

University of Cape Town

An analysis of communication between health-care workers and Xhosa-speaking patients in a Cape Town hospital, from the perspective of language cognition and inter-cultural communication

Minor dissertation submitted in partial fulfilment of the requirements for the degree: Master of Philosophy in Applied Language and Literacy studies

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Declaration

I hereby declare that this dissertation is my own original work and has not been submitted before to any institution for assessment purposes.

Further I have acknowledged all sources used and have cited these in the bibliography.

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I would like to thank God for His grace towards my family and me.

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Abstract

The investigation seeks to establish whether vital information is lost or not communicated properly due to differences in language between medical practitioners and patients. In particular the thesis is concerned with English-speaking doctors and their Xhosa-speaking patients in Cape Town. This thesis studies interactions between ten Xhosa patients and five English-speaking doctors at the Red Cross hospital in Cape Town. It examines terminological issues, especially the names for illness as understood by doctors and patients. It also examines communication difficulties pertaining to a lack of complete fluency in the respective second languages. Culture-bound assumptions about illness and communication of important information are also studied. The thesis contends that vital information does tend to be minimised or even lost and examines the consequences of this loss, and makes recommendations in order to minimise miscommunication and enhance communication.

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Chapter 1: Introduction and Overview

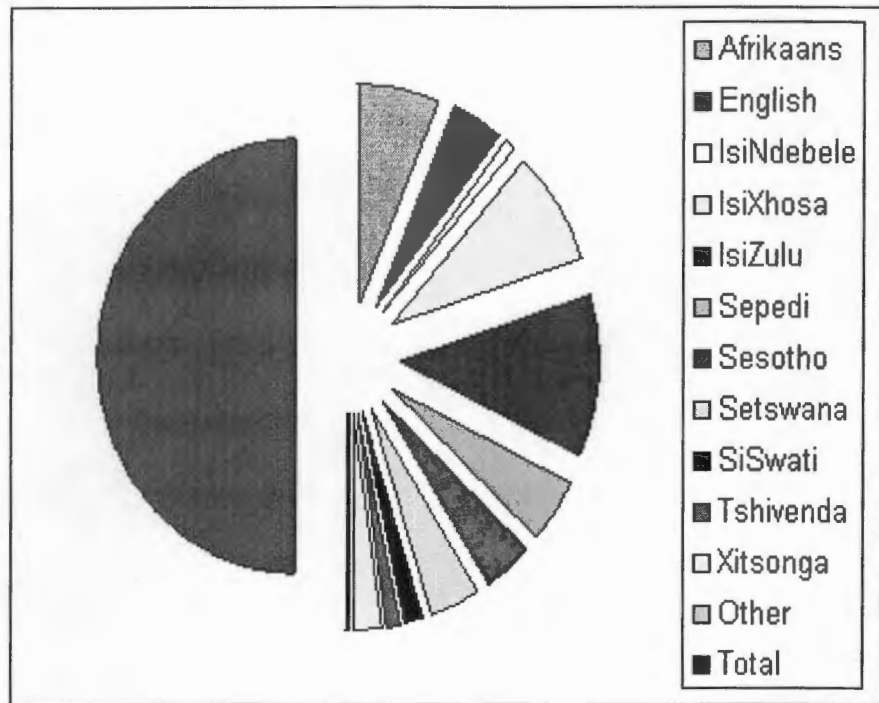
1.1 Background and Research Problem

There were a number of changes in South Africa after the first general Democratic elections of 1994. The national constitution was revised and redrafted to suit the 'New South Africa'. Section 6 of the New Constitution recognises all South African eleven Languages as equal and official, "The official languages of the Republic are Sepedi, Sesotho, Setswana, siSwati, Tshivenda, Afrikaans, English, isiNdebele, isiXhosa and isiZulu" (Chapter 1, section 6). By making all eleven languages official, the constitution encourages multilingualism in South Africa. Amongst other things that it recognises is that every South African is entitled to proper health care facilities and access to medication. However, the difference in languages remains a barrier in acquiring and accessing such proper health care services especially when other languages are more used and perceived to be more prestigious than others. As Crawford (1999:29) argues, "... the monolingual nature of the health systems must be understood in the context of any apartheid-constructed society where black voices have been historically suppressed; further, that the untrained, unrecognised interpreter/nurse occupies a contested and ambivalent position within the construction of a medical discourse that does not enable the patient's voice". If indeed doctor/patient communication, in the health sector, has been deeply affected during the apartheid era as argued by Crawford, this investigation hopes to work towards positive and practical linguistic solutions,

involving the study of concept formation for L1 speakers of African languages where an equivalent to English does not exist.

A contributing factor to the language problem in the health sector is cultural differences. Problems resulting from cultural differences are also pointed out by Trudgill (1984:131), quoted by Kaschula (1995:28), who argues, "differences...between cultures can often lead in cross-cultural communication, to misunderstanding and even hostility". The South African Health sector is no exception in this regard, as language plays a major role in communication.

Another contributing factor to the language problem in the health sector is the fact that the curriculum and literature student doctors' use is mostly written in English, which therefore restrict their terminology in examination and diagnosis to only English. The English terminology preference is in contrast with the national survey conducted in 2001 on Languages, which found amongst other things that 23.82% of the population speaks, understand and prefer Zulu; and 17.64% speak, understand and prefers Xhosa. English was found by this survey as spoken and understood by 8.20% of the population. See below the language statistics:



<u>Language</u>	<u>Weight</u>
Afrikaans	13.35
English	8.20
IsiNdebele	1.59
IsiXhosa	17.64
IsiZulu	23.82
Sepedi	9.39
Sesotho	7.93
Setswana	8.20
SiSwati	2.66
Tshivenda	2.28
Xitsonga	4.44
Other	0.50
Total	100.00

Survey: Statistics South Africa Language 2001

From these statistics, one can argue that the majority of the population does not speak or understand English and therefore, not (linguistically) well represented in hospitals, which indeed may impact on the nature of communication between doctors and patients. According to Mesthrie and McCormick (1999: 3), the South African government is aware that the language problems in the health sector resulted from the previous language imbalances in the country. Hence they point out that the health sector is "another key sector identified by the government as needing to shift towards a more inclusive primary health-care model". Should this 'shift' be successful, the government would have been able to successfully implement * point two of Section six of the national Constitution, which promotes "the recognition of historically diminished use and status of the indigenous languages of our people..."

Since the start of this research project in April 2003, the national government has embarked on what could be referred to as a major breakthrough in addressing *linguistic imbalances* in South Africa. The Director General of Arts and Culture and Science and Technology Prof. I Mosala presented the Implementation plan within the National Language Policy Framework. According to Prof. Mosala the implementation plan outlines the strategies that will be used in implementing the Language Policy, proposing structures that will be key to implementation and mechanisms that will be employed to accelerate the development and promotion of our African languages. (Final Draft, Implementation Plan 2003:3)

In his foreword, Prof. Mosala elaborates further that the implementation resulted from the government being “conscious of the challenges involved in the efficient management of linguistic diversity” (2003:3). The policy's main aim, according to him is to “... promoting the equitable use of the 11 official languages with a view to facilitating equitable access to government services, knowledge and information, as well as respect for languages rights” (Implementation Plan 2003:5).

After the implementation of language policy was launched at the national level, it was also presented and launched in all provinces. The provincial launch was due to the fact that different provinces abide by different provincial constitutions. For instance, “ The Western Cape Provincial Languages Act, 1998 (Act 13 of 1998) initiated the process of multilingualism by giving Afrikaans, English and isiXhosa equal status as the three official languages of the province.” (Costing the Western Cape Language Policy, 2003:8). On the 28 May 2003, the Western Cape Language Policy Framework was launched. The Western Cape Language Policy document expresses that “Health is one of the most critical areas on which the language policy will impact.” (Costing the Western Cape Language Policy 2003:20).

The reasons for the health sector to be seen as the “critical area” to be looked at by the language policy is raised by the available data on the first language profile of the health care professionals (doctors and nurses) in the

Western Cape. The first language profile of these professionals was as follows: "Afrikaans 12 013 (46%), English 11 218 (45%) and isiXhosa 1 394 (6%)" (Costing the Western Cape Language Policy 2003:49). It further established that further to the 6% first language speakers of Xhosa health care professionals, only 17 (1%) first language Xhosa speaking doctors forms part of the 1 691 doctors registered in the Western Cape.

To increase proficiency in all three languages in the Western Cape especially in Xhosa, the language policy promotes amongst other issues "a reward or merit system for staff who have competence in the three languages, including doctors, nurses and other health professionals and emergency services staff" (p20).

1.2 The issue of translators/ interpreters

The Western Cape Language Policy further expresses the view that in the health sector "interpreting between patients and health-care professionals is the critical area for improvement." The policy bases its emphasis on the fact that "doctors rely heavily in some areas on the use of informal interpreters for isiXhosa patients." (p20) this practice is found by the policy to be risking "poor interpreting and hence poor diagnosis of medical problems" (ibid.). Crawford (1999:29), who argues against the use of the "untrained and unrecognised interpreters/ nurse", expresses a similar argument. In her argument, Crawford also questions the commitment to and the quality of what is being interpreted if the interpreter is not qualified and not remunerated for his or her services.

Geist (1994:317) argues that translators can to a certain extent “mitigate” the problem. However, she quotes Fitzgerald (1998) and Galanti (1991) who argue that “parents or family members can complicate or obstruct efforts to negotiate understanding” (ibid.). This view contrasts with that of the Western Cape Language Policy (2003) and Crawford (1999) who argue that the use of untrained interpreters leads to the risk of poor diagnosis. Geist further suggests that the use of interpreters does not necessarily bridge the gap, sometimes created during doctor – patient communication. She believes this is so because “even with expert translation, problems such as linguistic differences between terms in English and other languages can present difficulties ... (ibid.)

One can also argue that the South African language situation is especially complicated. Not only does the country have eleven languages but also most of these languages have different dialects. For instance, within Xhosa-speaking community there are different dialects such as the Hlubi, Pondo, Baca and the Mfengu. Professional translators may also be at risk of using or be more familiar with a dialect different to that of the patient, if she is originally from the Eastern Cape. According to the colleagues I consulted in this issue of dialects, there is no common dialect in the Western Cape. The same dialects used in the Eastern Cape are also used in the Western Cape. Not only are dialects a “problematic issue, technical terms may sometimes encourage misunderstanding even to a skilled interpreter”. Geist (1994:317) argues, “Translator’s use of medical jargon and technical vocabulary also

may contribute to communication difficulties". She bases her argument on a case study where an Anglo nurse explained to her patients the harmful side of the medication the patient had to take. In the nurse's understanding and observation, the patient understood English. Her understanding was based on the fact that the patient and her husband kept on nodding "in agreement and understanding and laughed nervously". It turned out, as Geist put it, that the couple did not understand a word the nurse was saying. She argues that this pretence was because "dignity and self-esteem are extremely important" (1994:317) for some of the patients, who would pretend to understand when they do not.

The same argument could be made for translators. Geist further argues that "translators sometimes choose not to translate exactly what patients say for any number of reasons, embarrassment, desire to portray the culture in certain light, or lack understanding" (1994:317). She believes interpreters sometimes select from the patient's response that which they think is relevant, telling the doctor what they think of the patient's response. The problem with this behaviour is that in selecting what they think is based on reasons rather than superstition, they do not necessarily relay to the doctor the exact patient's response. Geist, cites Fitzgerald (1988:65) that sometimes when the health-care practitioner may ask "how do you feel?" and the translator spends a long time conversing with the patient but only relay "fine" to the doctor as the patient's response.

In the view of these problems presented in this chapter so far as outlined by the Implementation Plan (National Language Policy Framework 2003 and Costing the Western Cape Language Policy 2003,) the language policy strongly promotes "the development of terminology for medical use in isiXhosa and ensuring the use of the three official languages [English, Afrikaans and Xhosa] in health training materials and programmes, including the Nursing and Emergency Services Colleges". This research hopes, amongst other things, to also encourage not only the "terminology for medical use" in Xhosa but also to make strong recommendations for medical students' curriculum as far as languages are concerned. It aims to address language issues but also cultural diversity in South Africa, resulting in what Waxler-Morrison refers to as "cross-cultural caring" (1990:6).

The interest in conducting this investigation was prompted by involvement I had with a research team at the Paediatric hospital in Cape Town, December 2002 summer holidays as a senior researcher. The primary goal for the research was to establish whether English-speaking doctors and Xhosa-speaking patients understand and use similar words (Xhosa or English) to describe diseases. If so, do both patients and doctors understand illnesses like pneumonia similarly or differently? The interest in the naming of diseases and illnesses was done as to discover whether or not they understand each other during examination or they appear to understand each other as they use similar words but referring to different illnesses.

My involvement with the Paediatric hospital's research ended in December 2002. Agreements were reached that I could use the data for my Masters thesis, as I had been a senior researcher in the project. I was not involved with analysing the data generated in the previous project.

Chapter 2: Literature Review

Introduction

A vast literature exists about the issues, the problems and the concerns surrounding health communication in the United States of America. It is evident from the literature reviewed that the interest in the study of health communication, is triggered by the ever increasing number of immigrants in the USA. These immigrants are not always proficient in English, which is the language of majority. Quite a number of these studies have looked at and used Spanish and Chinese-speaking people as participants (Kleinman et al 1978).

Literature Review: Case studies around the world

One noticeable commonality in the studies of Spanish and Chinese speaking groups is that they are in minority as far as language representations in USA are concerned. The speakers of such minority languages are forced to conform to language expectation regarding English proficiency in the United States. For instance, the Spanish and Chinese-speaking people are in a way "forced" to speak English which some are not comfortable with and not proficient in. Hence Kay's (1979) study conducted in America using Spanish women as participants found that for the patient to switch into the *doctor's language* is often uncomfortable and indeed limits the conversation to *Yes* or *No*. She found that where a patient and a doctor do not share a common

language in many instances it is the patient who needs to “compromise” and uses the doctor’s language. Kay further argues that where patients compromise and uses the doctor’s language, they experience discomfort. Such discomforts, she adds, limit women from engaging into a lengthy conversation during examination, hence the use of ‘Yes’ or ‘No’ answers. She further found that where patients are uncomfortable in a doctor’s language, they develop a negative attitude towards it.

Kay found that the attitude to the doctor’s language may further discourage communication especially if the patient is perceived to be inferior due to her “communicative incompetence” in her second language, L2.

Kleinman et al (1978) takes a different approach in analysing the reasons for the communication breakdown between doctors and patients who do not always speak the same language. For Kay (1979), the reasons for a communication breakdown are largely due to lexical change and semantic shifts. Kay argues that culture is dynamic, it changes all the time. For Kay, this cultural change impacts on a number of cultural beliefs resulting in a shift in meanings and in change of the general view of things. She believes that in such instances, speakers of that language should make adjustments to their vocabulary. This change, she adds could be attained by borrowing or coining of new terms.

Kleinman et al (1978)’s view on this matter is that, the difference in cultural beliefs, traditions and different explanatory models, (the notions about an episode of sickness and its treatment that are employed by all to be engaged

in clinical process (Herman 1984:72)), and expectations of patients and doctors about an illness results to communication breakdown. Kleinman's conclusion is based on the studies he conducted in a US hospital, using Chinese men as his participants. He found that amongst other problems that impact negatively on doctor/patient communication, cultural beliefs play a major role in treating a patient from a different cultural background from the doctor's. To illustrate his view, he gives an example of his observation at the USA hospital. A Chinese-speaking man did not take his western medication as prescribed by the doctor and even refused psychotherapy. The Chinese man's reasons for rejecting biomedicine [on this term see 2.3], as later discovered by Kleinman, was due to his belief that his illness is a direct result of sleeping with prostitutes. Since the man "knew" what was "wrong" with him, he also believed that could only be cured by Chinese traditional therapy. According to Kleinman, the man's family and close friends also shared his beliefs, which made even his stance even stronger in rejecting biomedical treatment.

The patients' and doctors' explanatory model perspective is also shared by Helman (1984:72) who argues that "where the medical care is utilised also depends on the perceived aetiology of the conditions, whether it originated from the individual or in the natural, social or super natural worlds". Helman reinforces Kleinman's observation that cultural beliefs are very influential in a person's understanding of his illness and treatment thereafter. It is in this regard that Helman (1984) as well as Kleinman (1975) argue that it is highly critical that doctors do understand the patient's explanatory model to

understand the patient's culture, beliefs and expectation. This understanding of the patient's background could be achieved as both authors believe, by asking a patient direct questions and by communicating to the patient, the doctor's model in ways that the patient could either identify with or understand.

Like Helman (1984) and Kleinman (1975), Geist (1994) also shares the patient's cultural belief perspective. For Geist (1994) health-care workers should acknowledge the fact that the society we live in today is culturally diverse. Hence patients have "different, national, regional, ethnic, race, socio-economic and occupational orientations that influence interactions in health care settings" Kreps (1992) in Geist (1994:11). Geist argues that when healthcare workers are aware of such cultural diversity they tend to be understanding towards patients, perceptions and expressions of symptoms.

Geist (1994) believes that in any other countries, such cultural differences amongst patients and health-care workers could be somehow resolved, just like in the United States, by introducing the field of Transcultural Nursing. She quotes Leiniger (1991) who describes Transcultural Nursing as "a humanistic and scientific area of formal study and practice, focusing upon differences and similarities among cultures with respect to human care, health (or wellbeing), and illness based upon the people's cultural values, beliefs and practices" Geist (1994:311). Geist strongly believes that Transcultural Nursing is essential as it prohibits nurses from imposing on patients their own cultural beliefs this providing them with what she calls

“cultural-specific or culturally congruent care” (1994:312). However, Geist does mention that “Transcultural Nursing has been criticised by other scholars for its limited notion of culture as a “unified whole with a direct cause and effect relationship upon behaviour” (ibid.)

Although, cultural differences seems to be a major problem in cross-cultural caring and seems as if it could be addressed by introducing Transcultural Nursing, different languages involved are also key factor in misunderstandings between health-care workers and patients. Geist (1994) discusses patients whose languages are different from that of the doctor. Lack of English language competence complicates efforts to reach understanding between patients and health-care providers.

2.3 Literature Review: Case studies from South Africa

The South African situation is no different to that observed in United States by the scholars whose work is reviewed in this chapter. It may be argued that the South African situation as far as health communication is concerned is worse than that in the USA. This is so because, unlike in the USA where patients with difficulties in communicating with English-speaking doctors form a small part of the population, a large percentage of the South African population (as found by 2001 survey), cannot speak or understand English.

Crawford (1999) analysed language use in health services in Cape Town. She analysed the plight of Xhosa-speaking patients in their interaction with English-speaking doctors. One of the problems she found is that the

majority of doctors emerge from medical schools largely unequipped to function with Xhosa-speaking clientele. She argued that because of this problem, doctors often need interpreters to engage with their patients.

The problem with doctors who emerge from medical schools unequipped or not proficient in Xhosa as argued by Crawford, is being demonstrated by what emerged from Red-Cross Children's Hospital during the research conducted there in 2002. It will, however, be dealt with in depth in chapter IV.

Chick (1999) focuses more on the technical aspects of inter-cultural communication in educational and business, rather than medical settings. He uses as models, case studies of L1 (first language-speakers of South African English, interacting with L1 Zulu-speakers of English (ZE). He further looks at L1 SAE speakers interacting with L1 Afrikaans speakers of English. He maps out the communicative dynamics of intercultural communication. He does so by highlighting the role of power with politeness strategies that the participants engage in. He argues that, the chances of miscommunication based on the politeness strategies that a person on cultural group interact with a culturally different person or group, may lead to the formation of cultural stereotypes. He further argues that the stereotype problem may have far-reaching consequences as it often results in what he calls "misevaluation of the abilities" of people. Chick points out that consequences may be more severe for the evaluated people if they are from a "socially and economically weaker or politically sub-ordinated group" (1995)

Kirsch et al (1996) however attempt to respond to the problem sometimes faced by doctors who are not proficient in Xhosa. This she does by developing what she calls 'an English- Xhosa companion for health-care professionals'. Through this manual, she tries to bridge the language gap sometimes created during consultation when health-care professionals can't converse in Xhosa (Cape) and patients can't converse in English. According to Kirsch et al (1996), health-care workers do not have to be perfect in Xhosa for them to be understood. She believes even basic Xhosa greetings are able to make a patient relaxed and negotiate on a common ground. This she argues "indeed, even the most halting of attempts to address a patient in isiXhosa will immediately breakdown barriers, and reward the beginner with a greatly enhanced doctor-patient relationship" (1996: iii).

The English-Xhosa companion for health-care professionals, amongst other things, gives Xhosa equivalents of English greetings and English medical terminology. However, after careful review of this companion one cannot help but to be critical about the approach the writers took during compilation. At this point one should remember that the main purpose of this enquiry is to find out the nature of communication between English-speaking doctors who are not always proficient in Xhosa and their Xhosa patients who are not always proficient in English.

It is also my aim to ascertain whether doctors and patients understand a disease name similarly or differently. For these two purposes mentioned, it is therefore questionable as to how the companion was designed or

compiled. For instance, on pages 110 and 111 Kirsch addresses respiratory problems in both English and Xhosa. On page 110 Kirsch gives certain English medical terms and on page 111 their Xhosa equivalents. She refers to 'wheezing' as *ukutswina* in Xhosa, 'a cough' as *ukhohlokhohlo*, 'pain in the chest' as *ihlaba esifubeni* and 'chest infections' as *isigulo esingapheliyo sesifuba*.

The problem with Kirsch's equivalents is that they are untested. She does not say how she came about with these equivalents. For instance, she does not say whether doctors and patients share a common understanding of these words. The other problem with Kirsch's English- Xhosa companion is that it makes assumptions that there is only one standard Xhosa equivalent medical term for every English term. As there are different dialects in Xhosa, as discussed on chapter I on this thesis, one can argue that it may be dangerous to make such untested assumption. This is so because throughout the companion, the author, fails to mention where and how she came up with these standardised Xhosa terms. Also, she does not mention whether after coming up with these terms, studies were conducted to validate or test patients and doctors understanding of the terms. As it shall become evident in Chapter IV when analysing patients and doctors understanding of a term, arriving at Xhosa standardisation is difficult as English terms also sometimes have more than one word referring to a disease e.g. *germs, viruses, bugs, bacteria and infections*.

2.4 Issues in doctor/patient Consultation

Waxler-Morrison (1999:5) argues that the health professional with a different background from the patient runs a risk of being "ineffective", leading to unsatisfactory results. This argument she supports by stating that medical care is a technical task, which requires the individual co-operation of the patients. This, she says, becomes a problem since it forms part of the professional culture, which then tends to clash with the patient's culture of medicine and expectations. Like Kleinman (1979), Waxler-Morrison, observes that biomedicine is only interested in "curing" a disease and does not necessarily accommodate folklore healing. As per the literature reviewed for this thesis, the problem with the bio medicinal approach to illness is that it is not favoured by patients and their families [as has been the case with the Chinese man observed by Kleinman in 2.1]. It places far less emphasis on the illness and its treatment and has even in some cases ignored the experience of illness as a legitimate object of clinical concern.

For Kleinman (1979), the main problem with doctor/patient consultation is that if doctors and patients come from different ethnic, religious and socio-economical backgrounds, they possess different understanding of the illness, its symptoms and its management. He further points out that these different backgrounds often clash whenever they are brought together. Kleinman refers to these backgrounds that often clash as explanatory models of illnesses by patients and doctors. He differentiates these models as the professional, the popular (which is family, social network and the community and society) and the folk model (non-professional healers).

According To Kleinman, the popular model is the most popular model from the three. This is so because family, social network as well as the community a patient is from, shapes the cultural beliefs about the understanding and expectations of the illness. He points out that patient's explanatory models are therefore usually very concerned with the "meaning" of the illness. It is this concern, according to Kleinman, that usually clashes with biomedicine as it is less concerned with the meaning as such than other forms of clinical care. Bhugra and Kamaldeep (2001) argue that the patient's explanatory model should not be ignored as serious complications may occur. They suggest that an approach is to be adopted so that health-care professionals can learn more about the patient's culture so as to understand more about the patient's explanatory model.

