MULTILINGUALISM IN HEALTHCARE: COMMUNICATIVE EXPERIENCES OF EXPATRIATE HEALTHCARE PROVIDERS WITH VARYING LINGUISTIC REPERTOIRES IN WINDHOEK, NAMIBIA

By

Nelson Mlambo

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Supervisor: Prof C. Anthonissen

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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.

Nelson Mlambo

December 2017

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ABSTRACT

This study reports on the investigation of communicative practices among multilingual participants in healthcare in Windhoek, Namibia, from the perspective of expatriate healthcare practitioners working in the private sector. The multilingual environment of healthcare has remained largely uninvestigated in Namibia, which is a matter of concern considering how heavily Namibia relies on healthcare providers of foreign origin whose linguistic repertoires are diverse. The general objective of this research was to gain insight into multilingual communicative resources and needs, and how from the perspective of healthcare providers (HCPs), communication is managed. The study has a qualitative research design, using a questionnaire to collect data from 19 HCPs. The 19 HCPs who participated in this study self-reported a wide range of linguistic biographies; in addition to their mother tongue/home language the HCPs indicated that they had acquired various other languages. English was acquired by all participants at an early age, most between the ages three and nine years old.

The context of English language acquisition was reported as the school environment, starting as early as in pre-primary school. Expatriate HCPs with many languages in their repertoire working in a multilingual context found the linguistic diversity among colleagues and patients to be challenging to a lesser extent, and enriching to a greater extent. The study further found that the expatriate HCP respondents experience the use of many languages to be an engagement that broadens their professional, social and cultural views and this ultimately results in improved work relations and improved HCP-patient relationships. The use of English as well as indigenous Namibian and foreign languages was found rather to improve than prohibit efficient interactions with the patients, and multilingualism was found to be a resource, especially within a context like Windhoek, Namibia.

OPSOMMING

Hierdie studie doen verslag oor kommunikatiewe gebruike wat ontwikkel het tussen veeltaliges werksaam in gesondheidsorg in Windhoek, Namibië, gesien uit die perspektief van buitelandse praktisyns werksaam in die privaat mediese sektor. Die veeltalige omgewing van gesondheidsorg is nog nie wesenlik ondersoek in Namibië nie. Dit is kommerwekkend as in ag geneem word in watter mate Namibië afhanklik is van buitelandse gesondheidsorg voorsieners met uiteenlopende en verskillende taalkundige repertoires. Die oorkoepelende doel van hierdie navorsing is om inligting in te win oor veeltalige kommunikatiewe hulpbronne en behoeftes, en hoe, uit die perspektief van die buitelandse mediese personeel, kommunikasie tussen veeltaliges met verskillende repertoires bestuur word. ‘n Kwalitatiewe navorsingsontwerp is gebruik om data by 19 deelnemers, almal werksaam in gesondheidsorg, in te samel. Die deelnemers het gegewens uit hulle eie talige biografieë aangebied, en in die proses ook almal aangedui dat hulle naas hulle moedertaal verskeie ander tale aangeleer het. Engels is deur die meeste deelnemers aangeleer tussen die ouderdomme van drie en nege jaar oud.

Die konteks waarin deelnemers Engels aangeleer het, is aangegee as die skoolomgewing, van so vroeg reeds as in die pre-primêre skool. Die studie het bevind dat veeltalige mediese personeel van buitelandse herkoms wat in Windhoek se mediese sorgomgewing werk, ‘n ryk taalkundige omgewing teëkom wat tot ‘n mindere mate as ‘n uitdaging en tot ‘n groter mate as verrykend ervaar word. Die studie het verder bevind dat die mediese personeel van buitelandse herkoms die gebruik van verskeie tale in die werkplek beskou as ‘n gegewe wat op professionele, sosiale, en kulturele vlak hulle perspektiewe verbreed, en wat uiteindelik hul werksverhoudinge verbeter asook die verhoudinge tussen praktisyns en pasiënte. Die gebruik van Engels, inheemse Namibiese tale, asook ander nie-Namibiese tale het, volgens die deelnemers, eerder effektiewe interaksie met pasiënte verbeter as om dit te verhinder, en hulle het veeltaligheid as ‘n hulpbron ervaar, veral binne ‘n konteks soos Windhoek, Namibië.

DEFINITION OF KEY TERMS

The following are some of the key terms used in this thesis and their operational definitions:

- **Bilingualism** – this refers to the knowledge and alternative usage of two languages; in other words not monolingual. Thus bilingual people are conversant in two or more languages and such people may also be called plurilingual or multilingual or multilingual (Garcia and Wei 2014).

- **Multilingualism** – this refers to knowing more than two languages, or the use of three languages and more (see Deumert 2011, Garcia and Wei 2014, Garcia, Skutnabb-Kangas and Torre-Guzman 2006).

- **Healthcare provider** – this refers to anyone working in healthcare, whether in hospitals, clinics, private practice, pharmacies, old age home clinics and retirement village who comes in contact with clients or whose work both involves and influences care. This includes nurses, pharmacists, doctors, nurse aids, dentists, dental technicians, opticians and occupational therapists (Ulrey and Amason 2001:451). However in this study only medical doctors and pharmacists were considered as the sample of healthcare providers.

- **Linguistic repertoire** – this refers to the set of language varieties which encompass the various language registers and also the dialects which are used the members of the speech community speak and write. This also termed the verbal repertoire (Finegan 2015:540). Alternative terms to linguistic repertoire are code and verbal repertoire which are also used to encompass the whole spectrum of the codes available to the speech community for its usage in interactions (Kachru 1982:25). Thus in this study, of concern is how multilingual healthcare providers make a choice to move from one language to another in order to effectively function in a healthcare setting where more than one language can be used to effectively render service.

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Chapter One

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

This is a sociolinguistic study that is specifically focused on multilingualism in health communication in a globalising and linguistically diverse world. The aim of the study is to investigate communicative practices among multilingual participants in healthcare in Windhoek, Namibia, from the perspective of expatriate healthcare practitioners working in the private sector. The multilingual environment of healthcare has remained largely un-investigated in Namibia, which is a matter of concern considering how heavily Namibia relies on healthcare providers of foreign origin whose linguistic repertoires are diverse. Physicians, nurses and other healthcare providers (HCPs) who are not of Namibian nationality are invariably referred to as expatriate healthcare practitioners. English was constitutionally afforded the status of the only official language after independence in 1990 (Frydman 2011), though Afrikaans still remains the lingua franca in many contexts (Tötemeyer 2010). Even so, English at independence was a first language (L1) to a very small percentage of the population (0.8%) (Frydman 2011, Tötemeyer 2010), and a large portion was not fluent in English. This raises questions regarding communicative challenges and how this may have a negative impact on the quality of healthcare in the country. This study will give an exposition of a number of authentic, self-reported communicative experiences of multilingual expatriate healthcare providers with varying linguistic repertoires.

1.2 PROBLEM STATEMENT

This study intends to add to a growing body of research on profiles and patterns of multilingualism in African countries (see also Sobane and Anthonissen 2013, Sobane 2012, Nyaga and Anthonissen 2012, Zsiga, Boyer and Kramer 2014, Bayiga 2016). Specifically, it pays attention to the linguistic repertoires of selected expatriate HCPs established in private practice in Windhoek and it considers how these repertoires facilitate or hinder their

communication in the work place. The main problem to be investigated refers to the perspective of these HCPs themselves, and is dealt with in answering five interrelated questions on

(i) their own linguistic biography (i.e. which languages they have learnt that they know and use besides English),
(ii) how and when they acquired other languages than their mother tongue/home language,
(iii) how their linguistic identity (as reflected in their repertoire) affects their communication in the work place,
(iv) linguistic and communicative practices established in the work place that facilitate or inhibit the provision of quality healthcare, and
(v) the use of English as well as of indigenous Namibian languages and/or other non-Namibian languages in professional communication between the HCP and colleagues, as well as between the HCP and patients.

1.3 BACKGROUND TO THE STUDY

The processes of globalisation in the present world have resulted in increased mobility of professionals which include HCPs. This has had the effect that communication across language barriers and cultural divides in healthcare provision is now a widely distributed phenomenon. Namibia, as many other African countries is no exception. Currently a variety of fields is giving critical attention to communication in healthcare with a view to providing patient centred care of an acceptably high quality (see for example Gibson and Zhong 2005, Rosenberg et al. 2007, Meeuwesen et al. 2009, MacFarlane et al. 2008, Sobane and Anthonissen 2013, Gerber 2013). This study, on a limited scale, attends to multilingual profiles among relatively well-positioned international migrant workers within such a specific context. An international migrant is defined by the United Nations (2012:2) "as any person who changes his or her country of usual residence."

Country specific research in health communication is critical (Joubert and Ehrlich 2010), because of the differences in health care systems, in resources for healthcare, in local customs and beliefs, etc. Thus local research seeks to answer specific questions related to particular issues of concern. Polit and Beck (2012:3) have singled out the need for an "increase of small, localized research designed to solve immediate problems". They encourage researchers to be culturally sensitive in health interventions and to seek ways of improving the cultural

competence of healthcare workers. Linked to this are questions of language and how language discordant healthcare providers, their colleagues and the patients themselves manage communication in the work place when there is a mismatch in dominant language proficiencies. This study thus asks questions about the ability of physicians to engage with patients with whom they do not share an L1, and where the use of English as a lingua franca is most likely not adequate. Further, it gives insight into the strategies used in multilingual communication in healthcare between speakers of mutually unintelligible languages. Steinberg (2011) has mentioned a critical need for exploring health communication in South Africa and also pointed out the need for extending such research into other African countries such as neighbouring Namibia.

Moreover, the World Health Organisation (2011) has lamented a human resource crisis in the Namibian public health sector characterised by shortages of healthcare providers. For the year 2012-2013, it is recorded that 51% of HCPs (medical doctors) appointed in state facilities resigned (Ministry of Health and Social Services 2013). Notable is how "expatriate doctors abandon state hospitals" for neighbouring South Africa and also to open private practices in Namibia as indicated in the Namibian weekly newspaper, *Confidante* (Health Reporter 2013:16). In the period April 2012 to March 2013 alone, in the Khomas region (where Windhoek is situated), about 600 licences for operating private practices were renewed, while 119 new licences were issued (MHSS 2013). This is a positive growth in the private health sector as opposed to the 51% attrition in the public health sector. Therefore, it appears that expatriate healthcare providers largely prefer to work in private practices which they find more lucrative and professionally rewarding. Considering these numbers, as well as questions of access, this study chose private practices as the medical context for conducting the research. Still, despite this positive move of having medical centres and practices closer to the people, the matter of HCP/patient communication remains one of concern, to the extent that recently there has been a public outcry in the Namibian health sector on how "Language barriers hamper health service" (*New Era* 9 April 2015). Reference is also made to how language barriers hinder healthcare delivery in more isolated parts of the country, such as Kunene in the far north of Namibia (*New Era* 25 November 2015). Given such a background, this study started from an awareness of the need to gain insight into the multilingual expatriate HCPs' linguistic repertoires, their communicative needs and the strategies they employ in their work place communication.

Besides adding to the body of sociolinguistic and linguistic-anthropological research on multilingual work places, this study will contribute to the field of research into language in healthcare, particularly bringing the experiences of foreign doctors and pharmacists working with (mostly) indigenous patients into focus. Studies on language in healthcare in the African context are relatively rare and this gap needs to be addressed.

1.4 RESEARCH QUESTIONS

The general objective of this research is to gain insight into multilingual communicative resources and needs, and how from the perspective of HCPs, communication is managed. Besides documenting the linguistic repertoire and associated competencies amongst selected participants in Windhoek, Namibia, the study will investigate ways in which repertoires are put to use. The research questions to be answered are as follows:

1. What are the linguistic biographies and repertoires of the participating expatriate HCPs in this study?
2. How and when did the HCPs in the study acquire other languages than their mother tongue/home language?
3. How does the expatriate HCPs' linguistic identity (as reflected in their repertoire) affect their communication in the work place?
4. What are the linguistic and communicative practices established in the work place that facilitate or inhibit the provision of quality healthcare?
5. In what way do the HCPs use English as well as indigenous Namibian languages and/or other non-Namibian languages in professional communication between the HCP and colleagues, as well as between the HCP and patients?

1.5 STUDY SETTING

This study was conducted in Windhoek, the capital city of Namibia. According to the Namibia Statistics Agency (2011:35), Namibia has a total population of 2 113 077 people. Of this total population, 2 044 610 are Namibians, representing 96.8% of the total population, whilst 68 358 are non-Namibians, representing about 3.2% of the country's total population. Windhoek, the capital city of Namibia, has a total population of 325 858.

Namibia gained independence from apartheid South Africa on 21 March 1990. Due to a history of an apartheid government under a special arrangement with the South African government, Namibia inherited a fragmented healthcare system which was based on racial segregation. The healthcare system is pluralistic in nature in that there is both a public, state provided sector and a private sector which distinguishes between profit services and non-profit services such as those provided by Medicins Sans Frontieres (MSF) (WHO Namibia 2011, Brockmeyer 2012). The healthcare sector is grossly understaffed with over 1 789 vacant posts for HCPs (WHO 2011), such that there are 947 patients per registered nurse and over 7 000 patients per registered doctor (Brockmeyer 2012). The nurses are trained at the University of Namibia which trains 40 state registered nurses per year. Also, the Ministry of Health and Social Services trains a number of state certified nurses. According to an NGO online source, before 2015 all medical doctors working in Namibia were trained outside the country, mainly in South Africa (two thirds) and in Europe (one fifth) (Heath and the Environment, n.d). The lack of training programmes for most HCPs (notably medical doctors, pharmacists) explains why Namibia has relied on expatriates. It was only in 2016 that "The institution [University of Namibia] made history by graduating the first ever locally trained medical doctors" (Forum 2016:4 - 5). The 35 medical doctors who graduated in 2016 were the first to be trained in Namibia. The focus of this study, however, is on expatriate HCPs on whom Namibia has been relying on up to so recently and will continue to do for the foreseeable future. Their linguistic repertoires and language practices remain an interesting, yet under-researched, multilingual and multicultural phenomena.

1.6 ORGANISATION OF THE THESIS

This thesis is consists of five chapters which, besides the introduction, cover a literature review, description of the research design and methodology, the results and analysis, and a conclusion. This chapter has introduced the research aims and research questions and given a brief contextualisation of the study.

Following Chapter one, Chapter two presents a review of literature related to the topic of multilingualism in healthcare. The aim of the literature review is to give an overview of relevant research that has been published so that the body of knowledge on which this study builds upon becomes clear. This will also show which areas have not been attended to and how this study will contribute to new knowledge and insights in the field.

Chapter three presents the research design and methodology, giving information on the population from whom the sample is taken and the sample size. It describes the research instruments and procedures that were used as well as the ethical issues considered in the study.

Chapter four presents the collected data, the analysis of this data and then gives findings based on the analysis as guided by the research questions of the study.

Finally, Chapter five provides the conclusion of the whole study and suggestions on areas for further research are also presented.

Chapter Two

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the literature that is relevant to this study for its description and analysis of multilingual practices in health communication in Windhoek. It will first give an account of current and emerging patterns of multilingualism in Namibia as presented in available literature and it will give a brief discussion of the Namibian population's linguistic profile. The chapter will also provide a synthesised review of literature covering multilingualism in healthcare elsewhere as this will provide the framework for reporting on doctor-patient communication in a lesser researched context in an African country.

