OVERCOMING COMMUNICATION BARRIERS IN HEALTHCARE: A CASE FOR KISWAHILI MEDICAL INTERPRETING IN KIBRA INFORMAL SETTLEMENT, NAIROBI

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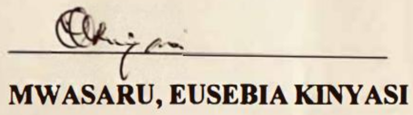
DECLARATION

This thesis is my original work and has not been submitted for examination in any other university.



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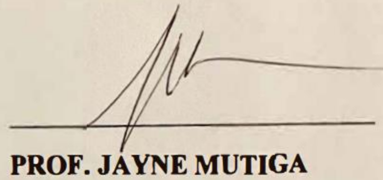

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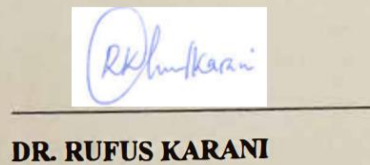

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DEDICATION

My Abba Father. You set me on this scholarly journey, and You have brought me to its completion. *Gloria Patri!*

My parents Bernard Mwasaru Malasi (OGW) and the late JaneGrace Malasi. Thank you for your love of education and being my first teachers of public speaking.

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ABSTRACT

This study presents the state of English-Kiswahili medical interpreting in Kenya's largest informal settlement, Kibra and the need for training among its current practitioners.

The study utilized the Communication Accommodation Theory guided by three objectives. These were to identify linguistic gaps in communication mediated by *ad* hoc interpreters. Investigating the process of *ad hoc* interpreting during patient-service provider interactions and lastly, to discuss the strategies applied by *ad hoc* interpreters to facilitate communication.

Data for this case study was collected through observation and recording of clinic consultations and interviews of health facility administrators in Tabitha clinic and Ushirika Health Centre in Sarang'ombe ward, Kibra. The recorded data was transcribed, analyzed and presented thematically. The study determined that medical interpreting in Kibra was carried out by the clinicians in a dyadic manner. All cases did not benefit from standard Kiswahili interpreting due to code switching.

Three recommendations were proposed in this study: First, the clinicians need basic interpreter training if they will continue in their dual role as clinician-interpreters. Secondly, a personal investment by the health care providers in improving their communicative capacity in Kiswahili is necessary. Lastly, an in-depth study on this phenomenon of the dyadic clinician-interpreter to provide insight into this practice.

ABBREVIATIONS

CAT	Communication Accommodation Theory
FBOs	Faith-based Organisations
LEP	Limited English Proficiency
LWC	Language of Wider Communication
MSF	Medecins Sans Frontiérs
NGOs	Non-governmental Organisations
SL	Source language
TC	Tabitha Clinic
TL	Target language
UHC	Ushirika Health Centre

DEFINITION OF CONCEPTS

- Bidirectional interpretation: Source language is rendered into the target language and vice versa.
- Working languages: The languages one utilizes actively. They have varying levels of fluency, professionally denoted as A, B or C.
- Language of wider communication (LWC): language developed and used by people as a means of communication beyond native language and cultural barriers.

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CHAPTER ONE

Introduction

1.1 Background of the Study

Communication is essential in providing human services. It is crucial in overcoming barriers caused by attitudes, cultural and societal differences. The world is becoming increasingly integrated through migration. Strelow *et al.* (2021) confirm that according to the Federal Office for Migration and Refugees, approximately one in four people living in Germany has a migration background. Community interpreting, therefore, is imperative in this multi-cultural context for two reasons. First, to cater for increasing divergent cultures and languages in a homogenous society. Second, to foster understanding in a heterogenous society.

Pokorn and Južnič (2020) define community interpreting as oral and signed communication by a third party that assists those with limited language proficiency in a societal language. Interpreting enables these individuals to gain access to services offered by public and healthcare institutions. Pöllabauer (2012) states that it is also termed as, but not limited to dialogue interpreting, public service interpreting, liaison interpreting and cultural interpreting. Hsieh (2003) elaborates, that unlike conference interpreting which is carried out in distanced booths, community interpreting is often face-to-face in nature. Pöllabauer (2012) elaborates further on how community interpreters usually work bidirectionally, into both the source language (SL) and target language (TL), often on their own. This differs from conference interpreting where interpreters work in teams.

As previously mentioned, the primary objective in community interpreting is to facilitate communication for persons of limited language proficiency to receive public services. In the context of health services, it is termed as Healthcare or Medical Interpreting. Barron *et al*. (2010)

aver that healthcare interpreters overcome obstacles in patient-doctor communication that would otherwise interfere with quality medical care. Such obstacles include religious beliefs, patient attitudes, cultural differences, and literacy levels. To overcome these difficulties, qualified interpreters are essential. Unfortunately, Pöllabauer (2012) points out that healthcare interpreting in various institutions continues to be carried out by untrained professionals recruited on an *ad hoc* basis. Hadziabdic *et al*. (2014) and Sobane (2014) affirm that family members and hospital staff have been documented as carrying out interpreting tasks. This has been attributed to a lack of professionalization of the field.

Leanza (2005) asserts that the professionalization of healthcare interpreting has only been possible in nations in the global west, where community interpreting services exist to assist immigrants and refugees in legal and health services. Galván (2020), corroborates this by noting that Australia, Canada, the United States of America, and the United Kingdom were the trailblazers in the professionalization of community interpreting, due to their cultural diversity that is attributed to immigration. Australia, as an example, has the National Accreditation Authority for Translators and Interpreters (NAATI) that was formed in 1977, since community interpreting was well-established in that nation in the mid-1970s. As of 2021, there are over 13,000 certified practitioners registered with NAATI as opposed to 176 registered members of International Association of Conference Interpreters (AIIC) Africa.

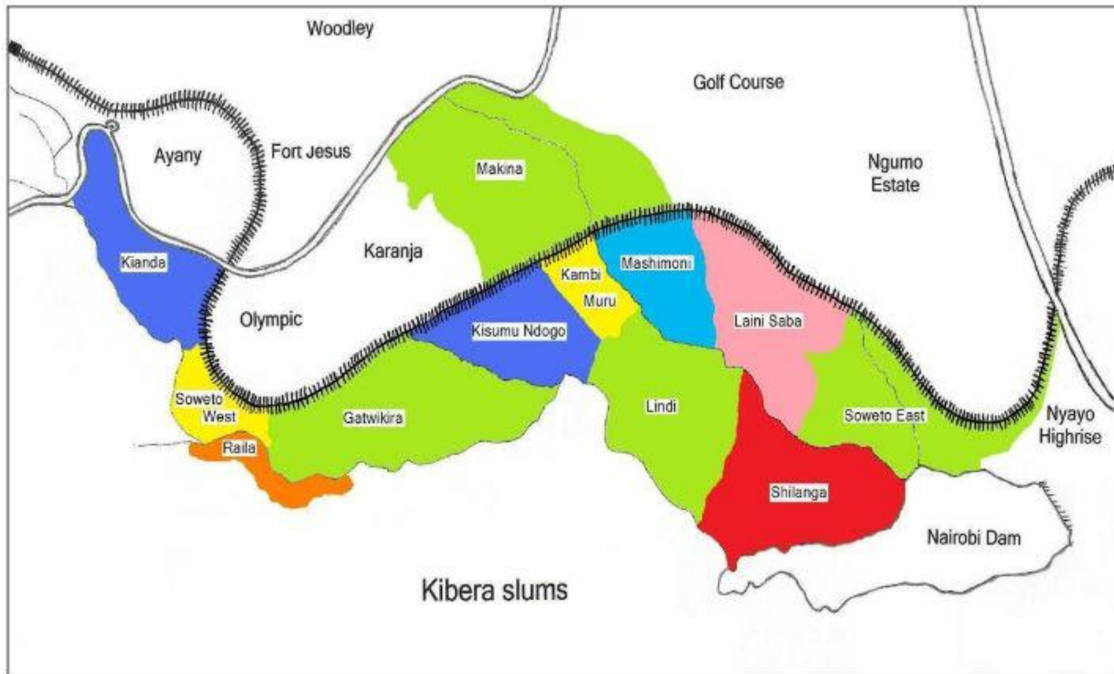
Immigrant communities in western nations are smaller groups relative to larger communities which cannot access medical care efficiently, due to communication barriers. Large communities in Africa are marginalized because of inadequate healthcare communication intervention. Sobane (2014) highlights the isiXhosa community in South Africa, whose language is one of the 11 official

languages. Its members do not enjoy equitable health care due to poor communication. Sobane opines that with such linguistic diversity, communication between health service providers and their patients requires facilitation. In Kenya the Kibra
informal settlement in Nairobi is an example of a large community of the urban poor, that faces a similar challenge. Its residents are multi-cultural, linguistically diverse, and many have limited English proficiency (LEP).

According to Mutisya and Yarime (2011), the Kibra informal settlement is the largest urban slum in Africa, owing its numbers to rural-urban migration. Kinyanyi (2014) expounds that lack of education and job opportunities are major influencing factors, for many migrants to Kibra. As a result of the affordable and ready labour, it provides work force for service industries in Nairobi. This ranges from factory work in Nairobi's industrial area to daily domestic employment. Since the first settlement in Kibra in 1910, Wanjiru & Matsubara (2017) and the UN HABITAT (2020), estimate its population to be between 250,000 to 500,000 settled in an area of 2.38 square kilometres. The settlement is resource poor, lacking running water and proper sewage systems making it a hotspot for recurrent diseases such as cholera, dysentery, and typhoid. Amnesty International (2009:6), affirms that the marginalization of Kibra informal settlement is the result of government policy and continued indifference to the plight of its residents.

Kibra residents are settled in twelve villages in the informal settlements (highlighted in colour), namely Makina, Kianda, Soweto West, Raila, Gatwikira, Kisumu Ndogo, Kambi Muru, Mashimoni, Lindi, Laini Saba, Silanga, Soweto East. It is surrounded by Karanja, Olympic and Ayany estates. Their locations are depicted in figure 1.

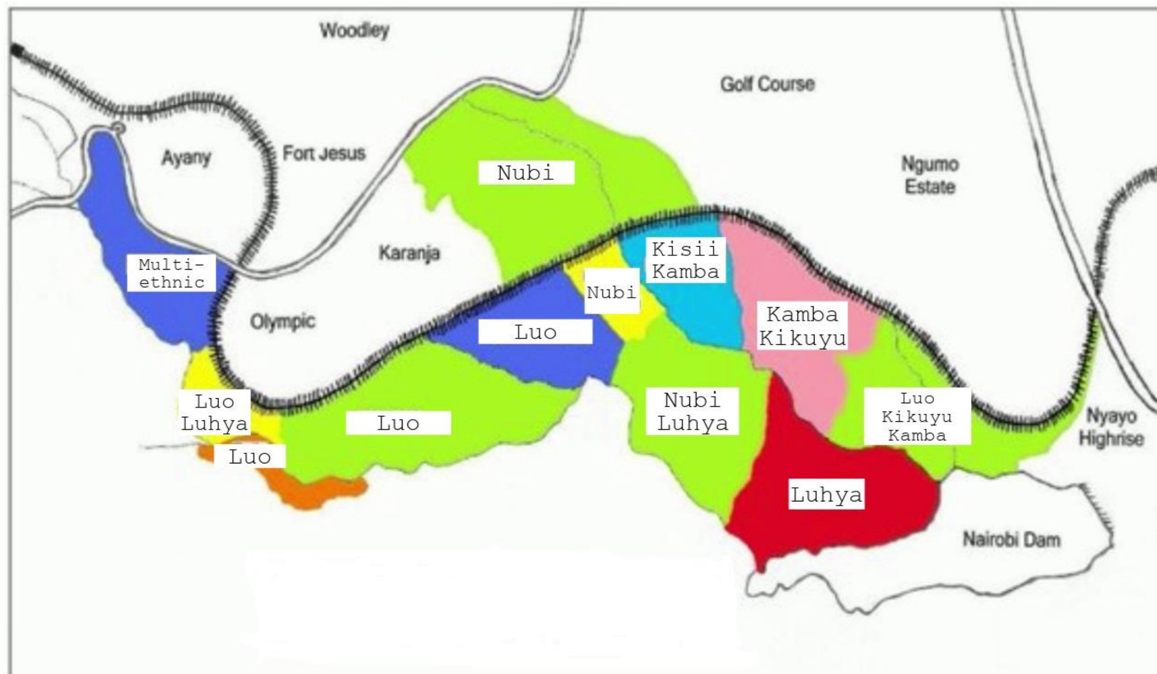
Figure 1: *Map of Kibra Informal Settlement*



(Source: Kenyapage.net)

Prior research in Kibra shows consensus on its cultural diversity. However, Gibson and Bagamba (2016), introduce the idea of Kibra being a 'salad bowl', as opposed to the clichéd term of a melting pot. This is because migration from the rural areas to the city, does not deter the residents from maintaining their communal languages. Maintenance of their mother tongues is easily achieved when residents of the same ethnicity live in proximity. Van Iwaarden (2015) and Wanjiru & Matsubara (2017) establish that indeed Kibera villages are populated along ethnic lines, as illustrated in figure 2. Each village, except for Kianda, has dominant ethnic groups.

Figure 2: *Map of Ethnic Groups by Villages in Kibra Informal Settlement*



[Source: Kenyapage.net, Author's reconstruction of map based on information from van Iwaarden (2015) and Wanjiru and Matsubara (2017)]

Thicke (2011) explains that Kibra residents speak their vernacular languages, *Sheng* (an urban slang language based on Kiswahili with influences from English and vernacular languages), Kiswahili and English, as a third, fourth or fifth language. Gibson and Bagamba (2016) confirm this, through the impact of settlement by ethnic groupings in Kibra. Their comparative study of residents of Kibra and Buruburu (an ethnographically diverse middle-class suburb of Nairobi) reveals that 70% of households in Kibra use their ethnic language as the dominant language, in stark contrast to 7% in Buruburu. Furthermore, the Luo residents display more maintenance of their mother tongue irrespective of the age of migration to Kibra. Other ethnic groups exhibit lower maintenance of their mother tongue, if migration occurred when the individual was below ten years. However, it increases with the individual's age upon arrival in the informal settlement.

The maintenance of ethnic languages, coupled with limited education, presents a communication challenge in an area that is served by local and international non-governmental organizations (NGOs). Venables *et al* (2016) cite that there are many service providers, from private clinics and NGOs such as Médecins Sans Frontiérs (MSF) that address the recurrent disease burden. Many of the health service providers working in the NGOs are foreigners, and Kenyans who do not reside in Kibra. They are well-educated in comparison to the populace they serve, who have limited English and Kiswahili proficiency or are illiterate. It is from this populace that *ad hoc* interpreters are derived.

There also exists a cultural aspect that cannot be ignored. A majority of the foreign and local health services personnel who work in Kibra, come from different social classes and cultural backgrounds. Ndung'u and Mbutu (2017) observe that socio-cultural factors such as societal norms, taboos, personal attitudes, among others, are prevalent in this milieu. A pertinent example is one where the patient can only receive medical attention from service provider of a particular gender or not discussing certain health concerns in the presence of a given a family member. It is evident that the socio-cultural divide affects the patient-doctor communication in terms of what is considered suitable verbally, non-verbally and contextually. Leanza (2005) remarks that if all these barriers are not overcome, then the entire healthcare process is at risk.

These highlighted complexities in Kibra are the impetus for this study - to demonstrate the need for qualified medical interpreting in Kibra.

1.2 Statement of the Problem

The Kibra informal settlement is home to the urban poor. Research by UN Habitat shows that people living in poverty are trapped in a situation where they fall through systemic cracks. These systemic cracks are occasioned by a large urban population, competing private medical facilities and lack of adequate resources in public medical facilities. Consequently, residents of Kibra do not benefit from public resources. It is in these poor environments where non-governmental organizations (NGOs) and faith-based organizations (FBOs) provide social services such as healthcare, education, and sanitation. Kibra has attracted medical camps and health facilities serviced by private local clinicians and foreign NGOs and FBOs.

Many of the residents of Kibera are rural-urban migrants, who have basic education and limited English proficiency or are illiterate. Linguistic studies contend that rural-urban migrants in the informal setting maintain the use of their ethic languages in their homes. This is especially true of the adults. The youth, in this environment develop what Gibson & Bagamba, 2016 refer to as their own Language of Wider Communication (LWC), derived from multiple languages in their environment. The combined use of the LWC and ethnic languages, hampers expression in Kiswahili and English. The presence of the LWC, active use of ethnic languages and poor literacy levels limit these residents' capacity of self-advocacy while receiving care in the health facilities. On the other hand, many of the clinicians use English as the main mode of communication and are not privy to the local LWC. As a result of this language barrier, service delivery is not optimal. Where poor communication exists, patients lack adequate information that is important in empowering them health-wise. It is in this complex communication environment where qualified healthcare interpreters would bridge the communication gap.

Currently, family members and staff serve as *ad hoc* interpreters. They lack adequate training to effectively play the role of linguistic and cultural mediation for the patients and heath service providers. Preferred language and linguistic aspects such as expression and terminology are potential impediments during communication. Moreover, many Africans adhere to their cultures, holding fast to certain social mores that greatly hamper communication. These include women being considered subordinate to their spouses, personal attitudes towards receiving care from a health care provider of a different gender, among others. Kibra residents are not an exception to this.

It is in this setting, that this study aims to investigate the facilitative role of *ad hoc* medical interpreting in improving treatment and care of patients in Kibra informal settlement.

1.3 Research Objectives

The following objectives will direct this study.

i. To identify linguistic gaps in communication mediated by *ad* hoc interpreters.

ii. To investigate the process of *ad hoc* interpreting during patient-service provider interactions.

iii. To discuss the strategies applied by *ad hoc* interpreters to facilitate communication.

1.4 Hypotheses

The following hypotheses will guide this study.

i. Socio-cultural and language barriers affect *ad hoc* interpreter communication.

ii. Cultural adherence promotes *ad hoc* interpreter specificity.

iii. *Ad* hoc interpreters use linguistic and extra-linguistic strategies to facilitate communication in the target language.

1.5 Significance of the Study

Previous research has concentrated on minority immigrant communities in different developed countries. This research has been instrumental in bridging the communication and cultural gaps between the immigrants and their hosts. It has also influenced important policy decisions in their nations.

Research on medical interpreting in African languages is not as prominent as that carried out in languages of interest in occidental nations. To the best of our knowledge, in the Kenyan context, there has not been any study carried out in the Kibra community, to explore how clinical communication occurs in foreign-sponsored health facilities.

This study is important in contributing to the corpus of research in medical interpreting, in the context of nations that have large urban poor heterogenous societies. It will provide insight on the need for professional healthcare interpreting services and open avenues for discussion on how such communities can derive long-term benefits from interpreting interventions. The study seeks to provide a basis for policy decisions on matters of health equity and demonstrate the importance of communication in empowering patients as health service recipients.

1.6 Scope and Limitations of the Study

This study examined the communication dynamics between physicians and patients with LEP during regular clinic consultations, in the Sarang'ombe ward in Kibra. This ward covers the Kisumu Ndogo, Gatwikira, Raila and Soweto West villages.

Although Nairobi has multiple informal settlements, the study is limited to Kibra because it is the largest and oldest. Furthermore, the study focused only on two clinics in Sarang'ombe ward,

despite the presence of multiple health facilities. This is because, many residents in this ward are from the Luo community, who have a high rate of ethnic language maintenance. These clinics are Tabitha Clinic (TC) and Ushirika Health Centre (UHC). These clinics have served the residents of Kibera for over 20 years, providing health care services through local and foreign staff.

The study was carried out in September 2022, over a period of two weeks. Each clinic was assigned a week for data collection. Data was collected during consultations. Interviews were conducted after consultations. It was assumed that the health care professionals and patients at the selected sites would be willing to participate.

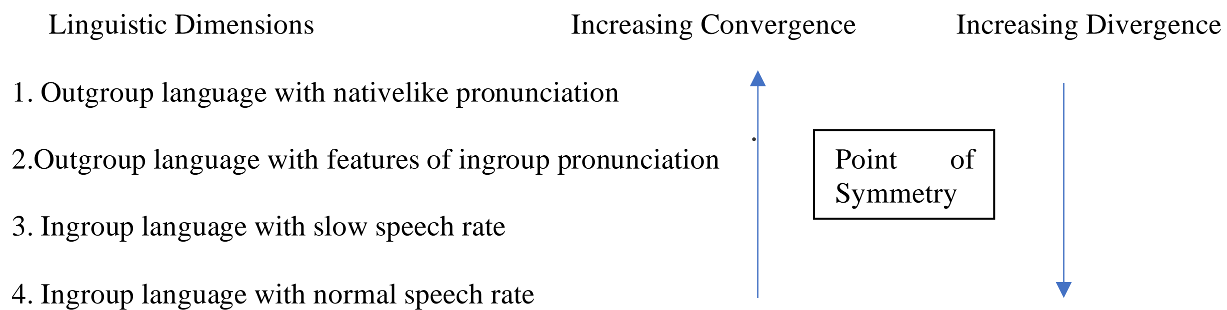
1.7 Theoretical Framework

This study focused on the process of communication between individuals from different cultures. It was paramount to utilize a theory that sheds light on communication and cultural influence on communication from the perspectives of the speaker and the listener. Therefore, this study employed the Communication Accommodation Theory (CAT), developed by Howard Giles in 1971.