2.5 Problem arising out of medical terminology

Helman (1984:90) argues that the problem with clinical consultations is that "where medical terms are used by either party, there is often a danger of mutual misunderstanding, the same term, for example, may have entirely different meanings for doctors and patients". Helman cites a study conducted by Boyle (1970), which found that doctors' and patients' interpretation of the same medical terms varies. For instance, the aim of study that Boyle conducted with patients was to "discover their knowledge of bodily structure and function, and then compare these with a sample of 35 doctors" (Helman 1984:10). Boyle found that most patients understood any discomfort localised in the chest as heart trouble. This according to Boyle was regardless of whether the doctor had confirmed it or not. Boyle also

was regardless of whether the doctor had confirmed it or not. Boyle also found that sometimes when patients complain of "a pain in the stomach" (ibid.) in many instances they are referring to a pain in the abdominal cavity. These different understanding of bodily structure may cause problems with the diagnosis especially if both patients and doctors are using the same words but referring to different interpretations. However, Helman does not say whether Boyle observed patients and doctors from different background. Or they were from the same culture and of the same language.

The problem that sometimes arises from medical terminology is a result of some patients' belief in folk illness. Rubel (1977) cited by Helman (1984:73) describes folk illnesses as "syndromes from which members of a particular group claim to suffer and for which their culture provides an aetiology, a diagnosis, preventative measure and regimens of healing". For instance, Snow (1978), cited by Helman (1984:90), claim that some patients who are diagnosed as having high blood pressure, may understand it to mean high blood, which according to folk illness, should be "treated by eating acid to astringent foods, as well as the brine from pickles or olives (the high salt content of which may aggravate the hypertension)" (Helman 1984:90). Helman concludes that the use of the same terminology by doctor and patient is not a guarantee of mutual understanding as the same terms may be conceptualised by both parties in entirely different ways.

Helman (1984) and Boyle (1970) conclude that these different interpretations of illness, different disease naming and different expectations can have serious clinical implications should they not be addressed.

Helman (1984) and Boyle (1970) conclude that these different interpretations of illness, different disease naming and different expectations can have serious clinical implications should they not be addressed.

It is this investigation's aim to establish whether do these clinical implications occur in South African hospitals, due to doctors' and patients, different medical terms. Terms such as *isifuba*, *ifiva*, *iTB* and *inyumoniya* [chest problems, fever, TB and pneumonia] will be looked at broadly and critically on Chapter IV where the data from interviews with doctors and patients will be analysed.

Chapter 3: Methodology

3.1 Introduction

"Qualitative methods have much to offer those studying health and health care settings... They are the principal methods employed by anthropologists to study the customs and behaviours of peoples from other cultures..." (Pope et al 2000:1) This investigation conducts a quantitative method of enquiry as well as qualitative analysis. As a point of departure, the terminology qualitative method or research will be defined.

3.2 What is qualitative Research?

Holloway (1997:1) defines qualitative research as a form of enquiry that tries to understand the reality of individuals, groups and cultures. She argues that the main purpose for a qualitative enquiry is to "explore the behaviour, perspective and experiences of the people" (ibid.) researchers are investigating. Like Holloway, Straus & Corbin (1997: vii) define qualitative research as a kind of research that is about people's day-to-day lives "lived experiences, behaviour, emotions and feelings as well as about organisational functioning, social movements, cultural phenomena, and interactions between nation" (ibid.).

For Pope (2000:3) qualitative research concerns itself more with the meanings that people give to the day-to-day social experiences. Pope believes it is how people make sense of their social world. From Pope

(2000) Holloway (1997) and from Strauss & Corbin (1997), one can deduce that qualitative research is aimed at interpreting social behaviour of people in their day-to-day-natural setting.

Giacomini (2000:357) shares the similar definition of qualitative research with Strauss & Corbin (1997) and Pope et al (2000). Giacomini sees the qualitative method of research as an instrument that “offers insight into emotional and experiential phenomena in health care to determine what, how, and why” (ibid.). He cites four of what he refers to as “essential aspects of qualitative analysis”

The participant’s selection must be well reasoned and their inclusion must be relevant to the research question. The data collection method must be appropriate for the research objectives and setting. The data collection process, which includes field observation, interviews and document analysis, must be comprehensive enough rich and robust descriptions of the observed events. Data must be appropriately analysed and the findings adequately corroborated by using multiple sources of information and more than one investigation to collect and analyse the raw data, member checking to establish whether the participants’ view points were adequately interpreted, or by comparison with existing social theories, (Giacomini 2000:357).

These four steps of data gathering are being precisely followed for the research. These steps will later be discussed in this chapter when explaining the process on how data was generated.

Pope et al (2000) cited three distinctions of qualitative research.

According to Pope, qualitative research's distinguished features are "interpretative," "naturalism" and "participant observation". By interpretative Pope means that researchers ask researching questions about events or social issues. A qualitative researcher avoids accepting information given at face value. Such information, which may have, is conceived assumptions. Pope argues that for qualitative research to be interpretative, direct questions need to be asked. "Qualitative research answers questions such as "what is X, and how does X vary in different circumstances, and why? Rather than how big is X or how many X's are there?" (2000:3). From Pope (2000) mentioned above examples, it becomes clear that asking searching question helps the researcher to understand what that specific participant understands by that question or by that term. It helps in minimising assumptions that the participant's understanding of the term, perhaps a medical term, is similar to the researchers. It allows for different interpretations or definitions of social phenomena.

In defining a second distinguishing feature of qualitative research, 'naturalism', Pope (2000 quotes Kirk and Miller (1986:9) who define qualitative research as a "particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms" (Pope 2000:4). Pope's naturalism feature of qualitative research is not concerned with, amongst other things, artificial or experimental settings.

The last distinguishing feature of qualitative research cited by Pope (2000) is “participant observation”. Pope believes that when a researcher observes the participant in her own setting, the researcher can be encouraged to join in by talking to people through interviews or chatting.

Like Pope (2000), Mason (1996) argues that qualitative research is

- a) “Interpretivist.”
- b) Not removed from real life social contexts, and not concerned with an experimental context
- c) Concerned with rich, contextual and detailed data (1996:4).

Pope (2000) argues that in many instances different research methods are linked to their theoretical perspective. She defines theoretical perspective as a “set of explanatory concepts that provide a framework for thinking about the social world and inform the research”.

Amongst some theoretical perspectives that inform qualitative methods, as listed by Pope (2002:1) is *ethnography*. How ethnography relates to qualitative research, will be discussed below. However, the term ethnography shall first be defined.

3.3 What Is Ethnography and Its Relations To Qualitative Research?

To be able to gain insight into the Red Cross social phenomena, the investigation is conducted using an ethnographic method of enquiry. Holloway (1997:59) defines ethnography as a method that describes the culture or cultures of people. She believed that ethnography puts more importance on the study of human behaviour "in the context of a culture in order to gain an understanding of the cultural phenomena, rules and norms". Like Holloway, Marshall et al (1995:2) see ethnography as a study that deals with human culture. She believes that it is the human culture that the researchers try to describe and analyse.

As is the case with the Red Cross Children's Hospital, different cultures and ethnicity are involved. It is these cultures that this investigation seeks to uncover and analyse. Different scholars argue, as we shall find, that where there are different cultures and ethnicities, there usually are cultural assumptions about language and about authority. It is these assumptions, if there are any, that this investigation hopes to uncover, amongst other things. As Kamadeep and Bhugra (2000) argue a "qualitative enquiry done through an ethnographic study, hopes to establish social rituals, symbols in communication, forms of knowledge and illness narratives."

Kapp (2001:72) argues that the use of an ethnographic method in an enquiry is to approach questions that yield to an account of what is said when, where, and by whom. She quotes Saville -Troike (1997:357-2) who argues

further that ethnography is an approach "not merely of what can be said but for when, where, by whom, in what manner and in what particular circumstances."

Holloway (1997:60) quotes Hammersley & Atkinson (1995) who argue that ethnography in health amongst other institutions is "specifically intended to improve practice." Hammersley & Atkinson's view, however, seems to be in contrast with their other argument that the ethnographer's primary aim is to produce knowledge rather than applying it to professional practice (Holloway 1997:60). The belief that ethnography can improve practice in the health sector motivates my investigation at the Red-Cross Children's Hospital.

Holloway (1997:61) quotes Sarandakos (1994) and Thomas (1993) who distinguish between two types of ethnographic methods "descriptive or conventional ethnography and critical ethnography." According to both these authors, as quoted by Holloway, descriptive ethnography focuses on the description of cultures of groups and through analysis, uncovers patterns, typologies and categories. Holloway sees it as a method that involves the study of macro-social factors such as power, and examines common-sense assumptions and hidden agendas, quotes critical ethnography. (Ibid.).

3.4 Data Generating

Through the ethnographic method of inquiry, data collection is done through observation, interviews, interpretations and examination of documents. However, Mason (1996:36) critiques the use of the term 'data collection'. She proposes that the term "data generating" is more appropriate when conducting qualitative research. She argues the term data generating is appropriate, as it is unlikely that a researcher is just a neutral collector of information about the social world. She believes that rather than just collecting information, a researcher constructs knowledge about the world according to the researcher's principles and standards, using methods derived from their epistemological position. It is for these reasons that she argues for the term data generating be used, as the researcher does not simply collect the data from the chosen data sources, such as people.

The term 'data generating' is adopted in this investigation. The reason for this is that at the Red-Cross Children's Hospital. Data was generated by using data sources such as people (doctors and patients) and patient's hospital folders for verification of disease naming by doctors to that understood by patients.

Parts of the data for this investigation are also used for another related but different study at the Red-Cross Children's Hospital in Cape Town. However, the purpose and the nature of Red Cross study and this investigation are different. I generated the data as part of the vocational job during the 2002 summer holidays. For a two-month period, I was appointed

as a researcher for that study. The Red-Cross study looked at disease naming by patients and by doctors. My involvement with the Red Cross Children's Hospital's studies ended in December 2002. Agreements were reached between me; the project co-ordinator and the Head of the Allergy Clinic that the data generated could be shared by me for my MPhil. research and the Red-Cross Hospital for their study.

Part of the data was collected from 6 November 2002 to 24 December 2002. The rest of the data was generated between March and May 2003.

3.5 Problems Encountered When Generating Data

My position during the Red-Cross study was to interview Xhosa-speaking patients in their mother tongue. My colleague, an English-speaking doctor who is also the project co-ordinator, was to interview English-speaking doctors. However, after the first two interviews, doctors interviewed expressed discomfort in being interviewed by another colleague (a doctor). They felt that they were being tested about their medical knowledge. The doctors further expressed that they were to feel comfortable and at ease when interviewed by someone not from the medical field. They argued they were to feel at ease being interviewed by someone else, as they would view the questions as genuine and sincere. I was then assigned to interview both patients and doctors.

After each interview was conducted, doctors were asked for feedback. They did indicate that they felt more comfortable in my presence and regarded my questions as unthreatening to their medical knowledge.

My responsibilities, therefore, included identifying semi-structured questions to be used for interviews, selection of all participants, interviewing, editing (using a transcribing machine and a video machine) what has been transcribed and filing of documents. My involvement with the Red-Cross study ended before data generating was completed and before data analysis began.

According to Strauss and Corbin, (1997:11) data obtained using qualitative method of inquiry is called "Qualitative Data". They argue that qualitative data comes from interviews, observation, documents, records and films. This form of data gathering is applied in this investigation. Using Strauss and Corbin's method, data is generated through interviews, observations and interpretations.

3.6 Sampling

Following Giacomini's four 'essential' points of qualitative analysis, participants selected are very relevant to the research. That refers to the Xhosa-speaking patients who do not always understand English-speaking doctors, who in turn do not often understand their Xhosa-speaking patients. Using a scale of one to ten, doctors are firstly asked how they rate

themselves in Xhosa proficiency. Doctors' proficiency in Xhosa ranged between one and four, one representing very poor and ten excellent.

Some Xhosa-patients interviewed are selected on the basis that they are proficient in English. This selection is done purely for determining the nature of communication that takes place between doctors and patients who understand and speak L2 English. 10 Xhosa-speaking patients were selected, 2 of who can speak and understand English. 5 doctors were interviewed. All five indicated that they were able to greet in Xhosa but unable to engage in a lengthy conversation in Xhosa during examination.

3.6.1 Interviews

The second point in Giacomini's 'essential aspects' for a qualitative research is that data collection is done through interviews and interpretation. Interviews are semi-structured. Semi-structured interviews "allows for issues to emerge from long responses", Kleinman et al (1978:251). Kleinman introduces what he calls 'explanatory models' of both patients and doctors. He expresses that in a cross-cultural studies, open-ended questions are able to compare the use of science concepts (doctor's explanatory model) to social sciences (patient's explanatory model).

Attached in this chapter as appendix A, are the semi-structured questions for the doctors' interviews. Appendix B, comprises interview questions for Xhosa-speaking patients.

3.6.2 Equipment

Equipment such as a tape-recorder, a video, transcribing machine and patients' files, (for verification of patients' naming of illnesses to doctors' diagnosis) was used. The tape recorder is used for recording the interview and the transcribing machine for transcription purposes. The video is used for editing the transcripts and for the analysis of any other information that is verbal or non-verbal, which could have been missed by the interviewer during the interview and by the transcriber. This kind of editing (using a video) is done for interpretation purposes.

Chapter 4: Analysis

4.1 Introduction

The aim of this chapter is to carry out a qualitative analysis of the nature of communication between English-speaking doctors and translators and Xhosa-speaking patients. This shall be done by analysing doctors, patients and interpreters' interviews.

The interviews with the Xhosa-speaking patients and English-speaking doctors show that there are sometimes communication problems encountered during examination. These problems are as a direct result of the following three categories:

1. Personal- that is problems that are peculiar to the individual patient.
These may include personality, temperament, level of formal education, exposure to English-speaking contexts (such as the workplace)
2. Generic, meaning those problems that tend to be found among all the patients interviewed
3. Technical problems that are part of the interviewing process itself.
For instance, the participant may respond during the interview in a manner that she thinks the researcher wants to hear. For example, when participant C was asked if she is satisfied with the conversation that takes place between her and the doctor during the consultation, she responded "Yes, because I want to be treated."

On the other hand it may be that participant C did not understand the question.

We shall look at these problem areas, citing examples from the interviews with patients and bearing in mind that categories may often overlap. We will then summarise the communication problems that patients and doctors encounter during consultation. Thirdly, we will examine the benefits and limitations of interpretation as a response and solution to the problem of communication. In addition at least two interpreters (one professional and one non-professional) were interviewed in order to get an insight of the nature of communication during consultation. The interpreter's interviews were conducted to ascertain whether any information is lost during interpretation.

4.2 An analysis of the responses of four patients

Participant A

Participant A is a 38-year-old mother from a Cape Town township. Her mother tongue (first language) is isiXhosa. In addition to a standard eight education, she speaks and understands English quite well. In this regard, on a scale of 1 to 10, where 1 represents "very poor" and 10 "excellent", she rates herself 5. She has a daughter (of about six years old in 2002) who is a regular outpatient at a day hospital in her township, with a condition, according to her known as *isifuba* in Xhosa.

The participant has good comprehension skills in Xhosa. She handles conversation competently. Where she is not sure about the answer to a question, she has the confidence to say so or that she does not know. It could be concluded that she is unlikely to answer questions in a manner that is calculated to give the interviewer what the participant thinks the researcher wants to hear. Her response that she has no problem understanding the doctor when the latter speaks English may be taken as credible and reasonable, given her level of education and judging from the way she handled the interview, although the interview was in Xhosa and not in English.

The participant understands her daughter to be suffering from *isifuba*. According to her when the doctor examines her daughter, s/he speaks English. The doctor asks whether the girl's *isifuba* had not *valeka* (blocked or closed up) or she had not *khohlela* (cough) the previous night. In response to questions, the participant uses more Xhosa words to explain the condition of *isifuba*. She speaks of *ukutswina* and *minxeka*. She says all these happen to a person who has *isifuba*. Her understanding of what *isifuba* is and its symptoms is that a person loses weight and that a person may have allergic reactions to substances (such as certain foods). According to her these symptoms maybe relieved by *isifuba* medicine (inhaler pumps mentioned). In the case of this child's *isifuba*, as understood by the mother, is caused by an opening in her navel and doctors were considering surgery [to close the opening] as part of the treatment.

When asked if she knew certain other words (cited during the interview) the participant answered in the affirmative. According to her *inyumoniya* (pneumonia) is a condition that one gets when one has “too much *ingqele* (cold)”. She further says someone not dressing warmly enough causes *inyumoniya*. While the participant did not think that TB (which she associates with *isifo sephepha*) was the same as *isifuba*, she was positive that *isifuba* is *esma* (asthma). When asked if she knew about *iphika*, she said she had no first hand knowledge of it, she had only heard that a person with *iphika* breathes heavily non-stop.

Participant B

Participant B is a Xhosa-speaking mother of a little girl (one year eight months in 2002). She comes from one of Cape Town's townships. She had taken her daughter to a big academic hospital and was later referred to this paediatric hospital. Her daughter had chest problems. Though she attained a formal education of standard seven, she does not speak English well. In the interview, she says she can understand what she calls “work-place English”, meaning that she can take instructions and carry them out satisfactorily. She adds however, that she cannot ask or answer questions well in English, let alone carry out a conversation. She can handle a conversation completely in Xhosa. She is not afraid to offer her own opinion or view when asked for one. Where she is not sure she is confident to say she does not know. It therefore appears that she also was not responding only in the way that she thought the researcher wanted to hear. Her responses to questions in the interview showed that she had a working

knowledge of Xhosa words for the various conditions often referred to as *isifuba*.

She makes it clear that the communication with the doctors she saw was difficult. A doctor from a private practice had referred her to this paediatrician hospital with a letter to her effect that the child had pneumonia. Doctors at this hospital confirmed the diagnosis and referred her to the big academic hospital where she was told in English that her child had asthma. She says the actual English word used for "chest problem" was cold. The patient then answered that in her knowledge, *ingqele* is cold and pneumonia is extreme cold "*ingqele enkulu kakhulu*".

According to this participant *ukuminxana* and *ukutswina* mean the same thing, namely, chest problems in which the chest is blocked and tight and there is noise when breathing. She says that another Xhosa word, *iphika* means the same thing as *ukuminxana* where a person especially older people, heave and wheeze with a tight chest accompanied by *amahlaba* (sharp pains). In her opinion there are two ways in which people gets asthma: through "*ingqele*" (cold) or through heredity in a form known as *ufuzo* (lit. hereditary)

According to her the doctors at the big academic hospital try to speak to patients in Xhosa, at least so far as greetings is concerned, for even when she knew her own command of English was not good, participant B elected that the doctor speak to her in English. At this big academic hospital, she

says she was told her child had asthma, which she also refers to as *isifuba*. She was told that HI virus (human immune) might cause this condition. However, the HIV test was negative. She says she was told later the child had pneumonia and was later told that it was asthma. During the interview when she was asked: "when you say that the child has *isifuba*, what do you mean by that word?" She replied, "I cannot tell you lies, I don't know".

Participant C

This Xhosa-speaking mother comes from a Cape Town township. Although she has a Xhosa name by which she is normally known, she elected for this interview to use her English name. Her ability to count is not very good judging from the way she handled her age and the dating of her pregnancy. Speaking in 2002, she gave her age as 45. With regard to her first pregnancy in 1975, if the stated date of birth (1969) were correct, she would have been only six years old when she became pregnant. Her highest school qualification is standard five. During the interview (which was conducted in Xhosa, her mother tongue) the participant showed signs of difficulty with comprehension and focus. For instance, she would be asked a question and answer something else. When asked if she encounters any problems when with the doctor, she responded, "You mean myself? Or are you referring to my health [life]?" Also at first she said that the doctor took long examining her child but later changes to this answer "not very long" Furthermore, when asked if she was satisfied with the nature of conversation between herself and the doctor her response was; "Yes, because I want to be treated". At this point it became clear that the participant was not very

clear even in her mother tongue. This raises questions as to how she handles English conversation with a doctor with or without an interpreter. It also raises concerns of how valid her responses were. On the other hand, it could be perhaps that questions from the researcher as well the video camera made her confused.

She had brought her child to this hospital for the first time. According to her, the child was suffering from *isifuba* (chest problems). She believed that it was caused by her father's smoking in the house and the child breathing the second hand smoke. Participant C makes her concerns clear that she at this point does not know what is wrong with the child as the doctor's initially told her that the child had TB but later on withdrew from that diagnosis.

She appeared not to be very willing to discuss it further, making it clear that she preferred waiting for the X-ray results, which were done earlier. She does not seem ready to accept that the child may have TB. She does not believe so because her child did not have a swelling in the arm, after a TB test, which is a sign of TB in the body. She believes "*isifuba* is asthma, TB and all those things"

She believes "a child is born with it if the parent was eating rich food during pregnancy". Also that a child gets *isifuba* if the pregnant mother allows herself to be cold by exposure to the night air or not dressing warmly. This is so because, according to her, the cold night air, which she refers to as *ingqele* get into the child's lungs, she refers to as *amaphaphu*.

She believes that a person with *isifuba* gets hot. He or she is given *impompo yesifuba* (a pump) for treatment. A person with TB loses weight. A person with *ingqele* (cold) gets a painful body and is hot. When asked if both *isifuba* and *ingqele* cause hotness in the body, she says, "*isifuba* is sometimes caused by dust" this she says is so because when dust or smoke enters imiphunga (lungs) it damages them. She also believes that drinking brandy also damages the lungs. She makes a connection between *isifuba* and *ukuminxana* (tight) in that *ukuminxana* is caused by *isifuba*. This *kuminxana* (tight chest) she says, makes the child not have oxygen, "or is it carbon dioxide?" she asked uncertainly

She also mentions that her father smokes and *khohlela* (coughs) a lot. He, however, dismisses calls for him to stop smoking, explaining that smoking does not cause this *isifuba* but that it is generic (family) *isifuba*. She believes that on the other hand *isifuba* may be caused by a change in environment being close to the sea may not be good for some people. She further makes a distinction between TB and *isifuba*. She believes a person with TB *uyakhohlela* (coughs) and that this cough, however, is different from that of a person with *isifuba*. In the case of TB, the chest makes a noise while *isifuba* is *esma* (asthma). She is strongly convinced that there is no difference between *isifuba* and asthma; they are one and the same, but in different language. *Isifuba* is in Xhosa and *asthma* in English. She however comes out as a bit confused as to what causes *iphika* (heaving and wheezing and shortness of breath). Initially she said she believes it is caused by *ingqele*

(cold) as a result of not dressing warmly. However, later on she asserts that *iphika* is caused by *ihlaba* (sharp body pains).

Participant D

The Xhosa-speaking mother from a Cape Town township speaks and understands three languages: her mother tongue – Xhosa, English and some Afrikaans. Participant D appears to be more educated than the other participants. She has a standard ten (grade 12), a secretarial and computer course. On a scale of 1 –10 on English proficiency, she rated herself 9. She said, she also could converse completely in Afrikaans. Participant D says with confidence that she has no difficulty conversing with English-speaking doctors. She seems to be sympathetic to those patients ‘that did not go to school’. This is so because, she says those people have difficulties when talking to doctors. She knows this because she says she had seen them leaving the doctor’s room or ward without understanding what the doctor said about their sick children. This, she was able to deduce from their facial expression.

It was not unusual for such mothers to seek her help, in translating, what the doctor has said. It is for these reasons that she strongly believes that the use of professional interpreters is a solution. She appeared competent in communicative English. While all other patients’ interviews were conducted in Xhosa, she however steered the interview into English. She said she felt more comfortable in English. Initially the questions posed to her were in

Xhosa and her responses in English. However, she had encountered her own problems as far as the nature of communication between her and her doctor was concerned.

On the day of the interview, she was visiting the paediatric hospital for the second time since she was initially referred to by the day hospital. She believes the reason for the second visit was due to the fact that she misunderstood the doctor when explaining how to administer an inhaler to her sick child. She believes this was a direct result of not understanding the medical terminology used by the doctor during examination, regardless of her proficiency in English.

However, given the nature of her problem, she still did not think her case warranted involving an interpreter. She thought the best way to deal with this problem was to ask questions immediately about anything she may not have understood. This procedure was very different to that of her first visit, when she thought she understood the doctor's instructions and did not ask clarifying questions. This resulted in her child's chest problem not showing signs of improvement, since she had not used the pump correctly. The second time she says, was much better as the doctor also understands where the problem was and resorted to using "everyday English" as well as demonstrations when explaining to her how to administer medication to her son. She was now confident that this time around she had understood exactly what she needed to do and how. She seemed very concerned that

her failure to understand the doctor's instructions the first time (despite her proficiency in English) had put her son's health at risk.

According to her, her child was receiving treatment for "allergy". This allergy caused her child to be "*asthmatic*", a condition that she understands perfectly, she says, but cannot explain in Xhosa. Her understanding is that a person with *isifuba* has a breathing problem. Sometimes, she elaborates; the person's chest makes a noise and *wheezes*. This she also experiences with her son before he was first treated at this paediatric hospital. She says sadly, his chest would close and make a lot of noise, making her unable to sleep at night. It was like, she says sadly, the breathing (purring) of a cat.

