Strategies that occupational therapists in the public health sector in KwaZulu-Natal use to navigate language discordance: A qualitative descriptive study

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Abstract

Background: Language discordance, a challenge of miscommunication between health professionals and service users, is a concern for occupational therapy, a profession that foregrounds a client-centred partnership. Occupational therapy literature highlights language discordance as one of the biggest challenges encountered when working in the rural public health sector. Language discordance affects the quality of health services which results in misdiagnosis, informed consent violations, decreased service user satisfaction and safety risks, among others. Occupational therapy is not immune to these negative consequences. In a country as linguistically diverse as South Africa, the need to find effective ways to navigate language discordance in occupational therapy health care, is crucial. However, there is limited literature on language discordance and the strategies used to resolve the issue. **Aim**: The aim of this study was to describe strategies that occupational therapists working in the public health sector in KwaZulu-Natal use to navigate language discordance and to understand the subsequent role that language discordance has on the quality of occupational therapy care. **Methodology**: The study adopted a qualitative descriptive design using semi-structured interviews with eight participants recruited using purposive and snowball sampling. Thematic analysis was used to analyse data. **Findings**: Four themes emerged, namely; using various communication strategies concurrently, *language definitely impacts that therapy process*, factors perpetuating language discordance and *I'm doing everything that I can, what more can I do?* **Conclusion**: The impact of language discordance on the quality of occupational therapy care is undeniable. However, the participants showed agency in navigating language discordance using personal and institutional resources amidst the complexities of applying various strategies concurrently in order to provide the best care that they could.

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Dedication

I dedicate this to Professor Bongani Mayosi. Thank you for being a shining light, pioneer and believer in African students and their research.

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List of Acronyms

OT – Occupational Therapy

OTASA - Occupational Therapy Association of South Africa

WFOT – World Federation of Occupational Therapist

Definition of terms

Community service occupational therapist: A first-year graduate who is legally required to work for one year in and for the public health sector in South Africa (South African Government, 2006).

Language discordance: A phenomenon that “occurs when the patient and care provider lack proficiency in the same language” (Sears et al., 2013, p1).

Informal interpreter: A person with no formal training in interpreting such as family members, friends (Zendedel et al., 2018), other service users and co-workers (Kilian et al., 2014).

Public health sector: The health system run by the government through which the majority of the population accesses health services at primary, secondary and tertiary levels of care (Mahlathi & Dlamini, 2015).

Service user: A person who accesses health care.

Chapter 1: Introduction

1.1. Introduction

Quality health care is an ideal that health professionals and systems strive for. There are various definitions and theories as to what makes up quality health care. What is agreed upon is that quality health care comprises of access to care (National Department of Health, 2007; World Federation of Occupational Therapists [WFOT], 2018). The WFOT (2018) add quality dimensions which include appropriateness, effectiveness, efficiency, person-centredness, safety, and sustainability. Donabedian (1966), a leader in theorising quality of health care, outlines that quality health care depends upon on *processes*, which are what the health care provider offers the service user, and *structure*, which encompass the physical environment, staffing, institutional culture, and policies. Lastly, *outcomes* which denote the result of the care processes, provided within the specific structure.

Of importance to this study, are the processes of quality health care in occupational therapy. Van Biljon et al. (2017) point out that in a linguistically and culturally diverse country like South Africa, providing adequate occupational therapy care is challenging. South Africa is a melting pot of ethnicities, music, cuisines, landscapes, and languages (Moloi-Motsepe, 2018), and with diversity comes both the opportunity for celebration and oppression. Specific to linguistic diversity, the National Language Policy Framework (National Department of Arts and Culture, 2003) states that there are roughly twenty-five languages spoken in South Africa, with eleven having official status since 1996. About 78% of the population speak an indigenous South African language as their home language (Statistics South Africa, 2017). Despite this, two of the official languages, English and Afrikaans, which are historically associated with colonialism and oppression, continue to be privileged in post-Apartheid sectors (Maseko & Kashula, 2009; Pillay & Kathard, 2015). These languages continue to dominate the health care sector (Deumert, 2010) with 80% of health professional-service user interactions in South Africa occurring across a linguistic divide (Penn, 2007). The inevitable outcome is language discordance.

Language discordance means that a health professional and a service user do not have proficiency in a common language (Sears et al., 2013). Alternatively, Weng and Landes (2017) define language discordance as “when providers and patients do not share the same system of communication used by a particular community or country” (p. 901). This definition is broader as it encompasses systems of communication which could include braille, sign

language, and body language. Both definitions are relevant to this study. Language discordance became the term of choice in this study as it does not implicitly indicate that the service user is the problem, as implied by terms like 'limited English proficiency', or assume insurmountable communication difficulties, as suggested by terms like 'language barrier'. Weng and Landes' (2017) definition indicates the presence of decreased communication in health professional and service user interactions. Communication difficulties have been said to account for service user dissatisfaction and reduce the quality of health care provided (Levin, 2006; Mirza & Harrison, 2018). If this is the case for communication difficulties, then it could be assumed true for language discordance, and specifically for occupational therapy care too. Structural barriers in the health sector, coupled with language discordance, further reduce the quality of health care in South Africa.

1.2. Background to the South African health system

The health care sector in South Africa is fraught with a complex history of segregation, and inequalities in health care budgets between races, sectors, levels of care, and geographical locations (Coovadia et al., 2009). The health system is currently split between the private and public sectors. Disparities persist, insofar as 73% of the population (Statistics South Africa, 2019a) access the public health sector, while only 54% of the health budget is allocated to the public health sector (Coovadia et al., 2009). In the public health sector, there are identified constraints on the quality of care. Firstly, understaffing is an issue as evidenced in the Health Systems Trust report: there are only 2.8 occupational therapists per 100 000 people, with the numbers being even lower in rural areas (Day & Gray, 2014). Secondly, the sector is under-resourced as shown by the weighting of health budgets. Thirdly, long waiting hours, inefficient appointment booking systems and malfunctioning equipment (Ameh et al., 2017) contribute to poor quality of care. According to Donabedian (1966), these factors are structural in nature. Language discordance is an issue of 'process' (Donabedian, 1966), that impacts quality of occupational therapy care.

Language discordance is a global phenomenon, both geographically and across health professions. It manifests in countries with higher numbers of immigrant and other minority groups (Martinez & Leland, 2015; Sears et al., 2013) and in countries such as ours, where the majority of the population does not access health services in a language that they understand (Claassen, et al., 2017; Hsieh, 2018; Janse van Rensburg et al., 2012). Despite policies such as the Patients' Rights Charter (National Department of Health, 1996) and the National Language Policy Framework (National Department of Arts and Culture, 2003) that outline the

importance of language equity and the provision of services in the preferred language of the service user, in reality this does not happen (Deumert, 2010). Less than 20% of occupational therapists registered with the Health Professions Council of South Africa self-identify as black South Africans (Y. Daffue, personal communication, January 13, 2021) and about 81% of the population are black South African (Statistics South Africa, 2019b). These statistics indicate a high possibility of language discordance and stunted therapeutic communication influencing the quality of care for the majority of South Africans. Communication difficulties in health care raise ethical, safety and health risks (Martinez & Leland, 2015). Service users in hospitals in South Africa and abroad report decreased satisfaction (Deumert, 2010) and increased frustration (Mirza & Harrison, 2018) with their care. They also report experiencing misdiagnoses (Levin, 2006) and delayed diagnoses (van Rosse et al., 2016) as a result of communication difficulties.

However, there are strategies outlined in literature that aid in navigating language discordance, with varying levels of success, including short language courses (Claassen et al., 2017; Penn et al., 2009), using interpreters (Benjamin et al., 2016; Wallmach, 2014), and relying on non-verbal communication (Govender et al., 2017; Van Stormbroek & Buchanan, 2019). However, this literature is limited.

1.3. Problem statement

The Patients' Rights Charter (National Department of Health, 1996) states that service users have the right to access health care information in a language that they understand. Despite the existence of this right, there is a stark linguistic divide in health services (Penn, 2007), known as language discordance (Sears et al., 2013). Language discordance is a public health care issue, particularly for occupational therapy care in the public health sector. The client-centred nature of occupational therapy emphasises the importance of "listening, communicating, partnership and choice" (Sumsion & Law, 2006, p. 153). Language and effective communication are therefore fundamental to client-centred practice. Without communication, the essence of the profession may be weakened and compromised. Lim (2008) recognises that if an occupational therapist works with a service user of a different background, the whole occupational therapy process needs to be personalised to their needs and what matters to them. In a country as linguistically diverse as South Africa, the need to find effective ways to navigate language discordance in occupational therapy care is crucial.

Local occupational therapy literature pertaining to language discordance is limited. Van Stormbroek and Buchanan (2017) and Naidoo et al. (2017b) found that novice and community service therapists experienced language discordance as one of their biggest difficulties, especially as their attempts to overcome it proved insufficient. These findings could suggest limited preparation of occupational therapists in navigating language differences. The lack of literature focusing on and exploring strategies used with navigating language discordance is a concern for occupational therapy care in South Africa. This study aims to assist in bridging the gap.

1.4. Rationale

Language discordance has been researched by health professionals, including occupational therapists, in countries abroad (Martinez & Leland, 2015; Sears et al., 2013). These studies are generally concerned with language discordance in relation to the immigration of minority populations into Western countries. Hsieh (2018), however, illustrated that service users in Taiwan who speak English are likely to access better quality of health care. Despite Taiwan having numerous local languages, health professionals study and practice medicine in English (Hsieh, 2018), limiting the language accessibility of health care for the majority population who do not speak English. Although these findings may be similar in a South African context, where the majority population is also affected by constrained language accessibility, the above study does not mention occupational therapy. This indicates a gap in the literature because occupational therapy foregrounds a client-centred approach that emphasises effective communication and collaboration (Martinez & Leland, 2015).

In South Africa, literature pertaining to language and communication difficulties either focuses on other health professionals' perspectives (Deumert, 2010; Levin, 2006) or, while relevant to occupational therapy, touch on communication as a by-product of the studies. For example, Van Stormbroek and Buchanan (2017) focus on community service experiences, and Govender et al. (2017) and Janse van Rensburg et al. (2012) focus on cultural competence. This indicates that the core phenomenon, namely language discordance has not been well-documented in South African occupational therapy literature.

In addition, previous research is bound up in problematic conceptual framing. Such terms as 'limited English proficiency' and 'non-English speaking', frame the phenomenon as a service user problem (Ian et al., 2016; Mirza & Harrison, 2018), which could absolve and distance health systems and health professionals from the matter at hand. In this study, the more

neutral term language discordance is used to discuss how this problem affects client-centred occupational therapy care in South Africa, and to build on the limitations and gaps of previous research. Although a range of strategies have been described in the general health care literature; the efficacy, efficiency and ethical considerations of using these are contentious. With occupational therapy being a holistic, client-centred practice, it is necessary to explore which strategies are efficient and appropriate for use by occupational therapists in a South African context when they encounter language discordance; a common phenomenon in this context. This study intended to highlight the presence of language discordance and to document strategies that are used to navigate language discordance by occupational therapists.

1.5. Purpose

The purpose of this qualitative descriptive study was to gain an understanding of strategies used by occupational therapists to navigate language discordance in their interactions with service users in the public health sector. The intention was to document local occupational therapy knowledge on language discordance, how it manifests, and what therapists do in the face of communication difficulties. Furthermore, this study seeks to understand the role language discordance plays in upholding or diminishing the quality of client-centred occupational therapy health care in South Africa. The findings of this study could contribute useful insights on how to improve quality care focusing on language as a key aspect of access to health care. In addition, the study could inform undergraduate occupational therapy curricula in terms of creating strategies that prepare students to successfully navigate language discordance.

1.6. Research question

What strategies do occupational therapists in the public health sector in KwaZulu-Natal use to navigate language discordance?

1.7. Aim of the study

The aim of this study was to describe the strategies that occupational therapists in the public health sector in KwaZulu-Natal used to navigate language discordance and the influence of language discordance on the quality of occupational therapy care.

1.8. Objectives

- To identify and describe the strategies occupational therapists used when encountering language discordance.
- To identify and describe factors that influence the use of strategies for navigating language discordance.
- To describe the impact of language discordance on the quality of occupational therapy care.

1.9. Significance

This study has significance for occupational therapy in South Africa today. This research was conceived in 2018, shortly after the monumental Rhodes Must Fall (2015) and Fees Must Fall (2015-2016) movements shook South African universities. These movements called for transformation and decolonisation of curricula. This study speaks to curriculum change as it shares insights about language discordance encountered in the public health sector. These insights on existing strategies could inform curriculum change that is necessary for future occupational therapists to better provide contextually relevant occupational therapy care to our diverse population. These insights could also inform policy makers on how to improve occupational therapy care in the health care system.

Chapter 2: Literature review

2.1. Introduction

This literature review will elaborate on topics introduced in Chapter 1, such as the impact of language on health care in general and then occupational therapy in particular. Following that, the causes of language discordance and the strategies used to navigate it will be discussed. The effectiveness thereof and the factors that enable or hinder the use of these strategies will also be unpacked.

2.2. The impact of language discordance on the provision of health care

Language discordance has an impact on the quality of care provided by all health professionals. Studies reported that language discordance caused safety risks, negligence (Elkington, & Talbot, 2016; van Rosse et al., 2016), and diminished rapport building (Mirza et al., 2020; Nakiwala et al., 2017; Pretorius, 2018). Language discordance also led to incomplete assessments (Probst & Imhof, 2016; White et al., 2018), caused delayed diagnoses and commencement of treatment, and negatively affected adherence to treatment (Nakiwala et al., 2017). These consequences highlight the impact of language discordance on the 'process' (Donabedian, 1966) of quality health care and the resulting impact on the service users' health outcomes.

The experience of language discordance seems to have frustrated both service users and health professionals. For instance, service users in the United States (Martinez & Leland, 2015) and Australia (White et al., 2018) reported dissatisfaction with their care and were frustrated by their health care interactions. In the United States, nurses navigating language discordance felt that it was highly demanding and time consuming, which had an effect on their productivity and ultimately impaired their provision of quality care (Ian et al., 2016). The above shortcomings of quality health care and reported dissatisfaction as a result of language discordance indicate the seriousness of language discordance in health care as a whole.

In South Africa, the weight of language discordance is different to that in other countries because it is experienced by the majority of the population. Studies referring to language discordance in South Africa reveal that poor communication between health professionals and service users stunted the appropriateness and acceptability of health care (Schlemmer & Mash, 2006), especially in rural areas (Van Stormbroek & Buchanan, 2017). This research

aims to examine what the studies do not discuss, namely, to whom language discordance is attributed, and what to do with this knowledge of decreased quality care as a result of language discordance.

A study conducted in a tertiary paediatric hospital in the Western Cape showed that isiXhosa-speaking parents reported poor communication as their biggest barrier to quality health care, primarily between the doctors and the parents (Levin, 2006). The parents mainly attributed poor communication to their limited proficiency in the English language, as well as to the lack of interpreters, and only occasionally criticised the doctors for not knowing an African language (Levin, 2006). Unfortunately, most parents took responsibility for the language discordance, perhaps not knowing their right to access health care in a language of their choice.

In a study on cross-border migrants from Zimbabwe, the Democratic Republic of Congo and Somalia living in South Africa, the issue of language discordance became even more complex, where several women had undergone tubal ligation operations without their consent (Hunter-Adams & Rother, 2017). This is an example of how language discordance could infringe on service users' rights and breach ethical principles. Gaining informed consent, a key part of health care, can be affected by language discordance (Parsons et al., 2014).

The service users' experience of health care could also be impacted by language discordance. Zimbabwean participants reported that the isiXhosa-speaking nursing staff in a hospital in South Africa purposefully spoke to them in isiXhosa, despite being proficient in English (Hunter-Adams & Rother, 2017). The participants expressed that they felt discriminated against and unable to receive adequate medical advice (Hunter-Adams & Rother, 2017). Service user satisfaction and general quality of care seem to decrease due to language discordance. These studies did not include occupational therapy care, which highlights the importance of the next section, where language discordance in occupational therapy will be explored.

2.2.1. The impact of language discordance on the provision of occupational therapy care

In a profession like occupational therapy, where emphasis is placed on prolonged effort and time with service users (Martinez & Leland, 2015) and, given the South African health care context where there is a shortage of occupational therapists (Naidoo et al., 2017a), the effects of language discordance can be devastating. Occupational therapists rely heavily on effective

communication for assessment, rapport-building, mutual goalsetting, treatment, and education of service users (Creek, 2014; Sumsion, 1999). Despite the importance of effective communication in occupational therapy, and the presence of language discordance in other health professions, there is limited literature on language discordance in occupational therapy. One relevant article is a single case study of a student and her encounters with a Spanish-speaking servicer user (Martinez & Leland, 2015). The findings of this study suggest that language discordance impeded the occupational therapist in explaining her clinical reasoning and educating the service user about the profession and its input, setting goals in partnership with the service user, and building solid rapport (Martinez & Leland, 2015). The occupational therapist was afraid that her broken Spanish may be offensive to her service user, and doubted the relevance or effectiveness of her care (Martinez & Leland, 2015). It would seem clear that language discordance greatly affected the efficacy of the core tenets of occupational therapy.

Another study reviewed language access in occupational therapy in working with service users with limited English proficiency in the United States of America (Mirza & Harrison, 2018). The review reiterated that there is a dearth of knowledge concerning language discordance in occupational therapy, and that the literature that does exist confirms that language discordance negatively impacts the quality of care provided, with low satisfaction and high frustration reported by service users (Mirza & Harrison, 2018). With regards to frustration, a study on the levels of cultural competence in South African occupational therapy students found that students were often frustrated by communication difficulties, yet they took personal responsibility to improve communication (Govender et al., 2017). Students identified that communication difficulties hindered therapeutic opportunities and that intervention processes were often shallow and misguided (Govender et al., 2017). With the prevalence and effects of language discordance in South African and international occupational therapy noted, it is important to explore the possible causes of language discordance.

2.3. Causes of language discordance

Various explanations have been provided for the existence of language discordance. Language discordance is encountered throughout the world, as more people move from their home countries to countries where their home language is not widely spoken. Sears et al. (2013) found that in the Canadian city of Ontario, Mandarin, Spanish, Portuguese, Italian, and Punjabi were the top five non-official languages, and that language discordance usually occurred in health interactions where a health professional and service user did not share proficiency in either English or French, or the service user's language. Other studies show

similar findings: migration has increased the prevalence of language discordance in Europe (Zendedel et al., 2018), North America (Inagaki, et al, 2017), the Middle East (Abdelrahim et al., 2017), and Asia (Hsieh, 2018). In the South African context, migration is definitely a factor, but there are additional factors at play.

Hunter-Adams and Rother (2017) found language discordance to be a concern among migrants that had moved to South Africa, largely from other African countries. However, language discordance in South Africa was most commonly reported by citizens of the country. Despite the National Language Policy's (National Department of Arts and Culture, 2003) aim of promoting multilingualism in South Africa, this mandate has not been fully realised, with lack of educational growth being one primary contributory factor.

The teaching of languages from basic to higher education needs to be explored to better understand the prevalence of language discordance in South Africa. The Curriculum and Assessment Policy Statement (National Department of Basic Education, 2011) stipulates that, in conjunction with being taught their home language, children need to learn two additional languages. Teaching a first additional language begins in grade one, with two to three hours allocated per week, which increases to four-and-a-half hours per week from grades ten to twelve. In addition, the learning of a second additional language is also outlined to begin from grade one, for one hour per week, increasing to a maximum of two hours per week from grades four to twelve (National Department of Basic Education, 2016). Both of these policy statements are relatively new; therefore, it is unclear if they have, or will have, any influence on building multilingualism and on the successful navigation of language discordance. Additionally, Heugh (2011, as cited in Madiba, 2012) problematises that even when another language is learnt, it is not being taught correctly. South Africa has a history of language being used to divide and oppress, with English and Afrikaans being the languages of power (Deumert, 2010). Despite the ending of Apartheid in 1994, the legacy of these dominant languages lingers. The hegemony of these languages, and the failings of the education system in aiding learners to become multilingual, could contribute to language discordance.

