

Implications of language barriers for access to healthcare: The case of francophone migrants in Ghana

Sewoenam Chachu

Senior Lecturer

Department of French

University of Ghana, Legon, Ghana

Email: schachu@ug.edu.gh

Submitted: December 10, 2020/Accepted: March 23, 2022/Published: May 1, 2022

Abstract

Ghana has become home to many migrants from Francophone countries due to educational, professional, economic, and socio-political factors, among others. These factors also interact well with the country's strategic location within the sub-region. As a result, migrants seek access to various public services including healthcare. However, language tends to be a barrier to their pursuit of quality healthcare. Based on the Communication Accommodation Theory (CAT) of Giles, the paper examines the implications of language barrier on Francophone migrants' access to healthcare in Ghana and highlights how the migrant patients and health personnel perceive and deal with the barriers during consultations. The study uses qualitative methods, including key informant interviews and participant observation to gather data from three border towns and one referral hospital in the capital of Ghana. Findings reveal that health personnel and patients from francophone countries, when communicating during the health care process, demonstrate the use of convergence/accommodation and divergence/non-accommodation or divergence. On the whole, the practices and experiences that demonstrate convergence produce better health experiences and outcomes for both the patients and the health personnel while those that show divergence have a negative experience and outcome.

Keywords: Ghana, Access to healthcare, Divergence, Convergence, Francophone, Migrants

Introduction

Ghana, though an Anglophone country, is surrounded to the north, east and west by francophone countries. Because the borders of many African countries were arbitrarily created, leaving people from the same family divided among two border towns, most indigenes who live in border towns freely move between the two countries for trade, education, and social events such as marriages and funerals. This paper presents findings from observations and interviews with health personnel and health seekers in three major border town facilities, and one Teaching hospital in Accra that serves as a referral center of international repute. We are particularly interested in two categories of people: those from francophone countries who have settled in Ghana for one reason or the other e.g., refugees fleeing conflict situations, students, and workers; and a second category - those living near border towns, who systematically and regularly cross into the adjoining country to access one service or the other or who may not necessarily live in or near a border town, but are referred to seek health services in Ghana due to the nature of their ailment. The latter category will be referred to as Migrants for Health Purposes (MHPs). We explore the role language plays in accessing healthcare by patients speaking minority languages in a community where a different language or different languages are more widely spoken and used.

Specifically, this paper aims at examining the effects of language-induced barriers on the healthcare received by patients from francophone countries of both categories, considering the challenges and coping mechanisms employed by health personnel and migrant patients and how this may affect healthcare outcomes. We also make some recommendations on how to optimize communication and access to healthcare for francophone migrants. With the findings from this research, the paper envisages building a case for a systematic and sustained policy and practice of providing trained public service interpreters for the health sector and other public services. This is

to ensure that linguistic challenges do not obstruct the healthcare process for minority language speakers in general, and those from francophone countries in particular. This paper is outlined as follows: After the introduction which presents a background to the study and a review of relevant literature, the following section, provides an overview of some studies in the domain of language and access to healthcare with a focus on minority language groups in different contexts. Section 3 presents the methods used for this study, while the data and its analysis are the focus of Section 4. Section 5 presents a discussion on the data and Section 6 is the conclusion.

Language and healthcare access across cultures

Research on issues of migration, language and health is an emerging trend. Of particular focus in recent studies is research on language and the provision of public services as a whole. These include, for example, the research findings of non-migrants and the provision of public service interpreting across a number of countries: For example Edelman (2004) who focuses on service provision to children with language and communication difficulties; and that of Brennan, Barnes et al. (2013), whose research considers the oral health of migrants in Australia. This notwithstanding, existing research seems to be skewed towards research in the global north as opposed to the global south, for example Boateng, Nicolaou et al. (2012) - Ghanaian migrants in Denmark; Martinez (2008) – the Mexican-US border, Chen, Youdelman et al. (2007) – language rights in healthcare in the USA. The central observation in many of this research is that language is important for access to quality healthcare, and that lack of effective communication can lead to dire consequences including death. Indeed, as cited in the abstract of Anderson, Scrimshaw et al. (2003), “When clients do not understand what their healthcare providers are telling them, and providers either do not speak the client’s language or are insensitive to cultural

differences, the quality of health care can be compromised” (p.68).

Furthermore, according to Chen, Youdelman et al. (2007), language barrier frequently leads to miscommunication in healthcare settings. This miscommunication can sometimes result in ‘life-threatening’ situations (Meuter, Gallois et al. 2015). Unfortunately, many patients and probably health personnel are not even aware that all patients have rights when it comes to healthcare. While in some countries such as the USA, this may be enshrined in a legislative instrument, this is not necessarily the case in other countries including Ghana and many minority language speakers may not have equality of access or treatment when it comes to healthcare because of communication challenges. In this same vein, Boateng, Nicolaou et al. (2012:1) confirm that “many ethnic minority groups are often dissatisfied with the host country’s healthcare system due mainly to language and cultural barriers which affect their quality of healthcare”. Though some countries and healthcare institutions have measures in place such as the provision of public service interpreters, this can sometimes be fraught with challenges including ethical dilemmas arising from differences in class, culture, language and power. (Kaufert and Putsch, 1997).

When it comes to data on intra-African migrants, research on language and health is rare. It should be noted however that the role of language in healthcare access, within the African context, has been sporadically discussed. Haricharan, Heap et al. (2013) for instance focus on how deaf people in Cape Town, South Africa, access healthcare. According to them “without language, deaf South Africans’ dignity and right to health is violated, resulting in serious consequences such as incorrect diagnosis, improper treatment and standard of care not being applied.” This assertion, it is argued, can be extended to describing the situation of all health-seeking persons who speak a language that the health worker is not familiar with. In our

case, this will refer to the MHPs from adjoining francophone countries.

Theoretical considerations

This work is grounded in the Communication Accommodation Theory (CAT) of Howard Giles and his collaborators. Founded in the early 80s, CAT seeks to provide social psychological insights into the dynamics of speech. According to Gallois, Giles et al. (1995), CAT as a theory serves many functions. It provides a conception of communication both subjectively and objectively and considers both intergroup and interpersonal characteristics. In addition to this, the theory takes into account various aspects of cultural differences.