Giles' (1971) theory asserts that when individuals from different cultures communicate, they must accommodate each other verbally and nonverbally to ensure that a preferred level of communication distance is maintained between the two parties. CAT dissects accommodation through Convergence, Divergence and Social beliefs strategies. There is a socio-psychological aspect that is involved in understanding the dynamics of speech. It is very evident when two individuals from different cultures come together in communication. Giles & Ogay (2007), posit that the process of accommodation, or adjusting to one another, seeks to facilitate understanding.

However, Giles (1971) cautions that accommodation is a bipartisan effort. When accommodation is approximately equal for both partners, it is said to be symmetrical as seen in figure 3.

Figure 3: *Some Increasing Variants of Convergence and Divergence*



Source: Adapted from Giles, Bourhis & Taylor, 1977

1.7.1 Convergence Strategy

This strategy is utilized by individuals, either linguistically or nonverbally to adjust to their fellow speaker, with the aim of reducing their social difference. According to Giles (1973 in Giles & Ogay, 2007), this occurs to gain approval from the speaker. The approval can be manifested in different ways, for example in social rewards such as a smile, a pat on the back or an arm around the shoulder. Spencer-Oatey and Franklin (2014) note that linguistic accommodation and stylistic flexibility can contribute towards this strategy. Linguistic accommodation involves adapting one's speech to suit the non-proficient listener. This is done by slowing speech tempo, using colloquial language, choice of simpler words and enhance pronunciation. Stylistic flexibility employs different language styles to meet the need of the audience. This strategy was used to analyze the *ad hoc* interpreter's strategies, as well as the service provider's efforts to facilitate communication during the consultation.

1.7.2 Divergence Strategy

Following the thread that languages are a part of one's social identity, divergence is applied through emphasis of verbal and nonverbal differences between the communicating parties. The driver for divergence is the maintenance of self-esteem and to draw further from the other party. Giles & Ogay (2007) affirm that self-esteem is part of one's social identity. When this social identity is threatened, the individual will resort to divergence, so long as the individual is happy to be part of that social group. Language is a social identifier, implying that in the intercultural setting, speakers must be cognizant of the pride that each has in their native language.

This study employed the guidelines for divergence to observe the communicative interaction between the parties involved, while respecting the individual's identity.

1.7.3 Social Beliefs

Social beliefs can be applied from the angles of societal norms on the perception of language, as well as communication, as is carried out by males and females. Giles & Ogay (2007) opine some societies perceive other languages as more superior than other others. Bourhis (1991) as quoted in Giles & Ogay (2007), observes how Francophones in New Brunswick, Canada, irrespective of their fluency in English, were more likely to converge to English. They did this even the Briton was of a lower social standing. Surprisingly, the English speaker would not converge to French but would maintain his use of English, situation notwithstanding. This demonstrates the role of social belief in the esteem with which a community holds its language.

In certain communities, men have a stronger linguistic stance than women, as a sign of their loyalty to their language. A study done by Al-Khatib (1995) showed that Jordanian men, when faced with the choice of speaking urban Jordanian Arabic or standard Arabic, they opted for the latter.

Women preferred the urban variety. This aspect of the framework was used to analyze language preference by the health service providers who can communicate in both English and Kiswahili. Secondly, it informed the study on the choice of *ad hoc* interpreters, familial or those provided by the health facility.

1.8 Literature Review

Literature is reviewed theoretically and empirically. The theoretical portion covers literature in the fields of interpreting and communication. It showcases the developments in the field, in different parts of the world and the gaps that can be filled. The empirical literature reviewed, is reflective of this study. It highlights research in different fields of community interpreting and how this study will contribute to this already established corpus.

1.8.1 Review of Theoretical Literature

Niang (2008:42) presents the world of interpreting in Africa. Interpreting is seen as a necessary tool for communication, owing to the cultural and linguistic diversity of the continent. She bases her study in West Africa, where she traces the origins of interpreting to trade with the Arabs in the 7th and 8th centuries A.D. These interpreters were not only instrumental in facilitating trade but were a vital part in the proselytization of the indigenous people, to Islam. This raised the status of interpreters in society, not only being seen as cultural mediators but intellectuals, through their polyglottal capacity. Onset of trade with European nations such as Portugal in the 12th to 16th centuries A.D, increased the interpreters' responsibilities. He took on the role of ambassador and adviser, as he was the only link between the two communities.

Throughout the period of colonization of Africa, Niang (2008:44) tracks the change in interpreter role to that of an administrator in the colonial government. He becomes the mouthpiece of the colonizer to his community and no longer possesses a place of privilege. His alliance with the colonialists alienates him from his community. The interpreter plays a significant role in the courts of justice, where he influences legal outcomes due to his partiality. Post-independence, the interpreter, takes on a new role as representative of their sovereign nation, facilitating multilateral communication. Niang demonstrates the importance of understanding the role of communication in space and time relative to the community. She reveals the impact in West Africa. The same should be replicated in East Africa.

Hertog (2010) highlights the importance of community interpreting in the context of minority who require public services in their host nations. According to Hertog (2010:49), community interpreting is defined by the dynamic institutional settings where the information being handled requires sensitivity in its handling. This is attributed to the clients who utilize the service. He further adds that community interpreting is a "product of civil rights and anti-discriminatory legislation" that led to the establishment of the sign language interpreter's registry in the United States of America, in 1965.

Hertog (2010:53) observes that this field is gaining more prominence, through the boldness of its practitioners in advocating for the rights of the minorities they represent. Furthermore, research in community interpreting is also on the rise, as the field is now increasingly recognized by leading academic journals such as Meta and Journal of Interpreting. Hertog's perspective on the importance of community interpreting research is important in the sense that it highlights the needs

and rights of the affected communities. This approach can be utilized in large, underserved communities in Africa.

Kainz *et al.* (2011) discuss on the institutionalization of community interpreting. Community interpreting has a low status, contrary to the workload that its practitioners bare. Kainz and colleagues (2011:8) argue that institutionalization is tied to boundaries. Community interpreting has no boundaries, it is clear in the many terms it is alternatively known as: dialogue interpreting, public service interpreting, ad hoc interpreting, to mention but a few. Kainz *et al.* (2011:9) note that a move to train community interpreters specifically, may contribute to the cause of institutionalization. Kainz *et al.* (2011:14) give an example of community service benefitting foreigners. During the Olympic games in Beijing, a telephone interpreting service provided important information for residents and visitors alike. In this light, community interpreting in 'seen' as the field that is concerned with fairness, in catering for the needs of the communities. The sentiments raised here are important in assessing the training of community interpreters and following it up with the recognition of the field. This is relevant in many parts of the world.

Spencer-Oatey and Franklin (2014) delve into intercultural communication. Spencer-Oatey and Franklin (2014:81) note that competence in communication is closely linked to intercultural competence. Cultural backgrounds have profound effects on communication based on the meaning of messages, both verbal and non-verbal. In addition, the authors (2014:89) point out the necessity of understanding one another's communication style, to avoid misunderstanding or offence. It is not surprising that Spencer-Oatey and Franklin (2014:97), advocate the use of an interpreter in intercultural settings with well-set guidelines on how to utilize interpreting services. These authors have underscored an area of communication that is underappreciated – the meaning of messages.

In a culturally diverse country like Kenya, studies could be carried out in various communities on different message meanings and their effects on communication.

1.8.2 Review of Empirical Literature

This section appraises research studies carried out by scholars in the field of community interpreting.

Onsongo (2010), in his published MA Thesis, carried out research on the effectiveness of interpreting services in case management, at the Magistrate's Court in Kisumu. He notes that one who cannot communicate faces a significant barrier in the justice system. In his survey of court interpreting services, his research established a general dissatisfaction with the court-provided interpreting service. Furthermore, there were very few qualified interpreters to deal with the rigours of courtroom interpreting, thereby limiting justice to those who need their services.

Wangui (2015), conducted yet another study based on the court system. In her published MA thesis, she asked whether training, as a minimum requirement for court interpreters, would improve service delivery. Her findings showed that court interpreters do not have set standards, court clerks assume the task of interpreting as long as they are knowledgeable in two languages. She concluded by stating that there is need for court interpreter training. She also made pertinent recommendations that targeted training and the creation of an official database of all trained court interpreters.

Munane (2014), conducted his research study in medical interpreting. He homed in on the challenge of interpreting cultural taboos. He analyzed the work of trained and untrained interpreters while tackling patient-doctor conversation that involved taboo topics. He found that training gives an advantage when dealing with such topics, as miscommunication and wrong

diagnoses are avoided. He emphasized on the necessity of hospitals retaining adequately trained interpreters. Furthermore, he recommended patient sensitization on the importance of eschewing certain cultural practices that lead to stigmatization and denying people the right to seek medical care.

Another medical interpreting study was carried out by Castle (2007). Her study centered on the role that culture plays in medical interpreting, with reference to Hispanic cultures and medical interpreters from that culture. In her findings, she observed that interpreters may not be as neutral as they are expected. They are porters of their 'culture', exuding it either because of their gender, social status, academic standing, among other factors. This affects the way they interact with the patients during interpreting sessions or within their institutions. She concludes that there are some cultures and cultural dynamics that are very complex.

The final study is also in medical interpreting. de V. Souza (2016), dissected the role and self-perceptions of interpreters in a study spanning 25 countries. She challenges the view of interpreters as detached conduits. She posits that the medical interpreter should be regarded a new, through the triple lens of a linguist, healthcare specialist and a cross cultural communicator.

These theses have provided valuable contribution to the field of community interpreting. These studies have all focused on different aspects of interpreter roles, perceptions and of course, their importance in bridging the communication gap. This research undertakes to explore intercultural communication in local communities. Its major goal is to highlight the importance of medical interpreting in large LEP communities, especially in Africa. This will augment to the research Sobane (2014) confirms that has been carried out in South Africa, Lesotho, Malawi, Nigeria and

Munane (2014) in Kajiado, Kenya. It will echo the calls on appreciation of the culture within the interpreter and the multidisciplinary task that interpreters undertake.

1.9 Methodology

1.9.1 Data Collection

This case study drew from the Luo community in Kibra informal settlement. It is one of the largest ethnic groups in the area, with the most maintained language. This afforded the opportunity to appraise the practice of *ad hoc* interpreting in the facilities in their locale. Two clinics were selected for this study. These are TC, an American-sponsored NGO; and the UHC, a British-sponsored NGO.

There are two criteria used in selecting these health facilities. The first criterium was staffing. The clinics have local staff, whose primary language of communication is English. In addition, the clinics periodically host visiting foreign medical practitioners and visitors. The second was location. The clinics are in Sarang'ombe ward, spanning four villages that are inhabited by members of the Luo Community. These are Kisumu Ndogo, Gatwikira, Raila and Soweto West villages. In this area, Dholuo is maintained from an early age, thereby making the case for observation of the practice of *ad hoc* interpreting.

This research utilized primary data, collected through observation of provider-patient communication and from semi-structured interviews. This type of data elicitation allowed for open expression of the study participants and afforded the researcher an opportunity to gather as much information as possible.

The researcher visited the two clinics on separate weeks, audio-recorded the consultations and noted down relevant observations. Key audio-recordings were transcribed for analysis in accordance with patient privacy protection requirements from the health facilities. Semi-structured interviews on site, were used to gather insights from the facilities' administrators on the general communication process and related challenges in providing quality health care. Interviews with the administrators were carried out after all the consultations were concluded. Questions derived from the research objectives were prepared, to gather insight beyond the consultations where the researcher was present. Specific questions that arose from observations were also addressed through the interview. The responses were recorded, to be augmented for analysis.

Purposive sampling was employed to have a representative picture of foreign NGO health facilities. Purposive sampling was necessary in enabling quality data acquisition, as the researcher will select from the pool of patients, acquiring information on patients of different ages. A minimum of ten patient-physician interactions, per institution, were targeted for audio- recording, permitting this study to pass the minimum threshold of subjects required for a qualitative study.

1.9.2 Data Presentation and Analysis

Data was analyzed through content and framework analyses.

Through content analysis, transcribed and behavioural data was summarized and presented in the form of tabulated excerpts. Demographic information is presented in the form of a table and pie chart.

The Communication Accommodation Theory (CAT) was the basis for framework analysis. Data will be analyzed using social beliefs, convergence, and divergence strategies of CAT.

1.10 Summary

This chapter presented the foundation of this study. It has provided the background of the study, introducing the concept of *ad hoc* interpreting and its use in facilitating medical communication in minority LEP communities globally. This was followed by the statement of the problem which revealed why there is gap in the study of this concept in majority LEP communities. The objectives presented draw from the topic while the hypotheses are derived from the objectives. The significance of the study is elaborated in the context of its importance in the urban poor majority LEP communities. This study's scope is limited to one area with high ethnic language maintenance in an urban poor LEP community.

The theoretical framework delved into the functionality of the Communication Accommodation Theory in analyzing *ad hoc* interpreter-facilitated medical communication. The literature review section presented the theoretical and practical contributions by various scholars on this topic. Lastly, the methodology section provided details on how the study will be conducted.

CHAPTER TWO

Ad hoc Interpreting

2.1 Introduction

The field of healthcare interpreting deals with diversity of the cultures and languages of health care recipients. Sobane (2014) posits that linguistic diversity requires facilitation of communication between health service providers and their patients. Pokorn & Mikolič Južnič (2020) elaborate that this communication can be carried out by professional interpreters who are bound by a professional code of ethics. It can also be carried out by non-professional or *ad hoc* interpreters. This chapter will delve into the features and communicative aspect of a*d hoc* interpreting.

2.2 Overview

Ad hoc interpreting is also known as bilingual interpreting or untrained interpreting. According to Pokorn and Mikolič Južnič (2020), *ad hoc* interpreting is utilized because there is a paucity of well-trained community interpreters. This is the reason why interpreting tasks in community-based settings have been taken over by mediators employed by various NGOs because established training institutions have not met the increased need for intercultural mediators.

Hadziabdic *et al.* (2014) attest that the deficit in trained interpreters has also led to an increase in use of lay interpreters such as family members and hospital staff. Family members step into the role of interpreter because they offer emotional support during and after the consultation, seek additional information and are trusted, as opposed to an unfamiliar interpreter. This overshadows the consequences of being the interpreter, that is lack of objectivity in delivering negative news, the emotional toll and lacking the capacity to deliver accurate messages. Sobane (2014)

substantiates that besides family members, interpreting services in health facilities have been carried out by bilingual staff such as cleaners, nurses, security guards and social workers. Their use in institutions continues due to the cost of hiring trained interpreters for face-face consultations.

2.2.1 Characteristics of *Ad hoc* Interpreting

Ad hoc interpreting differs from non-community interpreting (exemplified by conference interpreting) in various distinguishing aspects. Training is the fundamental aspect. *Ad hoc* interpreters provide interpreting services without formal interpreter training. This contrasts to qualified medical interpreters as well as other types of community and non-community interpreters. Nápoles *et al.* (2010), through their study of interpreter-mediated clinic visits in underserved primary care settings, rate professional in-person and video interpreting higher than *ad hoc* interpreting. Hartford *et al.* (2019) concur that professional interpreting is superior to *ad hoc* interpreting and no interpretation. Furthermore, language discordance greatly impacts diagnostic testing and higher hospitalization rates when a bilingual doctor or a professional interpreter does not serve the LEP patient.

Ad hoc interpreters, like conference interpreters mediate communication using consecutive and simultaneous interpreting. The interpreter may choose to interpret larger pieces of information when the patient pauses. Alternatively, Pöllabauer (2012) notes that they might choose to interpret simultaneously, which could result in confusion in taking turns or overlapping talk. The participants of the conversation are normally seated in proximity to each other. This set-up renders it less formal, differing greatly with conference interpreting. Moreover, ad hoc interpreting is conducted by an individual, working bidirectionally into both the SL and TL, for the duration of the appointment. This contrasts with conference interpreting where interpreters generally work in teams, in booths, rendering the speech unidirectionally, into the TL.

Hale (2007:32) asserts that *Ad hoc* interpreting, under the broader category of community interpreting, has greater consequences than conference interpreting. Community interpreting is premised on addressing a real need by residents of those communities, whereby in its absence, communication cannot occur. Inaccurate interpretation owing to lack of training, has a great impact on the lives of the consumers of *ad hoc* interpreting such as in a medical consultation. There are no opportunities to rectify misunderstandings or recognize errors in *ad hoc* interpreting. Hale (2007:33) continues further to show how this differs from conference interpreting, where native languages are used as a matter of sovereignty, not need. She states:

> "…in most conferences the interpreter's purpose is to enable delegates to understand the content of papers presented by the speakers, if the interpreter misses or distorts a point, the papers will usually be published, and confusing issues clarified."

This highlights the gravity of consequences in *ad hoc* interpreting, that continue to be witnessed as untrained individuals take on this role on a regular basis globally.

The concept of neutrality is pivotal in the process of communication. Hsieh (2003) remarks that strategies chosen during community interpreting are dependent on key factors such as the interpreters' linguistic capacity, their interpreting competence, the goals of the encounter and the role the interpreter will take on during each encounter. Owing to the triadic and personal nature of the community interpreting, the *ad hoc* interpreter often struggles with neutrality during interpreting sessions. Pöllabauer (2012) attributes this struggle to the fact that *ad hoc* interpreter are natural interpreters without formal training, in countries where the degree of professionalization for community interpreting is low. Neutrality in conference interpreting is synonymous with the practice. According to Hale (2007:28), the practice of neutrality in conference interpreting is attributed to its professionalization and status. The beneficiaries of

conference interpreting services such as diplomats, delegates, the business community, require the practice of neutrality.

2.3 Language In *Ad hoc* Interpreting

Moser-Mercer's (1997) interdisciplinary study reveals the importance of various skills and strategies that drive the expert interpreter's work. Some of the key highlights are the interpreter's capacity to present information, semantic knowledge, and comprehensive comprehension. In addition, the interpreter possesses skills in automation, planning, monitoring and employment of management strategies during the communication process. These are the products of drilling, acquired through training. This section evaluates the linguistic challenges that *ad hoc* interpreters confront on a regular basis.

2.3.1 Formality and Language Registers

Hale (2007:32) proffers that community interpreters, and by extension *ad hoc* interpreters, encounter different registers of language such as slang, argot, dialects, and non-standard language. They may also encounter languages that are often ethnic or not commonly used, whose speakers are considered to have lower status. Hale further expounds that the settings maybe formal or informal and have different degrees of technicality. Wang & Grant (2015) posit that the level of education of the interpreter influences how they handle different registers. Furthermore, knowledge of a particular field or setting is essential in interpreting messages that are semantically correct. Most *ad hoc* interpreters, lack the skills highlighted by Moser-Mercer (1997) as well as requisite background knowledge that would enable them to navigate through messages of different registers and levels of technicality. This reduces their ability to present comprehensive and beneficial information to the TL recipient.

2.3.2 Grammar

Language proficiency is a hallmark of the field of interpreting. Grammar is a determinant of language proficiency. Kai *et al.* (2021) echo this sentiment in their observation of untrained community interpreters, who are challenged by grammatical structure that is, subject-verb-object placement (S-V-O). In their study of six *ad hoc* interpreters in Malaysia, working between English and Chinese, the respondents state that complex sentences greatly affect their capacity to adhere to proper grammatical structure. Furthermore, Kai *et al.* (2021) observe that grammatical competence is greatly influenced by the degree of preservation of the standard languages. In Malaysia for example, English and Chinese are utilized formally, however, the languages also been integrated into Malaysian culture and evolved into Malaysian English and Malaysian Chinese. However, Malaysian Chinese has preserved standard Chinese as opposed to the level that Malaysian English has preserved standard English. This has given rise to *Manglish*, which is actively used. According to Kai *et al.* (2021), *Manglish* is grammatically flawed and the respondents in the study often find themselves in a grammatical dilemma of justifying the use of *Manglish* or appearing grammatically incompetent.

In Kenya and Tanzania, the upsurge of code-mixing or *Swanglish* is an equal menace to linguistic competency. It involves the use of part of a word in English and the second part of the same word in Kiswahili and blending them to make a new bilingual *Swanglish* word. A phrase such as *uta-do* as opposed to the standard Kiswahili, *utafanya nini* (what will you do) is one of the examples in current parlance. Macha (2021) opines that *Swanglish* has "created a very bad generation of English and Kiswahili users". Its use is ubiquitous from youth in the streets to Members of Parliament. Kai *et al.* (2021) and Macha (2021) concur that grammatical incompetence can be attributed to a lax in the pedagogical systems in the respective nations.