The current workforce in the health sector did not benefit from such policies, especially regarding learning a second additional language, which may explain why language discordance is rife. In South African universities, the teaching of indigenous African languages for specific professions such as journalism, health sciences and humanities varies from institution to institution in terms of the duration, content, and style of teaching (Docrat et al., 2019). It appears as though this language teaching is inadequate as psychiatrists (Kilian et al., 2014), psychologists (Elkington & Talbot, 2016) and occupational therapists (Van

Stormbroek & Buchanan, 2017) reported that their ability to overcome language discordance was insufficient. Of importance is that occupational therapists felt ill-prepared to navigate language discordance, which gives reason as to why this study is necessary.

Another cause may be that in addition to linguistic divides in South Africa, there are cultural ones, and often these are interlinked (Govender et al., 2017). This means that even if someone is proficient in another language, it does not necessarily mean they will understand the cultural nuances of the language. Leendertz (2012) asserted that the language barrier impacted on providing “culturally appropriate occupational therapy” (p. iv) care. The same could be said for cultural nuances: they compound and perpetuate language discordance. The causes of language discordance are multifarious, and are linked to migration, language education, and cultural differences. Despite these challenges that perpetuate language discordance, health professionals have come up with strategies to navigate language discordance.

2.4. Strategies that are used to navigate language discordance

In this section each strategy will be discussed, how it was used, its effectiveness and what made its use possible. Several strategies employed to counter language discordance in health care have been suggested locally and internationally, with varying levels of success. One such solution is to improve the communication skills of health professionals in the field through short-term language courses. A pilot study conducted in the Western Cape, South Africa, showed that a 12-week course led to an increase in proficiency in Afrikaans or isiXhosa among clinical and administrative staff (Claassen et al., 2017). Such courses are seen as attempts to bridge the language gap and a first step to becoming proficient in another language. A one-year African language course for audiology students improved their proficiency in that language (Penn et al., 2009). However, several South African authors have declared that short-term language courses do not adequately prepare students or health care workers to effectively communicate with most of their service users (Elkington & Talbot, 2016; Penn et al., 2009; Van Stormbroek & Buchanan, 2017). The language courses seem to fall short in capacitating future or existing health care workers to better navigate language discordance.

Another strategy, interpretation, is widely documented in the literature as being used to mediate mismatched language proficiencies. Several studies in South Africa and internationally have shown that the use of trained interpreters yielded improved quality of care and service user satisfaction (Benjamin et al., 2016; Karliner et al., 2007; Mirza et al., 2020; Wallmach, 2014). Of noteworthy mention is that the interpreters should be trained specifically

in health interpretation; however, Elkington and Talbot (2016) state that interpreters in South Africa are trained as generalists, catering to interpretation in various sectors. This is likely to increase errors in health concept interpretation (Probst & Imhof, 2016) beyond the commonly reported concerns of omission, addition, substitution, and condensation that occur even when using formal interpreters (Elkington & Talbot, 2016; Nakiwala et al., 2017). Peña (2007) asserts that even translation and back translation are not sufficient in ensuring that accurate meaning is communicated; functional and cultural equivalence need to be strived for too. Mirza et al. (2020) therefore advocate that interpreters receive culturally relevant input together with language training.

Beyond the content of interpretation, there are concerns that using an interpreter takes too long (Parsons et al., 2014), that hiring interpreters adds a significant cost to the health sector (Al Shamsi et al., 2020), and that interpreters are often unavailable when needed (Mirza et al., 2020; Solomon et al., 2012). Of note is that having an interpreter present disrupts the therapeutic relationship between the health professional and service user (Elkington & Talbot, 2016), which is a very important consideration in client-centred occupational therapy (Govender et al., 2017). Client-centredness is about partnership (Sumsion & Law, 2006), and having a third person involved threatens the partnership in terms of trust and rapport building (Martinez & Leland, 2015). This may mean that having an interpreter present in an occupational therapy session jeopardises the core of the practice.

As there are economic constraints in implementing interpretation services (Claassen et al., 2017), perhaps telephonic interpretation offers a better solution. Several authors advocate for telephonic interpretation, as it can be a 24-hour service (Partida, 2007) with greater ease in accessing an interpreter who is not institution-bound (Parsons et al., 2014). Tate et al. (2016) report that telephonic interpretation was the most effective strategy employed by emergency medical practitioners in the United States of America and in South Africa. Nevertheless, there are concerns regarding time delays (Tate et al., 2016) and the disadvantage that telephonic interpreters are unable to see the service user's body language (Mirza et al., 2020). It appears that telephonic interpretation has its limitations, but seems to be the most promising strategy in solving the issue of interpreter unavailability.

In the absence of formal interpretation services, health professionals resorted to asking bilingual health and non-health professional co-workers, family members, friends, and bystanders to do informal interpretation (Tate et al., 2016; Tschurtz et al., 2011; White et al., 2018). It is recognised that this is not ideal, but is often seen as most efficient under the circumstances (Parsons et al., 2014). Relying on informal interpreters has been found to

violate the ethics of health care, with concerns about breaching confidentiality, misinterpretation, and omission (Levin, 2006; Schlemmer & Mash, 2006; Tate et al., 2016; White et al., 2018). In addition, it takes time away from a co-worker's essential job tasks (Schlemmer & Mash, 2006), and from a family member who has taken time off work to act as an interpreter (Hunter-Adams & Rother, 2017). In the South African context, some service users may have diagnoses or presenting problems that they are not yet ready to discuss with their family members, or due to age or other social factors, these diagnoses and presenting problems cannot be discussed with particular family members or even other informal interpreters. (Levin, 2006). This poses questions of the ethics and effectiveness of using family members as informal interpreters.

One recommendation has been for institutions to employ a more diverse staff contingent to better mitigate language discordance (Mirza et al., 2020; Weng & Landes, 2017; White et al., 2018). Another recommendation is that multilingual staff members receive training in interpretation (White et al., 2018), something that is currently not in place in South Africa or internationally (Tschurtz et al., 2011). However, multilingual co-workers have often reported disdain at being required to perform a role that they are not required or equipped to do (Elkington & Talbot, 2016; Solomon, et al., 2012; White et al., 2018). In addition, they are not being paid for taking on this extra role, which may raise the question of the potential for exploitation. Considering everything, it does not seem to be a very effective or efficient strategy.

Additional strategies that have been documented in the literature include attempting to speak the service user's language in a basic manner (Parsons et al., 2014; Van Stormbroek, & Buchanan, 2019; Tate et al., 2016; Tschurtz et al., 2011), as well as speaking English slower, enunciating clearly and using plain language or refraining from using culture-specific expressions (Parsons et al., 2014; Weng & Landes, 2017). Although these strategies may help in bridging the communication gap, there is still a high risk of misinterpretation if there is no shared proficiency in a language. Doctors, emergency medical practitioners, and occupational therapy students and graduates have also reported using non-verbal communication such as gestures to communicate (Govender et al., 2017; Van Stormbroek, & Buchanan, 2019; Tate et al., 2016; White et al., 2018). In different cultures however, different gestures can mean different things, which indicates that this is not a fool-proof strategy. A common strategy employed by doctors was to rely more on objective information by ordering more tests and increasing a service user's hospital stay to have prolonged observation (Parson et al., 2014; White et al., 2018). The efficacy of the above strategies has not been reported on.

Translation has also been reported to have been used to navigate language discordance. Tschurtz et al. (2011) make mention of using “translated documents, communication boards and bilingual signage” (p. 409). Another example reported using information leaflets, Google Translate, and a tuberculosis-specific application that was translated into 38 languages to communicate with service users (Nakiwala et al., 2017). Despite these strategies assisting in relaying information, they “cannot mitigate the impact of language and cultural barriers on the patient–provider relationship” (Nakiwala et al., 2017, p. 2). The application MediBabble is currently available in six international languages and uses voice recognition for medical questions, as well as having a lexicon of medical instructions (Al Shamsi et al., 2020). It has been found to be effective in taking histories and making medical diagnoses (Rahman, 2016). All of the above strategies have their limitations but are worth considering for better navigating the diverse language plains in South African occupational therapy care.

2.5. Conclusion

The inadequate or unexamined strategies described above illustrate why this study is necessary in identifying what strategies are used by occupational therapists where communication difficulties are most prevalent. In addition, to navigate the effects of language discordance, all in the interest of improving the quality of occupational therapy health care. Communication difficulties have been alluded to in the profession, but only as by-products of other studies. This study will aim to generate language discordance literature specific to occupational therapy to better understand the phenomenon in context and how it can be addressed.

Chapter 3: Methodology

3.1. Introduction

This chapter covers the methodology that was adopted in this research study, and it describes why the research approach and research design were chosen, who the researcher is, and why the particular research site was selected. The participants, research process including data collection, management and data analysis will be outlined. The chapter will end off with a description of how quality in the study was maintained and the ethical considerations related to the study.

3.2. Research approach

A qualitative research approach was chosen for this study. Denzin and Lincoln (2018) define qualitative research as "an interpretive, naturalistic approach to the world" (p. 43), whereby phenomena are studied in their natural settings. Qualitative research offers an opportunity for complexities to be understood and organised in an inductive manner (Creswell, 2014). The research question is in line with a qualitative research approach as it seeks to explore strategies used for navigating a situation. The intent behind exploration is to understand a phenomenon (Green & Thorogood, 2014); to understand what "meaning individuals or groups ascribe to a social or human problem" (Creswell, 2014, p. 4). The study sought to understand a social problem, namely language discordance and how it is navigated, from the perspective of the occupational therapists experiencing the problem. A quantitative research approach would not have been suitable for this study as rich, detailed data was sought, and was analysed in a flexible, semi-structured and organic manner (Mason, 2002), focusing less on patterns and statistics and more on a comprehensive description of a phenomenon.

Qualitative research is a useful approach when little is known about a phenomenon, or when elaborate descriptions or a holistic account of a phenomenon are sought out (Creswell, 2013). Language discordance is a topic that is under-explored in occupational therapy and in South Africa, therefore it is logical to endeavour to understand it better, using a qualitative approach. A characteristic of qualitative research is reflexivity, as the researcher does not detach their personhood from the research to maintain objectivity, as would be done in a quantitative study (Creswell, 2013). Therefore, it is important for the researcher to continually reflect on how their background and frame of reference influence the research process. It is fitting for this study as the researcher has first-hand language discordant experience and reflexivity was required

to ascertain how these experiences affect, and possibly provide richness to the study design and findings.

3.3. The researcher

I am a white body, embodying and experiencing the benefits of whiteness. I am also an English South African woman, with a specific lived experience as a middle class, heterosexual, cisgender, able-bodied mid-twenty-year-old. I was born in 1994, a significant historical year that has shaped my commitment to counter oppressive systems and to having my way of thinking and doing challenged. I have lived most of my life on farms in rural Limpopo and KwaZulu-Natal. I completed my community service year at a district hospital in rural Eastern Free State in 2017 after graduating with a BScOT in 2016. The experiences from working in a rural public health facility and my passion for equity for rural citizens greatly impacted my decision to explore this topic. I encountered language discordance first-hand during my community service and realised how prevalent it is. I assumed that it would be rife in other rural contexts too. I realised how crucial comprehensive communication was for quality occupational therapy care and my pursuit for greater access to quality care motivated me to invest in this topic.

I learnt a total of two years of isiZulu between primary and high school, little of which is remembered to this day, whereas Afrikaans was learnt as a first additional language for nine years across my schooling career. I learnt basic, health-related isiXhosa for one year, as well as additional occupational therapy-focused Afrikaans during my studies at the University of Cape Town. I learnt basic, health-related Sesotho on the job whilst doing my community service in the Free State. From these experiences I generally assumed that white health professionals were complacent and resistant to learning African languages and that the service user is usually expected to conform to the language spoken by the health professional.

I did not know any of the participants prior to recruitment, with the only commonality being a shared profession and that they worked in the district that I call home. In line with the shared profession, I assumed from my undergraduate training and experience in the field that occupational therapists place more emphasis on clinical skills than on communication skills in training and practice.

3.4. Research design

A qualitative descriptive research design was adopted. Qualitative description is a research design used to gain detailed descriptions pertaining to a topic of interest with minimal interpretation or theorisation prescribed (Sandelowski, 2000). This allows for questions that may have significance for practice or policy to be answered (Sandelowski, 2000). This study elucidated the role that language discordance plays in occupational therapy care, which could aid in producing contextually relevant knowledge that could inform curricula and practice. This is relevant for the profession as occupational therapy services are founded on transactional relationships with service users (Martinez & Leland, 2015), therefore language discordance could impact the client-centred nature and quality of the services rendered. The aim of the study was to describe the strategies used by occupational therapists in navigating language discordance and to understand the subsequent role that language discordance has on their experience of the quality of care. This required rich accounts of the participants' experiences to be revealed, matching the nature of qualitative description (Sandelowski, 2000).

Although qualitative description is commonly employed in qualitative research, it is not well documented as a research design or deemed as comparatively valuable as other qualitative research designs (Sandelowski, 2000). However, it is a valuable research design as it aims to provide a comprehensive description of the meanings ascribed to relevant experiences through which researchers "stay close to their data and to the surface of words and events" (Sandelowski, 2000, p. 336).

3.5. Research site

This study was located in KwaZulu-Natal, one of the nine provinces in South Africa, which is divided into ten districts and one metropolitan municipality (Municipalities of KwaZulu-Natal, 2021). One district municipality was chosen as the research site, namely the iLembe district, with a total population of 678 048, as indicated in Table 1. It is made up of four sub-districts and spans the coastal and inland area north of Durban ("iLembe District Municipality", 2017) as seen in the map of the province in Figure 1 below. It was chosen as it is a rural area, largely made up of farmlands, with a few small towns and built-up areas, and agriculture as the main contributor to the economy (Department of Cooperative Governance and Traditional Affairs, 2020).

Table 1

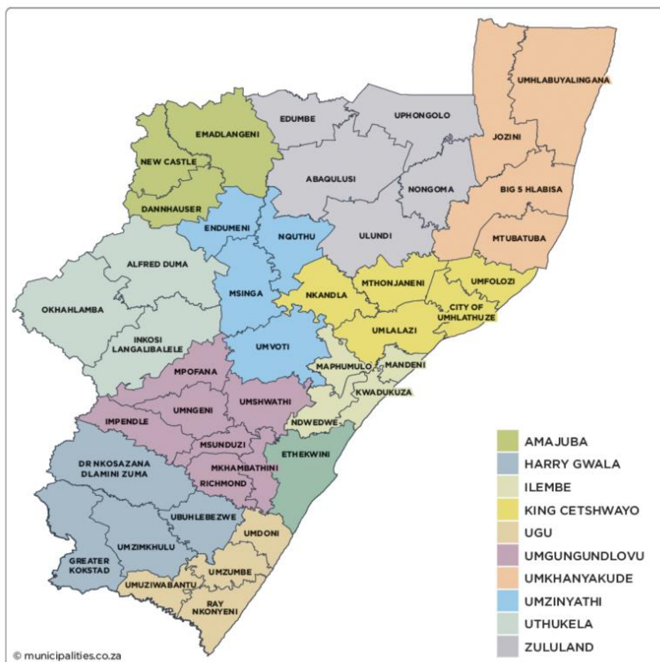
The iLembe district

Total population	678 048
Area size	3 269km²
Growth rate (2009-2019)	1.47%
Number of households	191 369
Average household size	3.4
Formal dwellings	73.9%
Access to electricity	70%
Access to piped water	18%
Unemployment rate	30.6%
Households below the food poverty line	63%

(Department of Cooperative Governance and Traditional Affairs, 2020)

Figure 1

Map of the KwaZulu-Natal province



(Municipalities of South Africa, 2021)

Table 1 reveals that 63% of the population lives below the food poverty line and the unemployment rate is about 31%, which could suggest that while just under 70% of the

population is employed, a lot of this employment is menial, such as farm work labour. As a result of the levels of poverty and unemployment, it is fair to conclude that the majority of the population in the district would rely on public health care. Consequently, the focus of this study was health services in the public sector. 90.8% of the population in this area speaks isiZulu as their home language (Statistics South Africa, 2019b).

The researcher is also from the area and has knowledge of the context. As this district is largely rural, there was a higher possibility of language discordance between occupational therapists and service users, which is another reason why it was chosen. With 86% of registered occupational therapists in South Africa being non-black (Y. Daffue, personal communication, January 13, 2021), the supposition that there would be language discordance in this area was warranted.

3.6. Participants

3.6.1. Description of population

The population of interest comprised occupational therapists who work, or have worked, in the public health sector in the iLembe district in KwaZulu-Natal. At the time of data collection there were nine occupational therapists working in the district: three permanent and six community service occupational therapists, with four working in the same regional hospital (A. Dawood, personal communication, January 13, 2021). There are four public hospitals (KwaZulu-Natal Department of Health, 2021a) and thirty-three primary health clinics in the iLembe district (KwaZulu-Natal Department of Health, 2021b). The occupational therapists are expected to serve some of these primary health clinics.

3.6.2. Sampling method

In qualitative research, the aim of sampling is to recruit participants that have rich, study-specific information to share (Sandelowksi, 2000). In addition, sampling is intended to be strategic in order to get participants who will add depth, nuance and understanding in answering the research question (Mason, 2002). Purposive and snowball sampling were used to recruit participants for this study. Purposive sampling involves carefully and purposefully selecting a site and a group of potential participants that will render the specific information that is desired (Holloway, 2008). Snowball sampling is a strategy whereby people who have agreed to participate in the research know of others that fit the selection criteria and refer them

on to the researcher (Omona, 2013). Snowball sampling was useful as the potential participants had greater knowledge of others who worked in the district, who met the selection criteria and who would potentially be open to partake in the research.

3.6.3. Selection criteria

The following criteria were used to select potential participants:

- Be an occupational therapist who works OR has worked in the iLembe district in the last five years (2015-2020).
    - Due to the shortage of permanent occupational therapists working in the district currently, the researcher was inclined to go back retrospectively for recruitment, and going back five years gave enough access to potential participants.
- Have had frequent exposure to language discordance in their work setting, i.e. did not share proficiency in the same language as service users.
- Willingly volunteer to participate in the study.

3.6.4. Sample size

There are no set guidelines on sample sizing in qualitative research, but the general assumption is that the sample should be big enough to ensure that the researcher reaches data saturation, but small enough to ensure deep, rich analysis (Omona, 2013). Guest et al (2006) propose that data saturation occurs after twelve to fifteen interviews, therefore in this study, a sample size of eight was chosen and each participant was interviewed twice in an attempt reach data saturation and having rich case-specific analysis.

3.6.5. The participants

All of the participants were female with an average age of 26.9. All of the participants were from South Africa, with the exception of one who was from Lesotho. The majority of the participants spoke English as their first language, as shown in Table 2, and most commonly experienced language discordance with the majority Zulu-speaking population. One of the participants, Monica, however, spoke isiZulu as her first language and experienced language discordance with Afrikaans- and Arabic-speaking service users. The majority of the participants had only had one year of experience in working in the public health sector.

