# THE INTERPRETER AS INTERCULTURAL MEDIATOR IN THE ACQUISITION OF HEALTH LITERACY: A CASE STUDY FROM KENYA

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ABSTRACT: This study discusses the role that interpreters play in contributing to health literacy. Culture and language, as constituents of the experiential context, affect the comprehension of health information (Andrulis and Brach, 2007) and therefore are of great relevance for community interpreting in healthcare settings. Based on data collected from personal interviews with healthcare practitioners in two health centres in Kenya between October 2018 and February 2019, this article showcases the need for culturally attuned interpreters in cross-cultural and interlinguistic contexts to facilitate the access to health literacy.
KEYWORDS: Health Literacy, Healthcare Settings, Community Interpreter, Intercultural Mediator, Kenya

## 1. Culture and language in community interpreting

Community interpreting, as a form of ad-hoc interpreting, is probably the oldest and most natural form of translation in the world. Like liaison interpreting, used in business and technical meetings, it is performed face-to-face by a single person working in both directions and involves frequent interruptions for the purposes of clarification or explanation (Riccardi, 2002, p. 75). The name "community interpreting", also known as "dialogue interpreting" and "public-service interpreting" (in the United Kingdom), is used when it is employed to cater for the social needs of a community of migrants or persons who, for some reason, do not speak the major language of the larger community and consequently face some disadvantage as regards accessing public services to which they have a right (Martin, 2000, cited in Tiayon, 2005, p. 2).

In African societies, the diversity of tribal/ethnic groups and the effects of European colonialism have raised considerable barriers to effective communication between the official channels and its citizens. This results in difficulties accessing information, a problem that particularly affects its most vulnerable population in the exercise of their rights. Indeed, some minority languages (local languages spoken by nationals or foreign languages spoken by refugees) are only interpreted at a community level. As we can read on the website of Translators without Borders: "Although Swahili is a prevalent language across most of East Africa, it is still largely a second language. In fact, well over 200 local languages are spoken in the region, making sharing of and access to information even more of an onerous task".[1]

Although there is clearly a need for community interpreting in Africa, there is still a lack of access to it. In many cases today, interpreting is done on a voluntary basis, either by NGOs such as Translators without Borders or, more frequently, by other members of the

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[1] Available at: https://translatorswithoutborders.org/our-work/kenya (Accessed: 12 October 2018).

community. As Tiayon (2005, p. 8) remarks: "In many cases of patient-doctor interaction, interpretation is simply done by health practitioners, patient's relatives, cleaners, etc". This form of interpreting is now beginning to attract attention of scholars from Translation and Interpreting Studies. For example, in a recent issue of *The Translator*, we read:

> Despite (…) specificities, we acknowledge that community interpreting in the Global North shares several important features with public-service interpreting in Africa. The modality used is generally dialogue interpreting, this task is carried out by bilinguals who have received limited (or no) interpreter training, and interactions might involve a considerable power asymmetry between speakers. (Marais and Delgado, 2018, pp. 389-390)

The relationship between language and culture is particularly important in community interpreting, given its embedment in the social codes of the community and its institutions. Indeed, due to the nature of the context, community interpreters are often considered to be advocates or "cultural brokers", who go beyond the traditional neutral role of the interpreter.[2] Culture is a complex concept that has been variously defined at different times.[3] Typically, it refers to the lasting basic intellectual characteristics that are shared and learned and that affect social behaviour based on specific systems, values, and ideologies (Depaula and Saucedo, 2010, pp. 1-15). In terms of the main categories that can be established, a distinction can be made between "objective culture", i.e. "patterns of behaviour in a habitat", and "subjective culture", referring to "shared structures of meaning" (Páez and Zubieta, 2005, p. 1) or "attitudes, regulations, beliefs and values that guide behaviour and that are shared by members of a nation or group" (2005, p. 3).

Hofstede, Hofstede and Minkov (2010, p. 4) define culture as a form of "mental programming", that is to say, "patterns of thinking, feeling, and potential acting that were learned throughout the person's lifetime". Their categorisation of national cultural dimensions has been used as a paradigm for research in cross-cultural studies, and some of these are particularly relevant to the case study reported here. For example, *power distance*, defined as the unequal distribution of power between interlocutors, is important in the case of patients and health providers and includes factors such as literacy, gender, social class, etc., that affect communication during a consultation; *individualism* vs *collectivism* refers to the different health belief systems found between two different cultures; and *masculinity* vs *femininity* concerns gender-based constraints such as stereotypes, social and cultural limitations, and hierarchical structures affecting communication. Finally, *uncertainty avoidance* deals with a society's tolerance for unknown/unexpected situations or practices. These four parameters have been adopted as the analytical framework for our study (see Section 3 below).

