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EFFECTS OF COMMUNICATION CHALLENGES ON HEALTHCARE

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ABSTRACT

Through language, a patient accesses the health care system, gets to learn about available services, so as to make decisions about her or his health. Language is also the means by which the health care provider accesses a patient's beliefs about health and illness, and thus creates an opportunity to address and reconcile different belief systems. In essence, communication between nurses and patients is the heart of nursing care. Communication between patients and chemists is also key to their access to healthcare. Such patients visit chemist for self-medication or to procure medicine for themselves or their families. The multilingual situation in Kenya and many African countries can complicate communication between healthcare providers and their patients. Such complications can cause language barriers that can impair access to healthcare. This is due to low literacy levels and challenges in understanding languages of wider communication such as English and Kiswahili for the case of Kenya. Under these circumstances, translation and interpretation become key to alleviating or eliminating communication barriers. This paper discuses linguistic challenges in access to healthcare in Kenya and proposes translation and interpretation as a way of dealing with the challenges. It argues that in a highly multilingual situation as is the case in Kenya, Translation and interpretation is a significant way of addressing challenges in medical access.

Keywords: Communication Challenges, Language Barriers, Patient-Provider Communication, Nursing Care, Pharmacy Communication, Multilingualism in Healthcare, Health Literacy, Linguistic Diversity, English and Kiswahili in Healthcare, Healthcare Access in Kenya.

1.0 INTRODUCTION AND REVIEW OF LITERATURE

Universal healthcare can only be achieved in a country if every individual can access healthcare. In Kenya, many issues which affect access to healthcare and universal healthcare have been discussed. They include insufficient drugs in hospitals, insufficient medical staff in Kenyan hospitals, poor infrastructure, insecurity and poverty. The issue of communication as a possible challenge to healthcare provision has not been addressed. In developed countries, the issue of effective communication between healthcare providers and patients is of utmost importance. In these countries, doctors and nurses are carefully trained so as to speak languages which patients understand. Healthcare providers who cannot speak patient's languages are never employed. In these countries, immigrant doctors and nurses are thoroughly vetted so as to ensure, only those who can speak fluent English are employed in both the public and private sector. Studies are also carried out frequently to ensure quick detection of any communication challenges in hospitals which can negatively affect provision of healthcare services. This is done with knowledge that communication challenges can have a big and negative effect on provision of healthcare in a country.

In Kenya, healthcare providers like nurses and doctors are trained and employed in any part of the country without consideration of the mother-tongue of the health provider and the languages spoken by patients who are attended to by the health provider. Healthcare providers in Kenya like doctors, nurses and chemists mostly speak Kiswahili and English. The question we should ask ourselves here is, do all Kenyans speak Kiswahili and English? And are there some Kenyans who cannot speak Kiswahili and English or who are not fluent in Kiswahili and English and therefore may not be able to effectively communicate with doctors and nurses?

Kenya has one national language, Kiswahili, and two official languages, Kiswahili and English, which are sole languages of wider communication. Due to their wide use, these languages have been adopted for use in hospital communication between care providers and patients. Against this background, and against the background of Kenya being a country with 44 languages and dialects, communication challenges between healthcare providers and patients are likely to occur. This study aims at investigating language communication in selected hospitals in Teso North, Teso South and Bukhayo Sub-counties of Busia County. Data from KNBS report of 2021 places poverty levels in Busia County at 67%, according to Busia County Intergrated Development Plan, 2022, illiteracy levels in the county stand at 62%. This means that a population of 38% are not literate and may not be able to speak English fluently. This population may also have difficulty communicating fluently in Kiswahili. This may affect communication between nurses, doctors and patients. Challenges in communication may lead to inability of patients to effectively explain their health problems to healthcare staff thus affecting effective access to healthcare. It may also lead to misdiagnosis. The study will look at communication barriers affecting healthcare provision in Busia County as its main focus. Purposeful sampling will be carried out in the five sub-counties of Busia County, namely, Teso North, Teso South, Samia, Marachi and Nambale. In doing this, the study will assess communication and other strategies used by patients and health care practitioners in overcoming the communication barriers. The study will also evaluate the cost of communication barriers and strategies employed to mitigate linguistic barriers and how the costs negatively affect patient's access to healthcare.

