NWU®

Implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention

MH Ramothamo

orcid.org 0000-0002-2202-1641

Thesis accepted in fulfillment of the requirements for the degree *Doctor of Philosophy in Social Science in Sociology* at the North- West University

Promoter: Prof HW Nell

COMMENTS

- Ethical approval was granted to conduct this research study (see Appendix 3).
- This study has been approved by the Optentia Research Committee.
- This thesis follows the stipulated guidelines as described by General Regulation A.4.4.2.3 of the North-West University. The article method was followed in compiling this thesis.
- The thesis was submitted to Turn-It-In.

DECLARATION

I, Mamello H. Ramothamo, hereby declare that “Implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention” is my work and that all the sources that I have used or quoted have been indicated and acknowledged using complete in-text references and reference lists.

I further declare that this work will not be submitted to any other academic institutions for qualification purposes.

Mamello H. Ramothamo November 2023

ACKNOWLEDGEMENTS

For their help in compiling this dissertation, I would like to thank the following individuals, without whom the final product would not have been possible:

- To my research supervisor, Professor Werner Nell. I thank you very much for your patience and magnificent supervision. This journey was bearable because of your outstanding support and guidance.

- To my parents Mr. and Mrs. Ramothamo, thank you for your never-ending encouragement, guidance, and prayers. Thank you for all the sacrifices you made for me throughout all the years.

- To my siblings Tiisetso, Katleho, and Mahlohonolo and my niece Kananelo, thank you for your support, love, encouragement, and the sacrifices you made for me throughout these years.

- To my friends. Thank you for all your encouragement.

- Finally, I would like to extend my appreciation to those who gave their time to participate in the study. I trust that your participation was enjoyable and fulfilling.

ABSTRACT

Globalization has coincided with increased migration, as people move from their home countries to other parts of the world for a variety of reasons, such as business, economic opportunities, security, and to escape civil wars (Czaika & Reinprecht, 2022). The healthcare sector is no exception to this general trend. There is an increasing demand for healthcare professionals worldwide to address the increasing global demand for healthcare service professionals (Ghorbani, 2021). Many governments have been forced to recruit healthcare professionals from different parts of the world to provide healthcare services to their respective citizens due to the severe shortage of staff in healthcare facilities witnessed in most countries (Aluttis *et al.*, 2014; Mandeville *et al.*, 2016). This strategy has been shown to pose some communication challenges due to linguistic and cultural differences between healthcare practitioners and patients. Many international studies indicate that the presence of language and cultural differences in healthcare is likely to lead to several negative outcomes. Chiehi *et al.* (2017) and Royski (2015) point out that cultural incompetence and lack of language concordance between patients and healthcare practitioners are likely to lead to poor relationships and promote medical errors, leaving patients at risk of delayed treatments, incorrect prescriptions, misdiagnoses and sometimes death. In light of this challenge, the study aimed to explore the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. There were three secondary objectives which were as follows: to provide a scoping review of existing literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in public healthcare facilities, to qualitatively explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals as well as strategies that they recommend be employed to reduce the noted adverse implications in these facilities and to develop an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals.

To address the first secondary objective, the researcher undertook a scoping review following the Arksey and O'Malley (2005) framework. A scoping review is a methodology that aims to provide an overview of a broad and complex topic (Pham *et al.* cited in Peterson *et al.,* 2016). It was found that the presence of language and cultural

differences between patients and healthcare practitioners adversely affected the delivery of quality healthcare, particularly by being associated with poor communication, delayed diagnoses, and treatments, failure to build rapport, decreased empathy, mistrust, poor patient compliance, increased stress and anxiety, increased patient frustrations, increased avoidance behavior, non-disclosure of medically relevant information, and the commission of medical errors.

For the second secondary research objective, the researcher undertook a qualitative exploration of the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals, as well as strategies that they recommend be employed to reduce the noted adverse implications It is a method for understanding and exploring the meanings that individuals or groups attribute to a social issue (Creswell 2014). Findings indicated that the presence of language and cultural differences resulted in miscommunication, poor patient assessment, negative emotional responses, patients' resistance to undertaking suggested treatments and medical procedures, avoidance behavior, and queueing of patients. In terms of strategies that could be used to mitigate these outcomes, patients and expatriate healthcare practitioners pointed out that it should be ensured that being multilingual expatriate healthcare practitioners is a requirement, that expatriate healthcare practitioners should receive an orientation to Basotho language and culture, that medical interpreting curricula should be developed and presented in schools, and that professional interpreters should be hired.

For the third secondary research objective, the researcher developed an intervention to assist expatriate healthcare practitioners working in Lesotho public hospitals with the opportunity to acquire basic skills in Sesotho and improve their cultural competencies, as this will increase the likelihood of the provision of quality healthcare. Intervention mapping was used to guide intervention development. It is a protocol that guides decision-making for the development, implementation, and evaluation of health problems (Van Mol *et al*., 2017).

This study has shown that the presence of language and cultural differences between patients and healthcare practitioners adversely affects the delivery of quality healthcare in healthcare facilities both in international contexts, as well as within the selected hospitals in Lesotho. The study points out that the presence of these discordances is associated with the failure of the two parties to satisfactorily communicate vital information

about illness symptoms and history, existing illnesses, current medication plan, and lifestyle, all of which were needed for correct diagnoses. This led to an array of unfavorable outcomes that in turn resulted in poor quality healthcare delivery in these facilities. In a bid to address these challenges, the researcher developed an intervention outline of a cultural immersion program for expatriate healthcare practitioners. It is aimed at equipping them with the basic communication skills required to reduce the adverse implications of the presence of language and cultural differences between themselves and patients on their ability to deliver quality healthcare while also increasing chances of attaining consequent enhanced healthcare-related outcomes.

Contents

LIST OF TABLES x
LIST OF APPENDICES xi
LIST OF ABBREVIATIONS xii
CHAPTER 1 1
1.1 Introduction 1
1.2 Problem statement 3
1.3 Research Questions 7
1.4 Secondary research questions 7
1.5 Research objectives 7
1.6 Research Methodology 8
1.7 Theoretical framework 9
1.8 Research Methodology 12
1.9 Qualitative study 15
1.10 Data collection 17
1.11 Research procedure 17
1.12 Data analysis 18
1.13 Quality and ethical considerations 19
1.14 Ethical considerations 20
1.15 Intervention development 22
1.15.1 Methodology 22
1.16 Proposed study outline 24
Reference List 25
Chapter 2 36
Article 1 36
Abstract 36
2.1 Introduction 37
2.2 Scoping review 39
2.3 Discussion 54
2.4 Limitations 63
2.5 Recommendations 64
2.6 Conclusion 65
Reference List 67
CHAPTER 3 76
Abstract 76
3.1 Introduction 77

3.2Culture 82
3.3Language 83
3.4The context of the present study: Lesotho 85
3.5Research Methodology 87
3.6Quality and ethical considerations 97
3.7Findings 100
3.8Discussion 117
3.9Limitations of the study 121
3.10 Recommendations for future research 122
3.11 Conclusion 123
Chapter 4 142
4.1. Introduction 143
4.2 Methodology 145
4.2.1 Intervention mapping 145
4.3Program: Culture immersion program outline for expatriate healthcare practitioners 160
4.4Limitations 164
4.5Conclusion 164
Chapter 5 173
Conclusion, limitations, and recommendations 173
5.1Introduction 173
5. 2 Findings 177
5. 3 Limitations 187
5.4 Recommendations 190
5.5Recommendations for practice and policy 191
5.6Conclusion 193
Appendix 1 202
Appendix 2 203
Appendix 3 204
Appendix 4 205
..... 205
Appendix 5 206
Appendix 6 215
Appendix 7 224

LIST OF TABLES

CHAPTER 3

TABLE 1 - CHARACTERISTICS OF PATIENT PARTICIPANTS 104

TABLE 2 - CHARACTERISTICS OF EXPATRIATE HEALTHCARE PRACTITIONER PARTICIPANTS ... 106

CHAPTER 4

TABLE 3 - SUMMARY OF THE EMPIRICAL RESEARCH FINDINGS 159

TABLE 4 - SUMMARY OF PERFORMANCE OBJECTIVES 165

LIST OF APPENDICES

APPENDIX 1- INTERVIEW GUIDE FOR EXPATRIATE HEALTHCARE PRACTITIONERS 211

APPENDIX 2 - INTERVIEWS GUIDE THAT WAS USED TO GUIDE THE INTERVIEWS FOR PATIENTS 211

APPENDIX 3 - ETHICS COMMITTEE CLEARANCE DOCUMENT 213

APPENDIX 4 - LETTER FROM THE MINISTRY OF HEALTH LESOTHO 215

APPENDIX 5 - CONSENT FORM FOR EXPATRIATE HEALTHCARE PRACTITIONERS 216

APPENDIX 6 - CONSENT FORM FOR BASOTHO PATIENTS 225

APPENDIX 7 - CONSENT FORMS FOR BASOTHO PATIENTS (SESOTHO) 233

APPENDIX 8 - DATA CHARTING FORM

LIST OF ABBREVIATIONS

HIV/AIDS Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

COVID-19 Corona Virus Disease of 2019

HBM Health Belief Model

URT Uncertainty Reduction Theory

CAT Communication Accommodation Theory

CHAPTER 1

INTRODUCTION, PROBLEM STATEMENT, AND OBJECTIVES

This chapter aims to introduce the reader to the study on which the thesis is based. The presented study aimed to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and to explore their views on strategies that can be employed to reduce the adverse implications and develop an intervention to limit the noted implications. A brief introduction is followed by an overview of the implications of language and cultural differences on the quality of healthcare provided in hospitals by healthcare practitioners who do not share a common language and culture with patients. The research problem is then discussed, followed by an overview of the key research questions and the objectives that guided this study. The theoretical framework underlying the study is explained, followed by a comprehensive discussion of the research methods that were employed. Ethical considerations are also described and lastly, the chapter division is outlined.

1.1 Introduction

Globalization and technology have made it easier for people to have access to foreign labor markets. As they leave their countries of origin and acquire a new migrant status, there is a likelihood that their language and cultural identifications may contrast with those of the domestic native ethnic majorities in the host countries. Here, the migrants are expected to communicate and interact with people to create and build relationships. According to Farooqi (2014), the two parties that form a relationship are interdependent and have an impact on each other. For new migrants to build relationships in the host countries, they must communicate with people who possess cultures and languages that are different from their own. This concept is known as intercultural communication and centers on the importance of understanding other people's language and cultural backgrounds during interactions to achieve effective communication (Jhaiyanuntana & Nomnian, 2020). According to Auwulu and Yunusa (2015), intercultural communication occurs when people from different cultural backgrounds interact. Scholarly interest has therefore since increased in the concept of intercultural communication, which is crucial for building interpersonal relationships between people of different backgrounds. Furthermore, Mokuoane (2018) points out that language and culture are two extremely important and interrelated aspects of human interaction that mutually influence each other. In this study, the term culture is taken to refer to shared and learned values, beliefs,

and norms of a particular group of people, which are transmitted from one generation to another, guide ways of thinking and acting, and influence decision-making (Spencer-Oatey, 2012). In turn, language is an important aspect of human interaction in which sounds, signs, and codes are established and used by a group of people to communicate with precision (Mokuoane & Moeketsi, 2018). These two factors are particularly important because language facilitates interaction while culture helps people learn contextually appropriate behaviors (Rabiah, 2012).

Healthcare sectors are particularly affected by factors associated with language and culture which stem to a large part from the ever-increasing migration flows taking place around the world. Many countries are experiencing an influx of expatriate healthcare practitioners who have been hired to work in various healthcare institutions and come from different countries to offer their skills and areas of expertise. These health practitioners often face challenges in their new roles because they have different cultural backgrounds and often do not speak the local languages that are spoken by those they are called upon to care for in host countries. This affects communication, which is a fundamental factor in clinical interactions. The lack of effective communication in healthcare could lead to negative health outcomes and thus hinder the delivery of quality healthcare (Holmqvist in Roysky, 2015:02). Many multicultural healthcare facilities appear to fail to maintain competent intercultural communication, resulting in compromised relationships between healthcare providers and patients, which contributes to inability to attain quality healthcare (Albougami, 2015; Almutairi, 2015; Schyve, 2007). According to Goold and Lipkin (1999), the doctor-patient relationship is interpersonal and complex as it involves two people who have unequal power. They further add that interactions are often voluntary, require cooperation from both parties involved, and address critical issues that could potentially evoke strong emotions. Schyve (2007) shows that the number of correct diagnoses and understandable prescriptions is likely to increase when the relationship between a patient and a doctor is good. In the context of this study, quality healthcare is defined as the level at which healthcare services for individuals and populations result in effective care that increases the likelihood of desired health outcomes (Mosadeghard, 2013). In healthcare settings that are culturally and linguistically diverse, it is important to focus on language and cultural differences between healthcare practitioners and patients as they are likely to negatively affect healthcare outcomes (de Moissac & Bowen 2018:01). Existing studies also suggest that when language and cultural differences are present in healthcare facilities, healthcare practitioners often fail to build trust and rapport

with their patients and to read their body language, a phenomenon associated with lower job satisfaction which ultimately signifies poor healthcare (Fong Ha & Longnecker, 2010; Sobane, 2015). It is hoped that the present study, which aims to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and their views on strategies that can be employed to reduce the adverse implications and to develop an intervention to limit the noted implications, will be useful in finding practical solutions.