This theory places an emphasis on how people adjust to each other when communicating. This is done in two main ways – by convergence/divergence or accommodation/non-accommodation. During convergence, interlocutors try to downplay the social differences of those they are communicating with. Divergence, however, is evidenced by emphasizing the social difference of your interlocuter. Accommodation can be through verbal communication or through non-verbal acts such as gestures and facial expressions and even clothing and food. CAT, originally framed within the context of intercultural communication, has been touted for many inroads into understanding not only communication between individuals but also communication among different groups. Indeed, research has shown that people adjust their speech and behaviour when speaking to a category of people that they consider different from themselves. These modifications can vary from speaking more slowly, speaking more loudly, using a condescending tone, or speaking in a hushed tone with someone they consider superior in hierarchy. This theory has been adopted in several domains of research including classroom interaction (Parcha 2014, Weizheng 2019), law enforcement (Giles, Fortman et al. 2006, Hajek, Giles et al. 2008, Giles, Linz et al. 2012), personal

identity (Soliz and Giles 2014), and family relationships (DiVerniero 2013, Speer, Giles et al. 2013).

In the health domain, CAT has been used in various studies including medication counseling by pharmacists (Chevalier, Watson et al. 2016), aphasia intervention (Simmons-Mackie 2018), communication training for health personnel (Meuter, Gallois et al. 2015, Watson 2020) and also, on health personnel-patient interactions (Hajek, Villagran et al. 2007, Jones, Sheeran et al. 2018, Pretorius 2018). Though most of these studies focus on CAT in the context of speakers of the same language but with differing social statuses, a few of them focus on CAT in the health sector with regard to patients who are minority language users (usually migrants). For instance, Meuter, Gallois et al. (2015) point out that the consequences of miscommunication in the healthcare sector can be dire; and that there is a high likelihood of errors in communication when either party speaks a different language from the other.

This research is focused on healthcare access by migrants from neighboring francophone countries who do not speak English or the dominant local languages proficiently to efficiently communicate when they visit the health centers. This paper seeks to examine how communication about health, between francophone patients and Ghanaian healthcare personnel, can be seen under the lenses of convergence and divergence. The analysis is based on the fact that convergence/divergence and accommodation/non-accommodation can be expressed through at least five sociolinguistic strategies including approximation, interpretability, interpersonal control, discourse management, and emotional expression (Giles, Gasiorek et al. 2015). For the purposes of this study, approximation strategies will involve how health providers and patients organize their language and communication patterns to make them more similar or dissimilar from each other's. Interpretability strategies will include assessing the health provider or health seeker's ability to have a clear grasp of the conversation being held whether

perceived or expressed. How health personnel and health seekers adapt their communication based on role relations, status and relative power will indicate interpersonal control strategies and how the parties involved adjust their communication based on perceived or stated conversational needs refers to discourse management strategies. Finally, emotional expression strategies pertain to how the interlocutors respond to envisioned emotional and relational needs. The paper will consider if any of these sociolinguistic strategies come into play either during the health communication process and consider the effect or implication on the healthcare process.

Methods

The main method employed in this study is qualitative. Semi-structured interviews were carried out with 61 health personnel comprising 13 doctors, 2 physician assistants, 30 general nurses, 2 public health nurses, 5 midwives, 1 laboratory scientist and 1 medicine counter assistant, 4 health administrators, and 3 other people who did not specify their role. Interviews were also carried out with 10 migrant patients and accompanying persons who served as interpreters, and 4 migrants (drivers) encountered at the Hamile border who had accessed health services in the past in Ghana and who routinely travel between Ghana and Burkina Faso or Mali. These four were therefore not at any health center as at the time of the interviews, they were in good health. All the other migrant patients and accompanying persons as well as the health personnel were interviewed at various health centers. These were mainly personal and key informant interviews as it was difficult to get the health personnel at each health center together due to their different schedules. This article only makes use of the data gathered directly in the health centers as the focus is on the real-time interactions within the health centers at the time of data collection.

Two interview guides were prepared – one for the health personnel and one for the francophone patients. The interview

guide for health personnel had questions to elicit demographic and linguistic information, experience with attending to francophone patients, communication challenges and strategies, perception of patients from francophone countries relative to Ghanaian patients, the use of interpreters in the healthcare process and their suggestions for facilitating communication with patients from francophone countries.

The interview guide for the francophone patients was in French and sought to elicit demographic and linguistic information, communicative strategies and perceptions of language use in the health centers and suggestions as well as questions around cultural and linguistic differences observed in interacting with health personnel in Ghana as opposed to health personnel from their countries of origin.

Discussion was conducted in English, French, Twi (a local Ghanaian language) and Ewe (also a local language spoken in Ghana, Togo, and Benin). There was also an opportunity to observe two patient-personnel interactions. These recordings were transcribed verbatim and then analyzed. The study was approved by the Ethical Review Committee of the College of Humanities of the University of Ghana and data for the study was gathered between August 2018 and August 2019.

Participants and recruitment

The sites for this research include the Korle-Bu Teaching Hospital in Accra, St. Martin de Porres Hospital in Eikwe (a border town with Ivory Coast), the St. Theresa's Hospital in Nandom (A district hospital that serves the border towns of Hamile Ghana and Hamile Burkina), and the Ketu South District Hospital in Aflao (a border town with Togo). Beyond the hospitals, we also visited strategic locations including the border posts of Aflao and Hamile and some community hospitals in Hamile to interview Francophones travelling to or from Ghana. In all, we interacted with 61 health personnel and 10 patients. Participant health personnel were purposively selected based on

their having ever had to attend to a patient from a francophone country and the few patients we came across were pointed to us by the health personnel. In all cases, informed consent was sought before interviews were conducted, or observations were carried out. The breakdown of interactions is indicated in Table 1 below:

Table 1: Number of respondents per community

Town	Health Personnel	Patients
Korle Bu	20	0
Eikwe	14	4
Aflao	15	2
Nandom	10	0
Hamile	2	0
Other (interviewed at the Hamile border)	-	4
Total	61	10

Table 2: Breakdown of Health Personnel

Health personnel	Number
Nurse	30
Medical doctor	13
Physician Assistant	2
Public Health Nurse	2
Midwife	5
Health Administrator	4
Laboratory Scientist	1
Medicine counter assistant	1
Others	3

Results

Reasons why migrant patients access healthcare in Ghana

The various hospitals and health centers we visited receive a lot of francophone patients. Unfortunately, none of the hospitals could provide us with data on the exact numbers and we were given terms like ‘a lot’, ‘many’. ‘They come here all the time’. One of the hospital administrators confirmed this with the following statement:

As a matter of fact, almost every day we receive clients from other countries especially the neighboring countries, the French-speaking countries especially Togo and then Benin and even sometimes beyond. So yes, we receive a lot of francophone speaking clients that visit the facility. (Hospital Administrator, Aflao).

