Language policy, public health and awareness campaigns: A study of some health institutions in Pretoria.

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LANGUAGE POLICY, PUBLIC HEALTH AND AWARENESS CAMPAIGNS: A STUDY OF SOME HEALTH INSTITUTIONS IN PRETORIA

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Declaration

I, hereby, declare that the dissertation, "Language policy, public health and awareness campaigns: A study of some health institutions in Pretoria." submitted for the degree of MTech: (Language practice) at Tshwane University of Technology, Soshanguve, is my own original work, and has not been submitted to any other institution of higher education.

I further declare that all sources cited or quoted in this dissertation, are indicated and acknowledged by means of a comprehensive list of references.

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D.S. MOKOENA

Dedications

This work is dedicated to my late parents; my father who passed on when this study was reaching its final stages, and my late mother, who passed on when my youngest brother was doing his Matric. May their souls rest in peace.

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Abstract

At the centre of the messages and information disseminated to the public, there is language. This study investigated the role played by language when health awareness campaigns are planned by the Department of Health (DoH) in South Africa. Data were collected, using 115 (questionnaires) and 18 (interviews), from Pretoria clinic patients/visitors. The study, thus, tried to find out if a representative sample of the Pretoria community are satisfied that they received public health awareness information in their languages, and that the DoH, is, thereby, adhering to the national language policy, in content and in spirit. Based on its findings, the study recommends that the DoH and the media need to reinforce their efforts to honour the language policy of South Africa, for the benefit of society, by making public health awareness campaigns more effective to achieve public health improvement.

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CHAPTER 1: INTRODUCTION

1.1 Background and Rationale

This study focuses on language, and, more precisely, language policy. Like the topic of the study indicates, language policy is looked at with special reference to the Department of Health (DoH) of South Africa, and its public awareness campaigns on health issues. This study was conducted in Pretoria. The background and rationale of the project is discussed, with special reference to the language speakers in Pretoria, since the study was undertaken in this area.

Pretoria is a city occupied by residents that are representative of all South African language groups; namely, English, Afrikaans, Sotho, Nguni, Venda, and Tsonga. A Pretoria outlook could be seen largely as a projection of more Blacks normally residing in the townships. The languages of the last four language groups listed above are spoken by the communities of this area. This means all the African languages of the country are represented in Pretoria. This coming together of all languages in one small area of the country has indirectly led to the evolution of a language that has never stopped to grow over the years. The language is not among the 11 official languages of the country, but the communities of Pretoria have adopted it as their language of communication. They feel comfortable speaking the language. It is a mixture of a number of languages, in a way that the words from other languages are converted into the Sotho morphological structure. The majority of people in Pretoria identify themselves as either Bapedi or Batswana. Many study the languages spoken by the two ethnic groups as their home language at school.

This language that has evolved in Pretoria is unofficially called *Sepitori* (Pretoria Sotho); it has become a language of pride, and the communities in and around Pretoria see it as a compromise between Sepedi and Setswana.

The language policy of the country gives official status to eleven of the languages spoken in South Africa. The community of Pretoria is predominantly Sotho language-speaking, with a few speaking Nguni, Tsonga, and Venda. Sotho has become so dominant that even people who have Nguni, Tsonga, or Venda as their home language, have switched to speaking the Sotho language. The evolution of a ‘new’ Pretoria language has, thus, come as an unplanned compromise to

everyone. Since Sotho is widely spoken in Pretoria, the communities have become so attached to this language that anyone who speaks English around them is seen as snobbish, or an elite who normally doesn't get a warm welcome by the average Pretoria township resident, and they are often labelled 'coconuts'.

In the health centres of the city and surrounding townships, health information is conveyed mostly in the English language. Through observation, one may say that important information might be ignored by the people visiting public clinics and hospitals, or they might have little or no interest in reading it. This might be because of various reasons which the study will try to find out, as guided by the language policy of South Africa in the DoH.

1.2 Aims & Objectives

The aim of this study was to: i) look at how language policy is implemented in the South African DoH - the focus is on the language(s) used in public health awareness campaigns; and, ii) evaluate the impact that health awareness campaigns have on the public, in relation to the language(s) used for this purpose.

The study's objectives were to: i) find out if the public find the language (s) used in public health centres accessible to them; and, ii) establish whether the public agree that local community languages are taken into account when health information is prepared for dissemination.

From the aims and objectives above, the analysis of the responses from the questionnaire will be made to get to the possible answers that the study would like to reach.

In this study, the two key aspects are language policy and health issues. There are so many health issues, which are all equally important. However, the primary concern of the study was public awareness campaigns that the DoH undertakes to reach out to the society in an attempt to minimise health problems. The South African language policy advocates equal treatment and equal status to all the eleven official languages. The information carried by the health awareness campaigns is, thus, expected to conform to, and reflection, the advocacy of the language policy. It is exactly what this study would like to find out: the fairness and equal usage of all the eleven official languages when the information carried by the health awareness campaigns is disseminated to the public.

Language policies are governmental statements made on whatever statuses and functions selected languages have been assigned, usually at national level (Mann & Wong, 1999: 17). Language policy, in this study, is understood as an official statement made by a government about the use of languages, and the statuses accorded to particular languages in a country. Language policies may be regarded as a way of safeguarding the capacity in the languages of the people they represent. The language policy of a country is also guided by the social, economic, and political character, and future needs and prospects of a nation

Since the new dispensation (post-1994), South Africa has faced a situation, whereby there was an urgent need for reform in all spheres of national life. Various government departments were faced with an obligation of fulfilling the promises made to the people during election campaigns as embraced in the election manifestos. The DoH is one of the departments regarded as offering essential services to the society. The Department, like the others that are regarded as essential service departments, became obliged as well to bring about improvements in its services. This could only be achieved through the introduction of new policies which would bring about change geared towards the improvement of health matters. Among the policies introduced and implemented was the "Policy on Language Services" - the most recent one in the year 2011.

Health awareness campaigns are a universal aspect. It is, however, very crucial to give an introductory explanation on how this concept is used in this study. This will help in bringing some understanding of what the study is looking at, in particular, so as to minimise the broader scope that these campaigns normally focus on.

Most of the poverty-prone people are deprived of the light of education; hence, they have little knowledge about good health, and its benefits in life:

> "The diseases like diarrhea, malaria, dengue, hookworm, diabetics, high blood pressure etc get spread due to irregular lifestyle and lack of knowledge. The awareness program will educate them how to adopt a healthy lifestyle and how to prevent unwelcoming diseases." (ASA, 2013)

Campaigns are normally carried by language. It is, therefore, imperative that the language used to conduct such campaigns be the one that tries to cover all the different language users of the country.

There is a lot of information displayed about health issues on the walls, inside the different health institutions. The information ranges from infant early developmental stages to terminal illnesses, like HIV/AIDS, and cancer. Most health information that is aimed at campaigning for health awareness is found on the clinic and hospital walls and notice boards. Leaflets and pamphlets are also used, sometimes. The more a disease becomes a threat to the society, the more focus is given to it, and the more campaigns are centred on it. Health awareness campaigns are, therefore, used as intended effective mechanisms towards making the public aware of the health problems, and related issues. They are aimed at educating the society about the situation, in order to minimise, or gradually eliminate the problem. It is vital to mention that health awareness campaigns are on-going phenomena that do not happen once, or in periodical turns. Health awareness campaigns in this study will refer specifically to written displayed information in health institutions.

The concern in this study is the language used for the displayed information. The study attempts to assess whether consideration is given to the language(s) of the locals when health awareness campaigns are prepared. Informal observation would lead one to take an initial stand that most public health centre daily visitors are likely to ignore, or show no interest in reading the information on the walls or information boards.

Another form of public health awareness campaign employed by the DoH is an outreach campaign, whereby information is sent to schools and workplaces. In this kind of campaign, officials or DoH agents are sent to different institutions in the society to inform and educate the public about crucial health issues, most especially threatening diseases. Alternatively the same types of charts that are displayed in clinics/hospitals are normally taken to schools and other target places for outreach projects. In this study, health institutions will be the main focus.

Since the research focused on use of languages in Pretoria health institutions, it is important to give an overview of languages used by the majority of the residents of this area when communicative interactions take place. There are eleven official languages in South Africa as enshrined in the language policy of the country that came about through legislation. These eleven languages are basically three main Sotho languages, four main Nguni languages, XiTsonga, TshiVenda, Afrikaans, and English. In addition, Pretoria communities speak a language that is not formal, but can be called 'Pretoria Sotho.' The concept of *Pretoria Pride*

(identity of a typical Pretoria-born South African citizen) will have a bearing on language use in this domain.

Pretoria Sotho is explained by Ditsele (2012), as a non-standard language spoken in the metropolitan district of Tshwane. Pretoria Sotho is popularly known as *Sepitori* - a name that emanates from the name Pretoria. The word, 'Sepitori', derives from two morphemes: *Se-* (language), and *-pitori* (the Black African way of pronouncing 'Pretoria'). Thus, the name, Sepitori, refers to a language spoken by the people who live in Pretoria.

The study sampled populations in the following locations in Pretoria which is recently referred to as Tshwane: Soshanguve; Atteridgeville - both predominantly Black; and, Eersterus - predominantly Coloured.

1.3 Key population information on Tshwane

Tshwane is not the highest, but one of the highly, populated metropolitan regions in the country. The following table represents the population in numbers:

Table 1.1: Tshwane Population by Sex (Statistics South Africa, 2014)

Male	Female	Grand Total
1 453 483	1 468 005	2 921 488
Total=1, 453, 483	Total=1, 468, 005	2, 921 488

The Tshwane region has, over the years, been the administrative capital of South Africa, since the apartheid years to date. Due to this factor, the city's government job opportunities have attracted the migration of people from other provinces. This is another contributing factor towards the large and diverse population in the area.

Other population figures are presented in the table below:

1.3.1. Population by Age and Sex

The population figures in Table 1.2 are the latest census results. The study conducted here focuses on the language policy of South Africa with special reference to this population. The present total number of the people in this Pretoria is put at 2 921 488.

Table 1.2: Tshwane Population by Age &Sex(Statistics South Africa, 2014)

Age	Male	Female	Total
0-4	137 848	136 018	273 866
5-9	106 232	105 659	211 891
10-14	97 306	94 045	191 352
15-19	112 418	116 160	228 577
20-24	170 994	169 851	340 844
25-29	174 314	164 499	338 813
30-34	145 298	132 071	277 369
35-39	121 415	114 373	235 789
40-44	98 807	98 319	197 126
45-49	78 813	85 378	164 191
50-54	65 524	70 816	136 340
55-59	51 149	55 090	106 239
60-64	35 611	40 576	76 187
65-69	23 244	29 258	52 501
70-74	15 799	21 887	37 686
75-79	9 331	14 984	24 316
80-84	5 513	10 398	16 912
85+	3 866	8 624	12 490
Total	1 453 483	1 468 005	2 921 488

1.3.2. Population by First Language Spoken at Home

Since the study has as its main focus, the language policy of the country, it will be in the best interest of the study to also reveal the population figures with regard to the languages spoken in the area.

The figures on the population of Tshwane per language spoken at home reveal that, in this metropolitan area, English is not the language spoken by the majority at home. It is interesting to note that Afrikaans and Sepedi are in the forefront, in terms of numbers. Sotho languages;

namely, Sepedi, Setswana, and Sesotho, form the largest group in the City of Tshwane. With this in mind, it would mean that much consideration has to be given to these statistics (e.g., a higher number of Sotho-speaking metropolitan residents in this area), when matters, regarding language, are decided upon. This also means that public health institutions are expected to give information that would cater for the language(s) spoken by the majority of these residents.

Table 1.3: Tshwane Population Home Languages (Statistics South Africa, 2014)

Language	**Number**	**Percentage**
Afrikaans	536 596	18,4
English	244 603	8,4
IsiNdebele	163 559	5.6
IsiXhosa	61 431	2.1
IsiZulu	242 615	8.3
Sepedi	567 372	19.4
Sesotho	150 395	5.1
Setswana	428 791	14.7
Sign Language	8 520	0.3
SiSwati	44 459	1.5
Tshivenda	66 521	2.3
Xitsonga	246 112	6.4
Other	89 084	3.0
Not Applicable(Institutional Population)	71 430	2.4

When language takes centre stage, serious consideration has to be given to the level of literacy of the community. If English is chosen as the language to be used when public health awareness communication is initiated, then this should be done with a view in mind that there might be many who find it challenging to comprehend the communicated information. The figures on literacy levels of the population of Pretoria would, thus, be relevant to look at, as shown below.

1.3.4 *Population aged 15 years and above by literacy*

The figures in Table 1.4 give us an indication that the population of Tshwane is mainly literate. This means that most people in this community are able to read and write (in a language). It should also be understood that being *literate* doesn't necessarily mean being intellectual or academic; it doesn't mean being *functionally literate* either. It is the basics of a person's understanding of letters (phonemes), and their inter-relatedness, towards producing meaning in words and sentences in the form of writing and reading. In this study, the type of language, i.e., medical jargon, used in the health's circuits is basically a key element. Health literacy will, therefore, be another important aspect to be discussed.

Table 1.4: Pretoria Population aged 15 years and above by Literacy (Statistics South Africa, 2014)

Numbers			***Percentages***		
Illiterate	Literate	Total	Illiterate	Literate	Total
220 660	1 944 339	2 164 999	10.2%	89.8%	100%

This study should look at the extent to which medical jargon plays a role towards the effectiveness of health awareness campaigns, with special focus on the application of language policy.

1.4 Division of Study into Chapters

Some key issues on language policy are discussed in Chapter 2 with the background of available literature. Multilingualism is reviewed with special focus on its positives and negatives. The inter-relationships between language and culture are also raised. The historical background of South Africa's language policy, as well as other aspects that are seen as crucial in shaping the chapter towards addressing issues linked to the hypotheses of the study, are also points of focus, i.e., language policy implementation; literacy; functional literacy; health literacy; and, functional health literacy.

Chapter 3 deals with the research methodology, instruments and procedures adopted for the study, as well as the sample population, and ethical issues of interest. Three clinics in three townships around Pretoria were used for the sampling of clinic patients/visitors and health personnel.

Chapter 4 presents, analyses, interprets, and discusses the questionnaire and interview findings, with a view to assessing the strict implementation of language policy by the DoH, and the success (or otherwise) of its public health campaigns.

Finally, Chapter 5, focuses on the conclusions and recommendations of the study. The efforts of the Department of Health are, thus, assessed, in terms of the extent to which its public health awareness campaigns are succeeding, or failing, and whether or not it is adhering to the content and spirit of the national language policy, and its own departmental language policy in the prosecution of their vital duties to the public.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reviews and discusses relevant literature dealing with the topic. A literature review is an account of what has been published on a topic by accredited scholars and researchers (Taylor, 2008: 1).

2.2Multilingualism in Developing Countries

Multilingualism is a concept with many definitions, but all stressing the ability of a person to speak more than one language. (Mrabet, 2012:1) defines multilingualism as a resource at the individual level; it refers to the speaker's competence to use two or more languages. Multilingualism is seen as a resource, rather than a problem. This doesn't mean that the exclusion of the word 'problem.' renders multilingualism an all-positive language concept.