1.2 Problem statement

Ellahhan (2021) explains that communication issues relating to the presence of language and cultural differences are a consequence of continuing migration. He further indicates that often, there are differences in the languages and cultures of migrants and those of the host country which result in communication barriers. In addition, he points out that in healthcare, communication involves the exchange of information and ideas among healthcare professionals and their patients where the latter express their needs, wants, and concerns with the former explaining appropriate medical care or procedures as well as answering any questions the latter might have. Due to the high demand for healthcare specialists globally, medical teams in healthcare facilities increasingly consist of people from different parts of the world who possess languages and cultures that are unique to their home countries and which are often different from those of patients and their colleagues in the host countries (Purnell 2000 in Schmidt *et al.,* 2023).

Many international studies indicate that the presence of language and cultural differences in healthcare is likely to lead to several negative outcomes. They may result in miscommunication between health professionals and patients, or prevent communicating altogether, all of which is likely to affect the quality of care and patient safety and increase the risk of medical errors. Chiehi *et al.* (2017) and Royski (2015) point out that cultural incompetence and lack of language concordance between patients and healthcare practitioners are likely to lead to poor relationships and promote medical errors, leaving patients at risk of delayed treatments, incorrect prescriptions, misdiagnoses and sometimes death.

Al Shamsi *et al.*, (2020) indicate that language differences between patients and healthcare practitioners in healthcare facilities present numerous challenges that may hinder the delivery of quality healthcare. These may include failure to achieve favorable levels of patient and healthcare practitioner satisfaction and the maintenance of patient

safety. In addition, a qualitative study was undertaken in six public hospitals in Addis Ababa Ethiopia, a multilingual and multinational federation where Amharic is given a unique legal status in the city and federal offices including hospitals. The objective was to investigate the impact of language barriers on healthcare and to suggest solutions to address the challenges. Findings from this study point out that Afaan Oromoo-speaking patients who seek healthcare assistance in hospitals where Amharic is used, face language barriers. This promoted the occurrence of medical errors, low adherence to treatment, decreased health-seeking behaviors, decreased confidence, poor therapeutic relations, increased treatment costs, and prolonged hospital stays. For healthcare practitioners, this hindered their ability to extract patient histories, which is critical to enable them to correctly diagnose patients and consequently provide the correct treatments (Olani *et al.*, 2023).

Similarly, several articles have articulated that the presence of cultural differences between patients and healthcare practitioners in healthcare facilities was associated with numerous adverse effects that hindered the delivery of quality healthcare. Awasom (2021) undertook a literature review based on qualitative primary research results and it was aimed at examining cultural barriers in the delivery of healthcare services from the patient's perspective. Results suggested that the presence of cultural barriers in healthcare facilities resulted in miscommunication during verbal and non-verbal interactions, reduced trust, discrimination, and reduced propensity to seek healthcare. In addition, a systematic integrative literature review was undertaken, and findings indicated that cultural diversity in healthcare (which is defined as an affiliation of people who have different norms, values, or traditions in a healthcare setting) negatively affected communication and integration among healthcare practitioners increasing conflict which consequently compromised patient safety (Schmidt *et al.*, 2023). This is an indication that in healthcare settings, it is important to take appropriate measures to ensure that any practices that could result in harm to a patient or a healthcare practitioner are minimized or eliminated and that the best practices are employed to ensure the maintenance of quality healthcare delivery and also to ensure that the nature and quality of clinical relationships are likely to lead to achieving optimal health outcomes (de Moissac & Bowen 2018).

In the case of Lesotho, there is a notable lack of research and scientific reviews on the implications of language and cultural differences on the quality of healthcare in healthcare facilities where practitioners and patients do not share a common language and culture.

The studies conducted by Sobane (2013), Thuube (2015), and Sobane (2015) appear to be the only three studies that address the issues surrounding this topic.

The first study was conducted by Sobane (2013) and focused primarily on HIV/AIDS patients. All other patient groups who were also cared for by expatriate healthcare practitioners in health facilities in Lesotho were not included. The focus was on linguistic discrepancies between doctors and patients. However, the cultural factors and their role in these interactions were not examined. Furthermore, this study was conducted in urban areas of Lesotho, thereby excluding the views, perceptions, and experiences of patients from health facilities in rural areas, who generally have different socio-cultural characteristics, backgrounds, and health needs and behaviors, and who therefore may face additional or different challenges in terms of the implications of language and cultural differences in healthcare facilities in their region. This study was also conducted in public clinics (not hospitals). These clinics are typically staffed by expatriate healthcare practitioners who are assigned Basotho nurse/nurse assistants to assist with other tasks, including communicating with Basotho patients who do not speak or understand English. Therefore, the experiences of both patients and expatriate healthcare practitioners in this scenario are likely to be different than in health facilities where the practitioners are not assigned Basotho nurses/nursing assistants. Finally, this study was conducted in public clinics where lay translators were employed, a phenomenon not common in several other clinics and public hospitals. Therefore, the data collected in this study may not reflect the healthcare situation in Lesotho, where healthcare practitioners and patients do not share a common language or cultural background and there are no readily available ad hoc translators.

The second study was conducted by Thuube (2015). The focus was on examining how ad hoc interpreters influenced communication between doctors and patients who did not speak a common language in two hospitals in Lesotho (a church-run hospital and a public hospital). The first hospital was a Roman Catholic hospital, which also included a nursing school. Part of the curriculum for nursing students is to help with translations between patients and doctors in the different departments of the hospital. This is an unrepresentative practice as many hospitals in Lesotho (particularly public hospitals that serve most of the Basotho population) do not have access to nursing students who can assist with ad hoc translations. The second hospital selected for this study was a rural public hospital in Quthing. This district is known for its wild vegetation of various species, including various types of medicinal aloe. According to Seleteng-Kose and Vuure (2019),

77% of the Basotho population live in rural areas far from health centers. They also add that over 60% of the country is mountainous and has limited road infrastructure. With Quthing being a rural district, it can be assumed that a relatively large proportion of the population uses the readily available alternative medicinal plants to cure their ailments as opposed to seeking medical help in the inaccessible public hospitals which are often manned by expatriate doctors who often possess linguistic and cultural backgrounds that differ from those of the patient population they serve. The noted use of alternative medicine by the majority population in the rural areas points to the fact that the results of this study may rely on the representation of a small population as the majority lack comprehensive experience regarding the issues of language and cultural differences in a public hospital where healthcare services are provided by expatriate doctors. Finally, the study focused on linguistic communication and did not consider the role of culture in cross- linguistic communication by ad hoc translators and how it may affect the delivery of quality healthcare.

The third study by Sobane (2015) focused on examining the challenges faced by healthcare professionals and patients in two clinics where physicians spoke both the community language (at a very basic proficiency level) and the non-native lingua franca which was English. This study was conducted in local clinics that serve a relatively small population of Basotho living in surrounding villages, compared to public hospitals that serve larger populations and serve as primary referral centers in each district. Translators were employed in the selected clinics, whereas the case was different in public hospitals as translators are not employed to support communication between patients and healthcare professionals. The study also did not address the issue of how the cultural differences between the healthcare professionals and patients in these two clinics affected the delivery of quality healthcare.

Given that only three studies have been carried out so far that relate to the topic, and that the focus, setting, context, and dynamics between healthcare professionals and patients that characterized these studies mostly do not reflect the prevailing situation in Lesotho public hospitals where translation services are not available, there is a need to conduct additional studies to better understand the implications of language and cultural differences and how they affect the delivery of quality healthcare to develop interventions to improve health communication between patients and healthcare professionals who do not share a common language and culture with patients. This will ultimately improve the delivery of quality healthcare because findings from previous studies point out that these

discordances are associated with poor doctor-patient relationships, a rise in the number of medical errors, prescription errors, risk of delayed or incorrect treatment for patients, and occasionally even deaths, all which compromise the delivery of quality healthcare.

1.3 Research Questions

Based on the research gap outlined above, the following main research question was formulated to guide the study:

1.3.1 Main research question

What are the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in public healthcare facilities?

1.4 Secondary research questions

The secondary research questions were as follows:

What does the existing literature reveal about the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?

- What are the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals? What strategies do they recommend be employed to reduce the noted adverse implications in these facilities?
- What type of intervention can be developed to address the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals?

1.5 Research objectives

The following main objective was formulated:

1.5.1 Main Research Objective

- To explore the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in public healthcare facilities.

1.5.2 Secondary Research Objectives

The secondary research objectives were as follows:

- To provide a scoping review of existing literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities.
- To qualitatively explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals as well as strategies that they recommend be employed to reduce the noted adverse implications in these facilities.
- To develop an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals.

1.6 Research Methodology

1.6.1 Literature review

To obtain an overview of existing research on this topic, a preliminary literature search was conducted. For the present study, literature was collected from several databases in search of relevant published research articles, including Science Direct, Jstor, Academia Edu, Sage, Ebscohost, SABINET, and Google Scholar. Keywords used to search for relevant articles included the following terms: *language and cultural differences, healthcare professionals, patients, provision of quality healthcare, and healthcare facilities*. The search focused on English-language articles published in the last decade, as they revealed current trends and insights into the phenomenon under study and this period made it possible to track academic progress in the field.

1.6.2 Ontological assumptions guiding the study

This study was conducted within the framework of a constructivist ontology, which assumes that people construct meanings and interpret situations and experiences by interacting with others and with larger social systems (Ahmed, 2008; Crotty, 1998). The study primarily aimed to collect data from patients and expatriate healthcare practitioners to provide evidence on the implications of language and cultural differences on the delivery of quality healthcare provided by expatriate healthcare practitioners in Lesotho public

hospitals. In this study, the focus was on the issues of socially constructed knowledge, values, and behaviors that the two social groups shared and that enabled and/or hindered these groups from functioning and adapting to their environments.

These constructs shape the way social groups think, and the way they form ideas and perceptions. According to Aeneas and Sandìn (2009), this in turn influences the way people interact with their environment. The constructivist ontology was therefore appropriate for this study as it allowed the researcher to examine the role of language and cultural differences in participants' thoughts, experiences, interpretations, perceptions, and consequent behaviors during health-related interactions.

1.6.3 Epistemological assumptions

The interpretivist approach which argues that human beings understand the social world through experiencing it was used. Adherents of this epistemology dismiss the idea that the truth is objective and argue that human beings gather knowledge, understand it, and make meaning out of such through interpreting events (Hiller, 2016). This is supported by phenomenologists' views that the best way to study and understand human behavior is by investigating them extensively and by experiencing them (Bahari, 2010). Sandìn and Aeneas (2009) further reveal that though positivist scientific knowledge aims to describe the reality of an object in and of itself, the idea that the object can be identified and grasped in a value-free way is unacceptable. The interpretivist epistemology holds that the researcher cannot be separated from the research because they undertake a social actor role where they interpret their daily lives via the meanings attributed to events and the social roles of others (Bahari, 2010). In this study, the interpretivist epistemology helped the researcher in recognizing, narrating and understanding views, interpreting the beliefs, motivations, and reasoning of both patients and expatriate healthcare practitioners in Lesotho public hospitals about their experiences of the presence of language and cultural differences and how they affect the delivery of quality healthcare.

1.7 Theoretical framework

Three theories were selected to serve as a framework for explaining the results of this study. These included the health belief model, uncertainty reduction theory, and communication accommodation theory, which are described in the following section.

1.7.1 The Health Belief Model

The health belief model is a psychological theory developed in the 1950s by Hochbaum *et*

al. (1952). It was designed to predict and explain people's attitudes and actions regarding health issues (Rosenstock *et al*., 1974 in Jones *et al*., 2014). The theory aims to analyze risks, evaluate proposed remedies, and consider people's beliefs in areas of health behavior (Rosenstock, 1974). According to Champion and Skinner (2008), the model includes four perceptual constructs: susceptibility, severity, benefits, and barriers. According to Turner and Hunt (2004:32), in terms of *susceptibility*, the model explains that people take preventative measures only when they have a subjective assessment of the risk of developing a disease. The model further explains that individuals only act when they believe an illness would have potentially serious consequences. In the context of the model, this construct is understood as *severity* (Butrapon *et al*., 2004:171). Regarding the notion of *benefits*, the model explains that individuals act by adopting health-safe behaviors or taking proposed remedies only if they believe that the actions would be worthwhile (Elmelegy & El Mahdy, 2018). The final construct of the model is perceived *barriers*. According to Turner and Hunt (2004), this refers to an individual's perception of potential obstacles that could prevent them from taking the recommended remedial action.

This model provided a framework for a description of how the presence of language and cultural differences in healthcare facilities where patients and healthcare practitioners do not share a common language and cultural influenced patients' perceptions of barriers that could hinder them from adopting certain health behaviors, altered their susceptibility regarding the risk of further illness complications, influenced how they comprehended the benefits of undertaking suggested treatment and procedures and the severity of the ilnnesses they were diagnosed with.