Table 2

The participants' demographic details

Name[1]	Years worked at the Department of Health	Age in 2020	Race	Home Language	Second Language
Libby	2012-2019	35	White	English	Afrikaans
TDubbs	2019	26	White	English	Afrikaans
Riley	2019	26	White	English	Afrikaans
Cassandra	2019	23	Coloured	English	Afrikaans
Demi	2017	27	Coloured	English	Afrikaans
Monica	2018-present	25	Black	isiZulu	English
Harsha	2018	25	Indian	English	Afrikaans
Moh	2018	28	Black	Sesotho	English

3.7. Research process

3.7.1. Gaining access

Prior to recruitment of participants, ethical approval was obtained from the University of Cape Town's Human Research Ethics Committee (HREC) (HREC number 081/2020 - Appendix A). Thereafter, ethical clearance was sought from the KwaZulu-Natal Department of Health (Reference number: KZ_202002_023 - Appendix B). The district representative of the KwaZulu-Natal Occupational Therapy Provincial Forum was then contacted via email (Appendix C). Her contact details were found on the KwaZulu-Natal Department of Health's website. In 2020 the representative changed, thus the researcher had contact with two different representatives. The representatives were the first point of contact and acted as the gatekeepers. These are people with whom the researcher consults in order to gain access to potential participants in a specific research site (Kawulich, 2011). The gatekeepers were sent the recruitment poster (Appendix D), as well as the outline of the selection criteria. Thereafter the gatekeeper shared email addresses of potential participants who met the selection criteria. The representatives had access to the potential participants' email addresses through their district database. The gatekeepers thought it reasonable to give out the email addresses of the potential participants as it was a less personal and invasive contact detail than a cell phone

[1] These names are pseudonyms

number. The recruitment poster was not circulated on the researcher's behalf, instead the researcher sent out an introductory email (Appendix E) with the recruitment poster attached (Appendix D) to the potential participants.

3.7.2. Recruitment process

Recruitment began by contacting potential participants via email on one to two occasions (see Appendices D & E). In alignment with the inclusion criteria, twenty-five people that had worked in the district since 2015 were contacted; eleven volunteered to be a part of the research, though one did not meet the selection criteria. Two responded after the first eight participants had already been recruited. Recruitment ended once eight participants had been recruited. Ten people did not respond and four declined. No-one dropped out of the study. Those who volunteered were sent the information sheet and informed consent form (Appendix F) via email. Arrangements for the first interview were made and any questions raised were also answered. Due to the COVID-19 pandemic, the interviews were conducted virtually via Zoom, with the consent of the participants. According to preference, the researcher and the participants liaised via email and WhatsApp throughout the research process. All interview dates were arranged according to the participants' preference and availability.

3.8. Data collection

Data in qualitative description can be collected using a variety of methods such as semi-structured interviews, open-ended interviews, or focus groups (Sandelowski, 2000).

3.8.1. Interviews

Semi-structured interviews were deemed appropriate for this study. The purpose of interviews is to gain an in-depth understanding of the participants' views, and the primary intention of semi-structured interviews is to gain a description of the views of the participants, with the researcher facilitating sharing through open-ended guiding questions (Hansen, 2006). The guiding questions were documented in an interview guide (Appendix G). Interviews were conducted by the researcher between May and July 2020 and the interviews were approximately 45-75 minutes each. With the exception of one participant, two interviews were conducted with each participant. This was necessary to delve deeper into topics that were mentioned in the first interview and reflected on in the reflective journals. No-one else was present during the interview except the researcher and the participant.

A limitation to this data collection method is that participants may feel intimidated by the fact that they are being recorded with the potential to stifle sharing (Denscombe, 2010). By having two interviews, the intention was to make the participants more comfortable with being recorded and thus share more openly. In addition, participants got the opportunity to reflect twice, post interview, using reflective journals.

3.8.2. Reflective journals

Reflective journaling is a tool that aims to foster reflection and introspection (Anderson, 2012). Guiding questions or statements for the reflection were generated by the researcher, based on what the researcher thought the participant could elaborate on, clarify, or think about more critically (Appendix H). The participants were asked to comment in a format of their choice (journal style, bullet points, voice note), and in as little or as much detail as they desired. The answers from the first reflection were used to generate some of the guiding questions for the second interview. Although journaling may cause distress (Naber & Markley, 2017), the participants had a choice as to whether to journal or not, along with choosing the mode of journaling in order to alleviate any possible distress.

3.8.3. Data saturation

According to Guest et al. (2006), if a study has a fairly homogenous group of participants, then it has relatively specific objectives, and if a similar set of questions is posed to each participant, data saturation usually occurs quicker, with fewer interviews or fewer participants. As this study included a specific group, occupational therapists, the majority of whom were reflecting on their community service experience, and since the objectives were narrow and an interview guide was used, it was easier to reach data saturation. Data saturation was evident as the same sharing began to emerge and was repeated, across participants and by individual participants. Guest et al. (2006) note that data saturation usually occurs within the first twelve interviews and in this study, fifteen interviews were done in total. Each participant was interviewed twice, with the exception of one. This means that views were shared by eight participants.

3.9. Data management

Data was collected and recorded using audio recordings as well as typed reflections. The recordings were transcribed by the researcher and the transcripts were sent to the participants for verification. Participants chose pseudonyms and all data was stored using these pseudonyms. All data was stored on a password protected online storage facility, namely Google Drive, that only the researcher and supervisor had access to. Where possible all data was managed electronically. Any written documentation pertaining to the research is being kept in a locked cupboard and will be destroyed after five years. All data stored electronically will also be destroyed after five years.

3.10. Data analysis

The data was analysed using thematic analysis, an apt form of analysis for qualitative descriptive research as it is not bounded to a specific epistemological frame of reference (Maguire & Delahunt, 2017). Thematic analysis involves locating patterns, whereby both semantic and latent meanings are interpreted inductively or deductively or both, in order to meaningfully address the research question (Maguire & Delahunt, 2017).

Braun and Clarke (2006) outline a six-step process for undergoing thematic analysis, which was used as a guideline for this study. The steps read as follows: 1) become familiar with the data, 2) generate initial codes, 3) search for themes, 4) review themes, 5) define themes, and 6) write up. The first step, 'become familiar with the data', involved immersing oneself in the data by repeatedly reading the interview transcripts and jotting down initial insights. This step was adhered to.

Step two, 'generate initial codes', was guided by Charmaz (2006), whereby line-by-line coding was done, in order to identify as rich, and as many, small segments of meaning as possible. The coding in this research was done by hand and 1461 codes were generated by one coder: the researcher. Coding was guided by the original objectives, including looking for descriptions of the thoughts and feelings of the occupational therapists in relation to how they approached language discordance and the context in which language discordance took place, factors contributing to or perpetuating language discordance, quality of services in relation to language discordance, and recommendations in navigating language discordance.

The third step, 'search for themes', involved reading through the initial codes to begin to identify broad themes (Maguire & Delahunt, 2017). The codes were systematically read, and hand sorted into different groups based on their patterns of meaning. This was an inductive process, in that the groups were generated by the codes, as opposed to codes fitting into

predetermined groups. These groups were given simple tags to easily distinguish one group from another. Thereafter, these simple tags were replaced with formal descriptors to become categories or broad themes, as described by Maguire and Delahunt (2017). The sorting of the codes was repeated to ensure that they were placed in the correct category. There were eleven categories and eight sub-categories in total.

Step four, ‘review themes’, involved moulding and developing the preliminary themes that were identified in the previous step. It is imperative to organise all the data to fit under each relevant theme (Maguire & Delahunt, 2017). The eleven categories were inductively placed into four preliminary themes by grouping categories that had shared meaning. Later, the categories were placed into four pre-set preliminary themes that were determined by looking at the categories as a whole.

The fifth step, ‘define themes’ pertained to refining and gaining the essence of each theme. This fifth step may yield sub-themes but none were educed. The four preliminary theme names were adjusted to best describe the essence of what the themes encapsulated. The last step ‘write up’ involved writing up the findings from the thematic analysis in the dissertation (Maguire & Delahunt, 2017), which may be found in chapter 4.

3.11. Quality in qualitative research

Rigor in qualitative research can be achieved by meeting the following trustworthiness criteria: credibility, confirmability, dependability, and transferability (Guba, 1981). Various methods were used in the intended study to ensure that the trustworthiness criteria are met.

Credibility pertains to accuracy; accurately portraying the results using various sources (Guba, 1981). Credibility can be assured by using: member checking, triangulation, reflexivity, peer briefing, and immersion (Liamputtong, 2013). Member checking was used to assess the accuracy of the interpretations of the data. This was done by bringing the findings back to the participants and checking if they agreed with the interpretations and conclusions (Creswell, 2014). This technique was employed in the final interview. The participants were also given an opportunity to review their individual interview transcripts.

Triangulation refers to using multiple data sources, methods, and perspectives in order to gain a comprehensive and valid picture of the data analysed (Creswell, 2014). Data was collected using two different data collection methods, semi-structured interviews and reflective journals,

while the different perspectives and inputs of the researcher and the supervisor assisted in strengthening the interpretation of the data.

Reflexivity, a strategy used to ensure credibility, involves the researcher examining and explicating their views, assumptions and beliefs so that the reader is aware of how the researcher's background influenced both the interpretation of the data and the formation of the study (Creswell, 2014). A reflexive journal was kept by the researcher throughout the research process, with thoughts and emotions pertaining to the research being recorded. The researcher used the journal to document thoughts immediately after each data collection session.

Peer briefing also aids credibility as outside input assists in validating and stretching thought processes and findings that emerge (Creswell, 2014; Liamputtong, 2013). The comprehensive input given by the supervisor falls under peer briefing. In addition, the researcher got substantial input from lecturers and fellow classmates in the beginning stages of developing the research study. Another technique that serves to strengthen the credibility of the study is immersion. Creswell (2014) proposes that the more time a researcher spends with participants, the more the credibility of the results increases. In this study there were eight participants recruited, fifteen interviews done in total and fourteen reflective pieces written. The researcher transcribed and hand coded the data independently, all of which indicates that the researcher deeply immersed herself in the data.

Confirmability is a measure of trustworthiness intended to affirm that the results are based on the participants' perspectives and not tainted or interpreted by the researcher (Guba, 1981). Confirmability can be assured by using an audit trail (Liamputtong, 2013). An audit trail consists of a detailed account of the theoretical, methodological, and analytic decisions, processes and interpretations that are pursued from the conception of the research topic (Liamputtong, 2013). In addition, themes were clearly supported by the data, with relevant direct quotes used to explicitly illustrate the inferences made, which ensured confirmability.

Dependability links with describing the research process in such detail that it could be replicated (Guba, 1981). This can be assured by using techniques such as an audit trail, thick description of the methods used, triangulation, and peer briefing (Creswell, 2014; Liamputtong, 2013), all of which have been described above. Dependability was also strengthened by ensuring that the research process was in alignment with the chosen research design.

Transferability is concerned with offering a detailed description of the context and other relevant information in order to ascertain whether the results could be transferred into other contexts (Guba, 1981). This can be achieved by using thick description of the research setting (Chilisa, 2012). Thick description involves providing a detailed account so that the reader clearly understands the setting and multiple experiences of the participants, adding richness to the findings and ensuring validity (Creswell, 2014). Transferability was applied by writing in-depth accounts of the participants' experiences and of the research context. The findings could be transferred to other contexts where language discordance is experienced by the majority population, but is still relevant wherever language discordance is present.

3.12. Ethical considerations

The Helsinki Declaration (World Medical Association, 2013) outlines certain ethical considerations that must be adhered to when conducting research with humans. This declaration and *four ethical principles* (Beauchamp & Childress, 2013) were adhered to.

Autonomy is the right of potential participants to make an un-coerced, informed choice to act in a certain way with no negative repercussions (Beauchamp & Childress, 2013). Autonomy was ensured by providing potential participants with an information sheet and informed consent form (Appendix D) prior to data collection, which gave them time to engage with the content of the research. The information sheet outlined that the participants partook in the research under no duress, were allowed to leave the study at any time, could decline to answer any question, and could request any information shared to be removed from transcription or analysis. The participants had full control over when the interviews would be held, if the video would be switched on or not, and in how much detail they shared. The above methods were put in place to promote the autonomy of the participants.

Negotiating informed consent: the potential participants were asked to sign the informed consent form and send it back via email to the researcher. They were also given the opportunity to ask questions about the research via email before the interview. In the first virtual interview, an opportunity was also granted for questions to be answered. Most of the participants had no questions and all participants signed the informed consent form prior to the first interview. The informed consent forms were then signed by the researcher and stored electronically.

Nonmaleficence is about ensuring that “one ought not to inflict evil or harm” (Beauchamp & Childress, 2013, p. 152), meaning that there should be minimal risk of harm by participating in the research. Language issues tie in with issues of race, ethnicity and power, making the topic of this study somewhat sensitive, especially in the South African context. Thus, participants may have been hesitant to share their thoughts and views and may have experienced slight unease. Post interview debriefing was made available to the participants by the researcher, however, no participants requested these services. Using pseudonyms for the participants when writing up the findings will ensure confidentiality (Beauchamp & Childress, 2013). The option for debriefing and using pseudonyms are measures that were put in place to ensure that the participants experienced minimal harm.

Beneficence connotes the researcher being morally obligated to act in a way that benefits the research participants (Beauchamp & Childress, 2013). There was no monetary gain for participating in the research, but participants may indirectly benefit by assisting the researcher in forming contextually relevant knowledge that can have an influence on practice.

Lastly, *justice*, the need to be consistently fair (Beauchamp & Childress, 2013) in ensuring that participants are treated appropriately and equally. There was fair access to participate in the research for anyone who met the selection criteria, and it was on a first come, first served basis.

Chapter 4: Findings

4.1. Introduction

This chapter describes the four themes and their associated categories that were generated from the semi-structured interviews as seen in Table 3 below. Findings from the participants' reflective journals will also be included in this chapter. Verbatim quotes from the interviews and journals will be used to substantiate the findings. To start off this chapter, a few of the participants' definitions of language discordance are presented.

4.1.1 Defining language discordance

Language discordance is not a common concept in occupational therapy, therefore it was important to establish the participants' definition of it to show how their definitions shape their sharing and the subsequent data analysis. This is how they defined language discordance:

> "Language discordance was **my** lack of proficiency in isiZulu in needing to communicate with Zulu-speaking clients/patients during my sessions" (Cassandra – Reflective Journal I Entry).
> "I would define it as the challenges faced when a client and health professional speak different languages and intervention needs to take place regardless" (Demi – Reflective Journal II Entry). "Difference in language and cultural literacy and competence between patient and service provider" (Libby – Reflective Journal I Entry).

These definitions illustrate that the participants view language discordance as something similar to what the literature shows; it involves challenges and resilience, it includes both linguistic and cultural components, and one participant even personalised and took responsibility for language discordance.

Table 3

Themes and categories

Theme	Categories
Using various communication strategies concurrently	Using an interpreter Attempting to use the service users' languages Using other modes of communication
"*Language definitely impacts that therapy process"*	Impact on the quality of care Language as a necessity in the therapy process

	Impact of demographics on ease of communication
Factors perpetuating language discordance	Attitudes towards learning others' languages Influence of cultural and linguistic nuances Poor educational preparation
"I'm doing everything that I can, what more can I do?"	Adopting an attitude of being kind to oneself Going the extra mile

4.2. Theme 1: Using various communication strategies concurrently

This theme encapsulates all the methods that the participants employed, often simultaneously, in order to communicate with service users, as TDubbs indicated, *"if one way doesn't work you try another. You don't just give up because you can't speak, you can't verbalise…there's ways around it"*.

The strategies used were mainly: 'using an interpreter', 'attempting to use the service users' languages' and 'using other modes of communication.' These strategies will be described, and the advantages and disadvantages of each will be discussed.

4.2.1. Using an interpreter

The most commonly used strategy to navigate language discordance was interpretation. All the participants reported using interpreters to varying degrees and in different ways, to assist them in communicating with service users during assessment and treatment. These interpreters were informal, untrained people who could speak the service users' languages, such as co-workers, family members, volunteers or other service users. In the absence of interpreters and/or coupled with interpretation, technology was used for translating text.

4.2.1.1. Having co-workers as informal interpreters

The term co-workers encompasses fellow multi-disciplinary team members such as nurses and physiotherapists, as well as other co-workers such as security guards, Human Resources (HR) interns, clerks, and maintenance workers. Participants had different reasons for choosing who would act as the informal interpreter, but the decision largely rested on; 1) who was available at the time, 2) their level of English proficiency, 3) their qualification, and 4) the amount of time that their co-worker had to assist them.

Harsha and Demi shared one big room with the entire rehabilitation team, and only had space for one therapist to see a service user at a time. This meant that co-workers, who were more proficient in isiZulu or were Zulu-speaking, were inadvertently present during their sessions and available to interpret. Libby, on the other hand, reported a more haphazard, frustrating process, saying "*you run around like a headless chicken in the ward trying to beg any nurse to help you*". TDubbs found that she had to request assistance in advance for a Portuguese-speaking audiologist to assist in her sessions with a Mozambican family: *"if it was that baby clinic…that week uhm…I would always ask…uhm the audiologist to, to just be available"*.

In terms of the co-workers' English proficiency, the majority of the participants expressed that fellow health professionals and non-health co-workers were proficient enough in English to interpret for them. This is illustrated by Cassandra's comment: "*just reflecting in terms of the workplace, I mean most of, well everybody there spoke English and understood English…so communicating with rehab or any other department wasn't that difficult*".

Participants had different views regarding the choice of interpreters, with some leaving co-workers' qualifications out of consideration. Moh, for instance, stated that she could ask anyone, like an admin clerk, for interpretation assistance, and as long as she used laymen's terms, she had confidence she would get the interpretation she needed. Other participants however, raised concerns over asking co-workers who were not occupational therapists, or at least trained in health sciences, for interpretation assistance, as they felt it dampened the efficacy of the interpretation and raised ethical issues. An example of this view was captured by Cassandra in her reflective journal entry:

> Although the physios were trained in rehabilitation, OTs [occupational therapists] have a different perspective and focus when assessing and treating a patient. I was not able to follow up on certain questions/information with the patients as neither the physio or patient understood what I was asking (Cassandra – Reflective Journal I Entry).

Monica commented: *"there was a time when I would ask like, a colleague or…another health professional, to help* [interpret]. *It was also a lot easier because, obviously with the confidentiality".* This quote illustrates Monica's decision-making to only ask fellow health professionals for assistance with interpretation because she assumed that they understood and valued the principle of confidentiality. Another consideration was that health professionals understood, to a certain extent, how to relate to service users, a skill non-health professional co-workers did not necessarily have, as illustrated by Demi:

> *What was also challenging was…you know, I have to make sure that the translators wouldn't laugh…or you know, they would have to be sensitive, you know because imagine an HR intern…she doesn't know…you know, how you have to handle yourself and present yourself during a session.*

Most participants were aware of their co-workers' time constraints when requesting assistance, as they recognised that interpretation went beyond their co-workers' job descriptions. The participants would therefore often get interpretation assistance at prime moments in the occupational therapy process, for example, at the beginning of a session for assessment purposes or at the end to confirm home programmes. Some participants found it helpful to voice record the service user's answer, leave the session, and get that answer interpreted. As Riley explained: *"one of the biggest struggles is understanding the answer! So if they* [the service user] *allow it, recording it and getting someone to translate what they said".* This strategy aided in protecting the service user's identity.

The most common critique or disadvantage of using (informal) interpreters was the obstacle of information getting lost in translation. The participants felt that information was on occasion summarised, left out, added, or misinterpreted. In addition, many participants revealed that they felt disempowered by having a co-worker interpret for them, as Cassandra expressed: *"me asking the physio to translate…for me, almost gave them* [the physios] *that power uhm, in…uhm, within the rehab facility*".

Despite the willingness of the majority of the co-workers to assist, all the participants touched on the unwillingness of nursing personnel to be of aid, as highlighted by TDubbs and Riley respectively: *"the nurses are never always happy to, translate, cos I feel like they kind of expect you…working in a government facility to…speak the basic language"* and "*when you're by yourself in a ward…90% of the time the nurses are not going to help you".*

In contrast to other participants, Moh specifically mentioned that the nurses were more resistant to assisting her with interpretation because she is black and therefore expected to be fluent in isiZulu. She said, "[the nurses would ask] *how did you expect to survive in KwaZulu-Natal if you're not gonna learn the language?"* This could signal the intolerance felt by the nurses regarding the limited language proficiency of fellow Africans as compared to practitioners of other race groups.