According to Mrabet (2012: 1), the ability to speak the language is not only the point of reference, but rather the competence in the language which refers to more than just knowing the language. This entails the ability to skilfully encode the communication symbols, in an interpersonal interaction, in such a way that communication is effective. Therefore, competence, in this regard, refers to the skills a person has to facilitate communication between himself and the next person, in such a way that the meaning is often not lost. People born in countries where the society is diverse, in terms of language and culture, are likely to know two or more languages; such is the reality in a country, like South Africa. South Africa is one country that has expressed its pride for being diverse, and yet so united. Although there have been attempts by the previous apartheid government to force people of different ethnic groups live separately in socio-politically demarcated areas (for example, previous homelands, and the 'so-called' independent states, where Blacks in South Africa were allocated land according to the languages they spoke), the separation has not made it impossible for many South Africans to know how to speak and be competent in more than one language.

Nkamigbo (2012) sees multilingualism as not only a concept confined to individual speakers, but one which also encompasses communities.

In another interesting contribution on this concept, multilingualism is broken down into two: *Elite Language* learned in a formal setting through planned and regular instruction as in a school system; and *Neighborhood Language*, i.e., language(s) acquired in a natural setting, acquired through interaction with people speaking different languages (Pushpa,2005: 3). Pushpa (2005: 3) states that multilingualism may arise from formal education in a classroom setting, or as a result of ordinary interactions between language users, with the aid of an environment that allows for it to occur. The latter stresses the fact that multilingualism can be a natural process, which implies that it is more of acquisition, whereas the previous is more of a learning process. The two, acquisition of a language, and learning a language, are different. Yule (2010) remarks that learning a language requires an instructor, whereas acquiring one requires only language users around. There are reasons behind learning other languages by a person through formal education; for example, a country's language policy sets up the need for learning a language through formal education. This is influenced by factors that include the local economic picture of the country, the need for its ability to compete internationally, and the educational factor in which the medium of instruction becomes a language that is not an indigenous or home one. In South Africa, many of the citizens have studied English and Afrikaans as compulsory school subjects; in this language ecology, we will encounter a situation where multilingualism arises as a result of both language acquisition and language learning.

Multilingualism may be associated with problems or benefits as well, in some instances. The next sub-topics will look into the two, since this language policy discussion will need to find out how this has become an issue in South Africa, and specifically, Pretoria, where the study was conducted.

2.2.1 The problems of multilingualism in developing countries

Most worldly phenomena present themselves in a two-faced character (positive and negative): "Multilingualism is a problem. Learning many languages may lead to shift or death of the individual's mother tongue" (Mrabet, 2012: 2). As mentioned already, the community where this study was conducted is multilingual, and it is also very important to look at how multilingualism threatens the mother tongues of these people to the point of dying. *Language shift* is less extreme, since it doesn't mean the total disappearance of a language. Holmes (1993) says that language shift generally refers to the process by which one language displaces another in the

linguistic repertoire of a community. It is, however, possible for the two language phenomena, shift and death, to co-exist in a given situation, with the former giving rise to the other. However, language shift can sometimes lead to language death or language loss, precisely for languages that are spoken by minorities (Mrabet, 2012: 2). In Pretoria there are languages that are spoken by minority communities, like TshiVenda and Sesotho, and language shift among these communities may arise.

In education, there are also challenges that emanate from multilingualism. If the language policy of a country aims at establishing multilingualism for whatever reason, it normally would not go without any difficulties. Not only do the challenges catch up with the learners, but also go as far as affecting even the teachers. In fact, the teachers themselves do not differentiate between teaching a language, teaching through a language, and teaching about a language, or teaching of language and literature (Cohen, 2005: 1802). This may be a problem triggered by the wrong formulation of the curriculum which is likely to emerge, should thorough planning not be of vital importance when the language curriculum is being conceived and prepared. These challenges cannot be alienated from multilingualism when it is policy of the state that each person is supposed to learn an extra language at school for the reasons that the state may find legitimate for the country's well-being.

Wong (2003) points out that in a linguistically and culturally diverse society, language may be viewed as the most important tool with which national unity may be forged, and considered to be inconsistent with the desire for national oneness. Though we find multilingualism opening up for some positive benefits in people of different languages and cultures living together, Wong (2003) points out, however, that multilingualism cannot be trusted for the establishment of national unity. It doesn't always work towards harmonious relationships among communities living in diverse societies, hence sole trust cannot be put on multilingualism according to the view raised by Wong (2003). The inconsistent nature of multilingualism to ensure national oneness renders it problematic and thus becoming an obstacle in the way of unity in developing countries. Ethnic differences, leading to internal conflicts within communities, may result, due to multilingualism, thus backing the point raised that national oneness may, in some instances suffer due to multilingualism.

In South Africa, there are some attempts made to introduce indigenous languages as media of instruction in formal education. This move is expected to not only be directed at basic education, but as far as the higher education level. For example, the University of KwaZulu-Natal (UKZN) has recently taken the decision to introduce IsiZulu as a compulsory subject to all undergraduate students enrolling at the university from 2014, which may be seen as one such effort to give African languages medium-of-instruction status. The challenge here is the perception that many people have towards any attempt to promote indigenous languages in an effort to enhance multilingualism. Natal is predominantly occupied by Zulu-speaking citizens. The attempt by the university to make IsiZulu compulsory could be just the beginning of formal multilingualism promotion which could likely later spread to other institutions of higher learning. "The Mercury" newspaper has opened a comment space in its social media, and some of the comments suggest that people still do not see multilingualism as a necessary societal ingredient for unity, progress, and better future prospects. Here is one of such comments:

> "This is just plain stupid-mandatory language classes have their place in high schools. Zulu will replace other courses meaning it will dilute every degree in the university; it will make UKZN less competitive but it seems the university management is hell bent on making UKZN the worst university in the country-despite being bigger than any university in South Africa it doesn't even make the global rankings." (Alexo, 2013)

There is no part of the comment that addresses the possibility of the creation of unity achieved through language; for example, the initiative could open up an opportunity to non-speakers of IsiZulu to learn how to communicate in the language.

Another comment says: "Why Zulu? Why not Xhosa or anything else for that matter?" (Fintel, 2013)

Although short, the message is significant. The province under discussion is predominantly Zulu. It would be more advantageous to people in this province to be afforded the opportunity to learn other South African indigenous languages, besides IsiZulu, since they are exposed to their language most of the time, and interaction with speakers of other indigenous languages is very minimal, since there are no other such languages within the borders of the province. The

advantage would go a long way in making the Zulu nation in Natal to face fewer language problems on occasions where they interact with other language speakers in other provinces. This would also serve as a good initiative towards minimising ethnically-based negative language attitudes toward other language groups. Learning other people's languages often includes learning about the ways of life of the speakers of those languages which can serve as one way of reducing the negative attitude that may have developed towards the speakers of those languages.

The newspaper provides some research supportive of the university's plan: "Recent research clearly shows that the number of students who left educational institutions without graduating has increased to 46% in 2010. Undoubtedly, language is regarded as one of the main factors contributing to this high drop-out and failure rate" (Madiba, 2013: 1). Madiba (2013: 1) suggests that one contributing factor in the high failure rates at tertiary institutions is the non-usage of indigenous languages as languages of instruction at higher education institutions. If all indigenous languages were to be given a chance to assume the status of media of instruction, then higher education students would be allowed the opportunity to learn in languages that they know and understand better - which would, in turn, reduce the failure rates, according to this view. Learning at tertiary level in an indigenous language implies the production of graduates who will be more locally oriented, in terms of international competitiveness. The current setup, whereby English is the medium of instruction creates opportunities for the country's higher education students to expand their horizons internationally, since English allows them that, because of it being an international language of business, networks, and, to a larger extent, education.

2.2.2 The positives of multilingualism in developing countries

There are languages that may be under threat of dying in the case where they are ignored or not catered for by the language policy of a country. In the United Kingdom, such a challenge exists:

> "In London, for example, the last census conducted by the Inner London Education Authority in 1989, before it was disbanded by the central government, revealed that there were speakers of 184 different languages in London's schools…Attempts to promote the other languages did yield some good outcomes. There has nevertheless been a series of policy responses to linguistic diversity over the last 35 years, ranging from an assimilationist focus on the teaching of

> English as a second language to a broader more celebratory attempt to recognize and promote the many community languages."(Richard & Baldouf, 2004: 1)

Multilingualism in this scenario appears to have led to a positive contribution in that it allowed for the recognition and promotion of those many other languages.

The issue of unity and harmonious relationships can be a possibility through language. Nations that differ in language and culture may seize the opportunity to ensure that their differences do not become sparks of hatred, if they start learning each other's customs and languages. Research has taught us that we have a greater appreciation of the differences of others, if we learn their languages and view the world from their perspective (Nkamigbo, 2012: 4). So, being multilingual as a nation can possibly minimize the tensions of ethnic or even racial hostility.

As a resource, multilingualism is potentially viable as a means of forging unity, and facilitating participation in a country's economy: "The culturally plural society frequently faces a relative absence of value consensus. It is important that education within such a society should provide the cohesive force which draws all groups together in an acceptance of a central common core of values and help to strengthen the will to maintain each an agreement" (Wong, 2003: 4). As Wong states, multilingualism can become a resource, if the educational establishment of a country provides for equal treatment of different languages in society, to allow for equal participation by its members, for the benefit of society at large. Cohen (2005:3) puts the positives of multilingualism, thus:

> "…Multilingualism should be looked at as an advantage offered to us by history rather than a problem. As has been mentioned above, Multilingualism helps to develop meta-cognitive and meta-linguistic skills. At a very early age children learn to express the same thought with different codes in different languages. At the social level they understand the cultural differences leading to different norms to be observed in interpersonal relations in different discourse situations. Thus it teaches them to live harmoniously with others in the society."

Multilingualism is regarded as the teacher of tolerance and harmonious social interactions. People of different languages are taught to live harmoniously with others in the society.

2.3 Language Policy and Language Planning

It would be proper that the two concepts of language policy and language planning be looked at as a pair, whereby one usually cannot be separated from the other.

2.3.1 An overview on Language Policy and Planning in the study's perspective

Language policy (LP) is the deliberate attempt to change an individual's use of language or languages or a variety or varieties (Kennedy, 2011: 2). Although language policy is a 'government to people' or 'state to citizens' process, in the sense that the state draws the policy for its citizens, this definition gives the impression that the state autocratically dictates the language of use to its citizens without giving any concern to their needs.

Language policy (statements of intent) and planning (implementation) (LPP) is defined as planning- often large scale and national, usually undertaken by governments, if not change ways of speaking or literacy practices within a society (Richard & Baldauf, 2004:1). Language policy and planning has as its main concern the aspects of life that are of crucial importance for societal progress, with regard to how a particular society interacts with other societies globally. The aspects of life are, as Wright (2007:129-148) puts it, the economy and social factors: "Language planning and language policy express particular efforts at official social intervention and control in the sphere of language. Normally, the direction and ambitions of language policy and planning embody an economic and social vision" (Wright, 2007: 129-148). In terms of economic viability, it is very crucial for any government to handle its language policy in such a way that the economic needs of the country are met. The policy should nourish the educational dimension of a society so that it trains the players for the economic playground. In other words, language shouldn't be planned in such a way that communities are forced to study languages that will not help them in them becoming economically-active members of society. If the policy gives a second language the status of medium of instruction at schools, this should be done after serious consideration. The second language chosen should be the one that conforms to the needs of the society both locally and internationally.

Wright (2007: 3) distinguishes between two types of language planning: the natural, and the interventionist. The natural type of language planning doesn't come about as a result of pressure of any sort. *Natural language planning* actively supports the evolving language needs of a society, as they emerge in response to other-than-linguistic pressures (Wright, 2007: 3). She

further asserts that, if language shift towards an international language is occurring because of the demands of the central economy and the impact of globalisation, there will normally be social pressure to ensure that requisite human and material resources are readily available for members of the society to learn that language well. In contrast, Wright sees interventionist language planning as prepared to challenge the dispensation of the sociolinguistic forces of today. The interventionist language planning as Wright puts it, looks at ways to preserve languages, finding ways to protect languages under threat, defend language rights and, above all, nurturing a linguistic ecology that is ethically satisfactory.

2.3.2 Brief Historical Background on South Africa's Language Policy

The history of South Africa, as a country, cannot be isolated from years of apartheid rule that have affected and shaped it to what it has become today. Although the liberation struggle had, as its priority, political revolution; language and linguistic problems have also co-existed with the racial discrimination policies of the past. The apartheid government, over the period of its reign, declared Afrikaans and English as the only official languages. Marjorie (1982:1) asserts that "On one level, there are linguistic tensions between its two official language groups, Afrikaans and English." Black African languages were not given any status in educational instruction at schools - which was one main feature of the apartheid policy. Blacks were supposed to be educated in the language of a White person, in order to be able to use the language during communicative interactions with the Whites.

There is no politically neutral theory of language planning, in spite of the fact that the power elites tend only to examine language policy under conditions of crisis (Alexander, 2004: 1). The past history of language in South Africa has been affected by Afrikaner political ideologies over the years of White apartheid rule. The linguistic problems of South Africa have not only been a Black-on-White issue. White-on-White linguistic problems also existed over a very long period during the apartheid years. English and Afrikaans have always fought for dominance. The conflict and rivalry between English and Afrikaans speakers goes to the heart of the history of white South Africa (Marjorie, 1982:1).

According to Marjorie (1982) Afrikaans was not a language for educational purposes until the year 1925. Afrikaners see their language as an important representation of their cultural existence, and have never been prepared to compromise their position on this. The taking over of

government by the white minority Afrikaner race culminated in the intensification of this notion of cultural existence. White Afrikaner rule then introduced laws to protect their rights over the rights of any other South African ethnic group. It was, therefore, not surprising to see how the-then apartheid rulers tried to impose their language, Afrikaans, on the Black majority nation.

It is interesting to note that the oppressed section of the country then, which comprised of the Black majority stood vehemently against the imposition of Afrikaans on them - which led to the Soweto riots that later spread across the country, culminating in a broader struggle that not only fought against Afrikaans, but sought political change as well. On another level, there were linguistic tensions between the ethnic Europeans and the Black majority, mostly with regard to the language of instruction in schools (Marjorie, 1982:1).

Marjorie (1982: 1) points out another move by the apartheid government to establish an education system that would see African languages become languages of instruction at tertiary institutions. Blacks had become so skeptical of any introduction of policy on them by the white apartheid government that this proposal was viewed as a plan to end up with separate institutions that would admit students according to ethnic origin, like it was the case with the Group Areas Act that divided Blacks according to the home languages they spoke for residential allocations. Blacks rejected this plan. Marjorie (1982: 2) states that: "First, they saw the "divide-and-conquer" motive behind this plan. Second, they wanted to learn English as a language of wider communication." Blacks had already started to fight for their rightful position in the land by then, through the liberation struggle, and they certainly couldn't agree to such plans that were orchestrated by the-then discriminatory government.

Given the nature of language-related historical events, South Africa should be one of the countries that take into serious consideration the promotion of previously-marginalised languages, and to fight for the cultural preservation of the previously-disadvantaged communities through language rights protection. It is a concern that, even today, there is a tower at Paarl town in the Western Cape that represents the preservation of the Afrikaans language, whereas there is no such symbol representing any of the nine Black African languages of the country.

If the new government is to really address the apartheid remains of the past, the language policy of the country should be fully representative of all the ethnic groups, and its implementation should reflect this representation in practice as opposed to only ona document.

