY**	
	TOPIC	**FAC.**
08h00	**Intra & Interpersonal Skills 2.** Counselling Problem Solving and Decision making Coping with Emotions (E.I.)	**PP**
09h30	**TEA**	
10h00	**Health care 1.** Introduction to Health & Basic Health Science (Anatomy and Physiology) Health and Disease/ Illness Common Health Problems Medical Terminology Health Services/ Organisations, WC Healthcare Professional's consultations with patients	**PP**
13h00	**LUNCH**	
14h00	**Health care 2.** Introduction to Health Promotion Lifestyle	**NN**
16h00	**END OF DAY**	

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
TIME TABLE

FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 5 15/08/2007		
TIME	**WEDNESDAY**	
	TOPIC	**FAC.**
08h00	**Introduction to Anthropology** Culture Belief systems	**NN**
09h30	**TEA**	
10h00	**Introduction to Sociology** Sociology and Health Diversity Management Interpreting in a multi-cultural health care setting	**NN**
13h00	**LUNCH**	
14h00	**Assessment**	**PP/NN**
16h00	**END OF DAY**	

GROOTE SCHUUR HOSPITAL
HUMAN RESOURCE DEVELOPMENT

INTERPRETER'S COURSE
TIME TABLE

FACILITATORS: (FAC.) Ms P Prinsloo (PP) Ms N Nkondlwana (NN)

JULY – AUGUST 2007

DAY 6 21/08/2007		
TIME	**WEDNESDAY**	
	TOPIC	**FAC.**
08h00	**Introduction to Medical Sociology** The multi-disciplinary team	**PP**
09h30	**TEA**	
10h00	**Practica** Visit to clinical area	**PP/NN**
13h00	**LUNCH**	
14h00	**Portfolio** Revision of course requirements	**NN**
16h00	**END OF DAY**	

NATIONAL LANGUAGE PROJECT
HEALTH PROGRAMME

CURRICULUM:
COMMUNITY INTERPRETERS' COURSE

COURSE OUTLINE: SEPTEMBER 1996

Student requirement
- Mature Xhosa speaking female
- Has attempted Std 9 or 10 and is able to converse in English
- Has background in health or community work

Duration: 2 months
- 1 month theory
- 1 month practical

NB: Short lectures and discussions will be conducted throughout the duration of the pilot project

COURSE CONTENT

INTERPRETING **1 week**

- What is a community interpreter?
- Role of community interpreter
- Interpreting and advocacy
- Code of practice for community interpreting
- How to handle terminology problems
- Interpreting method

CONSITUTIONAL AFFAIRS **1/2 days**

- SA Constitution
- Reconstruction and Development Programme (RDP)
- Human rights
- Concept of an ombudsman

SKILLS DEVELOPMENT **1 week**

- Assertiveness
- Advocacy
- Mediation
- Negotiation
- Problem solving

COUNSELLING AND CULTURAL ISSUES **1 week**

- Concept of counselling
- Knowledge of the self
- Verbal and non-verbal communication
- Listening skills
- Confidentiality

HEALTH INFORMATION INCLUDING HEALTH PROMOTION **1 week**

- Introduction to the health module
- The concept of health
- National and Provincial Health Plan
- Organisation of health services in the Western Cape
- Basic anatomy and physiology
- Sociology, psychology and illness
- Structure of a consultation between doctor and patient
- Common medical problems
- Role of health personnel in a health facility
- Patients' rights
- Introduction to health promotion

ETHICAL ISSUES **1/2 day**

- Concept of an informed consent
- Confidentiality
- Whose duty is it to break bad news to the patient

ADMINISTRATION **1 day**

- Orientation to NLP and health facilities structures and administration
- Reporting (verbal and written)

PRACTICAL CLINICAL TEACHING AND SEMINARS **4 weeks**

METHODS OF FACILITATING

- Short lectures
- Group discussions
- Assignments
- Case studies
- Role plays
- Seminars
- Clinical orientation

VISUAL AIDS

- Videos
- Overhead transparencies
- Pictures
- Clinical equipment

EVALUATION

- Evaluation at the end of each day
- A test at the end of the first month
- An examination at the end of two months

CERTIFICATION

Certificates will be issued at the end of the course to candidates who have successfully completed the course.

Job description for community interpreters

JOB DESCRIPTION FOR THE INTERPRETERS

JOB SUMMARY

To facilitate communication between Xhosa-speakers patients and non-Xhosa-speaking health care providers by offering interpreting services and also ensure that the Xhosa-speaking patients obtain appropriate health and service.

PRINCIPAL DUTIES

- To interpret for Xhosa-speaking individual patients in their interaction with health care providers in accordance with the project's code of practice.
- To identify needs of the Xhosa-speaking patients in respect to health care services.
- To advise patients of their rights and choices in respect to health care.
- To prepare proposals for submission to management of health care facility in conjunction with the co-ordinator/director.
- To take appropriate action and ensure that the patient receives appropriate service and that the health care provider understands the needs of the patient. This may require the interpreters to challenge discriminatory or culturally insensitive behaviour on the part of the health care provider.
- To assist with counselling when necessary.
- To observe confidentiality at all times.
- To help with social problems which may arise whilst the patient is attending the health facility.
- To assist with health promotion (e.g. give appropriate health message to patients; assist with directions of taking medications, referrals, etc.)
- To keep records of work done with detailed information of problem areas and present weekly reports in both written and oral form.
- To attend weekly in-service education sessions.
- To be able to function effectively within a multidisciplinary health team.

List of health care facilities in the Cape Peninsula

Health care facilities	Number of interpreters
Tertiary	
Red Cross War Memorial Children's Hospital	3
Groote Schuur Hospital	3
Tygerberg Hospital	3
Valkenberg Hospital	2
Secondary	
Somerset Hospital	2
Mowbray Maternity Hospital	2
GF Jooste Hospital	2
Primary	
Heideveld Community Health Centre	1
Good Hope Community Health Centre	1
Sexually Transmitted Clinic, Salt River	1
Total	20