This study hopes to contribute to the existing body of research on community and intercultural interpreting in order to facilitate the work of interpreters and health

[2] Available at: https://aiic.net/page/1546/the-professionalization-of-community-interpreting/lang/1 (Accessed: 21 May 2019).

[3] See early discussions of interpreting in terms of interactional sociolinguistics in Cokely (1985, 1992) and Metzeger (1995).

practitioners in the cultural context of East Africa, as well as to highlighting the importance of their role in health settings. Specifically, it aimed to collect empirical evidence to support the need for trained community interpreters to work in healthcare settings in Africa, by gauging the experience of providing sexual and reproductive advice and treatment to women in a given area of Kenya.

## 2. The role of the intercultural interpreter in healthcare settings

A milestone for the discussion of the interpreter's role in healthcare settings was the recent acknowledgement by the Institute of Medicine (IOM) that health literacy skills, defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Nielsen-Bohlman, Panzer and Kindig, 2004, p. 32), are affected by culture. Various language-related studies insist on the lack of a common language between a patient and a doctor as the major cause of outcome disparities[4] in healthcare (Cox and Lázaro Gutiérrez, 2016; Karliner et al., 2007, 2012; Nyandiva, 2009). However, there are also cultural barriers in place, since the exchange and interpretation of health information is clearly influenced by beliefs, traditions, and other social norms. Deumert (2010, p. 54) summarises three kinds of barriers to effective healthcare:

> a) Avoidance behaviour: Patients who are not proficient or comfortable communicating in the language(s) used by health providers are less likely to have a regular source of primary care and typically seek medical/hospital care in advanced stages of their illness.
> b) Errors in diagnosis and treatment: Quality of care is substantially compromised when patients and providers cannot communicate adequately with one another. This increases the risk of misdiagnosis and mistreatment. Medical providers have also been found to request more tests, hospitalise patients more often, and frequently delay initiation of treatment.
> c) Health education and compliance: Patients who have limited proficiency in the language(s) spoken by their health providers have an insufficient understanding of their condition and treatment options. This can lead to non-compliance and defaulting on medication.

In the more specific domain of sexual and reproductive health, account also needs to be taken of the gender factor. In Kenya, specifically, girls have far fewer chances of making it to school than boys,[5] which affects women's health literacy, especially in matters such as sexuality. Female and male language differences (e.g. Holmes, 1995; Lakoff, 1975) might also impact on healthcare outcomes. For instance, indirect non-confrontational styles of communication could lead women to say what they believe the health practitioner wants them to say, avoid questions, or voice agreement or understanding whether or not they actually do agree or understand. There may also be a preference for listening to a doctor over a nurse, or a male over a female, while in many situations, communication is

[4] Opportunities to achieve optimal health that are experienced by socially disadvantaged population.
[5] According to Unesco (2012), in 2008, "55% of poor girls living in the North-East had never been to school, with 43% of poor boys in the region in the same situation. This is, however, an improvement since 2003, when 71% of poor girls and 56% of poor boys in the North-East had never been to school".

established with male partners, depriving women of autonomy and not reflecting "her own wishes" (Upvall, Mohammed and Dodge, 2009, p. 4).

Existing gender hierarchies also determine who has access to which languages and which information, and this directly affects women's "soft skills", such as critical thinking, awareness, self-esteem, and ethnocultural and linguistic identities (Paltridge, 2012). This may affect the terminological decisions that the community interpreter is called upon to make. That is to say, in order to properly understand and transmit the meaning of terms, the interpreter needs to understand how the terminology may vary according to communicative context and domain (Moreno-Bello, 2017).

Finally, the community interpreter also needs to be sensitive to the emotional undertones of the interactions. As Bowen (2000, p. 2) points out in relation to community interpreting in general:

> The clients are worried, afraid, and sometimes illiterate. They find themselves in strange surroundings. Add to these difficulties the fact that the doctors, nurses, police officers, social workers etc. are usually in a hurry. They have a given caseload to take care of and are disinclined to let the interpreter do "a beautiful consecutive". In a nutshell, community interpreters need people skills as well as language and cultural knowledge – and interpreting know-how.

This is particularly relevant in healthcare settings like those that are the subject of our case study, given the delicate circumstances in which many patients find themselves. In practice, however, interpreters are not always available and, when they are, providers often find working through them frustrating and challenging (Lazar et al., 2013). There is, therefore, a need for further research into the cultural aspects of community interpreting in specific contexts such as these, with a view to implementing training for intercultural mediators and maximising available resources.