2.3.3 Language Policy and the Influence of Linguistic Culture

When language is discussed, there is a constant interlink between culture and language itself. *Culture* can be defined as the lifestyle of a group, which includes the values, beliefs, artefacts, and ways of behaving and communicating of that group (Cleary, 2010: 11). When related to culture, therefore, language would include looking at ways of a particular group that speak the language(s), with regard their social identity and lifestyle. The identity of a nation is reflected through the linguistic culture of that nation. In other words, the way a nation wants to be like, and how it would like to be part of the international world both economically and politically, will be guided by its own linguistic culture. Languages have complex implications, in terms of identity and social integration, both globally and locally, and, thus, are of strategic importance (Ncqobo, 2004: 1). This UNISA paper on language policy implementation, stresses the identity of a nation as one factor that reflects its wellbeing through social interactions both locally and globally. The paper further makes the assertion that languages are not only tools of communication, but also, and mainly, systems of perception and thought, mirrors of cultural identity, and vectors of its fundamental values (Ncqobo, 2004: 1).

Language policy is, primarily, a social construct, and, as such, rests on other conceptual elements which are belief systems, attitudes, myths, the whole complex that we refer to as linguistic culture (Routledge, 1996: 1). Routledge (1996: 1) in this quote, outlines that social perimetres, in any society, will play an important role in the language policy of that society. It is the shape of the society that will influence the shape of its language policy, according to this quote. Routledge (1996: 1) further stresses out of the content of this quote, that culture and language are two inseparable entities of society with one existing because of the other, creating a co-existence link that guarantees a never-ending bond between the two. The language of a particular community will play a major role in the shaping of, and passing over, of culture to the next generation of culture. Language is also shaped to a certain extent by culture itself but this doesn't render language to being prone to any form of political manipulation. Politicians my manipulate language policy, but not language itself (Routledge, 1996: 1). It therefore is a fact, as Routledge

(1996: 1) points out, in the latter statement, that language will have much control on its evolution and dynamics than politicians could have on language policies.

2.3.4 The Pan South African Language Board and the Language Policy

The Pan South African Language Board (PanSALB) plays a very crucial role in upholding language rights and equity on language statuses to ensure that the language policy of the country serves all the sections of the society the way it is supposed to.

The PanSALB is a body that has been approved by legislation to serve the nation in the interest of the protection, promotion, and preservation of all South African languages with extra commitment to setting a stage for the promotion of the previously-marginalised official languages. PanSALB participated in the drafting of the South African language policy when the-then Chairperson of the Board, Ms Z Desai, served on the Minister of Arts and Culture's advisory panel on the draft language policy and plan for South Africa (PanSALB Briefing, 2001).

PanSALB has also conducted a survey on sociolinguistic aspects of the country on language use and interactions. The findings of the survey played a pivotal role in guiding the Board in the drafting of the guidelines that were to be used for language planning and policy development. These guidelines and principles were the ones used by different government departments in formulating their individual language policies; the DoH developed its language policy, based on them.

On the issue of protecting the languages, it should be understood that it is not only about protecting the language from dying or disappearance. This also includes protecting the linguistic rights of the society at large. Multilingualism as the most striking feature of the language policy cannot be a success if the linguistic rights of some language speakers are violated. PanSALB has opened their doors to the society to report any form of violation of their linguistic rights. The board does receive and investigate language rights complaints. However, the majority of complaints came from the Afrikaans-speaking communities, rather than from speakers of the nine African languages (PanSALB Briefing, 2001).

This raises a concern about the language consciousness of the African people of South Africa. This is more aggravated by the non-reporting by speakers of the nine African language - which

may imply that they do not have any complains at all. It is, however possible that they may not be aware of the channels or just not aware of the PanSALB's initiative at all? Another possibility could be that the speakers of African languages feel comfortable with the implementation of the new language policy, such that they don't see any need to scrutinise it, and check for any form of disregard of their linguistic rights in all spheres of life, in the new dispensation?

The contents of the minutes of the PanSALB meeting in the 2001 briefing have, as their main stress, the equal status of the 11 official languages in South Africa.

In this study, language policy is discussed with special reference to the language policy and practice of the DoH, which is supposed to be guided by the national language policy. The language(s) used in the public health institutions should reflect all the official languages of the country equally without one appearing to be dominant over the others. If English dominates, for instance - which is likely to be the case, it would mean that health officials may be taking it for granted that the English language helps in getting the information to the people. Another possibility may be that the health officials think everyone accepts English (informally) as the only official language to be used to disseminate information. This could have dangerous consequences, because the majority of health centre visitors might not be receiving valuable, as the DoH might have wished.

2.3.5 Language Policy in the South African Context

2.3.5.1 The Special Need for a Language Policy for South Africa

South Africa has a very diverse society. Ethnologue.com reveals there are 31 listed languages in South Africa, and that, of the 31, 25 are living spoken languages are spoken in this country - which signifies that there is a cultural diversity that cannot be underestimated in any form. Language policy formulation is perceived as being normally a top-down exercise, where by the authorities decide for, and on behalf of, the people. The ruling party has the latitude of exploring the means of coming up with a policy that will enhance its image as a democratic representation of all the people in the country. The ruling party in the new dispensation is expected to come up with a policy that will protect, and be a reflection of, the country's diversity. The drafting of the language policy thus cannot be a one-man decision, or knee jerk reaction, just to facilitate its availability, but a well organised process with due consideration of the society's linguistic rights.

Aguilar (1967: v) states that: "No public authority, even a dictator, can order an abrupt change and expect to see it effected, unless the means and tendency for that change are already present in the practices and habits of the speakers, language engineering must be applied within a framework of realistic limits, to serve a useful and logical need."

Pretorious (2003: 6) states that "policy processes in transitional societies are especially prone to producing "gaps" and "disjunctions" between policy and implementation in "the pursuit of heavily contested, ideologically loaded, transformation goals." Language policy implementation is one factor, while language policy is another, whereby the one doesn't necessarily mean the automatic success of the other; implementation is crucial in that the way it is conducted becomes reflected in the success or failure of policy.

Language policies, like it is the case in South Africa, should produce the desired results, which are basically the equal representation of different language groups in all spheres of life. According to Beukes (2004:17), South Africa's language policy operates within the National Language Policy Framework (NLPF) that is aimed at seeing the facilitation of the following:

- To promote the equitable use of 11 official languages;
- Facilitate equitable access to government services, knowledge and information;
- Ensure redress for the previously-marginalised official indigenous languages;
- Initiate and sustain a vibrant discourse on multilingualism with all language communities;
- Encourage the learning of other indigenous languages to promote national unity, and linguistic and cultural diversity; and,
- Promote good language management for efficient public service administration to meet expectations and needs.(Department of Arts and Culture, 2003a: 13)

The framework of the South African language policy is guided by the establishment of three structures that are presented below, including the tasks assigned to them:

> "i.)**Language Units** in each government department and province to manage translation, editing and interpreting services with a view to the envisaged increase in the demand for these services and also for the terminology development in the indigenous languages. The establishment of these units was approved by cabinet

in July 2007, four years after the publication of the NLPF. So-called key service delivery departments will be prioritized and monitored to ensure that they set up the units responsible for the translation of all their documents. These departments are home affairs, justice and constitutional development, social development, Health, Safety and Security, Correctional services, education, Housing, Provincial and Local Government, and Land Affairs.

ii. **A National Language Forum (NLF),** a collaborating network of representatives from government and non-government structures, to monitor the implementation process, prioritize language-related projects and drive policy advocacy campaigns under the leadership of the department of arts and Culture. The NLF has been (partially) functional since 2004.

iii. **The South African Language Practitioners' Council** will be a statutory body established through an Act of parliament to manage the training, accreditation, and registration of translators and interpreters to raise the statuses of language profession and improve the quality of language products. This body will set and maintain standards. The council Act has not yet been promulgated."
(Beukes, 2004: 18)

The three structures mentioned above are, if truly and totally functional, are supposed to bring about a well-implemented language policy that will serve the needs of the South African society without any segregation or discriminatory principles. The three structures have as their one crucial point, the declaration of some departments of the government as service delivery departments. The DoH, which this study focuses on, has been declared as a service delivery department.

Beukes (2004) conducted a study on language policy implementation in South Africa, wherein she argues that it is not necessarily true that things go exactly as policy stipulates.

2.3.6 The Language Policy of The Department of Health of South Africa

The DoH, as a component of the government's functional departments, has, as its main task, the well-being of the country's citizens, concerning every health aspect. It is, according to the

NLPF, supposed to serve the interest of all South African language speakers of all the eleven official languages fairly without preference of one over another.

The DoH Policy Document of 2011 is prefaced, thus: "South Africa is a multilingual country with approximately 25 different languages spoken, of which eleven (11) have been granted official status in terms of section 6 of the Constitution (Act No. 108 0f 1999), on the grounds that their usage includes about 98 % of the total population."

Table 2.1: Policy on Language Services Document (2011)

EASTERN CAPE	IsiXhosa (83.4%)	Afrikaans (9.3%)		
FREESTATE	Afrikaans (64.4%)	Sesotho (11.9%)		
GAUTENG	IsiZulu (21.5%)	Afrikaans (14.4%)	Sesotho (13.1%)	English(12.5%)
KWAZULU-NATAL	IsiZulu (80.9%)	English (13.6%)		
LIMPOPO	Sesotho (52.1%)	Xitsonga(22.4%)	Tshivenda (15.9%)	
MPUMALANGA	IsiSwati(30.8%)	IsiZulu (26.4%)	IsiNdebele (12.1%)	
NORTHERN CAPE	Afrikaans (68%)	Setswana (20.8%)		
NORTH WEST	Setswana (65%)	Afrikaans (7.5%)		
WESTERN CAPE	Afrikaans (55%)	IsiXhosa (23%)	English (19.3%)	

Representation of the eleven official languages, according to predominance in percentages per province, in the policy document, derived from the year 2000 census:

The figures provided by Statistics South Africa in the table in the introduction indicate that languages other than English and Afrikaans constitute exactly 73.2% of the population of Pretoria.

The DoH policy on language services further states that:

> "The policy on Language Services (2011) has been developed for the National department of Health to encourage the use of eleven (11) official languages in

order to facilitate equitable access to government services and the information as well as respect for language rights.

2.1 The implementation of this policy in the healthcare setting can serve to:

(a) Increase access to care;

(b) Improve quality of care, health outcomes and health status;

(c) Increase patient satisfaction; and

(d) Enhance or ensure appropriate resource utilization."

Implementation of the policy should cover the four crucial points mentioned under 2.1 above. Pretoria has all the eleven languages spoken in the area. If the implementation is fully representative of this fact, then it is logically imperative that the four points in 2.1 above are achieved, but it remains the responsibility of this study to find out if this is the case, and if so, to what extent is this achievement; and, if not so, to what extent is that non-achievement.

Above all is the most important clause 5.1.1 (The Policy on Language Services, 2011) on "Objectives" of the policy in the language policy of the DoH, which states that "departmental services will be responsive to the needs of clients who are unable to communicate effectively in spoken or written English or require alternate mode of communication". This calls for the need for adequate translation services in the DoH which then calls for the adequate employment of language practitioners in the form of translators, editors, as well as interpreters.

The PanSALB briefing of 2001 has a sub-topic in its minutes on the importance of translation and interpretation of communicated information. In a country that has a language policy, like South Africa, that encourages every government department to have a language section that will look into the implementation of such a policy, it becomes imperative that the issue of employing an adequate number of language practitioners is prioritised. The question is: Is the DoH armed with the language practitioners to honour the expectations of the language policy?

2.3.7 Language Policy Implementation

Although language was not included in the Reconstruction and Development Plan (RDP) framework - an omission that could be construed as an indication that language would not clearly feature as part of the "centerpiece", a bold start was made with several ground-breaking language planning activities, among which the Language Task Group (Langtag) process, and the

establishment of the Pan south African Language Board PanSALB) within the first two years of democracy (Beukes, 2004:18). The RDP was introduced by the African National Congress as part of their election manifesto, and focused on the revival, if not establishment, of service delivery to the previously-disadvantaged communities. This effort was introduced to try and alleviate poverty, and give opportunities of participation to the community to those who were previously denied this right because of the apartheid laws.

Implementation in South Africa is more influenced by the dominance of the use of English across the many public domains as it has been the *status quo* in the years long before a democratically elected government could look at drafting a new language policy that includes the aspirations of the majority in the country. As Wright (2007: 6) says, "In South Africa, the ongoing tension between the demand for English and the character of South African multilingualism becomes immensely relevant for issues of language planning and policy."

McCarthy (2012: 1) highlights some important points on language policy implementation. The handout explains by stating that "implementation in language policy consists of measures (plans, strategies, timetables, mechanisms) that provide the authoritative backbone (including financial rewards and resources) to achieve the goals of the language policy, and the motivation to use the language by the people affected."

Another most important point highlighted by this handout is the following: "Implementation may also be highly dependent on funding, which is always a sticky issue." The handout asserts that, "Funds may be available when policy is first promulgated, and then dwindle, as other priorities come to the fore." This is true, in the sense that language is not usually looked at as very important in the society by those in government, especially in developing nations. Language policy implementation has experienced problems with funding. The minutes of the PanSALB: Briefing minutes (2001) singles out this funding problem: "The board has been allocated R11 million. The CEO highlighted that this amount fell short of the R20 million which the board has asked for."

Apart from the government appointing a board to look at implementation, it is its responsibility to see that implementation succeeds. Kuschula (2004:15) points out many valid points supported by the current state of affairs in South Africa:

> "It is further recognized that '…successful implementation will depend largely on collaboration with all national and provincial structures, as well as PanSALB' (Implementation Plan, 2003: 12). PanSALB will remain a strategic partner of the Department of Arts and Culture, more particularly, the National Language Services unit (NLS) of the DAC, and that collaboration will in fact take place.
>
> It is government's responsibility to drive the implementation policy. In other words, once provincial and national government departments begin implementing the policy, then it is hoped that the private sector, e.g. the banking sector and so on will follow this route."

The success of implementation will depend, amongst other things, on consultation, and the involvement of both provincial and national structures.

2.4 Functional Literacy

Literacy is a broad concept which basically refers to an individual's ability to read and write. Functional literacy will, however, assume a more extensive definition. Without the basic ability to understand simple reading materials, students cannot absorb information from textbooks for study purposes, nor can they easily comprehend general literature for functional use or pleasure (K5 Starts Blog Team, 2012).

Functional literacy can be defined as the ability to read and write for understanding, and for functional use or pleasure, so that the reader will act as instructed or requested by the document in question.

In South Africa, particularly Pretoria, where the study was conducted, the literacy rate is relatively low. In Chapter 1, it was stated that, out of a population of 2 164 999, only 220 660 people in Pretoria are illiterate, i.e., the number of illiterates constitutes only 10.2% of the population of the region. Furthermore, the relatively low rates of illiteracy in industrialised countries are misleading, as countries, like the U.S, come to grips with the fact that low literacy in this country may be just as troubling as in some developing countries (Wagner, 1993: 1).

Arko (2009:205) says that a functionally literate person should be able to take part in all social and cultural activities, making use of literacy. Functional literacy will directly or indirectly be influenced by education. The role of literacy is simple when looked at superficially, but it could

take a very complicated turn when looked at from other perspectives. Triebel (2005:793) observes that: "But discussion of the role of literacy in society has been hampered, to this day, first by the belief that literacy generates social change, and second by the belief that a script can change a person's cognitive abilities".