Libby added that, in her case, it took time to befriend the right nurses and that favours were not granted for free:

> *At the end of the day they* [the nurses] *got their own jobs to do. This* [interpretation] *is not in their sort of role, scope, so…you know, ja, you kind of learn to make friends or you learn to have the stash of chocolate lying around.*

It seems to have been harder to obtain nursing personnel's support with interpretation as compared to other co-workers. On the other hand, buy-in from family members and caregivers was much easier to obtain, which will be explained in section 4.2.1.2.

In one institution, matriculants from the area volunteered (temporary volunteer co-workers) at the hospital as informal interpreters, in an attempt to get a good reference for future employment. Libby describes what it was like having them around;

> *That* [having interpretation volunteers] *was really useful, so obviously it wasn't a steady flow and it was kind of hit or miss whether they were there, and they didn't necessarily have…the skill set to be a…correct interpreter…but it certainly is helpful having someone who can speak basic English and basic, whatever other language is in the area.*

Although volunteers were helpful, it seems their availability was not guaranteed and, due to lack of training in health care, the quality of their interpretation was questionable. Having informal interpreters available was an advantage, but the disadvantages include no interpretation or health training, which can lead to miscommunication and unethical practice.

4.2.1.2. Having family members' and the communities' English proficiency as a resource

Participants identified that it was an asset to have family members included in the session in order to interpret. Some participants relied on younger family members such as school-going family members or caregivers to interpret when working with elderly service users. Some participants asked parents to interpret for them in paediatric sessions, as Riley indicated: "*a lot of the time as long as the parents understood me, they'd explain it to their own child in Zulu*".

Some participants mentioned that they felt that including a family member in the session as an interpreter presented a lower confidentiality risk in comparison to asking a co-worker or a stranger, and this could be seen as an advantage. TDubbs added that she felt comfortable having family members in the session as it forms part of occupational therapy's holistic approach.

Participants also described that the community in which they worked got accustomed to having non-Zulu-speaking health professionals attending to them and that they would prepare accordingly. An example of this preparation was shared by Harsha:

> *They* [the community] *knew that uh the clinic itself got a lot of comm serves…and…a lot of them were, you know, different races, came from different provinces…they would just see our faces and they would know, like okay, maybe we need to send someone who speaks English*.

Overall, it seems interpretation offered an opportunity for collaboration between the participants, willing co-workers, family, and the community. In the absence of this collaboration, or coupled with this collaboration, was the participants attempting to actually speak the service users' languages.

4.2.2. Attempting to use the service users' languages

Attempting to use the service users' languages outlines the second category of the theme 'using various communication strategies concurrently'. The way in which the participants attempted to use this strategy included 'using short and simple phrases to convey basic meaning' and 'learning and immersing oneself in the service users' languages and cultures'.

4.2.2.1. Using short and simple phrases to convey basic meaning

Participants expressed that they mainly used single words or short phrases, not full sentences, to convey basic meaning during therapy. Participants referred to using broken isiZulu, but had different definitions for it. Moh explained broken isiZulu as "the isiZulu spoken with grammatical errors in an attempt to get the conversation going" (Reflective Journal I Entry) whereas TDubbs said that broken isiZulu is "vocabulary, not full complete sentences, English words used among Zulu words to make into sentences/make up for the Zulu that is unknown and not fluent/conversational" (Reflective Journal I Entry). Libby mentioned that she would use a mixture of multiple languages, coupled with actions to convey a message. She said, "*you kind of potter along in a bit of English, a bit of sign language, a bit of Afrikaans, a bit of acting and a bit of Zulu".* This indicates that her multilingualism was an advantageous strategy that aided in communication, even though her proficiency in isiZulu was inadequate.

On the other hand, Riley asserted that it did not matter if she only spoke using short and simple phrases, with incorrect grammar, the goal was to convey a message, and this was achieved. TDubbs and Moh agreed that even just one or two words helped to convey a message and build rapport;

> *If you know one word, or two words in a sentence that you're wanting to say, it's amazing how much more of an understanding they do gain, even if it is in a bit of a…like a different twang, or accent sort of thing, they, they completely understand it better and it…it does make…that communication…barrier, less* (TDubbs).

Riley did note that there were limitations or disadvantages to only communicating using short and simple phrases;

> *We learn when you're assessing pain…, you use a scale system, you ask them how the pain feels, you know, all these different questions…if I'm wanting to know I'd be like… Is it sore…where? …**that's all I could ask them*** [emphasis added].

In addition, Libby commented that speaking in single word-form made therapy very verb-based and concrete, which took away from the richness of the occupational therapy philosophy and process. Cassandra added that; *"you an English, uh speaking person and you speaking to someone who's home language is Zulu…and you have to go basic, basic, basic Zulu and your Zulu is not…*[laughs] *your vocab of Zulu, is like, it's minimal and that was an issue for me".* This indicates that when the occupational therapist's vocabulary in the service user's language is limited, communicating in laymen's terms, or what Cassandra refers to as basic isiZulu, was even more challenging.

Attempting to speak the service user's home language shows the participants' dedication to resolving language discordance, although there were notable challenges in conveying a message. The process and ways of learning the service users' languages will be described in the section below.

4.2.2.2. Learning and immersing oneself in the service users' languages and cultures

Even though the majority of the participants completed one to two semesters of isiZulu courses at university, they felt unprepared when they entered the work force in a Zulu-speaking context. TDubbs commented: "*I had no confidence in speaking it* [isiZulu] *whatsoever…but eventually like you start to learn…like, word by word, as you go along*".

Moh, in particular, continued learning isiZulu at university, beyond the first semester course, as a result of being in a predominantly Zulu-speaking friend group. Other participants began learning the language properly when they started their community service. Along the way, participants made use of various sources to improve their isiZulu, such as learning from the nurses, clerks and physiotherapists. Moh found that listening to isiZulu Gospel music and reading the lyrics extended her vocabulary beyond therapy language. TDubbs and her housemates, who were also community service health professionals, made it their goal to learn a few words of isiZulu after hours each week.

Three participants found writing down new words that they learnt aided them in committing the words to memory. Learning isiZulu or another language was something that required preparation, as Moh stated:

> *After the session I'll, I'll go and learn the, the terms, okay, this is what this word means, this is what this sentence means…by asking other people again…so that for the next time, then, if I come across such a word or such a phrase, then I know, okay, this is what this means.*

Monica added:

> *If the patient is going to come again, like I remember with the…Afrikaans patient, they, I think they came a few times uhm…, I obviously had to kind of, learn at least a few…basic Afrikaans, so…just for me to explain, arm or leg, or pain or…move, the, or whatever it is, just so for me to be able to communicate with them.*

Being immersed in a Zulu-speaking environment helped some of the participants in learning the language. For example, two of the participants who lived on the hospital premises, shared accommodation and socialised with Zulu-speaking co-workers, found that their ears became more attuned to isiZulu and their vocabulary increased as a result. For the majority of the participants, working in a predominantly Zulu-speaking context and being surrounded by Zulu-speaking co-workers aided their learning the language and may be seen as an advantageous strategy.

However, there were mixed views on the process of language learning as experienced by the participants. For instance, Moh found that her receptive language skills developed faster than her expressive language skills, whereas Harsha reported that she picked up on the questions that she needed to ask in the assessment process first, perhaps quicker than her receptive skills developed. Some participants found learning isiZulu to be an empowering experience. They were motivated to do so, and felt that it was a necessary part of doing their job, as

expressed by Riley and Harsha respectively; "*I would **constantly** be reminding myself of what those words are"*, and,

> *I wanted to be independent, to be able to stand on my own two feet…and not have to rely on someone the whole time. That was mainly what pushed me into learning it* [isiZulu] *myself. It was just, temporary, to have that help*.

Demi in particular, felt less urgency to learn isiZulu as she always had somebody to assist with interpretation, and she expressed that she lacked the propensity to pick up the language. On the other hand, Riley and Harsha found that they picked up isiZulu relatively quickly and easily.

The majority of the participants shared that they noted progress in their ability to communicate in isiZulu, steadily from the beginning of their working career to a few months in, or towards the end of the year. The participants recognised that richer language skills equipped them to better delve into deeper topics with their service users. Increased language skills also meant that the participants relied less on other communication strategies, as indicated by Harsha: *"then towards the end I was using…a lot less, Google Translate, a lot less pictures. I picked up the language".*

Despite attempting to learn the service users' languages and immersing themselves in the context, the participants noted that they still needed to rely on other modes of communication to supplement verbal communication, which will be discussed in the next category.

4.2.3. Using other modes of communication

Other modes of communication that the participants employed in their attempts to navigate language discordance included the therapist doing therapy in a certain way, or allowing the service user to actively do therapy. In addition, non-verbal communication as well as visual aids, online and self-made dictionaries, Google Translate, proforma scripts and collateral sources of information were used as other modes of communication.

4.2.3.1. Doing as a communication strategy

In addition to having interpretation assistance or using short phrases, participants reported relying heavily on demonstration in their therapy sessions to communicate. Riley said, *"nine times out of ten I was using my…painful Zulu…while uhm…demonstrating what I was saying,*

so it was actually two-fold, uhm…because obviously my Zulu wasn't really…enough, description for a lot of people".

The participants also required their service users to act out what was being shown to them, in order to ensure that the activity or exercise was comprehended. This strategy was often learnt after a while, as participants noticed that demonstration alone was not adequate. Riley found that demonstration had its limitations, especially when it came to anything cognitive or psychological.

> *Physically you can show someone…uhm, you know, this is how you must bend your leg, this is how you must use crutches, this is how you must do this…but you can't physically show someone, shared attention* [chuckles] *…you can't physically show someone…hallucinations* (Riley).

Other participants found that a way to navigate language discordance and provide their services was to do a hands-on session, playing on the strength of occupational therapy being activity-based. Demi explained: "*if there was no English at, at, at all, and I just had to rely on my…skills and had to make sure that the, the…the activity was so engaging that…you know I didn't…speech wasn't really…a thing*".

In addition to using activity, the participants explained that they had to be open to the activity changing if their instructions were not understood.

> *You've gone there with an idea, you want them to paint…uh…their favourite, animal, onto this piece of fabric…and you cannot communicate with them, but they take those…fabric paints and the brushes and they explore and they find like, uhm…like, out of, in terms of like a leisure time activity or just a mindfulness activity or you can see they experiencing flow…like, they are benefiting, like, out of it. Yes, you have gone there with a specific idea of what you want to achieve but…like, accommodate for that, adapt it* (TDubbs).

Adaptation seemed to have been important when using an activity; it formed part of reflection in action during therapy, which is a fundamental skill in occupational therapy. This will be discussed in more detail in section, 4.5.2.

Participants found that doing in the form of demonstration, gestures, touch, pointing, and using and reading body language assisted them in navigating language discordance. These communication strategies were often used in conjunction with visual aids, and using short and simple phrases. Monica stated, "*so more using visual aids or…uhm…using hand gestures or*

any or, or like, almost like trying to use my…body almost [chuckles]*, to kind of help, for them to understand what I'm trying to say*".

Libby explained that relying on non-verbal communication was sometimes inconsistent. She commented: "*you try to* [show your passion] *in your gestures, you try to in your non-verbals* [sighs] *but you know sometimes it is a hit and miss*". Relying on activity as a means of communicating, coupled with using gestures and pointing seem to have aided the participants in navigating language discordance, especially in conjunction with verbal communication. Other modes of communication were also used.

4.2.3.2. Using visual aids, manuals, proforma scripts and collateral sources of information

This sub-category includes all the other strategies the participants used to navigate language discordance. However, these were not the predominant strategies used. Visual aids used included charts, pictures found on assessment forms, and pictures on home exercise programmes. Videos and pictures found online were also accessed. Some participants found it useful to access words (a manual) on a Department of Health website, but they did note the limitations or disadvantages thereof, as stated by Cassandra: "*I used the manual, whatever was on the department's website...that, then, then is limited. It was quite general and not OT specific...uhm, there are terms in OT, like there is just no translation*".

Participants like Harsha and TDubbs found that using technology, such as Google Translate was helpful, although they noted its disadvantage of only accurately translating one or two words. In addition, translation of health-related words was also inconsistent. TDubbs added that she was mindful of when to use Google Translate as she relied on the service user's cognition and reading ability; she would ask the service user to read the translation as opposed to her saying the words in her English accent.

The internet accessed on the participants' phones was also used to communicate through videos and pictures, in addition to interpretation and other communication strategies, as illustrated by TDubbs;

> *You can use, videos, you can use like, technology, like, to your advantage now…if you have a video of a certain exercise or a certain, movement or…of a device that you want to provide them, or anything like that. You could show them the video or the picture and communicate through…diagrams or communicate through…ja, uhm, through the use of technology*.

Collateral sources of information such as service users' files and reports from fellow co-workers, if available, were also useful ways of navigating language discordance. Libby found that self-made proforma scripts for para-suicides were an effective communication tool: "*we kind of developed a proforma that you could ans-, that you could ask questions directly off the form in, you know pre-translated…and usually the answers you could kind of anticipate what the general set of answers would be"*.

Though the strategies described above were not the dominant modes of communication, they were also used to ensure communication and understanding during the occupational therapy process. The participants appeared to have tried by all means to facilitate communication.

Theme 1 covered the various strategies that the participants employed, often concurrently, in their attempts to navigate language discordance. Some strategies were more successful than others. The participants' agency and willingness to provide services was also evident in their approach. In addition to the challenges presented in Theme 1, there was an overall impact on the occupational therapy process, which will be discussed below, in Theme 2.

4.3. Theme 2: "Language definitely impacts that therapy process"

This theme describes the impact that language has on the entire occupational therapy process, best explained by Riley: "*firstly your assessments are…simplified, your…treatment methods are, limited, your treat-, your client factors are, are shortened because you're not looking at all of these areas because how you gonna dive into all these things?*"

The categories that make up this theme are languages' 'impact on the quality of care' and resulting breach of ethical principles, 'language as a necessity in the therapy process', and the 'impact of demographics on communication'. The first category was made up of sub-categories, which will also be discussed.

4.3.1. Impact on the quality of care

The participants unanimously reported that language discordance greatly impacted the quality of care that they could provide. An example of quality care was captured by Cassandra:

> Quality health services refer to the services provided by health professionals that not only meet the institutions standards of practices, but are efficiently provided, responsive to the

patients/clients' needs and ensure patient/client satisfaction and an overall good experience at the institution (Cassandra – Reflective Journal I Entry).

4.3.1.1. Impact on the occupational therapy process

The participants described that language discordance and subsequent miscommunication or lack of communication, had a knock-on effect on the quality of the care that they could provide. The effect on the quality of care would begin with the lack of holism or range of their assessments and history-taking, which in turn would affect the depth, suitability, and range of treatment. In addition, the ability to provide client-centred and comprehensive home programmes was also negatively affected by language. The participants reported feeling as if their therapy was basic, generic, concrete or just covering the bare minimum, as one participant commented: "*I know that if I could communicate in my home language that person would get a **much** better service than what I am currently offering"* (Libby).

Most of the participants spoke of the frustration of knowing that their services could have been better and struggled with feelings of inadequacy due to not being able to connect with their service users. The participants acknowledged that building rapport is a fundamental part of the occupational therapy process, and that it was negatively impacted by them not being able to connect with their service users. They were all in agreement that their ability to build rapport was hindered due to language discordance as described by Harsha: "*I think what I found probably to be the most difficult was actually like building a rapport with my patient, who couldn't speak the same language as me*".

In occupational therapy client-centredness goes hand in hand with having strong rapport. Client-centredness is the process of ascertaining and focusing on the goals that the service user chooses. TDubbs reported that:

> *If you're not able to paint that…that, like descriptive image of…what this person wants, you almost, you're going in your own direction, you're having your own goals…you…you kind of…I don't know, drawing the path for them, instead of doing it together, and collaboratively.*

The participants reported that due to language discordance, they often felt more like physiotherapists, whereby client-centredness, mutual goalsetting, and building rapport were less of a focus, as illustrated by Libby: "*a lot of the psychological work, the trauma processing, psychiatry, is kind of lost…uhm, you just don't get that richness, it becomes very…almost*

physiotherapy-like…at times. The more limited your language, the more concrete your therapy is". Cassandra supported this notion;

> *I would say that, that language is an enabler...uhm...in helping, or, or achieving the goals and...uhm...ja, meeting the needs of, of the person which is at least person-centred or client-centred uh, therapy…it's just a means of getting there and…by, and if you don't have that it just takes away from the quality of your service*.

There was consensus that language discordance impacted the quality of the care provided and led to them feeling that they themselves and their care was inadequate. However, this was not the only impact observed, as will be presented in the next sub-category below.

4.3.1.2. Breaching ethical principles

All the participants reported that they encountered ethical dilemmas in their language discordant situations. For example, Demi explained that:

> It wouldn't be right, for me…to exclude them [an interpreter] just because I want it to be private…informed consent includes providing information to a client in a language that they understand, so using a translator was the only way I could do that [Reflective Journal I Entry].

The participants recognised that using an interpreter broke service user confidentiality, but they often had no other option. They also recognised that the benefit gained (beneficence) from therapy was sometimes reduced because they could not speak the service user's language, as explained by Monica: *"I didn't feel comfortable with…the…how the treatment went…or how the session went rather…uhm…because I knew that I could have done more…I could have gotten more out of them…I could have uhm…shared a lot more, but I just, couldn't".*

In addition to beneficence being compromised, participants recognised that the service user's autonomy in goalsetting was diminished by language discordance:

> *In order for us to know what the patient wants...or for us to help a patient achieve independence, or achieve their goals...we need to know what the person wants...if you are not able…to ask the right questions...to get the answers to that, you won't be able...to understand what they need and if you don't understand what they need, then you're not able to meet...their, like what they aim to do* (Cassandra).

There were varying perspectives among the participants on whether harm was caused due to language discordance. Some participants argued that decreased rapport and limited services

did not harm the service users, whereas others were adamant that language discordance negatively impacted comprehension of home programmes, or care in general, which could lead to harm being caused. Libby stated that: *"the non-maleficence, I think that's still the spirit in which people work…uhm…well I hope! And even when you can't speak the language…I think intent goes a long way*".

Language discordance seems to raise ethical dilemmas for the participants, but they affirmed that they were doing the best that they could with what they had in those moments. The next section looks into language as a necessity in the therapy process.

4.3.2. Language as a necessity in the therapy process

The participants recognised that having adequate language proficiency was a necessity for the provision of their care. Monica, as a first language Zulu-speaker describes how:

> *Immediately when I'm greeting you…you are greeting me, I greet you, we…automatically have a communication. I can ask you what's wrong or what can I assist you with and it's easy and, and already…it's, it's easy for me to understand what is wrong with you, even before me assessing you…or before treatment*.

Cassandra added that when communication is lacking, it is extremely difficult to interact with service users, something that she only realised once she arrived at her placement. Libby confirmed this by saying: *"someone's had their…you know, hand half chopped off at work, you need to be able to coach them through the psychological process too, and then you can't do that*".

It appears that half of the participants, only reflected on the importance of language in delivering good quality care in hindsight, after completing their community service and beginning work in the private sector. This is described best by TDubbs: "*I don't think I…I was fully aware of how much more you could actually offer patients, like being OT's…uhm…because of that language barrier, or language…discordance*".

Participants have affirmed the importance of language in providing occupational therapy care, albeit often only realising upon later reflection exactly how crucial language is to the core of the profession's practice. In reflecting on the importance of language, mention can also be made of how demographics impact the quality of communication with service users, which will be discussed in the next category.