1.7.2 Uncertainty Reduction Theory

This theory was developed by Charles Berger and Richard Calabrese in 1975 with the aim of explaining the communication processes that occur when two people meet (Gudykunst, 2005). It explains that it is natural for strangers to become insecure when they first meet because they do not know what to expect from each other and therefore the outcomes of their interactions are unpredictable (Roysky, 2015). Berger and Calabrese (2006) explain that the process of developing relationships requires the parties involved to understand themselves and each other. They also add that communication allows the extracting and exchanging of information between two people. Saunders and Wiseman (1993) also explain that the two interacting individuals can use questioning and affiliation methods to obtain information about each other, which then leads to reduced uncertainty.

The theory states that the concerned parties must interact to obtain information about each other in order to reduce uncertainty. In the context of this study, the theory served as a useful framework for understanding how uncertainty during interactions between patients and expatriate healthcare professionals in Lesotho public hospitals where language and cultural differences are present affected the delivery of quality healthcare in facilities.

1.7.3 Communication Accommodation Theory

Communication accommodation theory was developed by H. Giles in 1971 as a general theoretical framework for interpersonal and cross-group communication (Kuruthan *et al*., 2018). It aims to explain how people adapt their communicative behaviors to accommodate each other during social interactions, and it also focuses on what consequences these adaptations have for social differences (Kuruthan & Kuruthan, 2019). “Accomodation” is used as a metaphor that represents a barometer indicating the level of social distance (Giles & Ogay, 2007). The theory further explains that individuals can control social differences by adapting different communicative approaches in different situations (Mlambo, 2017). It focuses on three types of adaptations that can occur during interactions. They are convergence, divergence, and maintenance (Gasiorek *et al.,* 2021). The types are explained below.

Elhami (2020) explains that *convergence* occurs when communication adjustments made during interactions result in reduced communicative differences. Furthermore, *divergence* is explained as a type of adaptation where the consequences reinforce communicative differences. Lastly, *maintenance* is explained as a situation in which neither of the two interacting parties makes an effort to accommodate each other since neither party takes measures to reduce or increase the social differences.

In the context of the present study, theory sensitized the researcher to examine the types of adjustments that patients and expatriate healthcare practitioners adapt in public hospitals and how they reduce or increase social differences and consequently, the delivery of quality healthcare. The theory proposed five sociolinguistic strategies that can be used to achieve during social interactions. These strategies were in line with the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences that were articulated in the qualitative study and will guide their implementation (reflected in article 2 chapter 3).

1.8 Research Methodology

A secondary aim of the study was to provide an overview of the existing literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in public healthcare facilities. Another secondary aim of this study was to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and to further explore their views on strategies that can be employed to reduce the noted adverse implications. The final secondary objective was to develop an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. The remainder of this section describes the methods used to address each of these secondary research objectives: a scoping review, an exploratory qualitative study, and intervention mapping.

1.8.1.1.1 Scoping review

A scoping review was used to provide an overview of this broad and complex topic of the implications of language and cultural barriers between patients and healthcare practitioners who do not share a common language and culture (as reflected in article 1 chapter 2). It aims to map literature on a specific research topic or area of research and provides a way to identify gaps and evidence in the existing literature and it includes narrative reviews, grey literature, and a range of study designs and methods in its scope (Levac *et al*., 2010).

In this review, PRISMA guidelines were adopted to support standardization of reporting. According to Arksey and O'Malley (2005), the framework of a scoping review includes six phases (of which the first five were relevant to this study as the aim of this review was to provide an overview of the existing literature on the examined topic). The phases include: (1) Identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, (5) collating, summarizing, and reporting the results, and (6) engaging in a consultation exercise.

Each of these five phases will now be discussed in turn.

1.8.1.1.2 Identifying the research question

For formulating research questions in a scoping review, the researcher should combine the main research question with an established scope of study to guide the selection of appropriate populations and contexts. Westphaln *et al.* (2012) emphasize that when

identifying a research question, the researcher must clarify the relationship between the main research purpose and the research question. The main research question of the current study was: What are the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in public healthcare facilities? Emanating from this overall question, the specific research question that guided the scoping review was: *What does the existing literature reveal about the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?*

1.8.1.1.3 Identifying relevant studies

The second step of Arksey and O'Malley's framework was to identify the relevant literature. In January 2021, the researcher identified five databases containing literature that could likely shed light on the implications of language and cultural differences on the delivery of quality healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. The researcher ensured that the literature identified in the selected databases was robust, credible, and suited to answering the research question to the required extent. Databases included: CINAHL, PUBMED, Google Scholar, APA, and PSYCHOINFO. Additional literature was located through a review of reference lists of initially identified studies.

1.8.1.1.4 Study selection

Following the Arksey and O'Malley's framework, in the third phase, the researcher selected studies for the scoping review. To facilitate this process, she defined the inclusion and exclusion criteria guided by the research objective and research question of this scoping review, as recommended by Arksey and O'Malley (2005).

Inclusion criteria

The study was concerned with the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients.

- The study was written in English language or translated into English.
- The study was conducted in a healthcare facility.
- The study was conducted in the last decade as it revealed current trends and evidence on the phenomenon being studied and enabled the tracing of

scholastic progression in the field.

Exclusion criteria

- The study represented a duplicate report.
- The study focused on a specific illness.
- The study's full text was not available even when efforts were made to obtain it were unsuccessful.
- The study focused on the implications of other communication barriers apart from language and culture.

The search also included grey literature, which provided relevant evidence and important contributions to the scoping review. It often serves as a valuable source of data because it also contains recent studies that may be more detailed and that were not restricted by publishers in terms of length or scope (Sibbald *et al.*, 2015).

The proposed inclusion criteria were operationalized using a specific set of keywords combined with several Boolean operators to focus on the search terms, *language, cultural differences, healthcare professionals, patients, AND quality healthcare*, and related word variants such as "*barriers*" produced the most effective results. To identify articles that may use similar keywords that relate to language and cultural differences in healthcare keywords, such as *language and cultural barriers, migrants/foreigners, healthcare professionals, patients, quality healthcare,* and *hospitals* were used to further broaden the search.

1.8.1.1.5 Data charting

In this fourth phase of Arksey and O'Malley's framework, the researcher developed a data

charting form which allowed her to categorize the data, extract and document variables related to the research question. The scoping review of the proposed study used data that is related to the implications of language and culture differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. The following key variables were charted:

Authors, year of publication, study location, study populations, aims of the study, methodology, results, and themes.

1.8.1.1.6 Collating, summarizing, and reporting the results

In this fifth stage of Arksey and O'Malley's framework, the data collected from the articles were analyzed through a thematic analysis. This method of qualitative data analysis reduces broad information into patterns and themes by using a coding strategy to interpret data and answer the research questions (Ibrahim, 2012). Braun and Clarke's (2006) six-stage framework approach to thematic analysis was used and it is arguably one of the most cited approaches for analyzing qualitative data.

The first step of this approach entailed becoming familiar with the data set by repeatedly reading through the selected articles with the aim of understanding and finding meanings and patterns. In the second phase, initial codes were generated and applied to identify interesting elements in the collected data that are related to and relevant to the research phenomenon. In the third phase, the codes emerging from the data set were collected and sorted into sub-themes and main themes. In the fourth phase, the researcher refined the themes to determine whether they formed a coherent pattern that reflected a valid representation of the data set or whether there was a need to merge some themes or break them down further into new themes. In the fifth phase, the researcher identified and reflected on each theme, then captured and narrated it in relation to the topic under study, and then named the themes accordingly to illustrate the key findings that emerged from the data. In the final phase, which began immediately after the researcher had fully developed the themes, a report was written that detailed what the themes from the data set indicated in relation to the phenomenon that was being studied.

1.9 Qualitative study

1.9.1.1.1 Methodology

According to Mabuda (2009), a research methodology is defined as specific processes and techniques used in conducting a study. The researcher used a qualitative research methodology in the second phase of the study, which according to Creswell (2014), is a method for understanding and exploring meanings that individuals or groups attribute to a social issue. In this approach, data is procedurally collected from research participants and then analyzed and interpreted (inductively, in the case of this study) to understand a research phenomenon (William, 2007).

1.9.1.1.2 Research design

A research design describes how the researcher plans to conduct a study. To pursue this, she used an *exploratory qualitative* research *design.* It aims to expand knowledge and understanding of the research phenomenon and discover new ideas to solve the problem being studied (Burns & Grove, 2003; Creswell, 2014). Mabuda (2009) explains that an exploratory qualitative research design is often used to establish new approaches that can be adopted to address an existing problem. This research design was therefore deemed suitable for use in this study, in which the researcher sought to develop an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho (as presented in article 3 chapter 4).

1.9.1.1.3 Sampling and research participants

Purposive sampling was used to find participants for this study. They were selected from two urban, one semi-urban, and one rural public hospital.

1.9.1.1.4 *Purposive Sampling*

The researcher used purposive sampling, which is a non-probability sampling technique to select participants who were knowledgeable about the information that answered the research question. She only selected participants who had relevant knowledge and experience about the research topic and who were available and willing to take part in the study. This sampling method requires the use of specific criteria to select participants according to the topic and objectives of the research (Creswell, 2014).

The following inclusion and exclusion criteria applied to this study:

1.9.1.1.5 *Inclusion criteria for patients*

- Participants had to be Basotho out-patients (18 years and above) in one of the 4 selected public hospitals.
- Their primary language had to be Sesotho.
- Patients were selected on the basis that they had been attended to by an expatriate healthcare practitioner in one of the selected hospitals.
- Patients who took part in this research were selected on the basis that the supervising healthcare practitioner considered them fit to take part in this study and indicated that they were unlikely to be negatively affected by their participation.

1.9.1.1.6 *Inclusion criteria for expatriate healthcare practitioners*

- Expatriate healthcare practitioners who were non-proficient or had very low proficiency in Sesotho.
- Expatriate healthcare practitioners who had attended to Basotho patients in the selected public hospitals.

1.10 Data collection

Individual semi-structured interviews were used to collect data. These interviews allowed the interviewee to use their own words to express themselves allowing for more detailed elaboration and allowing the interviewer to formulate impromptu follow-up questions that may help uncover more important details about the phenomenon under investigation. Interviews with both groups of participants were conducted using interview guides **(see Appendices 1 and 2)**, which are defined as lists of important topics that a researcher would like to cover in the interviews with participants (Bird, 2016).

1.11 Research procedure

After the NWU Human Health Research Ethics Committee (NWU-02127-20-A7) granted ethical approval for the study **(see Appendix 3)**, the researcher contacted the Office of the Principal Secretary in the Ministry of Health in Lesotho to discuss the proposed study and sought permission to conduct interviews in the selected public hospitals. When permission was granted **(see Appendix 4)**, the researcher contacted the administrators of Queen' Mamohato Memorial, Queen 2, Butha-Buthe and Berea hospitals and requested assistance in identifying, contacting, and arranging individual meetings with the potential participants *(expatriate healthcare practitioners)* who met the study inclusion criteria. The purpose of these meetings was for the researcher to explain to potential participants in more detail what the study entailed and to provide them with consent forms that they were requested to read at least 24 hours before signing, in accordance with the required ethical protocol. Appropriate dates, times, and locations for the interviews were then agreed upon and set with the participants. At the beginning of the interviews, the researcher reminded participants of the study's objectives and assured them that confidentiality would be maintained. The researcher used interview guides to facilitate the interviews **(see Appendix 1)**, which lasted between 20 and 30 minutes and were recorded using an audio voice recorder with the participants' consent. Data were collected until theoretical saturation was reached.

The researcher applied the same approach and appealed to the hospital administrators of the four selected public hospitals for advice and assistance in identifying the second group of potential participants *(patients)* who met the study's inclusion criteria. This was done through research advertisements that were attached to the hospitals' notice boards. The notices included information about the research, eligibility criteria, and researchers' contact details, which were to be used by potential participants to contact the researcher and express their interest in taking part in the study. After responding to the call for participation, potential participants were provisionally considered provided that the supervising healthcare practitioner considered them fit to take part in this study and indicated that they were unlikely to be negatively affected by their participation. The researcher was also provided with contact details of interested potential participants who, for various reasons, were unable to contact the researcher to inform her of their interest in participating in the research. Meetings were arranged with potential participants at times and locations convenient to them. The purpose of these meetings was for the researcher to explain to potential participants in more detail what the study entailed and to provide them with consent forms, which, by the required ethical mandate, had to be read at least 24 hours before they were signed. Appropriate dates, times, and locations for conducting the interviews were then agreed upon with the participants. At the beginning of the interviews, the researcher reminded them of the purpose of the study and assured them that confidentiality would be maintained. To facilitate the interviews, the researcher used an interview guide (**see Appendix 2**). The interviews were audio recorded with the participants' consent and lasted between 20 and 30 minutes. Data were collected until theoretical saturation was reached.

1.12 Data analysis

Thematic analysis was used to analyze the data. It is a method of analyzing qualitative data that involves identifying and interpreting patterns of meaning (Braun & Clarke, 2006). It involves 6 steps which include: 1. Familiarization with the data 2. Generating initial codes 3. Searching for themes 4. Reviewing themes 5. Defining and naming themes 6. Writing up the report. These steps are briefly discussed below.