Literacy is really a vehicle for social change. Literacy is part of education, and education itself brings about social change in any given society. Literacy helps in improving the standard of living by obtaining valuable printed information relating to health, sanitation, production, selection and preparation of food, childcare, and home management (Gray, 1990: Clause 2).

2.4.1 Functional Literacy in this Study's Perspective

Blumenfeld (2012:1) distinguishes between illiteracy and functional illiteracy thus: "an illiterate is someone who was never taught to read…a functional illiterate, on the other hand, is someone who may have spent up to twelve years in public schools and learned to recognize words as whole configurations, like Chinese characters, but is incapable of decoding the written language." In other words, a functionally illiterate person knows how to read, but the message may not be decoded to the understanding of the reader.

The DoH of South Africa uses a lot of written health information which is communicated to the public. If the audience receives the information fairly well, then a lot of money wouldn't be wasted by such an ineffective exercise.

Arko (2009:206) says: "Functional literacy is therefore the difference between an individual current level of literacy and the level demanded by his environment." Functional literacy can be related to health in that health information needs to be understood by those it is intended for.

2.5 Functional Health Literacy and Language Policy

In the brief report by Michael (2008:554), it is mentioned that "the US Department of Health and Human Services defines *health literacy* as the capacity to obtain, interpret, and understand basic health information and services needed to make appropriate health care decisions." What emerges in this definition is the fact that functional health literacy is not just about knowing how to read. It goes further to include message decoding. It has to be mentioned that interpreting any health expression that has been put in a form of writing for the sake of understanding helps to

facilitate appropriate responses to the message. The public needs to understand health information as a basis for ensuring a healthy life and the elimination of mass diseases.

Health literacy cannot be secondary to basic literacy which is often referred to as *fundamenta*l *literacy*. This implies that for functional health literacy to be there, fundamental literacy needs to first be there. Being illiterate signifies being health illiterate. Health literacy is clearly dependent upon levels of fundamental literacy, and associated cognitive development (Nutbean, 2006:263). The reality that can never be ignored is that health literacy depends on fundamental literacy. It is the reading and writing skills that an individual has acquired throughout the years of learning that will ensure the individual's understanding of health materials.

English has become the language of communication in many domains of South African society. This has led to the assumption in many spheres of life that everyone will be able to decode information easily when written in English than in other South African local languages. Mere observation will reveal that, in most of the health information written materials, English is the dominant language. If the South African population is functionally literate, and functionally health literate, then it is not, in any way, a waste of state resources to write such materials in English. But if the South African population has learned the English language through education, and has reached the levels of being functionally literate, which doesn't necessarily imply being functionally health literate, then the assumption to use English may lead to a barrier in the process of communicating the message to the public.

It is not accurate to assume that people who can read and write are automatically functionally literate. This includes functional health literacy in that, if a person knows how to read and write but is not necessarily functionally literate, it would imply that the person is also not literate when it comes to functional health literacy. This is not a minor issue because health is a major factor in human life. There is a lot of money injected towards health globally, with each country allocating billions of their monetary budgets for their health departments. This is a positive step towards ensuring better health for a country's society, but the language proficiency of the target audience in understanding the materials used for communicating health awareness is of the utmost importance. If recently voiced concerns about patient safety are to be addressed, the problem of patients with poor health must be confronted (Michael, 2008:554). In developing countries, such as South Africa, where the language chosen for medium of education is not a

home language to many, and where English has become so dominant, the language of choice should also be looked into to see if it doesn't lead or add to patient health illiteracy. Medical terminology comprehension is of vital importance, and it goes beyond just reading a clinic or hospital poster or pamphlet.

Clinics and public health institutions make great efforts in seeing to it that health information is displayed on the walls and information boards of their institutions. Health literacy is highly dependent on being functionally literate with written information (Schloman, 2004:9). It is a futile exercise to display this information to a community of patients who are not functionally literate.

Schloman (2004:9) raises some important points related to functional health literacy: "Often patients with low literacy develop ways to hide their inadequacy. Their strategies may include phrases such as "I forgot my reading glasses" or I will read this when I get home." He adds that: "Low functional literacy has serious consequences on individual health and places added demands on the healthcare system."

It is up to the government to look at language choices when disseminating valuable health information, looking at the fact that there is functional health illiteracy, which may, in the South African context, be triggered or aggravated by the use of English in many health materials which may not be receiving the expected comprehension by the public.

As it is a tendency in South Africa that, when one knows English, they are perceived as being educated or literate, it is likely that most people would not like to be associated with being uneducated or illiterate. It is one reason why inadequacies may be hidden by any functionally illiterate South African who may pretend to know what the information on health in the health institutions is about, whereas, in essence, they do not understand a thing about it.

The worst that can arise from functional health illiteracy is well outlined by Knight (2012):

> "The direct effects of poor health literacy are seen in the pharmacy everyday. People with limited literacy are less likely to use screening and prevention services, have less knowledge of their illnesses and medicines, are less able to self-manage their long term condition and are more likely to be hospitalized."

It has been stressed that health is a crucial social phenomenon which cannot be compromised. The consequences of compromising health may emerge indirectly through the government's ignorance, or not taking into serious consideration the issue of functional health illiteracy among the people it is serving. The South African society is exposed to health materials that are mostly written in English, and English is learned by the majority as a second language, added to the fact that some crucial medical terms are not so easy to understand by the average person. The choice of language will play a major role in ensuring that effective, preventative health is achieved.

2.6 Written Information on Health Issues: A Language Policy Perspective

The DoH in South Africa, like is possibly the case with other countries, produces a high volume of written materials for public consumption. Most of these written materials are produced in English. There are, however, some charts, and other health information notices and health awareness documents that are written in some indigenous languages. In this section, some commonly used health concepts, especially names of diseases, and information about them, will be briefly discussed.

A generally popular concept found in almost every hospital and clinic is immunisation. Immunisation is the most important way of protecting individuals and the community from vaccine-preventable infectious diseases (Public Health England, 2013). Diseases consume a lot of the budget from state funds. Immunisation is a solution towards saving money that could have been spent on controlling viruses that could spread throughout the country.

The public, which the message about immunisation is directed to, can make things much better if it did as the message guides them to do. By conforming to the message, the benefits are not only for the state (money will be saved through immunisation), but to the individual, since their health would be secured. The benefits extend to the entire community, because a healthy community thrives, and becomes socially and economically sound. The results of not immunising could be detrimental. There are many diseases that may be prevented by this protocol. The Patient. Co.Uk (2013) document explains, for example, measles:

> "Measles can be a very severe illness to deal with and painful to the sufferer. Measles is a highly infectious illness caused by a virus. The virus lives in the

mucus of the nose and throat of people with this infection. Physical contact, coughing and sneezing can spread the infection."

Language that is used to either make the public aware about it or warn the public, should not be difficult to comprehend. There are more diseases and concepts that call for the DoH to keep on disseminating information to the public. Women have a very important role that they play in society. Everything that has to do with them needs extra care.

'Ante-natal' is one other popularly used concept in health institutions. The prefix *ante* is likely to be understood by someone who has gone a bit far in education. When coupled with the concept, *natal*, it may even become complex to many people who haven't got the opportunity to expand the horizons of their vocabulary building. The World Health Organization (WHO, 2003) defines *ante-natal care* as the complex of interventions that a pregnant woman receives from organised health care services. Ante-natal, as a concept, has, as its focus, pregnant women. Pregnancy is a very sensitive issue, and so is the way it is treated. Pregnant women are given hints on charts at different health institutions on ante-natal care, but the target audience shouldn't be misunderstood to be only women. If the messages are encoded in such a way that everybody in the community takes ante-natal care as a community issue, and not just a doctor-patient one, then we may consider charts on this procedure effective.

Malnutrition, a concept used to guide the community, and for conducting health awareness, features in many of the health charts. Looking at the word from a distance, it is likely that it is misunderstood to mean 'lack of nutrition'. Malnutrition is a broad term, which refers to both *undernutrition* (subnutrition) and *overnutrition* (*Medical Today*, 2010-0:00. PDT). As stated, the concept includes the two, i.e., getting more than enough nutrition, as well as not getting enough of it. The understanding of this health concept can become a stepping stone towards the elimination of some diseases related to food consumption. There are many diseases that emanate from not eating properly.

It is interesting to note that the concept under discussion in this paragraph is not necessarily an English concept. More often than not, we are tempted to associate most concepts with English; typically so, because they have been used in an English text. The disease, *kwashiorkor*, is one such word. This term comes from a word used in Ghana that means a "disease of a baby

deposed from breast when next one is born." (*Human Illnesses*, 2013). Thus, the term cannot be English in its origin. It has found its origin through the explanation of a disease noticed in Ghana as being caused by the birth of a baby while its sibling was still breastfeeding. Kwashiorkor is a disease caused by the lack of protein in a child's diet (*Human Illnesses*, 2013). It is very important for the community to understand what this concept refers to, so that it can deal with it appropriately, as displayed in every chart or pamphlet that talks about it. This disease is linked mostly to children.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the research methodology of this study. It presents discussions on the research design, research approach, research setting, population and sample, research ethics and data collection.

There are two main statements to this study upon which the research methodology will centre: Hypothesis 1: The DoH doesn't treat all the eleven official languages of South Africa equally when awareness campaigns are conducted, regarding health issues in public health institutions.

Hypothesis 2: The communities that use public health institutions to consult for medical help feel the implementation of the language policy is not fair.

The study hoped to assess the truth of these statements, and would try to suggest ways to improve the situation.

3.2 Research Approach, Design, Methodology, and Procedures

Dawson (2002:2) defines *research* as a structured enquiry that utilises acceptable scientific methodology to solve problems, and create new knowledge that is generally applicable. In other words, research has to take the form of a structure, because a haphazard or random approach could lead to invalid answers or discoveries. Research is basically about problem identification and solving. By working towards solving problems, new knowledge will emanate from the findings that would have been arrived at in the study. It is the purpose of this study to identify the problems related to the implementation of language policy in the health spectrum, in order to create new information, regarding health issues and the language policy of the country. By so doing, the aim is to create information that could become valuable and further be used to improve the DoH's services to the society.

New Age Publishers (2013) defines research as a scientific and systematic search for pertinent information on a specific topic. The whole research exercise should be scientific, as there needs to be some kind of order in doing things, because of the academic nature of research work. A system used to conduct the process needs to be developed as well; gathering of data cannot be

left to chance, but to a well-arranged web of systems that will guide the study towards coming out with valid answers that will inspire an authentic explanation..

3.2.1Research Design and Approach

Research design is basically a plan that determines the outcome of the research. Planning is the driving force towards success in any given project. The whole study layout depends entirely on the design to make meaningful explanations of the research, and, most importantly, the data part of the study. Designing a study helps researchers to plan and implement the study in a way that will help them obtain the intended results, thus increasing the chances of obtaining information that could be associated with real situations (Burns & Grove, 2001:223). Since this study has more to do with language policy and health issues, the research design in this study has been prepared to source information associated with real situations, as health is a real societal matter itself.

A quantitative approach was adopted in this study. However, it is very significant for this study to include a qualitative approach to get a personal feel of the responses of the participants. Some clinic and hospital visitors were interviewed as a way of not excluding the qualitative approach, as it was seen as very vital to achieving the aim of this study.

There are many different definitions and explanations of these two approaches. It is worth mentioning how, in this study, the two differ, so as to get a better view, as well as indicating how the approaches' contributions played a very crucial role in this study.

A qualitative approach to research is focused on understanding a phenomenon from a closer perspective (Ben-Eliyahu, 2013: 1). Ben-Eliyahu (2013: 1) adds that, in defining a quantitative approach, it "tends to approximate phenomena from a larger number of individuals using a survey method."

The inclusion of more than one approach for data-gathering is often referred to as *mixed methods*. It refers to a research strategy that crosses the boundaries of conventional paradigms of research by deliberately combining methods drawn from different traditions with different underlying assumptions (Denscombe, 2010:137). Whisker (2013:1) points out that:

"…this is a common approach and helps you to 'triangulate' i.e. back up one set of findings from one method of data collection underpinned by one methodology, with another very different method underpinned by another methodology-for example, you might give out a questionnaire (normally quantitative) to gather statistical data about responses, and then back this up and research in more depth by interviewing (normally qualitative) selected members of your questionnaire sample."

Hughes (2006:5) states eleven ways to combine qualitative and quantitative research, which are:

"1.**Logic of triangulation**. The findings from one type of study can be checked against the findings deriving from the other type. For example the results of a qualitative investigation might be checked against a quantitative study.

2. **Qualitative research facilitates quantitative research**. Qualitative research may: help to provide background information on context and subjects; act as a source of hypotheses; aid scale construction.

3. **Quantitative research facilitates qualitative research.** Usually this means quantitative research helping with the choice of subjects for a qualitative investigation.

4. **Quantitative and qualitative research are combined in order to provide a general picture.** Quantitative research may be employed to plug the gaps in a qualitative study which arise because, for example the researcher cannot be in more than one place at any one time. Or if not all issues are amenable solely to a quantitative or qualitative investigation.

5. **Structure and process**. Quantitative research is especially efficient at getting at the structural features of social life while qualitative studies are usually stronger on process aspects. **Researchers' s and subjects' perspectives**. Quantitative research is usually driven by the research's concerns, whereas qualitative research takes the subject's perspective.

6. **Problem of generality**. The addition of some quantitative evidence may help generalisability.

7. **Qualitative research may facilitate interpretation of relationships between variables**. Quantitative research readily allows the researcher to establish relationships among variables, but is often weak when it comes to exploring reasons for those relationships. A qualitative study can be used to explain the factors underlying the broad relationships.

8. **Relationship between macro and micro levels.** Employing both quantitative and qualitative research may provide a means of bridging the macro-micro gulf. Qualitative research can tap large-scale structural features of social life while qualitative research tends to address small-scale behavioural aspects.

9. **Stage in the research process**. Use at different stages of a longitudinal study.

10. **Hybrids.** Use of qualitative research is a quasi-experimental quantitative study." (Adapted from *Punch*, 1998: 247)

In this study, a questionnaire was chosen as the main research instrument. Interviews were also included in the survey for more qualitative data.

Qualitative research begins with the specific, and moves toward the general (Devault, 2013:2). This is carried out when we wish to understand meanings, look at, describe, and understand experience, ideas, beliefs, and values, intangibles, such as these (Whisker, 2013: 1). The interviews ranged from the ones with ordinary clinic visitors to officials in both the health and other government departments, including some senior officials in the public sector.

With the quantitative approach, it was possible to reach as many respondents as possible. Quantitative research looks at the general case, and moves towards the specific (Devault, 2013:2). A quantitative approach to gathering information focuses on describing a phenomenon across a larger number of participants, thereby providing the possibility of summarising characteristics across groups or relationships (Ben-Eliyahu, 2013: 1).

3.2.2Research Methodology

There is a thin line that exists between research and research methodology. It may be understood as a science of studying how research is done scientifically (New age Publishers, 2013). A research methodology looks for better ways in which a research could be carried effectively. Research may be limited to looking or searching for answers to a particular problem, in order to

reach tangible solutions or explanations. On the other hand, research methodology may go farther by including aspects, like concentrating on the ingredients of the structure chosen to be used for conducting the research. New Age Publishers (2013) explain research methodology:

> "Research methodology is about safety, time, validity, professionalism, systematic operation, scope and focus, just to put it in brief. Researchers not only need to know how to develop certain indices or tests, how to calculate the mean, the mode, the median or the standard deviation or chi-square, how to apply particular research techniques, but they also need to know which of these methods or techniques, are relevant and which are not, and what would they mean and indicate and why."