2.3.3 Lack of Linguistic Awareness

A common challenge in *ad hoc* interpreting is lack of linguistic awareness. One of the characteristics of a trained interpreter as outlined by Moser-Mercer (1997) is the ability to monitor. The trained interpreter is always aware of the input from the speakers and his/her output. This affords the interpreter the opportunity to self-correct during the renditions and to improve in the long run. Masny (1997:106) defines linguistic awareness as the individual's ability to evaluate and relate their utterances to their knowledge of the language in question. Kai *et al.* (2021) remark that lack of linguistic awareness is observed in interpreters who cannot distinguish whether they have used standard or non-standard language for example *Manglish*, or *Swanglish* in the Kenyan context. Furthermore, those who lack such awareness do not find it necessary to change to improve the quality of their interpreting. Thuube (2015) upholds this view in his observation of an *ad hoc* interpreter who is a medical staff. The interpreter bizarrely renders the condition of arthritis as coldness of the bones. Despite the doctor's confusion upon that utterance, the interpreter makes no effort to self-correct.

2.3.4 Cultural Effect on Language

Wiersinga (2003:47) states that "the ability to interpret language codes and the ability to accomplish translation is partly a question of culture. Knowing how to render meaning within the prevailing cultural patterns is the ultimate way of bestowing real meaning at all levels". Interpreting relies on one's knowledge of the culture and language of the languages that they are working into. *Ad hoc* interpreters are hard pressed to convey messages effectively owing to lack of this knowledge. Usadolo & Kotzé (2014) cite the impact of dialects in the communicative process. An interpreter that does not have actual experience in encountering different dialects or accents contributes to a breakdown in communication.

Additionally, Munane (2014) confirms that a lack of knowledge of societal structures for example, where in the Maasai community men speak on their wives' behalf in public, can cause confusion and delay in delivery of care. Yet another pertinent example are cultural taboos. Certain cultural taboos dictate that women should receive medical service from female practitioners or certain diseases such as AIDS or conditions that are stigmatized in society should not be discussed. In addition, religion as part of culture has a profound effect on the interpreting process. Some religious sects will require their faithful to receive medical attention from doctors of the same gender, while others will forbid them to receive any medical care. The patient may be presented for care and object. The trained interpreter, being aware of cultural influences will seek further information. This may not be apparent to an *ad hoc* interpreter.

2.3.5 Voluntary Nature of *Ad hoc* Interpreting

Sobane (2014) asserts that the voluntary nature of *ad hoc* interpreting can be a source of dissatisfaction among its practitioners. 80% of *ad hoc* nurse interpreters in Lesotho view it as an inconvenience because it adds to the workload and is uncompensated. This negative attitude can lead to poor interpreting thereby affecting patient-doctor interaction, diagnosis, patient education and informed consent for further medical care. Sobane (2014) expounds further that some of the hospital staff refuse to interpret because it is not their responsibility, leaving the doctor and patient to navigate through their appointment on their own.

The other aspect of the unpaid nature of *ad hoc* interpreting, features language proficiency. *Ad hoc* interpreters perceive their service as one that benefits the community at their personal cost – time. Kai *et al.* (2021) validate this through their study where *ad hoc* interpreters use their volunteer status to defend their low standard of interpreting, since they are not remunerated for the

service. However, the lackluster attitude contributes to low self-motivation to better oneself linguistically. Ultimately, it is the community that is affected adversely.

2.3.6 Limited Working Memory

According to Kai *et al.* (2021), communication in non-professional community interpreting settings is mainly in short consecutive mode. It comprises of complex sentences, laden with varied subject -verb-object constructions, at times with idiomatic expressions, technical terms, to mention but a few. For the *ad hoc* interpreter, these factors are mentally taxing, causing cognitive limitations in their working memory. In their seminal work, Baddeley and Hitch (1974) in their development of the working memory hypothesis, explain how working memory is a system that has limits on the amount of information that can be stored and processed. The same system plays a vital role in communication logic and the understanding of one's style of speech. The untrained interpreter is therefore ill-equipped to counter these cognitive constraints because they do not have this knowledge and lack the strategies such as chunking, noting or regular practice to improve their interpreting. Kai *et al.* (2021) point out that the complexity of sentences in SL affect renditions to TL of gendered pronouns, tenses, cultural expressions (such as proverbs, sayings), idiomatic expressions, among others.

2.3.7 Errors That Affect Patient-Doctor Communication

Studies carried out mainly in casualty or emergency departments have shown a reasonable difference in the number or errors made by *ad hoc* interpreters in comparison to professional interpreters. Aitken (2019) reports potentially consequential errors at 12% for professional interpreters with less than 100 hours of training, in contrast to 22% when *ad hoc* interpreters are used. The most observed are errors of omission, addition, substitution and editorialization.

Cox *et al.* (2019) attest through several case studies, that untrained interpreters omit important details and terminology in questions that a physician directs towards the patient, while trying to ascertain the cause of a patient's discomfort. It is important to note that omissions mainly occur unidirectionally, from the physician's discourse. In addition, they exhibit the tendency to shift focus during consultations, thereby leaving sentences unfinished, disrupting the flow of conversation while stifling the patient's input. The researchers, note further, that at times *ad hoc* interpreters tend to answer questions on behalf of the patient (if a relative), without directing the question to the patient first. Omissions, therefore, are most likely to impact the patient-physician relationship negatively.

Thuube (2015) highlights the three errors of addition, substitution and editorialization in an inter-related way. This is because the *ad hoc* interpreter, takes "charge" of the role in a dominant way that the patient lacks contact with the physician. This is likely to occur when the interpreter is allied to the medical field. Errors of addition occur during the patient-doctor exchange especially in the initial stages of gathering information. The interpreter takes the liberty of asking for more information without the doctor's direct instruction.

Substitutions occur through the interpreter's decision to replace the doctor's words with their own, thereby eliciting different responses from the patient. An example that Thuube (2015) cites is the question "how do you feel?" replaced with "what else?" Furthermore, substitutions of the first, second or third person in sentences change the elicitation of questions from direct to indirect, which affect patient-physician relatability.

Errors of editorialization occur when *ad hoc* interpreters include their personal views while interpreting, denying the doctor control of the communicative exchange with the patient. Such views pre-empt the diagnosis or even later services that could be recommended by the physician, such as pharmaceutical, surgical, or counselling interventions.

Cox *et al.* (2019) argue that inaccuracies caused by addition have the least clinical impact. This could be because it provides more information that might be beneficial to the physician as s/he gathers the medical history. Substitutions can likewise be beneficial in terms of cultural brokerage and advocacy. The *ad hoc* interpreter who has some understanding of medical processes, can ease the concerns of a suffering patient who may be hesitant to receive, say, an important surgical procedure. Thuube (2015) differs in his view of substitution. He opines that it can create a distance between the language discordant doctor and patient. Editorialization can also contribute to this distance since the interpreter's expansion of the doctor's utterance, by his/her own views, can affect the patient's acceptance of the doctor's recommended actions.

2.4 The Relationship Between *Ad hoc* Interpreting and Patient Mediation

Nations such as the USA, have federal laws in place to enable people with LEP to access interpreters. Showstack *et al.* (2019) demonstrate the importance of access to interpreting service to monolingual Spanish speakers in Kansas, USA. Speakers of this group, have a strong sense of community and tend to experience worse health outcomes than monolingual English or bilingual English-Spanish speakers. In this system, physicians are dependent on interpreters to eliminate cultural impediments in the delivery of care.

In the African continent, on the other hand, linguistic diversity is considered a norm. Regrettably this fact has been used to ignore the need for medical interpreting, despite constitutional acts. Sobane (2014), points to the South African official languages Act of 2012 that promotes the parity of its 11 official languages to facilitate ease of access to government services. Sobane highlights the provincial language policy in Western Cape region that grants equal linguistic status to English, Afrikaans and IsiXhosa. However, most of the patients who are IsiXhosa speakers, do not benefit from professional interpreting services when in the care of their doctors who mainly speak English and Afrikaans. Instead, they receive *ad* hoc interpreting services from bilingual high school graduates, nurses, counsellors, or administrative staff. This reduces their access to equitable health care provided by the government. This situation is not unique to South Africa, in the African continent.

From the presented scenarios, it can be argued that marginalization of communities serves as an impetus for the use of untrained interpreting service in health care. This section examines the benefit of *ad hoc* interpreting in their patient-doctor interactions.

2.4.1 Language Proficiency

Language proficiency creates the greatest demand for *ad hoc* interpreting. This is because, in each environment, native speakers use their language fluidly and can appreciate its nuances and complexities. This is a great challenge to non-native speakers whether as migrants or second language speakers, despite the presence of language systems to facilitate communication.

According to Chauhan *et al.* (2020), there is continued use of untrained interpreters in countries where interpreter intervention is mandated by law or set as policy in health care institution. This is attributed to poor system support and reinforcement of policies for mandatory use of interpreter

services. This makes the system unreliable to the language-limited patients, thus driving the use of bilingual family members during doctor visits. In addition, Taira & Orue (2019) argue that there is a lack of sensitization of health care providers during their training on the importance of trained interpreter services. Language proficiency and language preference are a source of confusion for providers and patients alike, where without direct inquiry as to the level of linguistic competence that the patient possesses, the latter would not receive appropriate medical care.

Patients with limited language proficiency are seldom comfortable nor are they encouraged within their health system to develop their language skills. Khoong & Fernandez (2021) remark on the impact of the clinician's and patient's beliefs. Patients who lack confidence in communication in their second language will often ask a bilingual family member to interpret for them during hospital visits. Health care workers ingrain this mentality, as Pokorn (2020:6) cites how a Slovenian public health care worker told allophone patients to bring their own interpreters. Khoong & Fernandez (2021) elaborate on the failure of health care providers to empower their patients by informing them that they can request interpreter services should they feel dissatisfied with their communication encounters.

2.4.2 Socio-Cultural Factors

In occidental societies where interpreters are fully available in the healthcare system, some immigrant patients choose not to utilize their services. Hadziabdic *et al.* (2014) contend that some patients' family members feel that the objectivity of the interpreter makes them aloof. A family may not want the interpreter to deliver negative diagnosis to their relative, for example in the Serbo-Croat culture, where they do not believe in sharing bad news overtly. The bilingual family member being aware of this, must find a way of delivering the news gently being respectful of

cultural values. Hsieh (2003) affirms that this is a challenge for the interpreter, where s/he must be culturally aware and at the same time be cognizant of the potential conflict between the s/he and the physician if the information is not conveyed as well as the ramifications of that decision.

Crezee & Roat (2019) assert that there are concerns in establishing trust between patients and accredited medical interpreters. Patients explain that building trust with interpreters is difficult because they are assigned randomly. As a result of such an arrangement, their accessibility poses a fresh challenge because they cannot provide clarifications or follow up information beyond the consultation. Additionally, families have shared dissatisfaction with the higher register of medical terms used during interpreting sessions, that hamper their understanding. Owing to such frustrations, families prefer a bilingual family member as an interpreter because they are always available and can mediate in the continuity of care.

Stemming loneliness is another factor that causes patients to utilize *ad hoc* interpreters. Floríndez *et al.* (2020) observe that the Hispanic community in the U.S.A experiences communication, ethnic and cultural challenges. Its members have been victims of healthcare discrimination from health practitioners and lack access to helpful health care providers. This has led to an estrangement of LEP Hispanics in society. To their advantage, Hispanics have strong cultural values that transcend their national identities. Shared cultural values such as the importance of *familismo* (family) and *simpatia* (helping others), contribute to the use of bilingual family members or even strangers who are Hispanic to interpret for a fellow Hispanic.

Patients undergoing cancer treatment go to hospital with large groups of family members for moral support and to oversee the care of their loved one. The value of *simpatia* is evident when a bilingual Hispanic overhears a laboured conversation between a LEP Hispanic and a nurse, he

quickly steps in to assist, despite the ethical inappropriateness of it. In the absence of a professional interpreter, the LEP Hispanic can receive the required assistance instead of being excluded in the system. Many health care providers lack cultural awareness and view such practices among other things, as burdensome, inappropriate, and disruptive.

The unavailability of trained interpreters for varied language combinations is a drawback on encouraging the use of interpreting services. Smith (2018), notes that certain communities that have strong cultural adherence, such as the Chuuk from the Federated States of Micronesia, whose members migrate to the U.S. territory of Guam, tend to be disadvantaged in terms of access to trained interpreters. This situation is further exacerbated by institutions that do not have substantial budgets to cater for round-the-clock interpreting services. It should be noted that insurance companies do not pay for interpreting services, and as such, the institutions are solely responsible for the service. If at all, qualified interpreters are available for rare languages, they are not many. Therefore, the patients must wait for extended periods of time to benefit from their expertise. Unfortunately, many patients cannot afford to lose time and resort to readily available *ad hoc* interpreters.

2.5 Social Status and *Ad hoc* Interpreting

Cox *et al* (2019) observe that *ad hoc* interpreting services are often employed when an unscheduled clinic or emergency department (casualty) visit is necessary. In other circumstances such as those outlined by Floríndez *et al.* (2020) and Smith (2018), where there is cultural influence or a scarcity of interpreters of a particular language, then untrained interpreters are useful as mediators of communication. *Ad hoc* interpreters range from children, adolescents to adults of either gender.

Different communities and practitioners of ad *hoc* interpreting perceive this service in different ways.

2.5.1 Children *Ad hoc* Interpreters

Haffner's (1992) pivotal writing on her daily experience as a professional interpreter at Stanford University Medical Centre highlights the heavy burden of interpreting on children. Use of children, as young as 7 years old in interpreting puts them at risk for trauma from delivering difficult news such as a terminal medical condition or a death of a family member. Physicians have an upper hand in making this decision, failing to consider the emotional, psychological, and social well-being of the children. In such instances the health care providers insist that the use of children is warranted because they are the only bilingual family members and cite time constraint in waiting for the professional interpreter, who has many calls to attend to.

Orellana *et al.* (2003) elucidate that children are considered "invisible" in immigrant families. However, this "invisibility" sharply contrasts with the role that child interpreters take on, in facilitating communication that is crucial to their families. Interpreting flings the children to the forefront, as they interact with the monolingual service providers. Haffner (1993) elaborates how social hierarchy is significant in some immigrant cultures. Elders and heads of family are at the top, the family defers to them for decisions and leadership. She states that a family's social order is disrupted when a health care provider puts a child in control, via his/her role as an interpreter. The child is, inadvertently, in a much higher status than they ought to be. Consequently, the apparent shift in power dynamics affects the relationship between the child and the family. At the same time, the child must navigate, by themselves, the effects of the familial dynamics as well as the consequences of interpreting interventions, which distress many child interpreters.

2.5.2 Adolescent *Ad hoc* Interpreters/Health Care Brokers

Orellana *et al.* (2003) introduce "language brokers", a term that was coined in 1996 by Lucy Tse to describe children who mediate communication through interpreting and translating; between people who are culturally and linguistically discordant, in different social settings. Teenagers were the important linguistic link, especially in immigrant families. These are the middle- and highschoolers who are immersed in their new culture yet are part of their native cultures. The term language broker has now evolved and specialized, in the healthcare sector to adolescent health care broker.

Banas *et al.,* (2017) define adolescent health care brokering as the reliance of LEP patients on their adolescent children to interpret or translate necessary health-related information. The authors present the sense of familial contribution that adolescent brokers add to their families. The youth state that they are proud of their efforts in scheduling appointments, searching for more information online on the health challenges that the family member is suffering from, as well as their physical presence in offering moral support and interpreting. The instances of their participation range from simple one-time visits to multiple visits over an extended period. Banas *et al.,* (2017) observe that these adolescents, carry greater responsibility than their counterparts who do not take on the health care brokerage role. Iqbal & Crafter (2022) agree that the responsibility the adolescents' shoulder is great. These youth consider the position of power that comes with interpreting in a health institution as well as its consequences.

The adolescents are faced with several personal challenges in their service as healthcare brokers. According to Banas *et al.,* (2017), some adolescents perceive brokering as a burden. It denies them opportunities to carry out normal teen activities, such as socializing with their friends at

movies or playing video games. Others lament the fact that their relatives are culturally static, that they will not accept professional interpreting services, simply because they trust a family member more, who happens to be the bilingual teenager. In addition, the stress that is associated with the family's general efforts of assimilation to the new culture is noted as a contributor to negative emotions. Iqbal &Crafter (2022) include the sense of powerlessness that the teenager experiences considering a negative diagnosis of a family member. On the one hand, their contribution in the communicative process is positive but is the conduit for bad news. This emotional struggle is said to affect the adolescent health broker negatively.

Unlike the younger children who find themselves in a position of power but do not perceive it as such, adolescent health brokers are cognizant of a shift in societal power dynamic. Iqbal & Crafter (2022) observe that the adolescents' awareness of their native and host cultures, places them on a higher rung societally compared to their monolingual family members. To circumvent their position of power as a healthcare broker and maintain societal position, these youth employ different strategies such as withholding of information, delay in the relay of long, complex or controversial information or are biased with the pieces of information they choose to share. Russell (2019) affirms that such adolescents, give insight to the daily life of the patients to the physicians, which is important information to the physician. At the same time, they gain beneficial knowledge on how the health system works. All this, coupled with the fact that these are young people who are not fully mature, the amount the power they wield can affect the course of treatment of their family member, based on how they choose to disclose information.

2.5.3 Adult *Ad hoc* Interpreters

Kilian *et al.* (2021) present the untrained adult interpreter as a crucial link in the South African health system, be it in psychiatry or general medicine. In other parts of the world, as Cox *et al.* (2019) state, the adult *ad hoc* interpreter is present, to a large extent in emergency situations and non-routine clinical visits. These interpreters range from family members, friends, to bilingual hospital staff, that is nurses, cleaners, or counsellors.

There is a clear distinction in the type of communication intervention offered by adult *ad hoc* interpreters in comparison to the children and youth *ad hoc* interpreters. Their level of maturity is depicted in the manner with which they take charge of the conversation; as opposed to the relaying of messages and presenting of information, that is generally observed of their younger counterparts. The study by Kilian *et al.* (2021) reveals that the adult *ad hoc* interpreter takes on four roles as advocate, gatekeeper, cultural broker, and regulator of turn-taking.

In the role of advocate, the *ad hoc* interpreters not only speak on behalf of the patient but also demand a certain course of action or provide the patient with additional information that is related to their current health situation. Cox *et al.* (2019) remark on a male *ad hoc* interpreter who went to the emergency room with a female patient. He disclosed that the patient had suffered from the same condition before and asks for a similar treatment as they received in the past.

In his study, Thuube (2015) reveals that advocacy can occur inadvertently, at the expense of the consultation through overly enthusiastic interpreters who overstep their boundaries. Instead of letting the physician guide the patient, the *ad hoc* interpreter offers more information, related to the patient's condition, which had not been offered in the doctor's discourse. There is a difference in the type of advocacy that occurs between lay and professional (nurses) *ad hoc* interpreters. Lay

interpreters are allied to their patients, while health profession ad *hoc* interpreters can advocate for both physician (if a patient is not forthcoming with information) and patient.

As gatekeeper, the *ad hoc* interpreter controls the conversation between the two parties. They can withhold statements from the healthcare provider and from the patient (especially if the statements or questions are considered insignificant by the *ad hoc* interpreter). Kilian *et al.* (2021) show how nurse *ad hoc* interpreters converse with patients but refuse to relay the information to the doctors. Granted, some of the information is not related to the patient's condition, but is a statement related to a question that the doctor has asked. The authors of the study note that this role is arguably the one that makes physicians feel excluded.

Cultural brokerage is evident in the practice of many *ad hoc* interpreters living in the global north as minorities or in the global south where health care providers serve large populations who do not share a similar language or culture. Schouten *et al*. (2012) demonstrate, through their study of *ad hoc* interpreters of migrant families in Netherlands and Turkey, that despite the fact that interpreting takes them away from their daily activities, they cannot turn down a request to interpret because it is an opportunity to give back. At the same time it is, a way of ensuring their language has a place in society, a sort of defiance to assimilation in their new environment. Therefore, in their responsibility to interpret, they educate the health care providers on their culture, how certain topics are taboo and how best those topics can be handled.

Ad hoc interpreters regulate turn-taking by utilizing different strategies. Most common of these in interjection. Cox *et al.* (2019) and Kilian *et al.* (2021) portray untrained interpreters' use of interjection to enable transfer of messages from patient to healthcare provider. The word "wait" is used across cultures, in their equivalent, to signal the patient to allow the interpreter to render

the message. "And then" is used to beckon the patient to explain further if the doctor's question has not been answered comprehensively. Regulation of turn-taking can also occur through non-verbal gestures such as a pat on the arm or a nod, to encourage, mainly the patient to speak. However, Kilian *et al.* (2021) caution that interjections can be time-consuming and frustrating, in the presence of an overzealous *ad hoc* interpreter who usurps the doctor's position and denies him/her an opportunity to speak where necessary.

These roles that untrained interpreters assume are heavily influenced by society. Across different studies, female *ad hoc* interpreters are prone to interjecting and carrying the conversation. This is evident in the studies by Thuube (2015), Cox *et al.* (2019) and Kilian *et al.* (2021). Cho in Zhang (2022) remarks that this strategy is employed to "exercise micropower to ensure effective and efficient communication." The strategy is exhibited by allied health staff as well as friends or family members who serve as *ad hoc* interpreters.