Several reasons were proffered as explanation for why migrant patients access healthcare in Ghanaian border towns. Even though there are a few cases where a migrant in transit may be taken ill and may need to access healthcare in a border

town, most of the cases are cases of health tourism, where the migrants choose to come to these health centers due to cost, availability of better or of specialist care, and a perception of a more efficient health system.

An efficient Health System

One of the reasons we found for MHPs accessing health services in Ghana is their perception of Ghana having an efficient health system as compared to that of their countries of origin. According to one officer at the Aflao Customs Health post:

Really, they access our facilities over here. not only the government hospitals. They even access the private ones. Usually when they are coming, you see them holding their OPD card¹ so we just allow them. Somebody who is sick and wanting to seek for healthcare you don't have to put stress or put impediment on his/her way. So, we allow them. So that's basically what happens. They themselves per se, they don't have that belief in their health system.

One of the hospital administrators also confirmed this in his statement that:

Someway, somehow, healthcare delivery, people have confidence in our healthcare system, and you know if I access a facility and maybe the outcome isn't good, there's no way I'll come back again. So, the fact that people are still coming back revisiting the facility means that our healthcare system is quite good even though it's not the best, but it's quite good and whether we like it or not people will come and access these services.

This point is noteworthy as we consider the fact that these MHPs leave the comfort of their home countries and cross the border, sometimes with difficulty, to access healthcare in another

¹ OPD – Outpatient Department. Used in Ghana for a patient that is not on admission.

country with a different system. A fifteen-year-old francophone patient's mother explained why they come to Ghana to seek healthcare:

Ici, on prélève votre sang, ils confirment la maladie avant de vous donner un médicament. Mais là-bas, [en Côte d'Ivoire], dès que vous arrivez à l'hôpital, on vous demande d'acheter le médicament...si c'est le bon remède pour la maladie ou pas, ils vous donnent seulement le médicament. C'est pour cela que nous venons ici (l'Hôpital St Martin de Porres). Quand nous venons ici, ils vérifient l'urine et le sang avant de vous donner de médicament. Alors, si nous commençons le traitement en la Côte d'Ivoire et que cela ne va pas mieux, nous venons ici.

Here they take your blood, they check your urine, and they check how the illness is before giving you medicine. But there [Ivory Coast], as soon as you get there, they ask you to buy the drug whether the drug is for the illness or not they just give you the drugs. Because of that we come here (to Saint Martin de Porres Hospital). When we come here, they check the urine and the blood before giving you the drug. So, when we start treatment in Ivory Coast, and it is not getting better we come here. (Translated from French by author)

It is obvious from this response that as patients, they have confidence in the healthcare they receive in Ghana as opposed to their home country.

Referral for specialist services

Another reason cited for MHPs coming into Ghana to seek healthcare is that they seek to access specialist services that are either not available in their home country or that are too costly for them. In this case, many of them are referred by their

doctors to another hospital. This is the case especially for the Korle-Bu Teaching Hospital which is mainly a referral center and offers specialist services that are not easily available in the sub-region. Specialist services including radiology, plastic surgery, other kinds of surgery and cardio-thoracic care attract patients from francophone countries who do not have access to such facilities in their home country. The same is true of the border town hospitals which also provide specialist care. Indeed, at the St. Theresa's Hospital in Nandom, we were informed that some patients from Burkina Faso are referred to hospitals in the capital city, Ouagadougou, but due to reasons of proximity, most choose to come to Nandom instead of travelling all the way to Ouagadougou for the referral.

Reasonable cost

The study revealed that some patients from francophone countries preferred to travel to the border towns of Eikwe and Nandom to access healthcare in the two catholic mission hospitals because they were relatively more affordable than health centers in their countries of origin. This is not necessarily because healthcare in Ghana is relatively cheaper than in the francophone countries but more probably because the two hospitals cited above are mission hospitals that, according to one of the interviewees, receive some subvention from the catholic church and are therefore able to provide quality care at a more subsidized cost.

Language barriers and their effects on accessing healthcare

The ability to speak the language of one's contact point is very important in accessing healthcare. Not only does this ensure trust, comfort, and ensure inclusion as one is sure of understanding or being understood. This concerns both the health seeker and the healthcare provider. Several of the health personnel interviewed expressed language barrier as being a major challenge in providing quality healthcare:

Language barrier came out as the main challenge of health personnel attending to patients from francophone countries. In all the research sites visited, this was touted as a problem. At the Korle-Bu Teaching Hospital, the problem was very pronounced since most of the patients who came interacted in French.

There was language barrier; frankly. One (of the francophone patients) however could speak very little English, but she couldn't give a response. You speak English with her, and she speaks French back to you. But the ones I had to deliver, we ended up using sign language (gestures)... And the doctors we had didn't also understand... (Nurse 3, Maternity)

Yes, it was very difficult... It is difficult nursing francophone patients if you don't know how to interact with them. But communication in nursing is key to help you achieve whatever goal you set for your patient. [...] We look for francophone health personnel, but we don't usually get. So, we use sign language (gestures) sometimes... If the patient has a relation around who can interpret, we use the person. (Nurse 3: Maternity/Anesthetics)

In the two extracts above, we notice that there is an effort at accommodating the patients on the part of the health workers. This is demonstrated by their effort to either find a health worker who speaks French or to resort to gestures to carry out the healthcare process when this is unsuccessful. There is therefore the use of approximation strategies and interpretability strategies by using the gestures to communicate. On the part of the patient responding by speaking French back to the health workers who speak English to her, this could demonstrate divergence to bring to the fore the fact that she could not communicate in English at all and that another means of communication should be found.