She believes people "with asthma cannot eat because *isifuba sakhe* (his chest) wheezes" she understands asthma to sometimes causes swollen eyes due to allergies, resulting in her child for instance not to go to school.

I tried to probe more closely the relationship between *asthma and allergy*. It was not very clear whether she was saying allergy causes asthma or asthma causes allergy. She believes her child is suffering from both, *allergy and asthma*, although they are not the same thing, she says. She believes that "*kwisifuba* usually *uyavaleka* (you get blocked or tight chest) and then he gets asthma. *Kukuvaleka kwesifuba* [it is the closing up of the chest] that causes swollen eyes and a runny nose"

However, she believes *isifuba* and asthma are one and the same. Although, she adds further, one person's *isifuba* is different from that of another person, even though *isifuba* may present itself similarly to different persons. That is why she does not think it is safe for an individual to give prescribed medication to someone else as it may create complications. The only problem she has is the stigma attached to TB. She is concerned that people in the township sometimes associate TB with HIV even when the person is not HIV positive. For this reason it is important that people get tested, she adds, so they know exactly what they suffer from and get the right treatment for it.

4.3 Commentary on Xhosa-speaking Participants

What becomes evident from the four participants is that there is a problem with the nature of communication between English-speaking doctors and Xhosa patients. However, this problem is not only limited to doctors not being able to speak Xhosa and patients not being able to speak English. Technical medical terminology, even in a monolingual English consultation, proves to impact negatively on doctor-patient communication during consultation. This negative impact is best demonstrated by Participant D's experience. However we have no guarantee that should a technical Xhosa medical terminology equivalent in complexity to that of English arise, patients would understand the full impact of the terms.

Participants A, B and C are not competent speakers of English who, when available, sometimes require the help of an interpreter, although A does

understands some English. However, B seems to have knowledge of certain Xhosa medical terms such as, *isifuba*, *inyumonia* (pneumonia), TB and *i-esma* (asthma). The problem however, that comes out is that even amongst all three of them those medical Xhosa terms seem to differ in meaning and its prognosis thereafter. For instance, participant A believes that her child is suffering from *isifuba*, which is caused by the opening in her navel and treated through surgery. However, one confusing factor is that she does mention that the doctor specifically told her that her child has *isifuba* that is referred to as *esma*. Hence, she experiences tightness in her chest and painful breathing. But, she seems convinced that all these complications are simply due to the opening in the navel. On the other hand, she does not confirm whether her doctor has confirmed this navel problem. Also, if she was not told by the doctor, she does not give light as to how and why she came to believe in this reason. However her pattern of asking questions about things she did not understand during the interview suggests that she may have at some stage, been told about the link between the opening of her daughter's navel and her chest complications by sources other than doctors at the hospital. There is therefore a difference 'folk' belief based on symptoms of illness and that of the hospital's practice.

Participant B on the other hand does have problems with the nature of communication that takes place between her and the doctors. This communication problem is in spite of her understanding what she calls "work-place English". She implies that she can take instructions and carry them out satisfactorily although she does say that she cannot ask or answer

questions well in English or carry out a conversation. Although it could be argued that she was only familiar with her “work-place English” as far as instructions were concerned not perhaps what could be called ‘hospital English’.

Looking at how her diagnosis kept on changing from one doctor to another, it is no surprise that she was left not knowing exactly what *isifuba* was, hence her response that she “did not know” although, she does refer to her child’s illness as *isifuba*. It seems to suggest that the reason she understands her child’s illness as *isifuba* is due to the fact that at the big academic hospital the actual English word used was cold (*ingqele* in Xhosa) which she says they told her was causing her child’s “chest problem”. On the other hand, the doctor from the private practice had diagnosed her with an illness referred to as pneumonia, which was also confirmed by the doctors at the paediatric hospital. However, the doctors at the big academic hospital, she says, told her what she understood to be asthma. Even though as she puts it, it was not the actual word doctors used, but *cold*. She does seem to believe that asthma and cold are related. She believes there are two ways in which people get asthma: through cold (*ingqele*) and through heredity, which is referred to in Xhosa as *ufuzo* (pl. *imfuzo*).

She believes *ukuminxana* and *ukutswina* are the same. Like participant a, she believes *ukuminxana* and the two terms mean “chest problems in which the chest is blocked and tight and there is noise when breathing”. Although, they tend to differ on the understanding of *iphika*, considering it is the same

as *ukutswina* and *ukuminxana*, participant A believes that it happens to older people by heaving and wheezing with a tight chest, accompanied by *amahlaba* (sharp pain).

Participant C also encountered confusion created by different diagnoses. She understands the chest problems her child has as *isifuba*, which she thought was due to her father smoking in the house and the child inhaling the smoke. However, as with participant B, doctors would tell her that it was TB and then later say it was not. She does not say however, why doctors gave her different diagnosis, like participant D, she believes *isifuba* is asthma. Both these participants believe that asthma results in TB. They both make mention of their understanding that TB and *ingqeke* (cold) are related. Participant C believes that when a mother is pregnant and exposes herself to the cold night air, *ingqeke* (cold) gets into the child's lungs causing a child to be "born with TB..." Participant D also believes that "TB is when someone suffers from *isifuba*, *ekhohlela*, always sweating and *enengqeke* (cold) at the same time".

It is, however; interesting to note that participant D is proficient in English yet encountered communication problems. It now seems as if the communication problems sometimes encountered during consultation are more complex than the issue of two languages involved [see 4.2]. Although the aim of this research was not to interview English-speaking patients, participant D's interview however, did make a meaningful contribution.

The main problems were the technical terms used to explain the nature of the illness of her son as well as in instructions given to them on how to administer the pumps (inhaler). It therefore, could be argued that doctors should try and use, during consultations and where-ever possible, 'laypersons' English when communicating with patients. This everyday English, as far as medical terms is concerned, proved to work in participant's D encounter. Also, demonstrations in her case, proved to be one of the vital keys in negotiating communication and understanding.

The only concern, however, is that if a proficient participant experiences communication problems during consultation, which put her child's health at risk, is that what would have it been like if it was the other participants like B who do not ask any questions from the doctor. It can only be assumed that greater complications could have been encountered.

Based on these participants' interviews, it seems justified to conclude that the problem does not only live in the differences in language as such, but to different understanding of medical terms, even if they are said in Xhosa. These different understandings lead to different interpretations of the illness and therefore, result in different expectations of the treatment thereafter. It has become evident from these interviews that what one patient understands of mother tongue medical terminology may be completely different to the next patient. These differences in the understanding of Xhosa medical terms shall be looked at broadly after having looked at the doctors' interviews.

Also, it appears as if power relations are also important issues as far as doctor-patient communication is concerned. For instance when participant C is asked if she is satisfied with the nature of communication between her and the doctor, she responded positively, because she wanted to be treated. This response was in spite of the fact that she complained that doctors were telling her different things about her child's illness. Firstly, they said it was TB and later on said it was not. It could be argued that participant C as much as she was unsatisfied with how and what doctors communicated to her believed those doctors could not be questioned.

The same argument could be made on participant D's experience. She did not ask the doctor questions even though she did not understand the instructions given to her, which she did on the next visit. It seems as if her problem was more than power relations but more of what Geist (1994), as cited in 1.2 refers to as pretence to understand, because dignity and self-esteem are extremely important to some patients. It therefore could be that since participant D is proficient in English she did not want to lose that status in the doctor's mind, by asking for clarity.

4.4 An Analysis of the responses of doctors

Doctor A

Dr A is middle-aged female doctor who works at both academic hospitals in Cape Town. She specialises in chest problems in children. She speaks English as well as some Afrikaans. The interview focused on how she

communicates with her Xhosa-speaking patients. These questions were posed to ascertain whether she was satisfied with the nature of communication between her and the Xhosa-speaking patients given that they speak different languages. Also, should there be problems with communicating what recommendation, if any, she might want to give to help the situation.

Dr. A made it clear, from the onset that she was not satisfied with the nature of communication between her and her patients. This was due, she said, to the fact that she did not have a "big enough [Xhosa] vocabulary". She says, sometimes when the situation calls for it, she attempts to speak Xhosa. However, she finds that it gives a misleading impression of competence in Xhosa, leading to patients thinking that she understands them.

In cases like these, she finds herself having to draw pictures to interpret. However, she adds, interpreting has its own limitations. She complains that interpreters sometimes paraphrase patients' responses which sometimes risks losing some of the vital information which should be communicated to her. In cases where she feels even an interpreter is not communicating effectively, what is being said by the patient, she asks "a few standard things" in Xhosa.

She adds that where interpreters are not available and she experiences problems with communication, she resorts to the help of the Xhosa-speaking nurse. As she says "some of Xhosa-speaking sisters are very helpful."

However she is quick to point out that regardless of the interpreting assistance she sometimes gets, depending on a third person for translation or depending on her almost-non-existent Xhosa, “the health of the child is highly compromised” in such circumstances.

She believes however, that a child’s health endangerment is more complicated. She elaborated that it involves “beliefs about what other things are better for the child”. She cites a case where a child was brought to her with “severe asthma... almost dying”. She believes the child was in this critical state because the father who was “very Rastafarian” had repeatedly failed to give the child prescribed medication (from doctors) preferring to give her herbal remedies instead. To this example, the doctor believes the problem, which put the child’s health at risk, was not due to language problem but “the concepts you believe in”. What could be deduced from Dr. A’s statement is that social and cultural factors are also very important during consultation.

She suggests that all English-speaking student doctors, who are not proficient in Xhosa, should learn to speak Xhosa from their first year to the end of their training. She further adds that, not only do they need to learn Xhosa from training institutions, but also to “know more about Xhosa culture... [and] the different concepts of disease[s].” Since she spoke “limited Xhosa”, it was necessary to ask about terms she used for chest problems, during consultation where an interpreter is not present. She says she uses the word *isifuba* for chest, as in “*isifuba ubuhlungu, khohlela*” [lit: the chest is

painful, coughing?]. For *fever* she uses *ifiva*. She does not however have a Xhosa word, she says, to refer to a *tight chest*. Hence she says, "I don't know Xhosa word for wheezing, tight or anything like that. So it could encompass anything from *asthma* to *pneumonia*"

She points out that the way people speak about a disease in Xhosa is different from how they speak about the same disease in English. For instance, she adds, "Xhosa-speaking patients would say, "*I have a chest*" which she believes means that there is something wrong with the chest. Sometimes she says they complain of a headache but only say *ndinentloko* (I have got a head). She adds that the word *pain* is usually not mentioned but implied. In her case, she says, when she asks *isifuba buhlungu* meaning, is there something wrong with the chest, she is aware that in English the chest is just a part of the body and therefore tends to say, "the chest is sore".

She thinks other people use *isifuba* to refer to a person with *pneumonia*. Pneumonia, according to her is 'an infection in the chest". She does not think *pneumonia* and *asthma* are the same. This, she says, is because asthma is a chronic (lifetime) condition as opposed to a chest infection like pneumonia, which is caused by germs. She indicated that pneumonia is an acute (temporary) problem. She therefore does not think *isifuba* is the same as pneumonia.

Doctor B

Doctor B is a middle-aged doctor also working at both academic hospitals in Cape Town. He speaks English, Afrikaans, some German and a “few Xhosa words”. He thinks Xhosa is a difficult language to learn, despite several attempts to learn it. He pronounces the few Xhosa words that he speaks, he says, so badly that even when he calls people names they just cannot recognise their names.

In cases where patients do not speak English, he uses an interpreter, who is more often than not, a non-professional. He adds that where an interpreter is not available, mutual frustration, confusion, and misunderstanding are the sad results.

Although interpreters do help, however sometimes, he adds, interpretation creates confusion rather than communication. That is when he added the mother of the child became unhappy with interpretation. Like Dr. A, he believes interpretation may lose important information along the way. He referred to the interview in progress claiming that it was manageable although the researcher is a second language speaker of English. He stressed that this was due to the fact that both interlocutors “share the same lexicon, the same set of words [and] that makes it easier to understand each other”. He believes that in such a case it is possible to correct each other. He believes that this is sometimes not the case with interpreters, as they do not share the same set of words with the patient. Therefore, in his view

experienced by doctors and patients. In this regard Dr. B believes that the solution to this communication problem is all doctors take courses in communication in general so that they communicate their diagnoses effectively.

Dr. B indicated that he does use the term *isifuba*. He says he uses it to refer to "... short of breath and does not cope with breathing..." he further points out very clearly that, the English equivalent of *isifuba* is "shortness of breath or a tight chest although my understanding is there no word for a tight chest or asthma in Xhosa". He does not think *isifuba* and *pneumonia* are the same thing. Although he believes the word *isifuba* refers to a tight chest or shortness of breath, he however, does not use the term himself. Only the interpreter he adds, uses this term when speaking to patients. He says, he has never had of the word *ukuminxana*. He says when using the term *tight chest*, he does so to refer to a patient who "... has *fever* and *temperature*".

4.5 Commentary on doctors

Both doctors mention that sometimes there is a problem with communication between themselves and Xhosa-speaking patients during consultation. One commonality that comes out very strongly between them is that differences

in languages and their incompetence to speak Xhosa proficiently create communication problems during consultation. It seems as if both doctors believe that these problems could be overcome, should student doctors be familiarised with the Xhosa language during training. Doctor B even suggests that student doctors should take general communication courses, so that they are able "to communicate diagnosis effectively".

There also appears to be confusion about meanings attached to certain Xhosa medical words that both patients and doctors use. For instance, both do use or have heard of the term *isifuba*. However, based on participants and doctors responses, the term's meaning depends largely on who uses it for what purposes. For instance, as Doctor A puts it, patients tend to say 'I have a chest' (*ndinesifuba*), not referring to any specific chest problem e.g. pneumonia but rather to a general problem that is wrong with the chest. Doctors on the other hand as in the case of Doctor B, understand that the English equivalent of *isifuba* is "shortness of breath or a tight chest..." However, he does say even after using the word *isifuba* to refer to shortness of breath, he still has to ascertain whether it is caused by *pneumonia* or *asthma*. Both doctors however, do not think that *isifuba* refers to a specific medical term like *pneumonia*, *TB*, *Asthma* or *intliziyo*.

Dr. B does mention that interpreters, on the other hand, do use the word *isifuba* when talking to patients. Although he does not say why, it does seem that

the interpreter uses the words that he or she thinks patients are familiar with. However, the accurate use of this term, in such instances, cannot be determined. Both doctors do believe that interpreters do help where there is a communication problem. Both doctors, however, do point out that interpretation has its own limitations.

They link these limitations to the act of paraphrasing. For Dr. A, paraphrasing could be misleading and distorting because it may leave out important information that should be communicated to her. It is in such cases where she sometimes tries what she calls "few standard things" in Xhosa to probe directly to the patients. She does say that her few standard words in Xhosa and the interpreter's paraphrasing compromises the health of the child. Hence Dr. B's belief that "interpretation is really not a solution".

As in the case with patients interviews another key factor that impacts negatively on communication, that comes out strongly from Dr. A's interview is that different cultural beliefs may result in doctor/patient communication not being fruitful. From the Rastafarian example that she gave, she then concluded that as patients and doctors sometimes have different concepts that they believe in, it therefore would be worthwhile for doctors to know more about Xhosa culture and the different meanings and expectations they attach to diseases. For Dr. B, the language problem sometimes experienced during consultation could be

solved by teaching Xhosa to doctors, during training and engaging “well-informed language scientists to solve this problem”

It seems that not only should Xhosa be included in student doctor’s curriculum but cultural aspects of the Xhosa-speaking people should also be addressed. This should be done so that not only language but also cultural matters are attended to. In other words, the contribution of social science is crucial to the cognitive and communication aspects of medical science. Complications mentioned by Dr. B that many students complained that Xhosa is difficult to learn needs to be researched successfully.

4.6 Interpreter’s interviews

This section examines the nature of interpreting that takes place during consultation at the Red-Cross Children’s Hospital. It looks at, amongst other things, the pros and cons of using interpreters in general and that of using either professional or non-professional interpreters. Two interpreters have been interviewed for this study, one professional and one non-professional. The latter is, however, a nurse by profession.

Interpreter A

Interpreter A is a professional health interpreter who is proficient in at least three South African official languages. On a scale of one to ten in English proficiency, she rates herself at 7. After matriculating, she received her formal health interpreting training from one of the NGOs in Cape Town; The National Language Project herein referred to as the NLP. She had no

background in interpreting or in medicine. What she now knows about medicine is what she has learnt over the years as an interpreter.

She feels comfortable at her job and believes she is rendering good service. She is of the opinion that there are no problems with the nature of communication between herself, the doctor and the patient. She believes that the fact that she is "somewhat neutral", meaning without a medical background, helps her to ask more questions regarding the patient's illness. She does not remember an occasion where she used technical medical terminology when interpreting to the patient. In fact, she adds, she tries not to use any of the medical terms that she now knows because she is not yet confident to do so as she is not formally trained at it.

She answered the question whether she sometimes paraphrases a patient's explanation to the doctor if she feels that it is too long in the negative. She says the only problem in that regard is that, even though she tries her best to convey the explanation as it is, she is aware that she sometimes is limited by her English vocabulary as a second language speaker. She believes that it would therefore help if English speaking doctors themselves at least do understand "some Xhosa" even if they cannot respond in it. However, she believes that the overall interpreting during consultation is not only necessary but also valuable to the patient's life.

When asked how she conveys to the doctor that a patient has isifuba, she says she tries to leave the Xhosa naming of the illnesses in Xhosa. This

she does purely, she adds, on not trying to come up with her own diagnosis. Until the doctors diagnose the patient with, perhaps, *TB, pneumonia fever* or *asthma*. For *pneumonia* she uses the word *inyumoniya*, for TB she uses *iTB*, for fever *ifiva* or *ubushushu* and for asthma she uses *i-esma* or *isifuba*. She says the reason she uses *isifuba* and *esma* interchangeably is because she believes it is the same. Also, that it is called asthma in English and *isifuba* in Xhosa. She strongly believes there is no other word that can directly mean asthma in Xhosa other than *isifuba*. "Besides", she adds, "patients also know that asthma is *isifuba* or *esma*".

Interpreter B

Interpreter B speaks English and Afrikaans in addition to her mother tongue Xhosa. On a scale of one to ten, she rated her proficiency in both languages at eight. She has a four-year diploma in nursing from Groote Schuur hospital. She says, she regards herself as very well trained in her profession.

Although she is not a professional interpreter, she believes she is good at interpreting because of her medical and Xhosa language background. She believes her medical background helps her to converse with doctors about what the patient says. Her fluency in Xhosa, on the other hand, helps her she said, communicate with Xhosa-speaking patients, especially when using descriptive words that she believes the patient is familiar with and will understand.

She only uses medical terms when relating to the doctors what the patient says. When asked how she chooses her medical terminology, considering that the patient was using day-to-day Xhosa language, she replied that her medical background helps when choosing appropriate medical terms. However, she does not use English words/terminology when speaking to patients. Only, she adds, when conveying to the doctor what the patient says.

Interpreter B believes that it is necessary to probe further, by asking a patient questions that were not necessarily asked by the doctor. She believes that, while English sentences may be short and direct, interpreting that as it is in Xhosa will either be understood as being rude or may not hold substance. This, she says further, may result in a patient not being able to answer. However, she does not give examples to this effect. When asked whether, she sometimes paraphrases patient's explanations, she responded in the affirmative. She says the reason for paraphrasing is because some of the things the patient says are "irrelevant and unnecessary". Irrelevant and unnecessary information according to interpreter B involves long information about where was the patient when she started feeling ill and what the patient thought of it at the time.

Interpreter B reinforces that it is important for her to paraphrase as she is "merely helping out", in order to save time. Also, that while busy interpreting sometimes in a different ward, her nursing duties are either is neglected or delayed. This sluggishness of her duties, she complains, results in her having

to work under a lot of pressure as she tries to finish on time. Her superiors who do not like it much when she stops whatever she is doing in order to interpret, further add her on.

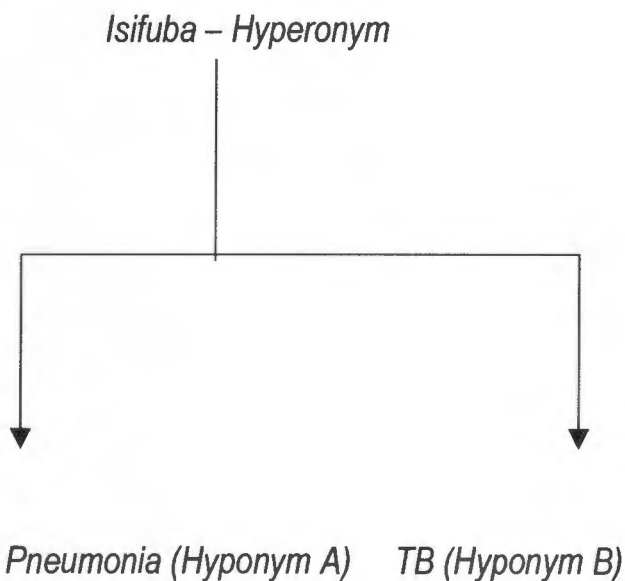
Interpreter B feels that her added duty is not recognised by both her superiors and by the doctors she is assisting. She believes that not being officially rewarded for her services means that what she is doing is not important or unrecognised. Moreover, being in two places at the same time means that she gets "torn apart which is both physically and mentally tiring". However, tiring or not, she believes, it would be much better if she was paid for her services.

However, she strongly believes that interpreting during consultation adds value. Certain information gets lost during interpreting only when the interpreter is not sure of his capabilities. Interpreters like her, with a medical background and a good command of Xhosa are much better at this job she says. She reported no problems during the interpreting process. When asked how she relays to the doctor that a patient complains of *isifuba* she responded that when patients complain of *isifuba*, she tells the doctor "the patient has chest pains". Sometimes on instructions from the doctor and sometimes voluntarily, she probes further as to what kind of pains the patient suffers from. Only after she is satisfied with what the patient says will she convey it to the doctor. In many instances, she adds, after much probing in Xhosa, she gets to know what kind of chest problems they are dealing with. That is when she simply tells the doctor "the patient has pneumonia".

Interpreter B insists that only people with medical background could be good health interpreters. Further that the job becomes much easier for the interpreter and the doctor once she has told the doctor her diagnosis of the patient and would save the interpreter time spent when the doctor is doing her own diagnosis.

When interpreter B is asked whether in her understanding, *isifuba* and pneumonia are related or similar, she responded positively. She believes that *isifuba* is just an “umbrella word” that needs to be unpacked by the health professional. This “umbrella word” she mentions is referred to as hyponym in semantics. For instance, figure 4.1 below shows how hyponyms are related.

Figure 4.1 – Hyponymic relations



Isifuba according to her can mean *pneumonia*, *asthma*, *TB* or any other chest infection. She says in instances like these her job becomes easy as an interpreter who is also a health professional. It is, she adds, when further probing becomes essential, which she does to ascertain what kind of *isifuba* the patient suffers from, she adds.

Lastly, interpreter B was asked what kind of words she uses to the patient that the doctor has diagnosed as having *pneumonia*, *TB* or *bronchitis*. She says she refers to TB as *isifo sephepha* or *ukhohlokhohlo*, *pneumonia* as *inyumoniya* or *ingqele* (cold) and *bronchitis* and other chest infections as *intsholongwana eyenza isifuba sibe mdaka* (a virus that causes the chest to be dirty.)

Looking at these Xhosa terms used by interpreters and patients one can argue that they use similar terms to refer to illness. For instance TB is understood by both as *isifo sephepha* or *ukhohlokhohlo*. The only noticeable difference between patients and interpreters found is their understanding of what causes certain diseases and their understanding of them thereafter. Patients understand pneumonia to be caused by not dressing up warmly and being exposed to *ingqele* (cold). Hence, they refer to it as *ingqele*. Interpreters as well as doctors understand pneumonia to be caused by viruses or germs that infect the chest. One can therefore argue that since patients and interpreters use familiar words to refer to illnesses, then doctors should be familiar with such words. This could be done while still on training or during practice.

Also, as much as they differ with regard to what causes the illness, it would also prove to be of advantage to the doctors to learn more about such beliefs. This would help both doctors and patients communicate effectively once they have established the common ground. By common ground it means sharing the same belief about an illness, what causes it and what names it is called. This ground would help encourage or motivate patients take their prescribed treatment.