Social status has a strong impact on adult *ad hoc* interpreting – conversation dominance. This can be categorized in two ways. Gender effect and social acclimatization. Cox *et al.* (2019) validate this through the cultural lens whereby a young Moroccan woman was represented by a male relative as her *ad hoc* interpreter. The male relative offered information on the patient's condition and answered all the questions. The researchers also show the effect social acclimatization in occidental nations. *Ad hoc* interpreters who are migrants that have acclimatized in their host nations, wield more power in communication and tend to have a higher status. Both male and female *ad hoc* interpreters speak for their beneficiaries, to the extent where the physicians demand the questions be directed to the patients. If the doctors do not rein-in the power of the interpreter,

the patient is not empowered to take charge of his health and understand the health system of his host nation.

2.6 Summary

This chapter has explored the communicative aspect of *ad hoc* interpreting, delving into the fundamentals of this practice and the perceptions and challenges that *ad hoc* interpreters espouse and encounter when they are called upon to interpret. The reason behind the continued use of untrained interpreters is discussed from the linguistic and socio-cultural perspectives. This allows for the appreciation on the issue of diversity in homogenous society and how tackling cultural differences is not as simple as asking allophones to forget about their languages. Finally, the chapter examines the different groups of *ad hoc* interpreters, the impact of interpreting on them in addition to the role they occupy in society, and the delicate balance in relations, as a result of this role.

CHAPTER THREE

Thematic Classification of Data from Health Facilities.

3.1 Introduction

This chapter presents the study's research design and thematic classification of data collected. The data presented here is primary in nature. These are audio-recordings of healthcare provider-patient consultations and semi-structured interviews.

3.2 Research Design

Schoch (2020), explains a case study as one that involves detailed analysis of a specific organization, event, situation, or social unit. In this study design, the focus is *ad hoc* interpreting in the social unit of the Luo community in Sarang'ombe ward in Kibra; where there is high ethnic language maintenance. The design further afforded the opportunity to gain deeper understanding of the clinical communicative process within this community. It features primary data, that is, audio-recorded consultations and semi-structured interviews with the administrators of the two health facilities. This follows the research methodology presented in chapter one.

3.3 Thematic Classification of Data from Clinic Consultations

The collected data is presented in this section. It is subdivided into the audio-recorded and interview data. Recording was carried out to satisfy the study's three objectives, namely
to identify linguistic gaps in communication mediated by ad hoc interpreters. Next, to investigate the process of *ad hoc* interpreting during patient-service provider interactions and lastly, to discuss the strategies applied by *ad hoc* interpreters to facilitate communication.

Interviews were carried out to acquire supplementary information according to the first two objectives.

The researcher collected 20 audio-recorded conversations. The recorded data was classified thematically: based on Language, Culture-specific topics, and Clinical terminology. Key excerpts have been included to demonstrate the thematic challenges. These themes have been adapted from the work of Kai *et al* (2021), in their classification of challenges faced by non-professional interpreters in Malaysia.

3.3.1 Language

Kai *et al.* (2021) underscore the following challenges in language: lack of intuitive grammar, use of non-standard language, lack of metalinguistic awareness, and the blended language culture (in this case, *Swanglish*). Code mixing, specifically, *Swanglish* is the use of part of a word in English and the second part of the same word in Kiswahili and blending them to make a new bilingual word. All the consultations where linguistic challenges were noted, have been classified as outlined in section 3.3, and recorded in this section. Of note, all consultations feature the attending clinicians as the *ad hoc* interpreters.

<u>Consultation 1 (Support Clinic): Female, 48 years old</u>

The patient went to pick up anti-retroviral medication, communication occured in Kiswahili. The nurse was familiar with the patient and spent a moment in pleasantries as she sought information on the last occasion the patient's blood sample was collected. The nurse informed the patient that the last sample showed an increase of positive cells, using code-switching. Deuchar (2020) describes code-switching as the practice by which a bilingual will borrow a word (s) from say their first language and use it in a speech in the second language, and vice versa. It is also referred to as 'on-the-spot borrowing' or 'nonce borrowing'. The nurse did not render the word 'copies' into Kiswahili to the patient though the patient, seemed to understand the message being conveyed.

Additionally, there was use of non-standard Kiswahili as evidenced in code-switching and lack of metalinguistic awareness in the words *miezi nne* as opposed to *miezi minne*.

Excerpt 1: *Consultation 1 (Support Clinic)*

	Statement	**Translation**
Nurse	*Hii ya mwisho imetoka, imetoka, lakini* ***copies zimeonekana****. Kuna siku ulikosa kumeza dawa?*	Results from your previous tests are available, but copies (increase in positive cells) are evident). Is there a day you did not take your medication?
Patient	*Ah ah*	No
Nurse	*Ama ulimeza kuchelewa?*	Perhaps, you took medication later?
Patient	*Niseme nikuchelewa tu na ni ma-seconds lakini si hata masaa*	I would say it was a slight tardiness, but only by a few seconds, not by hours
Nurse	*Shida ya kukohoa? Hakuna, Shida yoyote nyingine? So nikikupee dawa ya* ***miezi nne*** *utameza vizuri?*	Are you suffering from coughs? Do you have any other concern? So, if I give you medication for four months, will you take it properly?

Consultation 2 (Ante-natal/Support Clinic): Female, 25 years old

The patient arrived from Mbita. Her bag, which contained her child's medication was stolen during the trip. The patient expressed herself in Kiswahili that had a *Dholuo* accent. The health care provider's responses were in Kiswahili but there was code-switching in certain responses.

Consultation 3 (Ante-natal/Support Clinic): Female, 24 years old

This patient attends the clinic for her ante-natal care; however, her attendance became infrequent. She communicated in Kiswahili and was mainly reliant on the support group for information whenever she did not attend clinic. The nurse was friendly with her, as she encouraged her to share her current state of health. The clinician used non-standard Kiswahili that features code-switching and *Swanglish* as captured below.

Excerpt 2: *Consultation 3 (Ante-natal/Support Clinic)*

	Statement	Translation
Nurse	*Ah, ah. Tetanus unafaa ukumbuke. Umekuja clinic mara ngapi, mara mbili so far, si ndiyo. Hii ni mara ya tatu, naona tu mara mbili.* ***The last time ilikuwa July***	No. You should remember whether you got the tetanus shot. How many times have you attended clinic? Twice, so far, isn't it? This is the third time. I can only see two attendances. The last time was July.
Patient	(inaudible)	
Nurse	***Usicount*** *eh, support group. Clinic umekuja mara mbili? Clinic, ndiyo nijue kama* ***umepewa shindano*** *niangalie*	Do not include the support group attendance. Have you come to the clinic twice? So that I can ascertain whether you have received the (tetanus) vaccination
Patient	*Si ni, sijakuja mara nyingi*	Well…I have not attended frequently

The nurse used the Swanglish version *usicount* instead of *usihesabu*, while taking count of the number of clinic visits the patient has made. There was lack of language sensitivity as the nurse used the word *shindano* which means competition in lieu of *sindano* that is, in context *kudungwa sindano* which means to be vaccinated or injected. Furthermore, she did not offer the Kiswahili equivalent of tetanus (*pepopunda*) to the patient. This patient seemed to have a challenge in understanding English-only phrases, as follows:

Excerpt 2 continued

	Statement	Translation
Nurse	*Nisipokudunga unajua tutasahau. Umepimwa kweli kilo hapo nje? Nimekupima weight?*	If I don't vaccinate you, we will forget. Has your weight been measured, outside? Have I measured your weight
Nurse	**To check how you are doing. Today you will get two injections**	

Patient	*Hmmm?*	(not understanding)
Nurse	***Leo unaenda kudungwa mara mbili. Nikikudunga tetanus na ukitolewa damu*.**	Today, you will receive two injections. I will give you the tetanus vaccine and your blood will be drawn

The nurse interpreted the statement (in bold) when she perceived that the patient's failure to understand. Where conversation flowed with code-switching or *Swanglish*, interpretation was not considered.

<u>Consultation 5 (Wellness/Nutrition Clinic): 4-month-old baby, Mother: 23 years old.</u>

The mother brought her baby to the baby wellness and nutrition clinic and was being taught the importance of exclusive breast feeding and how frequently it ought to be done. The parent offered very terse responses or at times monosyllabically to show agreement. The nurse explained in detail, and although she utilized code-switching, she explained certain concepts in both Kiswahili and English, blended with *Swanglish.*

Excerpt 3: *Consultation 5 (Wellness/Nutrition Clinic)*

	Statement	**Translation**
Nurse	*Kama, kuna wale wako lazy, ameamka na anasikia njaa. Badala alie, ako tu. So wewe una-make sure every two hours, sawa?*	For instance, there are those that are lazy (babies) who will wake up and are hungry. Instead of crying, they will lie still. So, ensure (you nurse) every two hours, alright?
Parent	Mm	
Nurse	*Eeh. Si lazima kama analala, tunamwambia 'baby amka' unamshikashika. Unambeba tu, unaweka* ***chuchu yako,*** **nipple** ***yako***, *hivyo*	Yes. You do not have to nurse the baby when he is asleep. We wake him up by saying " wake up, baby", pat him severally. Simply carry him and place your nipple (in his mouth), like that

Parent	Mmm.	
Nurse	*Ndiyo maana tunasema haufai kufanya maziwa yako, kumnyonyesha hivi inakata hiyo mishipa.* (Demonstrating the index and the middle finger, placed on the top and bottom of the breast in a scissor-cutting pose) *Unaona kuna mishipa. Hizo ni ya kutransport maziwa,sawa ? So hakuna kukata, hiyo ni kuscissor. Sawa?*	That is why we say that you should not do that to your breast. It prevents the milk from flowing. Can you see the ducts? Those transport milk, alright? So, do not inhibit the flow, that is 'scissoring'. Alright?

<u>Consulation 6 (Wellness/Nutrition Clinic): 11-month-old baby, Mother: 22 years old</u>

The mother presented her child, who had been weaned. The parent received nutritional advice on the best food options for the child. The young lady was conversant with English, with some challenges in health literacy. She felt free to ask questions where she did not understand but did it in Kiswahili. The conversation between the health care provider and the parent is a blend of English, Kiswahili and non-standard Kiswahili, exemplified with the use of words such as *unampatianga* as opposed to *unampa.*

<u>Consultation 7 (Wellness/Nutrition Clinic): 3-month-old twins, Mother: 21 years old</u>

The mother brought her twins, one of them was reported to be warm. The clinician sought to clarify whether the child was too warm or had a fever, by giving the equivalent in Kiswahili – *joto*, the mother affirmed. Once again, there are multiple occurrences of code-switching and use of non-standard Kiswahili.

Consultation 9 (Wellness/Nutrition Clinic): 1 year old toddler, Mother: 27 years old

The toddler had to take a vitamin supplement orally. To encourage the child to take the medication, the nurse encouraged her to take *nyamnyam*, which is non-standard Kiswahili, a form of baby language, for a food item that is delicious.

Consultation 11 (Wellness/Nutrition Clinic): 6-week-old baby, Mother: 36 years old

The conversation between the nurse and parent was open. As with other instances, there is code-switching. As seen in excerpt 4, some interpreted phrases lack Kiswahili equivalents, for example, "*kilo kulingana na* age" (which should be *uzito kulingana na umri*) is stated correctly as "weight for age". There is also a lack of language sensitivity in the statement, "*nabeba na shingo"* which ought to be *nambeba kwa shingo*, that is, to carry (the baby) by the neck.

Excerpt 4: *Consultation 11 (Wellness/Nutrition Clinic)*

	Statement	**Translation**
Nurse	*Ah, ah, mmbebe X vizuri. Mkono inakua, so sishiki mkono* ***nabeba na shingo****. Eh. Haya mpeleke kule. Pole pole asigonge kichwa, hiyo ni mbao.* Make sure *amefika mwisho. Songa tu karibu na yeye. Haya, toa mkono yako hapo chini, shikilia juu. Kichwa yake iko vizuri.*	No, carry X properly. Her arm is developing, so I don't use the arm, I lift her by the neck. Yes, take her there. Gently, so that she doesn't bump her head. That is wood. Make sure she touches the tip of the board. Move close to her. Now, remove your arm from underneath her. Put your hand on top of her head. Her head is stable.
Parent	Mm, eh	Yes
Nurse	*Ako na* 3.9kg, *Urefu… mvalishe tukiongea, urefu ako na* 57.2 cm.	She is 3.9kg, height… dress her as we speak, she is 57.2 cm tall.
Parent	Mm	Yes
Nurse	***Kilo kulingana na*** **age, weight for age**, *eh, ako normal. Si yuko* six weeks?	Weight for age, she is within range. Isn't she six weeks old?
Parent	*Eh, ako* six weeks	Yes, she is six weeks old

Consultation 12 (Out-patient Clinic): 3-year-old child, Mother: mute, 30 years old

This consultation was unique, due to the parent's inability to communicate verbally. It was mainly carried out through gestures. The clinician spoke to the child in English and Kiswahili, code-switching to a lesser degree. After examination, he gestured to the mother to follow him to the pharmacy for assistance with the child's prescribed medication.

Consultation 13 (Out-patient Clinic): 7-year-old child, Mother: 35 years old

The conversation between parent and clinician was clear, but there was use of code-switching. The clinician interpreted certain words, for example *joto* for fever. Lack of language sensitivity was evident, in statements such as *meno inauma*, *masikio inauma* as opposed to *meno/masikio yanauma.*

Consultation 14 (Out-patient Clinic): 3-year-old child, Mother: 24 years old

Concurrent with the previous conversation, there was use of code-switching. The mother was comfortable speaking Kiswahili, as she described how the child had bouts of diarrhea and vomiting. She followed the conversation despite the doctor's intermittent use of English words.

Consultation 15 (Out-patient Clinic): Female, 23 years old

This consultation featured code-switching as well as *Swanglish*. The patient was very insistent on how she felt to the point where she suggested what type of treatment would be effective. The doctor upon examining her, explained what the findings were, employing *Swanglish* in statements such as "*hizi* lymph nodes *zime*-swell" (these lymph nodes are swollen) and "*uko*-sure *hazijakusaidia*" (are you sure (the medication) has not been effective).

<u>Consultation 17 (Outpatient Clinic): 1 year 5-month-old toddler, Mother:27 years old</u>

The parent had good command of Kiswahili and described the child's symptoms well. There was code-switching on the doctor's part, as seen in this statement "any sound *inatoka* kwa chest?" (does the chest produce any sound?), to which the mother responded in Kiswahili.

<u>Consultation 18 (Outpatient Clinic): Adult 24 years old</u>

Interaction in this consultation was brief since the patient had come to pick up a prescription for medication that she used regularly. It was straight forward as the English words used pertain to the medication. The health care provider explained the role of the two types of medication that she would use, very clearly in Kiswahili.

3.3.2 Culture-Specific Items

The following consultations feature cultural perspectives that would otherwise influence the course of treatment. Culture specific items featured here were myths and personal attitudes.

<u>Consultation 4 (Wellness/Nutrition Clinic): 10-month-old baby, Mother: 23 years old</u>

This consultation tackled a dietary misconception that is commonplace in the community. The nurse spoke to the patient in both English and Kiswahili, code-switching as well as non-standard Kiswahili on a few occasions. She interpreted some of the English words and on other occasions, explained the situation surrounding the use of that word. This demonstrated the effect of myths in society on health. The advice the clinician offered was corrective and informative.

Excerpt 5: *Consultation 4 (Wellness/Nutrition Clinic)*

	Statement	**Translation**
Nurse	*Sasa, unamlisha vizuri sijakataa lakini kwa hii picha, hizi ni vyakula tunakuanga nazo ama si zile hatukuangi nazo ama hujawahi ona hizi vyakula ziko hapa chini?*	Now, I cannot deny that you are feeding her well but, in this photo, do we have these foods (in our community) or don't we or you have never seen these types of food, shown here below?
Parent	*OK ziko but hatukuangi nazo.*	Yes, they are available, but we do not have them
Nurse	*Ziko. Number 1, hii ni example. Usiende kwa nyumba usiseme nashinda nikisema tukule nyama. Number 1, lazima ujue your* ***financial aspect****, sawa,* ***pesa yako****. Ukishajua financial aspect yako, vile unabudget nayo….so una make sure chakula ya mtoto iko na hizi zote, ten food groups. Utatumia kitabu yako pia inayo. Hebu penduka uangalie hiyo chart. Part 2.*	They are available. Number 1, this is an example. Do not go home and report that I insist you eat meat. Number 1, you must know your financial aspect, alright, your money. Once you know your financial aspect, the way you budget it…so make sure the baby's food has all these ten food groups. You can use your book; it is also there. Could you turn and look at the chart. Part 2
Parent	***Hataongea. Ati ukipea mtoto mayai ulimi itakuwa mzito***	She will not speak. If you give eggs to a baby, the tongue becomes 'heavy'
Nurse	*Sababu alikuambia ukipea mtoto mayai hataongea*? ***Hizo ni myths****. Fact is, mayai inakuanga a good source of protein. Mtoto usipomwongelesha, haumwelezi…tuseme unamwambia "mama vaa atu" unaongea ile lugha yenye anasikia. Usiongee ile lugha yake*	What are the reasons she gave you to support the idea that when a child eats eggs they will not speak? Those are myths. The fact is eggs are a good source of protein. If you do not speak to a child, you do not explain…say, you tell her "Sweetie, wear 'oos" speaking in the language she hears. Do not speak her language.
Parent	*Ile ya kitoto*	Baby talk

Consultation 19 (Outpatient Clinic): Adult male 57 years old

The patient returned from Ahero and complained of joint pains, fever and difficulty in breathing. The conversation was in Kiswahili, English, mingled with code-switching. The doctor observed a symptom the patient had not described and resorted to question the patient in Dholuo. He did this to understand the intensity of a specific symptom, since the patient was very talkative and presented multiple symptoms.

Excerpt 6: *Consultation 19 (Outpatient Clinic)*

	Statement	**Translation**
Doctor	*Mapua inafungana, ni kama uko na homa*	Your nose is blocked, you likely have a flu
Patient	Mmhm	Yes
Doctor	*Nimesikia ukikohoa*	I have heard you coughing
Patient	*Imejaa kwa kifua yangu*	My chest is congested
Doctor	***Ifwolo****?*	(In Dholuo to understand the intensity of the cough)
Patient	Responds in *Dholuo*	
Doctor	Headache? Kichwa haiumi, si ndiyo?	Headache? You do not have a headache, do you?

3.3.3 Clinical Terminology

The consultations below captured the challenge of terminology equivalents and how conversation surrounding those terms was managed.

Consultation 16 (Outpatient Clinic): Adult female 50 years old

This consultation was conducted in Kiswahili. The use of non-standard language was prevalent, but the conversation seemed to flow between patient and healthcare provider. The patient spoke in

Kiswahili but appeared to have a challenge understanding some words in English that she was not familiar with. The doctor interpreted his question into Kiswahili, as seen in the excerpt below.

Excerpt 7: *Consultation 16 (Outpatient Clinic)*

	Statement	**Translation**
Doctor	Elaraprine *ni ya? Sukari ama presha?*	What is elaprine used to control? Diabetes or high blood pressure?
Patient	*Ni ya sukari. Ni, ni ya presha.*	It is for diabetes; it is for high blood pressure
Doctor	*Na ya sukari*	What about medication for diabetes
Patient	Glucomate	
Doctor	Glucomate**.** **dosage**? (Brief pause as patient looks at clinician)	
	Unameza aje?	How do you take the medication?
Patient	Glucomate? *Asubuhi na jioni*	Glucomate? In the morning and evening

Consultation 20 (Outpatient Clinic): Adult female 33 years old

The patient returned for a new prescription since her condition had not improved. It was the same physician who attended to her during the previous visit. Conversation was in Kiswahili with instances of code-switching. The patient described her condition, with a bit of trepidation but later spoke up. The doctor named the area of concern in English but did not offer its equivalent in Kiswahili.

Excerpt 8: *Consultation 20 (Outpatient Clinic)*

	Statement	**Translation**
Doctor	*Leo uko na shida gani?*	What are you suffering from, today
Patient	*Kuna shida yenye ilinileta last time, nilipewa dawa na ninasikia ni kama imerudi tena.*	There is a problem that brought me here the last time, I got medication and I feel that it has recurred
Doctor	*Imerudi siku gani, imerudi lini ?*	What day did it reccur, when did reccur?
Patient	*Juzi, jana.*	Day before yesterday; yesterday
Doctor	*Uko na shida gani, by the way?*	By the way, what is the problem?
Patient	*Ni kuwashwa huku chini*	I am itching in my nether region
Doctor	***Chini kwa* vagina**	Below, in the vagina

3.4 Interviews

Interviews were carried out to obtain information that could not be gathered during the observation process as patient numbers vary daily. Furthermore, the interviews targeted the second objective which sought to gain more information on the *ad hoc* interpreter-mediated communication process, from the facilities' administrators' perspectives.

3.4.1 How Many Patients Does Your Facility Serve Daily?

Approximately 5 patients daily, visited UHC. This number was much higher prior to the Covid-19 pandemic and opening of the nearby Level 3 Government hospital. This clinic charges a nominal fee, whereas treatment is free in the public hospital. TC on the other hand, sees to 200 patients daily, in their different departments with approximately 35 patients daily in the outpatient clinic. Patients pay a nominal consultation fee as well.