It was observed that the situation was easier to manage in the border towns where there were shared common languages than in the referral centers where the health personnel were less likely to share a common local language with the patients. This ease of access was however only guaranteed where there was a shared common border town language and as this was not always the case, even the border town institutions expressed challenges with language. Indeed, health workers have different linguistic backgrounds and so even in the border towns, a health worker may be posted there who is not an indigene and therefore does not speak the language. Even for Ghanaian patients, this can be a challenge, but it is even more complicated in the case of francophone migrants who only have French or at best, a shared border language to fall on.

One of the key challenges we have is language barrier. In actual fact it's not even only the French-speaking countries. Sometimes some of our staff, in fact a number of them are not even Ewes. We have some who are Gas, Akans and the rest and they don't even understand the Ewe, so communication becomes a huge challenge. (Hospital Administrator, Aflao).

The challenge of language barrier leads to several other consequences that can affect the well-being and the migrants' perception of how they are received in health centres in Ghana. Among these are the following:

Longer diagnosis/treatment time

Not all health workers in the border towns are indigenes and so they have to rely on interpreters – either among the health personnel or relatives or other ad hoc interpreters. For those who only speak French, it is a bit more challenging as there are fewer personnel available who speak French. Some medical health personnel resort to using google translate to communicate with the patients in the absence of an interpreter. Most however, use

gestures to try to communicate. While this is all well and good in terms of oral communication, there is the other challenge of attending to patients who have been referred to the particular health centers. Since most of the nurses and doctors on duty do not speak French, there is a major challenge when they have to interpret referral letters or even patient information on cards of patients who come for antenatal care for example.

We personally witnessed a situation between a midwife and a patient (from Burkina Faso) who could speak the local language (Dagaare) but not French. She was about 5 months pregnant but was unwell. She had been given preliminary care at a health center in Hamile. The Physician Assistant who had attended to her had newly been transferred to the area and could not speak the local language but could only speak English and Twi. Originally, she was accompanied by a brother-in-law who was serving as an interpreter, but it became obvious that his English was not good enough to communicate effectively with the Physician Assistant. The Physician assistant therefore stopped the consultation and called one of the male nurses, who could speak the Dagaare language to come and interpret. Eventually, she was given some first aid and referred to the Nandom hospital. This particular scenario demonstrates convergence and accommodation on the part of the physician assistant who ensured that there was optimal communication by stopping the consultation in order to get an interpreter before proceeding. This was important because proceeding without an interpreter could have resulted in wrong diagnosis and treatment (even if it was just first aid). Unfortunately for the patient, who we met at the Nandom hospital upon our return, the nurses on duty that day could not speak Dagaare and so there was a delay in treating her – especially as they could also not understand what was written on her referral card – which was in French. She was made to retake tests she had already taken since the midwives attending to her could make nothing of what was written on her card. Thankfully, her case was not an emergency,

but it certainly could have degenerated had it been one. In this case, we see divergence and non-accommodation on the part of the nurse at Nandom Hospital. Considering how big the hospital is and based on our interviews and observations at this particular hospital, she could have called other units or departments to find a Dagaare speaking health worker to facilitate communication with the patient. The fact that the patient had to retake tests that she had already done (and probably paid for) also indicates lack of accommodation on the part of the hospital as such a large hospital could definitely hire the services of a translator who will translate referral documents from French to English and vice-versa.

This episode also points to the fact that the health systems do not necessarily have policies in place to accommodate minority language speakers. Indeed, in some cases, patients are sent away or asked to go back to look for interpreters. In other cases, when health personnel rely on other colleagues for interpretation, the patient may be made to wait for longer than the average person until the 'interpreter health personnel' is free. The interpreter may either be in another unit or department or may even not be on duty during the time their interpretation services are needed. The francophone patient may also be asked to step out and wait if the staff at the hospital are busy because the health personnel perceive that it will take a longer time to attend to them because of the language barrier. They may be called back for consultation when there are fewer patients and thus less pressure on the health workers. As one francophone patient in Aflao indicated : « *Des fois si on est là-bas on nous fait sortir. On nous dire de sortir un peu avant de revenir encore* ». (Sometimes, when we are there, they make us go out. They ask us to go out for a bit before returning [to the consulting room]).

In other instances, and in other health centres, this situation of delaying care of francophone or minority language patients is mitigated by relying on a health worker who speaks French. He is called from other departments or units when there

is the need and sometimes, even when he is off duty, he is called to interpret on the phone. This indicates a determination to accommodate the patient at all costs to ensure that the patient receives optimum care. This scenario was described by a male nurse who was educated in Togo for both his baccalaureate and nursing training. He works at the emergency unit in the Aflao facility but also serves as the interpreter for French when there is the need:

Sometimes if I'm not on duty they call me if they can't speak any language apart from French so I can communicate with the patient, on the phone with them, I translate it. Even sometime at night they call you". they call me to other places as OPD. Sometime for some lab results, scan, they come in from their wards to come and take it there. Last time ... somebody came but I was on night off so he tried to do it himself but if they can't do anything they call me on my phone so that I come if it's necessary. That one I see if I can communicate on phone (Male nurse, Emergency Unit, Aflao).

Even during treatment, there can be delays which can be costly. As reported by one nurse of a situation in which she and the patient could not understand each other,

I was also getting irritated... Because when you (pregnant woman) are in labor, action is so timebound... and when you (the nurse) don't take the necessary actions immediately, something may happen. (Nurse 4, Maternity, Korle Bu).

Beyond the delay and cost element, the extract above also indicates interpersonal control strategies and emotional expression strategies. As the nurse suggests, she has expectations of the patient's response to her instructions (due to her status) during labor and a perceived lack of compliance leaves her feeling irritated. Apart from the perspective of the health

personnel, the perspective of the patients is also very important to grasp the magnitude of the issue of communication barriers. The husband of one of the francophone patients interviewed had a lot to say about challenges in communication. The first of these is the quality of interpretation provided by the ad hoc interpreters. According to him, “it is very difficult finding people [to interpret] because the people who are directed to us do not even speak French very well”. In trying to communicate with the health personnel, they rely on the little English they have and then they use gestures.

