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Influence of Interpretation on Patient-Healthcare Provider Communication and Management of Chronic Conditions in Kenya: A Case of JOOTRH Hospital Kisumu

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Abstract
The Ministry of Health in Kenya projects that deaths from chronic conditions will increase by 65% by 2030. To efficiently manage chronic illnesses, effective communication between patients and healthcare providers is of crucial importance. However, studies have shown that many patients lack knowledge about their conditions and the treatment processes. This study investigated the experiences of patients and caregivers while communicating with healthcare-providers on management of chronic conditions. The study was undertaken at the Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) in Kisumu County, Kenya. It adopted the relativist-interpretivist paradigm and qualitative approach to generate and analyse data. Purposive and snowball sampling techniques were used to identify 10 patients and 5 caregivers who were drawn from patient support groups at the hospital. 10 healthcare providers were sampled. Data was generated through in-depth interviews and focus group discussions which were transcribed and analyzed using a thematic approach. Study findings indicate that healthcare providers were knowledgeable and believed that patients needed to be given relevant information. English was the main language used by health providers, which often created a language barrier among patients and caregivers who did not understand the language. This created opportunities for misinformation when interpreters were used. The hospital lacked trained interpreters, hence caregivers and hospital staff acted as interpreters. This was found to affect patients' privacy and disclosure, especially where the patient did not want their health information to be accessed by a third party. Patients felt the information they received to be inadequate.

Introduction
In the African context, studies have shown that healthcare provider-patient communication is affected by several factors. The multilingual nature of most African communities is one of the factors. In South Africa, consultations are frequently language discordant. This creates barriers to access to healthcare and has led to diminishing trust between healthcare providers and patients

(Anderson *et al*., 2003). This discordance has resulted in diagnostic and therapeutic errors (Fiscella *et* al., 2002). Research has been devoted to developing medical terminology in different African languages where none exists, defining existing words by local communities and documenting these terms (Madzimbamuto, 2012; Engelbrecht, 2010). The challenge in developing medical terminology has been that one word in one community may denote something entirely different in another. The multilingual contexts in Africa have forced healthcare providers, patients and caregivers to use interpreters.

Baron et al. (2010) opine that healthcare interpreters help overcome communication challenges that interfere with the quality of medical care. The training and use of interpreters have equally been an area of concern since it has led to numerous communication errors and are perceived negatively by staff and patients (Kilian *et al*., 2021). Contemporary patients want to be partners in healthcare decision-making and expect to be involved in medical care, unlike before, when the patient-physician relationship was based on blind trust (Norman, 2015). Language barriers between physicians and patients have been studied as possible sources of frustrations, misunderstandings and miscommunication (Garrett et al., 2018). Language barriers may also affect the patient's ability to understand the health providers' instructions, affecting the patient's disclosure. This may, in turn, affect the treatment and management of chronic conditions.

Kenya also faces the challenge of chronic conditions. Most patients report to patients report to the hospital when their conditions are advanced. In Kenya, multilingualism significantly impacts doctor-patient communication, particularly in chronic disease management.

Healthcare delivery processes demand communication between a healthcare provider and a patient. Communication is one of the strategies that can be used to manage chronic conditions. Empowering patients and giving them access to information will enable them to obtain, process, understand, and better manage their conditions. According to the Ministry of Health (2021), chronic conditions contribute to about 32% of the total mortality rate in Kenya. Kenya faces challenges due to a general lack of understanding and knowledge about chronic conditions among the public.

Moreover, the doctor-patients ratio in Kisumu is 1:144,634 and one nurse to 2,383 people. This indicates that healthcare providers hardly get enough time to meaningfully interact with the patients. Therefore, this study explored communication challenges affecting effective healthcare provider-patient and caregiver communication among patients with chronic conditions in JOOTRH in Kisumu County.

Literature Review

Healthcare Providers and Patient Communication of Chronic Conditions in Kenya

Statistics indicate that Kenya has a heavy disease burden, with an average life expectancy of 67.21 years (United Nations, 2022). Like the rest of the world, Kenya faces the challenge of chronic conditions. The most common chronic conditions reported in Kenya include cancer, diabetes, cardiovascular diseases and chronic obstructive pulmonary diseases. Cancer is the second cause of death among non-communicable disease-related deaths (Ministry of Health, 2021). Data from the Ministry of Health Kenya (2021) posit a 54% and 62% increase in outpatient visits attributed to hypertension and diabetes between 2016 and 2019 (MOH, 2021).

According to Osborne (2004), there are language and communication breakdowns because doctors are trained in English, yet most of their clients can hardly understand or communicate in English. In

addition, medical labels are in foreign languages, not Kiswahili or vernacular. Lastly, the number of illiterate people is high.