Research thus, is an involvement of many aspects, like developing certain tests, calculations, application of certain research techniques, the relevance of techniques and methods to the study, and their meanings - all of which, when combined, constitute a research methodology.

Dawson (2002: 1) says this about research:

a. When you say that you are undertaking a research study to find answers to a question, you are implying that the process;
1. Is being undertaken within a framework of a set of philosophies (approaches);
2. Uses procedures, methods and techniques that have been tested for their validity and reliability;
3. Is designed to be unbiased and objective.

It is the responsibility of the researcher to ensure that a study doesn't appear to have interferences of bias. This could affect the validity of answers, and may lead to many discrepancies, like the distortion of some important points or answers that are premeditated, or pessimistically-oriented. In this study, objectivity was taken seriously. The research involved no element of being biased, in order to guarantee authentic findings.

All the methods used by a researcher during a research study are termed *research methods*. They are, essentially, planned, scientific, and value-neutral (Rajasekar, 2006: 2). Rajasekar (2006: 2) points out that research methods include theoretical procedures, experimental studies, numerical

schemes, statistical approaches, etc. The methods applied in research help us in data collection, samples in order to find solutions to a problem. Scientific research does not depend on reasoning alone, but on collected facts, measurements and observations. They accept only those explanations which can be verified by experiments, as in this quote from Rajasekar (2006: 2):

> "Research methodology is a systematic way to solve a problem. It is a science of studying how research is to be carried out. Essentially, the procedures by which researchers go about their work of describing, explaining and predicting phenomena are called research methodology. It is also defined as the study of methods by which knowledge is gained. Its aim is to give the work plan of research."

The whole input that Rajasekar (2006: 2) makes is based on the stressed importance of relying on well observed, measured and tested collected facts for valid authentic results.

3.2.2.1 Research Methods, Instruments and Procedures

Data sources for measures used in pharmacy and medical care research often involve patient questionnaires or interviews (Kimberlin, 2008: 2276).

A questionnaire and interviews were used to find out if the language policy of South Africa has been well-implemented when health awareness information is displayed in public health institutions in Pretoria.

A *questionnaire* is defined as:

> "…a list of written questions that can be completed in one of two basic ways.
> Firstly, respondents could be asked to complete the questionnaire with the researcher not present. This is a postal questionnaire and (loosely) refers to any questionnaire that a respondent completes without the aid of the researcher.
> Secondly, respondents could be asked to complete the questionnaire by verbally responding to questions in the presence of the researcher. This variation is called a structured interview."(www.sociology-org.uk/method g.pdf, 2013)

Questionnaires offer an objective means of collecting information about people's knowledge, beliefs, attitudes, and behaviour (Boynton & Greenhalgh, 2004: 1).

Research participants must be able to give meaningful answers (with help from a professional interviewer, if necessary) (Boynton & Greenhalgh, 2004: 1). The questionnaire has been designed in such a way that respondents do not find it difficult to answer. As said previously, the researcher was available when the questionnaires were responded to at all the three health institutions. This helped a great deal because some sections of the questionnaire that needed clarification were handled professionally.

Kimberlin & Winterstein(2008: 2281) state what is very crucial when addressing the question of the research instrument:

> "Will the instrument be acceptable to subjects? Does the test require invasive procedures? Is the reading level appropriate? Is the respondent's burden, including complexity of questions and time needed to complete the instrument, unlikely to affect response rates or the quality of responses?"

The questions were structured to be as easy as possible; the time factor was given the attention it deserved, because the questionnaire was a four-page document which had mainly questions that needed only short yes-no answers, including responses by means of a tick/cross. Some questions needed reasons to be provided, but were not set to be time-consuming.

The sample selected for the study comprised of daily visitors to public health institutions, and the staff of the latter. In South Africa, it is generally perceived that the majority of citizens use public health institutions. Private health institutions charge high fees for their services - which leads to the exclusion of visits by ordinary people in their multitudes. The majority of the people cannot afford these high amounts demanded by private institutions. The questionnaire, as a research instrument, should seek for answers to the study questions and not to achieve persuasive goals. Denscombe (2010:155) puts it briefly:

> "As a research tool, questionnaires do not set out to change people's attitudes or provide them with information. Though questionnaires are sometimes used for this purpose-for instance, as a way of marketing a product-it is not strictly in

keeping with the spirit of a research questionnaire, whose purpose is to discover things."

Denscombe (2010:155) highlights a very important fact he mentions that questionnaires are sometimes used as a way of marketing a product. In this study, this was not the case. The questionnaire was been used solely for the purpose and not for persuasive purposes. There was the need to translate the original questionnaire from English into Sepedi (Soshanguve and Atteridgeville) and Afrikaans (Eersterus), given the ethnolinguistic backgrounds of the respondents sampled.

All the places where the questionnaire was taken had staff members who were very supportive - which made the exercise manageable. Some nursing and clerical staff members went to the extent of helping with the filling up of the questionnaire for some patients who indicated problems with their vision. Some patients who didn't understand some questions benefitted from the help of the clinic staff.

3.3.3 The Questionnaire

The questionnaire used in this survey was structured to include almost all the necessary aspects. The first part needed the personal information of the respondent, except names or identity. The purpose was to get the necessary demographics about the participants.

The second part focused on language proficiency. The respondent needed to provide information about the languages they were proficient in, and indicate the levels thereof. This will be helpful in analysing the languages spoken by the respondents, and the additional languages they knew, as encouraged by the language institutions, like PanSALB.

The third part of the questionnaire handled the domains of usage. The respondents indicated the languages they used, or preferred to use, in different domains of life, e.g., at home, in the neighbourhood, at work, with friends, etc.

The fourth part focused mainly on education – the respondents were to state how language was chosen in their different activities and scenarios at school. The part played by English also needed responses, since English has, over the years, been adopted as the medium of instruction in school. Its impact, whether negative or positive, is tested through the questionnaire.

The fifth part contained questions on the media, i.e., the role of the media in health awareness campaigns, and in relation to the national language policy.

The sixth part looked at language policy and attitudes. The respondents stated how they perceived the statuses of some languages, including theirs, thus signalling their language attitudes.

The next two parts comprised of questions in a tabular form. The first table had questions based on the languages used in health institutions, their translations, if any, and the languages translated into. The second table was a Likert scale with statements to be assessed by the respondents.(See Annexure A for copy of full questionnaire.)

3.3.4 The Interviews

As explained in the research approach, interviews were also essential, in order to see how qualitative data could help in the study's quest to reach answers to the research questions.

Interviews need careful considerations when conducted; otherwise, unwanted results may occur which may hamper the success of the whole exercise. Unlike a questionnaire, the researcher is in face-to-face communication when conducting an interview. Such a situation needs careful handling because human beings are different in many respects, and need careful interaction. Questions that may raise some emotions or those that can lead to personal experiences of some participants need to be avoided, if they may disturb the interview. An interview is fraught with dangers, and can fail miserably, unless there is good planning, proper preparation, and sensitivity to the complex nature of interaction during the interview itself (Denscombe, 2010:173).

In this study, questions about the language policy of South Africa, as implemented by the DoH when disseminating health information through awareness campaigns, were formulated.

The participants were sampled in two categorical groups: patients who came for consultation in the clinics; and, people who work in the health department. Clinic and health centre managers were very co-operative such that the interviews with them were like normal conversations.

The first category - the clinic visitors or patients - were asked few questions on language policy, and another set of questions on some names of diseases, and what those ailments are. This was to

test if it was necessary to translate each disease name and information into the African languages so that the communities got to know what the diseases were called in their own languages.

3.4 Research Setting, Population and Sample

3.4.1 The Research Setting

Setting is about the place where things are happening. In this study, setting can be viewed as the place where the research was undertaken. Pretoria was chosen as the place to conduct the research. The main reason for choosing this place was because of the availability of quite a number of public health institutions there. This city is predominantly urban in nature which influenced the decision to select a clinic in Soshanguve township, a hospital in Atteridgeville; and, a clinic in Eersterus. Pretoria is in the central location of Gauteng Province, which is seen as the economic hub of South Africa. The health institutions selected for the study had reliable access, and the staff, in particular the nurses, were helpful in the way they orientated the researcher.

3.4.2 The Population

In ordinary language, population is the occupants of a particular area. Population may refer to humans, and animals, in some instances. In this study, focus will be on humans since the topic chosen is about a life phenomenon that has to do with people's lives.

When we think of the term, *population*, we usually think of people in our town, region, state or country, and their respective characteristics, such as gender, age, marital status, ethnic membership, religion, and so forth (Carroll, 2013).

Carroll (2013) also states that "The population in statistics includes all members of a defined group that we are studying or collecting information on for data driven decisions."

Jones (2013) says the population includes all objects. In other words, a population comprises of everyone, and not only a particular section.

3.4.3 Population and Sample Size

To try and distribute the participants involvement evenly, health institutions in Soshanguve (a clinic), Atteridgeville (a hospital), and another clinic in Eersterus were selected for data

collection. (The logic behind excluding Mamelodi was that Eersterus is considered as part of Mamelodi because of it falls under the district of Mamelodi.)

The most important question was; how is the population going to be sampled to get a manageable number of respondents? McMahon (2013) defines sampling thus: "Population sampling refers to the process through which a group of representative individuals is selected from a population for the purpose of statistical analysis." Sampling is an effective way of minimising problems that could cause hindrances to the success of the study. Samples are associated with costs. It would be more costly to try to select every town in the country to have its population sampled as respondents to the research. Jones (2013) points out that sampling does not usually occur without cost, and the more items surveyed, the larger the cost.

Table 3.1: Participants' Profiles (in %) (N=115)

Variables	**Variants & Frequencies**				
Race	**Black**	**Coloured**	**Asian**	**White**	
	83.5	16.5	0	0	
Sex	**Female**	**Male**			
	68.7	31.3			
Ethnicity	**Sotho**	**Nguni**	**Afrikaner**	**Tsonga**	**Venda**
	40	22.6	16.5	13	7.8
Age Range	**20-29yrs**	**30-19yrs**	**40-49yrs**	**50-59yrs**	**60+yrs**
	20.8	22.6	21.7	**24.3**	10.4
Educational Qualification	**Below Matric**	**Matric**	**Tertiary**		
	50	37	13		
Occupation	**Unemployed**	**General Assistant**	**Self-Employed**	**Professional**	**Pensioner**
	42.6	26	19	13	10.4

Carroll (2013) says that a sample is a scientifically-drawn group that actually possesses the same characteristics as the population, i.e., what one finds in the whole population is actually being represented by a smaller part of the population which is known as the *sample*.

For this study, random sampling was used. We say we are using random sampling when the process, through which we choose the sample, guarantees that all the possible samples that we can take from the population have the same probability of being chosen, i.e., all the elements of the population have the same probability of being chosen to belong to the sample (Barreiro & Albandoz, 2001:5).

The places visited for collection of data for the study have many visitors on a daily basis. When the questionnaire was issued, there was random distribution. Clinic/hospital visitors were given the questionnaires according to the queues they were in, as guided by the benches they sat on. By so doing, the probability of being chosen was respected, because this gave a guarantee that it was probable that the questionnaire could have been received by anyone on any day to respond to.

The sample should be a *microcosm* - a miniature model - of the population from which it was drawn (*Population and Sampling*, 2013).

3.5 Ethical Considerations

In research, ethics plays a major role. Without ethical considerations, there would be chaos as loopholes would be opened up for manipulators who would use research to reach their own personal goals, at times, with the aim of harming others. Research ethics have been considered to be in place to safeguard participants from any harm or manipulation by any abuser of any given study.

Smith(2003: 56) cautions that: "Indeed, researchers face an array of ethical requirements: They must meet professional, institutional and federal standards for conducting research with human participants, often supervise students they also teach and have to sort out authorship issues, just to name a few."

Ethics are there to ensure professionalism in the researcher. The researcher has to show the highest professional standards because of the nature of their work.

Participants were guaranteed privacy and confidentiality of their responses, and their anonymity was also guaranteed.

The DoH was consulted by the researcher, and the application form seeking permission to conduct research was filled, and submitted to the office dealing with research at Hatfield Hilda street. The form has a part which has to be filled by the clinic/hospital CEOs, normally referred to as clinic managers, in respect of clinics. The CEOs were also consulted in the three townships Atteridgeville, Eersterus, and Soshanguve to get them to fill the part that needed their contribution in the form, and they did so. Permission was granted by the DoH.

As part of the research ethics protocols, all the respondents were given the opportunity to fill in the consent form, which clearly promises the safety, anonymity, and confidentiality of the information they provided for the study.

Politand Hungler(1999:133) state that: "This principle encompasses freedom from harm and exploitation."

3.6 Field Problems

There were very few expected problems. One common problem in all the clinics visited was the fact that patients who participated were normally in queues. Those who were about to enter the consulting rooms could not be stopped from doing so in favour of filling up the questionnaire. It was, in fact, the prior agreement made with all the clinic managers that the study would not, in any way, disrupt the normal running of the clinic. As a result, there were some participants who entered the consulting rooms or examination rooms before they could finish responding to the questionnaire. Some came back to finish responding and submitted, but there was quite a number that didn't come back. This led to a reduced number of the anticipated respondents. However, this didn't cause any harm to the survey, since only 35 participants couldn't respond and submit their questionnaires at the three clinics. Of the 150 targeted participants, 115 of the questionnaires were returned, i.e., a 75% return rate.

As expected some visitors/patients were very interested in responding to the questionnaire but had some literacy challenges. This field problem was handled collectively through the help of some staff members at the clinics. It appeared that the questionnaire was interesting to most of

them in that it was the first of its kind, given the content it focused on, i.e., language use in health awareness campaigns.

The other challenge was the availability of interviewees. Although time became the most challenging aspect, some health employees were interviewed to collect qualitative data.

CHAPTER 4: FINDINGS: PRESENTATION, ANALYSIS & DISCUSSION

4.1 Introduction

This chapter is a presentation, interpretation, and discussion of the findings. The quantitative data were elicited via a questionnaire. The key sections of the questionnaire were the domains of language usage and the Likert scale, which provide answers to the research questions of the study. A qualitative approach (interviews with patients and staff) was also adopted to complement the questionnaire data.

4.2 Questionnaire Findings (N=115)

4.2.1 Domain Usages

The table below represents findings on the respondents' domains of language usage. The intention was to get a sense of the respondents' language usage, and relate this to the likelihood they would functionally comprehend the messages in the public health awareness campaigns.

Domain usage 1: Directions in the clinic/hospital

The majority of the respondents (51.3%) indicated that they did not get directions in their home languages in the clinic/hospital; 41.7% said they did, while 6.9% said they were not sure.

Domain usage 2: Clinic/Hospital cards

Most of the respondents (52.1**%)** said their languages were not used for the information found on the clinic/hospital cards; 36.5% of them indicated they did, while 11.3% said they were not sure.

Domain usage 3: Patients' files

Again, most of the respondents (49.5%) said their home languages were not used for the patients' files; 35.6% of them responded in the affirmative, while 14.7% were not sure.

Domain usage 4: Verbal communication of health information

The statement refers to any communication that takes place at the health centre between patients/visitors and the clinic staff, in particular nurses and doctors, about health issues.