Step 1 Familiarization with the data

The researcher listened carefully and repeatedly to the audio recordings of the interviews. She then transcribed the recorded interviews verbatim and read through these transcripts several times to confirm that the transcribed information was accurate, and to familiarize

herself with the information.

Step 2 Generating initial codes

In this step, the researcher worked through the data to identify elements that were relevant to the research question and that were likely to influence the development of themes.

Step 3 Searching for themes

In this step, the researcher examined the generated codes to identify patterns within them and then began generating broader themes that answered the research question.

Step 4 Reviewing themes

In this step, the researcher read through the data associated with each theme to determine whether it actually supported the generated theme. When necessary, some themes and subthemes were split, or combined, or, in some cases, discarded.

Step 5 Defining and naming the themes

For this final stage of refinement, the researcher drew on the compiled data excerpts of each theme and sub-theme to organize them into a coherent and consistent representation with a clear description of their interrelationships.

Step 6 Writing up the report

For this phase, the researcher produced a report outlining the patterns and themes identified in the literature.

1.13 Quality and ethical considerations

Transferability

Babbie and Mouton (2001:276) point out that the results of a study should be applicable in other contexts or to other respondents. According to Bezuidenhout *et al.* (2014:258), transferability refers to the ability of findings to be applied to a similar situation and lead to similar results. This is facilitated by a detailed description of the study and the use of appropriate sampling methods (Anney, 2014). In the present study, the researcher provided sufficient information about the participants' context to enable the reader to make an informed decision about the extent to which the research findings might be applicable to the contexts they wish to understand. Furthermore, transferability was enhanced by using a purposive sampling approach and providing a clear description of study

participants, inclusion criteria, interview guides, and a clear representation of the research setting.

Confirmability

Confirmability refers to the extent to which the results of a study could be confirmed by other researchers and is about ensuring that the results of the study are, as much as possible, the result of the participants' experiences and ideas rather than preferences of the researcher (Shenton, 2004:72). To ensure this, following the recommendations of Koch (1994), the researcher thoroughly explained the theoretical, methodological, and analytical decisions she made throughout the study, as well as the rationale that informed these decisions.

Credibility

According to Bradley (1993: 436), credibility means ensuring accuracy of results, that is, whether the results actually reflect the scenario examined. In this study, this was ensured by only including participants who had insight into the topic under investigation and met the inclusion criteria. It was also ensured by using an established data collection method (semi- structured interviews), which enabled an interactive method of data gathering. According to Stahl and King (2020), this facilitates the collection of credible data and helps minimize the risk of misinterpretation by the researcher. To further ensure the credibility of this study, the researcher conducted interviewee transcript reviews. For this procedure, respondents receive verbatim transcripts of their interviews to be used for accuracy verification, error correction, and clarification (Hagens *et al.*, 2019).

Dependability

It is about ensuring that research findings are consistent and reliable (Bradley, 1993: 437). In this study, the researcher ensured this by collecting the data carefully, interpreting the results consistently, and reporting the results in a coherent, logical, and complete manner. Furthermore, it was ensured by providing an audit trail. This is defined as a detailed report on the processes of data collection, data analysis, and interpretation of data (Bowen, 2009).

1.14 Ethical considerations

Ethics are norms or standards of behavior that distinguish between right and wrong. They help determine the difference between acceptable and unacceptable behavior. According

to the National Committee for Research Ethics in the Social Sciences and Humanities (2005), considering ethical issues when conducting a study helps a researcher promote social values and accountability to the public by avoiding conflict and harming human subjects, and supports the researcher in making morally acceptable decisions. The following ethical issues were considered in this study:

- Informed consent

According to Shahnazarian *et al.* (undated), informed consent is a voluntary agreement to participate in research. In conducting this research, it was ensured that participants fully understood the research in which they were taking part. They were informed about the purpose of the study, the duration, possible risks, and potential benefits of their participation. After agreeing to participate in this study, they were given consent forms that had to be read at least 24 hours before signing. It was important to obtain consent from participants to avoid violating their integrity and harm.

- Voluntary participation

It means that individuals participating in a study are allowed to exercise their free will to decide whether or not to take part in a research activity (Smith, 2003:56). Therefore, participants in this study were not forced to participate. To avoid violating their integrity and causing harm to the participants, participation was completely voluntary, and they were informed of their right to refuse to answer a particular question or withdraw from the study at any time if they wish, without incurring any form of penalty.

- Confidentiality

It was important to maintain confidentiality in this research because disclosing and disseminating participants' potentially incriminating statements could result in harm, either to the research participants, or those that they speak about (Drew *et al.*, 2007:57). In this study, confidentiality was ensured by keeping the information provided by the participants confidential, known only to the researcher and therefore the information was not disclosed to other people without their consent. Transcripts were anonymized and no identities of any participants were revealed when writing up the findings.

- Fidelity

Fidelity is about building trust between the researcher and participants, as the former must protect the participants and their well-being in a research situation (Garity 1999, cited in Gelling, 1999:39). In this study, this was ensured by providing participants with all

information about the possible risks and burdens of participating in the study. In addition, the researcher ensured that the participants did not suffer any harm. This was achieved by avoiding exerting any pressure on participants to reveal confidential, private, degrading, or humiliating information. According to Drew *et al.* (2007:57), it is crucial that researchers respect the privacy, dignity, and sensitivities of participants. This was done by avoiding manipulative, suggestive, and leading questions. This was also avoided by respecting participants' privacy and protecting participants' reputations, relationships, and well-being.

1.15 Intervention development

To address the last secondary objective of the study, the researcher developed a culture immersion program outline for expatriate healthcare practitioners as a proposed intervention to be used to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. This is a type of cultural competency training program that utilizes transformative learning through direct interaction with populations that possess different cultures and languages (Jones, 2019). The ultimate aim of this proposed program is to provide expatriate healthcare practitioners working in Lesotho public hospitals with the opportunity to acquire basic skills in Sesotho and improve their cultural competencies, as this may increase the likelihood of the provision of quality healthcare. The proposed program is intended to run over a period of two weeks and includes lectures and immersion activities for the expatriate healthcare practitioners who will be selected through purposive sampling from the hospitals that participated in the researcher's empirical research **(refer to article 2 chapter 3)** and immersion participants who will be randomly selected in the areas near the selected clinics and healthcare centers. These activities will help them improve their Sesotho language skills, specific vocabulary, and communication methods. In addition, they will strengthen their cultural awareness and provide them with the opportunity to interact with diverse communities in Lesotho who have different educational, socio-cultural, socio-economic, and socio-political backgrounds to improve their cultural understanding thus an improved understanding of how Basotho perceives health and illness, as well as of their health behaviors and beliefs.

1.15.1 Methodology

Intervention mapping was used to guide the development of an intervention outline. It is a protocol that guides decision-making for the development, implementation, and

evaluation of health problems (Van Mol *et al.*, 2017). This approach is based on theory and evidence to assess and intervene in health problems and also includes community participation (Fernandez *et al.*, 2019). It served as a guide for the development of the cultural immersion program outline for expatriate healthcare practitioners. Intervention mapping included six steps, however, only four were applicable in this study because as much as the researcher had intended to develop a program, due to time constraints, bureaucratic and political barriers in the Lesotho government, and the challenges emanating from the Covid-19 pandemic, she was only able to develop an outline and hopes to develop the actual program, oversee the implementation and evaluation for the post-doctoral phase. The four steps were as follows:

(1) Establishing a detailed understanding of the health problem, the population at risk, the behavioral and environmental causes, and the determinants of these behavioral and environmental conditions; and assessing available resources.

(2) Describing the behavioral and environmental outcomes, create objectives for changes in the determinants of behavior and environmental causes, and specify the targets of the intervention.

(3) Identifying theory and evidence-based behavior change methods that influence the determinants and translate these to practical applications that fit the intervention context.

(4) Combining the intervention components into a coherent program outline that uses delivery channels that fit the context.

1.16 Proposed study outline

Chapter 1: Introduction

Chapter 2: Article 1 – The impact of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities: A scoping review.

Chapter 3: Article 2 – A qualitative study on the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and their views on strategies that can be employed to reduce the noted adverse implications.

Chapter 4: Article 3 – Development of an intervention to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

Chapter 5: Conclusion, limitations, and recommendations.

Reference List

Aeneas, M. A. & Sandìn, M. P. 2009. Intercultural and cross-cultural communication research: some reflections about culture and qualitative methods. *Forum: Qualitative Social Research*, 10(1). https://doi.org/10.17169/fqs-10.1.1251

Ahmed, A. 2008. Ontological*, epistemological and methodological assumptions: qualitative vs quantitative*. Faculty of Education, Helwan University Egypt. https://files.eric.ed.gov/fulltext/ED504903.pdf Date of access: 2 June 2021.

Akhtar, I. 2016. *Research design. Interdisciplinary perspectives*. *Social research foundation*.1st ed. Kanpur, India. https://www.researchgate.net/publication/308915548_Research_Design Date of access: 29 August 2022.

Albougami, A. 2015. Role of language and communication in providing quality healthcare by expatriate nurses in Saudi Arabia. *Journal of Health Specialties*, 3(3). http://www.thejhs.org/article.asp?issn=2468-6360;year=2015;volume=3;issue=3;spage=166;epage=172;aulast=Albougami Date of access: 9 Mar. 2021.

Almutairi, K. M. 2015 Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal*, 36(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4404475/#ref21 Date of access: 16 Apr. 2019.

Alshenqeeti, H. 2014. Interviewing as a data collection method: A critical review. *English Linguistics Research*, 3(1). http://dx.doi.org/10.5430/elr.v3n1p39

Anney, V. N. 2014. Trustworthiness. Helen Foster-Collins, Department of Education. University of Exeter, UK. South East Network for Social Sciences. https://sentiojournal.uk/wp- Date of access: 29 Aug. 2020.

Arksey, H. & O'Malley, L. 2005. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1). https://doi.org/10.1080/1364557032000119616

Auwalu, I. A & Yunusa, M. 2015. *The meaning and theories of intercultural communication.* Faculty of social and management sciences. (Working paper).

Department of Mass Communications. Bayero University, Kano. DOI:10.13140/RG.2.2.14026.36806

Awasom, N. F. 2021. Cultural barriers in healthcare delivery from the perspective of patients. Uppsala University, Disciplinary Domain of Medicine and Pharmacy, Faculty of Medicine, Department of Public Health and Caring Sciences. Thesis (Bachelors). urn:nbn:se:uu:diva-442091 Date of access: 13 Feb. 2024.

Babbie, E. & Mouton, J. 2001. *The practice of social research*. South African ed. Oxford University Press, Cape Town. https://books.google.co.za/books/about/The_Practice_of_Social_Research.html?id=vdOgQ gAACAAJ Date of access: 16 Jun. 2022.

Bahari, S. F. 2010. Qualitative versus quantitative research strategies: contrasting epistemological and ontological assumptions. University Teknologi Malaysia. *Sais Humanika*, 52(1). DOI: https://doi.org/10.11113/sh.v52n1.256

Berger, C. R. & Calabrese, R. J. 2006. Some exploration in initial interaction and beyond: Towards a developmental theory of interpersonal communication. *Human Communication Theory*, 1: 99-122. https://doi.org/10.1111/j.1468-2958.1975.tb00258.x

Bezuidenhout, R., Davis, C. & du Plooy- Cilliers. 2014. *Research Matters*. Juta and Company Ltd. http://search.ebscohost.com.ezproxy.iielearn.ac.za/login.aspx?direct=true&db=nlebk&AN=7 46917&site=ehost-live Date of access: 17 Sept. 2022.

Bird, C. 2016. Interviews. Perspectives on data science for software engineering. https://doi.org/10.1016/B978-0-12-804206-9.00025-8

Bradley, J. 1993. Methodological issues and practices in qualitative research. *Library Quarterly* 63(4):431-449. https://www.jstor.org/stable/4308865 Date of access: 18 May 2022.

Bowen, G. 2009. Supporting a grounded theory with an audit trail: an illustration. *International Journal of Research Methodology*, 12(4). DOI:10.1080/13645570802156196

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative*

Research in Psychology, 3(2):77-101. http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised

Burns, N. & Grove, S. K. 2003. *The practice of nursing research: conduct, critique and utilization*. 4th ed. Toronto, Canada. WB Saunders, Philadelphia. https://www.scirp.org/(S(vtj3fa45qm1ean45vvffcz55))/reference/ReferencesPapers.aspx?R eferenceID=1575182 Date of access: 21 Apr. 2022.

Butraporn, P., Pach, A., Pack, R., Masngarmmeung, R., Maton, T., Sri-aroon, P., Nyamete, A. & Chaicumpa, W. 2004. The health belief model and factors relating to potential use of vaccine for shigellosis in Kaeng, Koi Province Thailand. *Journal of Health, Population, and Nutrition*, 22(2):170-181. http://www.bioline.org.br/pdf?hn04022 Date of access: 13 Jan. 2019.