Language is a medium of human communication. This means that there cannot be human communication without language. This is the reason many scholars posit that language and communication are not separable (see Njogu, 2000; Simala, 2000; Kembo-Sure, 2000; Mwita, 2001; Muthwii, 2002; Luoch and Ogutu, 2002 and Wolff, 2006). Language must therefore be considered as a facet of any communication, including healthcare communication. Among the many challenges facing healthcare in the world today, is the role language plays in health communication. Language is a system of human communication, spoken or written comprising used words and enabling people to express their feelings and thoughts. When two or more people face difficulties during communication or experience a complete lack of it, it is referred to as language barrier. Language barrier may have considerable impact on verbal communication and as a result can affect access to quality care.

According to (Russell, 2009), many linguistically and culturally diverse patients, as a result of their inability to communicate with their healthcare providers, experience inadequate access to healthcare and poorer health status. Notable is the fact that, in the absence of effective communication, health providers experience many challenges which include simple care activities such as assessment, diagnosis and treatment, (Flores, 2005). These point to the fact

that language barriers can have severe effects in the medical context. Language barriers are especially common between healthcare providers and patients when the two groups do not share a common language. Growing evidence documents the fact that language barriers indirectly impact the quality of the healthcare that patients receive (see Perez-Stable, Napoles-Springer, and Miramontes 1997; Baker,Hayes, and Fortier 1998; Flores et al. 1998; Tocher and Larson 1998; Lee et al. 2002; Flores et al. 2003; Ku and Waidmann 2003). Notably, Perez-Stable, Napoles-Springer, and Miramontes (1997) posit that language barriers contribute to reducing both patient and medical provider satisfaction, as well as communication between medical providers and patients.

At the same time, Baker, Hayes, and Fortier 1998 argue that patients who face language barriers are more likely to consume more healthcare services and experience more adverse events. This means that health disparities such as unequal treatment related to language barriers are associated with unequal access to healthcare and unequal health outcomes. This has been demonstrated by studies in USA, where a substantial body of research demonstrates that children and adults with limited English proficiency (LEP) experience difficulties accessing mainstream health care services (see Lee et al. 2002; Flores et al. 2003; Ku and Waidmann 2003). This result is also attested to by Perez-Stable, Napoles-Springer, and Miramontes (1997), Baker, Hayes, and Fortier (1998), Flores et al. (1998) and Tocher and Larson (1998) who in their studies found out that language barriers can reduce the quality of care, while the use of trained interpreters can improve access, quality, and patient satisfaction. Further, Holmquist (2011) notes that if a customer and a health provider fail to communicate effectively, this would have adverse impact on the whole service. Holmquist (2012) in the same context, emphasizes that language barrier has been demonstrated empirically to have various negative consequences in patients. In addition, (Jacobs et al., 2006), also underscore the fact that an efficient dialogue between a doctor and a patient is of diagnostic import and therapeutic benefit. The effect of linguistic barriers are not limited to direct access to doctor-patient interaction. They also affect access to medicine. In a study in the United States of America covering eleven ambulatory clinics in Boston, in the year 2000, language barrier was shown to play a major role in outpatient drug complications (see Obel. 2013). A multiple regression analysis of the same study by Obel revealed that having a primary language other than English or Spanish was an independent predictor of patient reported drug complications.

From the foregoing, it is evident that language barriers affect healthcare provision in many ways. Patient access to healthcare depends on smooth communication between the patient and caregivers. Barriers in their communication will hamper service provision and the quality of services provided. Barriers have also been demonstrated to hamper access to medicine. This can have an adverse effect on patient access to prescribed medicines. It is in this vail that this study sets out to investigate language barriers in Teso North and Teso South health clinics with the aim of discussing mitigating strategies employed by interlocutors.