2.2 THE MULTILINGUAL STATE OF NAMIBIA

As a vast but sparsely populated country measuring approximately 824 116 km^2 and with a population of slightly over 2 million people, Namibia is considered one of the most sparsely populated countries in the world. Yet despite its small population, it is also a remarkably diverse country linguistically. Owing to the unique diversity of the population, the Namibian population is linguistically made up of speakers of 13 languages (ten indigenous African languages and three Indo-European languages) which have been recognised as national languages (Zannier and Lumbu 2012, Frydman 2011). These languages have all developed literacy conventions and a standardised orthography (Tötemeyer 2010). According to Tötemeyer (2010:40), the 13 standardised languages which are officially regarded as "national languages" are Oshikwanyama, Oshindonga (these two closely related languages are at times also considered as one under the name Oshiwambo) Khoekhoegowab, Otjiherero, Rukwangali, Silozi, Rumanyo, Thimbukushu, Ju|hoansi, Setswana, Afrikaans, English and German. Tötemeyer (2010) reports that in addition to these 13 languages, there are 16 more African languages which do not have a literacy tradition and therefore also no recorded orthography. Frydman's (2011) view is that Namibia's linguistic diversity is of a kind that makes it difficult to differentiate between certain languages and dialects, which explains why estimates of the indigenous languages in Namibia range between 10 and 30. This view is supported by Lusakalalu (2007:1) who argues that "the number of languages in Namibia, as it happens with linguistic diversity of

many countries, is a range (10 - 30)". These languages emanate from equally diverse ethnic groups which are conservatively identified as nine, namely the Ovaherero, Owambo, Kavango, Nama, Caprivian, Bushmen, Rehoboth Basters (descendants of indigenous Hottentot women and Dutch settlers who mainly reside in Rehoboth and prefer to be called thus), Damara and the Whites, who are collectively bunched together because of their European ancestry and skin colour as well as their link to the Germanic language family (Frydman 2011). On a more liberal count, however, the ethnic groups are extended to 13, to include also the groups named the Coloureds, the Topnaars, the Tswana and the Himba (Lusakalalu 2007).

Frydman (2011) and Njoze-Ojo (2013) categorise these Namibian languages into three language families namely Indo-European/Germanic languages, Bantu languages and Khoesan languages. An estimated 11.2% of the population have an Indo-European language (English, Afrikaans and/or German) as L1, while the indigenous African languages are spoken by 87.8% of the population (Frydman 2011:181). However, this is only an estimation as the total from this figure is 99%, hence there is a 1% which is not accounted for. According to Frydman (2011:181) and Ndjoze-Ojo (2013), the ten indigenous African languages fall into two groups, accounted as follows: first, the Khoesan family representing an estimated 11% of the Namibian population, which is subcategorised into Khoekhoegowab and the Bushman/San. Under the Khoekhoegowab subcategory belong Nama and Damara, whilst under the Bushman/San family belong Ju/'hoan and !kuna. Second, the Bantu language family representing roughly 77% of the population includes Setswana, Silozi, Otjiherero, Rukwangali, Rugciriku, Thimbukushu and Oshiwambo (which includes the Oshindonga and Oshikwanyama dialects). Oshiwambo is spoken by an estimated 49% of the population, Otjiherero by 8% and the Kavango languages (Rukwangali, Rugciriku, Thimbukushu) are spoken by 10% of the population. Thus the Caprivi/Zambezi, Setswana and other minority language account for a total of 10 - 11%.

The Indo-European (Germanic) language family consists of three languages, namely German (with 0.9% L1 speakers), Afrikaans (with 9.5% L1 speakers from three ethnic groups –Whites, Basters and Coloureds) and English (with 0.8% L1 speakers). Added to this family are other languages of European origin, which include Portuguese, Spanish and French. Because of Namibia's proximity and historical ties to Angola, formerly a Portuguese colony where Portuguese is still the primary language in education and in official life, much cross border mobility brings Portuguese into Namibia. French, although not indigenous to Namibia, is

represented among foreigner groups from Francophone Africa so that (as with Spanish) some schools and institutions of higher learning teach it (for example the University of Namibia).

To further clarify the distribution of Namibian languages, the table below gives an overview of the distribution of households by main language spoken in Namibia as recorded in the 2011 census (Namibia Statistics Agency 2011). Worth noting is that this table presents the number of households in which the language is mainly spoken and not the number of people themselves who speak the specific languages. Moreover, some languages which are from the same language family have been grouped together. However, the table gives an impression of how widely various languages are represented in Namibia and it includes the Asian languages (such as Mandarin or Chinese) used in the country as well.

Table 2.1: Distribution of main language spoken by household in Namibia

MAIN LANGUAGE SPOKEN	Number of households	Percent
Namibia	464 839	100.0
San languages	3 745	0.8
Caprivi languages	22 484	4.8
Otjiherero languages	40 000	8.6
Kavango languages	39 566	8.5
Nama/Damara	52 450	11.3
Oshiwambo languages	227 103	48.9
Setswana	1 328	0.3
Afrikaans	48 238	10.4
German	4 359	0.9
English	15 912	3.4
Other European languages	3 306	0.6
Other African languages	5 795	1.3
Asian languages	461	0.1
Don't know	92	0.0

Source: Namibia Statistics Agency: Namibia 2011 Population and Housing Census Main Report

One has to reflect on a linguistic dispensation where English was spoken as L1 by a mere 0.8% of the population at independence in 1990 and by 2001 English became the L1 to 1,9% of households of the Namibian population (Tötemeyer 2010) and the figure rose to 3.4% of the

households in 2011 as indicated in the table above. With so few L1 speakers of English and of households using English, one needs to provide an explanation as to why it was chosen as the official language. Although this is not one of the questions considered in this study, some background on such a choice will assist our understanding of linguistic diversity in the country.

According to Article 3 of the Namibian constitution of 1990 (Ministry of Information and Broadcasting 1990:3):

> The official language of Namibia shall be English. Nothing in this Constitution shall prohibit the use of any other language as medium of instruction in private schools or schools financed or subsidized by the state, subject to compliance with such requirements as may be by law, to ensure proficiency in the official language, and for pedagogical reasons.

The position of the Constitution of the Republic of Namibia with regards to language(s) can be traced back to the country's political history, and specifically to SWAPO's 1981 United Nations Institute of Namibia document titled *Towards a language policy for Namibia: English as the official language.* As far back as 1975, when SWAPO was still a banned organization in the country, it had identified English as the preferred official language for the envisaged future dispensation. The declaration below, published in 1981, illustrates the nature of the debates around linguistic diversity in Namibia. It also has a bearing on language use by HCPs in Namibia in the present day. The excerpt given here, and the document from which it has been taken, is the foundation upon which Namibia bases its approach to multilingualism:

> Multilingualism rather than monolingualism seems to be an increasingly natural development in African and other societies where exposure to more than one language is commonplace. This supports and adds to the overall theme that [English] and local languages have complementary roles. However … for local languages to play their full role in national life, government encouragement and promotion may be needed – status and respect do not necessarily arise naturally (UNIN 1981 as cited in Frydman 2011:187).

Though crafted almost a decade before Namibia finally got its independence, the above represents a critical watershed in the development of the current multilingual status quo in Namibia. Whilst in the 1980s Afrikaans was logistically and demographically better placed to become the official language, for political reasons this was unacceptable as Afrikaans was regarded as 'the language of the oppressor'. Therefore after years of oppression and suppression under the divisive South African regime, what SWAPO yearned for was a language that could

unite the people, therefore English, despite the fact that few people spoke it as a first language, became the desired option (Frydman 2011, Tötemeyer 2011).

Reasons for the selection of English as the official language also include the fact that it was seen as a symbol of nationalism and colonial resistance, especially considering that the exiled SWAPO leaders and combatants were resident in countries where English was used as a lingua franca (for example Zambia, Zimbabwe, the United States of America and the United Kingdom). Moreover, considering the diversity of Namibia, English was also considered as a neutral and unifying instrument that could bring about a "one Namibia, one nation" that is not ethnically fragmented along linguistic lines (Frydman 2011). As Hage Geingob (the current Namibian President who was the UNIN director in 1981) argued in the foreword to the SWAPO language document, "the aim of introducing English is to introduce an official language that will steer the people away from lingo-tribal affiliations and differences and create conditions conducive to national unity in the realm of language" (Frydman 2011:183). Although many disagree with this position, there has not been any consensus as to what could have been a workable alternative as, to recognize the real multilingualism of the country, would require a more complex policy and considerable resources to implement it. Those who argued for the adoption of English gave the following supportive arguments, as summarised from Frydman (2011):

- English has the capacity to bring unity, whereas German and Afrikaans, because of the political history of the country cannot. Thus many linguists also concur that as "an extra-ethnic, linguistically and politically neutral language" (Frydman 2011:183), English can bring about ease of communication amongst the linguistically diverse ethnic groups in the country.
- *Acceptability* was considered to be a critical factor for the adoption of English. Where German and Afrikaans were associated with oppression, domination and injustice, the local indigenous languages were not considered as satisfying this criterion.
- *Familiarity* is another factor which was considered since English was already in use in the country and it was being used by the exiled Namibians. Of course some have dismissed this point, arguing that the mere 0.8% of first language speakers and 4% of second language speakers was not convincing enough (Maho 1998 as cited in Frydman 2011:184).

- *Feasibility* was another criterion which was put forward to support the use of English as the official language. There were available resources to promote the use of English. Though some have counter-argued that other languages like Afrikaans and German could also fit this criterion.
- *Science and technology* was the fifth criterion put forward in support of English, and the other European languages, French and German were also deemed suitable for this purpose, whereas the indigenous languages were not considered to be developed enough for use in science and technology.
- The wave of *Pan-Africanism* at the time contributed to the adoption of English, as Namibia's neighbouring countries like Zambia and Zimbabwe were already using English as the official language.
- English was considered to be the best option for *wider communication* with the international community like the United Nations, African Union and SADC.

Thus, on the historical grounds provided above, English finds itself in the position of a lingua franca that is serving a myriad of purposes in a linguistically and ethnically diverse Namibia. Frydman (2011) finds that Namibia's education sector has been using English as a medium of instruction in a multilingual setting for the past 20 years now and this has benefitted a wider community than would otherwise have happened. It has strengthened the Namibian tertiary education sector, contributing to a larger international student body (including exchange students) and the members of faculty. In the Namibian context, the contention has been widely held that English impedes the transmission of knowledge and results in poor academic performance. This state of affairs was deemed a national disaster when in 2011 newspapers carried headlines about how, after a national English language proficiency test, a resounding 98% of teachers, representing 22 089 were assessed as not sufficiently fluent in English for professional purposes as they could not speak, read and write well enough in English (see Kisting 2011). This has resulted in intense debates about the use of English in the education system, what actually goes on in the classrooms and lecture halls, its advantages and disadvantages, and what can be done to mitigate the negative repercussions of using English in a multilingual context like Namibia. However, what has received considerably less attention in research is how languages are used and how the language policy is applied in communication in the Namibian health sector. The majority of the Namibian population makes use of the national healthcare facilities as compared to the smaller selection affected by language in the education sector.

What is notable from the foregoing exposition is that Namibia is, by the nature of its indigenous population, a multilingual country. According to Zannier and Lumbu (2012:77), Namibia promotes "national multilingual diversity" and the national language policy as it is directed at schools, is meant to ensure that it can "promote multilingualism and reject monolingualism". Mostert et al. (2012:169) also assert that "Namibia is a multilingual and culturally diverse country" (see further Tötemeyer 2011, Ndjoze-Ojo 2013). This categorisation of Namibia as a multilingual country therefore supports the claim made in this study that patterns of language use in Windhoek, Namibia need to be systematically investigated. The next section presents the state of the multilingual healthcare sector in Namibia and also the nature of doctor-patient communication.

2.3 THE MULTILINGUAL HEALTHCARE SECTOR OF NAMIBIA AND THE IMPORTANCE OF DOCTOR-PATIENT COMMUNICATION

The reality of a culturally, ethnically and linguistically diverse Namibia with various indigenous languages as well as citizens with Indo-European languages as L1s, affects the healthcare sector in the same way as other public service sectors.

2.3.1 Namibian reliance on foreign health care professionals

Compounding the indigenous language complexity is the reliance of the Namibian health sector on foreign expertise. This is particularly the case because besides nurses, the tertiary institutions in Namibia have not been training health professionals. Therefore, medical doctors, pharmacists, radiographers and dentists (among others) in the country have either been Namibians trained outside the country or expatriates from other countries who come to work in Namibia as government contract workers or as owners and operators of private medical practices and pharmacies.

It was not before 2016 that the country graduated its first cohort of Namibian-trained medical doctors from the University of Namibia's School of Medicine. What this scenario of a heavy reliance on expatriate healthcare practitioners implies is that, being of foreign origin, their linguistic repertoires necessarily add to the linguistic diversity of the country as many have other languages than the Namibian ones as their L1s. Therefore they do not fully share the language resources of their clients. This means that English becomes a lingua franca in this context as well.

According to the Namibian Ministry of Health and Social Services (MHSS) (2013), Namibia is faced with an acute shortage of medical healthcare professionals, especially doctors, pharmacists and allied health professionals. The country has yet to produce sufficient numbers of its own home-trained health professionals in these fields; therefore it relies on the recruitment of foreign health experts. In a Newspaper article titled "Namibia's public health system depends on foreign doctors" Isaacs (2008:1) indicated that only 261 doctors out of an approximate of 1500 medical doctors who are registered in the country are working in the public sector. This implies that in 2008, roughly 1239 doctors were working in the private sector. Further, it is noted that a third of these doctors are expatriates. Namibia's reliance on expatriate HCPs is also demonstrated by how in 2012 the MHSS recruited 812 new employees of whom 331 were non-Namibians (MHSS 2013). In addition, of the expatriate HCPs recruited, most have been recorded as immediately leaving the public service to join the private sector, whilst others leave the country altogether (Health Reporter 2013).

Non-Namibian HCPs find themselves in multilingual contexts in which they do not share the local linguistic repertoire. Public discourse, especially in Namibian newspapers, has raised alarm as to this particular circumstance. According to the *New Era* Newspaper of 9 April 2015 and 25 November 2017 (online), in articles entitled "Language barrier hampers health service" and "Language barrier hinders healthcare delivery in Kunene", there are language-related concerns in healthcare provision. According to *New Era*'s article which appeared on 9 April 2015 (online), the reporter laments that doctors, both local and foreign, fail to understand what patients are saying and vice versa (*New Era* 2015). Added to this is the difficulty that language is also a barrier between the HCPs and family members or other acquaintances who accompany patients when they are not proficient in the most widely used languages in healthcare, namely English and Afrikaans. The same article highlights this by citing an example where a female patient hospitalised in the Windhoek Central Hospital and suffering from goitre, could not speak any of the main languages in Namibia (*New Era* 2015). Reportedly she was from Oshikango in extreme north Namibia and spoke a minority language which has a very small number of speakers - hence the resultant difficulties HCPs had in communicating with her and treating her. This situation indicates how language is critical in the healthcare sector and how in the Namibian multilingual healthcare setting there are language-related challenges which still need to be addressed. This situation becomes more challenging when the HCP is an expatriate.

To illustrate this further, at country level and in the public health sector, the *New Era* article for 25 November 2015 (*New Era* 2015) refers to a scenario at the Ombombo clinic in the Kunene region, a government run rural clinic where a Kenyan expatriate nurse works, although she cannot speak the local language, Otjiherero. The newspaper reports that this circumstance is typical of five other clinics in the Kunene region where foreign nationals are employed while they cannot speak the dominant local language. As a result, "patients and the nurse ended up communicating by means of sign language and pointing to where they feel the pain" (*New Era* 2015). Similar conditions are reported by Sobane (2012:109) who asserts that in cases like this in Lesotho, language becomes a barrier to quality healthcare provision and for effective healthcare to be attained. In such contexts language becomes an in-transparent medium and it has to be overtly and attentively managed.