Byren, D. 2021. A worked example of Braun and Clarke's approach to reflective thematic analysis. *Quality and Quantity,* 56*.* https://doi.org/10.1007/s11135-021-01182-y

Champion, V. L. & Skinner, C. S. 2008. *The health belief model. Health behavior and health education: Theory, research, and practice.* Jessey-Bass, San Francisco. https://www.scirp.org/(S(vtj3fa45qm1ean45vvffcz55))/reference/referencespapers.aspx?referenceid=1456167 Date of access: 18 May 2023.

Chiehi, L., Abdulkerim, N., Jordans, C. A., Ga Eun Son, C. 2017. Overcoming communication barriers to healthcare for culturally and linguistically diverse patients. *North American* Journal *of Medicine and Science*, 10(30). https://www.exeley.com/exeley/journals/north_american_journal_of_medicine_and_scie nce/10/3/pdf/10.7156_najms.2017.1003103.pdf Date of access: 11 Feb. 2019.

Cohen, L. & Manion, L. 1994. Research *methods in education*. Longman. London. https://www.scirp.org/(S(351jmbntvnsjt1aadkposzje))/reference/ReferencesPapers.aspx?ReferenceID=1499667 Date of access: 04 Sept. 2019.

Creswell, J. W. 2014. *Research Design: qualitative, quantitative and mixed methods approach.* University of Nebraka- Lincon. SAGE. https://in.sagepub.com/en-in/sas/research-design/book237357. Date of access: 03 Jun. 2019.

Crotty, M. 1998. *The* foundations *of social research. Meaning and perspective in the research process.* National Library of Australia. SAGE Publications.

https://seminariodemetodologiadelainvestigacion.files.wordpress.com/2012/03/the-foundations-of-social-research-meaning-and-perspective-in-the-research-process-michael- crotty.pdf Date of access: 22 Jul. 2022.

de Moissac, D. & Bowen, S. 2018. Impact of language barriers on quality of care and patient safety for official language minority francophone in Canada. *Journal of Patient Experience*, 6(1). https://journals.sagepub.com/doi/pdf/10.1177/2374373518769008

Drew, C. J., Hardman, L. M. & Hosp, J. L. 2007*. Ethical issues in conducting research. Overview of research*. SAGE Publications. https://www.sagepub.com/sites/default/files/upm-binaries/26094_3.pdf Date of access: 23 Dec. 2018.

Elhami, A. 2020. *Communication accommodation theory: a brief review of the literature.* ResearchGate*.* https://www.researchgate.net/publication/341252455. Date of access: 24 Feb. 2022.

Elmelegy, O. I. A. & El Madhy, N. F. 2018. Application of the health belief model- based educational intervention on hand hygiene performance of intensive care units' nurses. *Journal of Health, Medicine, and Nursing*, 47. https://pdfs.semanticscholar.org/efa0/14a1760c09d82f01185f4f2789d91452e9f7.pdf Date of access: 28 Jul. 2022.

Ellahham, S. 2021. Communication in healthcare: impact of language and accent on healthcare safety, quality and patient experience. American Journal of Medical Quality, 36(5). DOI: 10.1097/01.JMQ.0000735476.37189.90

Farooqi, S. R. 2014. The construct of relationship quality. *Journal of Relationships Research*, 5. https://doi.org/10.1017/jrr.2014.2

Fernandez, M. E., Ruiter, R. A. C., Markham, C. M. & Kok, G. 2019. Intervention mapping: theory-and evidence-based health program planning: perspectives and examples. *Front Public Health*, 7(209). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6702459/ Date of access: 28 Jul. 2022.

Fong Ha, J. & Longnecker, N. 2010. Doctor-patient communication: A review. *The*

Oschsner Journal, 10(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/ Date of access: 25 Apr. 2019.

Gasiorek, J., Weatherall, A. & Watson, B. 2021. Interactional adjustment: three approaches in language and social psychology. *Journal of Language and Social Psychology*, 40(10). https://doi.org/10.1177/0261927X20965652

Gelling, L. 1999. Ethical principles in healthcare research. *Nursing Standard*, 13(36):39-42. http://journals.rcni.com/doi/pdfplus/10.7748/ns1999.05.13.36.39.c2607

Giles, H., & Ogay, T. 2007. *Communication Accommodation Theory. Explaining communication: Contemporary theories and exemplars.* Lawrence Erlbaum Associates Publishers. https://www.researchgate.net/publication/285632911_Communication_accommodation_the ory Date of access: 09 Aug. 2022.

Goold, D. S. & Lipkin, M. 1999. The doctor-patient relationship. Challenges, opportunities, and strategies. *Journal of General Internal Medicine*, 14(1). https://pubmed.ncbi.nlm.nih.gov/9933492/

Gudykunst, W. B. 2005. *An anxiety/ uncertainty management (AUM) theory of effective communication making the mesh of the net finer: theorizing about intercultural communication*. Thousand Oaks, California: SAGE Publications. https://psycnet.apa.org/record/2005-01619-013 Date of access: 08 Jan. 2021.

Hagens, V., Dobrow, M. J. & Chafe, R. 2009. Interviewee transcript review: assessing the impact on qualitative research. BMC Medical Research Methodology, 9(47). Doi: 10.1186/1471-2288-9-47

Hiller, J. 2016. *Epistemological* foundations *of objectivist and interpretivist research.* Music Therapy Research*.* 3rd. Ed. Barcelona. https://www.researchgate.net/publication/288832152_EPISTEMOLOGICAL_FOUNATIONS_OF_OBJECTIVIST_AND_INTERPRETIVIST_RESEARCH Date of access: 23 Jun. 2022.

Hochbaum, G., Rosenstock, I. & Kegels, S. 1952. *Health belief model*. United States Public Health Service. http://www.infosihat.gov.my/infosihat/artikelHP/bahanrujukan/HE Date of access:

09 Feb. 2019.

Ibrahim, A. M. 2012. *Thematic analysis: A critical review of its process and evaluation*. WEI International European Academic Conference Proceedings, Zagreb, Croatia, 14 - 17 October.http://www.westeastinstitute.com/wp-content/uploads/2012/10/ZG12-191- Mohammed-Ibrahim-Alhojailan-Full-Paper.pdf Date of access: 01 Jan. 2019.

Jamshed, S. 2014. Qualitative research method-interviewing and observation. *Journal of Basic Clinical Pharmacy,* 5(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194943/ Date of access: 21 February 2019.

Jhaiyanuntana, A. & Nomnian, S. 2020. Intercultural communication challenges and strategies for all Thai undergraduate hotel interns. *Journal of Language Teaching and Learning in* Thailand*,* 59. http://www.culi.chula.ac.th/publicationsonline/home_p1.php Date of access: 27 May 2022.

Jones, C. L., Jensen, J. D., Weaver, C. L., Scherr, N., Brown, R. & Christy, K. 2014. The health belief model as an explanatory framework in communication research: exploring parallel, serial and moderated mediation. *Health Communication*, 6(30). www.ncbi.nlm.nih.gov Date of access: 03 Apr. 2019.

Jones, M. E. 2019. Personal adjustment, language acquisition and culture learning in short term cultural immersion. *Journal of Phi Beta Delta Honor Society for International Scholars,* 9(1). https://files.eric.ed.gov/fulltext/EJ1271933.pdf Date of access: 23 Oct. 2023.

Karuthan, A., Kaur, S., Krishnan, K., & Abdullah, L. K. 2018. Communication accommodation: do nurses and patients speak the same language? *ASM Science Journal*, 13(5). https://www.akademisains.gov.my/asmsj/article/communication-accommodation-do- nurses-and-patients-speak-the-same-language/ Date of access: 03 Jul. 2021.

Karuthan, C. & Karuthan, A. 2019. Communication accommodation in healthcare provider- patient exchange. *ASM Science Journal*, 13(5). https://www.akademisains.gov.my/asmsj/article/communication-accommodation-in-

healthcare-provider-patient-exchange/ Date of access: 10 Jul. 2022.

Koch, T. 1993. Establishing rigor in qualitative research: the decision trail. Journal of Advanced Nursing, 53(1). https://doi.org/10.1111/j.1365-2648.2006.03681.xopen_in_new

Levac, D., Colquhoun, H. & O' Brein, K. 2010. Scoping studies: advancing the methodology. *Implementation Studies,* 5(69). https://doi:10.1186/1748-5908-5-69

Mabuda, B. T. 2009. Student *nurses' experiences during clinical practice in the Limpopo province*. Pretoria: University of South Africa. (Thesis-PHD). http://uir.unisa.ac.za/handle/10500/1961 Date of access: 03 Dec. 2018.

Maguire, M. & Delahunt, B. 2017. Doing a thematic analysis: A practical step-by-step guide for teaching and learning scholars. *All Ireland Journal of Higher Education*, 9. http://ojs.aishe.org/index.php/aishe-j/article/view/3354 Date of access 13 May 2022.

Miller, D. C. & Salkind, N. J. 2002. *Handbook of research design and social measurement.* 6th ed. SAGE Publications. https://books.google.co.ls/books?hl=en&lr=&id=sgoHv5ZP6dcC&oi=fnd&pg=PR19&dq= research+design+definition&ots=VoCsWx8ojy&sig=hZzP6arL8LsTcpP96UlelG-qpnw&redir_esc=y#v=onepage&q=research%20design%20definition&f=false Date of access: 15 Jun. 2018.

Mlambo, N. 2017. Multilingualism in healthcare: Communicative *experiences of expatriate healthcare providers with varying linguistic repertoires in Windhoek Namibia.* Department of General Linguistics. Stellenbosch University. (Thesis-Masters). http://hdl.handle.net/10019.1/102832 Date of access: 19 Jun. 2022.

Mokuoane, M. C. N. 2018. *The reflection of language in culture and identity: A case of Basotho in the Free State and Lesotho*. Faculty of Humanities. Central University of Technology, Free State. (Thesis-Masters). http://hdl.handle.net/11462/1917 Date of access: 29 May 2022.

Mokuoane, M. C. N. & Moeketsi, V. S. M. 2018. The role of Sesotho language and culture in shaping identities of speakers: A case of Basotho in Free State and Lesotho. *Interdisciplinary Journal*, 17(1).

https://journals.co.za/content/journal/10520/EJC- 14f2cd35f0 Date of access: 30 Mar. 2019.

Mosadeghard, M. A. 2013. Healthcare service quality: towards a broad definition. *International Journal of Health Care Quality Assurance*, 26(3). https://www.ncbi.nlm.nih.gov/pubmed/23729125 Date of access: 02 Feb. 2019.

Newton, N. 2010. *The use of semi-structured interviews: strengths and weaknesses.* Exploring qualitative methods. https://www.academia.edu/1561689/The_use_of_semi-structured_interviews_in_qualitative_research_strengths_and_weaknesses Date of access: 21 Dec. 2018.

Olani, B. A., Olani, A. B., Muleta, B. T., Rikitu, H. D. & Disasa, K. 2023. Impacts of language barriers on healthcare access and quality among Afaan Oromoo-speaking patients in Addis Ababa, Ethiopia. BMC Health Services Research, 23(39). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09036-z Date access: 13 Feb. 2024.

Paez, A. 2017. Grey literature: an important resource in systematic reviews. *Journal of Evidence-based Medicine.* https://pubmed.ncbi.nlm.nih.gov/28857505/ Date of access: 21 May 2019.

Peterson, J., Pearce, P. F., Ferguson, L. A. & Langford, C. A. 2016. *Understanding scoping reviews: Definition, purpose, and process.* School of Nursing, Loyola University. https://onlinelibrary.wiley.com/doi/pdf/10.1002/2327-6924.12380 Date of access: 26 Apr. 2019.

Rabiah, S. 2012. *Language as a tool for communication and cultural reality disclosure*. Faculty of Letter. Universitas Muslim Indonesia, Makassar. DOI:10.31227/osf.io/nw94m

Rosenstock, I. M. 1974. *Historical origins of the health belief model.* School of Public Health, University of Michigan. https://journals.sagepub.com/doi/10.1177/109019817400200403

Rosky, M. 2015. Overcoming *language barriers in health care services in the medical tourism context: Health care companies' perspective*. School of Business, Aalto

University (Thesis-Masters). www.aalto.fi: Date of access: 12 Feb. 2019.

Sandìn, P. M. & Aeneas, M. A. 2009. Intercultural and cross-cultural communication research: some reflections about culture and qualitative methods. *Forum: Qualitative and Social Research*, 10(1). https://doi.org/10.17169/fqs-10.1.1251

Saunders, J. A & Wiseman, R. L. 1993. Uncertainty reduction among ethnicities in the United States. *Intercultural Communication Studies* 3. https://www.semanticscholar.org/paper/Uncertainty-Reduction-Among-Ethnicities-in-the- Sanders-Wiseman/b13d59fa9bd142749e3aa4bbd80e637062080fce Date of access: 08 May 2022.