Donc nous faisons beaucoup de gestes. Nous disons que nous avons mal au ventre – nous plaçons les mains sur le ventre. Si c’est la tête, nous mettons les mains sur la tête. Et puis ils essaient de voir ce dont nous parlons, mais quand c’est un problème plus sérieux, c’est très difficile de nous exprimer.

So, we make a lot of gestures. We saying we are having stomach pains - we place our hand on the stomach. if it is the head, we put the hands on the head and then they manage to find out what we are talking about but when it is a deeper issue, it is very difficult for us to express ourselves. (Spouse of patient) - (Translated from French by the Author),

The two extracts indicate that even though the health personnel try to accommodate or converge by making use of ad hoc interpreters, it ends up seeming like divergence to the patients as the interpreters do not do a good job of facilitating communication. The health personnel and patients therefore end up using approximation and interpretability strategies of resorting to gestures to communicate.

In describing the conduct of health personnel when they go for consultation, he reports the following:

D'abord, il nous parle en Twi et puis ils se rendent compte que nous ne comprenons pas. Alors, ils nous parlent en Anglais et quand ils voient que cela ne marche pas, ils essaient de trouver une solution ou de chercher quelqu'un pour interpréter.

First, they speak to us in Twi and then they realize we do not understand. Then they speak to us in English and then when they realize it is not going well. They then try to figure it out or look for someone to interpret. (Spouse of patient) - (Translated from French by the Author)

This extract demonstrates the effort made by the health personnel to communicate with the patients by moving from one of the de-facto languages of communication for the community (Twi), to English and then trying to find alternative solutions to facilitate communication. Here, there is a clear demonstration of discourse management strategies as the health personnel try to adjust to the real or perceived needs of the health seekers,

Risk of misdiagnosis

One of the possible results of language barrier is a risk of misdiagnosis. Patients' symptoms may be misunderstood, and a wrong treatment may be prescribed or administered on the part of the health personnel. The patients may also provide wrong information if they misunderstand the question leading to wrong diagnosis and treatment. They may also misunderstand the instructions for dosage of prescribed medication and may take the wrong dose which can lead to complications. One of the patients (and spouse) that we interviewed in Eikwe indicated how the wife had unfortunately lost a pregnancy because they had misunderstood the instructions for dosage. In this case, there was evidence of divergence and interpersonal control strategy. This is because the patients considered the health personnel to be 'above them' in terms of status and when they did not

understand the instructions for dosage, they chose to be silent rather than ask relevant questions or seek out an interpreter to ask relevant questions. Unfortunately, the consequence was that the woman experienced a miscarriage.

Increased cost of healthcare

Some of the patients are made to repeat tests that they have already undergone in their countries of origin because the nurses, midwives and doctors do not understand the results that they have brought. This may mean paying for services they have already paid for especially if they are not covered under the health insurance. Indeed, as one of the nurses in Nandom mentioned, some of the francophone patients come with referrals with “francophone writings” and according to her, “we just look at it and put it aside”. Such patients are therefore obliged to retake tests they have already undertaken, at their cost, so that the health workers can get the results in English. This is a clear demonstration of lack of accommodation on the part of some of the health workers as ‘francophone writings’ should not be too difficult to decipher, and they could have made an effort to get a francophone health worker look at the referral or even try and get a cursory translation using tools like google translate. The fact that the health personnel just ‘look at it and put it aside’ is quite unfortunate as it doesn’t demonstrate any effort to understand the medical history of the patient or even show consideration for the patient’s finances.

Violation of certain rights

One of the challenges posed by languages to migrants’ access to healthcare is a violation of their rights – including – the rights to health, information, participating in decisions concerning their health, giving informed consent, confidentiality and being treated with respect and dignity.

When asked about how they felt about having to speak through an interpreter, one patient responded:

Nous ne nous sentons pas à l'aise de dire exactement ce qui ne va pas.

We are not at ease opening up with exactly what is wrong.
(Francophone patient, Eikwe). (Translated by the author)

Another patient in Eikwe also noted:

C'est très gênant d'expliquer votre problème à quelqu'un avant que la personne aussi l'explique au médecin...Je ne me sentais pas à l'aise de parler à quelqu'un avant que la personne parle au médecin à ma place.

It is very worrying to explain your problem to somebody before the person also explains to the doctor... I felt uneasy having somebody talk to the doctor on my behalf.

For the patients we got to speak with, the main issue that bothered them was the lack of confidentiality. For those who had to come with relatives, it is much more challenging as they may wish to speak of issues that are personal. They may therefore end up saying less than they would if they were alone with the health worker and if they could express themselves freely. One of the expressions of accommodation/non-accommodation that is at play here is emotional expression strategies. It appears that there is non-accommodation because some patients clearly do not feel comfortable discussing their health through a third person. In this case, it seems like a 'necessary evil' but it is possible that the health workers or the health center could show consideration for the patients by getting them prepared and psychologically ready – even if it is by using the same interpreter – before launching into communication about their health issues. We suggest that the challenge is not so much with the interpreter as it is with the fact that in some instances, an unknown person is thrust upon

the patients to serve as an intermediary between them and the health workers, without any prior psychological preparation.

Perceptions of ‘otherness’

Another major challenge brought on by differences in language is the perception of ‘otherness’ both on the part of the health personnel and on the part of francophone patients which can affect their health-seeking behavior. On the one hand, health personnel may tag patients from francophone countries as being more aggressive, timid, difficult, withdrawn, entitled, etc., while patients from francophone countries may feel misunderstood and discriminated against because of the communication barrier. There was just one case of positive ‘tagging’ of otherness: “Yeah Francophones are very open, and they can use the direct words to explain themselves” (Midwife who speaks French, Korle Bu).