4.3.3. Impact of demographics on ease of communication

The participants described that certain demographic characteristics of the service users, such as age, diagnosis and background, resulted in ease or difficulty in communication. Starting with age, participants shared that working with school-going children, who were likely to be learning English as a second language, and young working adults, who were more likely to speak English for their work, were easier to communicate with, as they could communicate in English. On the flipside, the participants found it difficult to communicate with the elderly because they had less or no English proficiency and also spoke a purer, less colloquial isiZulu.

Participants had mixed views with regards to children: Libby found that working with children was easier as her command of isiZulu matched theirs, and the language of therapy was play. Cassandra, on the other hand, described that without a shared language with a child, she lacked spontaneity and the ability to give praise, which she thought vital for paediatric occupational therapy.

The participants unanimously stated that communicating with service users with simple, physical diagnoses was easier, as assessment and treatment were often straightforward and they could rely more on demonstration and observation. Service users with psychiatric or intellectual conditions were harder to communicate with, as participants had to rely more on verbal communication to ask and listen to more qualitative, psychological-based questions and answers. In addition:

> *It's really difficult for people who don't understand what you are saying to understand what you want them to do, now you have someone with an intellectual impairment who will find it even more difficult for you, uh, for them to understand what...you know, what you want them to do* (Cassandra).

Monica explained that greater fluency is required in certain situations: "*any complicated hand injuries that have like…m-, any nerve injuries or…tendon injuries. Definitely psych…uhm I think more complicated psych, would be a lot more difficult to…uhm…communicate*". She also found that, as a first-language Zulu-speaker, there were often no direct translations for particular health and occupational therapy terms, which made communication less effective even when treating a Zulu-speaking service user.

The participants worked in a variety of rural and peri-urban locations. Riley noted that since 80% of the rural Zulu community did not speak English, naturally, communication was going to be more difficult. Libby found that service users in rural contexts were often a lot more

gracious and willing to fumble along in broken languages, whereas she experienced resistance to speaking a mixture of broken isiZulu and English in the peri-urban context. For the most part participants expressed that their attempts at speaking broken isiZulu were appreciated by the service users. There was also a level of service users being understanding, as explained by Harsha; "*I think they understood, like, okay, it's not your first language…and…we can see that you are* ***trying*** *to speak our language*". Moh was even praised for speaking isiZulu very well despite it being her third language. Participants described that service users were often willing to meet them half-way, with a mixture of broken languages being spoken, often because they realised that this was the only care that they had access to.

TDubbs and Libby reported having difficulty communicating with service users from other countries such as Somalia and Mozambique, because there was less likelihood that there would be someone who could assist them with interpretation. However, despite this challenge, they tried other ways of communicating. Libby shares a warm response from Somalian parents:

> *Being able to be hands-on and helped and shown one little thing that I as a parent can do with my child…and we're going to have to just revert to gestures and hand-over-hand…and getting a hug by the end of that from the parent*.

There were, however, instances where the service users were frustrated by the language discordant situations, as stated by Riley: *"their frustration is…damn, I'm just trying to…to help my child, or I'm just trying to explain to you…why my hand is sore".* Service users were sometimes offended that the participants were not more proficient in isiZulu, as Libby explains: "*I had a guy try and punch me* [laughs] *because I couldn't speak Zulu. Uhm, so that sense of complete outrage of you can't speak well enough for my liking so I'm going to hit you".*

The participants found it easier to communicate with younger South African service users with physical conditions. The challenges with offering occupational therapy care for those who did not fit those demographics, solidifies the theme that language definitely impacts that therapy process. The next theme will look at the fundamental factors that contribute towards language discordance.

4.4. Theme 3: Factors perpetuating language discordance

This theme unpacks what the participants describe as the causes of language discordance. The categories that make up this theme are: ‘attitudes towards learning others’ languages’, ‘cultural and linguistic nuances’ and ‘poor educational preparation’.

4.4.1. Attitudes towards learning other’s languages

Participants described that a contributor towards language discordance may be attitudinal, whereby an occupational therapist may be resistant to learning another language. For example, Riley explained: *“some people who complained that we had to do it* [the isiZulu course] *for one term, but I just thought they were being stupid, because they weren’t thinking about the context*”.

Riley continued by speaking of the arrogance that she had witnessed among white occupational therapists who chose not to learn isiZulu, despite working in Zulu contexts: *“it surprises me, the amount of, people…who are working, English-speaking people, who are working, have been in government for fifteen years and they can barely speak Zulu…and it, comes off as that…arrogance”.* She goes on to say; “English first language speakers are not commonly known to put effort into learning other languages. I don’t know why? Probably a form of arrogance, laziness or the effects of systemic white supremacy” [Reflective Journal I Entry].

Demi, though, expressed that despite wanting to communicate with her service users, she found isiZulu too hard to learn. She also explained that she had informal interpreters readily available, so she was never pushed to learn the language. The participants illustrated that attitudes towards learning a language greatly impact the readiness or motivation to actually learning a language. Next, the influence of cultural and linguistic nuances as a factor that perpetuates language discordance will be unpacked.

4.4.2. Influence of cultural and linguistic nuances

The participants described that there were certain cultural and linguistic nuances that contributed towards language discordance. They recognised that language and culture are intertwined. For example, Libby explained that the embodied or proverbial meaning of words shape understanding, and subsequently shape therapy;

> *I gave the example of, you know when the…some of the Zulu women say…the world feels, you know I’m, I’m sore everywhere…and it’s more of a thing of the weight of the world is on my shoulders.*

Moh agreed, and asserted that fluency does not guarantee that one will understand the contextual meanings of words. Accent was something that was also described as impacting communication and understanding, as illustrated by TDubbs: "when saying some English words (i.e., porridge) without an isiZulu accent, a lot of the time, it was not understood. However, if I added an accent (i.e., 'porrreeg') generally patients had a better understanding/responded more" [Reflective Journal II Entry]. This category illustrates elements of language that are often overlooked when educating students in language courses. This brings us to the most important factor that perpetuates language discordance, poor educational preparation, which will be discussed in the next category.

4.4.3. Poor educational preparation

Many of the participants spoke of poor educational preparation at school and university level as something that perpetuated language discordance. Four of the non-Zulu- speaking participants grew up in KwaZulu-Natal and they related that their school either did not offer isiZulu as a subject, or that isiZulu teaching from grade 3 to grade 9 was inadequate. Harsha explains:

> *Living in KZN, I was doing Afrikaans at school…and I live in KZN. It's not…it's not common, for people to speak Afrikaans. Obviously Zulu is a more common language, yet I did so much of time at school learning a different language.*

For some of the participants, the first time that they got exposed to isiZulu (or isiXhosa) was in their first year of university. The participants found that the timing of the language module was wrong; they recommended that they would have benefitted from having learnt isiZulu in third or fourth year, closer to the time they would enter the working world since they remembered little from their first-year courses. In addition, the participants expressed that one module was not sufficient preparation to learn a new language. The participants expressed unanimously that their language courses were irrelevant for practice, as described by TDubbs: *"nurses, physios, dieticians, radiographers…we were all, together, like learning Zulu together, uhm…which is fine for the basics, but…not to learn, like for your…practicali-, like for your role uhm…for your job"*. Riley added:

> *We had a Zulu course…with BComm students and this and that, so it wasn't, it was, it was like an, an extension of conversational…because obviously they're not going to go into all medical stuff when you've got BComm students sitting there*.

The language courses were described as superficial and inadequate as they only covered basic conversational skills. Cassandra and Demi explained that they were taught to rehearse isiXhosa and isiZulu scripts, but were not taught how to understand the responses. This indicates poor preparation for real-life conversations, with adverse consequences in therapy.

In addition to language education preparation, the participants also discussed not feeling adequately prepared at university to deal with the ethical dilemmas faced with language discordance, particularly with using an informal interpreter, or how to problem-solve in those situations. TDubbs explains below:

> *When it comes to working or to…comm serve, you then…through experience, learn, how to take that…undergrad thing that's been pushed into your head, adapt, adapt, adapt if things aren't working adapt…but you're very rarely told how, or…or what the, solutions are or what the options are to adapt*.

The above description about poor preparation illustrates that the participants were disappointed by their schooling and higher educational input into language studies and strategies of how to deal with the occurrence of language discordance. This theme has elucidated gaps in educational preparation in terms of culture and language, as well as showing how influential attitudes towards language learning can be. This is especially relevant in the South African context, where language was used to oppress and divide.

4.5. Theme 4: *"I'm doing everything that I can, what more can I do?"*

The last theme covers how the therapists approached language discordance to successfully navigate it. The categories that make up this theme include 'adopting an attitude of being kind to oneself' and 'going the extra mile'.

4.5.1. Adopting an attitude of being kind to oneself

Some participants expressed that one way of coping with language discordance was to have grace for themselves and their situation; some learnt this in the moment, whilst Libby observed that she only learnt it in hindsight. Harsha shared: "*you just tell yourself that you're learning, all the time. Everything is just, no, I'm going to learn from this and do better*".

Others recognised that one way of being kind to themselves was to accept that they were doing the best that they could with the skills and resources they had, as expressed by Moh:

In terms of, uhm…service delivery, I…think it's, it was just about, trying to remember, and remind myself that I'm doing the best I can, with the…vocabulary that I have, uhm…trying to communicate as much as I can, so let me not put any unnecessary pressure on myself.

Adopting an attitude of being kind to oneself was a useful tool for the participants to continue to try to learn the service users' languages, or employ communication strategies that enabled delivery of care. Their attempts at speaking broken languages were appreciated, but there were situations where frustration was palpable (and regarded as reasonable), as indicated by Riley; *"I can understand why they can be frustrated too, and I should be very sensitive to that, knowing what they've gone through, even before they've walked through the door"*. Going the extra mile to navigate language discordance was also a useful approach described by the participants and will be discussed below.

4.5.2. Going the extra mile

Most of the participants described that in order to resolve language discordance, they needed to go the extra mile. Riley, TDubbs and Libby described going the extra mile as making a special effort, and spending extra time either during their workday to find someone to teach them key phrases needed in an assessment, learning the language in their own time, doing a session with an interpreter, and even finding and negotiating with an interpreter. Riley goes on to say:

I think you can be…a good OT despite the language barrier…if you…if you are blessed to have the time in your context ***and*** *if on that day when you have the time, you really…are not drained, and have a hundred and fifty percent of your effort to, to go above and beyond basic treatment*.

Participants recognised that they either spent triple the time on doing a regular session with an interpreter present, or that they did not end up spending much time on doing actual therapy because the communication part of the session took so long. Harsha explains that:

You also sort of, have to use your discretion…and maybe, give a patient…extra time, if you feel like it wasn't, you know if you feel like something was lacking in the session…maybe giving them that little bit of extra time to sort of, make it as good as another session would be.

The participants did bemoan though, that often they did not have as much time and energy as they would like to resolve language discordance and provide quality occupational therapy

care. However, the shared feeling was that, while going the extra mile was time consuming, it was worth it in providing beyond basic care. This required determination and flexibility.

In addition to going the extra mile, participants spoke of being determined and flexible in navigating language discordance. Cassandra felt that: "*because I was an outsider coming into their home environment wanting to treat them…and…it was…ja, I felt like I, it was my responsibility, uhm, you know, to be able to speak the language*". Others shared the same sentiments and felt that they had a duty to speak as much isiZulu as possible, especially because they recognised that they may not always have the luxury of interpreter assistance. Some participants felt that they had no choice but to figure out how to deliver care despite language discordance, in order to survive in their work context. That is what drove them to both learn isiZulu and attempt using different communication strategies. Demi noted that she developed problem-solving skills and flexibility over time, through trial and error, but she had not been prepared for this on day one of her community service. Participants paid homage to their undergraduate training for being able to adapt, for example, Monica, stated that:

> During practicals in varsity, there would be a lot of things that would go wrong during a session. So yes, I do feel that the OT training I received equipped me with skills to adapt and problem solve during treatment sessions [Reflective Journal I Entry].

Libby recognises that South Africans in general have a culture of "'n boer maak 'n plan" (a farmer makes a plan), of making things work irrespective of difficulties or obstacles. Overall, the participants made it clear in this theme that they were determined to give the best treatment they could, despite the difficulties that language discordance brings. Language discordance seems to have provided an opportunity for participants to develop and enhance other skills that are important for occupational therapists.

4.6. Recommendations from participants

Participants recommended reform in additional language learning from primary to high school, whereby learning an African language becomes compulsory. In addition, they suggested reform of pre-existing language courses at the universities, whereby the duration, style, practicality, and content be revised to be more occupational therapy specific. Lastly, the participants recommended reform of the occupational therapy curriculum in better preparing graduates for language discordance, whereby strategies to navigate language discordance are taught. Regarding interpretation, the participants commented that telephonic interpretation would be the most feasible, or failing that, current employees should be trained in health

interpretation. Participants recommended that more emphasis should be placed on who gets placed where during their community service year, depending on their proficiency in languages. All the participants affirmed that despite there being certain demographic factors that make delivering occupational therapy care more difficult when there is language discordance, no area of occupational therapy should be removed as a result. For more in-depth explanations of the recommendations, see Appendix I.

4.7. Conclusion

The findings chapter has provided a glimpse into how the participants navigated language discordance in their isiZulu working contexts in the public health sector. It is apparent that the participants employed multiple communication strategies concurrently, and that interpretation is the most contentious of these strategies. Interpretation was always informal, which meant there were no guarantees for quality interpretation and often led to ethical breaches. Despite employing several strategies to navigate language discordance, the participants recognised that the quality of their care was hindered by language discordance. They did however, go the extra mile in learning their service users' languages, often outside work hours, and spent more time with service users in an attempt to give the best service that they could, despite language discordance being ever present. The participants were also able to recognise which factors perpetuated language discordance, and they unanimously agreed that poor educational preparation was the biggest factor. The following chapter, the discussion, will unpack what these findings mean and why they are relevant to quality occupational therapy care in South Africa.

Chapter 5: Discussion

5.1. Introduction

The aim of this study was *to describe the strategies that occupational therapists in the public health sector in KwaZulu-Natal used to navigate language discordance and to understand the subsequent role that language discordance has on the quality of occupational therapy care.* These strategies were outlined as themes in Chapter 4. This research was necessary as there was no existing literature explicating what occupational therapists in South Africa do to navigate language discordance. This is important because South Africa is such a linguistically and culturally diverse country, with the majority of the service users receiving professional health care in a language that is not their home language. It is especially important for a profession like occupational therapy, which depends on partnership, rapport, and mutual goalsetting, all of which require adequate communication, and form the foundation of how we do what we do, as discussed in the literature review. The discussion of the findings will address some of the gaps that were highlighted in the literature review such as the lack of occupational therapy knowledge regarding language discordance, how it is navigated, and its effects on the quality of occupational therapy care. The discussion will be framed according to the research objectives as well as other noteworthy topics related to the findings.

5.2. Strategies used to navigate language discordance

This first section will look at the first objective, *to identify and describe the strategies occupational therapists use when encountering language discordance*, as well as the second objective, *to identify and describe factors that influence the use of strategies for navigating language discordance*. The participants used several strategies concurrently to navigate language discordance, namely, using an informal interpreter, using non-verbal communication such as gestures, using technology for translation, learning and attempting to speak the service users' languages, doing a hands-on therapy session, and using visual aids, manuals, proforma scripts and collateral sources of information. However, there were factors that influenced the success of implementing these strategies.

Among the strategies named above, it is evident from the findings that the participants mainly employed the strategy of interpretation through informal interpreters. This finding is similar to that of several studies which indicate that using a trained interpreter, or if not available, informal interpreters, is the best and often only remedy to navigating language discordance

(Mirza et al., 2020; Probst & Imhof, 2016). In addition, literature shows that even when trained telephonic interpreters were available, health professionals opted to use informal translators as it was more convenient and quicker (Tate et al., 2016). The participants in this study did not have access to trained interpreters at their workplaces and this is not unique to this research setting. Claassen et al. (2017) affirm that the South African health system cannot successfully pay for and implement interpretation services. As a result, informal interpreters are usually used (Kilian et al., 2014).

However, the participants reported that informal interpreters were not always available. In addition, the participants were mindful of the time that their co-workers spent interpreting, as interpretation took time away from their co-workers doing their actual job tasks. This meant that the use of informal interpretation was calculated and concise. Accordingly, in instances where co-workers were not available, family members were asked to assume the role of interpreter. This is similar to what was reported by Zendedel et al. (2018), in that in some instances, asking family or friends to be informal interpreters was the only option available to the health professionals. In contrast, Parsons et al. (2014) encountered no difficulties in accessing informal interpreters such as co-workers. While challenges with regard to access to informal interpreters may have differed, the participants found it pertinent to mention the challenges experienced when using informal interpreters.

Participants stressed that they were uncertain of the accuracy of informal interpretation, especially if the person did not have a grasp of health and occupational therapy terminology. Additionally, they were aware that the informal interpreter's level of English proficiency possibly also impacted the accuracy of interpretation. A commonality between the literature and what the participants shared is the ever-present concern for omissions and miscommunication in interpretation in general (Elkington & Talbot, 2016; Zendedel et al., 2018). However, when a trained interpreter was used, Williams and Bekker (2008) assert that there was increased service user and health professional satisfaction, indicating that there was effective communication. Of importance is that a trained interpreter should be instructed in health and in profession-specific terminology and processes. Elkington and Talbot (2016) emphasise this need, especially in psychological and psychiatric care, which also falls into the scope of occupational therapy care. Currently, the interpreters that are being trained in South Africa, are trained as generalists (Elkington & Talbot, 2016). This means that the already small pool of trained interpreters in South Africa are not meeting the need for health-specific and profession-specific interpretation, which is a concern.

Tate et al. (2016) and White et al. (2018) note that even with institutional support in place, like trained interpreters (face to face or telephonic), emergency medical practitioners and other health professionals opted to rely on bilingual co-workers or bystanders as it was more time efficient. The logistics of organising a formal interpretation as a communication strategy was often deemed as too time-consuming by the health professionals. This poses the question of whether the solution to successfully navigating language discordance in South Africa is indeed with trained interpreters, or whether there are other solutions. It is known that the South African public health system has budget constraints (Claassen et al., 2017). When asked for their opinion on having formal interpreters, most of the participants in this study thought it unfeasible to create posts for trained interpreters, when there are not even enough posts for occupational therapists. Elkington and Talbot (2016), however, are of the opinion that it may be more feasible and cost-effective to have interpreters that provide telephonic interpretation for several institutions. In addition, Ku & Flores (2005, as cited in Elkington & Talbot, 2016) mention that the cost and consequence of using untrained interpreters is not well documented and could possibly outweigh the cost of employing a trained interpreter. This is noteworthy in that the ramifications of using untrained interpreters on the effectiveness of care provided is still relatively under-explored. Al Shamsi et al. (2020), on the other hand, argue that the cost of interpretation services in terms of employment and the increased time spent with a service user outweigh the benefits of the service. It is often assumed that trained interpreters will not find a place in South Africa's public health sector (Benjamin et al., 2016), but if the angle is turned to exploring the actual cost of using or not using interpreters, the findings may necessitate the need for trained interpreters. It is worth thinking about the costs and ethical risks associated with using informal interpreters and, moreover, the quality of service user outcomes.

Not having institutional support or structures in place to assist with navigating language discordance left the participants with the difficult dilemma of breaking confidentiality or not, in order to have basic communication with a service user. Parson et al. (2014) insists that it is necessary to use a trained interpreter when gaining informed consent but, since that is often unrealistic, informal interpreters are used. The participants weighed up the risks and believed that ethical and miscommunication risks aside, informal interpretation was still worth it. Of note though, is that the depth of risk differed depending on who was asked to interpret. For example, asking non-health and less educated co-workers, such as security guards or maintenance workers, to interpret was likely to increase the risk of errors and miscommunication, especially when it came to occupation-specific or health-specific terms.