Like in Domain usage 2, 52.1% of the respondents said their languages were **not** used during verbal communication at the health centres; 33% of them said their languages were used; and,

14.7% were not sure.(This may be attributable to a lack of understanding of what they were asked.)

Table 4.1: Respondents' Language Domain Usages (in %) (N=115)

Domains of usage	Yes	No	Not sure
1. Directions in the clinic	41.7	**51.3**	7
2. Clinic/hospital cards	36.5	**52.1**	11.4
3. Patient's file	35.7	**49.5**	14.8
4. Verbal communication of health information	33	**52.2**	14.8
5. Written displayed specific clinic/hospital information	32.2	**58.2**	9.6
6. Written general health information (e.g., HIV/AIDS, breastfeeding, etc.)	32.2	**56.5**	11.3
7. Doctor-patient communicative interactions	29.6	**60**	10.4
8. Me32dical prescriptions	26.9	**60**	13.1
9. Clinic/hospital procedure announcements	26	**56.5**	17.5
10. General clinic/hospital announcements	28.7	**61.7**	9.6

Domain usage 5: Written displayed specific clinic/hospital information

This statement refers to information that guides patients/visitors about things, like clinic/hospital rules, consulting rooms, and any other information about the health institution in question.

Most of the respondents (58.2%) indicated their home languages were **not** used in displayed specific written information at the clinic/hospital. was on display in these health institutions.; 32.1% said they were, and 9.5%.

Domain usage 6: Written general health information (e.g., HIV/AIDS, breastfeeding, etc.)

This one most crucial statement because it talks about the main reason why many people end up visiting health centres, i.e., to get help on matters related to these issues publicized in written form on the clinic/hospital walls/notice-boards etc.

Again, most of the respondents (56.5%) claimed there is no usage of their mother tongues when written information about diseases was displayed at the clinics. The response reaction to this statement was in which there were more respondents who were not sure, as compared to those who said not (18.2% and 12.1%, respectively). (This may reflect a lack of attention or observation to this detail at the clinics.)

Domain usage 7: Doctor-patient communicative interaction

This is the most intimate and crucial moment of any patient-doctor interaction. Most of the respondents (60% - the second highest negative response percentage) said their home languages were not used in such interactions. 26.9% said their languages were used in such interactions, while 18.2% claimed not to be sure. The implication here is that the home languages of the locals were not adequately used during doctor-patient communicative exchanges.

Domain usage 8: Medical prescriptions

This statement refers to the language(s) in which medicine issued to patients at the dispensary is delivered, including the language(s) used to indicate dosage, and the labelling of medicines. Most the respondents indicated that such prescribed medicines were not in their home languages; 26.9% answered in the affirmative; while 13% were not sure. The obvious implication is that prescribed medicines are rarely in languages understood by most Black patients, who visit the local clinics where they live.

Domain usage9: Clinic/hospital procedure announcements

The statement refers to the normal daily announcements about how the institution operates so that visitors are doing as expected by the staff to ensure order, and properly managed services. The participants who said their home languages were not used made up 56.5% of the total number of respondents; 26% said their languages were used, while 17.3% said they were not sure. This means that the languages of the locals in these predominantly-Black communities were not used when health institutions near them announced procedures to them.

Domain usage 10: General clinic/hospital announcements

This statement is basically about what nurses normally do on a daily basis. They advise patients on health-related matters, prevention of diseases, hygiene, pre- and ante-natal care, and other announcements meant to inform and advise the clinic/hospital visitors about good ways to take

care of their health. The participants who said their languages were not used when such announcements were made accounted for 61.7% - the highest negative response percentage. 28.6% of the respondents said their languages were used, while 9.5% were not sure.

The bar chart below visually represents the variance in the domain usage of all the languages in the DoH's public health awareness campaigns.

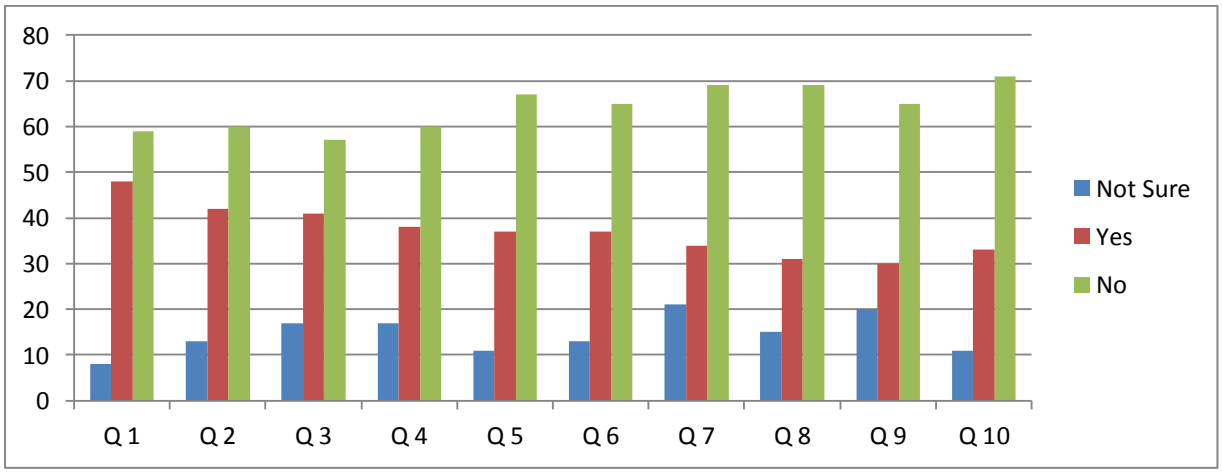

Figure 4.1: Respondents' Home Languages Domains of Usage (N=115)

Summary

The respondents who indicated that their languages were used in each of the domains of usage were in the minority, while those whose languages were not used made up the majority.

Some participants said they were not sure about the usage of their languages. This could be attributed to a lack of understanding about what is entailed in the statements, or mere inattention.

Statements10, 7, and 5 recorded the highest negative response percentages, while Statements 1, 2 and 3 scored the highest affirmative response percentages. This may suggest that there is some consideration (and usage) of Black South African languages, although not quite enough, nor at a convincing level.

4.2.2 Likert Scale Findings

Likert scale-type statements were used to test the participants' levels of agreement (or otherwise), with regard to aspects of the DoH's public health awareness campaigns, with a view to assessing its degree of success in the implementing its language policy, within the framework of the national language policy.

Table 4.2. Questionnaire Findings: Likert Scale (N=115)

Statements	Means
1. South Africa has a fair language policy.	**2.3**
2. All 11 languages get equal treatment.	**1.8**
3. The language policy is applied fairly in the public health institutions.	**2.0**
4. Enough health information is written in the languages of Black and Coloured communities in South Africa.	**2.1**
5. People with less English literacy are well considered, when health issues are handled by The Department of Health, and the media.	**3.5**
6. Efforts are made to develop black languages by The Department of Health.	**2.6**
7. Health information attracts more reading, when written in one's own language.	**4.0**
8. It is easier to understand health information when it is translated into one's own language.	**3.8**
9. The youth prefer health information in English at health centres.	**3.7**
10. The elderly should get health information in their own languages.	**4.3**

Statement 1. The mean of 2.3 suggests the respondents' disagreed with this statement. This was unexpected, since South Africa's constitution is regarded as one of the best in the world, thus making the language policy credible, since it is guided by the principles of the national constitution. However, this may also have been as a result of respondents' misinterpretation, in that they may have been assessing the implementation of the language policy, rather than the policy itself.

Statement 2. The mean (1.8) indicates that the 11 South African languages do not get equal treatment; this is against the spirit of the national language policy.

Statement 3. This statement is all-encompassing, in the sense that it states the overall use of language in public health centres. It wants to find out if all languages, in particular Black South African languages, are taken into consideration. The mean (2.0) does not indicate a fair application, because the respondents disagreed with the statement. There, in the aggregate opinion of these respondents, the language policy is not applied fairly at public health centres.

Statement 4. The mean here (2.1) implies that the respondents disagreed with this statement. In other words, not enough written information (with public health awareness content) is published in the languages of Blacks and Coloureds.

Statement 5. The mean score (3.5) suggests that respondents are mid-way between not sure and agree. This statement may be seen as that which is *knowledge-dependent* on the matter in question for one to respond reasonably. The media are trying to reach the public in their own languages, as they sometimes use Black South African languages to broadcast information on health issues. The respondents may have indicated that they were not sure because of the few moments on television when they hear their languages, but also wondering if this means those less literate in English are taken into consideration.

Statement 6. Respondents scored a mean of 2.6 which is between disagree and not sure. The mean is closer to not sure which makes it taken as a not sure score. The respondents were not sure about the efforts made by The Department of Health to develop Black South African languages.

Statement 7. This statement wanted to test whether readership of health information could increase if it was written in the languages of people who mostly visit the local health institutions. The responses produced a score of 4.0, which indicates that they agreed that we could have more readership of health information if it was written in one's own language - with implications for the success of the health awareness campaigns, and the language policy.

Statement 8. This statement wanted to test if there would be a better understanding of health information, if it was translated in one's own language. The mean score of 3.8 fundamentally suggests that the respondents agreed with the statement.

Statement 9. The responses scored a mean of 3.7; again, tending more towards agreeing with the statement. The youth are more into social media, which may influence their language choices - a fact that should be taken as a possible reason for the respondents agreeing with the statement.

Statement 10. This is the highest mean of them all (4.3). The respondents agreed that the elderly should get health information in their own languages.

Summary

The means here suggest that the language policy of South Africa is not well-implemented, with regard to language-in-health issues. The respondents disagreed with some crucial statements, like the one on the equal treatment of all the eleven official languages. The public's interest is not taken into serious consideration; hence, it is doubtful that the on-going awareness campaigns on health issues are delivering the desired outcomes.

4.3 Interviews Findings (N=18)

4.3.1 Clinic Patients/Visitors (n=10)

The patients were asked questions on their understanding of the names given to some diseases that are commonly displayed on the charts on the clinic walls. They were also asked about some language policy-related questions, as a follow-up to the questions they were asked on diseases.

Some of these diseases/medical concepts were mentioned in the review of literature chapter: *immunization*; *measles*; *ante-natal*; *malnutrition*; and, *kwashiorkor*. These were selected because they have been the most common ones on the charts on the public clinic walls over the years. The questions were structured in such a way that the first five were based on names of diseases/health concepts discussed under the review of literature chapter, and the last five were taken from the list of questions used during the interview with the health officials/personnel.

In total, ten clinic visitors were interviewed. This was done randomly where all the three townships used for sampling were represented. Seven participants couldn't answer the first question correctly, with some trying to show their understanding of malnutrition, but to no avail.

Only two interviewees made an attempt, but could only answer it in part, in the sense that they were able to say what immunisation is about, but struggled with other terms. One interviewee didn't say a word at all, while the others indicated that they often saw such terms, but had never thought of looking up their meanings. The two who answered the item on immunisation were female participants. They advised that immunisation should be followed at all times to avoid preventable diseases. It is possible that they came across this term when they took their children for immunisation. Most mothers who take their children for immunisation use the word, 'moento', which means 'getting an injection'. As stated, 'moento' actually refers to immunisation, but some female interviewees were not able to explain their understanding of the word - which implied they didn't know what it meant. It is, however, possible that they knew that 'moento' meant the prevention of diseases. This means that using one's own language, when conducting health awareness campaigns, could be more successful than using another language.

The health term, 'malnutrition', received the strangest of responses. Six participants said that malnutrition meant 'a lack of food for people'; two said it meant 'eating food that does not give the body vitamins and other nutrients that build the human body'. There were no suitable answers for the second question from participants. The remaining three, who couldn't answer the first question, maintained their inability to answer, citing a lack of information, on their part, about these terms.

All the participants responded in the affirmative to the third question (***Do you think people would get a better understanding of what the medical situations entailed in the five concepts in number 1, if they were written and explained in their own languages?***). They gave related reasons which centered around the fact that they served as an example of how language choice played a very important role when health information was written (and/or displayed) in public clinics/hospitals. They suggested that they might have been able to answer (correctly), if they had received the information first in their home languages.

All the interviewees answered in the negative to Question 4 (***Is there a possibility, in your opinion, that the majority of the people who visit public health clinics/hospitals understand medical concepts like the five mentioned in number1, as appropriately as it is expected?***). The reasons they all put forward in support of their answers was that they felt the home languages of

the people who visit public clinics/hospitals would serve them better than another language. The (low) level of education of people who visited public clinics was again emphasised.

One interviewee said he didn't know what could be done, regarding what Question 5 wanted (***What do you think the Department of Health of South Africa should do to ensure that more visitors to public health institutions understand health information better, like the one on the five concepts in number 1?***). Six of them said the information should be written in a language that could be understood by most people who used the clinics. The other three, who were female, generally said that people must try to find out what the information on the clinic walls meant by asking the nurses, because they were educated, and knew everything about these words, and language.

All the patient-interviewees responded in the affirmative to Question 6 (***Do you think people would feel more comfortable and eager to read health information that is written in their own language than that written in English?***).This was significant, in that it indicated the patients' views that the home languages of the locals were not adequately used when awareness campaigns were conducted.

All the patient-interviewees answered in the negative to Question 7 (***In your opinion, is the health information displayed in clinic/hospital walls and information boards written in all languages equally?***). They observed that there was no chart with content written as a translated version covering two or more languages, especially Black South African languages, in the clinics that they have visited so far.

Six patient-interviewees said 'yes' to Question 8 (***Do you think the language policy of South Africa is fair to all SA citizens?***). The common reason they gave was that the policy sought to cover everyone without discriminating. Four of the interviewees were not in agreement. They said it was not fair, because the promise made was not kept in the implementation.

The patient-interviewees didn't understand what *terminology development* meant on Question 9 (***Would the writing of health information in Black languages in clinics/hospitals help in terminology development of indigenous languages of South Africa?***). Following the clue given

by the interviewer, they then agreed with the point that, indeed, terminology development would take place, because some medical terms would get new terms in the indigenous languages.

The patient-interviewees gave similar responses to Question 10 (***What would be your suggestion towards the appropriate application of the language policy in the Department of Health when health awareness campaigns are undertaken?***). They all stressed the importance of doing research first before choosing to write in a particular language for a particular language community.

In sum, the patient-interviewees were in favour of the use of the language(s) of the local community when health information was taken to the people. The few medical terms/concepts used to test their understanding may serve as a microcosm of what could be a large scale misunderstanding of medical and health concepts by the people who use public health centres for consultation. This may very well be symptomatic of the unsuccessful dissemination of health information.

4.3.2 Clinic Staff Members (n=8)

Interviews were conducted with a random, convenience sample of eight clinic staff members at the three clinics (see Annexure C for the full schedule of the interview questions).

All the clinic staff interviewed indicated that the language policy of South Africa was fair to all the citizens. The reasons given were in line with what the language policy of South Africa set out to achieve.

All the clinic staff interviewees responded in the negative to the second question (***In your opinion, is the health information displayed in clinic/hospital walls and information boards written in all languages equally?***). However, the reasons they gave varied. Six of them stated that not all official languages were used, e.g., XiTsonga and Tshivenda, while information is displayed mainly in English, and sometimes in Sotho and Zulu. They stressed the point that it is taken largely for granted that English is understood by most people; hence, more health information appears to be composed in English. The remaining two interviewees remarked that even in areas where the language spoken is predominantly Tshivenda or XiTsonga, there is no

chart or notice written in the language of those locals; hence, the unfairness of the situation to the elderly, and the less literate in English, who spoke those languages.