However, for another midwife from the same hospital, who does not speak French, she is of the opinion that:

A lot of them are timid... because one found herself in the ward. The whole ward mixed with people - women speaking Twi, English, Ga and she was sitting there she is from Benin... and I think they also speak French. She was sitting there not knowing she had soiled herself and she wanted to get up and change and she couldn't say it. So, I was observing her. The way she was sitting down quietly so I went to her, and I did the sign and asked them what is wrong. I said she should get up and she shook her head and said no so she was pointing. So, when I checked, she had soiled herself plenty, so I had to help her. So, assuming I didn't go there, or I didn't observe her, but if she was fluent in English language, she would have told me that blah blah blah or if I was also fluent in French and also ask her in French do you need something? But for her until her husband comes, she will talk to her husband and the husband would talk to us or do sign language or when

the nurse from Togo is around. So if the nurse is not around that is when we do the sign language because if there is somebody here who can't speak English or Twi at all only French, it is the sign language or her relative. Most of the time we tell the relatives one of them to stay behind but sometimes she and the husband are alone...so when the husband leaves for work what happens is the sign language.

It is very possible, from this narrative, that the patient in question was not timid at all but just did not speak because she had nothing to say. We posit that the perception about the patients can also affect efforts at convergence/divergence or accommodation/non-accommodation. A health worker who keeps an open mind or who sees patients of a minority language group as open and able to ask questions is more likely to spend more time with such patients or try to draw them out to get them to express themselves. On the other hand, a health worker who considers the same category of patients as timid or withdrawn may just leave the patients to themselves.

One nurse describes the effect of communication gaps in reference to the behavior of some francophone patients:

*Some of them showed from their facial expression that they didn't understand. Some of them even got irritated... started smacking and throwing tantrums.
(Nurse, maternity, Korle-Bu)*

One patient from the Eikwe hospital tried to provide a perspective on why patients from francophone countries may be seen as difficult. According to him,

*We insist... Sometimes they may think that we are refusing to understand, and we also know that they do not understand so we insist and insist on our symptoms.
(Spouse of francophone patient) – (Translated from French by the author).*

The feeling of otherness causes some MHPs to hold a perception of being discriminated against. Some MHPs hold a perception of being discriminated against. According to one patient from Eikwe,

They do not put everybody on the same...level that is what I do not like here. They really want you to speak their language. That is all... Even when you manage to speak English they ask where you come from and why you do not speak their language. [...] Ghanaians like differentiating too much. They would attend to their people before they attend to you. (Francophone patient, Eikwe)

These extracts indicate non-accommodation both on the part of patients and health workers. Interpersonal control strategies and emotional adjustment strategies are at play here. On the one hand, the patients insist on what they believe is right thus asserting their role and their status in the group interaction. However, they may also not adjust emotionally to their interlocuters, and this is communicated through the tantrums and facial expressions – which are interpreted by the nurses as frustration at not understanding the communication process. The last extract indicates that the health personnel, by the way they react to the efforts of the francophone patients to speak English, demonstrate divergence or non-accommodation by letting the patients feel that they are not ‘one of them’.

The findings on longer diagnosis and treatment time, feeling discriminated against, risk of misdiagnosis and increased cost from our study are corroborated by other studies including Ngo-Metzger, Massagli et al. (2003), Wilson, Chen et al. (2005), who in their study also indicate that there are instances of misunderstanding a medical situation and confusion about medication use. This is usually because the patients are minority language speakers who cannot freely express themselves in the language(s) commonly used by the community, and thus by

the health workers. This affects the deaf as well, who usually find themselves in situations where health seeking becomes a challenge because the health workers do not speak the sign language of their country and there are usually no interpreters provided for the deaf as is the case of deaf patients in South Africa (Kritzinger, Schneider et al. 2014).

Resolving communication barriers

This section explores the various factors that contribute to resolving barriers in accessing healthcare as well as the coping strategies employed in the case where there is no common language. These include using shared border languages and provision of interpretation services.

Shared border languages

One of the main solutions found in dealing with the differences is sharing a common indigenous language. It was observed in the border towns that the locals and the migrants share a common language with the MHPs. Common local language in border towns (Ewe, Nzema, Mossi, Dagaare) are widely spoken among Ghanaians and patients from francophone countries even though there are usually slight variations or dialectal differences. Usually, there is intercomprehension.

You know, the staff I'm working with, majority of them are Ewes and the advantage here is even if you can't speak French most of them speak Ewe so the medium of communication is Ewe. I can say on authority for now, I have only one guy who is fluent in French but this week he is off. When they work for some period, they go off so this week that guy is off duty. But majority of us our medium of communication is Ewe. (Customs Health, Aflao)

The migrants who speak a shared border language are easily able to access healthcare when they come across health

personnel who speak the same languages. In fact, it was observed that because Ghana operates a National Health Insurance Scheme, some of the migrants who cross the border to seek treatment manage to get access to the Health Insurance Card and so can access healthcare for free, just like the Ghanaians do. For this reason, they do not readily admit to the fact that they are foreigners as this has cost implications for them. It is one of the reasons why it was so difficult for us to get access to patients from francophone countries as they refused to volunteer for the interviews, feeling that their cover may be blown, and they would have to pay for healthcare.

Beyond this, having a common indigenous language makes a big difference in healthcare access where both parties can neither speak English (the official language in Ghana) or French (the official language of the neighbouring countries). Even though doctors are in short supply in general and are not posted to various regions based on linguistic factors, a large percentage of nurses and other supporting staff in the health centres are locals and can easily communicate in the local language spoken in the town. They therefore communicate with the patients in these languages or serve as interpreters for their colleagues who may not be able to speak these local languages.

Provision of interpretation services

The question of having an interpreter during the health care process is a sensitive one as it can either facilitate the healthcare process – thus contributing to accommodation and convergence – or it can lead to dire consequences if it is not managed well. A well-planned interpreting process where the interpreter has the requisite skills and the patient is adequately prepared psychologically can bridge the communication gap and make both health workers and patients feel an active part of the healthcare process. Interpreting has been used in health sectors around the world as demonstrated by researchers such as

Metzger (2014) Farini (2013), Swabey, Faber et al. (2012) and Pöchlhacker and Shlesinger (2007). Indeed, access to healthcare is a fundamental human right and according to the Hippocratic oath, none is to be denied access to health care on the grounds of race, religion, origin, etc. Indeed, in some countries, access to medical interpreters is not only encouraged but even reimbursed by insurance.