## 3. Case study: interpreting in healthcare settings in Kenya

This case study examines the role that interpreters play in contributing to health literacy. Based on data collected from personal interviews with healthcare practitioners in two health centres in Kenya between October 2018 and February 2019, it showcases the need for culturally attuned interpreters in cross-cultural and interlinguistic contexts to facilitate access to health literacy.

### *3.1 Framing the context: languages in Kenya*

Ethnologue[6] shows that the number of living languages in Kenya is 67. Considering the variety of languages currently spoken in rural Africa, and specifically in Kenya, the need for information also includes the need for translation and interpreting services. To illustrate this, data from Translators without Borders show they provided around 2.5 million words

[6] Available at: https://www.ethnologue.com (Accessed: 4 November 2018).

to more than 70 NGOs in 2011 alone.[7] According to this organisation, health information is available, but only in languages such as English or French, depending on whether you are in East or in West Africa, and these languages are spoken by less than 20% of the population.[8] Wiener and Rivera (2004, p. 94) concede to this, noting that when there are no medical interpreters, patients lack understanding of the medical encounter in general and are therefore less satisfied and less compliant than in interpreted consultations.

In the case of Kenya, the diversity of languages seriously hinders the standardisation of information provision. Let us consider the two languages of Gikuyu and Kiembu, for instance, which are both spoken in Kenya. As described by Gomes (2017, p. 11), these are Bantu languages belonging to the broader Niger-Congo language family.

Their language family structure is formed by different branches from the broader Nilo-Saharan language family of Dholuo, which is another language spoken in Kenya. In the case of Gikuyu and Kiembu, Ethnologue shows that their lexical similarity is 73%. Gikuyu and Kiembu share many branches and belong to the same broader language family, in opposition to Dholuo, which does not share any branches with either of these languages. All three are considered major languages within the recognised non-official languages in Kenya (English and Swahili only). However, while Gikuyu and Kiembu speakers would be able to communicate between them, Dholuo speakers would not be able to communicate with any of them (Gomes, 2017).

### *3.2 Data collection*

Data was collected between October 2018 and February 2019 in two centres providing health services in rural areas of East Kenya. The sample selected for this article is comprised of narratives supplied by healthcare practitioners providing sexual and reproductive health services to women in rural areas. The narrations were obtained through interviews with ten health practitioners, including specialists in antenatal and maternity care, specialists in sexual and reproductive health, a gynaecologist, childcare specialist, comprehensive care clinician, counsellor and representative from the refugee department. All were Kenyan women of different ethnicities, which meant that they spoke at least one of the minority languages of Kenya, in addition to English and Swahili.

The practitioners worked in two different healthcare facilities, the St. Francis Community Hospital in Kiambu (a 5-level hospital supported by Caritas and USAID and run by the Little Sisters of St. Francis of Assisi) and the Kwetu Kenya Organisation in Mtwapa (a local NGO that provides training to caregivers in small local communities). Both are located in rural areas of East Kenya and also offer community-based services. Due to the lack of resources, hospitals and NGOs cover large areas where the ethnicity of the population is very diverse. In the first centre, most of the staff are Gikuyu, but there are also staff

[7] Available at: https://www.translatorswithoutborders.org/blog/translators-without-borders-is-just-a-step-away (Accessed: 1 February 2019).

[8] Available at: https://www.translatorswithoutborders.org/blog/dying-for-lack-of-knowledge-by-cheryl-rettig (Accessed: 30 November 2018).

members from other tribes (Meru, Luo, Luya, Kamba) and patients of different ethnicities, including refugees. Healthcare practitioners from the second centre speak mainly Swahili and English. However, one of the distinctive features of the Kenyan coast (where the centre is located) is the Mijikenda language, meaning "the Nine Tribes", which is a group of nine related Bantu ethnic groups, between the Sabaki and the Umba rivers and stretching from the border with Tanzania in the south to the border with Somalia in the north.

As for the patients, these are mostly local women and refugees, whose English/Swahili is very poor or non-existent. In fact, refugees account for a big percentage of the population in rural areas, and in East Kenya these are mostly from South Sudan (24.4% of the total refugees of Kenya), the Democratic Republic of Congo (8.8%) and Ethiopia (5.9%).[9]

Neither of the centres have access to professional interpreters, so they tend to use family members or other healthcare practitioners to interpret. In many cases, especially with refugees, no one is able to speak their language and diagnoses are made without further information or medical records. As we will observe in our analysis, even when there is someone available to interpret, health providers apply specific techniques and strategies in order to facilitate disclosure and to avoid ambiguity, cultural clashes, and asymmetry in this specific context.