According to Henry *et al*. (2021), healthcare providers struggle with vocabulary limitations when communicating with patients in indigenous languages since medical terminology does not have equivalents in most local languages. Due to vocabulary inadequacies, most patients and physicians maintained different levels of understanding of the diagnosis. Medical language differs significantly from everyday language, which may lead to miscommunication. Based on the information provided by the studies previously carried out (Osborne, 2004; Gatimu, 2018; Henry *et al*., 2021), it is evident that there are communication challenges in the interactions carried out between healthcare providers and patients with chronic conditions; hence the need to address this concern.

Management of chronic conditions calls for effective communication between healthcare providers and patients. Patients with such conditions should be sensitised to the need to get adequate information so that they are not only aware of their conditions but are equipped with vital information that will enable them to make informed decisions about their health.

Theoretical Framework

Communication Accommodation Theory

This study is based on Communication Accommodation Theory (CAT) developed by Howard Giles, which argues that "when people interact, they adjust their speech, their vocal patterns and their gestures, to accommodate others". It explores the various reasons individuals emphasise or minimise the social differences between themselves and their interlocutors through verbal and nonverbal communication. This theory is concerned with the links between language, context and identity. It focuses on the intergroup and interpersonal factors that lead to accommodation and how power, macro, and micro-context concerns affect communication behaviours (Gregory Jr. & Webster, 1996). This theory describes two main accommodation processes "Convergence" refers to how individuals adapt to each other's communicative behaviours to reduce these social differences. Meanwhile, "divergence" refers to the instances in which individuals accentuate the speech and non-verbal differences between themselves and their interlocutors (Gregory Jr. & Webster, 1996).

CAT sets out to 'describe and explain aspects of the way people modify their communication according to situational, personal, or even interactional variables.' The model provides a framework through which changes in communicative behaviour might be considered concerning specific psychological processes that either diminish or exacerbate the differences between interlocutors (Ryder & Garagounis, 2014). The processes of convergence and divergence are of significance to the healthcare provider-patient relationship since it is essential in the early phase, when a speaker aims to improve the quality of interaction, in a process called 'communicative tuning', he or she will select communication strategies that attend to or anticipate the communication needs and characteristics of another. This includes using plain language (rather than jargon), providing nonverbal cues, asking open-ended questions, and mimicking the other person's body language and verbal behaviour (Ryder & Garagounis, 2014).

Methodology

This study is situated within the relativist interpretivist philosophical research paradigm. Relativists take a subjective position that there is no single viewpoint of the world; therefore, reality depends on the individual's perceptions and experiences (Richards, 2003). The study used the qualitative approach, which was concerned with meaning (Willig, 2008). They are interested in how people make sense of the world and how they experience events.

Case Study Method

An instrumental case study was used. The case chosen was Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH), in which the Healthcare Provider and patient communication were studied. A case study was considered appropriate because it allowed the researchers to get a deep understanding of the content of the study. The research mainly used interviews to collect data. Purposive sampling was used to select health providers (doctors, nurses and clinical officers). Snowballing was used to select patients with chronic conditions. The researcher identified patients with chronic conditions who are members of the various support groups. Patients with chronic conditions referred the researcher to other patients willing to participate in the study. Using this method, patients with chronic conditions were selected. Non-probability sampling procedure does not afford any basis for estimating the probability that each item in the population has a chance of being included in the sample (Kothari, 2009). The number of participants was determined based on saturation level.

Some patients were accompanied by caregivers based on their current health condition or because they were not fluent in English or Kiswahili. Hence, they needed the caregiver's help in translation and interpretation. Five caregivers were included in the study.

Interviews were mainly used for data collection. Ten healthcare providers, 15 patients and five caregivers were interviewed. In addition to the interviews, the researchers also used focus group discussions. Focus group discussions arguably provide researchers with more information in that individuals are not restricted by the answers they give (Krueger & Casey, 2015).

Data Processing and Analysis

Thematic analysis was used to analyse the collected data. The thematic analysis moves beyond counting explicit phrases and focuses on identifying and describing implicit and explicit ideas within the data, that is, themes. The codes are then developed to represent the identified themes and applied or linked to raw data as summary markers for later analysis (Denzin & Lincon, 2011).