Considering the situation in Ghana, we posit that in the absence of having a common language between the health seeker and the service provider, the provision of adequate and quality interpreter services is the next best solution. However, this is not readily available and health personnel either rely on a few of their colleagues who can communicate in French to attend to the patients or to serve as interpreters. In the absence of qualified health personnel, health workers rely on relatives or any available person to serve as a liaison between them and the patient. This comes with a lot of challenges. As evidenced by one of the nurses from the maternity unit of Korle Bu who shared her experiences in attending to francophone patients:

It was very difficult... There was one patient. She's from Cote d'Ivoire she didn't even know anything about English or Twi or Ga. All she knew was French French French. So, we had to call somebody who could speak French. We had to call her relative. So, when we speak, then the person interprets to her and also when the doctor was seeing her. So definitely, there will be miscommunication somewhere.

On the details of the communication challenges, the nurse indicated that:

[the patient] was trying to[communicate]... I was the first point of contact she met. I was supposed to check her vitals, write her history, and send to the Doctor. But she couldn't describe what was wrong with her. She was a pregnant woman.

In every institution visited, it was observed that there were no professionally trained interpreters to help with interpreting during health personnel-patient interactions. In the Korle-Bu Teaching Hospital, out of all the specialist units, we discovered that only the Radiology Unit had interpreters. Interestingly, these were bilingual secretaries who had been sent to the Unit as administrative staff and who had learnt to interpret on-the-job as they were often called to help patients with communication during consultations. According to these interpreters, their role was very vital because they helped the patients feel comfortable right from their registration to the consultation and treatment and the patients felt comfortable because they could communicate with someone who understood them. As reported by a midwife at Korle Bu who serves as an interpreter when there is a need, patients feel well-received when there is a health worker who can speak their language: “They’re comfortable and they pick you as their friend. Anything they need, they would approach you and ask you”.

At the Eikwe and Nandom hospitals, there were also on average one health personnel each-but usually not permanent staff, who could speak French and who were often called upon to serve as interpreters. At Aflao, there was one Monsieur, at the Emergency Unit who was the go-to person. He had schooled and had his nursing training in Togo and so had the necessary medical jargon even though he had no formal training in interpretation. “Sometime if I’m not on duty they call me if they can’t speak any language apart from French so I can communicate with the patient, the phone on them, I translate it. (Monsieur, Nurse, Aflao).

Even though the use of an interpreter can resolve the issue of communication barriers, the emphasis must be placed on quality interpreting where the interpreter unconsciously becomes the voice of the interlocutors. Unfortunately, this is not always easy to achieve especially where the interpreter is untrained and a relative of the patient. This can make patients

divulge less information than they normally would or present their issue in what they consider an ‘acceptable light’. As one of the nurses who had to rely on the services of a relative of a pregnant patient said:

So, the relative came in, then she’ll tell the relative and the relative will tell me. Then I write. But definitely, I knew the same way she’ll tell the relative wouldn’t be the same way she would have told me, but we had to manage it like that.

Beyond the issue of poor quality of interpretation, there is also the issue of having to use multiple languages to get a message across, with the risk of information getting lost in translation. This is especially true in the case of medical doctors who are usually not indigenes of the health centers that they are posted to. One medical doctor at the St. Theresa’s hospital, who is originally Akan and whose proficiency in French is very basic explained the interpretation trajectory he has to go through when dealing with a patient whose primary language of communication is French:

Sometimes the people understand Moshi too and those who don’t speak Dagaare. So, it has to be translated among 2 or 3 people before I get it. So, the person will speak French to the one who understands Moshi or Dagaare and the person would then translate to me in English or in Twi if the person understands Twi.

As in the case of Chinese whispers, the issue of multiple interpretation can lead to misinterpretation by the time it gets to the final target language and thus is to be avoided as much as possible. However, there is no doubt that in the absence of a shared language, interpreting is the best option. The challenge is the quality of the interpreter. In the absence of a trained or professional interpreter in the health setting, a health worker who speaks the patient’s language is the next best option as s/he

will have an understanding of the main concepts and will be able to communicate most effectively to the other health personnel and also to the patients. The use of unqualified interpreters has been proven to lead to miscommunication while the use of qualified interpreters improves communication, satisfaction and adherence to treatment (Wilson, Chen et al. 2005).

Conclusion

The main objective of this article was to discuss the implications of language barrier on access to healthcare in Ghana with special reference to migrants from francophone countries. Indeed, the perception by these health seekers is that the health personnel in Ghana engage more in divergent communication rather than convergent communication. There is therefore a sense of non-accommodation on the part of the francophone health seekers. On the other hand, the health personnel express an effort and a desire to accommodate and demonstrate this by the strategies they adopt in trying to communicate with the patients. In addition to discussing the challenges and effects of language barrier on healthcare access with a focus on patients from francophone countries, certain strategies for dealing with these challenges and mitigating the negative effects have been presented.

The assumption, at the start of this research project was that language barrier will be a major challenge in accessing healthcare. In this regard, we posited that patients from francophone countries would speak French and therefore, the provision of language services in French would be the best solution enabling access to healthcare. However, the research revealed that even though French was the main language of communication for francophone patients who patronized the Korle Bu Teaching Hospital, it was not necessarily the case for the border town health centers. In the border town health centers, shared border languages including Twi, Nzema (Ghana-

Ivory Coast border), Dagaare or Mossi (Ghana-Burkina Faso), Ewe (Ghana-Togo border) were readily used. In the three border towns, quite a number of the health personnel were also indigenes and so expressed themselves fluently in these shared languages. They could therefore easily communicate with the patients who travelled across the border to access healthcare. Based on the findings of this study, we make the following recommendations:

The first of these is the fact that science students should be allowed to choose French as an elective subject right from the high school especially for those who live in or close to border towns. Additionally, the teaching and learning of shared border languages should be reinforced. Indeed, the geographical location of Ghana and the free flow of goods and services in the West African sub-region will lead to migrant flows across the various countries and if as a nation, we are serious about regional integration and being the gateway to West Africa, we need to provide services in languages that people across the sub-region can understand, including French.