### *3.3 Methodology*

The interviews were conducted in the workplace after ethnographic observation of real consultations with patients. All interviews started with oral informed consent forms. The form describes the research purpose, procedures (including audio taping), risks, and benefits, as well as an explanation of the voluntary nature of participation, participants' right to stop at any time and procedures used for confidentiality.

This study applied a qualitative research method. The central research focused on the experience of providing sexual and reproductive advice and treatment to women in a given area of Kenya. To allow this information to emerge from the health practitioner's narration, unstructured in-depth interviews were conducted. The following research questions were among those posed to start the unstructured interview: How do you establish the language of the conversation? How often do you need an "interpreter"? Do you think patients feel happy when a third party is introduced in their consultation? How do you manage to communicate when there are no "interpreters" available? How do you handle specific terms? Does sense of responsibility or shame affect patients' answers? Do gender issues prevent the communication of specific sexual matters?

The interviews were recorded on a digital USB device and were considered complete when each participant exhausted the topic. Interviews were conducted in English, but some expressions or terms were in Swahili and the main local language (Gikuyu) or a combination of these languages. The data was analysed using the following steps: (1) ethnographic

[9] Although the majority of refugees and asylum seekers in Kenya as a whole originate from Somalia (54.5%). Available at: https://www.unhcr.org/ke/figures-at-a-glance (Accessed: 17 October 2018).

bracketing: listening repeatedly to audio recordings to get the "intention" of participants' meaning; and (2) identifying important statements and classifying answers according to the themes/barriers mentioned above. The data was analysed while still in the field to ensure themes were determined as soon as possible after data gathering. The corpus in these articles has been divided into barriers (gender and cultural intrusiveness) and strategies (language switch and building trust).

For the analysis, we used four of Hofstede, Hofstede and Minkov's (2010) dimensions to categorise barriers and strategies experienced and used by those practitioners. The dimensions selected were "masculinity *vs* femininity", to explore disclosure from patients (women); "uncertainty avoidance", to explain how language switch is used to avoid ambiguity; "individualism *vs* collectivism", to account for the need for cultural adaptation between health-belief systems; "power distance" and how to build trust in asymmetric contexts.

### *3.4 Research findings*

In this subsection, we will discuss the findings from the aforementioned study which will expose health practitioners' experiences when dealing with female patients in a multicultural environment. As mentioned above, it is structured around four of Hofstede, Hofstede and Minkov's (2010) dimensions to categorise barriers experienced and strategies used by those practitioners.

*Masculinity* vs *femininity: disclosure from a cultural and gendered perspective*

The vast array of possible ways to express gender through language across different cultures poses challenges. Goodwin (1980), Holmes (1995), Milroy (1992), and Nichols (1983) are some of the many scholars who have addressed the issue of why gender variation arises in language. In the following example, we will observe other ways in which gender and culture affects communication in health settings, specifically in terms of disclosure.

| **Example 1: Disclosure from a cultural and gendered perspective** |
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| In this context, the practitioner (M.M.) from Kwetu Kenya Organisation in Mtwapa explained the importance of verbalising sexuality explicitly instead of using euphemisms. Even though there is an initial reticence, the repetition of terms helps to normalise and understand previously culturally censored concepts. However, the context (health centre) and the language (English) provide a safe space that is not easily reproduced outside that environment (household, community, etc.), therefore, the confidence to talk about certain topics remains within hospital walls. |
| *"We want to improve communication between caregivers and their daughters, adolescents, and children. To tell them that is important to talk about sex. If you say the word 'sex' to them is something. You cannot say that in public, they will get into a shell. From what I have seen over the years, we have decided to talk about it. If you engage them a lot of times, they tend to accept, so it becomes something normal. But they would never really take it to their houses, to their husbands and talk to their children about it. Still will remain something [taboo], that the teacher said this and that's all, I am not talking about it with someone else. And of course, in* |

(continues)