The term *isifuba*, as discussed on page 66, proves to be the key term when dealing with chest problems or complications. As is evident in the table on page 68, patients and interpreters tend to refer to any undiagnosed or diagnosed chest problems as *isifuba*. One can therefore argue that the term *isifuba* should be accepted as a Xhosa medical term, which is a hyperonym, by doctors. It would therefore, mean that doctors should take it up to themselves to investigate further as to what kind of *isifuba* it is and what causes it. It also means that doctors should start using the term, for diagnoses to patients, since most of them indicated that they never use the term as they are not sure what it means. Table 4.1 below compares the meanings associated with the same or similar terms used by patients, doctors and interpreters.

Table 4.1: Meanings used by patients, doctors and interpreters.

Patient	Doctor	Interpreter
<p><i>Pneumonia – inyumoniya –</i> a condition that one gets when having too much ingqele (cold) caused by not dressing warmly enough. It is also known as <i>isifuba</i></p>	<p><i>Pneumonia –</i> infection in the chest that is caused by germs such as bacteria, viruses and other types of germs. They do not think <i>isifuba</i> as an equivalent of pneumonia</p>	<p><i>Pneumonia –</i> <i>inyumoniya</i> or <i>ingqele</i> (cold) that is caused by viruses that cause the chest to be dirty. They sometimes refer to it as <i>isifuba</i> for patients to understand.</p>
<p><i>Asthma – iesma</i> is <i>isifuba</i>. The chest gets tighter and closes up. Cold and allergies cause it.</p>	<p><i>Asthma –</i> is not an infection but an allergy mediated inflammation of the respiratory system especially the lungs. It is a chronic illness. A person wheezes, breathes fast and coughs at night.</p>	<p><i>Asthma – isifuba</i> or <i>i-esma</i></p>

<p><i>TB – is isifuba or asthma?</i></p> <p>Pneumonia leads to TB.</p> <p>People with TB cough, sweat and have <i>ingqele</i> (cold) at the same time.</p> <p><i>Isifo sephepha</i> (no direct translation). <i>Isifo sesifuba somoya</i> (<i>isifuba</i> that is transmitted through the air.)</p>	<p><i>TB – is another form of pneumonia, which is caused by germs.</i></p>	<p><i>TB – is iTB, isifuba or isifo sephepha</i> (no direct translation).</p> <p><i>Isifo sesifuba somoya</i> (<i>isifuba</i> that is transmitted through the air)</p>
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4.7 Summary of the Discussions with Interpreters

Looking at these two interpreters' interviews one easily picks up that both are committed workers in their field. Both regard interpreting services in health communication as essential and highly valuable during doctor/patient consultation. However, they feel that they could be giving more, in terms of quality, commitment and time to their job if only their services were being recognised.

Interpreter A feels that her lack of medical background limits her vocabulary and terminology when conversing with a doctor. One picks up that even though she has been on the job for a number of years, she is still very much way of using medical jargon, which by now she believes she understands. However, for avoiding mistakes and sometimes even misdiagnosis, she prefers conveying the long explanation to the doctor as the patient has to her.

It seems the other problem facing interpreter A, as far as language is concerned, is that sometimes not only are medical terms problematic but also English vocabulary as well. Although she rated herself as highly proficient in English, the fact that English is a second language does affect her job. For instance, she complains that one must be always careful of grammatical mistakes such as *on* or *in* whenever conversing with a doctor. She says if one uses *on* instead of *in* may sometimes impact negatively on the patient's diagnosis. She makes an example that, at one stage she said a patient is complaining of a terrible pain *on* the left breast. The doctor had to tell the patient to take off her blouse. She (doctor) started examining the breast and the area around it. To which she (doctor) said she could not see any bruises or scars on the breast and asked if maybe the patient had accidentally bumped on something very hard or maybe had fallen, which the patient denied. It was only when the doctor was writing some notes to the patient's folder that she realised that on arriving at the hospital the patient's chest was nebulized.

This led the doctor to conclude there must be another problem the patient has other than that she had a pain "on her breast"? After much further probing by the doctor, through an interpreter, it emerged that on arriving at the hospital, the Xhosa-speaking nurses were the first ones to see the patient at the reception ward. As the two-way conversation was in Xhosa the nurses did understand exactly what the problem was.

It turned out that the patient was on asthvent spray (for asthma). She experiences the piercing pain every few minutes shortly after the puffs. The patient had been on the medication for a longer period before but had never experienced those pains. Not only she did now have sharp and painful pains after puffs but she also experienced shortness of breath and what she described as "a tight fist knocking her hard on the left breast".

Interpreter A related this experience because she believes that it was an eye opener for her. Also that it taught her a good lesson on how she relates her grammar to the English-speaking doctor. On the whole, she adds, such instances do not usually occur.

However, it is very interesting to note that both interpreters A & B mention what may be regarded as advantages and disadvantages of health interpreting. For instance, interpreter A does not have a medical background and does not use paraphrases when conversing with a doctor. She listens to the, sometimes-long, explanation of the illness of the patient and conveys it as it is to the doctor. During the interview, she gave an impression that during interpreting, she uses what could be called a 'layman's language' both to the doctor and to the patient. As she does not paraphrase patients' explanations, it could be assumed that little or no information gets lost during interpreting.

However, this assumption could be debated, considering her concern over her somewhat limited English vocabulary as a second language speaker. Also, it could be debated due to the fact that at some point she mixes up her prepositions.

Interpreter B on the other hand is very proud of the fact that she has a medical background. Also, that her medical background puts her at an advantageous position when trying to understand what could be wrong with the patient. She believes paraphrasing saves time, hence uses medical terms, which shorten the patient's explanation. Also, that it saves "her" time, as she has to get back to her "proper" job.

However, it could be argued that her medical background limits her attentiveness during consultation. She may tend to think she already knows what is wrong with the patient due to being selective about what to relay to the doctor. Selectiveness could amongst other things limit thorough examination. For instance, when she says "after listening to the long and sometimes irrelevant and unnecessary explanation about the patient's *isifuba*, I as a medical person know at that point what the problem is. I then tell the doctor that she has TB, when there is blood after coughing or just say s/he has pneumonia when there is shortness of breath".

The kind of the above diagnosis, which is only based on the patients' explanation thorough patient's examination, could come up with a few words of what *isifuba* is. As doctors indicate (see 4.3 on this chapter) that for TB to

be diagnosed for instance especially on children, a patient has to go through a number of tests. Doctor A believes that it is difficult to tell exactly initially what the problem is when the patient is wheezing and out of breath, sometimes coughing. She is hospitalised and put on antibiotics. Generally she says, if it is an infection like pneumonia, patients need to respond within three to five days. Should they not respond to antibiotics then it could be TB, "but you must remember that sometimes patients do cough up blood when it is pneumonia but not TB" hence the number of tests has to be done to ascertain diagnosis.

It is in this regard that interpreter B's medical background could in theory; in exceptional cases endanger a patient's health. In practice, her paraphrasing and 'diagnoses are justified by acute limitation in doctors and nurses time.

4.8 Conclusion

At this stage it cannot be said which interpreter delivers the best service, A or B. However, one commonality that comes out very strongly is that both interpreters feel that their service is very valuable. Interpreting contributes meaningfully to assist in communication problems sometimes experienced by patients and doctors. Their only problem in the field is that their profession is somehow unrecognised by the industry they are serving. Interpreter A complains that in a big hospital like Red Cross, it is unimaginable how only two professional interpreters are employed. Hence sometimes the needs to use services of unprofessional interpreters like interpreter B.

It can be argued that professional interpreters need to be employed in our hospitals and clinics. Furthermore, that part of the interpreters' training should include an in-depth understanding of medical terminology and the complications which may arise when interpreting technical medical terminology.

Chapter 5: Summary, Conclusions and Recommendations

5.1 Introduction

This study looked at the nature of communication that takes place in a Cape Town hospital where different cultures, different social classes and different languages are at play. Literature by Western scholars and South African scholars on health communication has been used to help characterise the interaction at the hospital. In addition Western Cape language committee's implementation language plan of 2003 was reviewed, for the directions that are likely to ensure in future in multilingual communication in the public sector.

English-speaking doctors, Xhosa-speaking patients and multi-lingual interpreters were interviewed to give concise insight into the nature of communication that takes place during consultation.

5.2 Patient's Communication Perspective

From the patient's interview, two categories are identified: a) those that cannot converse with English-speaking doctors without interpreters due to their inability to speak English; and b) those that can converse in English due to their educational background who however, do not understand medical terms, for instance participant "D"

Both categories suggest, although somewhat at different levels, that there are problems with the nature of communication during consultation. One

problem is not being able to express oneself fully in a second language. From the Western literature reviewed, it became clear that patients fear being embarrassed, humiliated or even prejudiced against whenever speaking a second language, which happens to be English, during consultation. From the study done by Kleinman et al (1979), Spanish – speaking women were so uncomfortable in conversing in what they perceived as a “superior language, the doctor’s language to an extent that their conversation is quoted to have only been limited to yes or No.”

It becomes evident that in a South African context, not only is language a barrier during consultation but so too are the power relations between doctors and patients. For instance when patient B is asked if she is satisfied with the nature of communication she has with the doctors, she responded “Yes, I think I am satisfied because they are doctors, and doctors know what they are doing, it is their job, they are here to help us”. From participant B’s response, it could be deduced that as far as she is concerned, her opinion or questions, should she have any, are not necessary and would not be valued since doctors “know” what they are doing.

5.3 Doctors’ Communication Perspective

The doctors interviewed for this study are aware that there are problems as far as health communication is concerned. They express regrets about not having learnt much Xhosa as student doctors. However, they feel that they have to make the best of the situation. For instance, most doctors mention that at least they can speak “basic Xhosa”, which seems to cover mainly

greetings. Even though they have limited Xhosa vocabulary as Dr. B mentions, they do know basic medical Xhosa terminology, as far as chest pains are concerned to get the communication started.

One of the purposes of this study was to ascertain whether those few words that they know of disease naming in Xhosa are indeed understood by patients to mean the same as their understanding.

5.4 Interpreters' Communication Perspective

The two interpreters interviewed for this study give us an insight into what happens during consultations. Both patients and doctors concede that interpreting is valuable, when necessary. Looking at the interpreters' interviews, one can argue that the information transmitted is not always accurate. This argument is based on two aspects of the interviews

Interpreter A complains of her limited English vocabulary as a Xhosa-speaker. Interpreter B believes in paraphrasing in the interests of time management and uses medical terms where she deems fit during interpreting.

As much as doctors value the interpreting service, there are different views amongst them on the accuracy of the interpreting. Doctor B argues that during consultation, he does not think "we are solving the problem by getting the interpreters". This is so because he has to make sure now and again

becomes a problem since his Xhosa is limited. Interpreters on the other hand feel that their services are not appreciated, as they are not rewarded accordingly. This, they argue, demoralises them and they become less committed.

5.5 Conclusion and Recommendations

It seems as if little could be done for those patients who are either not educated or could not speak English during doctor/patient consultation. Student doctors should learn as early as possible in their training at least the indigenous languages spoken by the community the training institution is situated e.g. Xhosa and Afrikaans in Cape Town and Zulu in KwaZulu Natal. The University of Cape Town has already implemented such a policy.

The Department of Education should include in the medical curriculum a course about the community the training institution serves so to enable student doctors to understand the cultural aspects of the community they may serve. This will further enable doctors to understand patient's belief models (see chapter 2), which is usually influenced by culture, during consultation.

Standardisation of the use of some of the Xhosa medical terminology is needed, to include in the student doctor's curriculum. For instance, in 4.5, patients, doctors, interpreters give similar interpretations of TB, as a chest

illness that is caused by germs in the air. Therefore, the Xhosa term *isifuba somoya* used to refer to TB by patients and interpreters could be standardised. Or alternatively government should make funds available for MPhil and PhD students to conduct research that intends suggesting terms for standardisation.

The number of professional interpreters in hospitals should be increased to befit the size of the hospital. This could be achieved if hospitals are able to increase the budget allocated to the interpreting services.

The Department of Health should invest in training second language speakers as interpreters so they could communicate effectively with both patients and doctors who do not often share the same language.

Studies done on this subject should be made available to health-care workers especially during training. This would help the health-care workers understand the likely problems, as uncovered in this thesis.

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Appendix A

Interpreters' Questionnaire

Introducing the study.

- I) What languages do you speak or how would you rate your proficiency from a scale of one to ten?
- II) What is your highest qualification?
- III) For how long have you been interpreting?
- IV) Do you have a medical background?
- V) During doctor/patient consultation, how is the nature of communication between you, the patient and the doctor?
- VI) How do you relay the patient's explanation of the illness to the doctor?
- VII) How often do you use medical jargons during interpreting and to who (doctor or patient)?
- VIII) During interpreting, do you sometimes find that you have to probe a patient further by asking other related questions which were not necessarily asked by the doctor?
- IX) If so, why?
- X) When a patient has a long explanation of when and why she has the illness, do you relay that explanation as it is to the doctor or do you paraphrase it?

- XI) Do you use your discretion of what is important from the patient's explanation and only relay that to the doctor?
- XII) From your experience, do you think that certain information gets lost during interpreting back and forth?
- XIII) Are there instances when you run short of terminology and vocabulary on both doctors and patients? Where you feel that you cannot express what has been said fully?
- XIV) How do you deal with that situation?
- XV) Do you think that interpreting adds value to doctor/patient communication breakdown?
- XVI) What difficulties do you encounter in your profession?

I would like to ask you meanings of certain disease names commonly used by some patients and some doctors in relating to illnesses.

- XVII) During interpreting, when a patient says she has *isifuba*, how do you convey that?
- XVIII) Do you think *isifuba* and asthma are related? Or is it one and the same thing?
- XIX) When a doctor diagnosis a patient as having pneumonia, what words do you use to convey the diagnosis.
- XX) Is there an instance where one word could refer to more than one illness/disease?

Thank you very much for your time. I may have to come back later if there is anything that needs clarification.

Enkosi.

Appendix B

Doctors' Questionnaire

We are doing a study to find out, how you and your patient talk to each other. This is not a test of how much you know about Xhosa or your full range of medical knowledge. We are interested in finding out what you think and believe, so that we can address any concerns you may have.

But first we need to ask you a few questions:

- I. Name
- II. Age
- III. Place of residence
- IV. Place of birth
- V. Home language
- VI. How well do you speak Xhosa on a scale of 0 -10?
- VII. Do you speak Xhosa to your Xhosa speaking parents: never, infrequently, frequently or always?
- VIII. What proportion of the conversation is in Xhosa?
- IX. What other languages do you speak?
- X. Now, I want to talk about the conversation you have with patients. Are you satisfied with the conversation between you and your patients?
- XI. If not why?

- XII. Are there problems in communication?
- XIII. What are the problems in communication?
- XIV. What reasons /causes for the problem?
- XV. What effect this has on you and your child?
- XVI. What are the possible solutions?

Now I want to find out what you believe about your patient's chest problem, and what the words that you use in English as well as Xhosa mean. There is no right or wrong answer to these questions. We don't want to test how much Xhosa you know or the entire range of medical knowledge you have, but we are only interested in finding out what you think about these things and more specifically what you tell your patients, and what you assume your parent already knows. We need you to limit yourself to telling us what you would tell the parent, not everything you know about the disease.

- XVII. What words do you use when you talk to your patient about chest problems?
- XVIII. What do you mean when you use this word?
- XIX. What does this sickness do to a person?
- XX. How does it work?
- XXI. What parts of the body are most affected?
- XXII. What are the biggest problems the sickness causes for a person?
- XXIII. How serious is it?
- XXIV. How much time does it take?

- XXV. What happens then?
- XXVI. What do you think has caused "X"?
- XXVII. How does one get "x"?
- XXVIII. Why do you think it started when it did?
- XXIX. What kind of people get "x"?
- XXX. Is it the same in different kind of people?
- XXXI. What can someone with "x" do about it?
- XXXII. What kind of treatment do you think you should administer \ prescribe?
- XXXIII. What are the most important results you hope the child to receive from this treatment?

Now we need to compare the way you use this word to the way you use other words to see they are the same or if they are different?

If they are different we want to know how they are different. You mentioned the word "y"

- XXXIV. What does it mean?
- XXXV. Is it similar to "x" how? If not, how does it differ?
- XXXVI. Are there any other word referred to or included in the definition?
- XXXVII. Are there any other different meanings / senses of the word?

List Of Terms

Chest diseases:

- *Isifuba*
- *asthma, l-esma*
- *isifuba somoya*
- *pneumonia, inyumoniya*
- *Ingqele*

Signs

- wheezing
- *ukutswina*
- *ukuminxana*
- tight chest
- shortness of breath
- *iphika*
- coughing
- *ukukhohlela*

Infectious Diseases:

- *intsholongwane,*
- germs,
- infection,
- *usuleleko*

Upper Respiratory Signs/ Illnesses: Flu

- *ifiva,*
- *umkhuhlane,*
- a "cold"
- *imifinya,*

Are there any other words that you feel are related or important. Explain these terms too,

Appendix C

Interview with Doctor A

Interview Date: 05 December 2002

Changed (modified): 12 December 2002

As I have introduced myself over the phone I am Jackie Nxasana and we are doing a study on how you and your Xhosa speaking patients communicate and we are not trying to test how much you know or speak Xhosa or your medical knowledge. All we would like to know is what you think and believe so that we may address issues regarding the nature of conversation with your patients. To do that I would like to ask you a few questions starting with your name.

A: Dr. A.

Q: Where do you live?

A: In Mowbray.

Q: Were you born in Mowbray?

A: No I was born and brought up in Durban, I went to school there and then I came to Cape Town when I came to university when I was 17

Q: Do you speak Xhosa, if you would put yourself on a scale of 0-10, how would you rate yourself.

A: 2 to 3

Q: Would 2 to 3 mean good or fair? Would you regard yourself as competent in Xhosa?

- A: Definitely not competent, no. I mean I've got a set of few questions that I can ask and answers that I can understand.
- Q: When you ask those questions do you use Xhosa or English or a mixture?
- A: Probably a mixture of both and sometimes Afrikaans.
- Q: What's your home Language?
- A: English.
- Q: Do you speak any other language except English?
- A: Afrikaans.
- Q: Only?
- A: Yeah.
- Q: Is there any other African language you speak?
- A: No.
- Q: Nothing at all. How often do you speak Xhosa to the mothers?
- A: It depends where you work. If you work in an outpatients or a busy ward you speak a couple of times a day with them.
- Q: If you can think in that period, where you are busy, what proportion of the conversation would you have in Xhosa?
- A: I only have a few standard things that I can ask. As soon as it gets beyond that then I'll need help. I can't really explain things in Xhosa.
- Q: With Xhosa.
- A: I'll know a few words to explain but then without being able to use English or Afrikaans, I'll have to get someone to help me.
- Q: Someone like an interpreter?

- A: An interpreter, yes.
- Q: A professional interpreter or anybody who speaks the language?
- A: It depends because some of the Xhosa speaking sisters are very helpful in that, but sometimes it is complicated and you need to get an interpreter to explain some things like an operation because you want to be sure if the patient receives the correct information.
- Q: Doctor I would like us to talk about the conversation you have with the patients. Are you satisfied with the conversation between you and your patients?
- A: No.
- Q: Why not?
- A: Because I don't have a big enough vocabulary so I can't ask everything that I want to and often if you give the impression that you can speak, then you tend to get a lot more back in response and you cant actually understand what's being answered. I cannot explain enough as much about things as I would like to.
- Q: Are you saying even when you use interpreters it's not helping?
- A: Oh, I use an interpreter but I also use pictures and drawings. But the problem with interpreters is, I sometimes think they directly translate and they sometimes say "I" for patients and sometimes you find out that you give a long explanation and they will only say two or three words...
- Q: They do paraphrasing ... taking what they think is important. Which may not be?

- A: Sometimes that may not be, so that's also not optimal. I mean after long explanations and they say two words and then you wonder if they said everything that you wanted to communicate.
- Q: How do you deal with that where your instinct tells you that this might not be what you said?
- A: I sometimes go back to explain again and ask the interpreter if they actually said this. I go back and try making sure.
- Q: Doctor you are saying you are able to speak to your patients in Xhosa in some instance but where you have to fully explain in more detail about the nature of the illness or disease, you'll need someone who is proficient in African languages but that you also are experiencing problems with these people?
- A: Yes.
- Q: When you are going through this period of having a communication breakdown between yourself, the patient and an interpreter; what effect does it have on a child, if I may use the allergy clinic as an example?
- A: I think, perhaps children don't generally look after themselves, so they by default, the care that they get is from the person who brings them to hospital, so if they don't have a proper understanding of the disease and the implications it has for the child then the care of the child might be compromised. If they don't fully know what to do at times of emergency, or what the dangers are, the health of the child is highly compromised.

Q: Have you come across a case like that before where the health of the child has been compromised through misunderstanding?

A: I don't know about this, because the other thing is that its much more complicated than that, because it's all very well to explain in the Western setting hospital what's best for the child because the person you are telling it to has got other beliefs about what other things are better for the child, then that can also influence it. I had a case of a child with severe, severe asthma, who came in status, you know, almost dying. She was brought in by her father who was very Rastafarian and he'd been on numerous times and had things explained over and over again yet he'd not been giving any medication because he believed herbal remedies or that kind of thing were better. So, I think it's double sided it's not only the language but also the concepts you believe.

Q: A social factor?

A: Yes

Q: So you are saying that problems maybe created not only through misunderstanding with a parent but there are also other factors, for example a social factor.

A: Yes

Q: Where communication is the problem, what do you think are possible solutions to that? Any suggestions?

A: I think first of all from the language problem, most of the Xhosa I learnt when I was at university at third or fourth year which I've kind of kept, and I tried to go to some classes but I always

seemed to be on call when there were classes. The one way of doing it is for all doctors to learn to speak Xhosa better if that's what your patients are and another thing that would be important to know more about the Xhosa culture and social things and explain what the different concepts of disease are and try to incorporate that in our understanding because if we have our understanding things may not be the same as the way they understand it.

Q: When you grow up in Natal did you learn any Zulu?

A: They were just starting with it at school and I didn't learn much at all.

Q: When you speak to Xhosa parents when exactly do you speak Xhosa?

A: If the mother doesn't speak any English or Afrikaans and there is no interpreter around I mean, I can ask them where they live, when did the child start to get sick,...

Q: You can ask in Xhosa?

A: What is wrong with the child? Is it the chest, the head, has he got a fever, has he been losing weight?

Q: And all this time you are using Xhosa?

A: Yes

Q: What word do you use to refer to the chest?

A: I use isifuba. I just ask " isifuba ubuhlungu, ubuhlela."

Q: What word do you use to refer to fever?

A: Unefiva.

- Q: I'm trying to find out what exactly the words are.
- A: I don't know if I've been right.
- Q: I don't know either, so you are saying according to you; the possible solution to these problems is that medical students are introduced to Xhosa early at university?
- A: Yes, I mean I had learnt at third year and it should be taught all the way through. I mean the problem is if you train and stay in the Cape it's fine, if you train in the Northern Province or in Natal and come to the Cape then it's problematic. I know there's a bit of overlap between Xhosa and Zulu so that should not be a problem but students from the Northern Province who come down here can't speak Xhosa either.
- Q: But, you still think that the solution is to introduce Xhosa to medical students as soon as possible.
- A: Even at first year, to make it compulsory will be great.
- Q: Did you learn it yourself?
- A: Only at third year.
- Q: Only for that year and never again?
- A: Yes
- Q: I would like us to talk about the words that you use to describe the chest problems to parents and for us to find out the meanings so that we can understand the words you have. What words do you use when you talk to patients about the chest problems, you've already mentioned isifuba, and what does it mean?

- A: Just chest because often when you ask what's wrong patients, would say "isifuba ihlungu" that my chest is sore, other than I ask about coughing.
- Q: What do you do for that?
- A: I use the word "ukhohlela" and other than that it's very limited because I don't have a word to ask if the chest is tight.
- Q: So what do you do, how do you handle that? You just use the English word?
- A: Yeah because I don't have a Xhosa word for whizzing, tight or anything like that, so it could encompass anything from asthma to pneumonia.
- Q: Now, isifuba what does it do to a person, is it a disease or illness?
- A: I mean like, now what I've learned and heard is that sometimes if someone says "I have a chest" then they are implying they have something wrong with the chest like, "unentloko", "I've got a head" and that actually means I have a headache, even though the word pain does not appear, it is associated with the part of the body. I know I tend to use the words "isifuba buhlungu" meaning that something is wrong with the chest. Isifuba though is really just a noun for saying the chest ... that part of the body So I tend to say the chest is sore.
- Q: What happens to a person with isifuba?
- A: When I explain it in the case of pneumonia, an infection in the

chest, I explain that the chest is sick and it is an infection. I'm trying to remember what I actually say.