Anecdotes such as the ones given above confirm that attention to managing multilingualism is important if HCPs aim to provide high quality healthcare in line with the principles of human rights and equity, as well as responsiveness and fairness (Antia and Bertin 2004, Bischoff and Denhaerynck 2010). Bischoff and Denhaeynck (2010), Deumert (2010) and Sobane and Anthonissen (2013) have from various contexts demonstrated how researchers agree that language discordance between the HCPs and patients often results in compromised health communication effectiveness. Difficulties likely to arise relate to understanding the reported medical symptoms, arriving at an accurate diagnosis, managing general misunderstandings, impediments to the establishment of rapport and trust, inaccurate prescriptions, poorer health outcomes and an increase in the risks of patient safety. In a review of literature on doctor-patient communication, Ha, Longnecker and Amat (2010:38-39) indicate that communication is a core clinical skill that, if mastered, has immense benefits. These benefits according to the authors, include the facilitation of information exchange between the HCP and the patient, improved interpersonal relationships, enhanced information exchange, involvement of the patient in decision making, reduced work-related stress and burnout by the HCP, as well as reduced cases of litigation and or formal complaints of malpractice. In her study, Sobane (2012:109) mentions increased prevalence of multilingualism in healthcare facilities owing to the acceleration in migration in African communities. This, she finds, necessitates attention to communication that fosters the accommodation of the linguistically diverse repertoires. These assertions have implications for the Namibian healthcare context that need to be considered, as similarly to Lesotho (if not more so), it is multilingual due to indigenous circumstances as well as increasing migration into the country.

For a study on communication in Namibian healthcare, 'multilingualism' is best defined as "the presence of two or more languages with different social statuses in a given community" (Moyer 2010 as cited in Sobane 2012:109). Even though as Warhaugh (2006:96) argues, the speakers of these languages do not necessarily need to have equal abilities in the languages they speak as multilinguals. Wardhaugh (2006:119) has pointed to the concept of a "speech community" which in earlier studies was widely used, but recently has proven to be less helpful as it seems to assume that there is "one language one speech community", while in fact there are various intersections and overlaps. However, Wardhaugh (2006:119) further posits that despite the 'fuzziness' surrounding the term; it is still an indispensable term in sociolinguistic research in as much as it delineates a specific social group whose linguistic characteristics can be explained in a more coherent manner. Hence the term will be utilised in this study owing to its explanatory significance.

2.3.2 Global migration in medical healthcare

In reflecting on multilingualism in the Namibian healthcare setting, it has to be highlighted that increased global mobility in the past 30 to 40 years has brought about higher levels of multilingualism in this context (of healthcare) worldwide. Migration generally has been changing the identity of communities, and this has been noted also in medical migration. Particularly, urban language diversity has increased markedly in the previously more established global north as much as in the global south, and it is the case of Namibia as a country in the global south that is of interest in this study. A compelling body of literature on the need for improved management of multilingual healthcare encounters in the global north indicates the importance of reliable and recent information on the nature of multilingual repertoires in an ever-changing world where people of different nationalities find themselves working together (de Sousa Santos 2006). Following Appadurai's (1990) consequential insight on difference and separation in the interactions happening in a global and globalising world, we understand globalization as operating on different levels at once in the lives of those whom it touches most directly and one area of interest is on how language amongst people that are brought together thereby gets affected (de Sousa Santos 2006, Appandurai 1990). Thus globalisation has an effect at the symbolic level, and the linguistic level is one such level that is affected. Moreover, in addition to the linguistic level, globalisation also shapes identities and the lived experience of persons and within the healthcare sector, HCPs' lives and interactions are also affected as they operate in communities which speak different languages and whose cultures are also

different. Moreover, de Sousa Santos (2006:393) in his work on the multifaceted nature of globalisation proffers that globalisation has resulted in a remarkable intensification of transnational activities which have had consequences of confrontations and disjunctions between the local and the global. In some instances in the global south, as an example in Namibia, this has resulted in the rise of local diversity. This study attempts to illustrate the multiplicity of levels at which globalization (as introduced by (de Sousa Santos 2006) operates, particularly looking at the linguistic concept of 'multilingualism'; how this manifests, and how differences are managed within the wider spectrum of intercultural health communication.

Extensive research has demonstrated that communication is central to patient-doctor interaction in general (Bischoff and Denhaerynck 2010, Ha et al. 2010, MacFarlane et al. 2008, Ulrey and Amason 2001), and that this becomes more evident in multicultural and multilingual contexts. My study will consider this in Namibia, especially in situations where the HCP is non-Namibian. According to Ulrey and Amason (2001:450) language discordance between HCPs and patients may result in misunderstandings which can end up in costly and life threatening misdiagnosis, as well as the violation of patients' ethical beliefs. In addition, if language presents as a barrier it is likely to result in the silencing of patients' voices, and possibly also in non-compliance to treatment (Sobane 2012). MacFarlane et al. (2008) argue that language matters in that when language is a barrier, it is likely to limit empathetic responses from HCPs and the patients will receive insufficient information about their health, which excludes them from participating in decision making. For Bischoff and Denhaerynck (2010), whilst there is ample literature about the detrimental effects of language barriers, there is an often overlooked association between language barriers and the costs of healthcare. These researchers conclude that indeed language barriers have huge cost implications. The work of previous researchers in various different contexts, thus implies that healthcare problems which emanate from language discordance such as those one comes across in multilingual contexts such as Windhoek need special attention, especially with a view to making healthcare more accessible, affordable, as well as effective (Sobane 2012:109).

2.3.3 Consequences of language discordance between HCP and patient

Specific problems which may be related to poor doctor-patient communication have been highlighted in various studies. According to Ha et al. (2010:39-40), the likelihood of non-disclosure of information by the patient, avoidance behaviour by the doctor, lack of collaboration between the HCP and patient, resistance, and non-adherence to medication

regimen by the patient are all pertinent (see also Ulrey and Amason 2001, Sobane 2012, Sobane and Anthonissen 2013). Ulrey and Amason (2001:454) particularly emphasise that the successful management and exploitation of multilingual language situations has the potential to positively affect communicative outcomes between patient and HCP; conversely, if this is not well managed it may result in stress and anxiety. This stress and anxiety manifests through such behaviours as uneasiness, being worried, being emotionally tense and apprehensive (Ulrey and Amason 2001). The consequences of such in the HCP are health problems which are coupled with higher levels of depression, low levels of job satisfaction and reduced self-esteem (Ulrey and Amason 2001:454).

The importance of gaining better insight into multilingual healthcare encounters is corroborated by Antia and Bertin (2004:107) who find it regrettable that language and communication are in most cases given a peripheral mention in matters of healthcare planning as well as management by policy makers, even though the level and effectiveness of communication between the patient and the HCP is a major determinant of the quality of healthcare provision. According to Antia and Bertin (2004:116), thorough research into multilingualism in healthcare will contribute to the goal of responsiveness in healthcare, which assures patient-centred healthcare delivery. A consideration of multilingualism and language diversity in patient care may result in improved access, quality and linguistic responsiveness of the healthcare delivery, which has advantages for both the patient and the HCP. Antia and Bertin's (2004) study concentrated on contexts where the patient is a foreigner; thus the present study brings an additional dimension where the HCP is the one who is foreign (expatriate). Lindström (2008:3) has remarked that "research that involves the physician as a foreigner is rare". Most studies in this field focus on the patient as the foreigner, reflecting for example on the experiences and needs of asylum seekers, refugees and migrants (see for example MacFarlane et al. 2008, Bischoff and Denhaerynck 2010, Golden and Lanza 2013, Meeuwesen et al. 2010, Rosenberg et al. 2007). The present study thus focuses on the generally less studied phenomenon of the HCP who is an expatriate working with patients who are mainly indigenous people and to a limited extent the patients might be foreigners.

2.4 LANGUAGE MEDIATION IN MULTILINGUAL HEALTHCARE SETTINGS

As a way of mitigating the challenges which result from language barriers in multilingual healthcare contexts, mechanisms for overcoming communicative barriers in the provision of healthcare have been reported. These include the use of a lingua franca such as English, the use

of an interpreter (this can be either a professional or an informal interpreter) and/or a situation where each uses their own L1 (or language of choice) which the other understands, but does not easily produce (see also MacFarlane et al. 2008, Ulrey and Amason 2001, Sobane and Anthonissen 2013, Hadziabdic, Lundin and Hjelm 2015, Sobane 2012). According to Ha et al. (2010:40), some of the strategies to improve doctor-patient communication include developing the HCPs' communicative skills, health communication training, collaborative communication skills training, conflict management skills impartation, improving HCPs' intercultural communication (see also Ulrey and Amason 2001:460) and utilising conflict management techniques. Sobane and Anthonissen (2013:268) have remarked that whilst interpreting is the most commonly suggested strategy to facilitate the transfer of information from the patient to the HCP, other linguistic strategies used in the multilingual healthcare context include using gestures, code-switching, and the use of sketches and visuals, even though these are very limitedly reported. The following section will introduce relevant aspects of the phenomenon of interpreting for medical care.

In her literature review, Sobane (2013) shows that in addition to the rare availability of contracted professional interpreters in Southern Africa, health institutions use many other forms of interpreting, including the *ad hoc* use of family members, nursing staff, ward cleaners, kitchen staff and security personnel, as well as referring to bilingual translation materials, medical dictionaries and bilingual glossaries. The available literature emphasises the value of using interpreting services in multilingual health contexts. However, some disagreements and unanswered questions with regards to the reliance on interpreting remain. For example, Hadziabdic, Lundin and Hjelm (2015) point out that interpretation in itself is not just a question of straightforward translation but a complicated activity. In their article on interpretation of elderly healthcare, they concluded that interpreting practices involve issues such as the availability of policies and legislation, interpreting guidelines, the cultural beliefs of the patient, as well as socio-economic determinants which are associated with the linguistic skills of participants. Their study reviewed the existing guidelines concerning the use of interpreters in specific contexts. The study was conducted in Sweden at an institutional setting for elderly migrants who do not speak the language of their host country (Swedish). Using perspectives of healthcare professionals who are experienced in using interpreters, the study sought to understand how interpretation proceeds among people who are from different linguistic and ethnic backgrounds. They found that the respondents considered professionalism, equity, efficiency and accessibility as important in the offering of interpreting services. However, they

also found the use of professional interpreters in an institutional setting for elderly migrants to be inefficient. Instead, they often relied on bilingual staff who were readily available as opposed to the professional interpreters, who, despite their extensive expertise, had to be booked in advance, while on many instances a lot of occasions do arise that need immediate resolution. The bilingual staff who were not paid for the translation services but offered the services for free were already familiar with the work environment. Thus familiarity with working conditions boosted their confidence and feelings of security. Almost in contradiction, the use of such staff was assessed as inadequate in that the patients were likely not to disclose valuable information to such staff so that through their mediation much may have been lost.

Coming closer to Namibia, Sobane (2014), studying healthcare communication in Lesotho, argued that whilst interpreting counted as a critical resource in multilingual healthcare contexts (such as around the capital city, Maseru), it remained a matter of concern that this service is neither regulated nor institutionalised. According to Sobane (2014), interpreting services offered on an ad hoc basis in a limitedly resourced country in the global south are haphazard. Often the HCPs themselves decide on who should interpret, rather than a systematic set of practices being in place. Even so, despite this challenge of disorganisation, Sobane and Anthonissen (2013:268) argue that if the interpreter is familiar with the context and is proficient in both the local language and the lingua franca, improved health outcomes are likely to follow. This finding is based on a contrast to HCPs choosing not to use interpreting services even when the situation demands that such a service be engaged.

MacFarlane et al. (2008) mention that health policies in the global north often advocate the use of trained professional interpreters, but in the United Kingdom (for example) the service providers' knowledge of the interpreters' availability and how to contract such services is minimal or is too cumbersome. Instead, informal interpreters are used, or in some instances the HCPs simply attempt to "get by" through the use of gestures and body language. Meyer (2002), Antia and Bertin (2004), Baraldi and Gavioli (2007), Bischoff and Denhaerynck (2010), Hadziabdic et al. (2015) as well as Sobane and Anthonissen (2013), are some of the notable researchers whose work I have consulted on the various dimensions linked to the use of interpreters in healthcare provision. Bischoff and Denhaerynck (2010) argue that the use of interpreters can positively affect the quality of healthcare and reduce the disparities associated with foreigners accessing healthcare. They present evidence that the use of professional

interpreters is effective and that on the whole, the costs of hiring a professional interpreter are lower than the costs of managing neglected chronic diseases.

To reflect on the various forms of mediation to which HCPs revert to mitigate the effect of linguistic repertoire mismatches, I shall refer to the communication accommodation theory put forward by Howard Giles (1973) and popularised by among others, Giles, Coupland and Coupland (1991). The theory posits that interlocutors make use of strategic communication behaviours which are meant to attain a specific social distance and effect. The mediating behaviours described above indicate how people adjust their communication styles to accommodate their interlocutors. Whilst this study will not apply the communication accommodation theory in itself; however, some of the tenets of the theory which explain the convergence strategies used to facilitate communication in a multilingual context are helpful. For example, the approximation and accommodation strategies that are evident in the use of interpreters who mitigate language challenges in multilingual healthcare settings do fit this theoretical position.

Finally, the concept of 'intercultural communication competence', particularly as explained by Gibson and Zhong (2005), is an important one to bear in mind in the healthcare context. In their study of the increasingly multicultural healthcare context in the United States of America, they explain the need for developing intercultural communication competence, which enables the effective use of the strategies explained above. Gibson and Zhong (2005) particularly emphasise what they identified as 'appropriateness' and 'effectiveness' as important measures of HCPs' abilities to provide holistic and satisfactory healthcare. In addition, they also put forward empathy, bilingualism and intercultural experience as additional indicators of intercultural communication competence. In the present study, the concept of 'intercultural communication competence' will be used to interpret and assess HCPs' management of a bilingual and multilingual healthcare environment according to their own related experiences.

2.5 CONCLUSION

This chapter has reviewed some of the relevant literature related to the topic, as well as the aims and research questions of this particular study. It has provided a linguistic profile of the country and demonstrated that Namibia is a country with a diverse linguistic heritage to the extent that it can be identified as a multilingual country. The literature review has demonstrated that owing to the country's linguistic diversity, even with a strong global language such as English as a

lingua franca, the healthcare sector faces communicative difficulties. However, the handling of linguistic barriers is largely recorded in public discourse, especially the print media, and is hardly represented in academic research. Hence, there is a general dearth of academic literature capturing the communicative experiences of expatriate healthcare providers with varying linguistic repertoires in Namibia. The literature review further highlighted the body of literature that emphasises the role and value of doctor-patient communication in multilingual settings. Some of the work dealing with linguistic strategies used to mitigate challenges faced in the multilingual health sector has been introduced. Finally, in this chapter I illustrated the kinds of concerns that arise when HCPs and patients do not share the same language repertoires and contextual information. This study intends to add to the currently still limited body of research on language practices in the Namibian healthcare sector, thereby addressing the need to add Namibian data and analyses to the existing literature.

The next chapter presents the research methodology that was used to conduct this research.

Chapter Three

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This study is a qualitative research project that worked with a small amount of data in order to record, analyse and understand the communicative experiences of multilingual doctors and pharmacists working as foreigners within the Namibian healthcare system. Their experience regarding the use of various languages in communication with colleagues and patients, the communicative needs they experience and the strategies they use in various kinds of circumstances are in focus.

3.2 RESEARCH DESIGN

This study has a qualitative research design as it is not possible in a study of limited scope such as this one to do a comprehensive and representative quantitative survey. Even so, a smaller data set was deemed suitable to find answers to the research questions. This would enable the researcher to investigate and understand the social phenomenon of multilingual communication in medical care in a limited set of cases, giving indicators of what works, what does not, what strategies participants in this setting prefer, and so on. All of this gives a first impression of how research of this kind could be done and also taken further. The social phenomenon under investigation, as has been mentioned, is the communicative experiences of multilingual expatriates in healthcare settings, and the participants are a number of HCPs (medical doctors and pharmacists) who work in private practice in Windhoek. The approach taken here agrees with those articulated by a number of scholars such as Creswell (2009:232), Given (2008:53) and Grove, Burns and Gray (2013:265) who motivate the value of such qualitative research in indication of how it provides a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem or situation such as the one addressed in this study. This project is intended to be interpretative and aspires to gain an understanding of particular qualities of social life, and to give an in-depth textual description of the HCPs' own interpretation of their communicative experiences in multilingual Windhoek.