All the clinic staff responded to Question 3 (***Would you agree with those who say that health issues should be communicated in the native languages of local communities where the information is being delivered?***) in the affirmative. Most of them indicated that this was obviously in line with the language policy of South Africa, and saw no point in using a language that was not the mother tongue of a particular community to communicate information about health issues to it.

Responses to Question 4 (***Do you think people would feel more comfortable and eager to read health information that is written in their own language than that written in English?***) were more divided. Five clinic staff interviewees responded in the affirmative, while three of them disagreed. In other words, more officials agreed with the notion that people would feel more comfortable and eager to red health information if it was written in their own languages rather than in English.

It was a similar outcome for Question 5 (***What do you think could be done about the language used when health information is passed to the public to ensure that this valuable information is received?***). Five clinic staff interviewees stressed that the language of the locals should be used. They emphasised the need to first look at the areas, and the people who lived in those areas per language spoken, before sending any information. This they said could help in ensuring that each area got health information in a language used by the majority of the community. Three only said the languages used should include both English and the languages of people who lived around the clinic, and used the clinic for consultations.

Question 6 (***In your opinion, would you think Minister Nzimande's view is valid in promoting indigenous languages, and would this go a long way in making all languages to get equal treatment when health information is passed to the public via the clinics and hospitals?***) had all the clinic staff respondents in agreement. They indicated that the Minister's initiative could really go a long way in promoting indigenous languages, given that the more a language gets exposure, the more it gets promoted, and the more each language may get equal treatment in publishing health information that got sent to clinics and hospitals.

All the clinic staff interviewees responded in the affirmative to Question 7 (***In your opinion, would you think that health institutions visitors and patients would prefer reading health information that is written in their own languages?***). They pointed out that, since the people

who used public clinics/hospitals were more likely to come from the lower social classes, they would prefer such information being written in their own languages, because their level of education in English was not high.

All the interviewees responded, again, in the affirmative to Question 8 (***Would the writing of health information in Black South African languages in clinics/hospitals help in the terminology development of indigenous languages of South Africa?***). After clarifying what *terminology development* meant, they all indicated that new terms would be created - which would be a way of developing the indigenous languages.

Question 9 (***Would you say that the use of Black South African languages when writing on health would attract more readership, since readers would be interested in knowing what some medical terms are called in their languages?***) also had the clinic staff in collective agreement, which suggests that readership of health information needs to be promoted by using some strategies, including the use of Black South African languages.

In response to Question 10 (***What would be your suggestion towards the appropriate application of the language policy in the Department of Health when health awareness campaigns are undertaken?***), all of the clinic staff interviewees indicated the need to study the languages used in different areas so that health information was delivered in the languages used by the communities of those areas.

Overall, the clinic staff interviews suggest that the application of the language policy at the public clinics needs reviewing. There is a general tendency to take it for granted that everybody who visits public clinics is in a position to understand the health information that is given to the public in English. Little is done to cater for the home language(s) of the locals when health issues are dealt with. Most people are aware that the dissemination of health information happens largely in the English language, but the majority of the people this information is intended for may not be proficient in English as the senders presume.

Synthesis and Discussion

Overall, both questionnaire and interview findings strongly suggest that there needs to be a (languages) review by the DoH in the conduct of its public health awareness campaigns. There are some attempts to get the campaigns successful through the inclusion of some Black South

African languages, but the effort is not as adequate as it is supposed to be, according to these findings.

The patient interviews revealed that most of them did not know what the health concepts displayed on the awareness campaigns mean, and terms used to name diseases, nor the details on the diseases. The patient respondents also felt it would be more interesting to know what some medical terms were called in their own languages, and to read health information in their own languages, rather than in English. These respondents indicated the need to see some changes in the language(s) used in the clinics and hospitals when health information is given to the public. They felt that the reason why they did not understand the information was the fact that it was brought to them in a language they did not understand, as compared to what could have been the case, if this was done in their home languages.

There was a general feeling among the health workers interviewed that the DoH needs to review the language(s) used in the public health centres, if the desired outcomes were to be reached when awareness campaigns are conducted, especially regarding the written information displayed at those centres.

Finally, the findings suggest that the two hypotheses mentioned in Chapter 3 should both be accepted, i.e.,:

H1: *The Health Department doesn't treat all the eleven official languages of South Africa equally when awareness campaigns are conducted, regarding health issues, in public health institutions.*

H2: *The communities that use public health institutions to consult for medical help feel the implementation of the language policy is not fair.*

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Overall, the findings of this study strongly suggest that language practice is not conforming to what the DoH language policy of 2011 states. The findings indicate that it is generally taken for granted (by the DoH) that everybody understands English, since it is considered the language of communication in many spheres of life. Hence, health information is written, and taken to the public, in English more than in any other language. However, the findings demonstrate that this belief is ungrounded, and could be misleading, in the sense that the reality is very different.

The DoH has a policy on language which is monitored to ensure that it is appropriately implemented and applied correctly in the centres that serve the public. However, most of the study's responses reveal a situation, whereby many clinic patients/visitors feel unfairly treated when it comes to the language of communication used for the dissemination of valuable health information.

In terms of the limitations of the study, there was a challenge for some respondents who did not understand some of the questionnaire items. If the researcher had not been present when the survey was undertaken, this could have created some problems. The English version of the questionnaire was further translated into Sepedi and Afrikaans to cater for those respondents who felt more comfortable answering in their languages. There were also some illiterate respondents, who had to be assisted in filling out their responses to the questionnaire. The clinic staff at all the clinics were very supportive in the study, in that they were available to help any participant who needed such help.

In terms of recommendations:

1) The public should be educated about the language policy of the country. There were instances when some members of the public didn't understand what was meant by 'language policy.' The institutions that are meant to promote equality in languages, like PanSALB, Department of Arts and Culture, and the language services section in each government department, should engage in public awareness campaigns on the existence and ramifications of the language policy.

2) The media should do more to promote all the languages, especially Black South African languages. Previously-marginalised languages, like XiTshonga, TshiVenda, and siSwati should get recognition like other official languages, because they as well have been granted equal statuses as the others. At present, some languages appear more than others on television; for example, Sotho languages (Sepedi, Setswana, and Sesotho), IsiZulu and Xhosa, in the case of Black languages.
3) The media should assist the DoH in making health information accessible in all the languages by translating such information into the other languages, and using subtitles, whenever necessary. (The subtitles should not be removed quickly from the television screen, either – a concern expressed in the respondents' comments in the questionnaire, as discussed in subsection 4.4.5, unless if the subtitles are backed up by verbal interpretation.)
4) The DoH should conduct awareness campaigns on health issues in all languages. Emphasis should be on written information that is displayed in the clinics/hospitals through wall charts and notice boards. Special consideration should be given to the use of the languages of the local communities who use the public clinics/hospitals near their places of residence for medical consultations.
5) The DoH should employ more language practitioners at national and provincial levels, who can translate documents, charts, pamphlets, etc., on health issues into other languages to make the awareness campaigns more effective.
6) Some language practitioners should be employed to work at the public hospitals and local clinics, to ensure that there are staff members at those centres who can interpret any information given to the patients who need interpretation thereof. These language practitioners should also be assigned the task of monitoring that the language policy is applied to satisfy the language needs of the communities using the local public clinic. They should also help in the translation of any written information that the clinic would like to pass on to the daily visitors/patients to the clinics/hospital.
7) The DoH should hire terminology developers, who will work with language practitioners, when to find suitable terms for medical and health concepts, when translation of valuable health information, especially into Black South African languages, is done.
8) There should be a research unit in the DoH that collect and capture data on the statistics of language speakers per language per area. This would help in channelling any information to

those areas using the language(s) of the communities living in those areas. This would ensure more success of the objectives of public health awareness campaigns.

9) There should be regular checks on whether the clinic patients and visitors understand the health information displayed for their benefit, especially the written one, sent to clinics and hospitals as public health awareness campaigns. This could be done by the language practitioners that would have been employed, and deployed at all the clinics and hospitals of the country.

The language policy is considered to be a 'guardian angel' of the language rights of everyone. However, it became apparent during the survey that many people who use public health centres/institutions felt discriminated against, with regard to language usage. Many of the respondents felt it necessary to frankly state that they found their language rights violated by the current state-of-affairs.

One may draw the conclusion that this study arrived at the expected findings, to a large extent. The research questions, findings, and recommendations of this study may be used to assess the present situation, so as to come up with a better way of planning for future programmes of action for public health awareness campaigns, so as to enhance the success in the dissemination of health information to the entire South African public.

Scholars of Applied languages should carry on with topics related to that of this study in order to give this special 'language in health matter' the attention it deserves. Health is a very crucial element of human existence and language used when health issues are handled must get serious attention the same way as legal matters are normally dealt with (in court there are always interpreters and everyone gets a chance to access to the language of their choice during proceedings). Therefore more studies like this one could be beneficial to everyone.

Addendum A: Questionnaire Findings: Likert Scale (N=115)

Statement		1	2	3	4	5	T	M
1	South Africa has a fair language policy.	54	16	13	18	14	**270**	***2.3***
2	All the eleven official languages get equal treatment.	61	60	42	12	35	**210**	***1.8***
3	The language policy is applied fairly in the public health centres.	45	82	54	16	35	**232**	***2.0***
4	Enough health information is written in the languages of Black/Coloured South Africans in clinics/hospitals.	46	78	27	48	45	**244**	***2.1***
5	Health information attracts more reading, when written in one's own language.	10	8	30	156	260	**464**	***4.0***
6	It is easier to understand health information that has been translated into one's own language.	10	42	18	76	290	**441**	***3.8***
7	The youth prefer health information in English at health centres.	15	22	30	116	250	**433**	***3.7***
8	The elderly should get health information in their own languages.	2	4	60	96	335	**497**	***4.3***
9	People with less English literacy are well considered, when health issues are handled by the Health Department and the media.	12	52	30	64	255	**433**	***3.5***
10	Efforts are adequately made to develop Black South African languages by the Health Department in clinics/hospitals	17	102	29	64	90	**302**	***2.6***

Likert Scale Key

1= Strongly disagree; **2**= Disagree; **3**= Not sure; **4**=Agree; **5**=Strongly agree

T=Total **M**= Mean

Annexure A: QUESTIONNAIRE

Dear Respondent,

I am studying for a Master of Technology Degree in Language Practice, at Tshwane University of Technology, in the Department of Applied Languages. The degree I am studying for requires me to conduct a research on "The Language Policy, Public Health and Awareness campaigns, A Study from Pretoria." I would be very grateful, if you could fill this form with as much truthfulness and as thoroughly as you possibly can. Your anonymity and confidentiality are guaranteed through this whole exercise. The data collected will only be used for the purposes of this research project.

Instructions : May you please be as honest as possible when you give your responses. Answer all the items. (The answers are neither right nor wrong.)

Personal Information and Background

1. Sex: ☐ Male Female ☐
2. Age range: ☐ 18-25yrs ☐ 26-35yrs ☐ 36-45yrs ☐)yrs
3. Racial Group: ☐ Asian ☐ Black ☐ Coloured ☐ White
4. Ethnic Affiliation: _____
5. Occupation: ☐ Professional ☐ General Assistant ☐ Not employed
6. Highest Qualification: ☐ Below Matric ☐ Matric ☐ National Diploma

   Degree ☐ Masters ☐ Doctorate ☐

7. Language Proficiency

7.1. Language Repertoire: Provide Languages you use in your community in accordance to your mastery of them. Indicate your proficiency using the scale: poor, fair, good, excellent.

Language(s)	Speaking	Listening	Writing	Reading
1.				
2.				
3.				
4.				
5.				

7.2.**Domain Usages**: Indicate Languages you use to communicate in these situations:

1.	At home	
2.	In the neighbourhood	
3.	With Friends	
4.	With strangers	
5.	On electronic devices/networking sites	
6.	At school	
7.	In the workplace	

8. Education:

8.1.Which language did/do you prefer for learning? _____
(Give reasons)

_____

_____

8.2.Which language(s) did/do you use in class? _____

8.3.When did you start learning English (Indicate grade/standard) _____

8.4.How did/do English affect your studies? _____

_____

9. The Media:

9.1.How important is the usage of your native language, for health information, in the media?
_____(Give reasons.)

_____

_____

9.2.Which language do you prefer for reading print media? _____

(Give reasons)

_____

_____

_____

9.3.How does English help you in the media? _____

_____

_____

10. Language Policy and attitudes in South Africa

10.1. Are you aware of South Africa's language policy? ☐ Yes ☐ No

10.2. Do you consider your language superior to other languages? ☐ Yes ☐ No

(Give reasons) _____

_____

_____

10.3. Is the implementation of language policy by the government succeeding?

Yes ☐ No ☐ (Give reasons)

_____

_____

_____

10.4. What is your opinion in the choice of English as a language of communication, among people of different ethnic groups?

_____

_____

_____

10.5. Is health information accessible in all official languages, particularly Black and Coloured communities? ☐ Yes ☐ No (Give reasons.)

_____

_____

_____

10.6. Are the previously disadvantaged Black languages getting developed in South Africa

☐ Yes ☐ No (Give reasons.)

_____

_____

10.7. Are there any subtitles of Black languages used when health information is shown on the SABC? ☐ Yes No ☐

10.8. Is there any interpretation or translation from English to other South African official languages in as far as you know, in the following domains of usage?

Domain of usage	Yes	Not sure	No	language(s) translated into
1. Directions in the clinic/hospital.				
2. Clinic/Hospital cards.				
3.Patient's file.				
4.Verbal communication of health information.				
5.Written displayed specific clinic/hospital information.				
6.Written displayed general health information (e.g., HIV/AIDS, breastfeeding, etc).				
7.Doctor-patient communicative-interaction				
8.Medical prescriptions				
9.Clinic/hospital procedure announcements				
10.General clinic/hospital announcements				

10.9. Tick in the box that matches your answer in the column according to the ratings indicated below:**1**=Strongly disagree; **2**= disagree; **3**= not sure; **4**=agree; **5**=Strongly agree

Statement	**1**	**2**	**3**	**4**	**5**
1. South Africa has a fair language policy					
2. All the eleven official languages get equal treatment					
3. The language policy is applied fairly in the public health centres.					
4. Enough health information is written in Black/Coloured languages in clinics/hospitals.					
5. Health information attracts more reading when written in one's own language.					
6. It is easier to understand health information that has been translated to one's own language.					
7. The youth prefer health information in English, in health centres.					
8. The elderly should get health information in their own languages.					
9. People with less English literacy are well considered when health issues are handled by the Department of Health and the media.					
10. Efforts are adequately made to develop Black Languages by the Departmentof Health in clinics/hospitals					

(Thank you. Your co-operation is highly appreciated)

Annexure A1: Afrikaans Questionnaire

VRAELYS

Geagte Respondent
Ek is huidiglik besig met my Meestergraad in Taalpraktyk by ‘n universiteit in Pretoria. Hierdie kwalifikasie vereis dat ek navorsing op “Taalbeleid, publieke gesondheid en bewustheidsveltogte: ‘n studie van Pretoria” doen. Ek sal dit opreg waardeer as u hierdie vraelys so eerlik en deeglik moontlik sal beantwoord.

U identiteit asook die vertroulikheid van u antwoorde word gewaarborg. Die inligting wat van u antwoorde versamel is sal slegs vir die doeleindes van hierdie navorsingsprojek gebruik word.