Schimdt, M., Steigenberger, N., Berndtzon, M, & Uman, T. 2023. Cultural diversity in healthcare teams: a systematic integrative review and research agenda. Health Care Manage Rev, 48(4). DOI: 10.1097/HMR.0000000000000379

Schyve, P. M. 2007. Language differences as a barrier to quality and safety in health care: The joint commission perspective. *The Journal of General Internal Medicine*, 22(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2078554/

Selete-Koseng, L & Van Vuuren, S. 2019. Medicinal plants used for the treatment of sexually transmitted infections in the Maseru district, Lesotho. Antimicrobial validation, phytochemical and cytotoxicity studies. *South African Journal of Botany*, 122. DOI:10.1016/j.sajb.2019.01.035

Shahnazarian, D., Hagemann, J., Aburto, M. & Rose, S. s.a. *Informed consent in human subjects research*. Office for the protection of research subjects. University of Southern California. http://oprs.usc.edu/files/2013/04/Informed-Consent-Booklet4.4.13.pdf Date of access: 02 Jan. 2019.

Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2). DOI:10.3233/EFI-2004-22201

Sibblad, S., Macgregor, J. C. D., Surmacz, M. & Wathen N. 2015. Into the grey literature: a modified approach to citation analysis to better understand research impact. *Journal of Medical Library Association*, 103(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279935/ Date of access: 29 Aug. 2019.

Smith, D. 2003. Five principles for research ethics. *American Psychology Association,* 34(1):56. http://www.apa.org/monitor/jan03/principles.aspx Date of access: 26 Feb. 2019.

Sobane, K. M. E. 2013*. Language* discordant *HIV/AIDS interactions in Lesotho health care centers*. Stellenbosch University. (Thesis-PhD). https://scholar.sun.ac.za/handle/10019.1/80323 Date of access: 21 Mar. 2018.

Sobane, K. M. 2015. Communication challenges experienced in Lesotho clinics where physicians speak both the community language and lingua franca. *Journal of Social Sciences,* 43(3). https://www.tandfonline.com/doi/abs/10.1080/09718923.2015.11893445 Date of access: 14 May 2021.

Spencer-Oatey, H. 2012. What is culture? A compilation of quotations. GlobalPAD Core Concepts. https://warwick.ac.uk/fac/soc/al/globalpad/openhouse/interculturalskills_old/global_pad_-_what_is_culture.pdf. Date of access: 12 Nov. 2019.

Stahl, A. N & King, J. R. 2020. Expanding approaches for research: understanding and using trustworthiness in qualitative research. *Journal of Development Education*, 44(1). https://www.jstor.org/stable/45381095 Date of access:17 Jul. 2022.

The National Committees for Research Ethics in Norway. 2005. *Guidelines for research ethics in the social sciences, law, and the humanities*. https://graduateschool.nd.edu/assets/21765/guidelinesresearchethicsinthesocialscienceslawhumanitiespdf. Date of access: 23 Feb. 2019.

Thuube, M. R. 2015. Communicative problems of interpreting during cross-linguistic interactions between non-Sesotho speaking Doctors and monolingual Basotho patients in Lesotho hospitals. *Journal of Humanities*, 2(3). https://journals.nul.ls/index.php/tsebo/article/view/5 Date of access: 27 Jun. 2022.

Turner, L. W. & Hunt, S. B. 2004. Design and implementation of an osteoporosis prevention program using the health belief model. *American Journal of Health Sciences*, 19. https://www.scirp.org/(S(351jmbntvnsjt1aadkposzje))/reference/ReferencesPapers.aspx?Re ferenceID=396442 Date of access: 18 Nov. 2022.

Van Mol, M., Nijkamp, M. & Markham, C. 2017. Using the intervention mapping approach to develop a discharge protocol for intensive care patients. *BMC Health Services*, 17(837). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2782-2 Date of access: 19 Jul. 2022.

Westphaln, K. K., Regoeczi, W., Masotya, M., Vazquez- Westphaln, B., Lounsburg, K., McDavid, L., Lee, H., Johnson, J. & Ronis, S. D. 2012. From Arksey and O'Malley and beyond: customization to enhance a team-based, mixed approach to scoping review methodology. *Journal of Child Abuse and Neglect*, 111. https://www.sciencedirect.com/science/article/pii/S2215016121001680

William, C. 2007. Research methods. *Journal of Business and Economic Research*, 5(3). **DOI** https://doi.org/10.19030/jber.v5in3.2532

Chapter 2

Article 1

Implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities: A scoping review

Abstract

Migration encourages and facilitates the movement of people leaving their home countries to pursue careers in various fields worldwide. The healthcare sector is no exception. Due to different pull and push factors, people migrate to pursue careers in healthcare. In contrast, other people migrate in search of healthcare facilities that can provide quality care and treatment for themselves and their families. This leads to the interaction of people who have different languages and cultures. However, this has been shown to pose some challenges that can hinder the delivery of quality healthcare in settings where patients and healthcare practitioners do not share a common language and culture. This study aims to review and examine the available literature to fill gaps in the scientific work on the implications of language and cultural differences on the quality of healthcare provided by practitioners who do not share a common language and culture with patients in healthcare facilities. Given the aim of this study, a scoping review was conducted according to Arksey and O'Malley's framework (2005). Five database search platforms were utilized to find some inclusive search results from CINAHL, PUBMED, Google Scholar, APA, and PSYCHOINFO to answer the research question which was as follows: *What does the existing literature reveal about implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?* A total of 18115 peer-reviewed articles were identified. Using distinct inclusion and exclusion criteria, 23 articles were then retained for analysis. They were conducted in 12 countries across the globe. Findings reveal that the presence of language and cultural differences between patients and healthcare practitioners adversely affects the delivery of quality healthcare, particularly by influencing poor communication, delayed diagnoses and treatments, failure to build rapport, decreased empathy, mistrust, poor patient compliance, increased stress and anxiety, increased patient frustrations, increased avoidance behavior, non-disclosure of medically relevant information, and medical errors.

Keywords: *Language and cultural differences, healthcare practitioners, patients, and quality healthcare*.

2.1 Introduction

The ongoing trend towards globalization has led to an increase in international migration flows. More people leave their countries of origin and migrate to other countries to look for work, escape poverty, achieve greater security, and escape the effects of climate change (Burnett, 2002). However, these migrant groups often face communication challenges as they find it difficult to interact with the people in the new host countries due to language and cultural differences. The healthcare sector is no exception to this trend, as there is an increased demand for the skills of practitioners in foreign labor markets (Allutis *et al.*, 2014). Several countries are experiencing an influx of expatriate health practitioners who have been recruited to provide their expertise in various healthcare facilities. They typically come from different linguistic and cultural backgrounds to those of the populations they serve. As defined in the context of this article, *language* is a medium used by patients to communicate their symptoms to doctors, who in turn use it to learn about the symptoms patients are experiencing, to communicate diagnoses, to communicate the health status of the patients, suggest treatments, recommend health-promoting behaviors, etc. (Allen *et al.*, 2007; Yeo, 2004). *Culture*, in turn, refers to the shared and learned values, beliefs, and norms of a particular group of people that are transmitted from one generation to the next, guiding ways of thinking and acting and influencing decision-making (Spencer-Oatey, 2012). It can be concluded that language and culture must be considered crucial factors in the healthcare context, as both play a key role in communication between a practitioner and a patient. Therefore, it is important to ensure the effectiveness and efficiency of communication in healthcare systems where there is an increase in the interaction of culturally and linguistically diverse groups of healthcare providers and patients.

In their new host countries, healthcare practitioners are forced to communicate with patients and colleagues who have different cultural backgrounds, a phenomenon defined as *intercultural communication* (Auwulu & Yunusa, 2015). This concept gained popularity due to the significant increase in human migration worldwide which results in an increasing rate of interaction between people from different cultural backgrounds. However, many multicultural healthcare organizations appear to be affected by a lack of adequate and effective intercultural communication. Such deficiencies often result in healthcare practitioners failing to advocate for the patients' rights and making beneficial

and health-promoting decisions on their behalf, which in turn often has negative consequences on patients' health outcomes (Holmqvist in Roysky, 2015:02).

In healthcare settings where linguistically and culturally diverse groups of patients and healthcare practitioners interact, it is important to focus on the implications of these differences on the quality of healthcare provided, as such environments are likely to serve as breeding grounds for incidents affecting both parties (de Moissac & Bowen 2018:01). Existing literature suggests that healthcare practitioners in settings where these barriers exist often fail to build trust and harmonious relationships with patients. In turn, patients are at increased risk of delayed or inappropriate treatments, misdiagnoses, costly and irrelevant tests, non-adherence to health plans, and even death (de Moissac & Bowen 2018:01; Fong Ha & Longnecker, 2010). Language and cultural differences have also been linked to practitioners' inability to read patients' nonverbal behavior; a phenomenon often associated with reduced job satisfaction (Sobane, 2015).

Therefore, it is important to ensure that both parties communicate in a manner that leads to good relationships, accurate diagnoses, a clear understanding of prescriptions, and consequently the provision of quality healthcare (Schyve, 2007). In the context of this study, *quality healthcare* is defined as the level at which healthcare services for individuals and populations increase the likelihood of achieving desired health outcomes (Mosadeghard, 2013). Findings from previous studies indicate that the discrepancies between the languages and cultures of patients and healthcare providers can negatively affect the delivery of quality healthcare.

Literature aimed at examining the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities is characterized by a wide range of methodological approaches, contexts, and settings. This hinders efforts to obtain an integrated perspective of research findings on the topic, making it difficult to develop evidence-based interventions to mitigate the existing challenges. Given the importance of this topic and the potentially serious consequences that a lack of adequate intercultural communication can have on healthcare, there is a need for a comparative synthesis of research findings through a review of existing literature on this topic to provide an integrated overview that could guide future research, provide new insights, support the conceptual clarification of constructs, assist in the identification of knowledge gaps and the mapping of literature which is likely to highlight areas that require further inquiry (Munn

et al., 2018).

In addition, Russell (2005) explains that this could help assess the strength of the available scientific evidence, helping identify connections within the existing literature, identifying key questions about the topic under investigation, theoretical or conceptual frameworks, and research methods that have been used previously and produced great results. This study aims to summarize and synthesize a wide variety of literature using a scoping review to provide an overview of existing studies on the implications of language and cultural differences on the quality of health care provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities.

2.2 Scoping review

A scoping review is an established methodology that aims to provide an overview of a broad and complex topic (Peterson *et al*., 2016). The aim is to map the literature on a specific research topic to provide an opportunity to identify knowledge gaps in the existing scientific and grey literature and to summarize the breadth of evidence from scientific work on emerging topics. This method involves systematically searching, selecting, and synthesizing existing knowledge (Levac *et al*., 2010). The use of a scoping review was considered relevant in the context of the present study as it focused on reviewing and identifying knowledge gaps, examining the diverse literature, and synthesizing concepts and themes related to this broad topic.

To guide the review, Arksey and O'Malley's (2005) scoping review framework was used. It comprises six stages of which five were relevant to this study: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing, and reporting the results, (6) consultation. (*The 6th stage is optional and is concerned with holding consultations with stakeholders to get additional information, perspectives, and insight beyond those found in the literature. For this study, the stage was omitted because the aim was to provide an overview of existing literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare settings*).

Following Arksey and O'malley's framework (2005), the first step entailed identifying the research question that would lead to effective search results. In the second step, the researcher identified relevant studies from various sources and databases that were

considered suitable to answer the research question based on the nature of the literature they contained. In the third phase, the researcher developed an appropriate set of inclusion and exclusion criteria that served to guide the final search protocol and the identification of literature to be included in the present study. In the fourth phase, the researcher created a data chart form **(see Appendix 8)** to systematically extract the relevant data from the selected studies which presented the salient features of the literature reviewed. The fifth phase included thematic analysis, in which the researcher examined the selected articles to extract the themes relevant to the scope of the study and that answer the research question.

To facilitate the implementation of the fifth phase, the researcher adopted Braun and Clarke's (2006) analytical approach framework for thematic analysis (TA), which includes six sequential phases. The remaining sections are devoted to detailed discussions of the execution of each of these stages.

2.2.1 Identifying the research question

Arksey and O'Malley (2005) noted that the first phase of a scoping review involves identifying the research question to be addressed, as this all-important step determines how search strategies should be developed. Due to the diversity and complexity of the literature, accuracy in identifying a research question was particularly important in the context of this study.

The presence of language and cultural differences in healthcare facilities hinders the access and delivery of quality healthcare. Therefore, they need to be given attention because if ignored, they are likely to lead to or worsen the occurrence of negative health experiences and poor health outcomes. This phenomenon appears to have attracted increased scholarly interest in recent years, necessitating an integrative review of the literature, which is the aim of the present study.

Furthermore, underscoring this need is the fact that the existing literature on this topic is scattered across numerous domains. The respective interest groups often approach the topic from divergent viewpoints, thus rendering it very difficult to achieve a coherent overview of the existing literature. This lack of coherence and integration makes the identification of directions for future research (as well as the consequent informing of intervention development) difficult.

Based on the above-noted reasons, the following research question was formulated to

guide the present scoping review:

> *What are the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?*

2.2.2 Identifying relevant studies

Following the phases suggested by Arksey and O'Malley (2005), the researcher began exploring and identifying appropriate databases in January 2021 in search for available literature. In line with the desired volume, depth, and diversity for the credibility and context of the current scoping review, the chosen platforms included: CINAHL, PubMed, Google Scholar, APA, and PSYCHOINFO. In these databases, the available literature was likely to depict results with maximum comprehensiveness, breadth, and inclusivity regarding evidence in the field of interest.