3.3 POPULATION

The population of the study was expatriate HCPs working in the private healthcare sector in Windhoek Namibia. In agreement with, for example, Neuman (2014:246) and Bhattacherjee (2012:65), who both give directives as to the population of a study being the unit of analysis which one would like to study, thus the population in this study consisted of HCPs who are foreign to Namibia in that they had recently relocated from elsewhere and thus had been trained outside Namibia. They all had linguistic repertoires that characterise them as multilingual. The decision to target only HCPs who work in the private sector or run their own private practices in Windhoek was made due to the accessibility of this group. Another consideration was that within the group the contextual variables would be more stable than if public healthcare professionals were to be included as well.

3.4 SAMPLE

According to Grove et al. (2013:351), sampling involves selecting a group of people with which to conduct a study. Sampling thus involves selecting participants from the target population which will be contacted and recruited in a manner that will ensure the data gathered may be reasonably generalised back to the population from which they were chosen. The concept of the sample arises from the idea that the researcher is not able to reach the whole population, hence only a representative sample can be used. Non-probability sampling was used in this study in that not every possible participant had a chance to be included in the research; the researcher selected only specific individuals who are able to provide rich insights into the phenomenon under investigation (Grove et al. 2013:364). As Maree (2016:197) argues, there are four main types of probability sampling, namely convenience sampling, quota sampling, snow ball sampling and purposive sampling. According to such a categorisation this study used purposive sampling: participants were recruited on the basis of them being likely to provide the kind of data needed to achieve the study aims (Grove et al. 2013:268). In other words, the researcher purposefully selected HCPs who worked in private practice, were of foreign origin, had been trained outside Namibia and had been working in the country not more than 10 years. The decision to select HCPs who had been in the country for not more than 10 years was taken on the assumption that after 10 years in the country HCPs were likely be proficient in the local language(s) to the extent that their communicative practices would no longer present the structures in which this study is interested. Thus, the national, professional and linguistic backgrounds of participants determined their eligibility.

In addition, the network (snowball) technique was also used in that the researcher got in touch with an existing network of HCPs to which he has personal access and he relied on those whom he already knew to give reference to further participants who fit the criteria. This is in agreement with Grove et al. (2013:366) who mention that it was helpful to take advantage "of social networks and the fact that friends tend to have characteristics in common". From this perspective the order in which participants are approached is important: first purposive sampling is done, then the sample size is expanded using network or snowball sampling. In this study, the researcher used purposive sampling in identifying three expatriate medical doctors and one expatriate pharmacist whom he already knew as he himself is an expatriate – though working in the higher education sector. These participants were asked to assist in the pilot study which tested the data collection instrument, a newly developed questionnaire. In the second stage of the study, the researcher then consulted this purposefully selected sample and requested them to give references to other possible participants. The result was that the sample expanded to 25 expatriate medical doctors and seven pharmacists whom the researcher contacted, but only 19 completed and returned the questionnaire.

3.5 RESEARCH INSTRUMENT

The research instrument used for this study was a questionnaire (see Appendix A). According to Grove et al. (2013:425) "[a] questionnaire is a printed self-report form designed to elicit information that can be obtained from a subject's written responses". The questionnaire used in this case was made up of three sections. Section A collected the metadata; it consisted of questions eliciting personal information on nationality, age, gender, linguistic repertoire, level of education and place of training. Section B of the questionnaire collected information about the participant's knowledge and use of languages; it consisted of two questions eliciting responses about the participants' linguistic profiles. Section C had questions which elicited information about the distribution and uses of language in the work place. This sequencing of the questionnaire sections and the questions themselves was done following Kothari's (2004:102) argument that "relatively difficult questions must be relegated towards the end so that even if the respondent decides not to answer such questions, considerable information would have already been obtained". Thus, question-sequences should usually go from the general to the more specific and the researcher must always remember that the answer to a given question is a function not only of the question itself, but of all previous questions as well. The use of open-ended questions at the end of the questionnaire follow Grove et al.'s (2013:427)

advice that they should come last because the respondents need more time to complete them. The open-ended questions gave the respondents an opportunity to fully express themselves and so to provide rich information about their communicative experiences in the multilingual and private healthcare context.

3.6 PROCEDURE

After the research proposal had been completed, the application for ethical clearance was written and submitted (see Appendix B). Once ethical clearance had been granted, the researcher piloted the study using four respondents, one pharmacist and three medical doctors, who were all expatriates working in the private practice and who had been living and working in Windhoek for less than 10 years. The researcher approached each of the respondents at their private practices and explained the reason for his visit and the purpose of the study. The researcher highlighted the procedures to be involved, the potential risks and discomforts associated with the research, the potential benefits of the research to the respondents and/or to society, explained that there was no payment for participation, that the information gathered would be treated with the utmost confidentiality, that their participation was voluntary and they could withdraw anytime if they so wished. The researcher then gave the consent form to the respondent and gave the respondent time to read through the form and ask questions if there were any. When the respondent was satisfied with what was written on the consent form and agreed to participate in the study, he/she then signed the consent form. The questionnaire was handed to the respondent along with a new and sealable addressed envelope in which the completed questionnaire could be deposited to maintain a high level of confidentiality.

The respondent was asked to indicate when the completed questionnaires could be collected, either directly from the HCP or from the receptionist at the private practice/surgery.

The four questionnaires used in the pilot study were returned. The researcher scanned the completed questionnaires and emailed them to the supervisor. The researcher and the supervisor were both satisfied with the quality of the responses and there was no need to adjust the questions in the questionnaires. Thereafter the full study commenced using the snowball research technique. A total of five pharmacists and 14 medical doctors completed and returned their questionnaires, thus the total participants were 19. No follow-up interviews were done because the information in the questionnaires was rich enough for the purposes of this limited

scale study. Interviews would certainly have given more, but this would have requested more time and resources than was available within the structure of the research programme.

3.7 DATA ANALYSIS

According to Corbin and Strauss (2008, as cited in Grove et al. 2013:279), qualitative data analysis is "a process of examining and interpreting data in order to elicit meaning, gain understanding, and develop empirical knowledge". The data from the questionnaires were analysed following the data analysis technique of content analysis in order to give answers to the set research questions. According to Grove et al. (2013:425), where questionnaires are used "content analysis may be used to extract meaning". In content analysis the researcher seeks to scrutinize respondents' answers in order to establish patterns within the framework set up in the structuring of the questionnaire. Where ratings on for example Likert scales are asked, the patterns are disclosed by compiling all responses into a single set. Where yes/no questions are asked, a similar compilation is possible. The content given in response to open ended questions requires more in that broad meanings can be extracted for categorization purposes. Also particular words selected by respondents can be examined and according to their functions, be dealt into categories (Grove et al. 2013:281). The latter involves looking at how content is packaged, which words, phrases, idiomatic expressions, patterns of thought and ideas are directly given or implied, and how various meanings are conveyed. Therefore the researcher looked for repeated patterns of words and ideas and analysed them using the guiding theoretical notion of 'intercultural competence'. Gibson and Zhong's (2005) definition of 'intercultural communication competence' was used as an instrument in reflection on the kinds of communicative sensitivity the expatriate HCPs in Windhoek exhibit in their responses. Based on the largely descriptive findings, the study summarised the kinds of communicative barriers highlighted by the HCPs, the strategies available and drawn on in overcoming such barriers, and the needs for communicative assistance that they indicated. The outcomes of this study could serve as a basis for developing support in communicative practices within this sector of healthcare provision in Windhoek.

The concept of 'communication accommodation strategies' was also used in the analysis and interpretation of the data in so far as the physicians referred to the strategies they follow. No recordings were made of authentic consultations and therefore the strategies mentioned and analysed as they appeared in reports could not be tested or verified against actual interactions.

Even so, how conversations are perceived also gives valid information about the nature of social relations and social interactions such as those in which this study is interested.

3.8 ETHICAL CONSIDERATIONS

This research involved human subjects with whom due ethical conduct is expected. Ethical clearance was granted by the Stellenbosch University Research Ethics Committee (REC) before data collection commenced. The respondents who were approached to take part in this study were informed of the purpose of the project and they were requested to give written consent for the data they provided to be used. Respondents were assured of their anonymity: once the raw data was prepared for analysis real names would be withheld. They were given the opportunity to select the pseudonym they preferred the researcher to use when their data is in issue. The respondents were all above the age of 18, and they were informed that they could withdraw from the study if they so wished, at any time. However, during the course of the study, there were no incidents with ethical implications which arose.

3.9 CONCLUSION

This chapter presented the particular kind of qualitative research design and methodology which was used to conduct this study. The chapter also discussed the population of the study, the sample, the research instrument used in the study, the procedures that were followed to conduct the research, the data analysis method and the ethical considerations which were followed. The next chapter is a presentation of the findings and their discussion.

Chapter Four

DATA PRESENTATION, INTERPRETATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents and analyses the data that were collected by means of a questionnaire with medical professionals, as described in chapter three. It provides details of the linguistic biographies and repertoires of the participating expatriate HCPs in this study. The biographies carry information on how and when the HCPs acquired other languages than their mother tongue and how such a linguistic identity ultimately affects their communication in the work place. Further, the chapter provides details on the strategies they mentioned as ones that assist in mediating between themselves and patients in cases of language discordance in their respective work places.

4.2 LINGUISTIC BIOGRAPHIES AND REPERTOIRES OF HCPS IN WINDHOEK

The wide range of languages represented among the HCPs who participated in this study is unsurprising as the study worked specifically with a sample of HCPs who are not native Namibians. It is common cause that Namibians themselves are multilinguals who know various indigenous languages and often also one or more of English, German or Afrikaans, so that the community as a whole can be characterised as one in which monolingualism barely exists. A total of 19 participants (14 male and 5 female) returned completed questionnaires (out of 32 that were circulated). These respondents represented five different countries as places of origin, namely Zimbabwe (12 participants), South Africa (four participants), Tanzania (one participant), India (one participant) and Cuba (one participant). The participants' first languages as well as their languages of learning and instruction other than English are presented in Table 4.1 below. From the table, it can already be discerned that all the participants claim to have more than one language and also that beyond the language of instruction in school, they have other languages and this will be further explained at a later stage in this chapter.

The institutions and places where the participating HCPs attained their medical training are further telling of the linguistic diversity and capabilities of those who responded. The following

training institutions were listed: the University of Zimbabwe, Harare Polytechnic, University of Pretoria, Stellenbosch University, University of Cape Town, University of the Western Cape, Nairobi (unspecified), in Cuba (unspecified), and Ryzan State Medical University (Russia). From the responses, what is immediately arresting is that there is mention of Nairobi (Kenya) and Russia as places of medical training, even though none of them indicated the place of birth to be either of the two counties. For respondent KSS, she was born in Zanzibar, Tanzania and got her medical training in Russia as well as Nairobi, Kenya. Whilst for the respondent Manie, he was born in Pondicherry, India but got his medical training from Ryazan State Medical University in India and this also explains why he can speak Russian, Tamil, Hindi and English. This is an indication of the general mobility of the respondents and also how globalization is a reality that affects a lot of people hence accounting for the varied linguistic biographies of the respondents in this study.

The table below presents the findings from the metadata of the respondents.

Table 4.1: HCPs' linguistic repertoires

Name (pseudonym)	Age range	Gender	Place of origin	Place of medical training	How long in Namibia (as of 2016)	Appointment as General Practitioner/ Pharmacist	First Language	Languages of learning and instruction other than English	Other languages
1. ATT	36-45	Male	Zimbabwe	University of Zimbabwe	5 years	General Practitioner	Shona	Shona, French	Ndebele, Oshiwambo
2. Kura	36-45	Male	Zimbabwe	University of Zimbabwe	7 years	General Practitioner	Shona	Shona	Oshiwambo, Afrikaans
3. TD	25-35	Male	Zimbabwe	University of Zimbabwe	3 years	General Practitioner	Shona	None	None
4. RK	25-35	Male	Zimbabwe	University of Zimbabwe	4 years	General Practitioner	Shona	None	Ndebele, Otjiherero, Afrikaans
5. Fay	25-35	Female	Zimbabwe	University of Zimbabwe	6 years	Pharmacist	Shona	Shona	Oshiwambo, Afrikaans, Portuguese
6. Mzaya	25-35	Male	Zimbabwe	University of Zimbabwe	5 years	General Practitioner	Shona	Shona	Ndebele, Afrikaans, Oshiwambo, Otjiherero
7. Doc	36-45	Male	Zimbabwe	University of Zimbabwe	6 years	General Practitioner	Shona	Shona	Ndebele, Zulu, Oshiwambo
8. BK	25-35	Male	Zimbabwe	University of Zimbabwe	8 years	Pharmacist	Shona	Shona	Oshiwambo Portuguese
9. Nena	36-45	Male	Zimbabwe	University of Zimbabwe	8 years	General Practitioner	Shona	Shona	Oshiwambo, Swahili, Portuguese
10. Angel	36-45	Female	Zimbabwe	University of Zimbabwe	2 years	Pharmacist	Ndebele	None	None
11. Shekih	36-45	Female	Zimbabwe	Harare Polytechnic	10 years	Pharmacist	Shona	None	Ndebele, Oshiwambo, Afrikaans
12. BZ	25-35	Male	Zimbabwe	University of Zimbabwe	2 years	General Practitioner	Shona	None	Oshiwambo, Portuguese
13. Merk	+56	Male	South Africa	University of Pretoria	10 years	General Practitioner	Afrikaans	Afrikaans	German
14. Huvan	36-45	Male	South Africa	Stellenbosch University	5 years	Obstetrics & Gynaecologist	Afrikaans	Afrikaans	None
15. KG	36-45	Male	South Africa	University of the Western Cape	9 years	Dentist	Sesotho and Setswana	Sesotho	Sepedi, Isindebele, Isizulu, Setswana, Isixhosa
16. KSS	46-55	Female	Tanzania	Russia and Nairobi	1 year	Sonographer	Swahili	Russian, Swahili	None
17. Maggie	25-35	Female	Cuba	Cuba	8 years	Specialist	Spanish	Portuguese	Oshiwambo
18. Manie	25-35	Male	India	Ryzan, Russia	2 years	General Practitioner	Tamil	French, Tamil, Russian	Hindi
19. Ham	36-45	Male	South Africa	University of Pretoria	8 years	Specialist	Afrikaans	Afrikaans	German

In order to take stock of respondents' linguistic repertoires, Section A (metadata) of the questionnaire requested information on (i) their L1s, (ii) all other languages they know and (iii) which language(s) they had had as a language-of-learning/instruction (Medium of Instruction = MoI). The responses from the participants indicated that other than English, in all, nine other languages had been used in education, namely: Shona (seven), French (two), Tamil (1), Russian (two), Swahili (1), Portuguese (1), German (1), Sesotho (1) (not an MoI in higher education but part of the respondent's repertoire) and Afrikaans (3). Five of the respondents indicated that they did not have any other MoI than English. However what could not be ascertained by the researcher is the role the first languages and community languages vs Medium of Education/Instruction (MoI) languages play. Table 4.1 above indicates the languages-of-learning which the respondents indicated in their responses.

Further insights from the information presented in Table 4.1 above are as follows: First, seven languages of the nine additional languages mentioned as ones used in learning are not indigenous to Namibia. Besides German and Afrikaans which are already national languages in Namibia, these seven languages, thus add to the already diverse Namibian linguistic landscape. Frydman (2011) already indicated that the health sector can be described as a linguistically diverse setting. Thus the profile of these respondents is in agreement with the literature (Zannier and Lumbu 2012, Tötemeyer 2011, Ndjoze-Ojo 2013, Frydman 2011) which characterises Namibia as a country with a rich linguistic diversity. Second, the diverse linguistic biographies of the HCPs imply that they can use these languages as communication resources in their day to day practices as they meet patients who may have repertoires similar to the HCP and who prefer to use these languages in consultation. Mention can be made of a language such as Portuguese: it is common cause that Namibia is a preferred 'medical tourism' destination of Angolans whose MoI in primary and secondary schools is Portuguese, and whose proficiency in English is very limited. For a considerable number of patients, finding an HCP who has Portuguese as a language-of-learning will prove to be beneficial.