2.0 BACKGROUND TO THE STUDY

In Kenya's Vision 2030 elaborately speaks about Universal Healthcare. As discussions emerge about the attainment of universal healthcare under Vision 2030, there is need to investigate all challenges that may affect the attainment of this universal healthcare in Kenya.

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Challenges against effective and equitable healthcare can result from many factors, one of them being language differences between patients and healthcare professionals (Muray, 2005; Jacobs, 2006; Hawthome, 2001). In Kenya, healthcare professionals are of two main groups. The first group is made up of expatriate doctors mainly from Cuba and India who are not fluent in Kiswahili, a language which is mostly used by patients in their medical communication. The second group is made up of healthcare professionals like doctors and nurses who are not expatriates, but who have diverse levels of fluency in Kiswahili which is Kenya's main language of wider communication; and medical communication.

Low levels of fluency in languages used in medical communication may cause language barriers between caregivers and patients. Studies in various countries have revealed this. For instance, studies carried out in USA posit that immigrant patients and medical professionals who have little or no understanding of English face language barriers when seeking healthcare (Hawthome, 2001). Yet, language barriers lead to increased psychological stress and medically significant communication errors for patients, something to which patients in language encounters without barriers are less vulnerable (Bowen, 2000).

According to (Russell, 2009), many linguistically and culturally diverse patients experience inadequate access to healthcare and poorer health status as a result of their inability to communicate with their healthcare providers. Notable is the fact that, in the absence of effective communication, health providers experience many challenges which include simple care activities such as assessment, diagnosis and treatment, (Flores, 2005). This happens even as scholars maintain that when communicating the details of a diagnosis or treatment, it is crucial to convey accurately the likelihood of the associated risk factors (Gillotti, 2002; Schenker & et.al 2007). Gillotti and Schenker insist that failure to communicate properly the seriousness of risk can have negative consequences: patients may fail to comply with instructions or elect not to have potentially life-saving treatment.

In mitigating these risks arising from linguistic barriers, caregivers and patients employ various strategies including translators. In Kenya, it is not official government or county government policy to have translator employed by for government hospitals. There is no programme for training medical translators. . This means that any effort towards translating communication between caregivers and patients will be personal effort of interlocutors. This study therefore aims at investigating linguistic barriers in communication between caregivers and patients with a focus on the six sub-counties of Busia County namely, Teso North, teso south, Samia, Marachi and Nambale. The cost of these barriers and barrier-mitigating strategies will also be investigated in the current study.

3.0 METHODOLOGY

Purposeful sampling was used to identify two hospitals in each sub-county of Teso North, Teso south, Nambale, Six (6) hospitals were be sufficient representative of the hospitals and health centers in Busia county whose inhabitants, just like many Kenyans, face many difficulties speaking English as a foreign language used in communication in Kenya. At the same time, many inhabitants, especially, the old face problems speaking fluent Kiswahili which is mainly used by doctors and nurses during healthcare provision. Communication between medical practitioners and patients was used as data for this study. The study took three months.

Interviews and questionaires were used as methodologies during this study. One doctor and two nurses were purposefully sampled from each hospital and interviewed with the objective of getting data about the presence of communication barriers and solutions employed by hospital staff in solving communication barrier challenges. This means that three (3) medical staff from each hospital were sampled and interviewed. In total, 18 members of the medical staff were sampled and interviewed. Four patients in each hospital were purposefully sampled and interviewed. A total of 24 patients were interviewed. Questionnaire research tool was used for the purpose of getting data useful for the four objectives. Each sampled medical staff was given a questionnaire to fill. Eighteen (18) medical staff were requested to fill questionnaires. Questionnaires were to help to supplement data from interviews.