Q: Do you say this in Xhosa or in English, doctor?

A: Well, it all depends on exactly how much Afrikaans or English the parent speaks, sometimes if there's absolutely no English at all then I'll try and say isifuba buhlungu. If it's a case of pneumonia I'll mention germs, I'll say something about the germ on the chest which is sore. I don't have much more experience speaking with Asthma, because it's more of a chronic diagnosis. I have more experience with the acute problems like a child with bad pneumonia who's breathing fast, explaining all that. With the child with asthma then that's a chronic disease you tend to get an interpreter in to help you explain specifically about asthma.

Q: Doctor you are saying that isifuba only refers to the chest which is a physical part of the body not a disease.

A: I tend to see it like that. I know from what I've heard about the way people talk. Sometimes, they tend to talk about the chest it means they've actually got a chest problem but I don't use it like that. But I do believe that I've heard that sometimes people say it is a chest it means it's a chest illness but quite what that actually means about the chest problem I don't know.

Q: What parts of the body get affected by isifuba?

A: The lungs.

Q: Do you think isifuba and pneumonia are related somehow; is it one and the same thing?

- A: I don't think it's the same thing. I think if you explain that the chest is sore and that there are germs that cause it but now I wouldn't say that they are one and the same thing, I wouldn't use it that way.
- Q: What's the biggest thing pneumonia causes to a person?
- A: It causes them to need oxygen sometimes, they can breath very fast and they get tired and need help, you know with a ventilator, and because it's caused by an infection, that infection can get into the blood and can make the child very, very, sick.
- Q: How serious is pneumonia?
- A: Serious. It is the second biggest killer of children in the third world. It kills a lot of children; you know chest infections of any cause.
- Q: Is pneumonia a chest infection?
- A: Yes, it is an acute respiratory infection. An A.R.I is an acute respiratory infection.
- Q: What do you mean by infection?
- A: Infection is something caused by some sort of organisms, either a bacteria or virus or lots of different things that can cause it. But, an infection is basically where anything that comes with the germ either a virus or bacteria or protozoa or whatever, and invades a part of the body where it shouldn't be and it comes and causes an illness.
- Q: When someone has been diagnosed with pneumonia how much time does it take or how long does it take for someone

to get better maybe or ...?

A: It's very variable and completely depends on what's causing it. If it's one kind of bacteria called a Strep pneumonia you can be better within twenty four hours but I mean pneumonia can be caused by TB and you can have TB pneumonia and it needs about six months of treatment. You can get a viral pneumonia that can go on for two weeks and you can get destructive pneumonia, which can go on for months. I mean its one word for a whole spectrum of different clinical pictures. I mean the common one is the bacterial pneumonia which takes about a week or so to get better and the children will have to be in hospital for about five days, they need to be on oxygen, antibiotics and the drip so that they can get better and go home. Some need longer and some shorter, some only need to sleep in for one night, some can be treated at home with oral antibiotics so it's very, very variable so it depends on what is causing it and how well the child is. If the child is already a sick child such as an HIV positive child it will take much longer to get over because their bodies can't fight as compared to a big fat healthy, breast fed baby they'll probably be fine at home on some oral antibiotics.

Q: If they go through this treatment is there a chance for them to get pneumonia again or is it curable forever?

A: Oh that particular bout of pneumonia can be cured; if it's a viral one it tends to just go away on its own, if its bacterial it can be treated but you can be infected again with the same

organism or it can cause damage to the lungs. Sometimes if it is a really bad pneumonia it can be caused by, something called Staphylococcus it actually eats the lungs away and leaves a big hole in the lungs and it can destroy the lungs and it can go on to have problems and some viruses can do that as well – it actually destroys the whole lung and the person can actually die from a lung related problem after that pneumonia. I mean it's very difficult thing I should say. But the majority of the children with pneumonia will get better, 95%... Only a few go on to have problems.

Q: You are referring to those who seek help?

A: Yes

Q: What happens to those who do not have access to facilities such as oxygen?

A: Some of them die because they would need oxygen for the lungs and the lungs need to supply the whole body with oxygen to the rest of the body, so if the lungs are not working in any way the body does not get enough oxygen, the baby can get blue and hypoxic and die. So, it does kill lots and lots of children.

Q: So are you saying germs from outside the body because pneumonia did you say germs or virus?

A: Yes, you know I use germs as a colloquial term that incorporates bacteria, viruses, protozoa. All sorts of things.

Q: So it's the germs that cause pneumonia? How does one get these germs?

A: Well they are all around in the environment and sometimes very well children pick it up but it's more common in children with lower immunity and children who've had measles, malnourished, HIV will be more susceptible to these germs. They are generally all around and they will tend to attack the weakest victim. I mean it's like the flu, some people get it and some don't it depends on what happens.

Q: Is pneumonia the same to everyone who has got it or is it different?

A: What do you mean?

Q: Is pneumonia the same to everyone who's having it. If you've got pneumonia and I've got pneumonia are we having the same thing or are we having two different things?

A: Pneumonia is a clinical diagnosis with a very wide spectrum, so pneumonia basically means the infection of the lungs caused by some sort of infective organism which can be anything, and there are completely different implications. I mean it's not the same thing. You know there's a common type which happens in 90% of children and there's a less typical type, but you can't say you have the same illness because it's not caused by the same germ. I mean you could have TB, I could happen to have HIV and have a bad PCP pneumonia but it's all termed under the same group and children who live in the hospital for a long time are at risk for other types of pneumonia and children who have cancer and adults who smoke who get pneumonia might mean they actually have underlying lung cancer. You know what I

mean, is it's such a wide spectrum but the concept of it is that some sort of germ has infected the baby or the person. It's caused symptoms like coughing, fast breathing, or fever so if you and I have pneumonia we'll probably have that in common; coughing, pain in the chest, breathing fast, maybe we'll be blue and need oxygen or we have fever but we can't say we have the same thing because it is caused by the broad spectrum of things. When the doctor examines the child, the signs will be fever, fast breathing, and crackles in the chest that's what they will pick up.

Q: What kind of treatment do you think a person with pneumonia should get?

A: The World Health Organization has a classification for children with respiratory infection depending on how severe it is. So if they are feeding fine, not breathing too fast, not getting any high fever, not making any noise when breathing, they can actually be treated at home sometimes not even with antibiotics. Then there's a group that's not feeding well etc, etc, and then you scale up the treatment according to how sick they are. So I mean if they've got a fever they need something to bring the fever down, an antibiotic, and if they are very sick they might need to be in hospital and put on oxygen and on a drip depending on how sick they are.

Q: What is the most important result you are hoping for after the treatment?

A: You want to prevent hypoxia, which is lack of oxygen in the blood and the baby from turning blue. The problem is when they breathe really, really fast they can't finish their feed so they get dehydrated so you want to make sure of that; and then you want to kill the germ that's causing it. A lot of them are caused by bacteria, which will be killed by antibiotics. We don't have the treatment that will treat some of the other things like the viruses but you tend to presume it's a bacteria and cover for that.

Q: Can we compare how you use some of the words like pneumonia to other words to see if they are the same or different. If they are different, how are they different from each other? You said pneumonia isn't isifuba? But you also said pneumonia could be a normal pneumonia or TB Pneumonia? What is TB?

A: That's the infection of the.... Because I mean TB is an organism, it is a bacteria that can cause wide varieties of illnesses including an infection of the chest. But, it can also infect other parts like the head, it can cause meningitis, it can cause TB of the bone, you can get it in the spine, you can get in the abdomen, in the kidney, you can get it anywhere but basically TB is a germ. I mean normally the common TB infects the chest, so normally when you talk about TB you presume it's in the chest but actually it can cause anything else. When someone has a normal pneumonia you'll try to distinguish between normal pneumonia and an underlying TB or associated TB.

Q: Doctor, are you saying TB and pneumonia are the same?

A: TB of the chest is one type of pneumonia so when you see a child with pneumonia you have to think could this pneumonia be caused by TB. It's like I said that pneumonia is a spectrum where you get that clinical picture with the fever, breathing fast and hypoxia, combined with the clinical picture where the doctors see the crackles, breathing fast, and the x-ray picture with the changes on the x-ray.

Q: What kind of changes?

A: Where you see different shadows on the x-ray and the type of shadow that you see gives you a clue of what type of pneumonia. So, if it's TB with adults the shadow can start up at the top if it's children it can be low or diffuse throughout the whole lung. So that's how we come up with a conclusion of what causes the pneumonia. So, we put together the whole clinical picture to go with the history of someone around, living with someone with TB, the history of sweating or losing weight; that gives us another clue. It's like putting a puzzle together really; the X-ray may look suspicious and at home there is someone with TB, the history sounds like TB, and the X-ray looks like B so they've probably got TB of the chest and that the changes on the X-ray that look pneumonia are probably caused by TB.

Q: Doctor if someone says, "I have isifuba," then you look for such things that could cause isifuba and such things could be TB,

pneumonia and so on. And you are saying TB is form pneumonia. And what is asthma?

A: Asthma isn't caused by infection, it's not pneumonia.

Q: So asthma is not related to TB and pneumonia?

A: No it is a completely different thing. It's allergic mediated. Again it's a clinical picture as well where you get recurrent tight chest and breathing fast but not associated with fever, not caused by an infection. It has a variety of different causes and some children have a tendency toward it, they've got family members, and it tends to be more an inflammatory process, inflammation in the lungs causing the airways to be tight, causing wheezing, causing breathing to be fast and causing coughing at night.

Q: Do you have an instance where a parent would say my child unesifuba and when you examine the child you find out the child has asthma?

A: Yes

Q: Do you find that the word isifuba used to refer to asthma?

A: Yes.

Q: Do you use it like that yourself?

A: I don't use it like that; I prefer using the English word asthma.

Q: You are saying the patients use the word isifuba referring to different things and it is up to you as the doctor to find out exactly what is meant?

A: Yes

Q: How do you find out?

A: The normal way we come to a diagnosis. Like the history; does it happen often; is it a very sudden onset, is something with a fever and the baby looking very sick.... You'll think more of pneumonia; or a long history sweating at night, any loss of weight.... You might think of TB; or the chest becoming tight or associated with exercise, the child is not unwell at the time, its just the chest is wheezing. So you get a history and you examine to see how it looks like. The child with asthma has a big barrel chest, they'll be hyper-inflated they'll be wheezing, they might have other signs of allergic problems, eczema or allergic rhinitis, so you are looking for clues. TB, you are looking at weight loss and then your X-ray for clues. By the end of that you should have a good idea. But you do need a good history from the parents about is it a recurrent problem, is there coughing at night to get to your diagnosis.

Q: Doctor, have you heard of ingqele? Have the patients used the word?

A: No, not that I remember.

Q: When you say that you check whether the chest is wheezing what do you mean by that?

A: The noise that we hear. You know sometimes you can even hear it without using the stethoscope. You know when they breathe out it's a type of musical sound and when you listen.... It's something that we get taught how to identify when we listen

with the stethoscope, but I don't know a Xhosa word for wheezing.

Q: Have you ever heard of the word ukutswina?

A: No.

Q: Have you ever heard of the word ukuminxana?

A: No.

Q: What do you mean by a tight chest you are not using a Xhosa word?

A: No, it's sort of what you associate with asthma and struggling to breathe really associated sometimes with a wheeze, drawing in of the chest.

Q: Is the tight chest the same as the shortness of breath or the tight chest causes the shortness of breath?

A: It's not really the same. I mean the shortness of breath can be caused by cardiac problems or pneumonia or asthma or anything. I mean really tight is more specifically wheezing, struggling to get the air out, and struggling to breathe.

Q: Have you heard of the word iphika?

A: It sounds vaguely familiar but I don't know. It's like getting tight or something.

Q: Do you associate it with chest problems or other problems?

A: I've just vaguely heard it.

Q: Is there difference between iflu, ifeva and cold?

- A: Yes, I would use ifeva as proper fever: as having a proper temperature. I use ushushu or unefiva and I use both of these to mean a temperature. If I ask about flu I'll ask if uneflu?
- Q: What's flu?
- A: Like a running nose, a bit of cold and a bit of cough.
- Q: And "cold"?
- A: Also more of like flu – like a bit of a cold
- Q: Do you ever use the word imifinya?
- A: No.
- Q: Umkhuhlane?
- Q: No. Do you know the word intliziyo?
- A: Yes, the heart.
- Q: Is intliziyo also an isifuba?
- A: No, two different things. Isifuba is more lungs. Even though it is "chest" itself. Isifuba – the lungs.
- Q: So one is not saying "I've got Isifuba" when one is having Intliziyo?
- A: No
- Q: Do you think there are other related words to the chest problems that we have left out, that you know of?
- A: Xhosa words?
- Q: Both Xhosa or English words or we have covered everything?
- A: Sometimes I ask if they get tired, ndidiniwe. You know sometimes the children run around a lot and get tired easily.
- Q: What would that relate to?

A: It means they could have a heart problem because children with heart problems get tired or it could mean they have asthma, because exercise brings it on and they cannot participate in any sports. So its just one of the things you get to try work out what's wrong with the child.

Appendix D

Interpreter B

Sisi, I have already briefed you as to who my name is, Jackie Nxasana. I am conducting a study to find out how you, patients and doctors communicate during consultation. I am more interested in the words you use to refer to illness, both in Xhosa and English. This is not a test on your interpreting but would like to know more about the nature of communication that takes place during consultation.

Q: What is your name?

A: B

Q: Where do you live?

A: I live in Cape Town.

Q: Were you born in Cape Town?

A: Yes, I was born here.

Q: How old are you?

A: I am 36

Q: What languages do you speak?

A: I speak Xhosa, English and Afrikaans.

Q: How would you rate your English proficiency on a scale of one to ten?

A: I would give myself eight. Eight for both English and Afrikaans.

Q: Do you have a medical background?

A: Yes, I am a professional nurse. I trained in Groote Schuur hospital. I am not a professional interpreter in that I did not train as one.

Q: Have you interpreting for long?

A: Yes, I like interpreting and I believe I am good at what I do.

Q: Why do you think so?

A: Look, my medical background helps me during interpreting in that I am able to understand what the patient is trying to say and therefore, helps me when conversing with doctors about the patient's illness. My Xhosa also helps me communicate better with Xhosa-speaking patients. This is more so when using descriptive words that patients are familiar with.

Q: Do you use medical terms during interpreting?

A: Yes, I do. But, I only use them to the doctors when I tell them what the patient has said.

Q: How do you choose your medical terminology?

A: My medical background helps. I am able to know which words need to be used. But, I do not use English words with patients. Only with the doctors about what the patient said.

Q: Do you find that, sometimes you have to probe the patient further to a point where you ask a patient questions, which were not necessarily asked by the doctor?

A: Yes, I do that. The problem is that English is usually short and straight to the point. Interpreting as it is, may be seen as being rude. Sometimes patients cannot answer such questions.

Therefore, I do have to probe further by changing the style of questioning.

Q: Do you paraphrase the patient's explanation?

A: Yes, I do. Because sometimes patients say irrelevant and unnecessarily things.

Q: What do you mean irrelevant and unnecessary?

A: You see when they tell you a long story about where they were when they fell sick and what the thought about the illness.

Q: Do you think paraphrasing is good?

A: Yes, I think so.

Q: Why it is so?

A: Because I am merely helping out with interpreting. So it saves me time. When I interpret in a different ward from mine, my duties as a nurse get neglected. Then I find myself having to work under a lot of pressure because I have to finish on time. My supervisors do not like it much when I seem to neglect my duties and helps out with interpreting.

Q: Do you feel that your job as an interpreter is being recognised?

A: No, it is not. Even doctors I am helping out do not recognise it as much as they should. The same goes for my superiors.

Q: What do you mean you not recognised?

A: Look, I am not rewarded for my services. So I think what I do is not important to the hospital. Even though, I sometimes get torn apart this is both physically and mentally tiring. I would be okay if i was paid.

- Q: Do you think that interpreting adds value during consultation?
- A: Definitely.
- Q: Do you think that certain information gets lost during interpreting?
- A: No, it does not. Only if you are not sure of what you are doing. Interpreters like me who are nurses and speak good Xhosa are good at the job.
- Q: Now I will ask you about the words that you use to refer to chest problems. How do you tell the doctor the patient complains of *isifuba*?
- A: I tell the doctor the patient has chest pains. I usually probe further to tell which *isifuba* it is.
- Q: Do you probe further on doctor's instructions?
- A: Sometimes, but also voluntary. After I have the information I want, then I am able to relay that to the doctor. But, I have to probe a lot. Then I tell the doctor the patient has pneumonia.
- Q: Do you think *isifuba* and pneumonia is related or one and the same thing?
- A: Yes, it is. I think *isifuba* is an umbrella word for many things. It can mean pneumonia, asthma, TB and other chest complications. As a nurse interpreter, it gets easy for me because I ask more relevant questions to determine which *isifuba* it is.
- Q: What kind of words do you use to patients after being diagnosed with pneumonia, TB, Bronchitis?

A: I refer to TB as *isifo sephepha* or *ukhohlokhohlo*, pneumonia as *inyumoniya* or *ingqele* and bronchitis and other chest infections as *intsholongwana eyenza isifuba sibe mdaka* (a virus that causes the chest to be dirty)

Thank you, Sisi for your time. I now have the information I need.

Appendix E

Participant C

Interview Date: 14/11/02

Date modified: 12/12/02

Mama, as I have earlier on explained briefly to you in the ward as to who I am, what we are doing and what we'd like you to do for us. My name is Jackie Nxasana and we are conducting a research.

As earlier explained, we are doing a research to find out as to how you and your doctor communicate when you are in the ward. To do this we will ask you a few questions. What we want to know is what you think about the nature of your conversation, we don't really want you to tell us what you think we want to hear but for you to tell us what you think and maybe that which you'd like to be changed and whether you are satisfied or not satisfied

Q: What is your name?

A: I am I in English, N in Xhosa.

Q: Which one would you like me to use?

A: I use the English one.

Q: Is that how they call you at home?

A: No, in the township they like using N, and I do not like the English one myself, since I am this old.

Q: Really, How old are you?

- A: I think I am 45 since I was born in 69 (1969) I live in those subsidised homes.
- Q: Where is that?
- A: Here at Kwa-Langa.
- Q: Were you born in Langa?
- A: Yes, I was born here in Cape Town.
- Q: Which other languages do you speak other than Xhosa?
- A: It is English but just a little. I speak Xhosa fluently.
- Q: When last were you in school, have you been to school before?
- A: Yes, I have been.
- Q: When was that?
- A: In 1976.
- Q: Oh! During the year of political riots.
- A: Yes, my child was born in 1976.
- Q: What was the highest standard passed?
- A: In Moshesh
- Q: I mean, what was the last 'standard' you were in, the class?
- A: In standard 5 the old one.
- Q: Oh! The old one, you had gone very far!
- A: The problem is that I got sick, ndithwasa and left school. I felt pregnant in 1975.
- Q: Oh! Okay.

- Q: How many times has the child been to the hospital regarding this current problem?
- A: This child, it is the first time.
- Q: Have you been to another hospital before?
- A: Yes, in Langa for immunisation injection.
- Q: The one for children? No mama, I am referring to the sickness that the child is admitted for now.
- A: Yes it is the first time.
- Q: Hasn't she been to another hospital other than Red Cross regarding this problem?
- A: No, it is the first time.
- Q: How much time did the doctors or nurses spend with you downstairs explaining about the child's problem?
- A: Long.
- Q: Which means they have thoroughly explained?
- A: I mean they were just popping in, checking on me since we are constantly checked in the wards.
- Q: I am referring to the length of time the doctor takes when explaining about the child's condition and what to be done next.
- A: Ah...ah.
- Q: What is ah...ah?
- A: It is not very long.

Q: Now I want to talk about the nature of the conversation you have with your doctor. When you are with the doctor, are you satisfied with the conversation between the two of you?

A: Yes, because I want to be treated.

Q: Does that mean you are satisfied with the way you and your doctor converse since I am only referring to the nature of your conversation?

A: And contacting each other.

Q: Yes, are you satisfied with that way you and your doctor talk?

A: Yes.

Q: Don't you encounter any problems when with the doctor?

A: You mean me?

Q: Yes.

A: Or are you referring to my health (life)?

Q: No mama, I mean the way you and your doctor talk in the ward, maybe when explaining or asking questions or any other things that you talk about when you are in the ward or a room. Are you satisfied with how things are conducted, the way you talk to each other?

A: Yes I am satisfied since I know that doctors are the ones helping us.

Q: During the time, the doctors were helping you, or if we talk about you specifically, did they assist you in the manner that you were expecting?

A: Yes.

- Q: Now I want to understand more about what you know, about your child's chest problem.
- A: I think it has been two months now, because her father smokes, there are other people that smoke and drink, I drink too but I only drink traditional beer (Umqobothi) I don't smoke. Even back there in the house we share the bedroom with a person that smokes dagga.
- Q: Really!
- Q: So according to you what do you think is wrong with the child?
- A: This *Isifuba*, they say sometimes say she has TB and sometimes say she does not have TB.
- Q: Did they say from this hospital that she has TB?
- A: Yes they said so, they sent her for X-ray.
- Q: Really, what are they going to do now, are they going to give you treatment?
- A: The treatment as you can see is the one for December that they have rounded here with that TB thing you see. I will go for the check up day after tomorrow. On the 13, I will come back here.
- Q: Mama, another thing I am trying to understand, is how many words do you use to describe your child's chest problem, and how do you use them. There is no wrong or right answer for these questions but I want you to tell me what you think these words mean or what you understand them to mean.

A: *Isifuba is Asthma, TB and all those things.* Isifuba is what the child is born with, if maybe a parent was eating rich food during pregnancy.

Q: Is that isifuba?

A: I can say so since whenever I am pregnant I like food that is; I usually like meat and food with fat.

Q: Does it mean that when you are pregnant and eating food with too much fat the child gets isifuba?

A: Yes, I can say so.

Q: Why do you say so?

A: Because when you are pregnant and walk in the *cold* or where there's too much wind or even the night's *coldness*, the *ingqele* can get to the child's lungs (*amaphaphu*).

Q: When that *ngqele* gets to the lungs what happens to the child?

A: I don't know, she gets "cold"?

Q: Lets us begin by discussing isifuba. You have mentioned here *isifuba, iTB, ingqele* and cold. Let us take one word at a time we I discuss others later. According to you, which one of these words would you use to describe your child's problem? Is it one of these words or all of them?

A: I would not know, the doctor will know on the day of the results. Because since I stay with people who drink and smoke I can say it is TB but I do not see TB, I do not see any swollenness in the arm. For TB they mark the arm using a pen, they injected her on it yesterday.

Q: So you don't think it is TB?

A: I will hear on that day whether it is TB or not.

Q: According to you, since the child has been sick before and have seen the symptoms, what do you think is the problem? Mama, I am just asking so that we can compare your explanation and that which will be given to you by the doctor on the day of the results. Therefore, to a person with isifuba not necessarily your child, maybe people you have seen before maybe your relatives, what do you think happens to that person?

A: He gets hot. With Isifuba, one gets *impompo yesifuba* (pump) with TB one *looses weight* and the one with ingqele gets a *painful body*. They get hot.

Q: Does the one with isifuba and the one with ingqele both gets "hot"?

A: Isifuba sometimes is caused by *dust*.

Q: When you are talking about dust, what are you referring to?

A: I mean when you are sweeping the house and have not opened the windows to avoid inhaling causing the nose to dry, it is like cigarette smoke, you have to open windows.

Q: This smoke mama, does it stay in your throat, it flows downwards, or what really happens when it has entered the body?

A: It damages the *lungs (imiphunga)*. It is just like someone who drinks brandy and hear that he has one lung that is not functioning because of brandy. There is nothing that is a disease.

Q: Really!

Q: Are you saying everyone who has inhaled dust get damaged in the lungs?

A: No, it depends on how weak a person is. Or it depends on how bad that dust was? Yes, because I also get exposed to places with dust but never discovered that I have TB, isifuba or any other things. I do stay with people that smoke but I never had any TB or anything.

Q: What happens to the child with isifuba?

A: She dies.

Q: Really!

A: Yes she dies.

Q: Are you saying once the child has it, it cannot be cured or that she dies quickly?

A: Isifuba causes "*ukuminxana*" and the openings do not get healed, and the child cannot be compared to an adult. I can say she does not get 'oxygen'.

Q: She does not get oxygen because 'kuminxene'? It is bad when it is like that what do you think?

A: Yes, they say she does not get 'carbon dioxide' I am not really sure in English.

Q: I don't know but I think it is oxygen although I am not very sure I think oxygen is the one needed for breathing with ease. Are you saying the oxygen does not penetrate properly?