Section B of the questionnaire profiled the HCPs' knowledge and use of languages more broadly, including English. The respondents were requested to rate their linguistic ability in the languages they had listed, self-assessing their skills in the understanding of the spoken form, speaking, reading and writing: responding to Question 6 of the questionnaire, participants indicated on a scale of 1 to 5, where 5 is excellent and 1 is poor, how they rated their own abilities. Since English is the lingua franca and official language in Namibia, the first entry that

the respondents were requested to indicate was with regards to their proficiency in English. Of the 19 respondents, 14 of them (representing 73.68%) allocated a score of 5 (excellent) for their ability to understand, speak, read and write English. The ranking of "excellent" by these 14 HCPs in the four language skills is a positive indication which implies that they will be able to communicate confidently with patients who can also speak and understand English. The implication from this result is also that they can excellently communicate amongst themselves as colleagues in the health profession.

The remaining five participants who did not give a score of 5 in all the four language skills in relation to English, all indicated a score of 4 on some of the language skills. Only one indicated a score of 4 for the skill "understand", two indicated a score of 4 for the skill "speak", four indicated a score of 5 for the skill "read" and three indicated a score of 4 for the skill "write". It should be noted as well that of these five respondents, one respondent ticked all the skills using a tick instead of allocating a score from 1-5, to indicate that s/he had mastered them, hence the researcher was not able to determine the exact level of English proficiency as no score was indicated. What can be concluded from this information as provided by all the respondents is that they are highly proficient in the use of the official language in Namibia, and such a level of proficiency should positively affect their provision of quality healthcare to those patients who are equally proficient in English.

The respondents also indicated their proficiency in the other languages they know, but which are not spoken indigenously in Namibia. These languages included Spanish, Swahili, Russian, Tamil, Hindi, French, Shona, and indigenous South African languages Sepedi, Sesotho, Isizulu, Isixhosa, Isindebele (also the Zimbabwean version) and Setswana. Notably, the HCPs' proficiency in the 'non-Namibian' languages has a linguistic advantage as these languages can also be used in other contexts within the Namibian healthcare context. Whilst this further corroborates the statement that the participating HCPs' linguistic biographies are indicative of multilingualism at play, also very interesting was the responses which indicated the respondents' level of proficiency in languages which are considered to be Namibian.

In the responses of the 19 HCPs, 14 indicated that they have some knowledge of Namibian languages other than English. The responses retrieved from questionnaires with regards to the HCPs' knowledge of other widely represented Namibian languages is presented in Table 4.2 below.

Table 4.2: Participants' knowledge of languages spoken in Namibia

Language	Number of respondents
Oshiwambo	10
Afrikaans	8
Otjiherero	2
German	2
Portuguese	5

Table 4.2 above shows that many of the expatriate HCPs indicated that they know these five languages which are widely spoken in Namibia, namely Oshiwambo, Afrikaans, Portuguese, Otjiherero and German. Out of 19 respondents, ten indicated that they have some knowledge of Oshiwambo, which is not surprising as Oshiwambo is spoken as L1 by 49% of the Namibian population (Frydman 2011, Namibia 2011 Population and Housing Census Indicators 2011). Therefore, it is most likely that the expatriate HCPs will come across more Oshiwambo patients than others; hence in various ways they do attain some proficiency in this language. With regards to their level of proficiency in Oshiwambo, Table 4.3 below summarises the 10 HCPs' responses regarding skills in Oshiwambo.

Table 4.3: Participants' knowledge of and proficiency in Oshiwambo

Language Skill	No. of responses on proficiency level where 5 is excellent and 1 is poor				
	1	2	3	4	5
Understand	2	5	3		
Speak	4	3	3		
Read	7	1	1	1	
Write	8	1		1	

With regards to the above table therefore, three marked their understanding proficiency at level three; five respondents marked their level of understanding as at level two, whilst two respondents indicated their level of understanding as level one (poor). From the above table, what is outstanding about the responses is that none of the respondents indicated an excellent (5) proficiency level of the Oshiwambo language in any of the four language skills (understanding, speaking, reading and writing). The highest level of four (4) was recorded in the domain of reading and writing Oshiwambo and this was indicated by the same respondent (Shekih). Three of the ten who indicated that they know Oshiwambo rated their speaking at

level (3), one rated the reading ability at level three; whilst five indicated their understanding of Oshiwambo at level two, three also indicated their speaking at level two, and one respondent indicated level two for reading and another respondent also indicated level two with regards to writing in Oshiwambo. Furthermore, two respondents indicated their level of understanding Oshiwambo at level one (which is poor), four respondents indicated their speaking level at one, seven respondents indicated their reading level at one and eight out of the ten indicated their writing level at one. Therefore from these results it seems that it is easier for the HCPs to understand Oshiwambo, followed by speaking, whilst reading and writing seems to be the most challenging. This pattern of language proficiency in the four skills is understandable considering that as expatriate HCPs who have been in the country for less than ten years as per the sampling procedure (see 3.3), it is highly unlikely that they could have mastered Oshiwambo to the level of 5 (excellent). In addition, the fact that average scores recorded were in the domain of "understand" and "speak" Oshiwambo (level three was indicated by three respondents in both cases) could be because of the fact that the HCPs have to understand what some of the Oshiwambo speaking patients have to say to them and also possibly respond in Oshiwambo. Clearly HCPs have 'picked up' Oshiwambo, probably informally, and not necessarily from their patients. But if they have to "get by" – some indicate a level of proficiency which indicates that they can marginally manage without interpreters as the ratings on understanding and speaking at levels two to three (that is average given a scale of 1-5) were indicated by eight and six respondents respectively.

However, the language skills "read" and "write" received the lowest scores (because 7 and 8 respondents out of 10 rated themselves at level 1, which is poor), understandably because it is highly unlikely for HCPs to use these skills due to the nature of consultations. As medical doctors, the most probable need that might arise in a multilingual setup where English may not be the best option for the patient would therefore be for the medical doctor to be able to understand the patient who speaks in his/her own language (Oshiwambo in this case) and also possibly for the medical doctor to explain something where he/she may need to use the patient's language (Oshiwambo). Thus reading and writing are the least used language skills, perhaps also because there is limited medical literature in Oshiwambo, and the same applies to pharmacists who mostly read prescriptions which are in written in English as these prescriptions are from the medical doctors who mainly use the official language (English). The pharmacists, like medical doctors also do not necessarily write extensive medical notes for the patients, other than the pharmacist's stickers for dosages and directions, hence the skill of writing in the

patient's language becomes less important; though it has to be argued that still being able to write in a particular language would be beneficial. This was in the exception of one pharmacist who indicated that her levels of proficiency on the language skills "read" and "write" were at level 4, and this is understandable because of the respondent's work history which was mainly in Northern Namibia (Ovamboland) where Oshiwambo is the main language spoken by more than 94% of the household population (Namibia 2011 Population and Housing Census Indicators 2011). However, the overall impression from the results indicates that 50% of the expatriate HCPs have in addition to their own languages, added Oshiwambo to their linguistic repertoire. Though most of the responses are in the "poor" range, it is noteworthy that they have got some knowledge of the Oshiwambo language and this has a potential communicative benefit in the provision of quality healthcare in a multilingual setting like Namibia.

Besides knowledge of Oshiwambo, eight out of 19 of the respondents indicated that they also know Afrikaans, which is one of the most widely spoken languages in Namibia. It is a first language for 10% of the Namibian households (Tötemeyer 2001, Namibia 2011 Population and Housing Census Indicators), which makes it the third most spoken language after Nama/Damara (spoken as L1 by 11% of the households). Therefore, it is not surprising that the HCPs' responses show relatively high proficiency in Afrikaans, that is, second after Oshiwambo. The indicated proficiency levels of the HCPs in Afrikaans are presented in Table 4.4 below:

Table 4.4: Participants' knowledge and proficiency in Afrikaans

Language Skill	**No. of responses on proficiency level where 5 is excellent and 1 is poor**				
	1	**2**	**3**	**4**	**5**
Understand	2	2	1		3
Speak	2	2	1		3
Read	5				3
Write	5				3

Table 4.4 above shows that three of the respondents indicated that their proficiency in Afrikaans on the four language skills (understand, speak, read and write) was excellent. These were respondents who came to Windhoek from neighbouring South Africa and possibly had Afrikaans as their mother tongue. The implications of such a proficiency level in Afrikaans for the multilingual Namibian health sector are that the HCPs can provide enhanced services to the

more than 10% of the Namibian population who speak Afrikaans as an L1 and even more who are strongly proficient in Afrikaans as L2. This becomes even more significant when it is considered that in Windhoek, Afrikaans is the main language spoken at home by 19% of the Windhoek households (Namibia 2011 Population and Housing Census Indicators 2011). Even those HCPs that can "understand" and "speak" Afrikaans at L1 competence level, all indicated at least minimal abilities in using the language. This is understandable considering that close to a fifth of Windhoek residents use Afrikaans as their home language. Thus, in Windhoek Afrikaans has a significant enough presence for the expatriate HCPs to gain at least basic competencies, even if not sufficient for consultation purposes. Just as with Oshiwambo, the weakest scores were indicated in the "read" and "write" skills categories, which is most likely attributable to the fact that HCPs use these two skills the least in their day to day professional interaction with patients.

One of the striking observations from the questionnaire feedback is that none of the participants indicated that they have knowledge of or use Nama/Damara, even though (after Oshiwambo) it is the language with the second largest percentage of L1 speakers in the country. In Windhoek 12% of the households have Nama/Damara as their main language (therefore it is the third most used after Oshiwambo and Afrikaans respectively), which represents a significant percentage of speakers (Namibia 2011 Population and Housing Census Indicators 2011). The possible linguistic reason for participants not indicating their knowledge and use of Nama/Damara can be the fact that it belongs to the Khoesan family (Frydman 2011), and counts as a "more difficult" language to learn, also because of the click sounds that typify these languages. Also, among the Nama/Damara people, a very high level of Afrikaans L2 proficiency is reported, which means that many are unlikely to insist on healthcare communication in Khoekhoeguwab or Ju/'hoan and !kuna.

With regards to Otjiherero and German, the same two respondents indicated that they have some knowledge of each of these languages. Although these two languages are not related, there is a long and eventful history of contact between the German and Herero communities in the country and many Herero L1 speakers indicate knowledge of German; but this study does not suggest that this history has linguistic significance in finding speakers who pair these two in their repertoires. The two participants who indicated that they had knowledge of German also indicated that they can speak, understand, read and write the language very well, scoring their abilities at three or higher. One of the respondents in this category indicated that German

was his/her language-of-learning in primary school, which explains such a high level of proficiency. The second respondent indicated a five for understanding, three for speaking, three for reading and three for writing German, which indicates a high level of proficiency.

For Otjiherero, these two respondents indicated some knowledge of this language: one gave a score of one for all the four language skills, while the other respondent gave the following scores: three for understanding, three for speaking, one for reading and one for writing. The information on the questionnaires reflect the same pattern for Otjiherero as has been observed for Oshiwambo and Afrikaans, that the expatriate HCPs mainly claim to understand and speak the language, rather than being able to read and write.

There were five out of 19 respondents who indicated that they had some knowledge of Portuguese. One of the respondents (Maggie) indicated that she had Portuguese as the language-of-learning and this is supported by the fact that she rated her understanding of Portuguese at level five, level four for both speaking and reading and level three for writing. However the other four respondents indicated that their knowledge of the language was almost poor as their ratings were as follows: three indicated level two for understanding, speaking and reading, whilst one indicated level one for understanding, speaking and reading. Moreover, of these four HCP respondents, two indicated level two for writing, whilst the other two indicated level one for writing. Therefore from these responses it can be argued that these five out of 19 respondents can have some meaningful interactions with Portuguese speaking patients.

The overall impression of HCPs in Windhoek as it becomes evident from the linguistic biographies and repertoires they give, confirms them to be a particularly multilingual group of professionals. They bring in a rich array of languages from their home countries and in addition they are have mostly, during relatively short stays in Namibia, developed minimal to fair levels of primary language proficiency, that is, their skills in understanding and speaking local languages are growing.

4.3 GENDER, AGE, AND EMPLOYMENT HISTORY

Five out of 19 respondents (26%) were females and out of these five female HCPs, three were pharmacists, one a sonographer and one a specialist. From the female respondents, Fay indicated that she had knowledge of five languages, of which three seem to be languages she acquired in Namibia, namely Oshiwambo, Afrikaans and Portuguese; whilst Shekih as well also

indicated some knowledge of five languages namely English, Shona and Ndebele which she acquired from her home country and Oshiwambo and Afrikaans which she acquired whilst working in Namibia. Of the other three female respondents, only one indicated some knowledge of one Namibian language, which is Oshiwambo (see Table 4.1 on page 31). However, when compared to their male counterparts, it can be deduced that gender does not seem to play any role in acquiring Namibian languages within the healthcare sector under study. This is because there were no significant differences between male and female respondents' reportages of linguistic knowledge.

The same applies to the age of respondents which seemed to be insignificant with regards to the acquisition of other languages; especially Namibian languages (see Table 4.1 on page 31). However, the length of stay in Namibia has an influence on the number of Namibian languages acquired. This is particularly in the case of those who have stayed in Namibia for less than three years. Five respondents indicated that they had been working in Namibia for three years or less and of these five respondents only one indicated some knowledge of Oshiwambo and Portuguese, whilst the other four reported that they had not acquired any languages in Namibia. Moreover, the respondent (BZ) who indicated some knowledge of Oshiwambo and Portuguese (having stayed in Namibia for two years), rated the skills "understand", "speak", "read" and "write" all at level one (poor). This is probably because the respondent has been in the country for a short period of time for him to be more proficient at these languages, but what is positive about the response is that there is an indication that he is willing to learn and indeed has some knowledge of these two "Namibian" languages. For the respondents who had stayed in the country for more than three years, there was also a relative increase in the number of languages acquired and the level of rating by the participants with regards to their knowledge and use of these languages. Eight of the respondents each had acquired a language which is indigenous to Namibia (see Table 4.1 on page 31). The exception was for respondent Merk (10 years in Namibia and has knowledge of German and Afrikaans), Huvan (5 years in Namibia and has knowledge of Afrikaans), KG (9 years in Namibia and has knowledge of Setswana) and Ham (8 years in Namibia and has knowledge of Afrikaans and German), who because they already had knowledge of Afrikaans, German and Setswana and these languages are common in Namibia, they did not indicate their knowledge of especially Oshiwambo and Otjiherero.

The influence of the respondents' employment histories to the acquisition of indigenous Namibian languages came out strongly from four respondents, namely Nena, BK, Shekih and

RK. Nena, BK, and Shekih had worked in northern Namibia before moving to Windhoek, and it is in northern Namibia where Oshiwambo is the dominant language and this could be the reason why they all indicated some knowledge of Oshiwambo. Whilst on the other hand, RK worked in Opuwo for two years, where Otjiherero is the mostly spoken language, and this is equally evident in that RK rated his understanding and speaking of the language at level three and level one for reading and writing (see section 4.2 above).

4.4 AGE AND PLACE OF LANGUAGE ACQUISITION OF HCPS IN WINDHOEK

In question 7 of the questionnaire, the respondents were requested to indicate the age at which they had acquired the languages which they use and the context or place where they had learnt the language (see Appendix A). From the responses, it can be discerned that except one respondent, English was acquired as an L2 in early childhood, that is between three and nine years of age by almost all the respondents (18 out of 19). The respondent of Cuban heritage started to acquire the language at 13 years of age at secondary school. The implication of the early acquisition of English is that there is a high possibility of the HCPs being fluent and thus able to use English proficiently in the discharge of their duties in Namibia.