After experimenting with several Boolean operators to focus on the search, the search terms *language AND culture differences, healthcare practitioners, patients, AND quality healthcare* as well as related word variations, such as *"barriers",* produced the most effective results in the context of the research objective. To identify articles that may use similar keywords that relate to language and cultural differences in healthcare keywords, such as language and cultural barriers, migrants/foreigners, healthcare professionals, patients, quality healthcare, and hospitals were used to further broaden the search.

The search also included grey literature which produced information from outside traditional publishing and distribution channels. It includes diverse documents such as government reports, policy statements, theses and dissertations, fact sheets, and research reports that are typically distributed outside of peer-reviewed publications and distribution channels (Paez, 2017). It allows for the inclusion of information that may have been omitted due to publication bias (Bellefontaine & Lee, 2013). In addition, they often serve as a valuable source of data as they often include more recent studies, which may be more detailed as they have not been restricted by editors in terms of their length or scope (Sibbald *et al.*, 2015). In addition, the researcher referred to reference lists in the initially identified studies, which contained additional expert articles on the research topic that were not identified in the initial keyword search.

2.2.3 Study selection

Following Arksey and O'Malley's (2005) framework, in the third stage, the researcher

selected studies to be included in the scoping review. To facilitate this process, the researcher defined a set of inclusion and exclusion criteria by the guiding research question.

Inclusion criteria:

- The study was concerned with the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities.
- The study was written in English or has been translated into English.
- The study was conducted in the last decade (as such articles revealed current trends and evidence on the phenomenon being studied and as this period enabled tracing of scholastic progression in the field).

Exclusion criteria:

- The study represented a duplicate report.
- The study focused on a specific illness.
- The study's full text was not available even when efforts were made to obtain the full text.
- The study was written in a language other than English and was not translated into English.
- The study was undertaken over a decade ago.
- The study was not conducted within a healthcare facility.

Next, the researcher applied the previously described search protocol. Using the Boolean phrases as mentioned earlier, the database search produced the following results (refer to PRISMA chart below): Google Scholar delivered 17600 items, CINAHL produced 71 full-text items, PubMed produced 278 and APA PSYCHOINFO delivered 166. The accumulative total was 18115 research studies. The researcher removed 1206 duplicates, leaving 16909 titles, of which 14166 were excluded based on their titles which displayed a lack of relevance relative to the inclusion criteria. The remaining 2743 titles were subjected to abstract appraisal and their relevance was evaluated in terms of the research question and the specified inclusion and exclusion criteria. On this basis, a

further 2205 publications were excluded. The remaining 538 studies were subjected to full-text scrutiny to determine their relevance to the current review, resulting in the exclusion of an additional 521 studies. Additionally, reference lists of the remaining 17 studies were inspected for further studies to be considered, which yielded 2 additional publications. Grey literature searches resulted in the consideration of 4 additional recent studies. Thus, 23 publications formed the basis for the current scoping review (see Figure 1 for an overview of the search process).

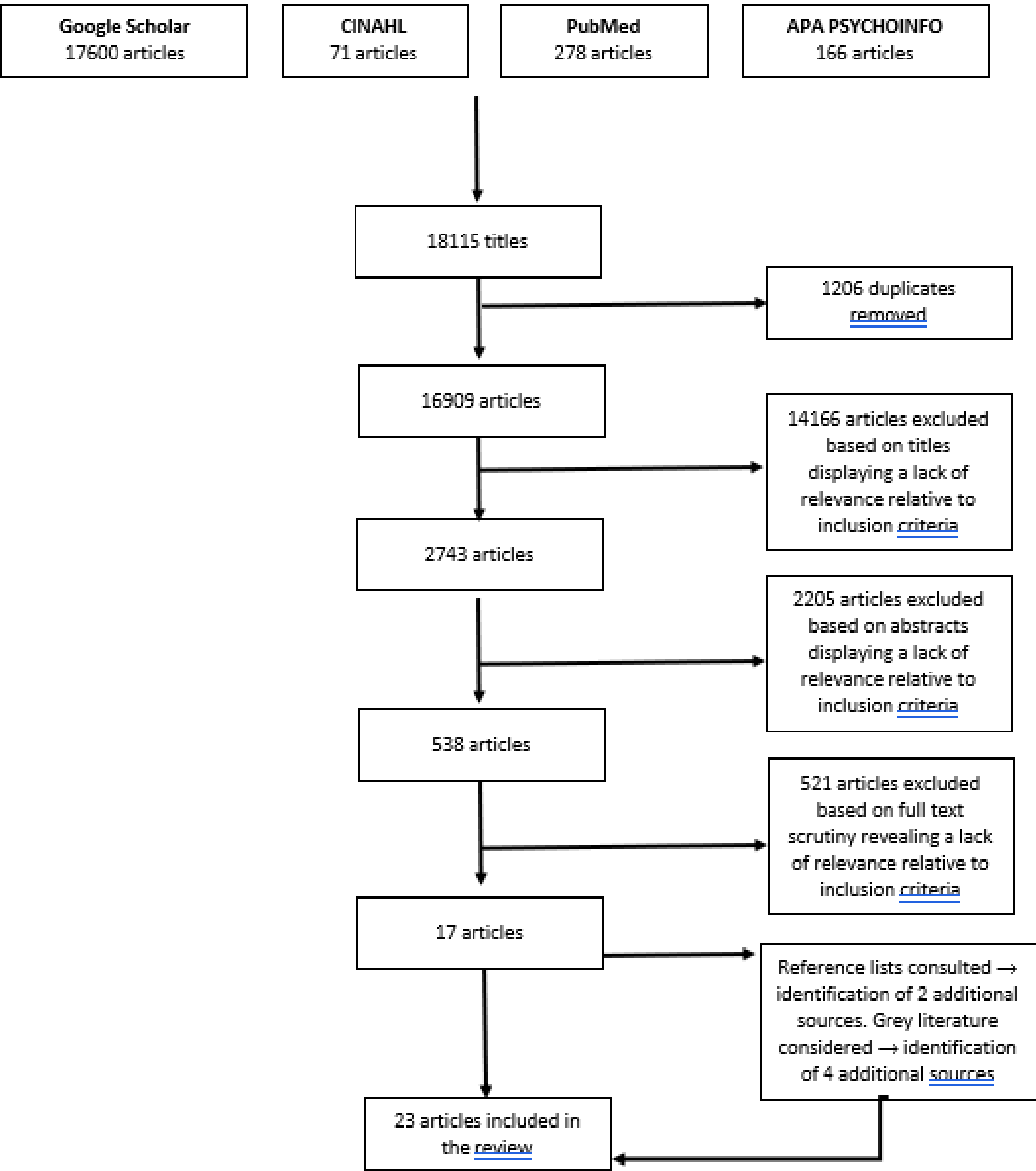


Figure 1. Prisma chart

Charting data

Following Arksey and O'Malley's (2005) framework, in the fourth phase, the researcher developed a data charting form using an iterative method that required continuous

updating and refinement (see Appendix 8). According to Levac *et al.* (2010), a data charting form allows a researcher to extract and document variables related to the research question. For the scoping review, only data related to the implications of language and culture differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities were depicted in the data-charting graph.

The following key variables were charted: *Year of publication, type of publication, aims of the study, sample size, research design, results, region, and healthcare setting*. According to Levac *et al.*, (2010), these categories enable the obtaining of an overview of the contextual and methodological aspects that characterize the existing research and are likely to facilitate the identification of gaps and the outlining of recommendations for future research regarding the research question.

The data charting results (as reflected in Appendix 8) suggest that a significant proportion of the literature on the phenomenon being studied is empirical (15 studies). As such, these studies are based on data gathered from original experiments and observations. Only six publications were theoretical, and a further two were expert opinions. Given the relatively small number of publications involved, it is evident that not just the empirical, but in particular the theoretical evidence and expert opinions relating to this topic are relatively scarce and that additional theoretical and empirical work is required to verify and expand upon the existing findings.

The data charting results further reveal that among the selected group of publications, nine had qualitative designs, four had quantitative designs, and one had a mixed-methods design. As such, there is a relative paucity of quantitative and mixed-methods studies on the topic in question, therefore, there is a need for more studies of these types to be conducted to provide a more complete picture and deeper insight into the topic under investigation to enable verification of the available findings.

Sample sizes varied widely, with qualitative studies ranging from 8 to 84 participants, and quantitative studies ranging from 93 to 717 participants, while the mixed-method study included 32 participants.

In the context of these studies, culture and language diversities that exacerbated the delivery of poor-quality healthcare were approached from varying viewpoints. In total, 12/23 articles investigated the impact of language and cultural barriers on the delivery of

healthcare; 2/23 investigated the lived experiences of patients and healthcare practitioners in multicultural healthcare settings regarding the impacts of language and cultural barriers; 4/23 investigated the facilitators of language and cultural barriers in healthcare settings; 1/23 investigated how dialect barriers contributed to ineffective communication in healthcare settings; 1/23 focused on the communication practices among nurses and patients and how they affected patient satisfaction; 1/23 examined how the nursing workforce narrated language barriers; and 2/23 focused on how language barriers in intercultural health communication could be mitigated.

Results from the data charting form show that the included studies were conducted in various places: nine were conducted in Saudi Arabia, two in South Africa, one in the Arabian Gulf, one in the Netherlands, one in Ghana, one in England, one in China, one in Namibia, one in Lesotho, one Qatar, one in South Korea, one in the United States, and two literature reviews covered studies that were conducted across the globe. From this, it is evident that most of the studies were conducted in the Middle East, specifically in Saudi Arabia. This is intriguing given that migration within the healthcare sector is a global phenomenon and that different groups of people with unique norms, beliefs, customs, religions, and languages interact to ensure access to and provision of quality healthcare across many regions of the world. Therefore, the cultural norms, values, beliefs, language dialects, and patterns that prevail in different contexts are likely to be reflected in unique experiences and perspectives of this situation, this paucity of studies beyond the Middle East therefore represents a significant gap. As such, future research on the same topic should be conducted in other regions to establish how their exclusive migration patterns combined with dominating languages and cultures may influence how patients and healthcare practitioners experience and perceive the implications of language and culture on the delivery of healthcare. This will contribute significantly to the existing literature on the topic.

2.2.4 Thematic analysis - Core themes

The researcher then proceeded to the fifth stage of Arksey and O'Malley's (2005) framework, which involved compiling, summarizing, and reporting the results. To accommodate this step, the 23 articles were subjected to a framework analysis approach and thematic analysis as proposed by Braun and Clarke (2006). Here the researcher aimed to provide a comprehensive framework for the scope of the literature.

Following the recommendations of Braun and Clarke (2006), in the first phase of this

approach, the researcher familiarized herself with the data by repeatedly reading through the selected articles to understand the meanings and patterns found in the data. In the second phase, the initial codes were generated. In the third phase, the codes resulting from the data set were collected and sorted into main themes and subthemes. In the fourth phase, the researcher refined the themes to determine whether they formed a coherent pattern that reflected a valid representation of the data set or whether there was a need to merge some themes or break them down further into new themes. In the fifth phase, the researcher reflected on each theme captured thus far, narrated it about the theme under study, and then named the themes accordingly to reflect the key findings that emerged from the data. In the final phase, a report was written detailing the themes from the dataset related to the phenomenon under study. (Refer to Chapter 1 for a more detailed discussion of this process).

The remainder of this section is devoted to a discussion of the themes that were generated during the analysis.

2. 2. 5. 1 Findings: The implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities.

Eleven themes were identified. As will be discussed next, the themes were: poor communication, delayed diagnoses and treatments, failure to build rapport, decreased empathy, mistrust, poor patient compliance, increased stress and anxiety, increased patient frustrations, increased avoidance behavior, non-disclosure of medically relevant information, and medical errors.

Poor communication

A theme that emerged during the analysis was poor communication. Findings suggest that language and cultural differences lead to discrepancies in information exchange between healthcare practitioners and patients who do not share a common language and culture. This was reflected in a lack of congruence between the information conveyed and the information understood. A study conducted in Saudi Arabia found that language and cultural differences limited effective communication between patients and healthcare practitioners. As a result, the two parties struggled to adequately share important health-related information (Alhamami, 2020). Similarly, a study conducted to examine the language and communication barriers within Saudi Arabia's healthcare systems found that the existence of these barriers resulted in poor communication between nurses and

patients (Albougami, 2015). Furthermore, physicians stated that poor communication of health-related information was a major concern as it greatly hampered the exchange of information required to diagnose patients (Alshammari *et al.*, 2019).

These findings highlight that linguistic and cultural discrepancies often disrupt the proper flow of important health-related information needed to help healthcare practitioners gain a clear understanding of a patient's situation, thereby hindering accurate diagnoses and likely leading to the administration of incorrect treatments thus failing to achieve positive health outcomes.