Secondly, the Ghana Health Service should make an effort at getting statistics of the demographic nature of the foreign visitors who patronize their services. This will guide them in making policy decisions as far as language and access to healthcare are concerned.

The most important suggestion, in our estimation, is that the training of medical interpreters be made a priority. Apart from one unit in the Korle Bu Teaching Hospital that had made systematic provision for interpretation services, all the other units relied on ad hoc interpreters. It is suggested that selected health personnel who are already well-versed in either the shared border languages or in French and who already play the role of interpreters be given on-the-job training in interpretation to enable them work more efficiently and provide more professional support to francophone patients seeking healthcare. As much as possible, a policy should be drawn up to support the

recruitment of staff taking into account the language needs of the communities in which they are going to serve.

References

- Anderson, L. M., et al. (2003). "Culturally competent healthcare systems: A systematic review." *American journal of preventive medicine* 24(3): 68-79.
- Boateng, L., et al. (2012). "An exploration of the enablers and barriers in access to the Dutch healthcare system among Ghanaians in Amsterdam." *I2(1)*: 75.
- Brennan, N., et al. (2013). "Trust in the health-care provider-patient relationship: a systematic mapping review of the evidence base." *International Journal for Quality in Health Care*, 25(6): 682-688.
- Chen, A. H., et al. (2007). "The legal framework for language access in healthcare settings: Title VI and beyond." *22(2)*: 362-367.
- Chevalier, B. A., et al. (2016). "Examining hospital pharmacists' goals for medication counseling within the communication accommodation theoretical framework." *12(5)*: 747-755.
- DiVerniero, R. A. (2013). "Children of divorce and their nonresidential parent's family: Examining perceptions of communication accommodation." *Journal of Family Communication* 13(4): 301-320.
- Edelman, G. J. C. P. (2004). "Improving provision for children with speech, language and communication difficulties: the role of the voluntary sector." *14(3)*: 223-228.
- Farini, F. (2013). "Interpreting and intercultural mediation in Italian healthcare settings." *Journal of intercultural communication*, 33: 1-19.
- Gallois, C., et al. (1995). "Accommodating intercultural encounters: Elaborations and extensions."
- Giles, H., et al. (2006). "Communication accommodation: Law enforcement and the public." *Applied interpersonal communication matters: Family, health*, 5: 241-269.
- Giles, H., et al. (2015). "Recent developments in communication accommodation theory: Innovative contexts and applications." *Language and Communication*, 41(1): 1-100.
- Giles, H., et al. (2012). "Police stops of and interactions with Latino and White (non-Latino) drivers: Extensive policing and communication accommodation." *Communication Monographs* 79(4): 407-427.
- Hajek, C., et al. (2008). "Expressed trust and compliance in police-civilian encounters: the role of communication accommodation in Chinese and American settings." *Chinese Journal of Communication*, 1(2): 168-180.
- Hajek, C., et al. (2007). "The relationships among perceived physician accommodation, perceived outgroup typicality, and patient inclinations toward compliance." *24(4)*: 293-302.

- Haricharan, H. J., et al. (2013). "Can we talk about the right to healthcare without language? A critique of key international human rights law, drawing on the experiences of a Deaf woman in Cape Town, South Africa." *28*(1): 54-66.
- Jones, L., et al. (2018). "Nurses' perceptions of communicating with minority parents in a neonatal nursery: a communication accommodation theory approach." *Journal of Communication in Healthcare, 11*(3): 175-185.
- Kaufert, J. M. and R. W. J. J. o. C. E. Putsch (1997). "Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power." *8*: 71-87.
- Kritzinger, J., et al. (2014). "'I just answer 'yes' to everything they say": Access to health care for deaf people in Worcester, South Africa and the politics of exclusion." *Patient education and counseling, 94*(3): 379-383.
- Martinez, G. J. L. P. (2008). "Language-in-healthcare policy, interaction patterns, and unequal care on the US-Mexico border." *7*(4): 345-363.
- Metzger, M. (2014). *Investigations in healthcare interpreting*, Gallaudet University Press.
- Meuter, R. F., et al. (2015). "Overcoming language barriers in healthcare: a protocol for investigating safe and effective communication when patients or clinicians use a second language." *15*(1): 371.
- Meuter, R. F. I., et al. (2015). "Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language." *BMC Health Services Research, 15*(1): 371.
- Ngo-Metzger, Q., et al. (2003). "Linguistic and cultural barriers to care." *Journal of General Internal Medicine, 18*(1): 44-52.
- Parcha, J. M. (2014). "Accommodating Twitter: Communication accommodation theory and classroom interactions." *Communication Teacher, 28*(4): 229-235.
- Pöchhacker, F. and M. Shlesinger (2007). *Healthcare interpreting: discourse and interaction*, John Benjamins Publishing.
- Pretorius, M. (2018). "Communication accommodation theory analysis of nurse-patient interaction: Implications for course design." *International Journal of Applied Linguistics, 28*(1): 71-85.
- Simmons-Mackie, N. (2018). "Communication partner training in aphasia: Reflections on communication accommodation theory." *Aphasiology, 32*(10): 1215-1224.
- Soliz, J. and H. J. A. o. t. I. C. A. Giles (2014). "Relational and identity processes in communication: A contextual and meta-analytical review of communication accommodation theory." *38*(1): 107-144.

- Speer, R. B., et al. (2013). "Investigating stepparent-stepchild interactions: The role of communication accommodation." *Journal of Family Communication*, 13(3): 218-241.
- Swabey, L., et al. (2012). "Domains and competencies for healthcare interpreting." *In our hands: Educating healthcare interpreters*: 1-26.
- Watson, B. M. (2020). Communication Accommodation Theory as an Intervention Tool to Improve Interprofessional Practice in Healthcare. *Professional Communication*, Springer: 169-189.
- Weizheng, Z. (2019). "Teacher-Student Interaction in EFL Classroom in China: Communication Accommodation Theory Perspective." *English Language Teaching*, 12(12): 99-111.
- Wilson, E., et al. (2005). "Effects of limited English proficiency and physician language on health care comprehension." *Journal of General Internal Medicine*, 20(9): 800-806.