Further, it is interesting to note that from the responses of the HCPs, 16 of them indicated that they learnt English at pre-primary school (kindergarten) and primary school. Only two respondents indicated that they had acquired English at home through the introduction of their parents from the age of two. One respondent indicated that he/she had been a "late learner", being introduced to English at secondary school, as Spanish was the language she learnt formally in primary school at the age of four. This respondent still reported that she is "excellent" at speaking, understanding, reading and writing in English. From these results, it can be noted that the school environment provided most of the respondents with the foundations of knowing and using English: they used English throughout their school and professional training days. This is the language which they are using as well in their daily execution of their duties as expatriate HCPs in Windhoek. The HCPs in fact confirmed that they currently use English on a daily basis at the work place and also at home and for social communication.

In addition, the respondents reported that other than their mother tongue which they acquired as from birth and English which they acquired at an early age, they also acquired other languages later in life, in formal (classrooms) as well as informal (outside of classrooms) settings, with varying degrees of success. The age of acquisition for most of these additional

languages ranged from between their mid-20s to early 30s. These languages include some Namibian languages and others which are widely spoken in Namibia, mainly including Oshiwambo, Afrikaans, Otjiherero and Portuguese. The context of acquisition of these languages was mainly reported to be the work place and the current use of the language was also indicated as mainly the work place. Moreover, some of the HCPs reported that they use these languages acquired in Namibia for social communication with friends and colleagues and also at social gatherings like the church.

4.5 LANGUAGE IN THE WORK PLACE

Regarding language of the work place, as introduced in Section C of the questionnaire, the HCPs reported that the languages which they use at work the most are English, Oshiwambo, Afrikaans and Portuguese. However, notably, all of the respondents indicated English as the main language which they use at work. This is in agreement with the reviewed literature which indicates that English is the official language of Namibia (Frydman 2011, Tötemeyer 2011, Ministry of Information and Broadcasting 1990). However, the fact that the HCPs in given circumstances use other languages than English also corroborates what the reviewed literature has indicated that Namibia is a multilingual country with a rich linguistic diversity (Frydman 2011, Zannier and Lumbu 2012). Further supported by Frydman (2011), Zannier and Lumbu (2012), Tötemeyer (2011), Ministry of Information and Broadcasting (1990) and Ndjoze-Ojo (2013), is the HCPs' claims to having access to a wide array of languages which they encounter in consultation with patients in Windhoek. These languages listed as being encountered in the work place (as reported in response to question 10), are Afrikaans, Damara-Nama, Oshiwambo, Otjiherero, Silozi, Portuguese, Chinese, Ndebele, Shona, Germany, French, Hindi, Spanish, Rukwangali and Tswana.

The multilingual Namibian healthcare sector, according to information for the 19 respondents in this study, is indeed multilingual, characterised by HCPs and patients using at least ten languages. This dispensation heightens the possibility of encountering language-related challenges such as those reported in the *New Era* (*New Era* 9 April 2015, *New Era* 25 November 2015. This points to the need to manage multilingualism in the Namibian healthcare sector so that patients can be provided with quality healthcare which is fair and responsive (Bischoff and Denhaeynck 2010, Antia and Berlin 2004).

Responding to question 16, participants reported that in addition to speaking languages other than English (LotE) to patients, the HCPs also, in specific circumstances, use other LotEs to communicate with colleagues. Five of the 19 respondents indicated that they do not use any other languages with colleagues than English. The following are some of the verbatim responses these participants gave in explanation for not using any LotE in the work place:

1. BK: No since all are expected to be proficient in English.
2. Angel: No. We usually communicate in English.
3. KG: With colleagues I only use English.

These curt responses all show support for the expectation that English, as the official language in Namibia, enjoys preference as a lingua franca in the healthcare sector.

However, 14 of the respondents indicated that they use LotEs with colleagues in the work place. These languages include Namibian languages to a limited extent: one respondent indicated the use of Oshiwambo and three indicated the use of Afrikaans. Interestingly, seven respondents, thus more than those using Namibian languages, indicated a periodic use of non-Namibian languages. These seven reportedly used Shona, while two indicated that they make use of Russian, one indicated the use of Hindi and Tamil, and one indicated the use of Spanish. One respondent had this to say about using LotEs among colleagues:

4. RK: Shona: When we deliberately want to discuss a patient's condition during e.g. awake surgery (spinal).

From RK's remarks, the circumstance explained is when there are two or more HCPs in theatre who share a common language (Shona). A situation may thus arise where they want to discuss the patient in his/her presence and yet they want to exclude that patient. Their preference is not to use English as the circumstances are not appropriate for including the patient. Thus Shona, a language shared by expatriate HCPs from Zimbabwe and not by the patient, paradoxically becomes a language of exclusion as well as a tool that can privilege the HCPs to share sensitive information about the patient in his/her presence. Instead of the HCPs having to leave the theatre in order to caucus, they can simply use another language with which the patient is not familiar.

In addition, another respondent had the following to say in response to question 16 of the questionnaire (which read "In communication with colleagues, do you at times use other languages than English? If yes, please name the languages and explain the circumstances.")

5. Manie: Afrikaans – greetings to the nurses.
   Russian – to make Russian colleagues comfortable.
   Hindi and Tamil – to make Indian colleagues comfortable.

These answers given by Manie (in example 5 above) and RK (in example 4 above) allow a conclusion that the HCPs' multilingual repertoire is a resource which can be used to foster a healthy communication environment which can improve intercultural interactions between colleagues.

This is further supported by the following responses received to question 16, which demonstrate that HCPs use a variety of languages, both Namibian and non-Namibian to foster better communication and cultivate good human relations in the work place. The following are some of the verbatim responses from the expatriate HCPs with regards to the use of LotEs in the work place:

6. Doc: Shona – If I meet Shona speaking friend. Oshiwambo – If I meet Oshiwambo speaking friend.
7. Huvan: Yes; Afrikaans. If the person's first language is Afrikaans.
8. Shekih: Oshiwambo – most of my colleagues are not proficient in English.
9. Maggie: Yes, I use Spanish with the other colleagues in our free time.

This set of responses paint a picture of English widely used as a lingua franca by all the HCPs, but not exclusively so. There are limits to its use as other languages are available to the HCPs when they communicate in the work place with colleagues, Namibian or non-Namibian. However, what stands out clearly from these findings is the fact that in a linguistically diverse healthcare set up in Windhoek, language is exploited to the benefit of the HCPs. Language is used as a communication accommodation strategy (Giles, Coupland and Coupland 1991) as using the colleague's first language may be preferred in making the colleague more "comfortable".

Given the pluri-linguistic situation in the Namibian private healthcare system in particular, it was important in this study to establish whether language at times does pose a barrier in communication with colleagues in the work place. Approximately more than half of the respondents (10 out of 19) indicated that language does not pose any challenges in the communication between expatriate HCPs and their colleagues in the work place. Whilst most

(8 out of 10) of the respondents in this category gave a flat and unexplained "no" in answer to question 17, one respondent explained it as follows:

10. BK: No, since all are expected to be proficient in English.

On the other hand, nine out of the 19 respondents mentioned that language barriers do pose some challenges. They raised the following as some of the challenges:

11. ATA: Yes, some colleagues are not proficient in English and getting information to or getting information from them can be challenging.
12. Kura: Yes, there are colleagues not keen on using English. They would rather avoid English-speaking colleagues.
13. Doc: Yes. There are conditions where English is not appropriate to describe.
14. Fay: At times they do not know the English word for what they want to put across, or they may not understand my English expressions.
15. Shekih: At my work place meetings are held in Oshiwambo. I have resorted to not attending them since I do not understand the proceedings. And colleagues will have to update me of the meeting.
16. Angel: Yes, some of the colleagues are not proficient in English and they misinterpret the meaning of what you say.
17. Manie: Only when people/nurses think that I can communicate in Afrikaans well.
18. RK: Yes: Most older white colleagues are more comfortable in Afrikaans and they fail to express (sic).
19. Nena: Yes – those from Francophone countries who are not proficient in English.

The above responses reveal that there are some language challenges which affect the communication between the expatriate HCPs and their colleagues (who may or may not be HCPs) in the private healthcare system in Windhoek. Therefore, according to the HCPs in this study, the difficulties they encounter are that there is limited English language proficiency amongst colleagues, such that the colleagues resort to the avoidance of those who use English at the work place. Whilst on the other hand according to some responses, English may at times

be not the best language to express some medical conditions (Doc, example 13 above) and in some instances other colleagues may not have the appropriate English medical jargon to talk about medical conditions (Fay, example 14 above). This results in the information being distorted due to wrong encoding or decoding. These challenges confirm what the reviewed literature has presented, namely that English in everyday life is generally spoken by a small percentage of the people in Namibia and that the proficiency levels are often low (Frydman 2011, Tötemeyer 2011, Kisting 2011). From these findings it is possible to foresee a situation where due to lack of English language proficiency some colleagues resort to avoidance of communication, which in turn may result in lack of team work between the expatriate HCPs and their local teammates (Kura, 12 above). Further, it is possible for communication to break down and/or for the wrong encoding or decoding of the intended meaning which may have a negative and even disastrous effect as the healthcare environment is highly sensitive. Here ATA (example 11 above) and Angel's (example 16 above) concerns that there might be miscommunication and also that where there is such a challenge it can be frustrating to both parties, are relevant.

In addition, what Doc (example 13 above) and Fay (example 14 above) raised is a concern that can possibly go beyond simple English grammatical proficiency, to that of register. It is possible that if the expatriate HCPs' work mates are not medically trained then they may not fully understand the medical register where medical jargon is used. This of course is possible when speakers have the same repertoires but different training, for example English medical professional and English patient. Based on this observation, if interventions are to be crafted, they should include a section on medical jargon and expressions in order to alleviate this challenge. Noteworthy is that the challenge faced by Shekih (in example 15 above) is in a different category, as Oshiwambo, although not an official language, is used in official meetings at the work place. This is likely because, as has been indicated, Oshiwambo is spoken as a home language by 49% of the households nationwide and by 41% of the households in Windhoek. This remark of Shekih (in example 15 above) gives a window onto language practices where, regardless of official policies, the dominant language of a community is often used even in work place interactions. Interestingly, although Shekih (in example 15 above) does not attend meetings where Oshiwambo is overwhelmingly used, she reported a fairly better understanding of Oshiwambo than other respondents who indicated that they had only "some" knowledge of Oshiwambo. This contradiction could be perhaps because in some contexts like meetings, speakers may probably use deep structures of Oshiwambo which she may find difficult to

understand; so instead of risking misunderstanding and being misunderstood, she thus opts to avoid going to such meetings. Furthermore, Manie (example 17 above) and RK (example 18 above) reported the fact that Afrikaans is one of the languages regularly spoken by their colleagues. This can be explained by the fact that some of the HCPs working in Namibia were trained in South Africa with Afrikaans being the language of instruction. More so, Afrikaans is also the main language spoken by 12% of households in Windhoek (Namibia Population and Housing Census Indicators 2011).

4.6 LINGUISTIC AND COMMUNICATIVE PRACTICES ESTABLISHED BY HCPS TO FACILITATE THE PROVISION OF QUALITY HEALTHCARE

While, according to the information given in the questionnaire (Question 6) all the HCPs rated their English language proficiency as high, it has to be reiterated that nationally in 1990 English was spoken as a first language by 0.8% of the population and only 4% of the population spoke it as a second language (Frydman 2011). Moreover, as Tötemeyer (2011) has indicated, the use of English in public spaces is not without its problems. For example Kisting (2011) points out that even professionals like teachers in Namibia demonstrated an alarmingly low proficiency in English: 98% of them had failed an English language proficiency test administered in 2011 (Kisting 2011). For this reason part of the aim of this study was to find out which course of action and strategies the HCPs take to overcome communication barriers if a patient is obviously not proficient in English. The answer to this challenge was got from question 11 where respondents had to answer the question: "If a patient is obviously not proficient in English, explain the course of action you take to overcome the communication barrier."

The HCPs reported that the linguistic and communicative practices which they have established include the following: using interpretation, trying themselves to speak the patient's language, using sign language, using google translator and making use of drawings. The following are some of the verbatim responses the HCPs' gave is response to question 11:

20. BK: We have employed assistants who are proficient in all the main languages whom we use for translation purposes.
21. Fay: I try with the limited Afrikaans, if I get stuck I ask for someone to translate (members of staff who speak the language).

22. Angel: I either draw a diagram on label to explain or ask the assistant who is proficient in the language.
23. Manie: Translator (professional), if not available then family member only for non-confidential issues or google translator app in iPhone.
24. TD: Translator, sign language.
25. Nena: For Oshiwambo and Portuguese I sometimes can, but for deeper stuff and Afrikaans I have a translator.

What needs to be highlighted is that for TD (example 5 above), the "sign language" in question is most probably makeshift sign language and not the formal sign language used by the deaf people; whilst for Nena, the "translator" in question should also most probably mean an interpreter.

These responses show that HCPs do face some language challenges and they also devise ways to mitigate these challenges to facilitate the provision of quality healthcare. The most common strategy reported by the HCPs is translation/interpreting by someone who is proficient in the patient's preferred language (18 out of 19 respondents). This finding is in agreement with the reviewed literature which has indicated that where a lingua franca like English fails, an interpreter/translator is often called on (Macfarlane et al. 2008, Ulrey and Amason 2001, Sobane and Anthonissen 2013, Hadziabdic, Lundin and Hlem 2015). Eighteen out of 19 respondents indicated that the use of a translator is one of the ways through which they may mitigate the challenges related to language and these are mainly informal translators who are engaged on an ad hoc basis.

An interesting strategy devised by some HCPs is the use of technological support to translate: Manie (in example 23 above) indicated his use of the google translator application on the iPhone. Of course, not all languages are registered on Google Translate, thus this could work between English, Afrikaans, German, Spanish and Portuguese – but not if the required language is an indigenous Namibian language such as Oshiwambo or Nama/Damara. This might, where the instrument is available, prove to be a viable option where concerns with regards to confidentiality are raised. This may also be a preferred alternative as the application is handy. In fact, the same or a similar application can be used to learn the language as most of the HCPs have indicated that they encounter and make use of different Namibian languages which they are also in the process of learning. As there are online resources such as Omniglot or the

Western Cape Department of Cultural Affairs and Sport publications which give online language learning resources, this could even work for some (see http://www.omniglot.com/writing/oshiwambo.php; https://www.westerncape.gov.za/text/2010/2/nama.pdf) – however, online learning is time-consuming and often not as well used as many claim. Even so, this information also corroborates what the HCPs report that they try to communicate in the patient's language in spite of the low level of proficiency the HCPs might have.

Another strategy reported by the HCPs is the use of diagrams, where the HCP draws a diagram in order to assist with an explanation which is difficult to express given the language challenges between the two speakers. Sign language was also indicated as a strategy where the use of hand gestures and bodily movements as well as facial expressions is meant to support a better understanding in the healthcare setting. Code-switching was also mentioned as a strategy to foster communication with the patients. This is in agreement with strategies used elsewhere and reported in the reviewed literature, for example in Lesotho where Sobane and Anthonissen (2013:267-273) have reported that the use of gestures, sketches, visuals and code-switching are strategies that HCPs fall back on.

Regarding situations related to code-switching, the respondents were requested (in question 13) to explain if they have ever encountered a situation where they use one language like English while the patient uses another language and they manage to understand each other. Some of the respondents reported that they have never encountered such a situation and they do not do that at all as indicated by the following responses:

26. ATA: We usually do not get by so I always insist on interpretation.
27. KG: No I have not as I do not understand the local Namibian languages.

However some of the respondents indicated that they have found themselves in a situation where they use English whilst the patient uses a preferred language other than English, such as Afrikaans or Oshiwambo and they get by. Some of the responses are presented in the extracts given below:

28. Kura: It has happened on a few occasions, but the Oshiwambo used was light, mixed with broken English and [l] used visual aids.