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| *English when you say these words, doesn't sound as vulgar as in Swahili, and even worse in Mijikenda. So, if you say a word like that… 'Gono' in Swahili, I don't even know it in my own language."* |
| As we can see, language plays a crucial role in the communication and normalisation of certain matters, specifically regarding women's sexuality. In this case, language can be perceived as violent depending on how the idea is presented. In this excerpt, register and language itself (English, Swahili or Mijikenda) need to be considered. Every language has its own rules directly related to culture and provides a channel through which ideas follow specific cognitive maps. In this case, the practitioner recognises the difficulties of conveying the idea from one channel (English) and environment (health centre) to another channel (Swahili/Mijikenda) and environment (house/community). However, she insists on the importance of repetition as a tool to normalise the idea in women's mindset. |

| **Example 2: Disclosure from a cultural and gendered perspective** |
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| The importance of gender is directly related to the influence of community bonds. In this excerpt, we can read how the gynaecologist (Dr. M.) suggests the relation between kinship and disclosure. In addition, we can observe that even though women tend to feel more comfortable when talking to female practitioners, they might feel different towards close family members. |
| *"Sometimes it is easier to communicate with another woman. Preferably not family because if you call a relative, they might feel that their confidentiality is being violated. But there are others who choose to come with a family member who feel more comfortable with. Surprisingly, I have seen women coming with their brother-in-law, discussing intimate issues."* |
| Professional interpreters are often replaced by any person who can interpret between both languages and, in many cases, relatives are the only ones available. This violates the confidentiality principle and hinders the creation of a suitable atmosphere for disclosure. In some cases, non-immediate relatives can be trusted and offer support in one's access to health services, but unacceptable social relations (e.g. a lover or a pimp) might be disguised as family members (e.g. a brother-in-law) to make it look socially appropriate. |

| **Example 3: Disclosure from a cultural and gendered perspective** |
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| Much in the same way as repetition and the use of the vernacular can help to normalise and assimilate delicate content, time and trust remain key to the process. In this case, J. K., the hospital counsellor, insists on reiteration as a way of creating rapport and building trust. In some cultures, women may lack experience in dealing with sickness or treatment. They might be unaware of the risks of not disclosing relevant information or be restrained by their own cultural values. |
| *"You work on creating the rapport and winning the confidence, that is why we have to run sessions, not just one session. As you continue meeting, she will get the confidence to share. If the person comes and it is not ready to open up, you cannot force someone, you give her an appointment and if she is willing, you bring her back and she is able to open up and be able to get something. That is why we know normally face first rejections because one is suffering deep inside. They are in denial, they have not accepted it, so she feels as if you are the one pushing this into her."* |
| This is a recurrent technique in cultural communication. Acceptance and understating might be achieved by reiteration and provision of time to process the information. The impact on healthcare perception is essential and articulating pain requires more time and trust in women than in men, especially for those women who have not been exposed to health information before. |

*Uncertainty avoidance: language switch as cultural adaptation*

In this context, uncertainty avoidance is related with the fear that some patients might experience when facing unknown medical practices (modern medicine *vs* traditional medicine). The ethnographic research revealed intolerance towards specific topics based on cultural or religious beliefs, especially in the area of sexual and reproductive health. In the following examples we will examine different communication strategies used by health practitioners, including code-mixing and the creation of hybrid languages such as Sheng in Kenya (Ferrari, 2012).

| **Example 4: Embracing the unexpected through language switch** |
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| The practitioner from the antenatal clinic (J.) indicates the need to consider the culture and the context. In first encounters with Kenyan women, it is always easier to use euphemisms and digression in order to address a delicate matter such as sexuality. This is a way of reducing the impact of words on the patient who perceives that switch as a change of register. |
| *"It is called Sheng, it is not a direct language, but you put it in such a way that it may not block them, you don't say it in a direct way. You can use many words to explain what you mean, like having sex. There is a way, we can use many other words that they would be more comfortable with, you handle it depending on the age, we look at the age. There are several ways you can express yourself; you can use several words to express the same thing."* |
| This excerpt highlights how specific lexical choices are often used as a tool for cultural adaptation at an interactional level. In this case, age and gender are addressed. Sheng is used as a strategy to soften the language, as Wachilonga (2015, p. 5) states: "foreignizing aspects of translation is closely related to the polite nature of Swahili". |

| **Example 5: Embracing the unexpected through language switch** |
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| Sharing the language provides an immediate feeling of belonging and sharing common spaces such as community ties, shared beliefs, and similar backgrounds. It is a way of both communicating better and of building trust from inner premises. |
| *"You find them very comfortable if the person is Gikuyu and you are Gikuyu, they feel so much comfortable with that, they feel happy with that. But for you, you can't start talking Gikuyu to them, you have to wait for them to start talking Gikuyu […]"* |
| As we can see in many of these examples, language is not only a communication channel but a cultural channel. Communicating in the same language immediately breaks barriers. |