A: Esifubeni, since everything is closed.

Q: Oh, because everything is closed *kuminxene* caused by dust?

A: Yes it is the dust maybe people are smoking.

Q: Is it the reason for preventing people from smoking in the house but outside?

A: Yes.

Q: That means it is for preventing a person from smoking...

A: People should smoke outside not in the house since we have children in the house. Some people don't like cigarette naturally, since it turns to smoke when inhaled, I don't like it either, because my father smokes a lot and he *khohlela* too much but I do use snuff, even now it nearly choked me and I hurriedly spat it out and some went down my throat. I realised that it does not like me.

Q: When it went down your throat, weren't you scared that it could harm you where you referred to me as *isifuba*?

A: I was very scared.

Q: Why were you scared?

A: I spat it out I am a person who has nerves sometimes and be worried, the thing is the house I stay in has too much noise/arguing. I feel like taking off.

Q: Let us finish with *isifuba*. When a person has *isifuba* what parts of the body get affected? What happens?

A: When you have isifuba the upper parts of the body gets affected, together with the arms; you get weak even walking with difficulty and very slowly, at the time you are really suffering. You will not even be able to fight with another person, you cannot even jump.

Q: What causes that?

A: Because you are having your isifuba at that time '*siminxene*'.

Q: What are the problems caused by this disease on a person? Is esma isifuba?

A: I don't know, I don't really know the difference I don't want to lie about it. lesma is the one that you use the pump for, you don't exhale but you swallow the air, it is that oxygen, you will see a person with esma calming down, but when attacked he speaks using his hands because uminxene as if drowning in the water.

Q: What do you mean when you a person with esma calms down after using a pump?

A: Because he gets weak from what he suffers from. And isifuba siyatswinya.

Q: What is ukutswina?

A: It makes very low sounds.

Q: Is it the air maybe that comes out slowly?

A: There is no noise.

Q: When it attacks a person at that time, how long does it last?

- A: I have only seen isifuba on other people I have never had it. The air he breathes becomes very little, he can die anytime, windows have to be opened or he is taken outside.
- Q: When a person is attacked how long does it lasts, is it 5minutes, an hour or the whole day?
- A: It is only for 5minutes not the whole day just minutes not an hour, he has to get new air.
- Q: What happens when he gets his new air?
- A: He gets better.
- Q: What happens when he does not get his new air?
- A: He has to have a pump.
- Q: What happens when it attacks a person without a pipe?
- A: An ambulance has to be called and be rushed to the hospital for help.
- Q: What do you think causes isifuba to a person who was not born with it since you mentioned earlier that a person gets born with it if the mother ate wrong food?
- A: I said when you are pregnant and eat wrong fatty food it all goes to the child, liquor also, brandy, beers also affect the baby.
- Q: What about the one not born with it? For instance, if I were to have isifuba as old as I am when I never had isifuba as a child did?

A: Some things are curses. Do you understand that my sibling had isifuba and was treated by doctor Steyn successfully? I cannot really say my father has isifuba because uyakhohlela not snores. When he snores his isifuba makes noises, he was told long time ago to stop smoking but he has not. Even when given a pump by the doctor he gives them away and argues that he does not have isifuba but has his *generic (family) isifuba*.

Q: Is there a generic isifuba?

A: I do not know, that is what he is telling us. This is the first time I have heard something like that.

Q: Okay, do you mean when a person changes environment or new area he gets sick?

A: A person will decide to change Cape Town for Eastern Cape and feel better there; it may be problematic here because we are next to the sea, when perhaps it affects him.

Q: When a person has isifuba is it the same isifuba that other people may be having or is it different according to different people?

A: You mean his name?

Q: Not his name but I mean when you have isifuba and me having isifuba are we having the same thing or different things?

A: They are different, others can be treated others cannot.

Q: In what way can the one be treated?

A: Isifuba? With that pump at that minute but will tswina forever and when it attacks him he can't even talk and gets hot, he will tswina like a cat. Other people do not survive. I have noticed here in the hospital that a person with isifuba gets oxygen and gets better after that and be given pills. A person with isifuba must start with that...to open.

Q: By "that..." are you referring to the oxygen that gets administered to a person? Do you think it can cure a person?

A: It does not cure but relieves only.

Q: Is isifuba not curable?

A: It is not curable. A person with isifuba has it for life. Isifuba does not want a person not to dress up warmly. This you have to do in winter and not minxa yourself in summer. Since summer and winter are different, you have to dress warmly and not be in places with smoke that brews imiqombothi and all that, you must not drink brandy when you have isifuba and must not smoke. Drink umqombothi.

Q: I want us to look at the words that you have used during this conversation to find out what exactly do they mean whether they are all the same referring to one thing or whether they are different and referring to different things. You have mentioned TB.

A: TB takes time and is caused by not dressing warmly, ingqele causes dirty air (umoya) inside and the doctor will say you have TB, TB can be cured.

Q: When a person has TB where is it in the body?

A: People will often say so and so has lost weight or that is caused by *amagama amathathu* (three words)

Q: What are these three words?

A: It is AIDS. When a person has been examined by the doctor he can be cured, TB can be cured.

Q: When a person has TB, which parts in the body get affected? A: TB affects the whole body; they sometimes say one has *ichaphaza* (stain) in the lung.

Q: What happens to the lung when a person has this *chaphaza*? A: One becomes very bad (sick); the lung sizes will not be the same.

Q: They are not the same size. What happens to a person thereafter?

A: He gets very sick until he dies. But that only happens when you are not treating it.

Q: Other than losing weight, as you have earlier on mentioned that a person with *isifuba uya minxana*, what happens to the one with TB?

A: *Uyakhohlela*, the sound of his *khohlela* is not the same as the one with *isifuba*. His *isifuba* makes noises, and the doctor will request for sputum others vomit blood. *Ingqele* and alcohol cause TB. TB is also caused by sleeping in an open area (outside the house) and not taking good care of oneself.

Q: By not taking good care of oneself are you referring to drinking too much?

A: Yes, when a person drinks too much especially *Viceroy* is very bad.

Q: When a person vomits blood is that TB?

A: It is definitely TB nothing else.

Q: When a person talks about ingqele, what is he specifically referring to?

A: It also causes iphika. It is not dressing up warmly.

Q: So what does it mean?

A: Ingqele, not dressing up warmly.

Q: Does it mean when I am not dressed up warmly now I will get ingqele?

A: No it does not affect you immediately right this minute, it takes time as you are growing up. People will wonder as to why he has lost weight when he is not even drinking (liquor) and find that he never took good care of himself.

Q: What I have noticed is that you are using the word ingqele and TB at the same time?

A: Yes I am, I do not know about other people.

Q: I am referring to you mama not other people, I have noticed that you are using them at the same time. Is ingqele and TB the same?

A: TB is caused by ingqele, which is not dressing up warmly.

Q: Oh! A person first gets ingqele then TB?

A: Yes TB is caused by ingqele you even get hot and loose weight.

Q: What causes iphika? I heard you say a person with isifuba cannot even talk because of iphika.

A: I can say iphika is caused by *ihlaba* (sharp pains).

Q: Where is this *ihlaba*?

A: It can be anywhere in the body and people will say *umama unephika*. It is when she is attacked by that *ihlaba*. You cannot talk when you have *ihlaba* you get pains.

Q: What is *ukuminxana*?

A: It is caused by *isifuba*.

Q: Are there any other words that are similar to these ones, I mean is there another word that means *isifuba*?

A: It is *esma*.

Q: Is it *esma*?

A: A person with *esma* uses a pump.

Q: Is *esma* and *isifuba* the same?

A: Yes, It is *esma* in English *isifuba* in Xhosa.

Q: Are there words from the ones we have used here that mean something totally different, in a different context, from the way we have used them in this context?

A: I do not think so.

Q: When you hear of these words being used, do you only think of these sicknesses we are talking about?

A: Yes.

Appendix E

An interview with Doctor B

Interview Date: 04/12/ 2002

Modified : 16/2/3

I would like to introduce myself I am Jackie Nxasana we are doing research in Red Cross Hospital. We are trying to find out how you and your parents the information to the parents. The purpose of the study itself is to actually find out what you think about the nature of the conversation between you and your patients and your general thinking and feeling about the whole communication. We are not trying to find out how medical knowledge you have but to find out how you convey messages and diagnosis to your Xhosa parents. We shall also look at the words that you and your patients use, to find out if they mean the same thing or they differ.

Q: Firstly may I ask your name?

A: B.

Q: Doctor, how old are you?

A: 52.

Q: Where do you live doctor?

A: In Cape Town.

Q: Were you born in Cape Town.

A: No.

Q: You were born outside of Cape Town. How long have you been in Cape Town for?

A: For about forty-six years.

Q: Quite a long time.

A: Apart from English what other languages do you speak?

A: I speak Afrikaans, a little bit of German and I have a few Xhosa words.

- Q: A few Xhosa words? You wouldn't regard yourself as someone proficient in Xhosa?
- A: No, I am not. I tried three times to learn to speak Xhosa, and I found it very difficult. I tried the tapes and I went to a course at the university, but for some reason, Xhosa is a difficult language for me to learn.
- Q: How long have you been a doctor for?
- A: I qualified in 1974.
- Q: How long have you been dealing with Xhosa speaking patients?
- A: In medical school which, was about in 1972.
- Q: I mean Xhosa patients.
- A: It was about 30 years of age, since I was a student.
- Q: During that period, was there any course offered in Xhosa or any other African languages?
- A: Yes there were voluntary courses, I tried them and I was too stupid, I just could not make it.
- Q: But was there a Xhosa course available at the time?
- A: There were courses available voluntary courses not compulsory and one had to pay for. I think for me the only white people who speak good Xhosa are people who grew up in the Eastern Cape.
- Q: But at least you can pronounce it, you can pronounce it well.
- A: I do not know.
- Q: At least you are not saying Kosa.
- A: I should be saying Xhosa, like when I call out patients' names in the waiting room the mothers often don't know what I'm saying. We put different emphasis on different syllables ****.
- Q: If we can talk about the nature of the conversation that you have with your Xhosa patients, for the purpose of this study we will refer to the children's parents as your patients. When you make diagnosis to Xhosa speaking patients, how do you relay that information to them?

A: It depends on how well the parents can speak in English or sometimes Afrikaans. If it looks like we are not going to make it in either of those two languages, I would usually get someone to help me with interpreting.

Q: Do you use professional interpreters?

A: No they are not professionals but they are people who are proficient in Xhosa.

Q: You mean you need those kinds of services if the parent can't speak English very well?

A: Yes. English or Afrikaans. I suppose you gauge how the conversation is going and if there is any sign that there could be a misunderstanding or confusion then I'm going to ask an interpreter to come in, and when I say an interpreter I don't mean a professional interpreter, I mean a health care worker who's part of the team. And they talk to the patient, and sometimes you can see from their response if they understand English anyway but one tends to have one's assistant or interpreter go over it, and then you look at the mother to see what her understanding is and then you follow on her questions, that helps you as well. The other thing is it doesn't happen in one sitting, most often the patients that I look after, it's a conversation that happens on numerous occasions, you'll go back to that particular discussion, the diagnosis, what this diagnosis means and so on.

Q: How often do you speak Xhosa to your Xhosa parents?

A: Ha-a, I don't know what you mean, do you mean with patients at the clinic or what proportion or what?

Q: No I mean the parents of the children how often do you use Xhosa or don't you use Xhosa at all?

A: I might use some words, and those are the ones I use to describe a symptom or maybe a body part.

Q: Which words?

A: Words like fever, pain, cough.

Q: You would use those words in Xhosa?

A: Yeah, sometimes I have not thought about how much, but sometimes. Most often, I use those words when asking about the history. I can only use a couple of individual words when I am taking a history rather than when I am giving a diagnosis. In the case of taking a history the information is kind of gleaned and I can interpret the information along with what I see in the child, but if I'm giving information out it's a completely different thing, I can't be sure, given that I'm talking about things to do with the sickness or maybe medical terms or so on, I can't be sure what the mother takes in, and I'm aware of when you work through an interpreter one isn't actually sure that what you're telling the interpreter is what the interpreter is telling the mother.

Q: So you are saying that relying on interpreters a lot maybe problematic itself in terms of getting the right information across and getting the right response?

A: Definitely it can be a problem, and hopefully part of the problem is resolved because the mother not just once but on several occasions. I can tell, from the work that we do, if the mother is happy with interpretation. I can pick up if it is not working well.

Q: What do you think causes that misinterpretation from the interpreter, seeing that the person whom you are using for interpreting is the health care worker who may be familiar with the medical terms?

A: I think that it has to do probably with the precision of the words that one uses.

Q: You mean the English words or the Xhosa words?

A: I mean the translation from the English to the Xhosa. I think even if I would learn to speak Xhosa, my Xhosa would not be as rich as the person to whom I am talking. And, when I am using words I would only have a choice between very few words and so I could easily choose the wrong words. I think second language speakers, speaking to first language speaker will always have that sort of problem and so I don't see it as necessarily a problem in sitting

with an interpreter. I see it as a problem that I am not in fact a Xhosa, so that is the problem. I've got a registrar at the moment who is a Xhosa, now I'm sure that when he speaks to another Xhosa the message gets through because he can pick up from the questions she asks whether the interpretation is correct or not. I mean that is what I do when I speak English to someone who speaks English. I say something and then I listen to what they say back then it's quite clear to me from what they say back if they understood what I've meant them to understand or not. I do not think communication is an easy thing at all. If you have got two first language speakers its already difficult, If any one of you is a second language speaker then you really have problems.

Q: So, basically one of the problems that you've experienced is that you relay the information to the interpreters and he being the first language speaker of Xhosa can actually talk to the parent, but then the response from the interpreter that you get from the parent may not be accurate?

A: Yes, exactly. I think that this discussion we are having now is an iterative discussion. I am saying something and you coming back with what you understand from what I am saying, and then I can correct that. You and I can only do it because we share the same language and actually the same lexicon. The same set of words that we can choose from, and that makes it easier to understand each other. But, when I am talking to an interpreter there are just too many differences and it becomes problematic. I mean, I will give you an example, I have been an examiner at MEDUNSA and in MEDUNSA they are many lecturers who are not South African, and their English is their second language. They are Africans who do not have English as the first language and they speak it very, very wrong. And, we are doing this examination here is a Sotho or a Xhosa or a Zulu it could be anyone and they are conducting exams in English. So, he asks the question using the words that he knows, and the student answers him using the words that he knows.

And from what I can hear its synonymous, the words are correct but the examiners say to the student that he's not getting it correct because he is not using the word that he as the second language speaker can recognise. And, here I am as the first language speaker I can see from the outside what is going on. So if that's what's happening between doctors or someone is going to be a doctor imagine what can go wrong between doctors and patients. So none of this is easy.

Q: Doctor, are you saying that the problem with the words that are used between doctors, patients and interpreters may in the long run cause problems for diagnosis?

A: I think there is no problem with diagnosis but probably with understanding what the diagnosis is all about, and then later on understanding of what to do about it. I will give you an example, if you ask a Xhosa mother "how many bottles do you give your baby a day?" She will tell you how many she gives during the daytime, and unless you say "and at night...?" . And that has got to do with presumably Xhosa grammar or whatever, whereas if you ask an English speaking woman "how many bottles do you give your baby a day?" she will tell you how many including the night time. So, there are subtleties. There must also be things that are not so subtle too. Very difficult. And I am not sure what we can do about that, beyond me having grown up in the Eastern Cape, and speaking Xhosa from when I was little.

Q: I think you can easily go to the Eastern Cape to speak more Xhosa as you have earlier suggested (both laughing). At the moment, what do you think could be the possible solution to this problem?

A: I think that the first thing is that people be aware that there is a problem.

Q: Which people?

A: Doctors. I think doctors have to be aware, I have to see it from my point of view. This is the product that I am trying to deliver is trying

to be a doctor. Doctors have to be aware of the pitfalls and of the difficulties in communication in general, and one has to spend more time.

Q: To do what...(END OF SIDE 1 TAPE 1)

(TAPE 1 SIDE 2)

A: You have to spend more time because, you have to make it part of a process. I am talking about communicating a diagnosis now, so you communicate that diagnosis now you say what you want to say to the mother and....

Q: Let's just say maybe you're telling me my child has pneumonia then you must relay that to a Xhosa speaking person who does not understand English at all?

A: Yes so I'll explain a little bit about fever, ushushu, and how something is happening here in the lung and try and keep it as simple as simple as possible, not because I think the person is stupid but because I think these things are complicated. So, through an interpreter try to send that message through and then to prolong the process, maybe ask the mother some questions. You put across the information you want to through the interpreter and then you need to ask some questions, through the interpreter, to establish whether the important elements of what you were trying to put across were understood. So for example, if the child has got pneumonia, the most important thing the mother has to understand is that this can effect the amount of oxygen in the babies blood, and so she has to understand that the child will

have oxygen going into the mouth; or if perhaps the child is very sick, she must understand that the child's head is inside the headbox. She has to understand that because she must resist taking things off, or she must put it back if the child takes it off, or must not take the child out of the headbox or something like that. There are certain critical parts that she has to understand about the pneumonia, so that is what one would have to do. And unfortunately, our time is a very expensive thing.

Q: So, this critical factor that the mother has to understand about the child's illness say to a mother who doesn't speak English at all, so you are saying that in many cases doctors only rely on interpreters for this message to get through?

A: I think that what a doctor would do is give this information to the interpreter and see that the interpreter is speaking to the mother and might not go the extra step of checking to see whether the important parts of the information has actually gone through.

Q: What effect could this have on a child, if maybe the information that has been received by the doctor through the interpreter was incorrect? What effect would that have on a child?

Q: Well it depends on the extent of what is wrong with the child, with what were dealing with. It could be very serious. For example, very often in the clinic I'll say to the mother "look, I think the child has got pneumonia. I think the child is at present not so sick, I think we can treat the child with an antibiotic we can give the child by mouth, and you can go home. But, if you see signs that the

child is becoming drowsy or does not want to eat, or is not getting better then you must definitely come back. That bit of information.

We cannot admit all the children to the ward and in fact, it would be bad to admit a child who does not need to be in the ward. So one very often sends children like that home, so I am giving the information so that the mother must really understand. But, it is not just that, it's also that mothers should feel strong enough about themselves as mothers and caregivers that if the child does not get better even if it's ten o'clock at night that the doctor said I can come back so I will come back and bad things wont happen.

Q: Is there a case where a child has been, I am not sure, which word is appropriate is it misdiagnosed or wrongly diagnosed?

A: Mh-h m-h (yes whichever).

Q: Is there a case where that happened, because of the wrong information that has been given to you by interpreters?

A: It could be. There is a child, for example in the ward now, but language is not the problem because the family speaks English, and they told us the story this morning. But there is a child in a ward, who received antibiotics for a sore throat until Thursday of last week. And, then on Friday went to the children's hospital and they did a lumbar puncture and the lumbar puncture went off to the laboratory, and it had some things that were wrong with it but not much, and so the doctor thought this was not a serious kind of meningitis, and then they sent the child home. The child came back very sick three or four days later and the child in fact

did have a very serious kind of meningitis. The critical information was that the child had already received antibiotics until shortly before the lumbar puncture. It could happen with a language problem that that critical information could ... and it happens – even though they all spoke English that bit of information did not come through at the Children's hospital. However, it could easily happen, if there was a language problem, that very important piece of information did not come through. Unless the doctor asked the question. I think probably at the end not being able to speak a particular language means that you have to ask more questions and be more careful to get what you want. I mean usually in paediatrics you get the story, we get the history and you have to examine the patient and look and see if the story fit is what you are finding with the patient, and if it does not.

Q: You mean in what you find, is it the symptoms that you are seeing at the time?

A: Not the symptoms, the signs. When you examine you look for physical signs. It is the signs that you check if they fit what the mother tells you about. And if they do not then you probably have to go back and ask the mother some more questions. The doctor has just to be more careful and ask more questions.

Q: So when you are with your Xhosa patients those who cannot speak English at all, are you saying that there is no direct communication between yourself and the patient at all?

- A: We are in the same room and we are looking at one another and there is many communications especially when it comes to communication concern about the patient. That comes across without words. I think that communicating reassurance: that comes across without words, so there is a lot of non-verbal communication happening.
- Q: But, in terms of asking certain questions or when informing the mother about certain things about the nature of the disease at the time you rely mostly on interpreters?
- A: Yes. I tell you that you rely mostly on interpreters and you rely a lot on your own knowledge on what could possible be wrong with the child. I'll give you a deferent explanation, there are two kinds of mothers who come to the doctor, some mothers who know what is wrong with the child and they come to you and say this is what is wrong with my child and I want you to do such and such. They come to you with the request and you comply with the request if you think it is right.
- Q: If you think it is okay?
- A: Yes. You do not need their consent to do that because they are asking you to do a particular service. So, there the balance between the mother and myself is very equal and that is good because she is taking a lot of responsibility off my shoulders. She said she knows what's wrong, she knows what she wants, if I agree with her, we are partners in the management. It is much more difficult when somebody, and it often happens with Xhosa

speakers who might not know so much about the child sickness. They will come to the hospital and will ask me to look at her child and tell her what's wrong with her child and tell her what treatment I want to give her child. There it's much more important that she be fully informed because in that particular situation she has to give me consent in that situation because she is not asking me to do something, I'm asking her whether I can do something to her child whether it's an operation or giving her medicine or whatever. There you are dealing with the situation which although one would like it to be equal in terms of power but it is definitely not. Because it is not equal, you have to put more work into that sort of interaction.

Q: Put more work in terms of what?

A: In terms of explanation, in terms of taking the responsibility on oneself of knowing what's wrong with the child and we can with my child, this is what I want you to do.

Q: How could you help her understand if you have a language problem, if the two of you have a language problem, when both of you understand and communicate through a third person?

A: I help her understand because I see her so often, we do the same thing a lot, the situation I'm thinking of now in the clinic, all we do we smile at each other and all the information comes through interpreters but it happens a lot. Every time there is an extra bit of information and better understanding, and her interpretation of what I am saying is better. There are other people in the clinic,

who are Xhosa speaking, so there's a lot of other stuff that is going on. So, when you looking after somebody with a chronic illness, the clinic is much more organic it is not just one visit and then never again. And in paediatrics, there is a lot to do with chronic diseases, paediatricians in fact look after chronic diseases by and large. General practitioners look after people who have acute sickness.

Q: Okay. Basically you are saying some of the communication problems that the doctors experience when speaking with Xhosa speaking patients could be solved by introducing or exposing doctors as early as possible to the Xhosa language?

A: Well if you can do it at the age of three or four years before they've even thought about doing medicine yes I think that would help. I have heard many medical students, even though I have not discussed this with them, complain about how difficult they found it and I have not seen many medical students actually using Xhosa much.

Q: Do you think it is because....

A: I don't know, I don't know, probably the same experience that I had but I'm not sure if they are still giving Xhosa now.

Q: Where?

A: At medical school.

Q: I am not sure if they have Xhosa courses.

A: They used to. There was a compulsory Xhosa course, I do not know.

Q: Do they still find it difficult regardless of which level of their study?

A: That's my impression, but as I say I was not doing that sort of work so that's just a general impression. The solution is to only train Xhosa speaking people to be doctors then we would not have that problem at all.

Q: What about the current doctors, who cannot speak Xhosa, what could be done in that case?

A: Not much except wait for them to die.

Q: I do not think it is a very good solution at all (both laughing). I would like to know what words you use to describe some chest problems to the parents. I would use chest not as a diagnosis but as the physical part of the body, to Xhosa speaking parents? What words do you use whenever there is a problem in that area? And when you use that word what do you actually mean and what is it that you are hoping the parent to understand when you use that word. For instance, *isifuba*, if you were telling me that my child has got *isifuba* what do you mean by that?

A: That means that the child is short of breath and is having difficulty breathing that is my understanding.

Q: Is there an equivalent of that word in English, if you were telling me that my child has *isifuba* what word would you use in English?

A: I would be talking about shortness of breath or a tight chest or something like that. Although my understanding is that there is no word for a tight chest or asthma in Xhosa, but it would be somewhere around that speech.

Q: Someone with isifuba, when you explain to me as a parent, that this is what it does to a child, this is the most important thing that as a mother I should know, what would that be?

A: Then she would definitely be telling me about the child's isifuba and then through an interpreter depending on what I find, I would be telling her the child has got asthma or pneumonia and this is what we will be doing about it. And as I said with pneumonia the most important thing is the child becoming short of oxygen.

Q: Which part of the body gets affected by isifuba in y...(END OF TAPE 1).

(SECOND TAPE)

A: I talk about khohlela shell say yes, and...

Q: When you use the word khohlela are you referring to coughing?