29. Fay: Yes. Some patients understand English but cannot speak, and I manage to understand their Afrikaans though I cannot answer back.
30. Shekih: Yes, my Oshiwambo is limited and some terms I do not know them so I end up using English and we manage.
31. KSS: Yes, I understand when they use sign language while talking.
32. Mzaya: Yes my vocabulary is limited but some words [are the] same with my local language and I also try to simplify my English and we get by.
33. Nena: Yes when my understanding is better than my spoken proficiency or the patient is in a similar situation.

From these answers it can be gleaned that in a multilingual healthcare context as in Namibia, the official language (English) might prove to be limited for the patient whilst for the expatriate HCP the patient's language might as well be limited. In such circumstances it has been made evident that each one may use his/her own language, each understanding the other (at least as far as they can assess themselves) but not being able to speak the other's language. For this strategy to work, a particular system of code-mixing, using simple vocabulary, accompanying the spoken language with signs and gestures and also incorporating visual images is required and these are in the communication accommodation strategies they employ. What can also be observed from the above is that there is collaboration between speaker and hearer: both parties contribute to advancing communication. Collaborative meaning making is a language practice often referred to in linguistic pragmatics where speakers and hearers are assumed to co-operate with intentions for the communication to succeed and various efforts to assure that intended meanings are communicated and well received.

Owing to the fact that the expatiate HCPs are multilinguals who are working in multilingual contexts, it was also important to explore what encourages them to switch from one language to another in an interaction with either a colleague or a patient, as was requested in question 18. Some of the insightful verbatim responses were as follows:

34. ATA: If we are both proficient in both languages and one can express something better in the other language.
35. Doc: When you are discussing the patient [with a colleague] in the patient's presence.

36. Fay: With a patient I would switch if they express failure to understand or if they express being more comfortable with another language.
37. Angel: The need to explain and get my message across so that no mistakes are made, especially regarding medicines dispensed.
38. Manie: To get better understanding and to make colleagues at ease with acceptable accent.
39. Huvan: If the person is more comfortable in using another language.
40. Merk: If I cannot express myself in one language I will jump to another.

From these answers one can note that indeed communication is important in the daily discharge of HCPs' duties. It is also clear that respondents see multilingualism as a resource and not a curse. Knowing various languages, even at rudimentary level, facilitates communication and improves the quality of healthcare provision. Patients are more likely to get accurate information and also the right instructions regarding medication dispensed. This was indicated by one respondent who had this to say:

41. BK: If I perceive that we are not understanding each other then I ask if the patient will be comfortable with another language.

Similar patterns of interaction are reported by Bischoff and Denhaeynck (2010) and Sobane and Anthonissen (2013), where it was emphasised that in spite of some success, language discordance between patients and HCPs results in compromised health communication. Where the HCPs are prepared and capable to switch from one language to the other in response to the patient's needs or preferences, there are good possibilities of offering improved healthcare marked by improved disclosure, collaboration, improved job satisfaction by the HCP and adherence to medication by the patient (Sobane 2012, Sobane and Anthonissen 2013, Ulrey and Amason 2001). Where use of more than one language by interactants does not succeed, interpreting services appear to be considered. This was indicated by one respondent who had this to say:

43. Kura: If not well-versed I would rather make use of a third person as a translator.

The importance of the use of translation as reported by the HCPs will be presented in the next section, as well as the challenges which the HCPs encounter in using this strategy.

4.7 THE USAGE AND CHALLENGES OF USING INTERPRETATION SERVICES IN THE NAMIBIAN HEALTHCARE CONTEXT

Interpretation is one of the most prominent strategies used in healthcare communication as reported by the HCPs in their answers to Questions 14 and 15. In this study context interpreting is understood as an oral activity whilst translating refers to an activity using written documents; however, among the HCP respondents these terms were used interchangeably. Interpreting services' role and value as a communication facilitating tool in the Southern African healthcare context are also discussed by Sobane and Anthonissen (2013:268). The HCPs were asked about their views with regards to using professional interpreting services and whether they see this as a possibility to facilitate communication. Eight out of 19 respondents reported that they are not supportive of professional translation services as reported in the responses to question 14. Some of the responses giving these HCPs' reasons for not preferring professional interpreting services are as follows:

43. Mzaya: No, some patients are not comfortable with that and it is not as often that we need them, most clients understand English.
44. KG: No, when we employ we consider language proficiency of our employees.
45. Fay: I believe we do fine with informal interpreters.

These findings indicate that some of the HCPs are satisfied with a situation where informal interpreters are used. These informal interpreters can be employees who were already selected for employment on the basis of their language proficiency. Mzaya (in example 43 above) expressed that they do not often require such services, thus finding it not warranted having professional interpreters. This argument holds water if one considers that Khomas region in which Windhoek is situated has a population of 342 141 (Namibia 2011 Population and Housing Census Indicators 2011). Given such a small population, professionals like Mzaya (example 43 above) believe that having such professional interpretation services may not be worthwhile.

Still, the majority of the respondents (11 out of 19) reported that professional interpreters could (if readily available) facilitate communication. Such services however are virtually non-existent in Windhoek. Some of the verbatim responses from the HCPs are as follows:

46. ATT: Yes, some languages have words which can mean different things and the interpreter [informal] can be subjective in deducing the intended meaning. Some interpreters lead clients in their interrogation.
47. Shekih: It would help avoid unnecessary mistakes that occur as a result of language barriers and not understanding information given. Sometimes patients take overdose or under dose of their medications and at times they miss their follow-up dates.
48. Angel: Yes, especially an interpreter that can speak all the Namibian languages as the assistants usually speak only their home languages.
49. RK: Yes, since they can be regulated as opposed to randomly assigning a translator.

These answers demonstrate a need for interpreting services within the healthcare fraternity so as to attain the provision of high quality healthcare that conforms to the principles of human rights and equity (Bischoff and Denhaerynck 2010). According to ATA (in example 46 above), if *ad hoc* interpretation is used, the possibilities of inaccuracies are a high risk; also untrained interpreters at times lead the patient by making suggestions rather than merely giving the patient's own words. This could result in wrong diagnoses and treatment. Macfarlane, Glynn, Mosinkie and Murphy (2008) reported similar concerns when they mentioned how informal interpreters sometimes include patients' children, relatives and friends. Moreover, Shekih's (example 47 above) views also demonstrate that professional/trained interpreters can reduce "mistakes" in medical care and these can be costly in terms of financial implications and also most importantly in terms of human health. Bischoff and Denhaerynck (2010:2) have argued similarly that "language barriers appear to increase the risks to patient safety". Considering the real possibility that a patient may "under-dose" and or "overdose" due to language barriers, the implication is that language does in fact impact on the quality of healthcare.

Angel's view (in example 48 above) can be linked to the fact that Namibia has a wide range of languages (Frydman 2011), which makes it difficult for the untrained interpreter to master all of them. However, if there were to be trained interpreters who are able to speak a variety of Namibian languages, then it is possible that HCPs working in environments with more pronounced language diversity can benefit. Moreover, from the viewpoints presented above, it can be concluded that with trained interpreters would bring some form of regulation in terms of sound translation and better confidentiality. In another context in Ireland where interpreting

services are centrally provided and paid for, Macfarlane, Glynn, Mosinkie and Murphy (2008:3) found that there are funds to support the use of professional interpreters during consultations, although often these services were not contracted. Contrastively, according to Sobane (2014:1), "this service is neither institutionalised nor regulated in Lesotho or in South Africa, resulting in haphazard interpreting practices often decided by healthcare providers." From RK's response (in example 49 above), it can be inferred that in Namibia there are no regulated translation services hence there is an *ad hoc* use of informal translators.

Many studies have set out to establish the possible difficulties that could arise if professional translation services are used during consultations (see Macfarlane, Glynn, Mosinkie and Murphy 2008, Sobane 2014). The main reasons reported by the HCPs in Windhoek according to this study relate to concerns about confidentiality, privacy, time, costs and the possibility that if the person is not medically trained it might be a problem for the interpreter to fully grasp the medical register. Some of the answers to question 15 on this concern are as presented verbatim below:

50. Kura: Patients are not willing to disclose confidential information with a stranger present.
51. BK: Some interpreters will have to be assigned to one place only for the sake of trust as sensitive matters are at stake. Patients can get attached to the interpreters who when transferred can affect a business' clientele.
52. Shekih: The interpreter would have to be medically trained as some medical terms are difficult to explain if you do not understand them.
53. Angel: Yes, explaining what medication is for is a sensitive, private matter and most clients want as few people as possible knowing what they are suffering from.
54. KSS: Yes. Translator may not be medical personnel hence there could be breach of confidentiality. And the patient may not give consent.
55. Nena: Issues of confidentiality of information, time frame required for them to show up at practice, financial constraints as the cost has to factor in that.

These answers indicate that the expectations expressed by some participants in this study are that although professional interpreters are the most important communication facilitating tool

for use among HCPs in Windhoek, there are also challenges associated with them. From the reported challenges that may likely arise, it can be discerned that some of them can be specific to private medical practices. For example, the issue of costs and the fact that the availability of an interpreter at each private practice would not be easily attained is an issue. At private medical practices the volumes of patients are not very high; having interpreters on standby is then unlikely. In the public health sector this could possibly work, especially at big referral hospitals like Katutura Hospital and Windhoek Central hospital. Private practices usually aim to maximise their profits, so they would not be willing to recruit a professional translator whose services are not consistently required, even though the benefits point towards improved quality of healthcare provision.

The most common concern raised in the responses by 13 out of the 18 respondents who responded to this question (one respondent left this question blank) is that of confidentiality. The prevailing view is that bringing in a translator who is "unknown" to the patient might not go well with the patient who may have trust issues towards someone who is not an HCP. Such a lack of trust also comes from the HCPs themselves who may be suspicious that even the trained translator may not strictly observe confidentiality. The implication of this lack of trust is that the HCP may not want to be associated with anything that may tarnish the image of the practice, thereby having a negative effect on the integrity of the medical practice and ultimately the financial standing of those involved. These findings thus point to the fact that it is unlikely that the HCPs will take up professional translators. Macfarlane et al. (2008) found similar concerns in their study in Ireland. In their case they had more respondents that expressed a preference for using informal interpreters as they were easily accessible, whilst those who opted for formal interpreters indicated that they were more accurate.

4.8 HCPS' CHALLENGING AND ENRICHING EXPERIENCES IN KNOWING, USING AND ENCOUNTERING A VARIETY OF LANGUAGES IN EVERYDAY LIFE

In concluding the study, the researcher sought (in questions 19 to 20) to gauge the general views of the HCPs with regards to their experiences of working in a multilingual community and communicating across languages and cultures in the work place. The respondents mentioned a wide array of experiences ranging from satisfaction to frustration.

On a positive note, the findings in this study indicate that many HCPs have varying levels of mastering the main Namibian languages such as Oshiwambo, Otjiherero, Afrikaans and Damara/Nama. The respondents felt that working in multilingual societies like Windhoek, getting to know as well as use a variety of languages, is enriching and it broadens their professional view of the world as well as the patient base. Some of the findings in line with this observation are as follows:

56. ATA: Can easily interact efficiently with a number of clients.
57. Kura: You can confidently talk to a patient and understand clearly what the patient is saying and be in a good position to give sound advice and correct treatment.
58. BK: People easily trust you and become more open to you and patients easily understand instructions or advice.
59. Fay: It brings exposure and broadens customer base, for example the Angolan nationals.
60. Huvan: Broadens your horizon as exposed to persons from different backgrounds and culture.

The above data shows that according to the respondents, being a multilingual expatriate HCP has numerous advantages. Those who have a wider linguistic repertoire find better job satisfaction, gain the trust of their patients, are better assured that they get correct information from the patients, and also that they give understandable instructions to the patients. This results in efficient interactions with customers and ultimately improved quality of healthcare. Moreover, a wide linguistic repertoire also has financial benefits to the HCP as a broader customer base is attained. A Portuguese speaking doctor, for example, is able to serve the large contingent of Angolan nationals living in Windhoek and those who travel to Windhoek to specifically seek for medical services.

On another level, the HCP as a social being also benefits through learning about other people's cultures and having a broadened understanding of the world. Thus language diversity is a resource which is beneficial to both the HCP and the patient. Most of the perceptions given by respondents to this study were in line with those of other researchers. Although Sobane and Anthonissen (2013:264) point out that language discordance between the doctor and patient carries the risk of inaccurate diagnosis and a general negative impact of healthcare provision,

and this was echoed in this study in Windhoek; that was not the overriding sentiment the HCPs in this study expressed. Perhaps more widely supported is the perspective Hall, Rotter and Rand (1981:19) put forward that "[m]edicine is an art whose magic and creative ability have long been recognised as residing in the interpersonal aspects of patient-physician relationship". Ha et al. (2010:39) state that "satisfied patients are advantageous for doctors in terms of greater job satisfaction, less work-related stress and reduced burnout". The expatriate HCPs in this study indicated that their rich linguistic repertoire enables them to have enriched experiences as well, and by extension this improves the quality of healthcare provision in multilingual Windhoek.

However, on a negative note, one respondent explained that what is challenging is as follows:

60. Doc: There are too many languages in Namibia, impossible to learn them all.

Of course, following the reviewed literature, there are many language communities in Windhoek: three language families with diverse linguistic characteristics and up to 30 dialects (Frydman 2011). This virtually implies difficulties for someone working "temporarily" in Namibia to master all the languages of the work place. This is supported by another respondent who lamented the following:

61. Mzaya: [The] volume of vocabulary is too much, sometimes you forget.

Furthermore, as noted by one respondent, the speakers of the language who should assist in the learning of the language are not helpful. This is indicated by the following remark:

62. Mzaya: Some patients/people are unforgiving; if you make a mistake which at times discourages the learning process.

In addition, the other concern raised with regards to working in a place like Windhoek is that it is difficult to linguistically cater for the needs of every one. This view is supported by the finding presented below:

63. Angel: It is difficult to cater for everyone, especially in a foreign setting; some clients would rather find a pharmacy where their language is spoken fluently.

From this response it can be observed that language affects both the expatriate HCP and the patient. The expatriate is affected in the sense that the medical practice/pharmacy will lose out on possible patients (customers) who will instead go to other pharmacies. Whilst for the patient there might be a challenge in that s/he will go in search of another pharmacy where a preferred language is spoken – yet this pharmacy might be far and on arriving there the specific medication might not be available. This again emphasises that "Language barriers have a major impact on both the quality and the costs of healthcare" (Bischoff and Denhaerynck 2010:1).

4.9 CONCLUSION

This chapter systematically presented the answers the respondents gave to the questionnaire which was the primary research instrument of the study. It categorised the kinds of responses that were given and related them to the findings on multilingualism in healthcare by scholars in other contexts. I referred to the linguistic biographies and repertoires of HCPs in Windhoek, the age and place of language acquisition of HCPs in Windhoek and their use of language in the work place. The chapter also discussed the linguistic and communicative practices established by HCPs to facilitate the provision of quality healthcare, their usage and challenges of using interpretation services in the Namibian healthcare context and finally the HCPs' challenging and enriching experiences in knowing, using and encountering a variety of languages in everyday life. In all, this chapter gave a detailed overview of the ways in which expatriate HCPs in Windhoek developed and perceived their own multilingual skills and how they assessed the value of these skills in their work place communication. The next chapter concludes the research by drawing together the various findings through returning specifically to the research questions articulated at the start of the project.

Chapter Five

CONCLUSION

5.1 INTRODUCTION

This chapter concludes the study and it summarises the findings regarding the perceptions of expatriate HCPs in the private healthcare setting in Windhoek, Namibia. The HCPs' language biographies and repertoires were investigated as well as their self-reported communicative practices in a multilingual and globalising Namibian context. As mentioned in Section 1.2, the study was mainly concerned about the HCPs' own report of their linguistic biography, how and when they acquired other languages than their mother tongue/home language, and how their linguistic identity affects their communication in the work place. The research interest has been in the linguistic and communicative practices established in the work place that facilitate or inhibit the provision of quality health care, and the use of English as well as of indigenous Namibian languages and/or other non-Namibian languages in professional communication. Two kinds of communication were in focus, namely conversations between the HCP and colleagues, and conversations between the HCP and patients.