Ethical Considerations

Ethical issues were addressed. The researchers obtained a letter of introduction from Moi University. The Ethics Review Committee of JOOTRH reviewed the study proposal. Researchers also got permission from the National Commission for Science, Technology and Innovation. Informed consent was upheld in the study. The anonymity and confidentiality of the participants were also upheld. The findings were treated with anonymity and confidentiality by ensuring that responses were not linked directly to specific participants. The principle of non-maleficence was also observed by considering a patient's health condition before seeking informed consent for an interview. Participants in visibly poor health conditions were not interviewed

Discussion

This paper examined how much the caregiver role impacted the healthcare provider and patient communication. The study findings revealed that caregivers mainly acted as interpreters in the healthcare provider and patient communication process. Interpretation refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language. Language barriers often occur during the health provider-patient encounter, necessitating an interpreter. Doctors revealed that whenever they found a patient who struggled to communicate, they would ask the accompanying relative or caregiver to provide the translation services. If the patient were unaccompanied, the health providers would seek an interpreter. As observed in this study, most health providers at JOOTRH were not native Dholuo speakers. A good number spoke

and understood basic Kiswahili, making it hard to communicate with patients. Similarly, most patients were drawn from the neighbouring Dholuo-dominant communities. Asked to explain their experiences with language problems and the role of caregivers as interpreters, the health providers made the remarks as cited below.

Healthcare Providers' Views

> I have noticed that when an interpreter is present, the conversation is rarely the same as a one-on-one encounter. At times, the patient gives a detailed answer. Still, the interpreter only passes the information in a sentence or two or uses a few words and phrases …in other cases, I would ask the interpreter a question so that they translate it to the patient. Some give me an answer without talking to the patient. If I insist on them seeking the answers from the patient, they say they have the patient's best interest at heart. (Health Provider 4).

> I struggle to communicate with patients who are not fluent in either English or Swahili. Language barrier is a challenge I have to face every day since I do not speak the local language. I see a lot of patients in this rural setup who come …… and are unable to express their condition. …When I explain that cancer occurs due to spontaneous mutation of cells in the body in Kiswahili, I translate it *as zile celli za mwili zinabadilika na mutation tunasema zinazaana tu. Radiation- miale ya radiation au ule moto unaenda kuchoma zile seli.* (Health Provider 5).

The healthcare providers thought that interpreters played an essential role in facilitating communication, but interpretation faced challenges. Caregivers who act as ad hoc interpreters interpret and translate messages from the patient to the healthcare provider and vice versa. However, sometimes, they answer questions concerning the patients' health/ status without getting a response from the patient. They summarised the response instead of giving the details as had been given by the patient. Healthcare providers equally voiced concerns about the interpreters' message accurately. Some reactions were either lengthened or shortened.

> I once came across an elderly diabetic man who had been accompanied by his daughter when they came to seek treatment. I suspected the man could be having kidney failure, and to ascertain, I had to ask questions. The daughter was the interpreter since the father only spoke Dholuo and a few essential words in Kiswahili. …then, during the discussion, she declined and asked if I could get a male interpreter who spoke Dholuo well. She later confessed that she found asking her father personal questions demanding and disrespectful and did not feel free to interpret. (Health Provider 6).

Health Providers 4, 5 and 6 confirmed that they encountered patients with communication difficulties due to language barriers. Although some patients and caregivers could speak English or Kiswahili, they had different proficiency levels. One patient confessed that he understood only simple Swahili but struggled with complex Swahili vocabulary.

> I have had patients, especially elderly women, who are accompanied by their relatives/children. They help with the translation and interpretation but never disclose to them the disease they are suffering from. Some argue they are protecting them to prevent their health from deteriorating.

On the contrary, healthcare providers voiced concerns about withholding information from the patients by the caregivers, who argued that they were doing so in the patient's interest.

The patients also gave various views concerning the healthcare provider and patient communication when they had interpreters.

> My son usually accompanies me and helps translate when I communicate with the doctors ….. I prefer it when I get a doctor or nurse who can speak my mother tongue. When I talk to a doctor who understands my mother tongue, I find it easier to express myself and understand the instructions he/she provides. I feel free to follow instructions, ask questions and seek clarifications. When my son interprets, I think he does not translate the whole conversation. There are things he hides from me…. he fears I will not respond well. (Patient 1).
>
> ... for example, several people do not understand English or Kiswahili and only know the Dholuo language. …find that explaining these things to doctors is very difficult for these people. You will find the doctor just writing. Sometimes, I understand the little the doctor translates to Dholuo. (Patient 3).
>
> Depending on who is translating, I don't feel free to say it all. I fear they may not keep it to themselves. (Patient 3)
>
> For example, a year ago, I was busy and requested my niece to accompany my mother to the hospital. …. the doctor changed Mum's medication regimen and the dosage. She was told not to use her other medicine for a month so that the doctor could monitor her progress. My niece, the caregiver at this time, misunderstood the instructions about the changes. Mum continued to take the old dosage and, I suspect, even mixed the medications. As a result, her health was affected … (Caregiver 5)

The study findings indicate that the presence of a caregiver as an interpreter can enhance the development of trust between the patient and the health provider. When patients are comfortable with their caregivers, they may be more open to disclosing information that can enhance the health providers' understanding of the patient's condition and needs.