The same could be said of asking family members to interpret. However, family members who were found to perhaps provide better interpretation were often school-going youth. Literature shows though, that asking children to interpret is deemed highly unethical; it poses a risk to their emotional well-being, as they potentially have to listen to and interpret sensitive information (Narchal, 2016). In a context like South Africa, there are cultural factors at play when asking family members and strangers to interpret. Deumert (2010), for example, mentions that male cleaners would omit or entirely change information regarding a female's reproductive health, because it was inappropriate for him to speak to her about that topic, or to convey bad news to a woman who is a stranger. Likewise, children or younger family members may not be informed about their parents' or elders' illness and thus it would be inappropriate to assume that they can be involved in interpreting private information.

In the absence of trained and informal interpreters, other strategies have been used. Literature indicates the use of other strategies in navigating language discordance, such as speaking a basic form of the service user's language (Parsons et al., 2014; Tate et al., 2016; Tschurtz et al., 2011), speaking plain English (Parsons et al., 2014; Weng & Landes, 2017), using non-verbal communication (Tate et al., 2016; White et al., 2018), using translated information sheets (Nakiwala et al., 2017; Tschurtz et al., 2011), and using technology (Nakiwala et al., 2017). Al Shamsi et al. (2020) propose that applications like MediBabble and Google Translate are the best solution. Most of the aforementioned strategies were also used by the participants in this study to provide basic occupational therapy care. They used various resources available in the moment, including visual aids, technology, demonstration, a bit of interpretation, and a mixture of broken isiZulu and other languages, to maximise communication. The use of a mix of languages could be considered a form of translanguaging. Translanguaging occurs when a person uses all their linguistic skills, irrespective of adhering to linguistic rules, which surpasses staying bounded in one language (Otheguy et al., 2015). In a South African context, it encompasses any encounter where more than one language is used to communicate, which is a common practice among multilingual people (Makalela, 2015). While the participants and future occupational therapists learn a new language, translanguaging could be a strategy to navigate language discordance.

The majority of the participants reported investing time and effort into learning their service users' languages, which was mainly isiZulu. Most of the participants only started learning the language once they began working in their community service year. They relied on their co-workers, online manuals and Gospel songs to increase their vocabulary, and also found that being immersed in an isiZulu context gave them an ear for the language. Pfaff and Cooper (2009) found that speaking to a service user in their home language, irrespective of their ability

to communicate in English, enhances the depth of rapport building and service user satisfaction. The participants did all they could to speak their service users' languages to communicate, which leads into the next section regarding occupational resilience of the participants.

5.3. Occupational resilience in navigating language discordance

This section addresses the second objective, *to identify and describe factors that influence the use of strategies for navigating language discordance*. The participants strongly expressed that they did all that they could, with the personal and external resources that they had at the time, to provide the best possible care, despite language discordance. This could be described as occupational resilience, a term originally used in organisational psychology, which encompasses a skill called cognitive flexibility (Magrin et al., 2017). Cognitive flexibility comprises of a sense of power, readiness to be flexible and adaptable, and to have self-efficacy (Magrin et al., 2017). In Govender et al.'s (2017) study, they found that South African occupational therapy students took initiative in navigating language difference by starting to learn their service user's language. This shows that these students had agency, were adaptable, and willing to learn, which all rings true to the concepts mentioned above.

Similarly, the participants described how they went the extra mile and put in a lot of extra effort (which equated to extra time) into better navigating language discordance. Most of the participants agreed that going the extra mile should be a standard to ensure the best possible communication with a service user. Literature pertaining to language discordance agrees that successfully navigating language discordance takes time, predominantly in locating an informal or trained interpreter and in the interpretation itself (Parsons et al., 2014; Probst & Imhof, 2016). What is dissimilar to the findings, however, is that health professionals in the literature often opted for the least time-consuming and often less rigorous strategies in ensuring effective communication. For example, Parsons et al. (2014) noted that physicians in the United States of America, despite having access to trained interpreters, would rather ask bilingual co-workers or family members to assist in interpretation as it was deemed as more time efficient. Although the participants also requested the support of available co-workers or family members, they did so because they did not have access to trained interpreters. In addition, the participants used multiple communication strategies concurrently, regardless of how time-consuming this became. The reason for this was because their fundamental aim was to ensure that the best possible communication and care was provided. This suggests that the participants exhibited occupational resilience in taking charge of their situation and being open to several solutions in best managing it.

In accounting for the resilience, the participants described that occupational therapists had both an innate and learnt drive to provide holistic care, and that that impacted the level of effort they put into navigating language discordance. The participants attributed their determination and flexibility in navigating language discordance to their character, having chosen to be in a caring profession, and to their occupational therapy training. Several opinion pieces cited in Van Stormbroek and Buchanan's (2017) study, reporting the experiences of community service occupational therapists, described that these therapists were adaptable and resourceful in facing challenges, including language challenges. It is unclear whether the writers of the opinion pieces felt that their resourcefulness and adaptability stemmed from personal or professional roots, or both. Naidoo et al. (2020) state that occupational therapy students are given sufficient opportunities to develop "problem-solving skills, lateral thinking, and the ability to be reflexive, flexible, and capable of ethical behaviour" (p. 1). In addition, McAllister and McKinnon (2009) make the point that undergraduate programmes will never be able to expose graduates to every possible scenario, and thus an emphasis should be put on fostering resilience instead.

The determination and flexibility that the participants described in their practice can be understood by looking at the concept of occupational resilience and its necessary place in occupational therapy curricula. Sanderson and Brewer (2017) assert that resilience is a necessary skill that health professionals should be taught in order for them to succeed in facing challenges in the workplace. Resilience is a key capability for occupational therapy students to possess, and educators are encouraged to foster it (Brown et al., 2021). This is especially relevant in a South African public health sector context where there are limited resources, under-staffing and additionally, language discordance. However, gaining insight on causes of language discordance could lead to the development of long-term solutions.

5.4. Factors that perpetuate language discordance

The participants described several factors that perpetuate language discordance. One factor that came up repeatedly was the lack of educational preparation at school and university level. The participants stated that options for learning African languages were limited and basic in primary and high school. Additionally, they expressed that a one-semester, generic, conversational course in an African language in the first year of university did not prepare them to interact and communicate effectively with service users. This finding is similar to that of studies among audiology students, speech therapy students (Penn et al., 2009), clinical psychologists (Elkington & Talbot, 2016), and community service occupational therapists (Van

Stormbroek & Buchanan, 2017), who all agreed that a short-term language course does not prepare a newly qualified health professional to successfully communicate with service users. Regarding the one semester African language courses; of note, is that the majority of the participants did not continue to learn the African language beyond that one course. This meant that most of the participants started re-learning the language when they commenced their community service year. The occupational therapy model, the Ecology of Human Performance (Dunn et al., 1994) explains that context shapes the performance of a task. In the participants' cases, their practice learning contexts did not warrant the need for isiZulu to be spoken as they were in more urban settings where English was more prevalent. As a result, the participants did not need to adapt in order to communicate with service users until they arrived in a new, more rural context. One participant stood out in continuing to learn isiZulu beyond the first year, one-semester course. She is not from South Africa but identifies as black, and found that she naturally felt affinity with other black occupational therapy students, who were predominantly isiZulu-speaking. Being in a friend circle where mainly isiZulu was spoken pushed her to learn the language. In addition, as a black person in KwaZulu-Natal, she felt pressure in every-day situations to be able to speak isiZulu proficiently. What this participant's experience shows that immersion is a successful way to gain proficiency in a language, which is supported by Pfaff and Cooper (2009). If immersion is a successful way to learn a language, it is proposed by the participants and the researcher that immersion into new languages, and thereby cultures, should happen from an early age in the educational system.

The participants recognised that language and culture are intertwined and noted that culture was consequently another factor that could perpetuate language discordance. Brown (1994) states that language and culture are one and the same. Jiang (2000) goes on to describe the relationship between language and culture as that of flesh and blood, that together make an organism and "form a whole" (p. 329). This is confirmed by other occupational therapy students in South Africa, who state that they "view language and culture as synonymous with each other or as having a dynamic influence on each other" (Govender et al., 2017, p. 6). Other occupational therapy students in South Africa suggest that in order to become more culturally competent, they would need to learn more African languages (Janse van Rensburg et al., 2012), again showing the direct correlation between culture and language, either in enhancing competence, or perpetuating discordance.

In addition, the participants realised that simply knowing the literal meaning of a word did not guarantee comprehension, and that misunderstandings could occur despite one being relatively proficient in a language. It was suggested by several participants that emphasis on culture whilst learning a language is necessary. Kramsch (2015) supports this notion, that

one cannot learn a language without learning a culture. Therefore, participants recommended that it is necessary to prepare students to navigate cultural and language differences in the undergraduate occupational therapy programme. This is supported by Janse van Rensburg et al. (2012) as they state that occupational therapy students do not get enough education or practical-based exposure regarding culture. What is of significance is that in order to graduate as an occupational therapist in South Africa, it is required to have "an awareness and sensitivity towards culture, language, socio-economic, political, gender and other diversity issues in the South African context and be tolerant of these" (Leendertz, 2012, p. 2). It is questionable whether graduates fully acquire this awareness and sensitivity during their training, and if they are not adequately prepared, language discordance may be perpetuated in practice.

Another factor that was identified as possibly contributing to language discordance was attitudes. Albeit not the direct attitudes of the participants themselves, they recognised that negative attitudes towards language learning, or specifically learning an African language were a contributor towards language discordance. Riley mentions, "*English first language speakers are not commonly known to put effort into learning other languages. I don't know why? Probably a form of arrogance, laziness or the effects of systemic white supremacy".* Swartz and Drennan (2000) support the notion that English speakers world-wide are resistant to becoming multilingual. This suggests that this attitude is not only prevalent in South Africa. Deumert (2010) adds that "entrenched behaviours and attitudes of Afrikaans/English-speaking service providers contribute to the on-going reproduction of a monolingual, English-centred approach to health care, and African languages are made invisible by the irregular exclusion from the hospital setting" (p. 59). However, the majority of the participants in this study showed an eagerness and willingness to learn their service users' languages, attitudes which Pfaff and Cooper (2009) identify as being integral to successfully learning a service user's language. One participant however found that learning isiZulu was difficult and that it was easier to rely on the readily available informal interpreters.

Further, the participants commented on the need for improved language proficiency preparation. Govender et al. (2017) propose that curricula should be adjusted to also include comprehensive cultural competence training. As it has been discussed that language and culture are inextricably linked, it is presupposed that training on cultural competence would address language too. Given the number of African languages in South Africa and their connection to provinces, it is possible that the language that a student learns at university may not be one of those spoken in the province that they get placed in for community service. A few of the participants recommended that more consideration be given at undergraduate level

to community service placement and aligning provincial choices with the language that they choose to learn. For example, if the student is interested in working in Limpopo, the student should be given the choice to learn Sepedi, Xitsonga, or Tshivenda, and preferably from first or second year. A study that sought to ascertain what influences occupational therapists' choices for community service placement did not find that language proficiency played a role in shaping choices (Maseko et al., 2014). Perhaps going forward more attention needs to be allocated to the importance of language in therapy, and provision made to plan for community service placement sufficiently.

Another recommendation from some of the participants was that explicit strategy-based training on how to navigate language discordance be implemented. They suggested that occupational therapists get introduced to using augmentative and alternative communication (AAC) systems, generally used by speech therapists, in order to better communicate with service users. A study that sought to find out what level of training undergraduate rehabilitation students had with AAC in the United States of America found that across the board the students had little exposure to or competence with using AAC (Costigan & Light, 2010). The thinking in Costigan and Light's (2010) study is that AAC would be used with service users who struggle to communicate as a result of their diagnosis, not as a result of language discordance. What this study reveals is that in an American context, there is already some exposure to the use of AAC systems in a traditional, diagnosis-relevant way for occupational therapists in the undergraduate programme. It is unexplored if AAC systems would assist occupational therapists in navigating language discordance in a South African context, but participants recommended that it is worth exploring. Lastly, it is important to reflect on what impact language discordance has on the quality of occupational therapy care.

5.5. The impact of language discordance on the quality of occupational therapy care

This section speaks to the third objective of the study: *to describe the impact of language discordance on the quality of occupational therapy care*. The participants repeatedly voiced the negative impact that language discordance had on the quality of the occupational therapy service provision. A similar study done in the United States of America revealed comparable findings. Martinez and Leland (2015) found that language discordance affected effective communication of clinical reasoning, the ability to provide education, set goals mutually, and build rapport with the service user. All of these factors are fundamental to providing effective occupational therapy services. Occupational therapy as a profession prides itself in being client-centred (Sumsion & Law, 2006), but what the findings of this study indicate is that therapy is more therapist-centred and directed when there is language discordance. This

means that a core tenet of occupational therapy is not being consistently upheld in these language discordant instances, as a result of difficulty in communicating. Does this mean that the care that the participants provided was a lesser form of occupational therapy but still beneficial? The next paragraphs will unpack this.

The WFOT (2018) states that quality of health care is dependent on several factors such as accessibility, appropriateness, efficiency, effectiveness, person-centredness, safety, and sustainability. All of these factors speak to the primary health care principles put forth by the World Health Organisation, namely effectiveness, access, appropriateness, equity, and affordability (Occupational Therapy Association of South Africa [OTASA], 2015). *Accessibility* is most often viewed as just the physical accessibility of care (OTASA, 2015), but in this instance, accessibility to care is decreased due to language discordance. That is, access to comprehensive and high-quality care is constrained. Govender et al. (2017) confirm that language (and the culture aligned to language) impeded the ability for occupational therapy students in South Africa to provide client-centred care, which subsequently impacts on accessibility of the care to the service user.

Appropriateness indicates that "occupational therapists strive to make their services responsive to the complex needs of the people with whom they work and are committed to deepening the cultural fit and sensitivity of practice" (OTASA, 2015, p. 58). The participants expressed that often they provided care that was generic, performance component-based and therapist-directed. Gray (1998) asserts that performance component-based therapy lacks the "purposefulness, meaning and holism" (p. 354) that is associated with occupational therapy. What the findings also show is that the care that was provided by the participants was perhaps less appropriate and less client-centred, as it was not tailored correctly to the service user, due to language discordance and lack of communication or miscommunication. Client-centredness, a core part of occupational therapy, is made up of: partnership, respect and listening, empowerment, goal negotiation, language, and informed decision-making (Parker, 2011). All of these components require effective communication, as Parker (2011) clearly illustrates by including language as a core component. She acknowledges that occupational therapists and service users may not share the same language, but emphasises that clear communication is key in providing client-centred care. If this is the case, it is uncertain whether the participants provided appropriate, client-centred care. The majority were not entirely satisfied with the care that they provided as a result of language discordance.

Efficiency is the best use of resources in delivering good quality occupational therapy care (WFOT, 2018). The participants reported that navigating language discordance always meant

more time was spent on non-therapeutic activities such as looking for an informal interpreter and going back and forth during interpretation, which took away from therapy time. Despite that, the participants stated that spending double to triple the amount of time with a service user was worth it in order to deliver the best care that they could provide irrespective of language discordance. It is evident that due to language discordance, the participants were restricted to serving a smaller number of people. Considering there are already so few occupational therapists (2.8) per 100 000 people (Day & Gray, 2014), it is of concern that perhaps fewer service users were seen due to language discordance. However, it is commendable that the participants took this time to be adaptable and reflect in-action, to do their best in offering occupational therapy care.

The principle *effectiveness* speaks to "achieving desired outcomes" for the service user, based on up-to-date research (WFOT, 2018, p. 3). Language discordance could hamper the effectiveness of treatment. In Levin's (2006) study, isiXhosa-speaking caregivers described that doctors only spent an average of sixteen minutes trying to communicate with them about the service user and only 30% of the caregivers were satisfied with the medical care. The participants in their sharing affirmed that they did meet desired outcomes, but that sometimes it took longer as miscommunication regarding appointments delayed therapy. In addition, they reported that they met the basic needs of a service user, but that they were unable to wholly meet their needs due to language discordance. Van Stormbroek and Buchanan (2019) confirm this in their study with novice occupational therapists, that when language discordance was present, therapeutic gain was limited.

Safety is about non-maleficence, or avoiding harm (WFOT, 2018). The participants indicated that harm could potentially be caused by less adherence to home programmes, less comprehensive treatment, misunderstandings regarding appointment dates (i.e. prolonged periods without care), and by miscommunication when the participant may inadvertently offend a service user by speaking an immature or basic version of their language or by using swearwords. Hunter-Adams and Rother (2017) stress that harm can be caused in language discordant situations. In addition to the quality of care being compromised, a glance also has to be given at the role language discordance plays in rights violations. As mentioned previously, service users have a right to access health care in a language of their choosing. It is clear from the participants that they attempted to meet that need by relying on informal interpreters and through speaking basic and broken language. The question is, are these strategies considered enough to warrant a right being upheld? One participant was of the opinion that as long as the principle of non-maleficence, of first do no harm, was upheld, that that was a good starting point to then attempt addressing beneficence. This comment speaks

to the participants' willingness to provide quality services and awareness of the potential impact of language discordance on their treatment.

5.6. Conclusion

In closing this section and chapter, it is important to remember that it is every service user's right to access health care (information) in a language of their choosing. In this discussion the following topics were raised, communication strategies, the efficacy, effectiveness, and ethics thereof as well as the real consequences of language discordance on the quality of occupational therapy care. In addition, occupational resilience of occupational therapists and the entrenched reasons as to why language discordance exists were unpacked. Several questions have been raised and recommendations made about the way forward.

Chapter 6: Conclusion and Recommendations

This chapter presents the overall conclusion of the study, and provides recommendations that are of use to the education and health system and for further research. The limitations of the study will also be discussed.

6.1. Conclusion

A qualitative descriptive design was used to ascertain what strategies occupational therapists in the public health sector in KwaZulu-Natal used to navigate language discordance. This study was motivated by experiences of language discordance in occupational therapy and the dearth of literature on this topic. This research has confirmed that language discordance is prevalent in occupational therapy care in KwaZulu-Natal. It has also shown the agency, adaptability, and determination of the participants in navigating language discordance using personal and institutional resources; and the complexities of applying various strategies concurrently to navigate discordance in order to provide the best care that they could. In addition, the ramifications for the quality of occupational therapy care when language discordance is a reality were discussed.

In closing, it is worth re-examining the assumptions (section 3.3) that the researcher had coming into this research. The first assumption was that language discordance is rife between service users and health professionals in South Africa, especially in rural contexts. From the findings it is evident that this assumption is true. The majority of the participants did not share proficiency in the same language as their service users when they began working in the iLembe district, which is largely rural. It did not appear that the participants had many language discordant experiences as students. Given that only 27% of the population speak English and Afrikaans outside of the household (Statistics South Africa, 2017), this leaves 73% of the population open to experiencing some level of language discordance in their occupational therapy interactions.

The second assumption was that a service user is usually expected to conform to the language spoken by the health professional and that there was resistance to learning African languages. The participants described that the easiest way to communicate with a service user was when they could speak English. Despite this finding, the participants did for the most part push themselves to learn and speak their service users' languages. This, however, predominantly happened at the commencement of community service and not before then. Looking back,

the participants wished that their university isiZulu courses had been longer so that they could have been more prepared when entering the working world. Participants in Deumert's (2010) study also show a resistance from health professionals to speak the service user's language. The findings and the literature above affirm that English is the lingua franca in the South African (public) health sector, and despite there being national and provincial language policies to promote multilingualism in all sectors (National Department of Arts and Culture, 2003), English is still dominant.