3.4.2 Does This Facility Offer English-Kiswahili Interpreting Service?

The two health facilities do not provide qualified interpreting service. According to the TC's administrator, the cost of hiring qualified interpreters is prohibitive for a not-for-profit organization

as theirs. Instead, interpreting services are offered through the clinic staff, which includes the health care providers. UHC also relies on external partnerships for their activities. Consequently, its interpreting burden falls on staff that are fluent in English, Kiswahili, Luo, Luhya and Kikuyu. At TC, the language competency is similar in English, Kiswahili, Luo, Luhya and Kisii. In addition, TC has a nurse that is trained in sign-language interpreting. This clinic prefers to maintain interpreting services among its staff because of patient confidentiality and trust.

3.4.3 What Are the Factors that Affect Choice of *Ad hoc* interpreters?

There are patients, especially on their first visit, who lack proficiency in English and Kiswahili and opt to be accompanied by a family member or friend to act as *ad hoc* interpreter. Unlike other studies that suggest that such patients may consider the gender, social status, or level of education of their interpreters; these factors are not as important in the Sarang'ombe setting. The two important factors are the level of trust between the patient and the *ad hoc* interpreter, as well as the interpreter's fluency in the required languages. This level of trust is extended between clinicians and repeat patients who are not fluent in any of the languages mentioned. The patients are comfortable with the degree of care and communication of their healthcare providers.

3.4.4 Do Socio-Cultural Factors Affect Health Service Provision and How Are They Dealt With?

Communal and religious beliefs are a constant challenge in health provision. Both health facilities deal with these socio-cultural factors on a regular basis. Myths, communal culture, religious teachings affect patient up-take of important information. Patients compare their lab tests, while in the waiting room, assuming they need to be similar. Religious teachings, for example on the use of contraceptives, is met with trepidation among many residents. As a result, the health

facilities must invest in community health education sessions. UHC has a counsellor on site to explain to the patients the importance of the services that everyone receives, and why they vary from patient to patient. TC offers individual counselling and conducts regular education sessions to their patients on the importance of setting aside negative cultural values in favour of their health. These lessons are taught at the patients' levels, over different health topics.

3.4.5 How Do You Deal with Your Patients' Language Needs?

TC and UHC value their patients' ability to express themselves during the consultations. UHC's administrator notes that their staff's capacity to communicate in ethnic languages that are common in the area, is a motivation for patients to communicate in vernacular. Some patients have been observed, to enter the consultation room and assuming ethnic connection to the clinician, switch from Kiswahili to their mother tongue. TC's approach is more formal, as patients register, they are asked if they understand Kiswahili. They are then asked for their preferred language, in Kiswahili. Depending on the response, they are assigned to a clinician that understands their mother tongue, or if in Kiswahili, to the next available clinician.

3.5 Summary

This chapter presented the primary data from clinic observations and semi structured interviews with hospital administrators. The data has been summarized, with key excerpts of the three selected themes included. All the consultations featured use of English, Kiswahili, code-switching and *Swanglish.* There are only four consultations where interpreting was employed. Key excerpts were transcribed in full, together with the two interviews. They can be found in the appendices section.

CHAPTER FOUR

Analysis of the Clinician-*Ad hoc* Interpreter Communication Process

4.1 Introduction

Lester *et al.* (2020) convey the importance of qualitative data analysis in bringing meaning to a particular observed phenomenon, that is rich and distinct in its nature. Furthermore, given the nature of qualitative data such as observation, conversational data, semi-structured and structured interviews, there cannot be a single way of analyzing this data. It is therefore necessary "to find ways of using the data to think with."

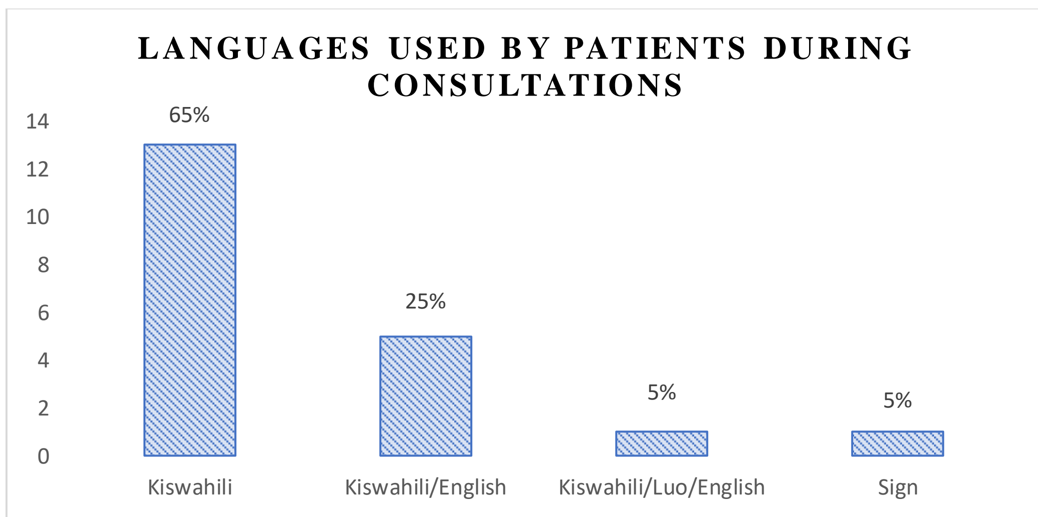
In this chapter, the themed data presented in chapter three was analyzed based on the satisfaction of the research objectives. The communicative process between the clinicians and patients will be analyzed concurrently through the Communication Accommodation Theory (CAT), developed by Howard Giles in 1971. This theory focuses on how communication occurs between the speaker and listener, accommodating each other verbally and nonverbally. In exploring how the clinicians and patients in this study accommodate each other in their discourses, accommodation will be analyzed through convergence, divergence strategies and social beliefs aspect of the CAT as discussed in chapter one. Ultimately, the *ad hoc* interpreters' performance will be evaluated according to Moser-Mercer's strategies.

4.2 Patient Language Profile

Majority of patients in the subject area use Kiswahili in communication, outside of the domestic setting. There is use of English, albeit sporadic, during the consultations. It is used by some of the patients or parents in their 20s and the only male patient. This could be explained by the fact that the area has several public and small private schools, where English is used as a language of

instruction. Kiswahili is the *lingua franca* for those who have attended these schools and for those who have come from the rural areas. This contrasts with the clinicians, whose language of instruction and conversation is predominantly English. Some of the clinicians in the study, prior to their appointments in Kibra, had been working in clinics and hospitals in settings where English was the primary language used during consultations.

Figure 4: *Languages Used by Patients During Consultations*



Graph depicting languages used by patients and their percentage of use.

According to the bar graph, Kiswahili (albeit, non-standard) remains the dominant language of communication, from the patients' perspective. The number of conversations that have interjections of *Swanglish* and code-switching are greater on the clinicians' part than the clinic attendees. The use of *Swanglish* and code-switching among health care providers has an impact on their role as communicators and *ad hoc* interpreters in Kiswahili.

In terms of the patients who visited the facilities during data collection, 95% of clinic attendees accounted for in this study were female, this included patients and parents of minors who were unwell. 65% of these attendees were below the age of 30. This could account for the use of

Swanglish, because the clinicians assume understanding of English for this younger group, despite Kiswahili being their preferred language of communication. In instances where communication progressed in English and the clinician sensed discord, the clinician rephrased the statement in Kiswahili (standard and non-standard).

The following table presents the information in the preceding page, as a representation of patient attendance in TC and UHC on the days of data collection.

Table 1: *Patient Profile and Languages used During Consultations*

Serial no.	**Gender**	**Age (years)**	**Language used**
1	Female	48	Kiswahili
2	Female	25	Kiswahili
3	Female	24	Kiswahili
4	Female	23	Kiswahili
5	Female	23	Kiswahili
6	Female	22	Kiswahili/English
7	Female	21	Kiswahili
8	Female	24	Kiswahili/English
9	Female	27	Kiswahili
10	Female	24	Kiswahili
11	Female	36	Kiswahili
12	Female	30	Sign
13	Female	35	Kiswahili/English
14	Female	24	Kiswahili
15	Female	23	Kiswahili/English
16	Female	50	Kiswahili
17	Female	27	Kiswahili/English
18	Female	24	Kiswahili
19	Male	57	Kiswahili/Luo/English
20	Female	33	Kiswahili

4.3 Classification of Linguistic Gaps in Communication Mediated by *Ad hoc* Interpreters

Interpreting tasks in these two health facilities, according to the facility administrators, are carried out by clinic staff or trusted family members or friends. However, during data collection for this study, it is the attending clinician that took on the role of *ad hoc* interpreter when communication with the patient was discordant. He therefore served as a clinician-interpreter. Unlike in many medical interpreting situations where the setup is triadic, that is involving the clinician, patient, and interpreter; the set up in this study is dyadic. It involves the patient and the clinician who also serves as interpreter.

4.3.1 General Language Equivalence Gaps

As seen in most of the excerpts, there is a knowledge gap of equivalents in Kiswahili. The clinician-interpreters were less fluent in Kiswahili as evidenced by many statements where they utilized both formal and informal registers. They employed code-switching, code mixing – that is *Swanglish* and English. Out of the 20 cases, there were four cases where interpretation was noted. There was one case of interpretation of a statement (consultation 3); another where a term was interpreted to Kiswahili (consultations 5); one where a term was described in Kiswahili for the patient's comprehension (consultation 16); and lastly one where the clinician gave the patient the English equivalent of a concept she was describing (consultation 20).

Low rates of interpreting to Kiswahili can be attributed to the language options available to the clinician and the level of understanding in the community. The clinicians' principal language of training is English. This contributes to the frequency of falling back on *Swanglish* and code-switching instead of using Kiswahili. *Swanglish* and code-switching employ Kiswahili words

either in blended form or alternated with English words. As a result, some patients can decipher the conversational thread from the Kiswahili words.

A supporting suggestion is presented by Sobane (2014) about the voluntary nature of *ad hoc* interpreting. These health facilities operate on limited budgets and the interpreting duty is an addition to the daily tasks. According to Sobane, the voluntary nature affects the quality of interpreting, especially language proficiency. Equivalence is an important aspect of language proficiency and in the delivery of messages. The practitioner may not feel tasked to perfect the second language, but instead, can utilize other means such as *Swanglish*, to interpret

This emphasizes the need for strengthening Kiswahili interpreting because the current state of *ad hoc* interpreting by the clinicians does not fully employ Kiswahili, the LWC. Some patients cannot comprehend English and rely heavily on Kiswahili or their ethnic language. There is also a high likelihood that in code switching and use of different registers, some patients may miss crucial pieces of information. What worsens the situation is that many patients do not raise questions when they do not understand. Unless the clinician really probes or repeats the initial inquiry. This may not be possible all the time, because it depends on the daily patient load.

The four cases where interpreting occurred were analyzed below to understand the communication process between the patients and health care providers as well as the importance of those interpreting interventions. The strategies from CAT were utilized to facilitate this understanding.

Application of Convergence Strategy in General Language Challenges

<u>Consultation 3: (Ante-natal/Support Clinic): Female, 24 years old</u>

Consultation 3 is the only case where the clinician interpreted an entire statement, into Kiswahili, yet without an equivalent for the infection (tetanus: *pepopunda*). This is because the patient failed to understand the statement in English. As seen in excerpt 2, The nurse's quick interpretation resolved that social difference. Unbeknownst to the nurse, she utilized the convergence strategy to ensure that she and the patient are on the same communication level. This was vital in ensuring that the patient understood the instructions and was comfortable enough to execute the instructions. By expressing the next course of action in Kiswahili, the clinician gained the approval of the patient, through her compliance in receiving the injection and giving a blood sample.

Excerpt 2: *Consultation 3: (Ante-natal/Support Clinic)*

	Statement	**Translation**
Nurse	*Nisipokudunga unajua tutasahau. Umepimwa kweli kilo hapo nje? Nimekupima weight?*	If I don't vaccinate you, we will forget. Has your weight been measured, outside? Have I measured your weight
Nurse	**To check how you are doing. Today you will get two injections**	
Patient	*Hmmm?*	(Does not understand)
Nurse	***Leo unaenda kudungwa mara mbili. Nikikudunga* tetanus *na ukitolewa damu*.**	Today, you will receive two injections. I will give you the tetanus vaccine and your blood will be drawn

<u>Consultation 5 (Wellness/Nutrition Clinic): 4-month-old baby, Mother: 23 years old.</u>

Excerpt 3: *Consultation 5 (Wellness/Nutrition Clinic)*

	Statement	**Transcription**
Nurse	*Kama, kuna wale wako lazy, ameamka na anasikia njaa. Badala alie, ako tu. So wewe una-make sure every two hours, sawa?*	For instance, there are those that are lazy (babies) who will wake up and are hungry. Instead of crying, they will lie still. So, ensure (you nurse) every two hours, alright?
Parent	Mm	
Nurse	*Eeh. Si lazima kama analala, tunamwambia 'baby amka' unamshikashika. Unambeba tu, unaweka* ***chuchu yako,*** **nipple** ***yako****, hivyo*	Yes. You do not have to nurse the baby when he is asleep. We wake him up by saying "wake up, baby", pat him severally. Simply carry him and place your nipple (in his mouth), like that

In consultation 5, the clinician interpreted the word *chuchu*, the Kiswahili term for nipple into English. Many speakers of Kiswahili are familiar with the term *titi* for breast but not the specific terms for different parts of the breast such as *chuchu* for the nipple. However, the English term, nipple is more familiar. This could be the reason why the nurse chose to mention the term in both Kiswahili and English. It should be borne in mind, that she was speaking with a young mother, who most likely understands English. She utilized the convergence strategy through stylistic flexibility by speaking *Swanglish* to ensure that the patient understood the importance of frequent nursing and how it should be done. This was approved by the patient who responded outwardly with an affirmative nod. The patient in this consultation mostly responded in the affirmative "Mm". There were exceptions where she communicated in Kiswahili when responding directly to questions posed by the clinician.

Consultation 16 (Outpatient Clinic): Adult female 50 years old

The consultation that follows, Consultation 16, featured a case of paraphrasing into Kiswahili. The clinician was following up on the patient's awareness of the drugs that she has been prescribed. The doctor's inquiry in English, baffled the patient. Upon recognition, the clinician utilized the convergence strategy by accommodating the patient linguistically. He did this by interpreting the statement to Kiswahili. He also applied stylistic flexibility when he could not offer the equivalent of dosage (*kipimo*) but instead paraphrased in Kiswahili to "*unameza aje?*" (excerpt 7). This elicited a response from the patient, bridging the socio-linguistic difference.

Excerpt 7: *Consultation 16 (Outpatient Clinic)*

	Statement	**Transcription**
Doctor	Glucomate. Dosage?	(Brief pause as patient looks at clinician)
	Unameza aje?	How do you take the medication?
Patient	Glucomate? *Asubuhi na jioni*	Glucomate? In the morning and evening

Consultation 20 (Outpatient Clinic): Adult female 33 years old

Consultation 20 highlighted in excerpt 8 presented an interpretation to English as the patient described her area of discomfort in Kiswahili. Even though the clinician did not offer the Kiswahili equivalent of vagina (*uke*), the clinician, managed to apply the convergence strategy in an unconventional way. Convergence reduces social difference between the speakers through linguistic accommodation, mainly through speaking a common language. However, in this case, convergence occurred in the psycho-social level of language where the societal male-female conversational topic restrictions were eliminated. The male clinician, by speaking openly and naming the specific area that the female patient was talking about (in a coy manner), gained the

patient's approval. This was evident in the patient's subsequent state of ease and disclosure of her suffering in detail

Excerpt 8: *Consultation 20 (Outpatient Clinic)*

	Statement	**Transcription**
Doctor	*Uko na shida gani, by the way?*	By the way, what is the problem?
Patient	*Ni kuwashwa huku chini*	I am itching in my nether region
Doctor	***Chini kwa* vagina**	Below, in the vagina

Application of Divergence Strategy in General Language Challenges

Consultation 3: (Ante-natal/Support Clinic): Female, 24 years old

In excerpt 2 of Consultation 3, the clinician and patient were not at a point of communication symmetry when the nurse spoke in English. The patient, as a participant in the communication process utilized the divergence strategy. The patient's identity is through her language and divergence seeks to maintain one's social identity in the communication process. Consequently, the patient's "hmmm?" expression of lack of understanding, pointed out to the health care provider that she did not identify with English. This directed the clinician to remember her patient's language preference and interpreted the statement, for their mutual benefit. Through this accommodation, the clinician gains continuity of care and the patient receives the medical treatment that is crucial for her and her unborn child.

Consultation 16 (Outpatient Clinic): Adult female 50 years old

The patient's pause and look (excerpt 7) are akin to that in Consultation 3 (where the patient uses the sound "hmm?"). It alerted the clinician that she did not understand what was being said. This is a non-verbal divergent strategy to remind the clinician of her social identity as a speaker whose

preferred language was Kiswahili. The clinicians are familiar with the non-standard Kiswahili, *Swanglish* and ethnic languages of their facilities' locales. In such cases, they must choose the responding language, depending on the patient they are attending to.

4.3.2 Equivalence Gaps in Culture-Specific Items

Culture specific items pertain to the residential culture in Kibra villages as well as their ethnic culture. They present unique challenges in terms of communication and health choices that members of the community make. The two items here are myths and the intensity of illness. In African culture, myths and superstitions abound and have an impact on people's decision-making processes and actions. Illness always has a negative connotation, and it is common for many people, especially men, to trivialize their symptoms or avoid medical care all together. In both situations, the clinicians do not offer equivalence in Kiswahili. The first case is handled through an explanation of the myth while the second case, the clinician opted to use Dholuo.

Application of Convergence Strategy in Culture Specific Challenges

Consultation 4 (Wellness/Nutrition Clinic): 10-month-old baby, Mother: 23 years old.

In consultation 4 (excerpt 5) the parent presented a dietary dilemma based on a common myth in the Sarang'ombe area. This myth was about the consequence of consumption of eggs by weaned babies - it delays their speech. The nurse applied the convergence strategy in this example in two ways. She reduced the social difference between her and the parent through stylistic flexibility as she utilized the local Kiswahili, which is the parent's preference. Secondly, her detailed rebuttal of the myth served to enlighten the patient and gain the patient's approval on the cultural item as the nurse teaches her on the importance of eggs in the diet. The nurse further elucidated on how speech is developed through proper conversation with the child while avoiding baby talk.

Excerpt 5: *Consultation 4 (Wellness/Nutrition Clinic)*

	Statement	**Translation**
Nurse	*Sasa, unamlisha vizuri sijakataa lakini kwa hii picha, hizi ni vyakula tunakuanga nazo ama si zile hatukuangi nazo ama hujawahi ona hizi vyakula ziko hapa chini?*	Now, I cannot deny that you are feeding her well but, in this photo, do we have these foods (in our community) or don't we or you have never seen these types of food, shown here below?
Parent	*OK ziko but hatukuangi nazo.*	Yes, they are available, but we do not have them
Nurse	*Ziko. Number 1, hii ni example. Usiende kwa nyumba usiseme nashinda nikisema tukule nyama. Number 1, lazima ujue your financial aspect, sawa, pesa yako. Ukishajua financial aspect yako, vile unabudget nayo….so una make sure chakula ya mtoto iko na hizi zote, ten food groups. Utatumia kitabu yako pia inayo. Hebu penduka uangalie hiyo chart. Part 2.*	They are available. Number 1, this is an example. Do not go home and report that I insist you eat meat. Number 1, you must know your financial aspect, alright, your money. Once you know your financial aspect, the way you budget it…so make sure the baby's food has all these ten food groups. You can use your book; it is also there. Could you turn and look at the chart. Part 2
Parent	***Hataongea. Ati ukipea mtoto mayai ulimi itakuwa mzito***	He will not speak. If you give eggs to a baby, the tongue becomes 'heavy'
Nurse	*Sababu alikuambia ukipea mtoto mayai hataongea*? ***Hizo ni myths***. Fact is, *mayai inakuanga* a good source of protein. *Mtoto usipomwongelesha, haumwelezi…tuseme unamwambia "mama vaa atu" unaongea ile lugha yenye anasikia. Usiongee ile lugha yake*	What are the reasons she gave you to support the idea that when a child eats eggs they will not speak? Those are myths. The fact is eggs are a good source of protein. If you do not speak to a child, you do not explain…say, you tell her "Sweetie, wear 'oos" speaking in the language she hears. Do not speak her language.

The nurse's rebuttal of this claim is proof that such myths are commonplace in this community. The only drawback was, in a community that uses Kiswahili and Dholuo as the languages of wider communication, the healthcare provider lacked the Kiswahili equivalents for myth (*kasumba*) and the important statement: "The fact is (eggs) are a good source of protein" (*ukweli ni kwamba, mayai ni chanzo kizuri cha protini)*. These equivalents could be beneficial if the patient were to

share the information with a friend. The patient's profile revealed that she spoke only in Kiswahili. Therefore she may not easily remember some of the English statements although the explanation and the example given in Kiswahili may serve as a foundation for discourse with her friends.