However, the presence of a third party affects the patient-healthcare provider communication. Family members lack impartiality. Their emotional ties led to biased interpretations. Some unintentionally alter or filter information to protect the patient or themselves. This may affect the discussions about treatment options and patient care goals.

Reliance on family interpreters is associated with miscommunication and increased communication errors. This may result in mismanagement since the patients may not fully grasp their diagnosis, treatment options, prescription or the necessary lifestyle changes.

The presence of an interpreter also affects clinical assessments and discussions on sensitive issues related to prognosis and treatment adherence. Healthcare providers may struggle to gauge the patients' understanding and feelings. This, in turn, affects patient satisfaction.

Some concerns included extended, uninterpreted, and ignored turns during consultations. According to Health Provider 4, the challenge with interpreter-mediated encounters is that providers are not in a position to control the flow of the conversation as effectively as they rely on the interpreter to prevent or limit the patients' narrative. They rely on the information interpreters give to make clinical decisions that may not reflect the patient's actual position.

Interpretation affects privacy and disclosure issues. Sometimes, healthcare providers had to rely on relatives or friends present to translate information to the patient. Some interpreters would freely

ask the patients questions and convey the same information to the doctor/nurse. On the contrary, some conversations were difficult based on the age and relationship of the patient and caregiver, as in the case of the diabetic father and the daughter, where the daughter found it difficult to ask for personal and medical-related information as required by the health care provider. Culture played a significant role in the above; in the African culture, in this case, the Dholuo culture, there are private matters that a daughter cannot freely discuss with the father.

One healthcare provider observed women were not willing to disclose some issues to a male interpreter. Opening up to a stranger was equally difficult for a patient. Some patients were also not comfortable with having relatives as interpreters as they feared that they would discuss their conditions with family and friends.

Healthcare providers also raised concerns regarding interpreting medical terminology and some English words in Kiswahili and the mother tongue. They felt that a lot of meaning was likely to be lost in simplification and translation. Interpreters have difficulty in translating. It was also clear that most interpreters are not trained and, as a result, do not give the exact translation as required. This lengthened the consultation time, yet in some cases, the healthcare provider did not fully understand the patient.

Medical jargon without translation and detailed explanation posed challenges to the patient. The translated message at times retained the non-translated scientific term, e.g. cancer. Medical jargon affected their understanding and discouraged their participation in the conversation. Patients felt that most of the medical information provided to them was unfamiliar or in English, making it hard to understand the details of the disease. The translation process failed in its purpose because the patient's needs were not fully addressed. When the translators found complex terms, they sometimes skipped the term, yet this could be the word key to understanding the message.

In the local languages, healthcare providers found it hard to explain specific terms to patients, like hypoglycemia, echo–test, artery, chemotherapy and radiotherapy. Interpreted communication denies patients a chance to fully tell their side of the story since it does not encourage dialogue and active participation of the patient. Previous studies on vocabulary and medical terms found that patients' limited vocabulary, compounded by the physician's overuse of medical terms, is the primary source of inadequate communication between the patients and healthcare provider (Davis et al., 2000)

A study carried out in South Africa revealed that while medical staff spoke English or Afrikaans, yet many patients spoke Xhosa. Patients had a culture of specific disease labelling that differed from that of healthcare providers. This resulted in misunderstanding and misdiagnosis. Findings from the study indicate that due to limited vocabularies and assumed meanings, patients' care was affected and could be compromised. Illiterate patients felt they did not have adequate knowledge about their condition. They were reluctant to ask questions or actively participate in their conversations relating to the treatment (Van den Berg, 2016).

Previous research findings suggest that using interpreters to provide language-concordant care is not free from limitations. Interpreters are not always aware of medical terminology and may find it challenging to explain it to patients (Bischoff & Hudelson, 2010). Ideally, hospitals should have medically well-trained interpreters. However, in most African countries, there are very few interpreters. Interpretation is equally time-consuming and expensive. This finding contradicts previous research, which suggests that using interpreters can reduce the cost of care (Jacobs *et al.*, 2007).

Conclusion

In conclusion, although interpreters significantly enhance communication between healthcare providers and patients in Kenya, ongoing efforts are needed to address training gaps and improve interpreter availability. These measures are essential for ensuring equitable access to healthcare services for patients with chronic conditions.

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