A: Just to coughing, yes, and as a sort of follow up to try and figure out what is happening to the chest. And at that point I am using an interpreter and find out how long the child has been coughing and whether the child's coughing anything up, and one would use non-verbal stuff like...

Q: Do you find it helps the parents when you are demonstrating?

A: Well, I have always thought so.

Q: Do they respond?

A: Yes they do?

Q: When someone is having isifuba, is it treatable for a short time or is it curable?

- A: I do not know, I cannot answer you, I do not know. My assumption is that it is curable, but I do not know what that concept means.
- Q: Now I would like us to compare some of the words we have used in this interview and find out what they actually mean. Your understanding of what they mean in Xhosa and in English. We have talked about isifuba and pneumonia; do you think that isifuba and pneumonia are the same? I mean if I come as a parent if you diagnose my child with pneumonia when you try to meet me half way with my Xhosa and in English would you simplify that by saying my child has isifuba?
- A: No. I would never use that as an exclusive diagnosis, for me isifuba has always been a symptom associated with some chest disease, and it doesn't have to be pneumonia, whether I'm right or wrong, that's always what I've thought. I have never thought of isifuba equals to pneumonia.
- Q: If my child has pneumonia is that the word you would use to me as the parent?
- A: I never used that term before.
- Q: Pneumonia?
- A: Isifuba to explain to anyone, I've only ever interpreted it from the history that they've given me to mean the child is short of breath, and then the diagnosis can be anything that is associated with the shortness of breath, so I've I never used the word to mean pneumonia and I've never used the word except as a question.
- Q: Okay, is your understanding of Asthma the same as isifuba, or is it something different?
- A: My understanding is, and this is from general discussion around the issue, is that there is no word in Xhosa for asthma, but isifuba is used mainly mentioned when a mother describes the symptoms of

a child who later we discover to have asthma. So once again, for me it is a general description of someone who has problems breathing, that is my interpretation of the word isifuba.

Q: Would you use that word when you diagnose somebody with asthma?

A: As I said I do not use that word diagnostically, I would use a description through the interpreter of what the asthma is about inside the chest. I would try to explain to the mom that the chest is tight and this is what the medicine I am trying to give to make it better.

Q: And TB, what would you say to a mother when the child has TB?

A: Okay, we ask about ukukhohlela, then ask through the interpreter if that has been going along for a long time and then I ask once again, through the interpreter if the child has been losing any weight or has had a loss of appetite. I mean the word I use for appetite or eating is sometimes I talk about ukutya what that means I don't know but it sometimes gets the right...

Q: Ukutya is eating.

A: Yes, OK. I would ask that with a questioning inflection, and if she says he does not eat, well then that is interesting information.

Q: Is TB and asthma somehow related or they are two different things?

A: I do not think mothers of children with TB, often talk about isifuba.

Q: But you think mothers whose children have asthma talk about isifuba?

A: Yes, they might well talk about it, they might mention that as their symptom.

Q: So have you heard the word ukutswina has it been said to you before?

A: Never heard of that, maybe they have said it but I have never heard it. What does it mean?

Q: I am not sure. When you diagnose someone and say this child has got a wheezing chest what do you mean by that? Or if this child is wheezing, what do you mean?

A: It is usually a noisy chest, which somebody can hear.

Q: Is that something you can hear with a...

A: No it is something anyone can hear just when a child is breathing, but sometimes it is something that you can hear with a stethoscope as well.

Q: Okay.

A: And usually a wheeze has something to do with asthma that is the most likely, so I do not know.

Q: Have you ever...

A: It could be that the mother who's got a child who is wheezing will tell me isifuba as well, I don't know, all that I know is that when the mother uses the word is that there is some discomfort with breathing.

Q: Have you heard of the word ukuminxana?

A: No, what does that mean?

Q: I do not know that is what I want to find out. When you tell the parent that the child has a tight chest, what are you exactly saying to a parent, by "tight chest"?

A: Again through an interpreter, you are usually talking about asthma.

Q: And that breathing noise?

A: Usually but not always.

- Q: And "shortness of breath" is that also related to asthma, does it...
- A: For me the shortness of breath is tied up with this word isifuba, that's what the shortness of breath has to do with the discomfort of breathing, the sense of having to breathe hard.
- Q: Is the shortness of breath a symptom for asthma?
- A: It can happen in children with asthma it is not something that often happens in tuberculosis, it's more likely to other conditions.
- Q: Pneumonia?
- A: Pneumonia you can have shortness of breath, and heart failure and all sorts of things.
- Q: And then children with asthma do they cough a lot?
- A: Yeah they do especially at night.
- Q: Children with TB can also cough a lot?
- A: They cough but their cough is one that is characterised by being there for a long time, it might be more than two weeks.
- Q: Doctor, if you use the word "ifiva" if you say it like that in Xhosa as in "ifiva", what are you saying to a parent.
- A: I have never used that, I have only ever-used ushushu.
- Q: What do you mean by ushushu?
- A: What I'm asking is if the mother has ever thought the child is hot, if she has ever thought the child has a fever. Now if she tells me yes, the child has ushushu then it can mean all sorts of things, yes it can mean the child does have a high temperature, a high body temperature, or it can mean the child was sweating, or it can mean, what else can it mean... basically those things.
- Q: So in other words your understanding of the word ifiva means high temperature?

- A: No, I have never heard of the word *ifiva* before, that is something new to me. What I have heard is *ushushu*, I have not heard that much.
- Q: So when they talk about *ushushu* to your understanding, they are talking about high temperature?
- A: That's at least one possibility, but once again if they tell me that the child is *ushushu* then I'm more likely to think of that as being important than when I ask them. If they volunteer it means more than if I ask a question because they are likely to say yes just because I have asked the question, because it is a leading question.
- Q: Would you ask a question like *mama is your child shushu?*
- A: Yeah in English I would say *has your child been feverish* and in Xhosa I would say, I mean I don't know how to phrase it but I would say "*ushushu?*" with a questioning inflection.
- Q: By asking that would you be asking if the child were feverish?
- A: Yes.
- Q: Or the child is getting high temperature?
- A: My understanding is either of the two.
- Q: Okay, are there any other words that we haven't used in this interview which you think are very relevant to chest problems?
- A: Not that I know of.
- Q: Are there any other words that you find problematic when you talk to your Xhosa speaking patients?

A: They are very few words that I use in terms of the history, I often ask something about, like *intloko, intliziyo, yambis, yokhapha*.

Q: Doctor is *intliziyo, isifuba*?

A: Not the way I understand it no, *intliziyo* I would use when I'm explaining to the mom and once again I might be working through the interpreter, but I am talking about the heart like if I'm trying to explain that a child with lung disease is also developing a heart problem?

Q: Is it possible that a person with a lung problem could end up with a heart problem?

A: Yes that is what I am talking about, because we see that in the clinic a lot that children who have had lung disease for a long time develops heart disease.

Q: Doctor, have you ever heard of patients using the word *iphika*, a mother comes to you and say I don't know what's wrong with my child but *unephika*? Have you ever-heard patients talk of *iphika*?

A: I am sure I have heard about that before but I do not know what it means. What does it mean?

Q: I am not sure.

A: I am sure you know some of these things!

Q: I do not know. What I need to find out is when they say that what things come to mind.

A: No I do not know.

Q: So when you talk and demonstrate it works.

A: I tell them *yiza*, to come along and I want to weigh them.

- Q: So you are saying even though you are not proficient in Xhosa the few words you know are useful to you?
- A: I am terrible with Xhosa but I tell you the few that I know are very useful to me which is why I get the response I am expecting. I know very little Xhosa like *ufuna ntoni*, I also know that because that's what people used to ask me when I was a kid, what are you doing here? I am hopeless in Xhosa but I use the words I have. My experience is that it is not an easy language to learn.
- Q: Apart from your first solution that the doctors should die, what is your second solution to that?
- A: think the best that medicine can do is to have well informed language scientists who could come in and tell us that this is something that they want us to try.
- Q: What if they say since it is your own problem since you are the ones faced with it on a day to day basis, how do you think these problems could be solved?
- A: My answer would be I've been trying for twenty or thirty years to try and come up with something, not because I don't want to be understood or I don't want to understand people, but there is a very big problem here despite the fact that one wants to learn so that its worth them doing some work on trying to find out what it is and how we can make this better.
- Q: Well let us hope that through this study we will be able to tell
- A: I think it is a very useful thing that is why I signed up and said yes. I think we need more years and we need to find out what are the

most used words for both and what could be the solution, like introducing Xhosa while still studying I'm sure we can make this a bit better.

Q: Maybe you can suggest that to medical school.

A: That's a thing, sitting with suggestions not doing anything about them.

Thank you very much for your time doctor.

Appendix F

Participant B

Interview date: 05/12/02

Modified: 22/1/3

Sisi, I have explained earlier on, as to what are we doing here and that my name is Jackie Nxasana. We are doing a research to find out how do you and your doctor speak to each other. Are you satisfied by how you and your doctor speak to each other? To do this I am going to ask you some questions, there is no right or wrong answer we are interested in knowing what you think about these things. Sisi, you said your name is?

A: A

Q: And what is your surname?

A: B

Q: Where do you live, Sisi?

A: KwaLanga.

Q: Were you born KwaLanga?

A: No. I was born in Idutywa.

Q: In Transkei?

A: Yes.

Q: Okay, how long have you been staying KwaLanga?

A: I arrived there in 1992.

Q: Were you staying in the Eastern Cape, before?

A: Yes.

Q: Apart from, Xhosa, which other languages do you, speak?

- A: None, because even with English, I understand it because I work but I did not understand it before.
- Q: Okay.
- A: Let me say, I only understand workplace English. I do not really know English much.
- Q: Which one is the workplace English, Sisi?
- A: I understand when someone speaks but maybe I have difficulties in responding.
- Q: Sisi, did you go to school before?
- A: Yes I did.
- Q: In which class did you leave school?
- A: In standard seven.
- Q: In standard seven, okay. The child is O, am I right?
- A: Yes.
- Q: How many times has you been coming to the hospital, for the same problem that she has come for today.
- A: I started coming to the hospital, six weeks after she was born.
- Q: Six weeks, coming to Red Cross.
- A: Yes. The doctor referred her because I took her to the doctor and he wrote a letter stating that she must come to Red Cross because she has pneumonia. She was admitted and I slept here for two days and she was transferred to Groote Schuur. So, she has been going to Groote Schuur until they sent her back here to see a special doctor.

- Q: How old is she, now?
- A: She is one year, eight months.
- Q: But, she always comes here to see the doctor.
- A: Yes.
- Q: Sisi, how much time can you say a doctor or a nurse spends with you, explaining the illness of your child, or what will happen after taking the treatment?
- A: It is not much, maybe thirty minutes.
- Q: Thirty minutes?
- A: Yes, trying to explain to me what the problem is or ask me to go back to the X-ray and taking some stuff back to him. He will try to check what's wrong with the child and they will explain to me the problem of the child.
- Q: Let us talk about how you and your doctor communicate about the problem of the child and what will happen to the child. Sisi, are you satisfied by how your doctor speaks to you?
- A: I am satisfied, because they try by all means to make sure that you are satisfied. Yes, there is nothing one can do if she does not understand English it becomes difficult. I understand it but it becomes difficult for me to ask questions, like I would want to know if this is the situation what is going to happen? But, if s/he is telling me that the problem is this and that, I understand and I am satisfied.

- Q: Even if s/he explains in English?
- A: Yes. I understand and am satisfied but it's hard for me to ask questions, like to ask him/her if now doctor...
- Q: So, when you want to ask the doctor to explain to you about the problem, which language do you use?
- A: I try by all means to communicate even if my English is poor and when he answers, he responds to what I asked.
- Q: Sisi, are there any other problems you have when you speak to your doctor?
- A: No. I do not have any problems I do not want to tell lies. You mean when I want to ask?
- Q: Sisi I mean when you and your doctor speak to each other, when you communicate with your doctor, you don't experience problems?
- A: When I want to ask questions?
- Q: Yes.
- A: I do have problems, sometimes when I want to ask or explain something to him and it becomes difficult because I don't have much English vocabulary. If there would be an interpreter because other people can't even understand at least I do understand but when I want to ask what to say about the problem and that becomes a problem because I wouldn't know if what to do.
- Q: Do you think that the doctor has problem in of communicating with you?

- A: To the ones I've been with none of them showed any problem because they do not go to the black nurses to ask for help because they could not understand me. He would write what I tell him and will write down anything I say.
- Q: Okay, Sisi you are talking about people who have problems when they talk to the doctor because they don't understand each other, maybe the parent doesn't understand English well and the doctor doesn't understand Xhosa. According to you, how can such a problem be solved?
- A: I think each and every doctor should have an interpreter who would explain what the person is saying because when you speak the doctor writes and maybe he is not writing what you are saying because he is not going to show you anyway.
- Q: If, he is not writing what you are saying what could he be writing?
- A: I am just saying when they don't have interpreters and do not understand what you are saying, and not being able to have a two way dialogue with you.
- Q: So Sisi, you are saying sometimes it happens that doctors write something which is not what you say or they think that this is what you are saying and in the meantime you are not saying that?
- A: Yes. It will be better if doctors can have interpreters because some Blacks did not go to school.
- Q: Sisi, when there is that problem between the doctor and the parent, where the doctor thinks that this is what the parent says

and when the parent is not saying that, how do you think that can be solved?

A: It could be solved by what I'm saying that doctors must have interpreters on their side to interpret for people who cannot speak English, do you understand? That will satisfy the person who has come to the doctor and the doctor as well.

Q: When you think about this problem, when you think about it, do you think that can put the child at a risk? Do you think that could endanger the way in which the child is treated by, the doctor?

A: It can endanger the child because when the child gets the prescription by a doctor who speaks English talking to someone who does not understand English, she may give the child the incorrect measurement which could be more than what the doctor prescribed because of the misunderstanding. In that way you endanger the child's life and that is why it is important to have somebody who will help with Xhosa because not all of us went to school.

Q: Does your doctor speak any Xhosa, Sisi?

A: No. My doctor doesn't, isiXhosa even at Groote Schuur...

Q: Doesn't he include at least one Xhosa word in your conversation?

A: No. I cannot tell lies the one at Red Cross I do not even think he understands the language, and doctors from Groote Schuur do try, they will come and greet in Xhosa and you will greet them back. You can see that they want to learn isiXhosa and they are interested in learning it, they will ask you if you can understand

them, then the choice in that moment is yours to say he must speak in English or not. I let them speak English because as I said to you I make mistakes trying hard.

Q: Sisi, are you saying that even those who try to speak it by greeting you but when they consult, they speak English?

A: Yes. They speak in English and I would understand that it is not their language anyway so, he does not know what to say in Xhosa.

Q: Okay, now Sisi, I would like us to talk about the chest problem that Okuhle has, and the meaning of the words that you use. I said earlier on that there is no wrong or right way of giving answers I want to know if doctors use them the same way you understand them. According to you, what is wrong with the child?

A: I think the child has *isifuba*.

Q: Okay.

A: In Grootte Schuur they tried to explain to me what causes *isifuba*. They said, HIV causes sometimes *isifuba*, *isifuba* varies in children so I asked them to do an HIV test and the results came back negative. They discovered that she has asthma and that was it, they later said she has pneumonia and then they said asthma again.

Q: Sisi, when you say that the child has *isifuba*, what do you mean by that word?

A: I cannot tell you lies, I do not know. I did not ask them because back home people would have it and we never knew what causes

it. They would say it is caused by *ingqele* and it was clear that he got it from me while I was carrying her (pregnant).

Q: Okay, When someone has *isifuba* what happens exactly especially if it is a child?

A: Her chest gets tight (*uyavaleka*), struggles to breath, the temperature rises, and *isifuba* gets tight like someone *onamahlaba* and they told me that it was *ingqele* which is inside his body but we Xhosa speaking people refer to it as *isifuba* and doctors say it is asthma.

Q: Sisi, are you saying that *isifuba* is the same thing with asthma?

A: Yes in my own opinion. I say my child has *isifuba*, that is how it has been referred since I up.

Q: They say that to someone who has what exactly?

A: They mean that a person's chest get tight (*uyavaleka*) when I came here they were using the word asthma, an English word.

Q: Are you saying it is an English word because the asthma symptoms that you notice are similar to symptoms of *isifuba*?

A: Yes.

Q: So Sisi, you are saying *isifuba* and asthma is the same thing, *isifuba* is Xhosa and asthma is English?

A: Yes, in my own opinion.

Q: When a person suffers from *isifuba* or asthma which, parts of the body get affected?

A: In Okuhle's case, it is *isifuba* (the chest), the chest bones. When you are looking at her the chest bones are not fine, they are not all

right, they are not structured like mine. They are kind of brought together.

Q: What brings them together?

A: It from that breathing, you can look at her as we speak, they are brought together. I ask doctors if they notice that her chest (*isifuba*) is not like mine, when I gave birth to her, she was not like that.

Q: Did they say the bones would be okay later?

A: They said the bones will go back to normal place when she grows old and I was not satisfied because I was wondering if the bones won't get hard as she grows older. (Change tape)

Q: Maybe they will not.

A: And that means she will remain with this oval/sharp chest?

Q: Sisi, when someone has *isifuba* what things could endanger her?

A: Endanger her, in what way?

Q: Maybe things that could cause harm to someone with *isifuba*?

A: I do not understand that question.

Q: I'm asking if the child with the problem of *isifuba*, like you said in your child's case that her chest bones got affected, what other problems could *isifuba* cause to a child?

A: I do not know other problems with my child I noticed *isifuba*, I do not know with other children.

Q: Do you think that *isifuba* or *asthma* is a serious illness or is just an ordinary illness?

A: It is a very serious illness because her chest becomes tight (*siyamvala*), it tightens to such that she may die, *isifuba* is very serious to a child.

Q: For, how long does asthma attack take her?

A: I do not know how long it takes I never asked the doctors, all I know is that she is taking treatment. But, I do not want to tell lies she is now better to such that I am only bringing her so that the doctor can check her progress. She is better from and using the pumps all the time. I only give her the pump that is meant for treatment and it takes time in the body. I can see that the treatment is working well.

Q: According to you, as you said that *isifuba* and asthma is the one and the same thing, how does one get it, what causes it?

A: I do not know what causes it I was satisfied when they said it is caused by, *ingqele*. I also felt that she was cold and I was satisfied (when they said her asthma is caused by cold).

Q: What satisfied you?

A: I was satisfied because even after giving birth at Somerset Hospital, I was told that she was feeling cold and I also got ill because of the same cold so that's the reason I'm satisfied. I am sure she got it while I was still carrying her.

Q: Sisi, at the time when they said the child has *ingqele*, what language were they using?

A: They were speaking their language.

Q: English?

- A: Yes.
- Q: When they said *ingqele* which English word did they use?
- A: They used cold.
- Q: Are you saying that *ingqele* and cold is the same thing?
- A: Yes.
- Q: People who did not get asthma through cold, how do you think they got it?
- A: Sometimes the parent is the one who got it and then it becomes hereditary it is called *imfuzo* in Xhosa, I do not know what is it called in English. Sometimes people get it from their parents.
- Q: Do you think that people get it differently and asthma is different?
- A: Yes I can say that because Okuhle got it through *ingqele* and others got it through *ufuzo*. That is why they ask you in hospital if there is someone from your family members who, has asthma.
- Q: When a person did not get it through *ingqele* not through *imfuzo*, how do you think it starts?
- A: My doctor in Groote Schuur said there is AIDS and it starts with *isifuba* in a child, that is why I asked them to test her in case she is HIV.
- Q: Okay.
- A: A person can have *isifuba* and the other may have *ingqele nje* (which may not be *isifuba*).
- Q: Are you saying *izifuba* are different?
- A: They are different.

Q: When you say they are different, you mean that they differ from problems each person experience or how did it start with a person?

A: It is the same to everyone. From the people I was with in hospital, I did not see anyone with different signs from the others.

Q: When a person has *isifuba*, what causes it?

A: That is never explained.

Q: Can it be treatable whatever the cause

A: Okuhle's is treatable, I do not know about others.

Q: Let us compare ways in which you use words for *isifuba* if they are the same or different, and explain how are they different.

You said *isifuba* and asthma is the same thing. So, when you sometimes use the word *isifuba* and the word asthma you mean one and the same thing. What are the symptoms of a person with *isifuba* or asthma?

A: A person has a sharp/oval chest, the bones are brought together (*amathambo esifuba atsolo*), *aminxane*, *avaleke isifuba* (has a tight chest).

Q: The person who's chest bones are not brought together (*amathambo angekho tsolo*), how do you know that the person has asthma?

A: I do not know anything about *izifuba*.

Q: Sisi, you spoke about pneumonia. You said, you were told that your child has pneumonia, she got *ingqele* at the birth. Sisi, you

also said *ingqele* is the same with cold. Sisi, do you think that asthma and pneumonia is the same thing?

A: Yes. Especially *inyumoniya*.

Q: Was it treated?

A: Yes, she is much better. They said you also get it through *ingqele*, but I am not sure if what it is.

Q: So Sisi you are saying the doctors said the child has *ingqele* and they used the word cold. When you arrived here in Red Cross the doctors said it is pneumonia. According to you, pneumonia means a stronger *ingqele*?

A: Yes. When I arrived here at Red Cross, they said it was pneumonia and I went to Groote Schuur.

Q: What does pneumonia mean?

A: I am convinced it is an extreme *ingqele*, but I am not sure. But I think it is worse than *ingqele*.

Q: When you arrived at Groote Schuur what did they say the problem is?

A: They said it is asthma and they gave her asthma medication and she took that treatment.

Q: So Sisi, you are saying the doctors said, the child has *ingqele*, the word which, they used was cold. When you arrived here doctors said she has pneumonia and in your thinking, Sisi does pneumonia mean *ingqele* maybe *enkulu*?

A: Yes *ipneumonia inkulu kakhulu*.

- Q: Do they treat it?
- A: Yes she is much better, now.
- Q: Sisi, when you use the word *ukutswina* what are you talking about?
- A: The wheezing of the chest.
- Q: How do you know that the person is wheezing?
- A: He has difficulties in breathing, and you would see that the nose has a problem as well and he is really struggling.
- Q: Sisi, what is *ukuminxana* and *ukutswina*, is the same thing?
- A: *Ukuminxana nokutswina* is one and the same thing but we, Xhosas use these words the same way, to refer to chest problems. We use them in different ways but referring to the same problem. *Ukuminxana* means that *isifuba sivalekile uyakhefuzela, uminxene*. *Ukutswina* is the noise that the chest does when it is tight, *sivalekile* (demonstrating).
- Q: Sisi do you ever hear doctors talking about a tight chest?
- A: Yes I do.
- Q: In your own thinking what are they talking about, what do they mean?
- A: They talk about *ukuvaleka isifuba sivalekile*.
- Q: Sisi, have you ever heard of the word *iphika*?
- A: Yes I have. It is one other Xhosa word used to mean *ukuminxana* a person heaves and wheeze and your chest is tight for that particular, moment. Normally, older people suffer from that and it is the same thing with *ukuminxana*.

Q: Are you saying *iphika* is the same as *ukuminxana*?

A: I see it as the same as, *ukuminxana*.

Q: Does it mean the difficulty in breathing?

A: Mhh-mh. (Yes).

Q: When you hear the word pneumonia, TB or asthma do you relate those words to illness or something else?

A: I do not think of something else.

Q: Thank you very much Sisi for your time

Appendix G

Participant D

Sisi, I had already explained to you what we do. My name is Jackie Nxasana and we are doing a research. We are trying to find out how you communicate with your doctor during consultation. We are going to ask you a few questions as to what you think about certain things. You must not tell us that which you think we want to hear but that which you think. I will start by asking your name.

Q: What is your name?

A: My name is D.

Q: How old are you?

A: I am 43 years old.

Q: Where do you stay?

A: I stay in Langa, Harlem Avenue

Q: Were you born there?

A: Yes, I was born there.

Q: You grew up there?

A: Yes.

Q: Other than Xhosa, what other languages do you speak?

A: It is English and Afrikaans. I understand Afrikaans just a little.

Q: How is your English?

A: It is very good. I speak it well.

Q: You also understand it well?

A: Yes.