Consultation 19 (Outpatient Clinic): Adult male 57 years old

In this consultation, a male patient described his symptoms. The doctor followed along only to note that the patient did not include an evident cough in the list of symptoms. The doctor seized the opportunity to ask him questions about the cough, switching to Dholuo so that he could understand the cough's intensity.

Excerpt 6: *Consultation 19 (Outpatient Clinic)*

	Statement	**Transcription**
Doctor	*Mapua inafungana, ni kama uko na homa*	Your nose is blocked, you likely have a flu
Patient	Mmhm	Yes
Doctor	*Nimesikia ukikohoa*	I have heard you coughing
Patient	*Imejaa kwa kifua yangu*	My chest is congested
Doctor	*Ifwolo?*	(In Dholuo to understand the intensity of the cough)
Patient	Responds in *Dholuo*	
Doctor	Headache? Kichwa haiumi, si ndiyo?	Headache? You do not have a headache, do you?

The clinician's decision to switch to Dholuo can be seen through CAT's convergence strategy. It can be observed that the thread of conversation flowed in Kiswahili. Naturally, the next course of action would have been an inquiry on intensity in Kiswahili such as *makali ya kohozi* (intensity of the cough) or *unakohoa sana* (frequency of the cough). The clinician chose to use the mother tongue, which is dominant in this residential area, to accommodate the patient in the language that

the patient may most easily express himself. In doing so, the clinician could provide the best course of treatment. This occurrence exemplified men's attitudes toward healthcare in that community – it is sought when it becomes an absolute necessity. Recall that 95% of the patients or parents who visited the facilities in this study were female. Women are more open to receiving care. Consultation 3 supports this position. The female patient's husband consistently refuses to go for testing despite multiple requests.

Application of Social Beliefs Aspect in Culture Specific Challenges

Consultation 19 (Outpatient Clinic): Adult male 57 years old

Excerpt 6 can also be examined through the lens of CAT's social beliefs aspect. This deals with society's perception of language where one language is considered more superior to another; and that there is a gender inclination to that language. In an area with heavy Dholuo maintenance, it is most likely that its native speakers consider it superior, in this residential setting. Additionally, it is preferred by males and spoken freely in the environs. The doctor opted to use this avenue, tapping on the male proclivity to the language they consider superior, so that he could gain insight on the patient's condition.

Hesitation by males to receive healthcare services is a regular challenge that the healthcare providers realize needs consistency while inquiring during the consultations. Interviews with the administrators from the two health facilities indicated that socio-cultural influences are a constant challenge. TC and UHC counter these influences through on-site counselling services. This is done on individual basis, enabling the patient to understand the impact of the attitude or belief on their health status and why the course of care is beneficial. Community health education is offered

on varied topics, some of which encompass socio-cultural influences. This improves the patients' health literacy and makes the patients receptive to the recommended treatment.

4.3.3 Challenge of Equivalence in Clinical Terminology

There is a lack of consistency in Kiswahili equivalence for clinical terms. Terms such as *joto* for fever, *kuharisha* for diarrhea, *kutapika* for vomiting; do not pose equivalence challenges to the clinicians. This is because, according to one of the clinicians, these conditions occur frequently. Therefore, use of their equivalents has become second nature. Other terms, however, were not assigned their equivalents, instead they were described by their effects. As seen in consultation 6. In this consultation, the mother of the toddler has been feeding the child Weetabix cereal, yet his digestive system is not yet capable to breakdown the fibre present in this cereal brand. The nurse, eschewing the equivalent of fibre *(nyuzinyuzi)* in Kiswahili, describes the effects of consumption of fibrous foods. This could have been propelled by the fact that the patient said she could understand English, despite the nurse's use of Kiswahili in the same statement.

Application of Convergence Strategy in Clinical Terminology Challenges

<u>Consultation 6 (Wellness/Nutrition Clinic): 11month old, Mother: 22 years old</u>

Excerpt 9: *Consultation 6 (Wellness/Nutrition Clinic)*

	Statement	Translation
Nurse	Is he 36 and above?	
Parent	No	
Nurse	36 (months) is three years. Number 1, however much, yes, you say he eats sometimes, it has a lot of fibre. So, hii iko na high fibre content. Now, when you give this to the baby, the baby will always be full. ***Hata wewe mwenyewe ukikula Weetabix, si utakuwa umeshiba?*** Because it has a high fibre content.	When you eat Weetabix, won't you be sated?

The parent in this consultation is conversant with English, providing responses in both English and Kiswahili. She is the youngest of the parents and this could account for her fluency. The healthcare provider is most comfortable speaking in English, as it is more grammatically correct than Kiswahili. Here, the clinician and young mother utilized the convergence strategy in this case, to reduce the social difference between them. The clinician through language accommodation by switching between English and Kiswahili since the parent understands and expresses herself well in both languages. The parent converges to English to gain the approval of the clinician as the conversation flows more smoothly in English.

In consultation 16, discussed in section 4.3.1, the patient did not understand the word 'dosage'. Instead of *kipimo* the doctor asked the patient, "*unameza aje?"* (how do you take it?). It is well known that the residents of Sarang'ombe speak non-standard Kiswahili, it may be possible that even if the doctor used standard Kiswahili, it could have been lost upon the patient. This could possibly account for the use of explanatory statements or paraphrasing, to allow for unhindered communication.

The final observation of terminology challenge is in consultation 20, also discussed in section 4.3.1, as one of the four cases of interpretation. The patient complained of "*kuwashwa huku chini*", to which the doctor gives her the correct term in English (vagina) but not in Kiswahili *(uke*). This is the second visit by the patient and given her strict use of Kiswahili, the term could be beneficial for her knowledge. Evidence of convergence was noted through communication symmetry when the clinician gained the patient's approval, through her open conversation of her medical condition.

4.4 Analysis of Clinician *Ad Hoc* Interpreting Performance

Moser-Mercer (1997) highlights four important strategies in interpreting, that are necessary from the nascent stage of interpreting. These are comprehension, planning, monitoring and workload management. In comprehension, the interpreter uses his knowledge base to understand the ongoing speech. The planning strategy involves analysis of the speaker's input in readiness for the interpreter's output. It occurs on the lexical, semantic, syntactic levels and includes choice of register. Monitoring requires the interpreter's active comparison of the input and output statements in the levels mentioned under planning. Lastly, workload management allows the interpreter to utilize his resources appropriately. The researcher has opted to use these performance strategies as a benchmark on the performance of the *ad hoc* interpreters in this study.

The comprehension strategy did not pose a challenge to the health care providers. This is because they understood English, Kiswahili and for some clinicians, the ethnic languages. This meant that they did not experience any challenges in following their patients' speeches, as they presented their health challenges. Additionally, their background knowledge as clinicians enabled them to make the connection between their patients' conditions and what they presented as diagnoses to them.

Planning strategy involves preparation for the output, following the input from the patient. The *ad hoc* interpreter at this point should be thinking of the choice of words, their meaning, expression in the language of preference of the patient as well as the register they will use. This strategy was problematic to the clinicians in their capacity as *ad hoc* interpreters. Despite the frequent use of code switching and *Swanglish*, the messages they conveyed had meaning. However, some of their lexical choices were poor, for example use of *kudungwa shindano* instead of *kudungwa sindano*

(to be injected), *kusiaga chakula* instead of *kumeng'enya chakula* (to digest food). Syntactically, subject-verb agreement seemed to challenge these interpreters as exemplified in *meno inamuuma* as opposed to *meno yanamuuma/ meno yanamsumbua*. Choice of register oscillated between formal and informal. The informality could be attributed to the community setting and the greater need for the message to be delivered. It also facilitated the creation of a safe space for the patients, to express themselves freely in their local Kiswahili.

The *ad hoc* interpreters' capacity to monitor their speeches was yet another hurdle. The issue of equivalence was not as important. If the word did not immediately come to mind, it was said in English while being placed in context. This is because, their most important goal was communication with the patients, give them the appropriate medical care and attend to the next patient. It is not clear, however, how many patients truly understood the clinicians' statements in their entirety, especially when code-switching is employed because they tend to respond monosyllabically, with a "mh" or "eh."

Workload management on the part of the attending clinician-interpreter was lighter. This is because they were not hard-pressed to respond in Kiswahili. The ability to code-switch simplified the task and minimized the mental load.

4.5 Other Strategies Used By *Ad Hoc* Interpreters to Facilitate Communication.

Collins *et al.*, (2011) affirm that linguistic and extra-linguistic skills are essential in the establishment of patient-clinician relationships. This is because communication can affect patient adherence and overall health outcomes. All the consultations that have been observed during this study, show a genuine effort on the clinician's part to establish good rapport with new patients while maintaining cordial relationships with returning patients.

4.5.1 Verbal Strategies

Pleasantries

There are various linguistic strategies that healthcare providers used in the study, exhibited through different consultations. Conversations started with pleasantries or a welcoming greeting such as "*Umetutembelea leo?*", "*Unaendeleaje?*", "*Sasa* baby girl" (for the paediatric patients). Such greetings put the patient at ease, enabling them to share their concerns openly. A good example is consultation 3:

Excerpt 10: *Consulation 3 (Ante-natal/Support Clinic)*

	Statement	**Translation**
Nurse	*Una disappear unarudi, una disappear una rudi, mmh? Unaendelea aje?*	You disappear and return, disappear and return, mmh? How are you getting on?
Patient	*Niko poa*	I am well
Nurse	*Kabisa, kabisa?*	Really, truly?
Patient	*Si sana*	Not so much
Nurse	*Si sana, shida iko wapi ? Nilikuambia urudi na mzee tumpime*	Not so, what is the problem? I told you to come with your husband, so that we can test him
Patient	*Sasa kama hataki?*	What if he does not want to?
Nurse	*Eh!*	Expresses shock

From this last expression by the nurse, her shock is allied to the patient's frustration at her husband's lack of cooperation. This encouraged the patient, who discussed more on the issue (refer to appendix 1). According to Giles (1971), the patient's initial hesitance in communicating, is met with the clinician's convergent strategy, to minimize their communicative distance resulting in a point of symmetry. Both interlocutors are at an agreeable point, through the clinician's shared frustration with the patient's husband's reluctance towards testing.

Empathy

The expression of empathy is an important factor in clinical care. Female-female empathy is observed because many of the patients are women and most of the health facility staff are women. The interview with the administrators from the two clinics confirms that there are more female staff members than there are men. It is encouraging to note that in this study, empathy was not restricted to female clinicians. In consultation 15, the patient was suffering from tonsilitis. The male clinician's empathy encouraged the patient to speak more on her condition. This is an important attribute that validated the patient's sense of self and dignity. Empathy not only benefited the patient but the clinician as well because he was able to give a comprehensive diagnosis when the patient shared openly.

Excerpt 11: *Consultation 15 (Outpatient Clinic)*

	Statement	**Translation**
Patient	Tonsils, *hata ukishika hivi unafeel*	Tonsils, when you touch (the neck) you can feel them
Doctor	Hapo ndani kwa koo, ndani kwa..si inaitwa koo	Inside the throat, inside, it is called the throat
Patient	So *nikimeza tu kitu – uchungu*	So, when I swallow something – painful
Doctor	Pole	I'm sorry
Patient	*…nakwambia* tonsils*, inanifanya nikiinama hivi, hii kichwa yangu inakuwa nzito sana*	I'm telling you, tonsils – if I bend forward this way, my head feels so heavy

Questions

The use of questions is another vital strategy that granted the health care provider an opportunity to ensure all the patients' concerns had been addressed. An example is in Consultation 16. The doctor started with the question "*Leo, uko na shida gani*?" (What is troubling you today) and

concluded with "*hakuna shida yoyote*?" (There's no other problem?). Questions enabled the clinicians to apply convergence strategy from CAT. This is because they accommodated the patients linguistically or changed their style of questioning if they failed to answer the presented questions.

Linguistic Flexibility

Linguistic flexibility is a significant aspect of communication, especially the ability to switch to the patient's first language. This was an important strategy that made the patient feel esteemed, that her need to understand the discourse was important. This is where the interpreter aspect of the clinician came into play. Referring to Consultation 3, the nurse interpreted in Kiswahili so that the patient understood the next procedure. Linguistic flexibility is attributed to the divergent strategy, where one interlocutor cannot continue in the conversation for lack of understanding, as exemplified in this consultation. The clinician's flexibility in reverting to Kiswahili was the only solution that safeguarded the patient's social identity. Additionally, from the data, the clinicians exhibited continuous stylistic flexibility. They switched from being formal, consultative to casual throughout the consultation.

	Statement	**Translation**
Nurse	To check how you are doing. Today you will get two injections	
Patient	*Hmm?*	
Nurse	*Leo unaenda kudungwa mara mbili. Nikikudunga tetanus na ukitolewa damu.*	Today, you will receive two injections. I will give you the tetanus vaccine and your blood will be drawn

Paraphrasing

Linked to flexibility, is the ability to paraphrase. Its express goal was to suit the listener's understanding. In consultation 16, the physician asked the patient in English about the dosage of her medication. Unfortunately, the patient did not understand the word dosage. Instead of using the equivalent for dosage in Kiswahili, which is *kipimo*, he instead paraphrased to "*unameza aje?*" (how do you take the medication?). Paraphrasing appeared central in the convergence strategy as it was the meeting point of the clinician's ability to accommodate the patient linguistically and their ability to exhibit stylistic flexibility in how they re-expressed the initial message for a desired response.

4.5.2 Non-Verbal Strategies

Collins *et al.*, (2011) opine that extra-linguistic strategies enable the conversing parties to gauge the productivity of their discourse. These strategies also give the assurance of interest, for example, when one leans the body in; and can also demonstrate agreement when one nods their head (in the culturally understood manner). Various non-verbal strategies have been observed during this study. The use of these strategies reveals the health care providers' awareness of their patients' settings and needs, as well as the providers determination to ensure communication is not disrupted.

Gesturing

The first striking non-verbal strategy observed was during consultation 4, where the parent of the patient is mute. The doctor proceeded to great the patient by waving and keenly observed all the gestures that the parent made as she described what was bothering her child. The doctor only spoke while greeting the young one and examined her. He then explained in gestures to the parent,

where the problem was. He arose, gestured to the parent to follow him to the pharmacy, where he asked the pharmacist to follow up. The clinician was not a trained sign language interpreter, neither was the pharmacist, but the two of them were able to assist this special need parent to receive care and medication for her ailing child.

Eye Contact

In all the consultations, the health care providers made good eye contact with the patients and parents as they entered the offices at the beginning of the sessions. This was an important strategy that dignified the patient.   In the nutrition clinic, the nurse made eye contact with the babies and toddlers, as she first interacts with them to check on their developmental milestones. She then proceeded to show them her colourful home-made toys and how they moved or the noises they made. The children, as a result, went through the consultation without a lot of fussing.

Head Movements

Head movements were utilized to a great extent in many of the consultations. Clinicians employed head movements to show agreement with a patient's statement or curiosity when they required further explanation from the patients.   Whenever the clinicians explained a procedure or a diagnosis to the patients or parents, the latter would nod their heads in the up and down motion, affirming their understanding, as is in most Kenyan cultures. They did not verbalize their agreement in any way, so as not to disrupt the clinician's speech. In the case a statement was not clear, there were some patients who slightly tilted their heads to the side, while verbalizing the head tilt with the sound "hmmm?".

Smiling

Smiling was an significant extra-linguistic strategy. This was most evident in the nutrition clinic, as the babies respond to the smiling nurse by smiling back and then began cooing as their weights and heights were being taken and recorded. The effect of the smile was apparent during consultations with adult patients. Consultation 3 is a prime example. The truant patient returned, and the nurse offered a smile as soon as the patient entered the room. This made the patient feel at ease, despite her truancy. As a result, they had a lengthy and productive consultation.

Demonstration

The final effective extra-linguistic strategy observed was demonstration. In Consultation 5, the nurse had been explaining the importance of exclusive breast feeding to this first-time mother, who had a 4-month-old baby. The nurse noticed a poor common breast-feeding practice in the waiting area and decided to caution the young mother by demonstrating it for her benefit. She followed the demonstration by directing the parent's attention to the chart on her desk to ensure the she understood what she had been taught.

	Statement	**Translation**
Nurse	*Ndiyo maana tunasema haufai kufanya maziwa yako, kumnyonyesha hivi inakata hiyo mishipa.* (Demonstrating the index and the middle finger, placed on the top and bottom of the breast in a scissor-cutting pose) *Unaona kuna mishipa. Hizo ni ya kutransport maziwa,sawa ? So hakuna kukata, hiyo ni kuscissor. Sawa?*	That is why we say that you should not do that to your breast. It prevents the milk from flowing. Can you see the ducts? Those transport milk, alright? So, do not inhibit the flow, that is 'scissoring'. Alright?

The verbal and non-verbal strategies are important in these clinics in Kibra in two important ways. First, they demonstrate the rapprochement between the health care providers and the people they serve. The clinicians have learned cultural sensitivity regarding their patients, in the way they live and communicate. As a result, they have developed flexibility in their speech and patience in their interactions. If a patient does not attend all their appointments, they are not lambasted but instead encouraged to do so through understanding their health conditions. A prime example was the interaction in Consultation 3 in the Ante-natal clinic, with the truant patient who was welcomed back to the clinic after a period of absence and the quickly returned to her course of treatment.

Secondly, the clinicians treat their patients with dignity. The initial greetings, pleasantries, inquiries into other conditions, all contribute towards building trust with the patients. This is evident in all the consultations at the Ante-natal, Wellness/Nutrition and Outpatient clinics in the two facilities in this study. This treatment relies heavily on the convergence and divergence strategies posited by Giles (1971). The clinicians utilized convergence to reduce the social distance and to gain approval of their patients through being cognizant of the language differences. They adjust accordingly to ensure their patients are heard and receive the appropriate treatment. Through divergence, patients maintain their social identity and esteem through their language of preference. The adjustment of the clinicians to their patients' needs, accounts for the over 200 patients for example, that are attended to daily at TC. There are many facilities, private and public, in this area, however patients choose to visit these two clinics repeatedly. This is because of the quality of care they receive.

4.6 Summary

This chapter delved into data analysis, using the objectives that had been set out in the first chapter. The data was analyzed based on themes that had been assigned in the third chapter. It was also dissected using the convergence, divergence strategies and the social beliefs aspect of Giles' Communication Accommodation theory. In addition, the clinician-interpreters' performance was analyzed based on Moser-Mercer's interpreter strategies and concluded by the examination of other verbal and non-verbal strategies that facilitated communication. This analysis has shown that communication is a bipartisan effort. Both parties ensured their messages were understood, although, more effort was imparted by the clinicians as they took on two roles – healthcare service provider and *ad hoc* interpreter.

CHAPTER FIVE

Conclusion And Recommendations

5.1 Introduction

This chapter covers the summary of the research findings. Secondly, it revisits the research hypotheses. This will be followed by the conclusion in the third section and finally, recommendations for future study.

5.2 Research Findings

This study sought to explore *ad hoc* interpreter intervention in English-Kiswahili communication in the clinical setting. The study was based in Sarang'ombe ward, in Kibra, Nairobi. This area has strong native language maintenance, especially in the Luo community. Kibra hosts medical facilities and camps that are sponsored by foreign and local NGOs, whose personnel do not speak Kiswahili fluently. This presents occasions for language discordance where communication can break down.

This research determined that *ad hoc* interpreting was carried out by attending clinicians in a dyadic set-up, that is with a patient and clinician. This differs from the conventional set-up which is triadic, that involves a patient, clinician, and an interpreter. These health facilities operate on tight budgets whereby hiring qualified interpreters is untenable. This is one of the reasons their clinicians take on the role of interpreter. Additionally, as the administrator mentioned, trust is an important factor in Kibra. They trust their clinicians, hired interpreters may vary based on assignment, which disrupts continuity hence trust. The dyadic nature of this interpreting setup occurs because of the high patient to clinician ratio. Unless a particular clinician does not share the same ethnicity as the patient, then the triadic set up would be possible.

According to the findings, 65% of patients spoke only in Kiswahili during consultations. (Figure 4). The clinicians utilized English, Kiswahili, *Swanglish*, and code-switching. It was evident that the Clinicians were more fluent in English than Kiswahili. Only four cases of *ad hoc* interpreting were recorded. The other instances, communication was carried out in Kiswahili, *Swanglish*, and code-switching.

The Communication Accommodation Theory (CAT) was the basis for analysis in this study. It vital in examining communication in language discordant settings. CAT was necessary in analyzing the different consultations where language discordance arose, using its social beliefs aspect, convergence, and divergence strategies. The clinical data collected showed application of convergence and divergence strategies by the healthcare providers and patients to get to the point of symmetry. This is the point of communication where both parties are heard and understood in a satisfactory manner.

5.3 Review of the Hypotheses

Three hypotheses were presented in Chapter One. These are:

i. Socio-cultural and language barriers affect *ad hoc* interpreter communication
ii. Cultural adherence promotes *ad hoc* interpreter specificity
iii. *Ad hoc* interpreters use linguistic and extra linguistic strategies to facilitate communication in the target language.