*Individualism vs collectivism: health belief systems in perspective*

As culture and gender determine preference of register and approach, the use of direct, confrontational styles of communication could be a cause of conflict or could lead patients to say what they believe the practitioner wants them to say. This asymmetry, or just the fact that in some cultures there is a disproportionate social distance between practitioners and patients, could lead a patient to agree or express understanding, whether they actually do or not. As explained by Singleton and Krause (2009), "asking questions and self-advocating in high context cultures might not be acceptable. Sometimes culture even influences which healthcare provider(s) a patient or family member will listen to and/or speak with". These cultural preferences can influence a patient's listening and speaking practices when receiving delicate health information.

| **Example 6: Cultural intrusiveness** |
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| In this case, the practitioner (E. K.) from the Community Based Healthcare Programme refers to the cultural intrusiveness of international organisations. She speaks about the cultural clash when international organisations provide services to local communities in Kenya. |
| *"But you know, once you go to another country and you want to do your own thing, those people will find it very different. So, when you come with those things from Spain maybe they will not bring that much difference in Kenya […] As, when you are in Kenya the services are very different from Spain and now you want to come with your [ideas] to Kenya?"* |
| In this case, communication is prevented by cultural intrusiveness. Provision of services and communication of information need cultural adaptation. Patients are less willing to listen or collaborate if what is offered is unknown. |

| **Example 7: Cultural intrusiveness** |
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| The hospital counsellor (J. K.) describes the lack of trust in rural communities towards health centres. She refers to the bond that community creates and the perception of distance in relation to the practitioner. |
| *"They feel they can own their problems as a tribe. So, someone from outside, they feel you [can] not understand deeper their stuff. You always see them talking together, walking together. Suddenly, the whole hospital would be populated with most of them, they believe that it's their problem. They don't want to disclose it."* |
| A disagreement on health belief systems could be a reason for conflict and affect the assimilation of the message. When providing health education, it is important to always adapt the message to the belief of the target culture (Chang and Kelly, 2007). Besides, people's behaviours and actions, when taking crucial health decisions, depend not only on their literacy level but also on their cultural understanding of risk. As Singleton and Krause (2009) state, "understanding the concept of risk and/or the degree of risk of developing a disease or experiencing an adverse event involves complex, numeracy-based, health literacy skills". These skills "draw upon culturally driven value and ethical systems, preferences, norms, and time-sensitive responsibility". |

| **Example 8: Cultural intrusiveness** |
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| A similar case of how cultural intrusiveness affects trust and provision of services is narrated in this excerpt. In order to avoid this situation, M. M. from KKO normally relies on untrained interpreters from the community. Even though M. M. is Kenyan, she is considered a foreigner, since she does not belong to the same tribe or community. She also points out that the message is better communicated if it comes from someone who has authority in the community, such as a local leader. |
| *"It is always the best thing to have someone within that community itself, because if someone comes from outside their perception [is]: This is a foreigner, someone from a different area and they wouldn't speak as free and convincingly as with other people. So, it's better. If I want someone to interpret for me, I will go to those local leaders."* |
| In this case, someone from the community who can interpret would at least provide some sense of trust and be able to facilitate the channel of communication. |

*Power distance: building trust in asymmetric contexts*

Another specific characteristic of healthcare settings is the asymmetry between patients and healthcare providers (Lazaro, 2014). Understanding language in the context of a medical encounter can be difficult to navigate even when language competence is high.

Difficulties increase when the patient does not speak the language used by the practitioner, literacy is low or cultural protocols are not followed.

| **Example 9: Communication in asymmetric contexts** |
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| The following scenario also presents the need for linguistic and cultural adaptation. E. K. from CBHCP (Community-Based Health Care Program) describes the importance of knowing to whom you are passing the message on, in order to communicate accordingly. |
| *"[…] and then also it will depend on the age because you cannot just go and visit the Shosho, an old man or woman, and then you start talking English to that Shosho. You have to, first, know the tribe of this person so that you can make sure that whatever you talk helps this person."* |
| Social hierarchies, cultural beliefs and protocols are key when making linguistic choices. English is not an option when entering and targeting a local community, even though individuals might understand the language. |

| **Example 10: Communication in asymmetric contexts** |
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| In many cases, as explained by Herselman (1996, p. 159) in his ethnographic study of health communication in the Eastern Cape, patients tend to answer questions about their knowledge of English in the affirmative because they fear "risking anger or ridicule from doctors and nurses" if they were to admit that their proficiency was limited (see also Schlemmer and Mash, 2006). In this case, the practitioner from the CBHCP highlights the asymmetry between practitioner and patient. |
| *"You know, when the doctor says you have to do this [blood test], you have to cooperate, even if you fear. We have to tell them I want to do this and this, and now the patient will be able to know you want to take blood from them."* |
| Asymmetry in health care contexts can cause fear and may lead to rejection and hostility. Explanations and descriptions of steps are helpful when building trust and conveying information in such contexts. |

| **Example 11: Communication in asymmetric contexts** |
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| The practitioner from CBHCP reiterates that time is key in the creation of rapport and the building of trust. |
| *"When they don't want to talk to you, you just give them time, talk to others and then you will go back there again, many times until they open to you. You don't force them."* |
| This is another example of how reiteration and time are key for intercultural communication in the given context. In this case, mainly due to asymmetry between participants. |