The final assumption was that occupational therapists place more emphasis on clinical skills than communication skills in training and practice. Based on what the participants shared, it is evident that little emphasis was put on communication skills in undergraduate studies. Most participants were only taught isiZulu or isiXhosa for one semester. Matthews and Van Wyk (2016) confirm that the University of KwaZulu-Natal teaches an isiZulu module in first year to health sciences students. This means that for the remainder of the four-to-six-year undergraduate programmes, there is no further formal engagement with communication skills training. This suggests that the researcher's assumption is true for undergraduate training. Participants reported that they often had to learn their service users' languages in their own time, and that the focus of their working hours was to deliver clinical care, albeit communication being central to the therapy process. With the researcher's assumptions having been examined, attention will be turned to the concluding comments of this research.

This research has provided food for thought on how to better educate undergraduate occupational therapy students, and how the Department of Health can support therapists in learning a new language and navigating discordance. This is especially relevant in this post-Fees Must Fall context, where decolonisation has been foregrounded and continues to be relevant. Language politics and decolonisation go hand in hand and this research provides some insights to encourage curriculum change so that future occupational therapists are able to better meet communication and thus, therapeutic needs of our diverse population.

6.2. Limitations

The data collection took place during the height of the first wave of the COVID-19 pandemic in 2020. For that reason, data collection had to be virtual, as the researcher was in a different province to the participants, and to adhere to COVID-19 protocols. Although this data collection turned out to be more convenient for the participants as they did not have to take time off of work, it is possible that sharing was affected as a result of conducting research

virtually. Including reflective journals, however, gave the participants another way to share, beyond a virtual interview.

Another limitation was that six out of the eight participants only spent one year in the public health sector, which meant they potentially had less time to learn how to navigate language discordance. In addition, seven of the eight participants were not working in the public health sector at the time of data collection, which meant that they did not have the opportunity between interviews to reflect in-action on the strategies that they used. That is not to say that they did not experience language discordance in different working environments, but that the research was specifically looking at how they dealt with language discordance in the public health sector. However, insights gained from their experiences still provided invaluable information.

It is mentioned in the methodology chapter that peer briefing was done in the developing stages of the research. Due to COVID-19, all Dissertation Occupational Therapy meetings at the university were cancelled, which would have given the researcher further opportunity to receive feedback from peers. However, to ensure rigor, interactions with the supervisor were increased.

6.3. Recommendations

6.3.1. Recommendations for occupational therapy

It is recommended that universities offer more than one indigenous African language to occupational therapy students so that there is choice and opportunity for improving language skills that can assist them in their community service placements, beyond the province that they are studying in. This would be possible by implementing a language policy where multilingualism in higher education could be the norm. It is also recommended that language courses be provided from first to fourth year at university as it is extremely difficult to learn a language in a semester course, as indicated by the participants as well. In addition, it is recommended that these courses focus on language that is profession-specific, informal, and practical as this is what will best aid communication with ordinary citizens.

It is also recommended that universities prepare occupational therapy students with awareness of language discordance, and strategies to employ in the face of language discordance. In addition to learning a language and about language discordance, it is also

recommended that universities prepare occupational therapy students to be aware of culture and how it shapes language and subsequently, therapy. Of further importance is for universities to add intentional resilience-building into the curriculum. In dealing with occupational therapy practice, it is recommended that occupational therapy departments in the public health sector consider creating language manuals and resources for incoming occupational therapists to aid incoming therapists with resources for navigating discordance. For example, by training them on the merit and efficiency of asking an interpreter to assist at specific times in a therapy session and by training them to hone their reasoning in who is best to ask to interpret based on their understanding of health and therapy concepts and of ethical considerations.

6.3.2. Recommendation for policy makers

It is recommended that policy makers consider making it compulsory to learn an indigenous African language as a first or second additional language from grade one, as is outlined in Curriculum Assessment Policy Statement (National Department of Basic Education, 2011; 2016), as it is best to start learning languages from a young age. It is also recommended that policy makers consider creating informal networks of health professionals in a particular hospital, district, or province who can speak another language and are willing to interpret, and remunerate them accordingly for their services. In addition, policy makers might find it worthwhile exploring the financial costs of establishing a telephonic interpretation service. Lastly, it is recommended that policy makers consider formalising the up-skilling of current staff members who are interested in taking on an interpretation role and that this be incentivised.

6.3.3. Recommendations for further research

In terms of further research, it is recommended that more research is done to explore systemic solutions to better navigating language discordance, and that this study be repeated in different contexts, i.e. different provinces, urban vs. rural settings, and in the private health sector. Lastly, it is recommended that research is done to focus on how language discordance is navigated with service users with hearing and speech impairments, as this was not addressed in this study. Of importance to occupational therapy specific research, it is worthwhile exploring language discordance as experienced by service users: how they see it impacting the care they receive and the strategies that they employ in interacting with occupational therapists. In addition, research is recommended to understand what

occupational therapy departments at universities do to prepare graduates for language discordance. Lastly it is worthwhile to explore the feasibility of using trained interpreters in occupational therapy care in South Africa and how using these interpreters affects the therapeutic process.

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[2] Abbreviation used in the original title.
[3] The published article includes this typo.
[4] Abbreviation used in the original title.

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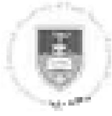
Appendix A: Human Research Ethics Committee approval letter



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room G50- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

24 February 2020

HREC REF: 081/2020

Dr M Ramafikeng
Division of Occupational Therapy
Health & Rehab Sciences
F-45, OMB

Dear Dr Ramafikeng

PROJECT TITLE: THE STRATEGIES THAT OCCUPATIONAL THERAPISTS WORKING IN THE PUBLIC HEALTH SECTOR IN KWAZULU-NATAL USE TO NAVIGATE LANGUAGE DISCORDANCE: A QUALITATIVE DESCRIPTIVE STUDY (MSC DEGREE - MISS EMILY MARSHALL)

Thank you for your response letter, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

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

Approval is granted for one year until the 28 February 2021

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: - Miss Emily Marshall will also be involved in this study.

Please quote the HREC REF in all your correspondence.

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

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

HREC 081/2020sa

Appendix B: KwaZulu-Natal Department of Health approval letter

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:
Health Research & Knowledge Managemen

Postal Address : Private Bag X9051, Pietermaritzburg
Physical Address: 330 Langalibalele Street
Tel: 033-395 2805/3189/3123 Fax: 033-394 3782
Email address: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

NHRD Ref: KZ_202002_023

Dear Ms E. Marshall
(University of Cape Town)

Approval of research

1. The research proposal titled **'The strategies that occupational therapists working in the public health sector in KwaZulu Natal use to navigate language discordance: A qualitative descriptive study'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken among occupational therapists using online platforms.

2. You are requested to take note of the following:
   a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Elutge

Dr E Lutge
Chairperson, Health Research Committee
Date: 31 July 2020

GROWING KWAZULU-NATAL TOGETHER

Appendix C: Draft email to district representative

Dear Chairperson

I hope that this email finds you well. My name is Emily Marshall, and I am an occupational therapy master's student at the University of Cape Town. I got your email address from the KwaZulu-Natal Department of Health website.

I am currently finishing up my last course and finalising my research proposal and hope to do data collection next year, and that is why I am contacting you. I am interested in hearing the perspectives of occupational therapists working in public health care, concerning how they navigate language discordance (not sharing the same home language as a service user). I am interested in this topic as it is something that has concerned me since doing my undergraduate degree and continued into my community service experience (Elizabeth Ross District Hospital, Free State, 2017) and beyond. I am interested in collecting data in KZN as it is where I am from, and it is in rural areas where I have noticed the effects of language discordance most starkly.

The title of my research is – “The strategies that occupational therapists working in the public health sector in KwaZulu-Natal use to navigate language discordance: A qualitative descriptive study”.

I am still in the process of gaining ethics review, but I thought it would be good to initiate contact with you. Do you have any questions, insights or thoughts regarding my proposal to do research in KZN? Would you be willing to act as a gatekeeper and assist me in recruiting participants? Do you have monthly or quarterly district/provincial meetings where I could potentially get the opportunity to present my research and invite people to participate?

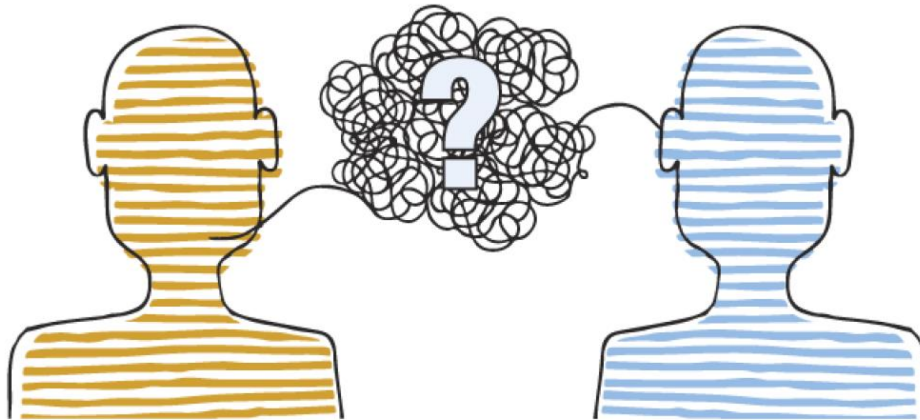
I look forward to hearing from you.

Thank you.

Kind Regards
Emily Marshall
072 710 1069

Appendix D: Recruitment poster

INVITATION TO PARTICIPATE IN RESEARCH



Have you ever experienced not being able to communicate fully with a service user? How did that make you feel? What did you do to make it easier? I would be interested in finding out from you...

Title: The strategies that occupational therapist working in the public health sector in KZN use to navigate language discordance

Selection criteria

- Are you an occupational therapist registered with the HPCSA that is working/has worked in the iLembe district, KwaZulu-Natal within the last two years?
- Have you had frequent exposure to language discordance in your work?

If yes, then you are legible to participate in this study!

What would participation entail?

- One 1 hour semi-structured interview in a venue of your convenience.
- Two 45-90 minute focus groups in a venue of the groups convenience.
- Availability between February 2020 and June 2020.

Benefits

- ↑SA OT literature
- ↑quality of services
- Support network
- Refreshments

Risks

- Sensitive topic
- Time out of work
- Time commitment
- No remuneration

Please contact Emily Marshall* on emzkmarshall@gmail.com if you are interested in getting more information about the study.

*Master of Science in Occupational Therapy student at the University of Cape Town.

Appendix E: Invitation to participate in research email

Dear [potential participant name]

I hope that this email finds you well. My name is Emily Marshall, and I am an occupational therapy master's student at the University of Cape Town. I got your email address from [district representatives name].

You are invited to participate in my research. I am interested in hearing the perspectives of occupational therapists working in public health care (specifically in the iLembe district, KwaZulu-Natal), concerning how they navigate language discordance (not sharing the same home language as a service user). I am interested in this topic as it is something that has concerned me since doing my undergraduate degree and continued into my community service experience (Elizabeth Ross District Hospital, Free State, 2017) and beyond. I am interested in collecting data in KZN as it is where I am from and it is in rural areas where I have noticed the effects of language discordance most starkly.

The title of my research is – “The strategies that occupational therapists working in the public health sector in KwaZulu-Natal use to navigate language discordance: A qualitative descriptive study”.

Attached is a poster explaining what participation will entail. If you have any questions or are interested in getting more information about the study, you are welcome to email me. If you would like to participate in the study, I will send through the information sheet and informed consent form for you to complete. If you are not interested in participating in the study, you need not reply to my email.

Thank you for taking the time to consider this research invitation.

Kind Regards
Emily Marshall
072 710 1069

Appendix F: Information sheet and informed consent form – interview

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

Department of Health and Rehabilitation Sciences

Divisions of Communication Sciences and Disorders, Nursing and Midwifery, Occupational Therapy, Physiotherapy; and Disability Studies

F45 Old Main Building, Groote Schuur Hospital

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Information sheet

Student Researcher: Emily Marshall
Supervisor: Dr Matumo Ramafikeng
University of Cape Town

Study Title: The strategies that occupational therapists working in the public health sector in KwaZulu-Natal use to navigate language discordance: A qualitative descriptive study.

Introduction

My name is Emily Marshall, and I am a Master of Science in Occupational Therapy student at the University of Cape Town.

I would like to invite you to take part in this research study. This form will give you all the information you need before deciding whether you would like to participate in this study.

Information sheet

What is the study about?

This study is about language discordance and the role it plays in occupational therapy health care. Language discordance is a term used to describe when a health professional and service

user do not speak the same language or do not share proficiency in the same language. I would like to hear your views as an occupational therapist: how do you deal with situations where you do not understand the service user? What are your thoughts and emotions attached to these situations? I am interested in hearing about your experience in navigating these situations.

Why is this research important?

This research is important because there has been little research conducted in South Africa exploring how language (discordance) influences occupational therapy health care. Your input will help to build the literature base on this topic and assist in ways to address any foreseeable difficulties that arise from language discordant encounters.

Who will participate in this study?

Occupational therapists that work in the iLembe district of KwaZulu-Natal have been asked to participate in this study.

What would your participation in the study involve?

- Should you agree to take part in this research, you will be asked to avail yourself for two virtual interviews (between the months of April 2020 to July 2020), on a day and time of your convenience.
- Each interview will be roughly sixty minutes long.
- Between interview one and two you are invited to write in a journal post each interview, reflecting on your experiences (present and past) of navigating language discordance at work.
- It is recommended that prior to the interview that you reflect on past scenarios where you experienced communication difficulties whilst interacting with service users so that you can draw on these scenarios in the interviews.

Where will the interview take place?

The interview will be held virtually using either Skype or Zoom to have a video call. It is recommended that you situate yourself in a place that is comfortable and quiet, with good signal.

How will the researcher collect the information shared during the interviews?

The interview will be recorded using a voice recorder and occasional notes will be taken during the interview.

What are the risks/harm/costs involved in taking part in the study?

- No risk is foreseen in participating in this study.
- You may however feel slight unease or heightened emotion when sharing as language discordance may be considered a sensitive topic. I am available to debrief with you afterwards if you require support.
- It is also possible that you will feel tired during or after the session. You are welcome to ask to take a break at any point during the interview.
- Depending on the day and time that you choose as most convenient, you may need to take some time off work which may have cost implications for you.

Will there be any payment or direct benefit offered to you?

There will be no direct material benefits if you participate in the study and there will be no payment made. However, your contribution will assist in building South African occupational therapy literature and possibly assist in contributing to policy and practice changes centred on language accessibility in health care.

What will happen to you if you decide to exit the study at any point?

- You are free to leave the study at any time and there will be no negative consequences for doing so.
- You will not be treated any differently if you do not participate or if you leave the study.
- If you leave the study, the information that you have already shared will not be used and will be discarded.

How will your identity be protected in this study?

No-one other than the researcher and supervisor will see the information that you share and know your real name. This information will be stored on a password protected online storage

facility that only the researcher and supervisor will have access to. Upon completion of transcription of the interviews, the audio recordings will be destroyed. You will be given the opportunity to choose a pseudonym for yourself that will be used to protect your identity.

What will happen at the end of the study?

A summary of the findings from the study will be shared with all the participants at the end of the study. The findings may also be shared with the district office, provincial department of health or whomever the participants deem appropriate, to provide insight into language discordance and occupational therapy.

I would appreciate you taking part in this study. If you need more information, or have any questions, the researcher or my supervisor may be contacted using the contact details provided below. Contact details for the University of Cape Town's Human Research Ethics Committee are also listed below; should you have any questions or concerns that you would like to address.

The contact person for the researcher is:

Emily Marshall: emzkmarshall@gmail.com ***072 710 1069***
UCT supervisor: Dr Matumo Ramafikeng: mc.ramafikeng@uct.ac.za ***079 224 7992***

If you have any concerns regarding your wellbeing as a research participant, you may contact the Faculty of Health Sciences Human Research Ethics Committee (HREC) on:

021 406 6492 (ask to speak to Professor Marc Blockman)
Or you may visit the HREC offices at:
The Human Research Ethics Committee
E53, Room 46, Old Main Building
Groote Schuur Hospital
Observatory
725

Informed Consent Form: Declaration by participant

- I have been invited to participate in research looking at language discordance and how occupational therapists navigate it.

- I have read the information sheet and I understand the content.
- I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- I understand that I can change my mind at any point and that it will not affect me in any way.
- I understand that none of my personal identifying information will be made public.
- I do not feel that I am forced to take part in this research, and I am doing so of my own free will.

Agreement Document

I ___________________________ have read the information sheet.

I consent to (please check the boxes that you consent to):

☐ Voluntarily participate in the study

☐ Participate in two individual interviews (±60 minutes each)

☐ Audio recording of the interview and verbatim transcription of the content

☐ Sharing relevant personal demographic information (participant's discretion used here)

☐ Using email or telephonic communications for contacting the researcher

Signed:

____

Print name of the participant

_____________________________________ _________________________________

Signature of the participant Date

Statement by the researcher obtaining consent

I certify that I have followed the study standards of procedure to obtain consent from the participant. S/He apparently understood the nature and the purpose of the study and consents to participation in the study.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this informed consent form has been provided to the participant.

Print name of researcher obtaining consent___________________________________

Signature of researcher obtaining consent_______________________________

Date __________________________

Appendix G: Semi-structured interview questions

Interview guide I

Have you been in a situation where you and the service user do not speak the same language? What language did the service user speak?

- Can you describe what it is like to be in a situation with a service user where you do not speak the same language please?
- How did you approach situations where there is language discordance?
- What strategies, resources or ways do you use to deal with language discordance?
- Do you think these strategies/resources/ways of dealing with language discordance are effective?
- How do you think language discordance affects person-centredness and quality of occupational therapy service delivery?

Possible follow-up questions

- What language did the service user speak?
- Where did you study, and did you get taught an African language?
- What was the duration of the course? How prepared did you feel afterwards?
- Is there a particular interaction that you remember and would like to share?
- Describe a day/critical incident where you encountered language discordance.
- How did language discordance and the strategies used, differ when working with different groups like children, the elderly, those with neurological impairments?

Interview guide II

- How was the reflection process?
- Any thoughts since we last chatted that you'd like to share?
- Any more instances of LD that you've thought of?
- Any more strategies that you have noted?
- Any more insights into how quality of services is affected by LD?
- Did you ever have an instance where a misunderstanding led to harm/sub-optimal care/wrong referral? Describe my "sefapano" story.
- What are your thoughts with regards to the way forward?
    - What therapies/conditions are appropriate to deliver and treat in these instances?
    - What about placement of comm serves?
    - What of training at university?
    - What of translators? Training of them? Ethical considerations?

Appendix H: Reflection points and questions for participants' reflective pieces

Cassandra - reflection points from first interview

- What was it like right in the beginning of comm serve when you were confronted with language discordance?
    - Share your thoughts and feelings on what the impact of language discordance had on your professional identity; contrasting your experience from the beginning to the end of comm serve.
- From experience, describe what language discordance is.
- Hesitance to ask for assistance with translating.
    - What sparked you asking for help?
    - What assumptions were you making regarding asking for help, i.e. unpack why you were so hesitant to ask for assistance.
    - What assumptions did you make about the level of preparedness you felt you were required to have, having chosen a Zulu-speaking site?
    - What did it feel like, constantly having to ask for translation assistance?
- Is communication a means for therapy to occur or is communication therapy, i.e. can communication and therapy be separated?
- Unpack what the term 'broken Zulu' means in your experience.

Cassandra – reflection points from second interview

- Reflecting on your community service experiences especially in relation to language, being in an unfamiliar context and being forced to grow and learn.
    - Would you choose a different placement if you had the option to go back and choose again? Why or why not?
- In relation to your comment about there being systemic issues with regards to a general lack of health professionals graduating and being placed yearly.
    - Can you think of other systemic factors that aid or hinder communication or contribute to language discordance? Comment on systemic factors in education and health and broad societal factors too.
- Do you think that relying on/using translation services (formal or informal) would inhibit a health professional/OT from actively learning the language of that context?
    - And is that a good, bad or neutral thing?