Socio-cultural and language barriers did not affect *ad hoc* interpreter communication. This is because of the dual role of the clinician as the interpreter. Most of the clinicians observed, were socially and culturally aware of their patients' backgrounds. In addition, health education offered at the sites, be it communal or one-on-one sessions, builds a knowledge foundation for the patients

and allows for better consultation sessions. In terms of language, there were no substantial barriers. If the health care provider spoke in English and the patient did not understand, the clinician reverted to Kiswahili. Where the patients spoke in *Swanglish*, the clinician understood, therefore communication was not hampered.

In an area where there is strong language maintenance, one would assume that the influence of culture would impact *ad hoc* interpreter specificity for patients who need communication interventions. This was not the case in Sarang'ombe. Clinical observations and health facility interviews revealed that neither culture, gender nor social status influence the choice of *ad hoc* interpreters. The salient factors were the level of trust between the interpreter and patient, along with the interpreter's language fluency. Patients in need of interpreting services found ready assistance in the clinicians, especially among those who did not have family members to aid in interpreting. The health care providers in the two clinics treat their patients with dignity, which builds trust. As a result, they prefer visiting these health facilities where they receive quality health care because of communication intervention measures that are always reliable.

Clinician-*ad hoc* interpreters in Sarang'ombe employ linguistic and extra linguistic strategies to acquire detailed information so that they can provide comprehensive care. Linguistic strategies include the use of pleasantries such as "*umetutembela leo*" that help the patient to feel at ease as well as sympathetic language such as "*pole*" that encourages the person to share in depth on what is ailing them. Other linguistic strategies involve the use of questions, to ensure that all the patient's concerns have been addressed. Linguistic flexibility and paraphrasing are the other strategies that ensure effective communication. Flexibility in language allows for speedy transition to the patient's first language, whereas paraphrasing is carried out expressly for the listener's understanding.

Extra-linguistic strategies gauge the productivity of the communication process and give assurance of interest in said communication. One such strategy employed in the study was the use of gestures while communicating with a mute parent, who gave assurance of interest by continued gestured communication. Eye contact was an important strategy that made the patient feel recognized, setting off the consultation on a good start. Head movements were utilized to show agreement or curiosity, beckoning further explanation by the patient. Smiles were used by clinicians in various instances, for example while welcoming patients – making them feel at ease and to show agreement with positive feedback from the patients. Demonstration is the other non-verbal strategy that was utilized as an education tool to ensure that the information conveyed was properly understood.

5.4 Conclusion

The healthcare providers' dual role as interpreters affected their language choices and communication style. This, however, did not deter their communicative process with the patients as analyzed through the communication accommodation theory (CAT). The theory is necessary and sufficient to dissect communication between these clinicians and patients, through its strategies of convergence, divergence, and social beliefs. Using convergence, the clinician drew closer to the patient by using language that the patient was comfortable with. Through divergence, the clinician ensured that the patient's social identity through their language preference, was respected. In social beliefs, the healthcare providers gave patients free reign on the language they wished to utilize. This is despite the dominance of Dholuo in the area. Generally, symmetry was achieved through both parties ensuring that they were understood.

5.5 Recommendations

Communication in the clinical setting is an important practice, more so, when the clinicians must take on two communicative roles – healthcare provider and interpreter. The following are the proposed recommendations:

The clinicians need basic interpreter training if they will continue in their dual role. This will enable them to acquire the necessary skills and confidence to be able to interpret into one language without code-switching. This will be particularly useful for communication in Kiswahili because it has the highest rate of usage in this area. Furthermore, it will satisfy the need for vernacular-Kiswahili interpreting.

The health care providers could invest in improving their fluency in Kiswahili. This is achievable through frequent reading of Kiswahili publications or listening to Kiswahili programs. Majority of the conversations depict frequent use of Kiswahili by the patients than the clinicians, who utilize *Swanglish* and code-switching. More fluid conversation in Kiswahili may aid in patient understanding.

Further research to gather the perspectives of the clinician-interpreter will be insightful. In the same vein, the patient's input on the quality of communication and care they receive from the clinicians in this dual role, will illuminate on their practice. As noted, this is not the conventional interpreting set up that involves three parties.

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APPENDIX 1: KEY CLINIC CONSULTATIONS' TRANSCRIPTIONS

ANTE-NATAL/SUPPORT CLINIC

Consultation 1. Patient: Female, 48

Nurse: Imetoka. Naona tarehe ingine ulitolewa mwezi wa sita

Patient:Yangu, nishatolewa damu

Nurse: hadi we mwenyewe umechoka ukishinda kama umedungwa

Patient: Hata leo nilikuwa nikisema kama ni kutoa damu, Hapana

Nurse: (laughs)

Patient: Unatoa ukirudi, tena uende utoe ukurudi, ai hapana

Nurse: Wacha niangalie, hii ilitolewa ya mwisho (soft mumbling)

Nurse: Hii ya mwisho imetoka, imetoka, lakini copies zimeonekana. Kuna siku ulikosa kumeza dawa?

Patient: Ah ah

Nurse: Ama ulimeza kuchelewa?

Patient: Niseme nikuchelewa tu na ni ma-seconds lakini si hata masaa. Hiyo siku nilikuwa nimeenda hosi, nilikuwa nimepeleka jirani yangu alikuwa mgonjwa kabisaa lakini kurudi si kwa siku, dakika tu kidogo

Nurse: Ulichelewa kidogo

Patient: Lakini kutoka siku hiyo sijawai tena

Nurse: Ni sawa. Damu ya mwezi bado inakuja? iliacha kuja ?

Patient: (Nods) kitambo

Nurse: Iliacha kuja. Hata family planning uliacha kutumia.

Shida ya kukohoa? Hakuna, Shida yoyote nyingine?

So nikikupee dawa ya miezi nne utameza vizuri?

So nikupee miezi nne ni sawa?

Bado unameza Septrin

Patient: Mm-mmh (negating)

Nurse: And then, uh, uchukue dawa

Patient: Niende wapi

Nurse: Kule nyuma na upewe booking.

Patient: Asante.

<u>Consultation 2. Patient: Female, 25 years old</u>

Patient: Ile kadogo ya red ama hisi zingine

Nurse: Syrup za mtoto, syrup za mtoto ulipewa ngapi

Patient: Nilipewa hii kubwa

Nurse: Moja tu, normally unafaa upewe mbili, but pia sisi pia tukona hiyo moja tu

Patient: Hata mimi nilipewa hiyo moja kubwa

Nurse: Tutakupea hii moja kubwa and then hiyo ingine utapewa… so utapewa, we don't have it, Hatuna.

Patient: Hata hiyo mwezi ingine

Nurse: Hiyo mwezi ingine, tutafuatilia lakini saa hii tutakupee ile tuko nayo

Patient: Sawa

Consultation 3. Patient: Female, 24 years old

Nurse: Una disappear una-rudi, una disappear una rudi, mmh? Unaendelea aje?

Patient: Niko poa

Nurse: Kabisa, kabisaa?

Patient: Si sana.

Nurse: Si sana, shida iko wapi ? Nilikuambia urudi na mzee tumpime

Patient: Sasa kama hataki

Nurse: Eh!

Patient: Kama hataki

Nurse: Kabisa, kabisa hataki kupimwa?

Patient: Kama mwenyewe nilimwambia usiponipeleka clinic, sitaenda clinic

Nurse: Hashtuki (not concerned)

Patient: Hashtuki

Nurse: Ah!

Patient: Ameniambia ngoja tu, we ngoja kama unataka mi niende

Nurse: Na hivyo ndiyo venye hakukuja, eh!

Nurse: Wacha tutamwachia Mungu, kwani this time hukudungwa tetanus (implying the vaccination). Hujadungwa tetanus kwa hii mimba, si ndiyo? Hujadungwa?

Patient: Ni ile tu sijui nilidungwa lini, sijui ni Covid

Nurse: Ah, ah. Tetanus unafaa ukumbuke. Umekuja clinic mara ngapi, mara mbili so far, si ndiyo. Hii ni mara ya tatu, naona tu mara mbili. The last time ilikuwa July.

Patient: (inaudible)

Nurse: Usicount eh, support group. Clinic umekuja mara mbili? Clinic, ndiyo nijue kama umepewa shindano niangalie

Patient: Si ni, sijakuja mara nyingi

Nurse: Majina yako ni X, ile huwa unatumia…tetanus hujadungwa, haujadungwa. Hata wewe hukumbuki

Patient: Ile nilidungwa waliuliza ID

Nurse: Hiyo ni Covid. Covid ukidungwa ndiyo wanaitisha ID ndiyo wajaze kwa system. Sasa leo tutakudunga tetanus. Si unajua kazi ya tetanus ni nini.

Patient: Leo? Sawa.

Nurse: Nisipokudunga unajua tutasahau. Umepimwa kweli kilo hapo nje? Nimekupima weight? To check how you are doing. Today you will get two injections.

Patient: Hmm?

Nurse: Leo unaenda kudungwa mara mbili. Nikikudunga tetanus na ukitolewa damu.

Patient: Ni sawa

Nurse: Tukumalizie once and for all, tusishinde kama tunapostpone hizi vitu. Usiogope, ya uchungu tu ni hiyo tetanus, lakini hutaisikia saa hii, utaisikia baadaye kama mkono imeganda, sawa?

Patient: Mm-hmm.

Nurse: Nakupea dawa ya one month ndiyo usikuwe unapotea. Ukikuja unachukua dawa ukikuja clinic, otherwise utadisappear na sitaki, so unachukua dawa kama unakuja clinic. Hapo hautakuwa na option.

Patient: Niko tu sawa.

Nurse: Eh, nataka ikuwe hivyo, ndiyo usikuwe unapotea haki. Hapo umepotea sana, na najua ni juu ulikuwa na dawa, hmm?

Nurse: Na mtoto amepata vaccines zake zote, imebaki tu moja. Amefanyiwa PCR ya one year?

Patient: Alifanya

Nurse: Alitolewa June, tunangojea results. Sijaangalia, nitaangalia, kama ziko sawa nitakuambia. Tunakufanyia vitu nyingi mara moja. Enda lab wakutoe damu and then uende X akufanyie booking, upewe dawa. Ni sawa?

Patient: Sawa

Nurse: So, X ataona kama akupatie dawa ya mtoto this month, ama angojee next month. But next month si ni sawa. Akikupee next month si iko sawa kuliko akupee saa hii mapema, Saa hii itakuwa mapema sana.

Patient: Hiyo ya mapema ndiyo hata poa.

(Both laughing)

Nurse: Bado lazima ukuje, uchukue dawa zako. Lazima ukuje X, na mi sitaki upotee. Nilikuwa nataka kuambia X, hiyo dawa unapewa next visit ukikuja then tena hiyo time, nitakupea dawa nyingi hiyo time ukikuja, dawa ya two months ama three months. Ni sawa?

Patient: Poa

Nurse: Sindano nitakudunga on the left hand. Uchungu hautasikia saa, utasikia baadaye, utasikia ni kama mkono inaganda, lakini itaisha. Kawaida, kawaida. Najua we si mwoga. Hukai mtu mwoga kwangu kabisaa. Si mbaya. Haikuwa mbaya hivyo sana. Endelea kumeza dawa, usiache. Enda kwa lab kwanza halafu kwa X.

WELLNESS/NUTRITION CLINIC

Consultation 4. Patient 10 month old, Parent: Female 23 years old

Nurse: Vitu za Watoto za kucheza, si lazima ununue vitu lakini unaweza kutengeneza mwenyewe…Si ndiyo mama, unaona vile ikona colours supuu, ona vile macho yake inafanya…

Parent: Mmmh (agreeing)

Nurse: Saa zingine unapika chakula kwa nyumba, sivyo, na chakula yake labda hukuweka colours colours but yenu mpika ugali, mboga na mayai, utaona haraka yake atakataa juu

hii ikona rainbow colours, inafurahisha macho…so ningeomba tuongeze bidii sana kwa kula. Asikatae yake na mnakula yenu. Sivyo?

Parent: Mmmh.

Nurse: Mtoto X., mnamlishanga chakula gani? kuanzia asubuhi.

Parent: Asubuhi huwa ninampea uji, ikifika tuseme kitu saa nne, saa tano, namtafutia machungwa ama ndizi, tunakaa kaa. Ikifika kitu saa saba, anakula ugali na mboga. Ikifika jioni kitu saa kumi, nampea maziwa. Six, namcheshea ndizi halafu usiku nampea tena ka ni ugali au ndizi waru (potatoes) nampea alafu analala.

Nurse: Sasa, unamlisha vizuri sijakataa lakini kwa hii picha, hizi ni vyakula tunakuanga nazo ama si zile hatukuangi nazo ama hujawahi ona hizi vyakula ziko hapa chini?

Parent: OK ziko but hatukuangi nazo.

Nurse: Ziko. Number 1, hii ni example. Usiende kwa nyumba usiseme nashinda nikisema tukule nyama. Number 1, lazima ujue your financial aspect, sawa, pesa yako. Ukishajua financial aspect yako, vile unabudget nayo….so una make sure chakula ya mtoto iko na hizi zote, ten food groups. Utatumia kitabu yako pia inayo. Hebu penduka uangalie hiyo chart. Part 2

Parent: Hataongea. Ati ukipea mtoto mayai ulimi itakuwa mzito.

Nurse: Sababu alikuambia ukipea mtoto mayai hataongea? Hizo ni myths. Fact is, mayai inakuanga a good source of protein. Mtoto usipomwongelesha, haumwelezi…tuseme unamwambia "mama vaa atu" unaongea ile lugha yenye anasikia. Usiongee ile lugha yake

Parent: Ile ya kitoto

Nurse: Akiongea ile lugha yake, unamrekebisha. Kama humwongeleshi, hatajua kuongea. Mtu asikuje kukuambia usimpatie hii, sababu hii itafanya nini, ah ah! Akikwambia wewe nyamaza, njoo uniulize. Daktari, niliambiwa hivi na hivi. Ni ukweli ama si ukweli ? Nitakueleza. Sawa mama X.? Kwa hiyo ukipika mayai kwa nyumba, mpe ! Unaeza chemsha, unaeza kaanga, mpee….Unaeleza baba yake, pengine ameelezewa na hajui.

Nurse: Ukishamaliza, si chakula yote imeshaiva, unachukua chakula yako inakuwa hapo na ya X. inakuwa hapo. Inaitwa responsive feeding. So akifungua mdomo, unamfanyia "mama ha", ukifanya ha, pia wewe unafungua « ha », you open your mouth. So ukiweka kwako, pia yeye unmwekea anakula…

Consultation 5. Patient: 4 month old, Parent: Female 23 years old.

Nurse: Halafu Mama X, umeniambia wewe unamnyonyeshanga sana na uko na maziwa sana! Haya, ukamiliza kumvalisha, njoo nataka nikuulize mawili matatu, eh, nione tunafanya vizuri ama tunafaa tuendeleshe mahali.

Nurse: Haya sasa, ningependa kukuuliza. X unamptianga nini?

Parent: Kunyonya tu

Nurse: Unamnyoyesha mara ngapi?

Parent: As in, kila wakati

Nurse: Haya akichapa usingizi kutoka 8 mpaka 11, what happens? Si kuna muda ana-oversleep, inamaanisha nini? Kama, kuna wale wako lazy, ameamka na anasikia njaa. Badala alie, ako tu. So wewe una-make sure every two hours, sawa?

Parent: Mm.

Nurse: Eeh. Si lazima kama analala, tunamwambia 'baby amka' unamshikashika. Unambeba tu, unaweka chuchu yako, nipple yako, hivyo.

Parent: Mm.

Nurse: Haya, akinyonya, lazima afungue mdomo kama samaki. (Demonstrating) Hii inakuja hivi, hii inakuja hivi, sawa? So akiingiza unaona kwa chart, hii yote inaingia kwa mdomo. Ndiyo maana tunasema haufai kufanya maziwa yako, kumnyonyesha hivi, inakata hiyo mishipa. Unaona kuna mishipa. Hizo ni ya kutransport maziwa,sawa ? So hakuna kukata, hiyo ni kuscissor. Sawa ? Unamshikilia vizuri mkono huo, sasa huyu ni wewe na X wako. So unashikilia hivyo, unampea ananyonya. Akishamaliza, unachukua unamweka hapa kwa shoulder, unam-rub, ana-burp, anatoa hewa, sawa?

Parent: Mm.

Nurse: Maanake ukimregesha kama hujamweka hivyo, ataumwa na tumbo ama anaweza choke. Ile maziwa inaweza kuja hivi irudi. Ikim-choke, kitu ni mbaya inaweza fanyika, sawa?

Parent: Mm.

Nurse: Sa akishanyonya unamwekelea hapo anatoa hewa, akishatoa hewa unamlalisha chini. Kitu ingine anaweza lia kama hataki kulala. Eh! Saa zingine amechoka, we umekazana "toto lala", unang'ang'ana X alale. Ye hataki kulala, anataka kucheza. Si unaona ananiangalia vizuri, ona vile anasmile, mama!

Consultation 6. Patient: 11month old, Parent: Female 22 years old

Nurse: Ningependa unianzie siku ya jana

Parent: Alikunywa maziwa

Nurse: Jana asubuhi alikunywa maziwa na nini

Parent: Uji

Nurse: na Uji

Parent: Weetabix

Nurse: Weetabix, saa ngapi

Parent: Mmh, kitu saa saba tu and then sometimes huwa nampea scones

Nurse: Scones, tuseme jana, siku ya jana

Parent: Jana nilimpea scones, sikumpikia.

Nurse: Lunch, lunch amekula scones?

Parent: Mmm, alafu tu na uji. Alafu usiku alikula ugali na fumbu, supu ya fumbu (a type of small fish)

Nurse: Supu ya fumbu? Weetabix unampatianga mara ngapi ?

Parent: Weetabix, jana nilimpea tu mara moja.

Nurse: Kwa wiki unapatiana mara ngapi?

Parent: Kwa wiki naweza mpatia mara tatu au nne.

Nurse: Naomba, unajua kusoma ?

Parent: Eeeh.

Nurse: Kuna ile place nime-circle hivi, naomba usome. Ama si weetabix unampeanga ?

Parent: Eeeh, ni hii. Where our products fibre content exceeds 5% mm, hii inamaanisha nini?

Nurse: Hapo mahali nimeweka hivi, soma tu circle, kuna age nataka usome

Parent: Product is not recommended for individual under the age of 36 months.

Nurse: How old is X?

Parent: 11 months.

Nurse: Is he 36 and above?

Parent: No

Nurse: 36 is three years. Number 1, however much, yes, you say he eats sometimes, it has a lot of fibre. So, hii iko na high fibre content. Now, when you give this to the baby, the baby will always be full. Hata wewe mwenyewe ukikula Weetabix, si utakuwa umeshiba? Because it has a high fibre content. That is why they are disclaiming, hii inakuwa disclaimer, in case of anything, you give your baby, hakuna kitu itafanyika. This is a disclaimer. It is 36 months and above. If you want to give your baby cereal, you can give cerelac. Cerelac iko na high content of iron for the body. So unaweza mpea cerelac, maharagwe, dengu, hizo ni pulses. Njugu ikisiagwa, unaweza siaga vizuri unampea anakula. Sawa?

Parent: Mm.

Nurse: Hii usimpee, hii imeandikwa because it has a high fibre content. Ukimpatia hii anakulanga kirahisi? Si rahisi akule sivyo, juu anasikia tumbo imejaa, so anajua ni vita. So hiyo usimpe. Hiyo badala ya kumpea, hiyo pesa yako unaweza nunua nayo ndizi imeiva ama machungwa unampea anakula. Sawa?

Parent: Mm

Nurse: Unampikia kama mfano kama ni mchele, na maharagwe na carrot moja and spinach. Unakaanga vizuri alafu unampea, si unaona imekaangwa vizuri, eh, unaweka nyanya na kitunguu. Si umesema ako 11 months?

Parent: Eh

Nurse: Unaweka nyanya, kitunguu, carrot, hizi. So, mchele ni carbohydrate inatoshana nguvu kwa mwili. Meat ni what? Nyama ni group gani ya chakula?

Parent: Mi hata sijui

Nurse: Protein, ya kujenga mwili, sawa ? Eh, Carrot na vegetables? Hizi ni roughages, si ndiyo? zina saidia ku-protect against illness.

Nurse: So una make sure siku mix mchele na waru, mchele na waru ni one food group, sawa? Same as matoke, same as ndizi imeiva, ni one food group. Uji, bado ni food group moja, uji iko kwa starch. So, kama unampea una make sure, kama ni wali, kama iko na maharagwe karibu, unachukua na kamaharagwe unaweka pamoja unampea…halafu, mnakula pamoja na… akishamaliza unamwambia "good boy" ile unamweka self-esteem.

<u>Consultation 11. Patient:6-week-old baby, Parent: Female 36 years old</u>

Nurse: Mweke hapo, bora asigongwe kichwa

Parent: Mm.

Nurse: X, ulimzaa na 2.2(kg), leo uko na ngapi? 3.9 (kg)

Assistant: Haya mlete

Nurse: Shingo, unashikilia na shingo

Parent: Nimbebe na kitambaa?