## 4. Conclusions

In this article, we have discussed how culture affects communication in health settings and its impact on health literacy, with a special focus on women's sexual and reproductive health. The study explored cultural and linguistic barriers between healthcare providers and patients from two health centres in East Kenya with a view to providing relevant information that could be used by interpreters who wish to work with patients of this specific culture. From it, we learned that: 1) in this multilingual environment, the choice of which language to use in the healthcare encounter affects transmission of information, as

well as the use of a particular register within each language; 2) every language/dialect has its own rules according to the culture to which it belongs (full knowledge of these rules will facilitate disclosure and compliance during consultations, while factors such as reiteration and time can also help with normalisation of unknown elements); 3) fear of the unknown can be reduced by adapting methods and language to the target culture, and code-mixing is often used as a strategy to show politeness or reduce emotional burden of words; 4) understanding risk is highly related with health literacy, and patients are less likely to follow unknown treatments, therefore, cultural adaptation is key for communication; and 5) following protocols of the target culture and rapport building can help reduce asymmetry in this setting.

As foreign and Westernised views have proven to be obsolete in this context, good practices and lessons learned by local health practitioners should be applied to training. Therefore, a more indigenous look is recommended in future studies and applications to training.

Despite the work of organisations such as Translators without Borders, which provide local language analysis and content, language training, capacity building, language technology solutions and overall translation, the lack of specific resources for minority languages is still a challenge in Africa. This vision is clearly at odds with the training received by interpreters in the field. Specially-trained local interpreters within the community could be helpful in solving most cultural and linguistic barriers in this setting.

**REFERENCES**

Andrulis, D. and Brach, C. (2007) 'Integrating literacy, culture, and language to improve health care quality for diverse populations', *American Journal of Health Behavior*, 31(1), pp. 122-133.

Bowen, M. (2000) 'Community Interpreting', *International Association of Conference Interpreters* [online]. Available at: https://aiic.net/page/234/community-interpreting/lang/1 (Accessed: 13 December 2018).

Chang, M. and Kelly, A. (2007) 'Patient education: addressing cultural diversity and health literacy issues', *Urologic Nursing*, 27(5), pp. 411-417.

Cokely, D. (1985) 'Towards a sociolinguistic model of the interpreting process: focus on ASL and English', PhD diss., Georgetown University.

Cokely, D. (1992) *Interpretation: a sociolinguistic model*. Burtonsville: Linstok Press.

Cox, A. and Lázaro Gutiérrez, R. (2016) 'Interpreting in the emergency department: how context matters for practice' in Federici, F. M. (ed.) *Mediating emergencies and conflicts*. London: Palgrave Macmillan, pp. 33-58.

Depaula, P. and Saucedo, B. (2010) 'Globalización, cultura y desarrollo de inteligencia cultural en contextos militares. Algunas aproximaciones teóricas', *Revista Digital Universitaria del Colegio Militar de la Nación*, 22(8), pp. 1-15.

Deumert, A. (2010) ''It would be nice if they could give us more language': serving South Africa's multilingual patient base', *Social Science and Medicine*, 71(1), pp. 53-61.

Ferrari, A. (2012) *Émergence d'une langue urbaine: le sheng de Nairobi*. Louvain: Peeters.

Gomes, J. (2017) 'The health costs of ethnic distance: evidence from Sub-Saharan Africa', *ISER Working Paper Series*, 33, pp. 1-49, [online]. Available at:

https://www.iser.essex.ac.uk/research/publications/working-papers/iser/2014-33.pdf (Accessed: 13 December 2018).

Goodwin, M. H. (1980) 'Directive-response speech sequences in girls' and boys' task activities', in McConnell-Ginet, S., Borker, R. and Furman, N. (ed.) *Women and Language in Literature and Society*. New York: Praeger, pp. 157-173.

Herselman, S. (1996) 'Some problems in health communication in a multicultural clinical setting: a South African experience', *Health Communication*, 8(2), pp. 153-170.

Hofstede, G., Hofstede, G. J. and Minkov, M. (2010) *Cultures and organizations: software of the mind*. 3rd edn. London: McGraw-Hill.