Persoonlik Informasie en Agtergrond.

1. Geslag Manlik ☐ Vroulik ☐
2. Ouderdom 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ +60 ☐
3. Ras Erkenning: Asian ☐ Swart ☐ Kleurling ☐ Wit ☐
4. Etniese Erkenning: _____

Hoogste Kwalifikasie : Onder Matriek ☐ Matriek ☐ Nasionaal Diploma ☐
Graad ☐ Meestergraad ☐ Doktoraal ☐

5. Beroep : _____

6. TAALKUNDIGHEID

6.1. Taal Reporttoire: Dui die taal aan wat u kan gebruik volgens u beheer. Dui u kundigheid in die Taalbekwaamheid wat hiereonder staan.Gebruik Utstekkend, goed, gemiddeld, swak.

TAAL/TALE	PRAAT	LUISTER	SKRYF	LEES
1.				
2.				
3.				
4				
5				

6.2.**DOMEIN GEBRUIK:** Dui die taal wat u gebruik om te kommunikeer in hierdie geval:

Situasie	Taal/tale
1. By die huis	
2. Met bure	
3. Met maats	
4. Met vreemdelinge	
5. Op eletroniese toesttelle	
6. By die skool	
7. By die werk	

7. OPVOEDING:

7.1.Watter Taal het /verkies u om te leer _____

Gee redes _____

7.2.Watter tale het u in klas gebruik?

_____

7.3. Wanneer het u ENGELS begin gebruik?(Dui graad/standard

_____

_____

7.4. Hoe tas Engels u aan?

_____

_____

8. Die Media

8.1.Hoe belangrik is die gebruik van u Moedertaal vir gesondheidsinligting in die Media?

Baie belangrik ☐ Belangrik ☐ Nie belangrik nie ☐

(Gee redes)

_____

_____

_____

8.2. Watter taal/tale verkies u vir lees gepubliseerde media?

_____

_____

Gee redes

_____

8.3. Hoe help Engels u in die media ten opsigte van gesondheidsinligting en bewusheid?

_____

_____

_____

9. TAALBELEID en SIENSWYSE in Suid Afrika

9.1. Is u bewus van Suid Afrikaanse Taal Beleid? JA ☐ NEE ☐

9.2. Dink u u taal is oormatig as ander tale? JA ☐ NEE ☐

Gee redes _____

9.3. Is die regering se Taalbeleid toepassing suksesvol?

JA ☐ NEE ☐

Gee redes

_____

_____

9.4. Wat is u mening oor die keuse van Engels as taalgebruik vir mense van verskillende etniese groepe?

_____

_____

9.5. Is Gesonheidsinligting beskikbaar in alle amptelike tale veral in Swart en Kleurlinge gemeenskappe?

JA ☐ NEE ☐

Gee redes _____

_____

_____

9.6. Volgens u mening, is daar huidige pogings om die vorheen onderbevooregte Swart Suid Afrikaanse tale te ontwikkel

JA ☐ NEE ☐

Gee redes

_____

_____

_____

9.7.So ver u weet , wanneer gesondheidsinligting in Engels op SAUK gewys word is daar byskrifte/ondertitels wat in Swart tale gebruik word ?

JA ☐ NEE ☐

9.8. Is daar enige vertolking of vertaling van Engels na ander amptelike Suid Afrikaanse tale, so ver u weet ,in die volgende domein:?

Indien JA by enige kolom ,dui die tale aan wat vertaal is in vrae.

	Domein Gebruik	JA	Vertaalde taal	Nee	Nie seker nie
1.	Padaanwysings by die kniniek/hospital.				
2.	Kliniek/hospital kaartjies.				
3.	Pasiente leers.				
4.	Mondelinge kommunikasie/mededeling van gesondheids inligting.				
5.	Skriftelike gespesifeerde uitstalings inligting van kliniek/hospital.				
6.	Skriftelike algemene uitstallingsinligting (bv) MVI/VIGS borsvoeding ens.				
7.	Dokter-pasient kommunikatiese interaksie.				
8.	Mediese voorskrifte.				
9.	Kliniek/hospital aankondiginswyse.				
10.	Algemene kliniek/hospital aankondigings.				

9.9. Merk die blok vat u antwoord pas in die kolom volgens die onderstaard aangeduide syfers.

1=Sterk Verskil 2=Verskil 3=Nie Seker Nie 4=Toestem 5=Sterk Toestem

	Stelling	1	2	3	4	5
1.	Suid Afrika het ‘n regverdige taalbeleid.					
2.	Al die 11 amptelike tale kry gelyke behandeling.					
3.	Die taalbeleid word regverdig toegepas in al die publieke gesondheidsentrums.					
4.	Genoeg inligting word in Swart en Kleurling tale geskryf.					
5.	Gesonheidsinligting trek meer aandag vir lees wanneer dit in eie taal geskryf is.					
6.	Dit is maklik om gesondheidsinligting wat in u taal geskryf is te verstaan.					
7.	Die jeug verkies gesondheids inligting in Engels by gesondheidssentrums.					
8.	Bejaardes moet inligting in Engels in hulle eie tale kry.					
9.	Mense wat min Engels geletterd is, word in ag geneem waneer gesondsheidssake deur die Gesondsheids Departement behandel word.					
10.	Genoeg pogings word deur die Gesondheids Departement in klinieks/hospitale aangewerd om die Suid Afrikaanse Swart tale ontwikkel.					

(Baie dankie)

Anexure A2: Sepedi Questionnaire

DIPOTŠIŠO TŠA DINYAKIŠISO

Moarabi yo a hlomphegago

Ke moithuti wa tikri ya *Masters in Language Practice* ka Tshwane University of Technology, diphatmenteng ya Applied Languages. Tikri ye ke ithutelago yona e nyaka gore ke dire dinyakišišo ka "Pholisi ya Maleme mabapi le pholo ya setšhaba le dikhampeine tša go tsebiša setšhaba ka ga pholo, thuto ye e tlo go dirwa motseng wa Tshwane." Nka thaba kudu ge o ka tlatša foromo ye ka nnete ye e feletšego ka moo o ka kgonago. Botlhokaina le polokego ka ga wena di tshepišwa ka mehla mošomong wo ka moka. Dintlha ka moka tše di hweditšwego go tšwa sebotšišweng se di tlo šomišetšwa fela projeke ye ya dinyakišišo.

Ditaelo: ka kgopelo, araba ka botshepegi bjo bo kgonegago ge o efa dikarabo. Araba dikorolo ka moka. (Ga go na dikarabo tše di nepagetšego le tše di fošagetšego)

Tshedimošo ka ga bowena le maemokakaretšo

1. Bong ☐ Monna Mosadi ☐

2. Mengwaga ☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46-60 yrs

3. Sehlopha sa Bosetšhaba mošweu ☐ Moešia ☐ Mothomoso ☐ Mokhalate ☐

4. Morafe: _____

5. Mošomo ☐ ga ke šome ☐ profešenale ☐ Mothuši wa kakaretšo

6. Tša dithuto ☐ fase ga matriki ☐ Matriki ☐ Diploma ya Bosetšhaba
   ☐ Dikri ☐ Mastase ☐ Bongaka

7. Bokgoni bja polelo

7.1. Tšeo di tsebjago malemeng: Efa maleme ao o a šomišago setšhabeng go ya le ka bokgoni bjo bo tseneletšego bja gago go ona. Bontšha bokgoni bja gago go ya ka tšhomišo ya sekala se:

Leleme/maleme	Go bolela	Go kwa	Go ngwala	Go bala
1.				
2.				
3.				
4.				
5.				

7.2.Domeine ya Tšhomišo. Laetša maleme a o a šomišago go bolela mo mabakeng a a latelago:

1.	Ka gae	
2.	Le baagišani	
3.	Le bagwera	
4.	Le bathotsoko	
5.	Didirišweng tsa elektroniki/disaete tša neteweke	
6.	Sekolong	
7.	Mafelong a kua mošomong	

8. Thuto

8.1. Ke leleme lefe leo o bego/ leo o le kgethago ge o ithuta?

_____

(Efa mabaka)

_____

_____

8.2.Ke leleme/maleme afe ao o bego/ o a šomišago ka klaseng?

_____

8.3.O thomile neng go ithuta leleme la Seisemane? (Laetša mphato/grata)

_____

8.4.Seisemane se ama/amile bjang dithuto tša gago?

_____

_____

9. Mediya

9.1.Go bohlokwa bjang go šomiša leleme la geno ge go phatlalatšwa tša pholo mediyeng?

_____(Efa mabaka)_____

_____

_____

9.2.O kgetha leleme lefe go bala ditšweletšwa tša mediya tše di ngwadilwego?

_____(Efa mabaka) _____

_____

_____

9.3.Seisemane se go thuša bjang mo mediyeng? _____

_____

_____

10. Pholisi ya Maleme le mekgwa ya batho mo no Afrika Borwa

10.1. Na o tseba ka ga Pholisi ya Afrika Borwa ya Maleme? ☐ Ee ☐ Aowa

10.2. Na o tšea leleme la geno go ba le le lego godimo ga maleme a mangwe ka maemo?

☐ Ee ☐ Aowa

(Efa mabaka) _____

_____

_____

10.3. Tsentšhotšhomišong ya pholisi ya Maleme e a atlega na go ya ka moo wena o bonago?

☐ Ee ☐ Aowa

(Efa mabaka)_____

_____

10.4. Kgopolo ya gago ke eng ka ga kgetho ya Seisemane bjalo ka leleme lapoledišano magareng ga batho ba merafe ya go fapana?

_____

_____

10.5. Na tshedimošo ka ga pholo e hwetšagala malemeng ka moka, kudu ditšhabeng tša bathobaso le tša makhalate? ☐ Ee ☐ Aowa

(Efa mabaka)_____

_____

10.6. Maleme ao a bego a sa fiwe sebaka a a godiswa na mo no Afrika Borwa?

☐ Ee ☐ Aowa

(Efa mabaka) _____

_____

10.7. A naa go na le disapthaetlele tša maleme a babaso tšeo di šomišwago ge tshedimošo ka tša pholo e gašwa mo go SABC? ☐ Ee ☐ Aowa

10.8. Na go na le phetolelo go tšwa go Seisemane go ya malemeng a mangwe a Afrika Borwa go ya le ka moo o tsebago, didomeining tše di latelago?

Domeine ya Tšhomišo	Ee	Ga ke na bonnete	Aowa
1. Ditšhupetšo tša tsela ka kliniking/bookelong			
2. Karata ya kliniki/bookelo			
3. Faele ya molwetši			
4. Tsebišo ya bomolomo ka ga tshedimošo ya pholo			
5. Tshedimošo ye e kgethegilego ye e beilwego pepeneneng ya kliniki/bookelo ye e ngwadilwego.			
6. Tshedimošo ya kakaretšo ye ebeilwego pepeneneng (Mohlala HIV/AIDS, kamušo ya masea b.j b.j.)			
7. Kgokagano le poledišano ya ngaka le molwetši			
8. Setlankana sa dihlare			
9. Ditsebišo ka ga tshepidišo ya kniniki/bookelo			
10. Ditsebišo tša kakaretšo tša kliniki/bookelo			

10.9. Swaya ntlha ka lepokisaneng leo le sepelelanago le karabo ya gago go ya ka di kabelo tše di latelago.

1= Ganetša ke tiišitše **2**= Ganetša **3**= Ga kena bonnete **4**= Dumela **5**= Dumela ke tiišitše

Setatemente	1	2	3	4	5
1. Afrika Borwa e na le Pholisi ya Maleme ye e lekalekanetšago					
2. Maleme ka moka a lesometee a hwetša tshwaro ya go lekana					
3. Pholisi ya Maleme e šomišwa ka go lekalekanela mafelong a pholo a bosetšhaba					
4. Tshedimošo ye e lekanego e ngwadilwe ka maleme a Bathobaso le Makhalate					
5. Tshedimošo ya pholo e na le maatlakgogedi ge e ngwadilwe ka leleme la gago					
6. Go bonolo go kwešiša tshedimošo ye e ngwadilwego ka leleme la geno					
7. Baswa ba kgetha tshedimošo ya pholo ye e ngwadilwego ka Seisemane					
8. Batsofadi ba swanetše go hwetša tshedimošo ya pholo ka maleme a bobona					
9. Batho ba maema a fase a Seisemane ba tšeelwa hlogong ge tša pholo di hlagišwa ke ba lefapha la maphelo le pholo gammogo le mediya					
10. Go dirwa mo go lekanego go godiša maleme a babaso ke ba Lefapha la Pholo ka dikliniking le maokelong.					

(Malebo, tšomišanommogo ya lena e lebogwa go menagane)

Annexure B: Test on Knowledge of Diseases and Health Issues (Clinic Patients/Visitors)

1. ***What do you understand by the following diseases or health concepts: immunisation, measles, ante-natal, malnutrition and kwashiorkor?***
2. ***What can one do in order to prevent any problems that may be associated with the five medical situations mentioned in number 1 above? Explain per each of the five.***
3. ***Do you think people would get a better understanding of what the medical situations entailed in the five concepts in number 1, if they were written and explained in their own languages? Give reasons.***
4. ***Is there a possibility, in your opinion, that the majority of the people who visit public health clinics/hospitals understand medical concepts like the five mentioned in number1, as appropriately as it is expected? Give reasons.***
5. ***What do you think the Department of Health of South Africa should do to ensure that more visitors of public health institutions understand health information better, like the one on the five concepts in number 1?***
6. ***Do you think people would feel more comfortable and eager to read health information that is written in their own language than that written in English?***
7. ***In your opinion, is the health information displayed in clinic/hospital walls and information boards written in all languages equally? Why do you think so?***
8. ***Do you think the language policy of South Africa is fair to all SA citizens? (Please, give reasons.)***
9. ***Would the writing of health information in Black South African languages in clinics/hospitals help in terminology development of indigenous languages of South Africa? (Please, give reasons.)***
10. ***What would be your suggestion towards the appropriate application of the language policy in the Department of Health when health awareness campaigns are undertaken?***

Annexure C: Interview Schedule (Clinic Staff)

2. ***Do you think the language policy of South Africa is fair to all SA citizens? (Please, give reasons.)***

3. ***In your opinion, is the health information displayed in clinic/hospital walls and information boards written in all languages equally? Why do you think so?***

4. ***Would you agree with those who say that health issues should be communicated in the native languages of local communities where the information is being delivered? (Please, give reasons.)***

5. ***Do you think people would feel more comfortable and eager to read health information that is written in their own language than that written in English?***

6. ***What do you think could be done about the language used when health information is passed to the public to ensure that this valuable information is received?***

7. ***In your opinion, would you think Minister Nzimande's view is valid in promoting indigenous languages, and would this go a long way in making all languages to get equal treatment when health information is passed to the public via the clinics and hospitals? Why do you think so?***

8. ***In your opinion, would you think that health institutions visitors and patients would prefer reading health information that is written in their own languages? Give some reasons to your answer.***

9. ***Would the writing of health information in Black South African languages in clinics/hospitals help in the terminology development of indigenous languages of South Africa?(Please, give reasons.)***

10. ***Would you say that the use of Black South African languages when writing on health would attract more readership, since readers would be interested in knowing what some medical terms are called in their languages?***

11. ***What would be your suggestion towards the appropriate application of the language policy in the Department of Health when health awareness campaigns are undertaken?***

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