

Speaking the language of the patient: indigenous language policy and practice

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South Africa faces numerous challenges in healthcare, with the result that communities in many rural provinces are grossly underserved. These problems are compounded when doctors are unable to communicate with their patients. *IsiZulu* is spoken by most people in KwaZulu-Natal. Older and rural patients often present as monolingual *isiZulu* speakers. The need and ability to speak an indigenous language is emphasised in communication, identified as a core competency for doctors. The benefits of language-concordant health care have been documented, and policies at national, regional and institutional level provide for language diversity. As first-language English users, medical students have to be trained to become competent in speaking *isiZulu*. This mixed-method study assessed the knowledge, attitudes and perceptions of third-year students who had received *isiZulu*-training during their first year at the University of KwaZulu-Natal. The results indicated an improvement in students' communicative competence. In general, positive attitudes were held by the students towards the language, but there was a perceived need for additional input in order for the students to become competent.

Keywords: communication, *isiZulu*, language, policy, practice, rural patients

Introduction

IsiZulu is spoken by the majority of the population in KwaZulu-Natal (78%). This region is one of the poorest and most densely populated (10.3 million people) provinces of South Africa. Older and rural patients often present as monolingual *isiZulu* speakers. Even peri-urban patients increasingly prefer *isiZulu*, while many medical students are first-language English users and are not proficient in *isiZulu*.

The benefits of language-concordant health care include improved health outcomes, whereas communication challenges have been associated with the use of expensive diagnostic tests and poor patient follow-up.¹ The South African Constitution recognises patients' rights to access health care in their preferred language, and policies at national,² regional³ and institutional level⁴ support language diversity. Communication, a core competency for all healthcare professionals,⁵ is being taught in most Bachelor of Medicine and Bachelor of Surgery programmes. While aligning teaching and learning with national and regional priorities, training is being moved to decentralised platforms, where there is increasing emphasis on the need for doctors to become competent in the language of their patients.

IsiZulu language teaching is offered as a year-long module in the first year at the University of KwaZulu-Natal. The module was evaluated through an observational, analytical, cross-sectional study, in which approximately one third of the third-year cohort, who were not able to speak *isiZulu* at the start of the programme in 2010, was sampled. The cohort was assessed after receiving language and communication training, and additional assessments in *isiZulu* in their second and third academic years. The study was conducted to determine students' perceptions of their ability to communicate in *isiZulu*, and to measure their knowledge of, attitudes to, and use of, the language.

Method

Quantitative data was collected using a knowledge, attitudes and practice survey using a five-level Likert scale, a written test, and a third-year oral assessment during the objective structured clinical examination. Six of the 86 students were no longer registered in the third year, and 61 of the remaining students (76%) completed the questionnaire. Qualitative data on the students' experiences and recommendations was gathered in an open-enquiry section. The quantitative data was analysed using an appropriate statistical method and analysed thematically.

Results

The results demonstrated that students' knowledge in both the written (Table 1) and oral assessments had improved. Students held positive attitudes to learning *isiZulu*. A Likert score analysis reflected a mean of 3.96 [95% confidence interval (CI): 3.79–4.14, p 0.000]. Although the students perceived their *isiZulu* communicative competence to have improved, their ability to communicate with their patients had not improved sufficiently for it to be used practically. A Likert score analysis for practice reflected a mean of 3.18 (95% CI: 2.94–3.41, p 0.000).

Students noted some benefits: "The course was very helpful, and gave me confidence when communicating with Zulu-speaking patients". Others found language acquisition to be challenging: "Learning a language at an older age is much more difficult than (having) grown up with it". Students perceived a need for addi-

Table 1: Written test results for the study cohort (2010 and 2012)

Test	Range (%)	Mean (%)	Standard deviation
2010 ($n = 61$)	0–47	7.31	11.972
2012 ($n = 60$)	22–95	61.77	18.061

tional input in order to achieve an appropriate level of communicative competence.

Conclusion

Although the results showed an improvement in the knowledge and positive attitudes of learners with respect to learning *isiZulu*, the benefits gained did not translate into their practical ability to communicate with patients. In response to this need, efforts are being made to improve language learning by emphasising communicative language teaching methods in the first year of study, and by providing additional input. For example, videos of consultations in *isiZulu* are being integrated into teaching in the second and third years of study. An ongoing interdisciplinary terminology development project has been launched in the College of Health Sciences at the University of KwaZulu-Natal. It is envisaged that these efforts will enhance the existing favourable language policy framework and

ultimately translate into patient satisfaction and improved health outcomes in the region of KwaZulu-Natal.

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