- Describe your thoughts on how power and language interact?
    - i.e., how does attempting to speak or being proficient in Zulu/any other African language influence the power dynamics between a health professional/OT and a service user?
- What is your understanding of the term 'quality health services'?
- Do you have any other comments or suggestions with regards to the way forward (plural)?

<u>Demi – reflection points from first interview</u>

- From your sharing it is evident that you have high self-efficacy, that despite the challenges you were confident that the quality of your services was satisfactory.
    - What enabled or facilitated your self-efficacy or confidence?
- What was it like to always be the 'outsider' and that 'activity' or 'exercise' lady?
- Discuss how you think ethics are affected in situations of language discordance (reflect on rights and ethical principles).
- Discuss how efficient (time and usage of staff members) using informal translators was, in your experience.
- Do you think it was your responsibility to train informal translators (HR interns)?
- Having read through Zulu books from first year; what would you have wanted your Zulu course to consist of?
    - Additionally, what suggestions would you make i.e., duration, content, assessment methods etc?

<u>Demi – reflection points from second interview</u>

In speaking about your prac blocks during varsity, you mentioned that you did sometimes have Zulu-speaking (only) service users.

- Could you describe in more detail how you navigated those situations? I know you mentioned that "I always again, I had someone with me" – was this a fellow student?

"I think we should maybe include training for translators".

- Who do you recommend these informal translators should be? Explain your choice.

- From your experience, how would you define language discordance?

In the past you have mentioned that you used very focused conversations to get the information that you needed succinctly.

- How did you balance the above with “I try to give them as much information”?

“You know, there’s isiZulu-speaking…uh, doctors as well, as well but there’s still that element of power. Why? Because they’re there to provide a service and they’re there in a uniform”.

- Explain your thoughts behind why you consider providing a service as embedded with power?

“I don’t think we should exclude…uhm, psych OT [laughs] because then we basically physios”.

- Could you explain this further please.

- Does the fact that we are activity or occupation-based serve as a protective factor in providing services in language discordant situations?

<u>Harsha – reflection points from first interview</u>

- You have mentioned that even if the service user could speak some English, that you would really make an effort to speak Zulu.
    - What led you to do this? (And not revert to comfort in your home language)
    - How do you think the power dynamics between the service user, and you are affected when you attempted to speak Zulu? And how would power play out if you maybe stuck to speaking English?
- In thinking about the younger family members that accompanied the elderly to clinics,
    - What are your thoughts on the time usage of the young people? Were they potentially missing school/work to accompany their family member?
    - What do you think was the driving factor behind them spending their time this way and how do you think they may have felt about it?
- Having lived in KZN since 2005, I have some shame around not being fluent in Zulu. Being born and bred in KZN, do you have similar feelings?
    - Do you think we should be fluent in Zulu, by virtue of living in KZN?
- How important do you think rapport is?
    - Without rapport, what does OT look like?
    - What are other ways of building rapport despite language discordance existing?

Harsha – reflection points from second interview

- Do you think that in learning Zulu, that it brought about an increased appreciation and respect for the people, the language and the culture?
- In not talking about not excluding any groups from receiving OT care where there is language discordance, is it possible to say, "that everybody is getting the same service?" Again, just playing devil's advocate.
- Do you think your OT training equipped you with the skills to adapt and problem-solve as in when encountering and navigating language discordance, if we think about your quote "think on the spot"?
- What would you define harm as?
- How would you define quality services?
- "I just don't think that, that that forms part of what he was supposed to do, like, part of his job description…wasn't to help me with, seeing my patients. If it was something maybe…more therapeutic that I needed his help with"
    - What made seeking assistance for something therapeutic different from seeking assistance with language?
- Do you have any other comments or suggestions with regards to the way forward (plural)?

Libby – reflection points from first interview

- Right to access health care in service users own language vs. health professional's right to work in a safe environment.
    - Share your thoughts on these two rights.
- Did you notice a shift in the relationships built with service users and Zulu-speaking staff as your mastery of the language increased?
- Rural vs. peri-urban navigation of language discordance from both parties.
    - Why do you think there was a difference in service users' reception of you and your attempts to speak Zulu?
- Professional identity.
    - Share your thoughts and feelings on what the impact of language discordance had on your professional identity.
- From experience, describe what language discordance is.
- Navigating looking after oneself and a responsibility to the population.
    - How did language discordance impact your ability to cope?
    - How did language discordance impact the quality of care that you provided?

Libby – reflection points from second interview

- A quote from your previous reflection that we never unpacked: "interestingly, in some communities, the 'white' or 'foreign' healthcare worker is still regarded as more competent, so sometimes the more elderly would ask to see them even if language was a bigger barrier".
    - Why do you think this is the case?
- Do you think that in learning Zulu, that it brought about an increased appreciation and respect for the people, the language and the culture?
- You referred to making a recommendation about grade R, but we never go to it, what were you going to say?
- "You say I can't help you this time…but bring in a family member who can…speak basic whatever language".
    - What are your thoughts on the time usage of the family member having to accompany the service user? Were they potentially missing school/work to accompany their family member?
    - What do you think was the driving factor behind them spending their time this way and how do you think they may feel about it?
- Do you have any other comments or suggestions with regards to the way forward (plural)?

Moh – reflection points from first interview

- Unpack what the terms 'broken Zulu' and 'basic Zulu' mean from your understanding and experience.
    - What would you consider is enough communication/language proficiency (i.e., is broken or basic Zulu enough) in order to ensure quality of OT services?
- From your experience, describe what language discordance is.
- In thinking about the double standards that you experienced when it came to asking for translation assistance and the general expectation for you to be proficient in Zulu (despite not even being from South Africa):
    - Why do you think the expectations of you were different to those of other races?
    - How did this impact your ability to cope/survive in the province as an OT (student and comm serve)?
- In thinking about receptive language skills developing faster than receptive language skills.

- What did you do in order to improve your expressive language skills?
- How did it feel learning a new language?

Moh – reflection points from second interview

- Do you think your OT training equipped you with the skills to adapt and problem-solve as in when encountering and navigating language discordance?

"I wouldn't say there's harm caused…because, I think the session would still be going on uhm…as much…as, possible but it's just that uhm, you w-, you wouldn't be getting as much from the session as you would have loved or, as the p-, service user would have opened up and let you know to…about different things that could have helped you, to actually… [sigh] attain information, bits and pieces of information that can also…add onto your assessment that is, like informal assessment or, in, to your observations or whatever it may be…something that is besides the formal, uhm, assessments, you know".

- What would you define harm as?

- How do you think that coming from Lesotho/a different country/context has shaped the way that you view and navigate language discordance?

- Do you think that relying on/using translation services (formal or informal) would inhibit a health professional/OT from actively learning the language of that context?
  - And is that a good, bad or neutral thing?

"…so, this, this uh, notebook that you're talking about, when do you recommend that people have this notebook? Is this something that they should uh, I know you had a notebook in varsity as well…but I…definitely, you, you wouldn't say that that was common practice, was it?"

- In asking about the notebook, I was wondering, not necessarily about the mode of making record of new words learnt, but about whether other students did the same thing as you? Why or why not?

- Do you have any other comments or suggestions with regards to the way forward (plural)?

Monica – reflection points from first interview

- You mentioned that you felt disheartened when struggling through language discordance.
  - Can you describe in more depth why you felt this way?
  - Did you feel defeated or resigned to go the extra mile (as in the care that you explained that you gave to the service users that you could communicate with)?
- In choosing to use only family members and other health professionals to act as informal translators:
  - Discuss your reasoning behind how ethical dilemmas/violations were reduced (in comparison to using a security guard, for example)?
  - Why do you find translators to not be useful and consider them a last resort?
- From your experience, describe what language discordance is.
- How important do you think rapport is?
  - Without rapport, what does OT look like?
  - What are other ways of building rapport despite language discordance existing?
- How does your family-based approach (seeing Zulu service users as family) aid or hinder the delivery of quality OT services?
- Out of curiosity, why did you default to speaking English to African service users at [X] hospital?
- May you please elaborate on the psych service user example; how did you navigate that situation specifically?
  - You mentioned that it is more difficult to communicate, in comparison with a physical condition, but that "the patients were, were not difficult cases, it was very, it was simple…uhm…diagnoses" – could you clarify if this psych interaction was difficult or simple or both?
- Do you think your OT training equipped you with the skills to adapt and problem-solve as in when encountering and navigating language discordance?
- Do you have any other suggestions or recommendations with regards to effectively navigating or reducing language discordance in our context?

Riley – reflection points from first interview

- Unpack what the terms 'broken Zulu' and 'basic Zulu' mean from your understanding and experience.
- It appears that mental health and family education discussions were the most complex/tricky and language-laden parts of OT.

- What does this mean in terms of recommendations for how and what OT services are provided in this context?
- You mentioned that language is 'small', the only thing getting in the way of getting your job done.
    - Upon further reflection, do you think language is small or big? What makes it either, or both?
- Why do you think that the mom who refused to respond to your attempts to speak Zulu, refused to do so?
- Do you think any attempt to speak a service user's language should be appreciated by the service user?
    - Why do you think it is so surprising to hear a 'white girl' speak Zulu in 2020 in your context?

<u>Riley – reflection points from second interview</u>

- Reflecting on your comment "But…we don't have the numbers of Zulu-speaking people for that", referring to the current number of Zulu-speaking OT's, what are your thoughts on why our profession is largely white (62%) female (65%) dominated? Or rather, why do you think the number of Zulu or African OT's is significantly less (17%)? [Stats taken from HPCSA, 2019].
- It was mentioned that you had training on how to use a translator in your undergrad studies. Do you perhaps still have those notes, the PowerPoint presentation or do you recall any of the specifics of that training?
- Do you have any other comments or suggestions with regards to the way forward in terms of navigating/reducing language discordance?

<u>TDubbs – reflection points from first interview</u>

- Unpack what the terms 'broken Zulu' and 'basic Zulu' mean from your understanding and experience.
    - What would you consider is enough communication/language proficiency in order to ensure quality of OT services?
- Do you think the expectation from nurses that you should speak Zulu considering that you are working in a Zulu area is justified?

- Do you think their resistance to assisting with translating is justified? Why? Why not?

- Eroding professional identity and confidence in relation to language discordance
  - What buffered you from not burning out?

TDubbs – reflection points from second interview

- How has navigating language discordance differed in private practice, in comparison with your comm serve experience?
- How much did accent play a role in how effectively you were able to communicate with and understand service users?
- Do you think that relying on/using translation services (formal or informal) would inhibit a health professional/OT from actively learning the language of that context?
  - And is that a good, bad or neutral thing?
- In navigating language discordance as you have and mentioning that it requires going the extra mile (effort and time):
  - Does going the extra mile need to become the norm, i.e. the baseline of service delivery being able to communicate, going to whatever lengths to do so?
- Please may you elaborate on the interpretation services that were offered at your hospital i.e., with the P-R-O? Was that a formal service? What impacted your decision to access this or not?
- Do you have any other comments or suggestions with regards to the way forward (plural)?

Appendix I: Participants' recommendations for resolving language discordance

The participants made many recommendations about how to move forward to better navigate language discordance. The recommendations covered; 1) reform of school and university curricula, 2) consideration of where graduates are placed for community service, 3) the types of occupational therapy care to be provided when language discordance is present, and 4) interpretation and institutional reform.

Reform of school and university curricula

Firstly, participants made comments on reform of language learning and curricula from primary schooling to tertiary education. They recommended that learning African languages like isiZulu should be compulsory, starting in pre or primary school, as described by Cassandra: "*pre-school tho-, that's the time when we, need to be able to develop those skills, uh, whether it's communication skills or learning skills*". The participants affirmed that it is too late for the university to attempt to teach a language to upcoming health professionals and thus should be covered in primary and high school. Harsha asserted:

> *I feel like because we live in KZN, it **should be** more important, people should place more impo-, importance on learning it as a language and…not just, you know, doing it like, as a one semester…in first year of campus. Especially for health professionals.*

Participants were also of the opinion that the isiZulu or isiXhosa courses at universities need to be adapted. All the participants agreed that ideally, the language course should run throughout the four years of the occupational therapy degree, even if it is just a semester course each year. TDubbs indicated that: *"you cannot learn a language in six months, like…you should probably do it for the full four years…like, a module maybe, even if it is just a module a year".* If this is not feasible, the participants recommended changing when language courses are offered, from first to third or fourth year, when it is closer to them entering the workforce. The reasoning behind this is that the content learnt would be fresh in their minds when they do practical blocks as well as when they graduate and begin their community service year. Another recommendation pertained to changing the language course content to be more health and occupational therapy-specific, and that the course be more practical-based. Riley explained that the isiZulu course "*should be in, the OT, the OT curriculum, because they know us, you know, and they know the OT words that we might need*".

A few participants recommended that there should be more than one African language course available at each university, as Demi described: "*I think, maybe, introducing other languages,*

like more common languages uhm…but not as much as the predominant…language in that area. So that could be something so like for example, teaching…Afrikaans, teaching Xhosa, or, or Sotho". One participant suggested that the course should focus more on vocabulary and less on grammar. In addition, some recommended that they be taught every-day isiZulu, not formal university-level isiZulu. Lastly, they recommended that the language courses also incorporate learning about culture, as Libby stated: "*other recommendations I think, is to highlight…uhm, the issues of around language and culture…more prominently when we studying*". Demi agreed:

> *I think…people need to be exposed to more than just a language. They need to be exposed to…how, you know, how the people live. They need to be exposed to their traditions. They need to be exposed to their cultures.*

In addition to the language course reform, there were also recommendations with regards to the occupational therapy course content. Participants recommended that part of the occupational therapy curriculum should cover how to adequately navigate language discordance; being taught about the existence of language discordance and strategies to navigate it. Libby described this well:

> *Maybe a, a whole session needs to be spent on how do you do an interview…without an interpreter and without the language abilities…what other techniques could you use? Could you use pictures? Could you ask people to, you know, show on diagrams or…how do we express certain terminology using our body or…? I, there are so many strategies that you have to figure out yourself and actually…why? Because you could do this in half a day at university*.

In addition, one participant recommended being introduced to some speech therapy modalities like Makaton "*which covers symbols and sign language and the spoken word, which might be able to bridge gaps*" (Libby). Participants also suggested that a course of lectures on training informal translators be included in the curriculum. One participant recommended that the occupational therapy department at the universities should develop their own isiZulu (or other language) assessment forms to encourage students to continue learning and using isiZulu in their practical blocks.

Not related to the actual course content but relevant to the how students are recruited and accepted into the occupational therapy degree, participants recommended that more diverse groups of people be accepted into the occupational therapy programme. Their belief was that if there are more African occupational therapists entering the work force, the prevalence of language discordance may be reduced, depending on where they are placed. This brings us

to the next set of recommendations, how and where students should be placed for community service.

<u>Consideration of where graduates are placed for community service</u>

Participants recommended that under the best of circumstances, a Zulu-speaking occupational therapist be placed in a Zulu context for their community service year. In conjunction with this, a further recommendation was that a community service occupational therapist must be proficient in the language that is most common in the area of their placement. Despite the participants making these suggestions, they acknowledged that they were unrealistic. TDubbs mentioned that she elected to learn isiZulu (over Sepedi) in first year because, "*then if you know where you are, more or less likely to end up you'd want to then select…so I chose Zulu because I knew, or I was hoping that I'd end up back in, in KZN*". This shows some foresight in considering her community service placement.

Cassandra highlighted that:

> *I think…more emphasis should be placed on uhm…considering the languages of the placement when you are, applying for comm serve initially…whether that's part of, uhm at the, if the university does that or if the department sends out some circulars you know, emphasising that…if it's on the application.*

Harsha continued saying, "*what languages you can speak or what you fluent in. It's something that is considered, so it would be nice if they considered that for comm serve*". A more realistic suggestion was :

> *So learning* [a language] *is an ongoing…thing, when you start it at campus it doesn't have to stop or you don't have to say no, I'll start learning the language when I go for comm serve… it has to start from the moment that you know* [where you are being placed]. *But don't put it for later and say no, I'll learn when I now am a qualified uhm, professional because that's when I'll need it more* (Moh).

Another suggestion was that time be given in the working day, at the beginning of a community service year, to adjust to the context and to learn the language. As Monica says, "*it would be easier for us, as therapists first, to change…uhm, we cannot change the population that we'll be placed in*". Attention will now be turned to what types of occupational therapy care participants recommended be offered when language discordance is a factor.

<u>The types of occupational therapy care to be provided when language discordance is present</u>

All of the participants emphatically stated that no area of occupational therapy care should be removed, however difficult it may be to communicate as a result of language discordance. Cassandra best described this: "*the services should not be tailored to what the OT can do or communicate but to what is needed in the community and then we have to problem solve*". Participants were divided on whether their training had adequately prepared them in being able to take initiative and adapt to language discordant situations, and acknowledged that their care may have been limited in areas or types of occupational therapy, such as psychiatry, complex hand conditions, geriatrics, or cognitive rehabilitation. Participants therefore recommended that problem-solving skills and adaptability should be highlighted so that novice occupational therapists are able to be flexible in their approach, take initiative and provide the best care possible, regardless of their language capabilities. Libby explained this best;

> *I definitely wouldn't say, cancel it* [OT services]*. I would say make a plan, work around it…and…every little bit helps. Even if you can just provide…a tiny bit of reassurance, one small strategy that will make a difference…and not cause harm…that one strategy…is still one strategy. It may not be…you know, the whole package, but it may be, enough…just to keep someone…from the edge. From the edge of extreme pain, from the edge of…suicide, whatever it might be.*

Part of problem-solving is making a plan, which is where interpretation comes into the picture, which will be discussed next, along with institutional reform.

<u>Interpretation and institutional reform</u>

Most of the participants recognised that having a formal translator at each institution is unrealistic due to budget constraints, and that it would actually stunt their impetus to learn a language. However, they did have recommendations on how to better use informal translators such as co-workers. For example, one recommendation was that interested co-workers like admin clerks, be given the opportunity to attend a basic health interpretation course. This up-skilling was proposed to be incentivised. Another option for interpretation was that it be telephonic, whereby a formal interpreter would not be affiliated with one institution alone.

Participants advocated for an informal network of health professionals that speak various languages being made available to interpret (telephonically or in person). This was described by Libby: "*we should at least be having a network…each hospital should have one or two of the, the local language and then there's perhaps a network that is telephonically…accessible if you're got a…Ethiopian patient or a…whoever*". One participant mentioned a hospital that

used translator volunteers intermittently, and recommended this to be formalised as an internship interpreter programme.

Beyond interpretation, there were recommendations for how institutions can be better equipped to deal with language discordance. One recommendation was that working occupational therapists create assessment tools, either in the local languages or less language-laden and more picture-based. Monica described this:

> *I think also what'll be very helpful is, that, there should be more, uhm…assessment tools, I would say, that are…our, that are in our context, South African context. And that use visual aids, uhm…in order for them to do the assessment.*

A previous recommendation was that universities do the same, so there could be a partnership and flow of materials between universities and institutions.

Another recommendation was that the institutions offer support services for navigating language discordance such as language manuals or lists of where language courses are offered. If possible, Riley recommended that language learning courses be subsidised by the institution and done during work hours. Lastly, one participant recommended that the occupational therapy departments at the institutions be equipped with resources as described by Libby:

> *That departments would equip their staff, with support tools, when they walk in…so…if I've worked in a particular hospital, knowing that it's a problem for me, why don't I leave something behind that will help the next therapist coming in. Be it, visual aids or…a basic word dictionary, you know like, a self-created relevant one…or…diagrams, whatever it might be.*

The participants have described a multitude of recommendations spanning from education, community service placement, types of occupational therapy care offered and institutional support, some feasible and some not. However, these recommendations remain noteworthy in beginning the conversation on how to tackle language discordance in our language diverse country.