5.2 SUMMARY OF THE STUDY FINDINGS

In order to achieve the aim of the study, five questions were proposed (see Section 1.4); the findings are presented in the following subsections organised according to the research questions, to indicate in which ways the aims of the study could be met.

5.2.1 What are the linguistic biographies and repertoires of the participating expatriate HCPs in this study?

The 19 HCPs who participated in this study self-reported a wide range of linguistic biographies. Regarding their linguistic biographies, the respondents represented five countries as places of origin. The information they gave on early schooling and secondary education gave some insight into the variety of languages they encountered whilst growing up. Although none had English as an L1, all except one had been introduced to English from a very early age. Living in multilingual communities assured contact with and knowledge of linguistic variety, thus

developing linguistic awareness, if not proficiency, in all the community languages with which they came into contact.

The participants had completed their medical training at 10 different universities, which already indicates diverse backgrounds. With regards to their linguistic repertoires, the respondents indicated that they did in fact have other languages in addition to English as languages of learning. A total of nine other languages were identified (including Afrikaans and German which are also spoken as L1s in Namibia). Other than the language of learning, the HCPs also indicated that they have knowledge of Ndebele, Spanish, Swahili, Russian, Tamil, Hindi, French, Sepedi, Sesotho, Isizulu, Isixhosa, Isindebele, Setswana and Shona. These responses again indicated linguistic awareness within the communities where they lived and worked. The working history of the respondents indicated that those who had worked in northern Namibia where Oshiwambo is mainly spoken also indicated their knowledge of Oshiwambo, and one respondent who had previously worked in Opuwo where Otjiherero is the main language spoken also indicated some knowledge of Otjherero. The biographies and repertoires of HCPs give evidence of how they add richness to an already linguistically endowed Namibia with a wealth of languages.

5.2.2 How and when did the HCPs in the study acquire other languages than their mother tongue/home language?

In addition to their mother tongue/home language, the HCPs indicated that they had acquired various other languages. English was acquired by all participants, most of them within the 3-9 year age range, with the exception of one respondent who started learning English at age 13. The context of English language acquisition was reported as the school environment, especially the pre-primary school context. Later in life, from their mid-20s to early 30s the participants indicated that they acquired more languages and these include languages which they acquired in Namibia, namely Afrikaans, Oshiwambo, Otjiherero and German. The context of acquisition of these Namibian languages was given as mainly the work place and the social environment as well. Having knowledge of languages other than English, for example Russian, Tamil, Kiswahili and Portuguese, as well as languages indigenous to Namibia are positive indicators of the HCPs' language awareness. Having been in and working in communities where multiple languages are used, even if not learnt to more than basic conversational level, is helpful even if it is to be used just in ice-breaking and creating positive social connections with patients.

5.2.3 How does the expatriate HCPs' linguistic identity (as reflected in their repertoire) affect their communication in the work place?

The HCPs indicated that at the work place they mainly use English to communicate. However they also use local Namibian languages like Oshiwambo, Afrikaans, Otjiherero and Portuguese. Yet the various languages they encounter in the healthcare context in Namibia include Otjiherero Silozi, French, Hindi, Spanish, Germany, Rukwangali, Chinese and Tswana. Given this pluri-linguistic body of clients, the HCPs expressed that there is a challenge to understand all of them but they try to speak the basics like greetings in order to cultivate intercultural interactions. Basic knowledge of the other languages acts as a communication approximation strategy as they are able to foster closer HPC/patient relationships. However, it was also found that patients from Francophone African countries who cannot speak English pose a challenge as French is not a commonly spoken language among the responding HCPs.

On the positive side, for some of the HCPs' linguistic identity as Shona speakers was mentioned as an advantage in certain clinical situations; for example if another colleague is also Shona speaking they can discuss the patient's condition without disclosing concerning information to the patient. Thus it allows peer consultation in circumstances where they do not want to alert the patient to difficulties they may be having at that particular moment.

Furthermore, it appeared that knowledge of English in itself is not enough as there is also a need to manage the appropriate medical jargon. It was found that those who may lack in this respect still find it difficult to linguistically cope with the demands of a healthcare setting where the use of medical register is a reality on a daily basis. Of interest here is also the indication that locals who are not confident with English and find the HCP a foreign language speaker, may prefer to seek assistance elsewhere (e.g. at another pharmacy), thus isolating the expatriate worker in his/her new work place.

5.2.4 What are the linguistic and communicative practices established in the work place that facilitate or inhibit the provision of quality healthcare?

The HCPs mentioned a variety of linguistic and communicative practices established in the work place to facilitate the provision of quality healthcare. Many did not seem to experience linguistic discord as a big problem, because they found that most patients knew enough English for the needs they had in the consultations. Even so, the most strategy referred to was the use of an interpreter who was in all cases an informal interpreter. This person could be a relative, a

nurse, a colleague or an assistant. Some mentioned that assistants'' linguistic skills were specifically checked in the process of appointing them – their ability to speak a variety of languages being one of the requirements for their mediating role. Regarding family members, there was awareness that this should only be allowed if the information being shared between the patient and the HCP is not strictly confidential. Even with the use of an assistant to interpret, at times it was reported to be necessary to also draw a diagram as a way of helping the interpreter convey the information better. One difficulty they mentioned was that the number of languages spoken in Namibia made it difficult to find an assistant who can speak all the languages.

With regards to the use of professional interpreters, the HCPs were hesitant, remarking that it may not work as the number of patients they see per day and who require such services is not high enough to hire a full time interpreter. The high cost of such an appointment was also mentioned. Therefore because of possible cost implications, they expressed reservations in hiring a professional interpreter, though some felt that this could indeed improve communication. The issue of confidentiality was raised as an important challenge when an interpreter is used.

Finally, the HCPs mentioned that they do often try to speak the patients' languages and also allow the patient to speak the Namibian local language if they can understand it whilst they will be using English. Another strategy is to use signs and gestures accompanied by some English explanations or alternatively by drawings to enhance communication.

5.2.5 In what way do the HCPs use English as well as indigenous Namibian languages and/or other non-Namibian languages in professional communication between colleagues, as well as with patients?

The study found that knowing, using and encountering a variety of languages in a multilingual context like Windhoek is an enriching experience, though at the same time it is also a challenge. The study found that the expatriate HCP respondents find the use of many languages to be an engagement that broadens their professional, social and cultural views, and this ultimately results in improved work relations and improved HCP-patient relationships. Through the use of English, indigenous Namibian languages and other non-Namibian languages was found rather to improve than prohibit efficient interactions with the patients, and multilingualism was found to be a resource, especially within a context like Windhoek, Namibia.

In conclusion therefore, the study found that expatriate HCPs whose linguistic repertoire is diverse and who find themselves working in a multilingual context face a rich linguistic environment which can to a lesser extent be a challenge and to a greater extent enriching as multilingualism is a resource. On the basis of the findings summarised above, it can be argued that the questions of this study were all satisfactorily answered by means of the particular research instrument. Certainly, with more time and resources the study could have been more elaborate. Following up on questionnaires with one-on-one interviews would have given an opportunity to check certain matters, and to gain more detailed information. Also, with a larger group of participants, the validity of some conclusions may have been better checked.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

On the basis of the findings presented in chapter four and summarised in this chapter, the following directions are suggested for future researchers:

- A nationwide study can be conducted with a bigger sample, as each of the regions have expatriate HCPs and the different regions' differing linguistic characteristics may show different results to those in Windhoek.
- The same study using HCPs working in state healthcare facilities as opposed to private practice may deliver very different and important results. Considering the differences in workload, medical resources and patient profiles in the two healthcare systems, this could be a very important study.
- Future research could consider looking at HCPs who are all from Namibia but with different linguistic backgrounds as the country's diversity may result in Namibian HCPs still having similar challenges to foreigners when they encounter patients with other Namibia languages.
- Future researchers can also consider exploring doctor-nurse communication in various kinds of medical contexts to determine how communication is managed at professional level. Typically, there are more nurses from the local population who speak the same languages as patients in comparison to the numbers of expatriate doctors and pharmacists.
- Finally, it is suggested that future researchers consider the intercultural communication competencies of HCPs as this concept has been articulated by Gibson and Zhong (2005). Since Namibia has different cultures and culture plays an important role in the

healthcare consultation setting, checking for the particular competencies referred to by their study is likely to be very helpful.

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Appendix A

QUESTIONNAIRE

Multilingualism in healthcare: communicative experiences of expatriate healthcare providers with varying linguistic repertoires in Windhoek, Namibia

Please fill in the following as completely and accurately as possible. There are no right or wrong answers – this is a survey from which the researcher wishes to draw an accurate profile of the multilingual skills and how they are used among a particular group of respondents in medical practice in Windhoek.

You are requested to answer the questions in the spaces provided or to tick a box where applicable.

SECTION A: Metadata

Personal information

Surname and name : .....

Preferred pseudonym: .....

Gender: Male ☐ Female ☐

Age bracket: 25 - 35 yrs old ☐ 46 - 55 yrs old ☐

36 - 45 yrs old ☐ 56 yrs and older ☐

1. Country and place of birth .....
2. Secondary school completed at .....
3. Medical training at .....

   .....
4. Any other tertiary qualifications obtained: .....
5. Did you ever have any language other than English as ***language-of-learning***? If so, which one?

   .....

5. Employment history:

Place	**Facility**	**Dates**
(e.g. Durban	Addington Hospital	2001 - 2005)

.....

.....

.....

.....

SECTION B: Participant's knowledge and use of languages

6. Please list all the languages you know, even if you are not very proficient. Mark your first language as such. For each language, rate your ability in the language for the skills listed in columns (ii) to (v) (understanding the spoken form, speaking, reading, and writing) on a scale of 1 to 5, where 5 is excellent and 1 is poor.

i	ii	iii	iv	v
Languages	**understand**	**speak**	**read**	**write**
English				

7. This question has to do with where and when you learnt the languages you listed in question 6. Please complete the table below for each language you listed. In column (i) fill in the name of the language; in column (ii) give the age at which you learnt it; in column (iii) give the place and setting in which you learnt it; in column (iv) state whether and where you currently use the language.

i	ii	iii	iv
Languages	**Age of acquisition**	**Place/context of acquisition**	**Current use**
English			

SECTION C: Language in the work place

8. Which of the languages that you listed in questions 6 to 7 do you use

   (i) at home .....

   (ii) at work.....?

9. If at times you use other languages than English at work, explain the circumstances:

   .....

   .....

10. Name the languages other than English which you encounter in consultation with patients in Windhoek:

    .....

    .....

11. If a patient is obviously not proficient in English, explain the course of action you take to overcome the communication barrier.

    .....

    .....

12. Do you ever make use of interpreting services in the course of consultation with or treatment of patients? If yes, please explain (i) who the interpreter is, and (ii) who introduces the interpreter.

    .....

    .....

13. Have you encountered a situation in which you use one language (e.g. English) and the patient uses another (e.g. Oshivambo), and you actually get by? If yes, please explain the circumstances.

    .....

    .....

14. If there were formal or professional interpreting services available for use in your consultations, would you regard that as facilitating? If yes, in which way?

    .....

    .....

15. If there were formal or professional interpreting services available for use in your consultations, do you envisage any difficulties? If yes, please explain the kinds of difficulties.

.....

.....

16. In communication with colleagues, do you at times use other languages than English? If yes, please name the languages and explain the circumstances.

.....

.....

17. Does language at times pose a barrier in communication with colleagues in the work place? If yes, please explain the circumstances.

.....

.....

18. Please explain what would make you switch from one language to another in an interaction with either a colleague or a patient.

.....

.....

19. You are a multilingual person working in a multilingual community.

    (a) What do you find ***most challenging*** about knowing, using and encountering a variety of languages in everyday life?

.....

.....

    (b) What do you find ***most advantageous*** about knowing, using and encountering a variety of languages in everyday life?

.....

.....

20. Please give any other information on your experience in communicating across languages and cultures in the work place which you would find relevant to this study.

.....

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Appendix B

INFORMED CONSENT

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Multilingualism in Health Care: Communicative experiences of expatriate health care providers with varying linguistic repertoires in Windhoek, Namibia

You are asked to participate in a research project conducted by Dr. Nelson Mlambo, a researcher in the Department of General Linguistics at Stellenbosch University. The results of this study will be used for writing a thesis towards an MA in Intercultural Communication. You were selected as a possible participant in this study because it focuses on the communicative work place experiences of multilingual physicians practicing in Windhoek as expatriates.

1. PURPOSE OF THE STUDY

The study will investigate the reported experience of physicians who are themselves multilingual and work with colleagues and patients who have linguistic proficiency in various languages (official and non-official Namibian languages as well as other languages not indigenous to Namibia), and do not necessarily share the same linguistic repertoires. The research focus is on the communicative needs experienced and the communicative strategies used in managing mismatches in linguistic and communicative capacity in consultation and other work related interaction.

2. PROCEDURES

If you volunteer to participate in this study, you will be asked to give general information on your linguistic background, after which you will be asked (i) to complete a questionnaire on the uses of various languages in your work place, and (ii) to follow this up with a 30 minute interview in which aspects not covered in the questionnaire can be clarified.

3. POTENTIAL RISKS AND DISCOMFORTS

Participation in this study will not hold any risks or discomfort you in any way. If at any stage you do feel uneasy, you may request information to be removed, or you may yourself withdraw your participation.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not benefit directly from this research in terms of material gain. The indirect benefit may be in (i) enhancing awareness of communication as a critical element in medical practice in Windhoek, and (ii) the potential uses of findings and suggestions that result from the study.

5. PAYMENT FOR PARTICIPATION

This exercise is voluntary, and as such there will be no remuneration for participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study will remain confidential in that no personal information will be divulged in the presentation of data and results. All data will be handled by myself and my supervisor, and will be anonymized before it is processed, transcribed or analysed. Confidentiality will be maintained by means of the use of pseudonyms. All data will be in my safe custody. If you wish to review it to be sure that what it contains is what you really wish to say, that is possible at any stage. The data will be used for academic purposes only.

7. PARTICIPATION AND WITHDRAWAL

Taking part in this project is entirely voluntary. You are allowed to withdraw at any time, or not answer some questions but still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Dr Nelson Mlambo, researcher, on +264 814218613, e-mail: mlambons@yahoo.co.uk and Prof. C. Anthonissen, supervisor, at ca5@sun.ac.za (Stellenbosch University).

9. RIGHTS OF RESEARCH SUBJECTS

You are not waiving any legal claims, rights or remedies because of your participation in this research project. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development, Stellenbosch University.

SIGNATURE OF RESEARCH SUBJECT

The information above was described to *me* by *Dr Nelson Mlambo* in *English* and *I am* in command of this language. *I* was given the opportunity to ask questions and these questions were answered to *my* satisfaction.

I hereby consent voluntarily to 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 .....

[*name of the participant]*. *H*e/she was encouraged and given ample time to ask me any questions. This conversation was conducted in English.

....
Signature of Investigator **Date**

Appendix C

ETHICAL CLEARANCE FROM STELLENBOSCH

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

20-May-2016
Mlambo, Nelson N

Proposal #: SU-HSD-002425
Title: Multilingualism in Health Care: communicative experiences of expatriate health care providers with varying linguistic repertoires in Windhoek, Namibia

Dear Dr Nelson Mlambo,

Your **New Application** received on **05-May-2016**, was reviewed
Please note the following information about your approved research proposal:

Proposal Approval Period: **18-May-2016 -17-May-2017**

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number** (SU-HSD-002425) on any documents or correspondence with the REC concerning your research proposal.

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

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

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

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.