Nurse: Ah, ah, mmbebe X vizuri. Mkono inakua, so sishiki mkono nabeba na shingo. Eh. Haya mpeleke kule. Pole pole asigonge kichwa, hiyo ni mbao. Make sure amefika mwisho.

Songa tu karibu na yeye. Haya, toa mkono yako hapo chini, shikilia juu. Kichwa yake iko vizuri.

Parent: Mm, eh

Nurse: Yes, mama X, kama X amekua mrefu ama hakui, sawa?

Parent: Mm

Nurse: 57.2 (cm), haya mvalishe nguo mummy. Unaanza na socks, baridi.

Parent: Mm

Nurse: Ako na 3.9kg, urefu… mvalishe tukiongea, urefu ako na 57.2 cm.

Parent: Mm

Nurse: Kilo kulingana na age, weight for age, eh, ako normal. Si yuko six weeks?

Parent: Eh, ako six weeks

Nurse: Eh, kilo yako kulingana na 6 weeks yake, age. Ako sawa Urefu pia kulingana na age yake, inasema yuko normal.

Parent: Eh

Nurse: So kwa hivyo leo, nitamdunga sindano mbili. Moja kwa paja yake na ingine kwa paja yake. Sawa.

Parent: Mm.

Nurse: Pia jambo linguine, ni vizuri tukianza family planning. Si tumefika six weeks? Ndio tunapatia mtoto spacing ndio agrow vizuri. Eh, so that even you, your body goes back to where it is supposed to be. Sawa?

Parent: Mm

Nurse: Eh, then anakua vizuri ndiyo sasa ukitafuta mwingine, wanaachana wanakuwa salama.

Parent: Mm.

Nurse: Haya. Alafu pia kukula, jana asubuhi ulikula nini Mama X

Parent: Leo?

Nurse: Jana asubuhi, eeeh, jana asubuhi

Parent: Si ni chai tu

Nurse: Chai na

Parent: Chai na mkate

Nurse: Na mkate, alafu saa nne ulikula nini ?

Parent: Uji

Nurse: Uji, na nini ?

Parent: Ndizi moja

Nurse: Yenye imeiva?

Parent: Mm

Nurse: Ehe, saa saba? Jana saa saba

Parent: Nilikula ugali

Nurse: Ugali na ?

Parent: Sukuma

Nurse: Na Sukuma, ikifika saa tisa, saa kumi, ulikula nini?

Parent: Chai

Nurse: Chai na ?

Parent: Mkate

Nurse: Na mkate. Kisha usiku

Parent: Nilikula ugali

Nurse: Ugali na ?

Parent: Saget,

Nurse: Na?

Parent: Saget, isagaa

Nurse: Isagaa,

Parent: Eh

Nurse: Isagaa, oh. Leo asubuhi?

Parent: Chai

Nurse: Chai na?

Parent: Pamoja na cake

Nurse: We unakula vizuri, endelea kula hivyo vizuri. Sawa? Una make sure unakula vizuri ndio usisikie kizunguzungu. Eh.

Parent: Mm

Nurse: Pia una make sure unazingatia usafi wa mwili yako na ya X. Eh. Mwenye X anfuata ako how old?

Parent: Eh?

Nurse: Mwenye X anafuata ako na miaka ngapi?

Parent: Ako na 8.

Nurse: Hiyo ni sawa. Utaenda hiyo room ya kwanza, atadungwa. Halafu mkimaliziwa, mwenye atamdunga, mtafuatana na yeye kule nyuma kwa family planning.

Parent: Sawa

Nurse: Ama unaenda kudiscuss na Baba X? Method?

Parent: Ah, ah, hiyo haina story. Hiyo ni chaguo languo. Mimi ndiyo nitaamua

Nurse: We ndio unaamua. Huendi ku consult na Baba X (both laughing lightly)

Parent: Hakuna

Nurse: Mbona? Atakataa usifanye

Parent: Hawezi kataa, lakini hiyo ni yangu.

Nurse: Kweli.

Parent: Mi ndio nalea, siyo yeye.

Nurse: Wewe ndiyo unalea siyo yeye. Lakini ni vizuri, wazazi wawili mkiamua

Parent: Ye hana shida.

Nurse: Sawa sawa Mama X, ushasema!

Parent: Sawa.

OUT-PATIENT

Consultation 12. Patient: 3 year old child, Parent: Mute Female 30 years old

Parent: Gestures greeting and points to the child

Doctor: Returns greeting in gestures

Parent: Rubs chest to show congestion in chest and runny nose.

Doctor: Sasa X. Uko poa ?

Patient: Poa

Doctor: Kuna infection, hata macho yanaonesha (examines the child)

Doctor: Gestures to the parent to follow him to the pharmacy.

Consultation 13. Patient: 7 years old, Parent: Female 35 years old

Doctor: X. ako na shida gani leo ?

Parent: Ako na fever

Doctor: Joto

Parent: Kichwa ina muuma na anasema meno

Doctor: Meno inamuuma pia.

Parent: Na hana appetite.

Doctor: Siku ngapi sasa?

Parent: Alianza Wednesday.

Doctor: Anakohoa, hana homa?

Parent: No

Doctor: Temperature saa hii ni 35. Mwili inakua moto saa ngapi?

Parent: Inakuja tu dakika yoyote halafu inapotea.

Doctor: Hajasema masikio inauma?

Parent: Sijasikia akisema masikio.

Doctor: Alright, hebu tuone mdomo….Eh, meno yake imepasuka pasuka.

Parent: Meno nayo hananga meno, hata ishaoshwa, hiyo tunaita root canal. Ishaoshwa moja ikatolewa. Walisema mtoto kama huyo hafai kutolewa meno lakini hiyo ilikuwa imeoza, ilikuwa na uzaa.

Doctor: Hiyo ndiyo inaleta joto kwa mwili. Tutampatia some antibiotics na pain killers lakini itabidi aone daktari wa meno.

Consultation 15. Patient: Female, 23 years old

Doctor: Tuko na shida gani leo ?

Patient: Tonsils (whispering). Uchungu hata usiku mzima sikulala.

Doctor: Wapi?

Patient: Tonsils, hata ukishika hivi unafeel

Doctor: Hapo ndani kwa koo, ndani kwa..si inaitwa koo

Patient: So nikimeza tu kitu – uchungu

Doctor: Pole.

Patient: nakwambia tonsils, inanifanya nikiinama hivi, hii kichwa yangu inakuwa nzito sana

Doctor: Headache. Joto, baridi?

Patient: Hiyo ilikuwa lakini nili-buy-ingi dawa ya malaria sababu nilikuwa natoka mapema narudi late

Doctor: (laughs) ulikunywa dawa ya malaria?

Patient: Si nilikuwa na hiyo, nasikia baridi

Doctor: (interjects) joto na baridi

Patient: lakini nikilala, ukinikugusa hivi unasikia kama mimi ni moto sana

Doctor: Hmm? hiyo ilikuwa lini?

Patient: Ilikuwa last week

Doctor: Last week. Ulimaliza dose

Patient: Hiyo ya malaria? Sikuwa na pesa ndiyo nika-buy half of it

Doctor: Kwani ulikuwa umetravel

Patient: Ah ah!

Doctor: Na sore throat imeanza lini?

Patient: Hii, ilianza tu hiyo siku, kuna capsules za purple na huku side ingine ni black, hiyo pia nili-buy half of it, ah ah, hiyo nili-buy full, ya malaria ndiyo nili-buy half, lakini haikunisaidia

Doctor: hebu tuone koo, sema ah, hebu meza mate. Naona tonsils ziko a bit swollen.

Patient: Hata ukishika hivi unafeel

Doctor: Hizi lymph nodes zime-swell. Hapa

Patient: Hizo tu mbili, ndiyo sababu zinauma sana ?

Doctor : Hizo capsules ulimeza siku ngapi hivi ?

Patient: Nilimeza 4 days zikaisha. Sababu ilikuwa ikimezwa a day 4.

Doctor: Uko-sure hazijakusaidia?

Patient: Haijanisaidia sababu ndiyo hiyo tonsils yenyewe haijaisha. Eh! Imeniuma usiku waah!

Consultation 19. Patient: Male, 57 years old

Doctor: Leo ukona shida gani?

Patient: Nilikuwa Kisumu juzi

Doctor: Kisumu wapi?

Patient: Ahero, pahali ya mchele bwana. Niliumwa na mosquito mbaya huko.

Doctor: Hakuna net nyumbani?

Patient: Hata kama iko net. Jua saa ile hujaanza kulala, unakaa vile umekaa

Doctor: Si unatumia long sleeved clothes

Patient: Iko zingine zilipita

Doctor: Ingine iliingia? Uko na dalili gani?

Patient: Joto, baridi, joints zangu nasikia uchungu hmm, halafu ikifika usiku ni kama kifua yangu haiwezi breathe in.

Doctor: Eh? Hauwezi breathe in properly?

Patient: Mara mdomo, mara pua lakini mashida shida. Kama last night nilikuwa na hii problem sana

Doctor: Mgongo?

Patient: Nikitaka kubreathe, pua – hakuna, so na breathe na mdomo, mdomo pia saa ingine pia inasumbua

Doctor: Mapua inafungana, ni kama uko na homa

Patient: Mmhm

Doctor: Nimesikia ukikohoa

Patient: Imejaa kwa kifua yangu

Doctor: *Ifwolo?* (asked in *dholuo* to understand the intensity of the cough)

Patient: Responds in Dholuo

Doctor: Headache? Kichwa haiumi si ndiyo ?

Patient: Inaniuma. Nilikuwa ninatetemeka hivi bana, mdomo tarararara, kama jana.

Doctor: Eh? Siku ngapi hivi?

Patient: Ilianza Wednesday na jana, hmm, 2 days…

Doctor: Haya, enda ufanye malaria test, hii ndiyo itahakikisha kama uko na malaria au hauna.

Consultation 16. Patient: Female, 50 years old

Doctor: Umetutembelea leo.

Patient: Mmh

Doctor: Leo unasemaje?

Patient: leo nimekuja tu, clinic

Doctor: Clinic. Clinic ya pressure ama sukari?

Patient: Yote.

Doctor: Kitabu iko wapi?

Patient: Kitabu nilikuwa nayo. Nimetafuta kitabu, hata sijui imekuwa wapi. Sa ndiyo nimekuja na ingine

Doctor: Umeshachukua breakfast?

Patient: Leo?

Doctor: Eeh.

Patient: Hapana

Doctor: Tupime sukari

Pressure imepanda juu. Dawa ilikuwa imeisha ?

Patient: Eeh.

Doctor: Hujatumia dawa siku ngapi?

Patient: Siku mbili

Doctor: Unasumbuliwa, mbona hutaki kutumia dawa?

Patient: Si hizi dawa sitaki kutumia, saa zingine inataka pesa

Doctor: Huh?

Patient: Saa zingine huna pesa

Doctor: Si unakuja unanunua hapa. Hapa ni cheap.

Patient: Unakuja tu kwa chemist

Doctor: Ah, ah. Unakuja nakuandikia ndio unachukua.

Patient: Si ndiyo unachukua na pesa. Ama?

Doctor: Eh. Leo hakuna shida yoyote

Patient: Mm, mm.

Doctor: Wacha upimwe sukari kwanza.

Doctor: Lakini dawa unakumbuka

Patient: Eh. Najua kweli.

Doctor: Unatumia dawa gani?

Patient: Elaraprine

Doctor: Elaraprine ni ya?

Patient: Na glucomate.

Doctor: Elaraprine ni ya? Sukari ama pressure ?

Patient: Ni ya sukari, ni, ni ya pressure.

Doctor: Na ya sukari

Patient: Glucomate

Doctor: Glucomate. Dosage? (Brief pause as patient looks at clinician)

Doctor: Unameza aje?

Patient: Glucomate? Asubuhi na jioni

Doctor: Asubuhi ?

Patient: Nameza mara mbili.

Doctor: Asubuhi unameza tembe ngapi hivi

Patient: moja moja

Doctor: za 500mg ama?

Patient: Mmh.

Doctor: si 850? Naona 850, ulipatiwa 850 last. Unatumianga 850

Patient: 850, eh.

Doctor:Si ndiyo. Hujakunywa chai ? Sukari ni 11.3. Iko juu kidogo si ndiyo?

Patient: Eh

Doctor: Inafaa ikuwe chini ya sita, kama hujakunywa kitu. Hujatumia dawa leo?

Patient: Mm, mm.

Patient: (inadudible) niliandikiwa dawa ingine hapo.

Doctor: Uliandikiwa lini?

Patient: Dawa inajiita vasoprine, sijui vasoprine, na ECTZ

Doctor: ya pressure?

Patient: Eh, ya pressure.

Doctor: Vasoprine unameza aje?

Patient: Moja moja.

Doctor: Nogluc. Nogluc , ile ndogo ya sukari unameza moja moja

Patient: Ya sukari si na kuanga tu na moja

Doctor: Eh, ziko mbili

Patient: Hmm? ati inajiita?

Doctor: Nogluc. Ile ndogo ya sukari. Hiyo utameza moja kwa siku.

Patient: Eh, iyo ndogo.

Doctor: Hakuna shida yoyote?

Patient: Mm, mm.

Doctor: Enda uchukue dawa

Patient: Asanti.

Consulation 20. Patient: Female, 33 years old

Doctor: X. Leo uko na shida gani?

Patient: Kuna shida yenye ilinileta last time, nilipewa dawa na ninasikia ni kama imerudi tena

Doctor: Imerudi siku gani, imerudi lini ?

Patient: Juzi, jana.

Doctor: Uko na shida gani, by the way?

Patient: Ni kuwashwa huku chini

Doctor : Chini kwa vagina

Patient: Mmh. Halafu hata nilikuona tu wewe, ukaniandikia dawa. Sijui ilikuwa mwanzo ya hii mwezi ama last month ikiisha lakini sijakawia sana. Ndiyo hiyo imerudi, sasa sijui shida ni nini.

Doctor: Unajikuna chini kwa vagina

Patient: Mmm, inawasha kabisa.

Doctor : Hmm ? Shida ingine ?

Patient: Ni hiyo tu inanisumbua

Doctor: Damu ya mwisho ilikuwa lini

Patient: Niko mja mzito saa hii.

Doctor: Clinic unaenda wapi?

Patient: Naenda level 3

Doctor: Kitabu iko wapi?

Patient: Sijakuja nayo.

Doctor: Unasema inawasha sana? Hakuna dawa ingine unatumia?

Patient: Mm -Mm.

Doctor: Hiyo ni yeast infection. Inapenda kusumbua waja wazito.

Patient: Hmm?

Doctor: So this time, tutaongeza dawa ya kupaka, sawa? Tutarudia ile ingine ya kuingiza ndani. Sawa sawa?

Patient: Sawa

Doctor: Inasumbua lakini si shida kubwa sana.

APPENDIX 2: HEALTH FACILITIES' ADMINISTRATORS INTERVIEWS

USHIRIKA HEALTH CENTRE

RESEARCHER: Approximately how many patients does your facility serve daily?

ADMINISTRATOR: It serves on average 5 patients daily. This is slow. Before Covid, we used to serve 20 patients per day but that has changed since the Level 3 Government hospital was opened. Patients go there for consultations because it is free. We charge a small fee.

RESEARCHER: Does this health facility offer English-Kiswahili interpreting services?

ADMINISTRATOR: Not formally. We do it through our nurses because we tend to serve female patients.

RESEARCHER: If this facility offers interpreting services, are the interpreters:

a. **Qualified interpreters within your organization?**
b. **Free-lance interpreters?**
c. **Staff within your organization who are fluent in English and Kiswahili?**

ADMINISTRATOR: Staff within our organization who are fluent in English and Kiswahili.

RESEARCHER: If this facility does not provide interpreting services, which option closely accounts for this:

a. **Cost of hiring qualified interpreters**
b. **It is not necessary because communication is not hampered.**
c. **Patients recruit family members or friends as interpreters**

ADMINISTRATOR: Sometimes patients recruit family members or friends as interpreters
Our nurses and staff serve as interpreters when need arises

RESEARCHER: Does social status, gender or level of education of family members that serve as interpreters affect communication during clinic visits?

ADMINISTRATOR: The members of the community who come with interpreters don't seem to have any preference, as long as they feel comfortable in our facility and with our staff. It does not affect communication.

RESEARCHER: Socio-cultural factors (for example, personal attitudes, communal beliefs) are a challenge to health service provision – Strongly agree, Agree, Neutral, Disagree, Strongly disagree.

ADMINISTRATOR: I agree. Communal beliefs are constant challenges. Sometimes, they will look at each other's lab request forms, curious as to why they have varying check marks on the forms. We must explain to them why the tests are different and necessary for each individual.

RESEARCHER: How does your organization deal with the socio-cultural factors presented. Kindly explain.

ADMINISTRATOR: To deal with these factors, we have a counsellor on site to help them understand the importance of the services they will receive, despite their beliefs or attitudes.

RESEARCHER: Are there any communication intervention measures that your organization could benefit from? Kindly list them.

ADMINISTRATOR: Our facility serves people from different ethnic communities. These are people from the Luhya, Luo, Kikuyu and Maasai communities. There are many Luhya people who live around here. The Luo community are populous but need the most intervention because

even the younger ones speak Dholuo more than Kiswahili. We receive elderly Kikuyu patients, and the Maasai are now present because they are the security guards for shops in this area.

Some patients prefer the use of their mother tongue. They will go into the consultation speaking Kiswahili then quickly switch to their mother tongue.

Maybe vernacular to Kiswahili interpreting is more beneficial.

RESEARCHER: Does your facility still benefit from services offered by foreign doctors?

ADMINISTRATOR: Yes, they do come, but randomly. They will be invited for medical camps sponsored by international bodies such as UNICEF. When they come individually, it will be done in collaboration with our nurses and doctor. Our staff serve as interpreters, when needed.

RESEARCHER: You mentioned different communities that frequent your clinic, from a previous question. Do you have staff members that can interpret from and into all those languages?

ADMINISTRATOR: From the Luhya, Luo and Kikuyu perspective, we have at least one staff from each of those ethnic communities who can interpret.

TABITHA CLINIC

RESEARCHER: Approximately how many patients does your facility serve daily?

ADMINISTRATOR: We serve 35 patients daily, in our outpatient clinic. 200 in total daily across different departments in the entire hospital.

RESEARCHER: Does this health facility offer English-Kiswahili interpreting services?

ADMINISTRATOR: Yes, through our staff and clinicians

RESEARCHER: If this facility offers interpreting services, are the interpreters:

- **a. Qualified interpreters within your organization?**
- **b. Free-lance interpreters?**
- **c. Staff within your organization who are fluent in English and Kiswahili?**

ADMINISTRATOR: There are staff members who are fluent as well in Luo, Luhya and Kisii. They are called upon to interpret when needed. There is a nurse who is trained in Sign language interpreting.

RESEARCHER: If this facility does not provide interpreting services, which option closely accounts for this:

- **a. Cost of hiring qualified interpreters**
- **b. It is not necessary because communication is not hampered.**
- c. **Patients recruit family members or friends as interpreters**

ADMINISTRATOR: I would say option (a) and (c). This is a Not-for-Profit organization. Our budget restricts us from hiring qualified interpreters. In addition to family members, our staff facilitate the communication process well. At the end of the day, communication is not hampered.

RESEARCHER: Does social status, gender or level of education of family members that serve as interpreters affect communication during clinic visits?

ADMINISTRATOR: No. The patients chose a relative they trust irrespective of the above factors. They also consider the level of fluency of language of their interpreter. Those that interpret, only want to get help for their relatives.

RESEARCHER: Socio-cultural factors (for example, personal attitudes, communal beliefs) are a challenge to health service provision – Do you Strongly agree, Agree, Neutral, Disagree, Strongly disagree?

ADMINISTRATOR: I agree. Cultural and religious factors, for example use of contraceptives are a challenge.

RESEARCHER: How does your organization deal with the social cultural factors presented. Kindly explain.

ADMINISTRATOR: Heath education. At TC, we regular sessions where we teach members of the community on importance of putting culture aside to safeguard their health. We teach them at their own level, covering every aspect of health topics. We also offer counselling services for cases that need to be dealt with on an individual basis.

RESERACHER: Are there any communication intervention measures that your organization could benefit from? Kindly list them.

ADMINISTRATOR: Interpreter training will be beneficial to our staff. We prefer our staff to interpret because of patient confidentiality. However, the cost of training is an issue for us since we are a Not-for-Profit organization. If we could get assistance in training, that would be wonderful.

Across two languages, it is very important for meaning to be preserved. I believe training will assist us in this respect.

RESEARCHER: Your facility is located in an area that is known for Luo language maintenance, what is the first language used when new patients visit?

ADMINISTRATOR: The staff will speak to them in Kiswahili, they'll ask "unasikia Kiswahili?", we then ask for their preferred language.

RESEARCHER: You mentioned the dual-role that some of your staff take on as interpreters, does it affect their regular duties?

ADMINISTRATOR: Their busy schedules may affect follow up questions beyond the consultations, since they have their own patients in other departments to cater to.