4.0 THEORETICAL FRAMEWORK

Communication Accommodation Theory (CAT) as developed by Giles (1972) and elaborated by Gallois et.al, (1995) and Galloise, Ogay & Giles, (2005) guided this study. The CAT theory has a particular relevance for comparing language-discrepant and language-congruent communication. In theoretical terms, CAT gives several proposals: (i) speakers attempt to converge (or not) their manner of speaking, to accomplish important social goals around attaining social approval, identity etc.; (ii) the extent to which speakers converge reflects in part the need for communication efficiency; (iii) convergence is viewed as positive and normative; and (iv) divergence in manner of speaking reflects a specific intention to do so, and is normally perceived negatively. CAT thus provides a useful framework for examining the dynamics of patient-practitioner communication, especially when at least one of the speakers uses a Second Language (L2). In such cases, an inability to achieve convergence (i.e. to appear more similar in speech) can affect how the speakers perceive not only each other, but also the quality of the working relationship between them (See Segalowitz, 1976 and Segalowitz, 2010). The relevant research goal here is to identify what specific impact language discrepancy has on accommodation, and what the consequences are for patient-caregiver communication.

5.0 DISCUSSION

This research unearthed language barriers in communication between patients and medical staff. The communication challenges mostly affected communication between patients and nurses and doctors. The challenges are discussed in the following section.

5.1 Language barriers

(i) Total inability to communicate

This barrier was caused by total speech impairment. There were patients who could not speak for various reasons. These included patients who had lost speech or had never had speech at all. 8.3% of patients (two of the twenty four) sampled were in this category of patients with inability to speak. These patients relied on relatives who accompanied them to clinics to interpret their communication. The patients were in two different hospitals. 83% of nurses (10 out of 12) and 67% of doctors (4 out of 6) said they had served patients with inability to communicate.

(ii) Language impairment

This affected patients who have speech problems. They included stammer and mental illness and could not speak coherently. 12.5% (3 out of 24) of patients were in this category. Two of the patients had severe stammer challenges which affected their communication with healthcare givers. Nurses and the Doctor who were interviewed said that they had challenges understanding communication from the patients and had to speak to the patients in the presence of a family interpreter who interpreted communication which they had challenges understanding. All doctors and nurses (100%) interviewed said they had encountered language impairment barriers in their health clinics and hospitals.

(iii) Use of mother tongue

Busia is a cosmopolitan county with many communities. They include Abaluhya, Iteso, Luo, Baganda business people who seek medication from across the Kenya Uganda border. There are also substantial populations of Somali, Kalenjin, Kikuyu, Kamba and Maasai who work or do business within the town. Residents from these communities seek medication from the available medical and health centres within Busia County. Rural health centres, however, receive, mainly, Iteso, Luhya, Luo and Kikuyu patients. Use of mother tongue is a cause of communication barriers due to the linguistic background of healthcare givers within the hospitals. 100% of nurses and doctors interviewed said they had served patients who communicated in local language which are not used for wide communication. Of these, 89% said they had encountered challenges from some of the mother-tongue communications. The doctors and nurses who said they had experienced communication challenges also said the patients they had encountered did not speak their mother-tongue.

(iv) Muteness

This involved patients who refused to speak to doctors. 11% of the doctors and nurses interviewed said they had at one time encountered patients who refused to speak. These patients had been taken to hospital by relatives against their wish. This mainly involved elderly patients. Doctors and nurses concerned said that the patients had refused to seek medication because they believed they had gone through so much suffering and did not want any more treatment. The patients seemed to have decided. One of the patients was a suicide attempt case.

(v) Use of code switching

Code switching was the most preferred mode of communication within the health centres. 80% of communications within select health centres used code switching. The code switching involved Kiswahili, Teso language, Luhya and English. 12.5% of communication using code switching had communication barriers. Of the 12.5%, barriers involving Teso language comprised 66.6% while 33.3% comprised communication in Khayo language (a dialect of Luhya).