- Q: If you were to rate yourself on a scale 1 to 10, how would you rate yourself?
- A: I would give myself 9.
- Q: That means you understand and speak English well?
- A: Yes.
- Q: What is your highest qualification?
- A: I have grade 12, and have a Secretarial and Computer course from the Academy of Learning.
- Q: For how long has the child been coming to the doctor for the same problem, he is here for today?
- A: It is for the second time. I have been going to the Day Hospital. They could not see the problem so they referred me here at the Red Cross.
- Q: Was he going to the Day hospital for the same problem he is here for today?
- A: Yes, sometimes uyavaleka isifuba, has a runny nose and swollen eyes.
- Q: For how long do doctors or nurses spend time explaining to you what the probe is?
- A: They take about 30 to 45 minutes, I think it is 30 minutes.
- Q: Are you satisfied with that time?
- A: Yes, I am very satisfied. They have patients. They want you to leave satisfied.

Q: Let us continue with the nature of conversation you had with your doctor. Are you satisfied with the nature of communication that takes place between you?

A: A lot. But, I can see there is a problem with people who did not go to school. Like, I would suggest that they employ more interpreters. Because when they talk about things like pollen, an uneducated person will not understand things like insulin.

Q: Do you encounter problems when the doctor uses those terms?

A: No, I am referring to a person who has not been to school.

Q: Do you sometimes hear other parents voice their concerns about these issues?

A: Yes.

Q: What do they say?

A: Others do not say it out. You just see facial expressions that they did not understand. They would ask from you what the doctor was saying.

Q: After the doctor has left?

A: Yes, things like that.

Q: Do these parents only have difficulties with English medical terms or with English in general?

A: It is medical terms and English. I also encountered that.

Q: What kind of the problem?

A: I do experience problems with medical terms. Then I would ask the doctor to repeat it for me and explain further. They would do.

Q: So you are saying, you do not need an interpreter because you understand English very well?

A: Yes.

Q: So how do you deal with this problem?

A: I believe that when a person did not understand, it is better to ask than to leave the room not having understood a thing.

Q: Do you ask clarity immediately from the doctor?

A: Yes, immediately. I ask her to explain.

Q: What language do they use when explaining?

A: Their language. She explained to me how to administer pumps (inhalers) to my child. I did not know how many puffs to give him because the doctor did not explain well the first time. So she realised that I did not use the pump as earlier directed. Then she asked me whether I did not understand her. She said she can hear that *isifuba* of my child is still *minxekile* which shows that I did not use the puffs well. I explained to her that I thought I understood the first time. That means she also did not explain well or she thought I understand. Then she demonstrated how I should use it next time.

Q: What do you think is the cause for your misunderstanding, the first time?

A: It is how she put it. I did not understand.

Q: How did she put it?

A: She used medical terms.

Q: Oh, she used medical terms? But, you did not ask her for clarity?

- A: No, I did not. I felt so stupid.
- Q: So, she only gave you instructions in English that you should give him pumps and you did not understand how?
- A: Yes, I did not understand that. I thought...
- Q: You are saying the reason you did not understand us because the doctor was using medical terms?
- A: Yes.
- Q: So, has she explained to you thoroughly this morning on how to use it?
- A: She said to me, could you see that your child's *isifuba* is till tight? That means you did not use it the way I said you should. She explained that from now on, I should give it twice a day, in the morning and in the afternoon. She gave me two medications, one called preventer and the other called reliever. One is a reliever when his nose is blocked and the other is to prevent the chest from being blocked. So, he can breathe normally.
- Q: Does it mean you are now satisfied with the way the doctor explained to you?
- A: A lot.
- Q: Did she use the medical terms that she used the first time?
- A: No, she saw from this chart that I did not understand a thing the first time.
- Q: So you are saying, you did not give your child puffs (inhaler) as instructed because you did not understand?
- A: Yes.

- Q: Okay. So Sisi, were there problems resulted from misunderstanding on how to use puffs?
- A: Yes because when the doctor gives you instructions, she expects you to follow them. So, we should follow instructions.
- Q: Are there bad consequences resulting from your misunderstanding?
- A: Yes.
- Q: Sisi, how do you think this problem could be overcome?
- A: Like what?
- Q: Like other people. The fact that it happened to you. It means it could still happen to someone else. How do you think it should be addressed?
- A: Like I said, I really think there should be interpreters for people who did not go to school. Because a person may keep quite and not ask questions even though she does not understand simply because she is scared to be shouted at by the doctor. You see other doctors shout at patients. They become so impatient. Sometimes they are stressed when they see too many patients. Sometimes you just get scared to ask for clarity that why interpreters should be available all the time.
- Q: In your situation, you understand English, you only have problems with the medical terms, how do you think your problem could be solved, since you do not need interpreters?
- A: I think doctors should demonstrate because even when a person does not understand English but she can understand demonstrations.

- Q: So you are saying when the doctor explains in English, she needs to demonstrate by hands?
- A: Yes, I can understand what to do.
- Q: So your problem is different from a person who is not educated, because you understand English? Except that, the doctor still needs to demonstrate?
- A: Yes.
- Q: I understand. Let us talk about your son and the names you use to refer to his illness. There is no right or wrong answer. We are just interested in what you think. What do you think is the problem with your son?
- A: He has allergy. When we came here the first time, they asked me if we have pets at home. I said no. They asked if I have flowers at home and I told them I do. They told me that flowers are some of the things that cause *isifuba*. And that when I am cleaning my house, he is not suppose to be
- Q: You can continue
- A: He is not supposed to be in the house when clean because the dust affects him.
- Q: If you could give us the name of what is wrong with him, what would it be?
- A: What do you mean?
- Q: I mean what would you say is the problem with your child?
- A: He is asthmatic but I do not know how to say it in Xhosa.
- Q: What do you mean by asthmatic?

- A: It is someone with *isifuba* and a breathing problem like (demonstrating heavy breathing). Like the problem, he had before coming to Red Cross. I was not sleeping at all at night. You would think that I was sleeping with a cat, the way it would make noise.
- Q: Really! So you are saying his *isifuba* makes noise?
- A: A lot. He breathes through his mouth.
- Q: And that is asthma according to your knowledge?
- A: Yes. It is asthma when someone cannot eat, breathe and has *isifuba* that makes noise.
- Q: What do you think this illness does to a child?
- A: He does not go to school, sometimes.
- Q: Why?
- A: Because of allergy that causes swollen eyes.
- Q: What does this illness do?
- A: It affects the child a lot because he cannot even play with others. He cannot play where there is grass.
- Q: What would happen?
- A: It will cause an allergy.
- Q: Mh-m.
- A: Even when it is dusty. He cannot play outside because that air can also affect him.
- Q: What parts of the body get affected the most when he is asthmatic?
- A: It is *isifuba*. Because his asthma is related to allergy. It is *isifuba* and eyes.

- Q: What happens to the eyes?
- A: His eyes get swollen especially in Spring around August to September. His eyes cry all the time. His nose runs as well.
- Q: Sisi, I am noticing that you use the word asthma interchangeable with allergy. I am not sure whether you say allergy is asthma or what. How are they related?
- A: He has both.
- Q: Is allergy and asthma one ad the same?
- A: No, they are not. They say he has allergy but I brought him here for asthma.
- Q: What do they say is asthma?
- A: Its symptoms?
- Q: Yes, what is it?
- A: It is like having a reaction to things like pets and flowers.
- Q: What happens when he plays with pets?
- A: His eyes will get swollen and gets runny nose.
- Q: So, these allergic symptoms are similar to those for asthma?
- A: No.
- Q: But, I thought that is what you meant?
- A: *Kwisifuba* usually *uyavaleka*, when he has asthma, *kukvaleka kwesifuba*, and then the allergy is the swollen eyes and runny nose.
- Q: What are referring to when you talk about *isifuba*?
- A: It is asthma.
- Q: So, asthma and *isifuba* is one and the same?

- A: Yes it is.
- Q: How do you think a person gets it?
- A: Here at the hospital they also asked me if there is somebody at home who has it. And I said no.
- Q: What word did they use when they asked you that, was it asthma or *isifuba*?
- A: Asthma
- Q: And you translated to Xhosa?
- A: Yes.
- Q: Do you think this illness is the same to everyone who has it, or it is different?
- A: I think they are different. Because before I started coming here at the Red Cross, my friend's child who lives opposite our house had *isifuba* also. I sue to take from her medication to give to my son. Now I can see that I was doing a wrong thing because the medication is only prescribed for a certain person. I thought my child would be better if she gave me her child's medication. But, I was wrong.
- Q: Did your friend's child have asthma?
- A: Yes.
- Q: Do you think your son's treatment is the same as that of your friend's child?
- A: No, not at all.
- Q: So you think *izifuba* are not the same?
- A: Yes, they are not.

Q: Let us look at the ways you use the word asthma. You said you use both words, asthma and *isifuba* because they mean the same thing?

A: Yes, that is what people say.

Q: You say *isifuba* wheezes?

A: Yes, it makes noise like this (demonstrating breathing with noisy sounds)

Q: Is it the same as *ukutswina*?

A: Yes, it is. It *ukutswina* in Xhosa.

Q: Have you ever heard of *isifuba somoya*?

A: No.

Q: Is it the first time you hear about it?

A: Yes.

Q: Have you ever heard of pneumonia?

A: Yes.

Q: What do they say it is?

A: Is not it when someone has *isifuba*? You can relate it to someone with *isifuba*.

Q: Do you mean someone with asthma?

A: Someone with pneumonia is someone with *isifuba* that results in TB.

Q: But, you do not know how one gets it and what happens when one has it?

A: No, I do not know.

Q: I heard you talk about TB. What is TB?

- A: TB is when someone has *isifuba*, *ekhohlela*, and sweating *enengqele* at the same time.
- Q: When you use the word *isifuba* do you mean asthma?
- A: A person with TB gets *isifuba*, sweats and does not eat. Like my sister did not eat when she had TB.
- Q: Have you ever heard of the word *iphika*?
- A: Yes, I have heard about it.
- Q: What do they say about the word?
- A: It affects the older people. When they do strenuous things and would hold just below the breast and complain of *iphika*. Especially when one is very tired.
- Q: I see. Are there other words that we have used in relation to *isifuba* that can also mean something else?
- A: It is just that, in the township when people have TB, people conclude it is pneumonia and that it is HIV. It has a bad stigma.
- Q: So you say when people use the word TB or pneumonia, others think of HIV?
- A: Yes.
- Q: What do you think when you use these words like TB?
- A: I thought about it at first and then I took her to the doctor. But, she is fine now because she finished her treatment.
- Q: I see. Thank you sisi for your time. I can see your son is getting restless
- A: Okay

Appendix H

Participant A

Date Interviewed: 12/12/02

Modified 22/1/3

I have explained a little as to what my name is Jackie Nxasana and that we are doing a research to find out how you communicate with your doctor. To find out if you understand each other properly. Sisi I am going to ask you certain questions. I don't want usisi to tell me that which she thinks we want to hear. It is not for finding out how much you know about the answer but are interested in finding out whether you and your doctor understand each other and whether or not you understand his explanation of the cause for the disease your child is suffering from at that time. I shall ask you certain question sisi, firstly:

Q: What is sisi's name?

A: My name is Ntombekhaya Mfaku.

Q: You are Ntombekhaya, how old are you sisi?

A: I am 38.

Q: You are 38. Where does sisi live?

A: I live in Litha Park in Khayelitsha.

Q: Were you born there?

A: I was born in Gugulethu, we stayed there at first.

Q: But you were born here in Cape Town?

A: Yes.

Q: Which other languages do you speak other than Xhosa?

A: It is English.

Q: It is English. Do you speak it well?

- A: Yes.
- Q: If you were to weigh your proficiency in English on a scale of 1 to 10, how much would you give yourself? This question refers to speaking and understanding it.
- A: I can give myself 5.
- Q: Does this 5 mean you can speak and understand it well?
- A: I speak it well and I understand it well.
- Q: Has sisi been to school before?
- A: I had been to school before.
- Q: What was your highest standard (grade) passed?
- A: I stopped in standard 8.
- Q: What is this little girl's name?
- A: She is Queen.
- Q: How many times has Queen been coming to the hospital regarding the problem she has come for this time?
- A: She started in July.
- R: This year?
- A: Yes, this year.
- Q: How many times has she been here before today?
- A: It is the fourth time.
- Q: Have you been coming here every month or on specific days?
- A: I come here every six weeks sometimes twice a month, like now she was here on the 1st of November and now she is back again on the 22nd.
- Q: So sometimes she comes twice a month?

- A: Yes.
- Q: How much time does a doctor or nurse spend with you explaining about your child's problem?
- A: Mh.mh... You mean when she is with a doctor in the ward?
- Q: Maybe when she is with a doctor in the ward or in the doctor's room or when she is here for check up.
- A: He takes time. At least half an hour being busy with her.
- Q: Busy doing what?
- A: Being busy, examining her checking how is her isifuba and if she does not have any other problem other than isifuba.
- Q: How does the doctor find out which other problem Queen has other than isifuba, does he ask you questions?
- A: Yes he asks me questions.
- Q: And you respond to those questions?
- A: Yes.
- Q: Now I want to ask you about the conversation you have with your doctor. Are you satisfied with the nature of the conversation between you and your doctor when you bring the child?
- A: I have not seen any problem.
- Q: When you say you haven't seen any problem are you saying you don't have communication problems with the doctor?
- A: No I don't have problems with him.
- Q: What do you think prevents you from having these communication problems with the doctor?

- A: When he talks you see, or when he informs me about, okay, sometimes he tells me that her isifuba is coming okay...
- Q: Would you please stop there for a while sisi, when he informs you that her isifuba is coming okay, what language is he using?
- A: He speaks English.
- Q: The one that sisi said she understands perfectly?
- A: Yes.
- Q: Okay, you can continue sisi, I am listening.
- A: He examines her and tells me that her isifuba is okay today and asks whether her isifuba had not valeka the previous day or if she had khohlela. He gave me a timetable to always sign when she khohlela, and evalekile. Then he gave me two pumps. When she is valekile he gave me a pump called (inflammide) to administer twice in the morning and again in the afternoon. Then after that I give her invent...; I don't remember very well the other pump.
- Q: The other pump? Okay.
- A: I must use the other when I hear her khohlela, and give her two pumps.
- Q: So sisi you are saying you don't have a problem with the doctor because he uses a language that you understand. You don't find problems conversing with the doctor.
- A: No I don't.
- Q: Now sisi I would like to know what you understand about the problem of isifuba that your child has and what do the words you use to describe it mean. Please note that there is no right or wrong

answer in answering these questions I am only interested in finding out what you think of these things. Please explain fully what you know when answering these questions so we can find out if you agree with the doctor's explanation or not. Do you understand sisi?

A: Yes.

Q: According to you sisi, what do you think the child has?

A: I think she has got isifuba, I know her to have isifuba because she takes treatment and it is not the first time for her in Red Cross. She has been to Site B Day Hospital in Khayelitsha I only rush her there when she is valekile and she be given oxygen and feel better. So, she got her first pump here in Red Cross.

Q: What does the isifuba do to a child?

A: Siyatswina, siyavaleka and it is on and off and sometimes it depends on the weather. When it is cold or raining it gets tight and she minxeka and unable to breath it tswina and breaths like that.

Q: Ukutswina sisi being..?

A: It is that noise we hear, that sound that comes out when she breathes.

Q: And that is ukutswina?

A: Yes, uyavaleka and unable to breath.

Q: So sisi you are saying when a person tswina and makes sounds when breathing, that means he has isifuba?

A: Yes it means uminxekile and uvalekile, uminxekile.

Q: If a person uminxekile and uvalekile is that isifuba?

A: That is how they explained to me.

- Q: What happens to a person suffering from this disease besides ukuvaleka? Is there something else that happens in his body?
- A: I don't understand.
- Q: I mean what happens to a person with isifuba?
- A: What I have personally noticed is that she loses weight.
- Q: Mh..mh. Does it mean that, since Queen has isifuba, has lost weight?
- A: Yes that is my observation.
- Q: Are you referring to her losing weight since birth or she is losing it now that she has isifuba?
- A: She has lost it now that she has isifuba.
- Q: When did her isifuba start sisi?
- A: When did it start (trying to remember) I don't remember very well, one month, no no not one month it got serious at one year.
- Q: So it started at one year?
- A: It had bothered her before one year in...No it didn't bother her but what happened was in 1996 we brought her here but I did not understand it was isifuba at the time. It was diagnosed at one year.
- Q: According to you, before it started at one year, do you think it did not affect her weight that much?
- A: No it did not affect her weight.
- Q: It only affected her weight only when she was one year and according to you that is when her isifuba started?
- A: Yes.
- Q: Okay, how does isifuba affect a person?

- A: The signs that I see is when evalekile and unable to breath. This part gets sucked in (demonstrating pointing at the line between the neck and the chest), her stomach gets pulled in and can't breathe properly then I rush her to the Day hospital. They give her oxygen.
- Q: Are you saying when her isifuba starts her breathing is slow (little)?
- A: Yes it is slow.
- Q: Which parts of the body are affected when a person has isifuba?
- A: I have never noticed.
- Q: I mean any other person that you have seen before.
- A: No I don't know.
- Q: What are the problems that this disease causes to a child?
- A: I only notice weight lose. She has also been allergic and had rash . They checked what she was allergic to.
- Q: Did they find it?
- A: They found she is allergic to peanut butter. They asked if we don't have any dogs and cats at home. I told them no we don't have.
- Q: So she doesn't eat peanut butter anymore?
- A: Yes she doesn't.
- Q: Did the rash disappear?
- A: The rash is okay.
- Q: When Queen has isifuba, how long does it last?
- A: It doesn't take long and when it starts I rush her to the Day hospital and spend about an hour, they examine her temperature and put her on that oxygen and they wait for a while. When they see that she is still not better, they inform a doctor to examine her and they give her

oxygen again until she feels better, and notices that the problem is gone.

Q: Is it ukuminxana that is gone?

A: Yes.

Q: How long does it lasts when a person has isifuba?

A: I don't know because I rush her to the hospital.

Q: And you say when you get to the hospital they put her on the oxygen?

A: Yes they put her on the oxygen.

Q: Does she get better or cured, what happens?

A: What I notice at the Day hospital is that it relieves at the time and they would give me Panado and a medicine for isifuba called Ventez, and they'd discharge me.

Q: Okay.

A: I used to stay for a month or two without taking her there. Until the school doctors noticed that she has a problem and has an opening on the inside of her navel. It is this opening that causes her to have a tight chest, that breathing because she breathes with pains.

Q: Does the air come out from there?

A: Yes.

Q: Can't they treat this opening and close it?

A: That is why they sent me here, they gave me a letter to take to the school which explained that they examined the child and found out that the reason her isifuba doesn't get better is because of this problem she has and that she be sent to a private doctor. I took her

to a private doctor, Dr Bhikitsha of eLitha Park and he also found the same thing that has been found by the school doctors.

Q: You referring to the opening?

A: Yes, and the doctor made me an appointment for here and indeed they did find that opening through x-ray. Doctor ***(name not clear) told me that he didn't want to operate immediately.

Q: Sisi are you saying that the doctor recommends an operation?

A: Yes, but he says he can't just operate, she firstly needs to be on treatment so he can see how she responds to it, you understand.

Q: So sisi you are saying Queen's isifuba results from this opening?

A: Yes it is caused by that opening in her navel.

Q: Now I understand, what causes isifuba to other people or does it mean everyone with isifuba have openings in the navel?

A: I don't know.

Q: Do you think there are different kinds of isifuba or you think it is the same?

A: I don't know.

Q: What do you think a person with isifuba can do with it?

A: What can he do with it? What I think he could do is to go for treatment.

Q: Which treatment, for isifuba?

A: Yes he has to go to the doctor and be checked.

Q: According to you sisi do you think isifuba can be cured when one is on treatment?

A: What I think is that it can be cured.

Q: So sisi you are saying you think isifuba can be cured completely?

(Stopped recording, checking on the tape).

A: I don't know, that is what I think.

Q: Why do you think that way?

P: I have observed that Queen is not as bad as she used to be since she was given pumps.

Q: .Okay, what important results are you expecting from this treatment?

A: I don't understand.

Q: What results are you expecting from using pumps.

A: She uses it when I see that uvalekile, I use it the way I was directed to use and she gets relieved.

Q: Does it attack her at some other times after that?

A: Yes it does attack her at some point even when she had been relieved by the pumps.

Q: Now I would like us to compare the way you use this word to other words that you have used during this conversation and find out if they are the same or not, if they are not the same to find out how are they different from each other. Sisi has mentioned to me that Queen has isifuba and she khohlela, when it attacks her she tswina and that ukutswina is a sign that her isifuba is minxene. So sisi do you think that ukukhohlela, ukutswina and ukuminxana are the symptoms of isifuba or that they mean the same thing or they are different from one another?

- A: Ukukhohlela is different, ukuminxana and ukutswina happens at the same time. She minxana and tswina at the same time and valeka and tswina.
- Q: What are you referring to by 'isi'? (A prefix that she uses all the time without completing it).
- A: Isifuba.
- Q: I wanted to be sure what this 'isi' means. I wanted to know if sisi is referring to isifuba when she uses 'isi'. What is isifuba?
- A: Isifuba is esma.
- Q: What is esma? I am trying to understand because I don't know what it is.
- A: When she valeka it's difficult for her to breathe, you understand? That's when she gets her attack of isifuba.
- Q: Okay, what I've noticed is that you continuously talk about ukuvaleka, what is it that valeka?
- A: It is her isifuba that valeka.
- Q: What is it that valeka, what is isifuba?
- A: It is when she has an esma attack.
- Q: How does it attack her?
- A: I attacks her in the way that uyavaleka and breaths with difficulty.
- Q: For me to understand better let us start from the bottom, sisi is saying isifuba siyavaleka, siyatwina, a person khohlela, is that what you are saying?
- A: Yes those are the symptoms.

Q: What is isifuba? When sisi says siyavaleka, please show me isifuba so I will know if we are talking about the same thing.

A: Uvaleka here (pointing just below her neck) and breathing becomes a problem.

Q: When you say uvaleka here are you referring to the throat or what?

A: What I think is that it is when the air that is supposed to be exhaled gets blocked.

Q: Okay now I understand. What does sisi think blocks that air? Sisi is saying the air gets blocked and Queen uyaminxana, what do you think blocks the air?

A: I think it is blocked by isifuba, her esma.

Q: Is isifuba and esma the same thing sisi?

A: Yes the doctor told me that it is one and the same.

Q: Now I understand, I didn't know how sisi differentiate between the two. I didn't want to conclude that sisi is referring to this when sisi is not referring to that. So you are saying isifuba and esma are the same?

A: Yes.

Q: So a person with esma is the same as a person with isifuba. Now I understand. Are there any other words that we have used here that mean something else other than how we have used them in this context? Maybe when someone talks about isifuba and you think about something else which does not mean a person's disease or illness?

A: No.

Q: When you hear the word isifuba being used you think of esma? Is it the same thing that refers to a person's disease or illness?

A: Yes it refers to a person's disease or illness.

Q: Okay, I would like usisi to tell me if she has heard these following words used before. If you have heard them used, to tell me what do they mean. You have already explained to me what isifuba is and further said esma is the same as isifuba. Have you heard about the word inyumoniya before?

A: Yes, what I know is that it is the ingqele that a person gets, and you hear that he has inyumoniya.

Q: What are you referring to when you talk about ingqele?

A: It means he has ingqele in his body.

Q: I want to understand properly, when sisi talks about ingqele is she referring to the day to day ingqele or something else?

A: Ingqele is caused by not dressing up warmly, wearing light things that causes you to get ingqele which causes inyumoniya.

Q: Where does this nyumoniya...

A: Internally.

Q: What happens to a person with it?

A: He has too much ingqele.

Q: Do you mean ingqele that is not wanted internally?

A: Yes.

Q: Do you think this ingqele is dangerous to people?

A: Yes.

Q: How is it dangerous?

- A: Because it requires a person to be on treatment and meets with doctors and so on, until he gets better.
- Q: Is it curable?
- A: I don't know because I have never heard it but what I hear is that it is curable.
- Q: That is what you hear?
- A: Yes that is what I hear.
- Q: Sisi have you ever heard of the word TB?
- A: Yes I have heard of the word TB.
- Q: You have never had it?
- A: No.
- Q: Isn't there anyone at home who has had it?
- A: No.
- Q: When you hear this word being used, how do they use it?
- A: They say it is the disease of iphepha, I don't know.
- Q: Which iphepha?
- A: I don't know; besides I don't know of any one who has had TB in my family. I would know better if there's one.
- Q: Okay, you don't even know how a person with TB gets or how he breathes?
- A: No.
- Q: Sisi have you ever heard of the word iphika?
- A: I don't know that thing I only hear about it but I have never seen a person with it.
- Q: What are they saying about a person with iphika, what does he do?

A: He breaths non-stop (demonstrating fast and heavy breathing) I
have never seen one.

Q: Okay sisi we are finished now and your child is sleeping. Thank you
very much you have explained very well, thank you.