Holmes, J. (1995) *Women, men, and politeness*. London: Routledge.

Karliner, L., Jacobs, E., Chen, A. and Mutha, S. (2007) 'Do professional interpreters improve clinical care for patients with limited English proficiency?: a systematic review of the literature', *Health Services Research*, 42(2), pp. 727-754.

Karliner, L. S., Auerbach, A., Nápoles, A., Schillinger, D., Nickleach, D. and Pérez-Stable, E. J. (2012) 'Language barriers and understanding of hospital discharge instructions', *Medical Care*, 50(4), pp. 283-289.

Lakoff, R. T. (1975) *Language and woman's place*. New York: Harper and Row.

Lazar, J., Johnson-Agbakwu, C., Davis, O. and Shipp, M. (2013) 'Providers' perceptions of challenges in obstetrical care for Somali women', *Obstetrics and Gynecology International*, 13, pp. 1-12.

Lázaro, R. (2014) 'Use and abuse of an interpreter', in Valero Garcés, C. (ed) *(Re)visiting ethics and ideology in situations of conflict*. Alcalá de Henares: Universidad de Alcalá, pp. 214-221.

Marais, K. and Delgado, C. (2018) 'Motivating the translation-development nexus: exploring cases from the African continent', *The Translator*, 24(4), pp. 380-394.

Martin, A. (2000) 'La interpretación social en España" in Kelly, D. (ed.) *La traducción y la interpretación en España hoy: perspectivas profesionales*. Granada: Comares, pp. 207-224.

Metzeger, M. (1995) 'The paradox of neutrality: a comparison of interpreters' goals with the reality of interactive discourse', PhD diss., Georgetown University.

Milroy, L. (1992) 'New perspectives in the analysis of sex differentiation in language', *Sociolinguistics today: international perspectives*. London: Routledge, pp. 163-179.

Moreno-Bello, Y. (2017) 'Aplicación de estúdios sociolinguísticos en zonas de conflicto: el caso del intérprete de guerra', PhD diss., Universidad de Alcalá.

Nichols, P. (1983) 'Linguistic options and choices for Black women in the rural South' in Thorne, B., Kramarae, C. and Henley, N. (ed.) *Language, gender and society*. Rowley: Newbury House, pp. 54-68.

Nielsen-Bohlman, L., Panzer, A. M. and Kindig, D. A. (ed.) (2004) *Health literacy: a prescription to end confusion*. Washington, DC: The National Academies Press.

Nyandiva, O. (2009) 'The role of culture in a patient's healthcare literacy: a case study of patients from Galkayo, Puntland Somalia', *OJIN: The Online Journal of Issues in Nursing*, 14(3), [online]. PDF file.

Páez, D. and Zubieta, E. (2005) 'Cultura y psicología social' in Páez, D., Fernández, I., Ubillos, S. and Zubieta, E. (ed.) *Psicología social, cultura y educación*. Madrid: Pearson Education, pp. 25-44.

Paltridge, B. (2012) *Discourse analysis: an introduction*. London: Bloomsbury.

Riccardi, A. (2002) 'Translation and interpretation' in Riccardi, A. (ed.) *Translation Studies: perspectives on an emerging discipline*. Cambridge: Cambridge University Press, pp. 75-91.

Schlemmer, A. and Mash, B. (2006) 'The effects of a language barrier in a South African district hospital', *South African Medical Journal*, 96(10), pp. 1084-1087.

Singleton, K. and Krause, E. (2009) 'Understanding cultural and linguistic barriers to health literacy', *OJIN: The Online Journal of Issues in Nursing*, 14(3), Manuscript 4.

Tiayon, C. (2005) 'Community interpreting: an African perspective', *Hermêneus. Revista de Traducción e Interpretación*, 7, pp. 1-12.

Unesco (2012) 'Fact sheet: education in Kenya' [online]. Available at: https://en.unesco.org/gem-report/sites/gem-report/files/EDUCATION_IN_KENYA_A_FACT_SHEET.pdf (Accessed: 13 December 2018).

Upvall, M. J., Mohammed, K. and Dodge, P. D. (2009) 'Perspectives of Somali Bantu refugee women living with circumcision in the United States: a focus group approach', *International Journal of Nursing Studies*, 46(3), pp. 360-368.

Wachilonga, S. C. (2015) 'Politeness as an impediment to translation: a case of medical translation', Masters diss., University of Nairobi.

Wiener, E. and Rivera, M. (2004) 'Bridging language barriers: how to work with an interpreter', *Clinical Paediatric Emergency Medicine*, 5(2), pp. 93-101.

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