(vi) Use of slang

This was evident in health centres which were within urban and urbanizing areas. Busia, Nambale and Malaba, Mungatsi, Lukolis, Adungosi and Alupe are the main urban centres within the three sub-counties of Namable, Teso South and Teso North. This research revealed that communication within health centres which are situated within urban centres and market

centres is affected by slang. 100% of the doctors and nurses interviewed said they had encountered patients who used slang. Of these, 22% said they had experienced communication challenges from the slang.

(vii) Lack of interpretation services

Lack of Interpretation Services was mentioned as a cause of language barriers. All hospitals (100%) did not have official interpreters employed to carry out interpretation services. Some countries like USA, have a policy which requires hospitals to offer interpretation services to patients who do not understand English. This policy forces hospitals to make use of qualified interpreters who may be present in hospitals or may offer their services through phone and other communication technology. Kenya does not have such policy on the national scale, which may force hospitals to provide interpretation services. The multilingual landscape in Kenya can complicate communication where patients who do not understand English and Kiswahili (or who have little understanding of them) are involved. Lack of interpretation services in Kenyan hospitals can lead to language barriers which can affect communication between healthcare providers and patients who do not understand English or Kiswahili.

(viii) Lack of fluency in languages of wider communication

Kenya has two languages of wider communication. These are Kiswahili and English. Lack of fluency in these two languages caused challenges in communication which affected medical service delivery. 11% (2 out of 18) of doctors and nurses interviewed said they had met patients who could not speak in Kiswahili and English, thus causing challenges in communication.

(ix) Foreign Workers and Language Barriers

Use of foreign workers as health workers in Kenya was mentioned as a possible cause of language barriers in the healthcare system. 78% of doctors and nurses believed that this was a cause of language barrier. They said this arises from the use of foreign doctors employed in Kenyan hospitals. They also mentioned foreign intern doctors as a cause of the barrier.

5.2 Remedies deployed to counter communication barriers

(i) Use of hospital Interpreters. Some of the hospitals surveyed have come up with mechanisms of interpreting communication between hospital staff and patients. This was evident in three (50%) out of the six hospitals surveyed. The mechanisms involved use of nurses and other paramedical staff to interpret communication from patients who have communication challenges. It should be noted however that these services are not formal and only happens in situations where there is a member of staff who can understand the patient's language. It emerged during interviews with staff that patients who speak languages which none of the staff understands are usually not assisted. However, such patients are those who are brought in the hospitals during emergencies and are not accompanied by family members who can translate their communication..

(ii) Use of family interpreters. Some patients who have communication challenges visit hospitals in the company of family members who also act as interpreters. This was seen in 90% of the cases with communication challenges. It emerged during this study that many of the

patients who had communication challenges visited the hospitals in the company of family members. These always acted as interpreters in the event that the medical staff had challenges understanding the patients.

6.0 CONCLUSION

Language is the means by which a patient accesses the health care system, learns about services, and makes decisions about her or his health behavior. Language is also the means by which the health care provider accesses a patient's beliefs about health and illness, and thus creates an opportunity to address and reconcile different belief systems. In essence, communication between nurses and patients is the heart of nursing care. Communication between patients and chemists is also key to their access to healthcare. Such patients visit chemist for self-medication or to procure medicine for themselves or their families. The multilingual situation in Kenya and many African countries can complicate communication between healthcare providers and their patients. Such complications can cause language barriers that can impair access to healthcare. This is due to low literacy levels and challenges in understanding languages of wider communication such as English and Kiswahili for the case of Kenya. Under these circumstances, translation and interpretation become key to alleviating or eliminating communication barriers. Interpretation of Patient-Doctor Communication There is need for national policy that will require hospitals to ensure successful communication between patients and doctors and nurses. There is therefore need to have interpretation services in hospitals to help doctors to communicate with patients who have little understanding of English and Kiswahili. With the advent of the Cuban doctors, there is urgent need to

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