Delayed diagnoses and treatments

Another theme identified was delayed diagnoses and treatment. Findings point out that language and cultural differences between patients and healthcare practitioners often lead to lengthy consultations because the two parties take longer to understand each other, leading to delays in patient diagnoses and consequent delays in providing treatments. A qualitative study conducted in Saudi Arabia found that when there are language barriers between patients and healthcare professionals in healthcare settings, consultations become lengthy as it takes longer for healthcare professionals to understand the information conveyed by patients. This results in delayed diagnoses and administering of treatments (Alhamami, 2020). Another qualitative study was conducted to examine language barriers and their impact on patient care in England. Findings show that these barriers result in delays in the support given to patients because consultations take a long time as the nurses face some difficulties understanding vital information narrated by patients (Ali & Watson, 2018). Finally, in an article that focused on transcultural and linguistic barriers to patient care in South Africa, results show that consultations take longer because patients have difficulties communicating with doctors who do not understand their language (Naidoo, 2014).

In conclusion, the literature indicates that language and cultural differences are significant reasons for delayed support given to patients because consultations become lengthy as patients and healthcare practitioners struggle to understand each other. This indicates another important factor relaying how these discordances could affect the delivery of quality healthcare.

Failure to build rapport

Another significant theme was the failure to build a rapport. Communication forms the

foundation of a relationship between a patient and a healthcare practitioner and is necessary to establish the mutual rapport required to achieve positive health outcomes. In particular, the findings suggest that the presence of language and cultural differences between healthcare professionals and patients often results in the two parties failing to build close and harmonious relationships.

A mixed methods study was conducted to examine barriers and facilitators of effective communication between nurses and patients in the Saudi Arabian cultural context. The findings show that patients and caregivers are unable to establish good relationships due to communication difficulties attributed to cultural differences (Albagawi, 2014). Furthermore, an empirical study conducted in Qatar to examine patients' perspectives on language discordance found that patients are unable to form meaningful relationships with healthcare professionals. They stated that they feel like they come from different worlds and therefore cannot relate well with them (Abderahim *et al*., 2017).

In addition, a qualitative study conducted in Saudi Arabia to examine cultural and linguistic differences found that nurses are unable to communicate effectively and build harmonious relationships with patients due to language barriers and this creates a hostile environment (Almutairi, 2015). A qualitative study was undertaken in UAE, to identify language-related communication barriers that expatriate (non-Arabic) healthcare practitioners encounter in their daily routine. Findings from this study pointed out that the practitioners expressed that they felt alone because they perceived themselves as burdens to their colleagues due to having to beg daily for assistance in translations with patients instead of having social conversations that could contribute to the building of harmonious work relationships (Al-Yateem *et al*., 2023). Similarly, an article that focused on transcultural and linguistic barriers to patient care in South Africa also found that the doctor-patient relationship is most likely to break down when language barriers are present (Naidoo, 2014). Furthermore, a study designed to examine the discourse on communication challenges between expatriate physicians and Arabic-speaking patients in the Arabian Gulf found that participants (physicians and patients) reported that communication challenges hinder the development of good doctor-patient relationships (Malik & Khan, 2020). Finally, findings from a qualitative study conducted in Lesotho to examine communication in the organizational structure of local medical centers in HIV and AIDS care centers found that effective communication is limited in these centers because language barriers hinder face-to-face communication during clinical encounters. This negatively impacts the doctor-patient relationship, thereby hindering the achievement of

positive health outcomes (Sobane, 2013).

These results highlight that the presence of language barriers and cultural differences between patients and healthcare professionals often lead to communication gaps, which then contribute to the failure of the two parties to build a good relationship which is problematic because rapport is a critical element in fostering positive clinical outcomes (Butt, 2021).

Decreased empathy

Another significant theme that emerged from the scoping review was the decreased empathy that healthcare practitioners either felt and/or demonstrated toward patients. Empathy focuses on understanding and compassionately dealing with the next person's situation (Reiss, 2017).

Existing literature suggests that healthcare practitioners sometimes fail to show empathy due to their inability to communicate well during interactions with patients, which occurs as a result of the presence of language and cultural differences. Findings from an article that focused on transcultural and linguistic barriers to patient care in South Africa show that in cases where these barriers exist, physicians often fail to relay empathy and warmth to patients (Naidoo, 2014). In addition, a literature review that was also undertaken in South Africa found that healthcare providers feel that the inability to understand patients' language affects their ability to be empathetic and kind (Van den Berg, 2016).

Findings from the literature illustrate that the presence of these discordances hinders efficient communication during consultations, this reduces the healthcare professionals' ability to sense patients' emotions and, consequently, to feel and display empathy.

Mistrust

Another significant theme that was identified centers on mistrust. Language and cultural differences often make it difficult for patients to trust doctors. This situation is complicated by the fact that the nature of their relationships compels patients to rely on doctors' skills and knowledge to meet their health needs. Problems arising from inconsistencies in language and culture contribute to the development of insecurities in patients. In response, they begin to doubt doctors' ability to correctly diagnose, and prescribe medications for them.

A qualitative study conducted to explore language barriers in a multilingual Saudi hospital

revealed that patients develop distrust of doctors who do not speak the same language as them. As a result, many patients believe that they have been misdiagnosed (Alhamami, 2020). In addition, another qualitative study conducted in Lesotho found that healthcare professionals within HIV/AIDS centers face communication difficulties and it found that this contributes to failure to gain the trust of their patients, particularly since they deal with HIV/AIDS, which is a sensitive issue (Sobane, 2013). Likewise, a quantitative study was conducted to assess the impact of language barriers in healthcare facilities in Saudi Arabia. Findings show that the barriers result in the patients not being able to communicate effectively with caregivers and that this reduces their confidence in the caregivers' abilities to support them with their health-related needs (Al-Harasis, 2013). Lastly, a literature review was conducted to examine the impact of language barriers on health service delivery in South Africa. The findings show that parents of patients in the children's wards report that they do not trust the diagnoses and treatments suggested by doctors due to communication difficulties that were a result of the existence of language barriers (Van den Berg, 2016).

In summary, the findings illustrate that the presence of language and cultural differences between patients and healthcare practitioners hinder effective communication, which according to Biyazin *et al.* (2022), is a fundamental element necessary for the development of trust between two parties in a therapeutic relationship. Distrust from patients, in turn, could jeopardize the delivery of quality healthcare as patients are less likely to adhere to prescribed treatment plans, as will be discussed next.

Poor patient compliance

Poor patient compliance was another theme identified in the scoping review. Findings revealed that the presence of language and cultural differences results in patients not understanding diagnoses, treatment, medical procedures, and their meaning, consequently ignoring them and not adhering to prescribed treatment protocols. The results of an integrative review suggest that these discrepancies lead to patients not following the nursing staff's instructions in hospitals in Saudi Arabia (Alshammari *et al.*, 2019). In addition, findings from a cross-sectional study state that cases of poor patient compliance occur as a result of unpleasant clinical encounters due to language barriers in healthcare settings in China (Zhang *et al.*, 2022). Furthermore, a qualitative study undertaken to explore language barriers reveals that communication difficulties due to language barriers in a multilingual hospital in Saudi Arabia result in patients not believing that prescribed treatments are correct and they consequently do not comply with such

(Alhamami, 2020).

This is an indication that the language and cultural differences between patients and healthcare professionals lead to conflicting views and perspectives that influence patients' decisions to refuse some of the treatments and procedures recommended to them by these doctors. As a result, patients are likely to suffer disease complications and disease progression, and they may lose their lives, all of which indicate negative health outcomes.

Increased stress and anxiety

Findings from several studies suggest that patients and healthcare practitioners are likely to be worried and experience stress, tension, and anxiety when faced with language and cultural differences in healthcare settings. A qualitative study examining language barriers in a multilingual Saudi hospital found that the inability of patients and healthcare professionals to communicate effectively during consultations due to language barriers causes them stress (Alhamami, 2020). Similarly, integrative research conducted in Saudi Arabia to identify and summarize evidence on communication practices between nurses and patients found that communication problems arising due to language barriers result in increased stress for nurses (Alshammari *et al.*, 2019).

The results suggest that these differences increase the likelihood of the occurrence of incidents that are likely to cause emotional distress to both parties. Stress and anxiety are associated with the deterioration of a patient's health, the development of new stress-related diseases by both parties, and lowered job satisfaction for the practitioners. All of this contradicts quality healthcare.

Increased patient frustration

The presence of language and cultural differences has been found to commonly result in increased frustration levels among patients. Findings suggest that many patients get angered and annoyed by their inability to satisfactorily engage with doctors during consultations. A qualitative study conducted to examine the lived experiences of American service members in South Korea found that members' inability to properly communicate during consultations and understand South Korean healthcare providers due to linguistic and cultural differences leads to frustrations (Turner, 2015). Similarly, an article looking at transcultural and linguistic barriers to patient care in South Africa found that patients' parents report that they have difficulties communicating with pediatricians who do not understand their language, as a result, they spend a long time in consultation

rooms, and this increases their frustrations (Naidoo, 2014).

This is an indication that the discordances lead to patients not understanding healthcare practitioners during consultations, resulting in them becoming irritated. As a result, they are likely to discontinue therapies and treatment plans, which could lead to further disease complications and progression, and sometimes fatalities.

Increased avoidance behavior

Increased avoidance behavior was also identified as a recurring theme. Findings show that healthcare professionals and patients avoid consultations with each other when they do not share a common language and culture to minimize adversities and inconveniences, they are likely to experience due to communication difficulties resulting from the presence of these barriers. A qualitative study was conducted to examine the impact of language barriers on the care of patients with limited English proficiency in England. The findings show that nurses avoid conversations with patients to avoid communication difficulties that ensue during consultations (Ali & Watson, 2018).

In addition, a systematic review undertaken in Saudi Arabian healthcare centers found that patients are hesitant to seek healthcare assistance for fear of not understanding them during consultations due to the presence of language barriers (Al-Kabani *et al*., 2020). Lastly, a South African study reveals that patients avoid consultations with some healthcare practitioners because of their inability to communicate properly when language barriers are present because according to them, such incidents turn out to be traumatic and scary (Naidoo, 2014).

The findings illustrate that the differences contribute to both patients and healthcare practitioners shying away from consultations to avoid enduring communication difficulties. For patients, this behavior could lead to failure to seek help the next time they become ill, which could lead to illness progression and complications that are likely to result in fatalities. For healthcare practitioners, this could result in patient abandonment which is associated with malpractice.

Non-disclosure of medically relevant information

Another theme that was identified centered on the non-disclosure of medically relevant information by patients to healthcare practitioners during consultations. The findings suggest that patients' inability to communicate well with doctors who have different cultural and linguistic backgrounds often leads patients to omit some medically relevant

information during consultations because they fear that they would not be able to properly convey this information in a way that the healthcare practitioner would understand.

A systematic review examining the impact of language barriers on healthcare found that healthcare practitioners noted that they often observe patients' behaviors such as giving vague responses which often signal withholding of some information during consultations when their ability to express themselves is limited by language barriers (Al Kabani *et al.*, 2020). Similarly, a qualitative study conducted in Lesotho found that patients sometimes omit health-related information during consultations because they are unable to sufficiently express themselves due to language barriers (Sobane, 2013). Finally, a comprehensive systematic review examining cultural and linguistic differences as a barrier to the provision of quality healthcare shows that patients sometimes fail to report adverse drug reactions to healthcare practitioners because of language barriers (Almutairi, 2015).

Findings from literature point out that the existence of language and cultural differences between patients and healthcare practitioners results in patients withholding some pertinent health-related information in fear of not being able to explain themselves properly or at times this occurs because they have limited vocabulary of the appropriate terms to utilize when communicating with practitioners who spoke a different language to theirs. This behavior is likely to result in misdiagnoses because healthcare practitioners are forced to diagnose patients based on incomplete information, this could also result in the administration of wrong medication which could lead to further illness complications, the development of new illnesses due to incorrect medication, and fatalities.

Medical errors

Several studies indicate that the existence of language and cultural differences prompts the committing of medical errors by healthcare practitioners. It has been found that the inability of patients and healthcare professionals to correctly exchange important health-related information during consultations leads to errors in the execution of healthcare processes such as diagnoses, prescriptions, and patient discharge procedures. Results from a qualitative study conducted in Armed Forces hospitals in Saudi Arabia show that misunderstandings that occur due to the presence of language barriers between patients and caregivers lead to the committing of medical errors (Al-Harasis, 2013). An article that focused on examining language and communication barriers within Saudi Arabia's healthcare systems also found that language barriers lead to misunderstandings between caregivers and patients, which subsequently results in the administration of incorrect

medications to patients, which could probably lead to complications and sometimes even fatalities (Albougami, 2015).

Evidence from the literature highlights that language and cultural differences between patients and healthcare professionals were the primary cause of misunderstandings that influenced the making of medical errors which were likely to negatively affect health outcomes.

2.3 Discussion

The purpose of this scoping review was to summarize and synthesize the available literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. The review specifically aimed to identify key themes and also to capture the scope and nature of the current literature to enable the identification of trends, gaps, and areas for future research.

Data charting

The scoping review captured recent evidence from 23 articles selected based on a set of inclusion and exclusion criteria. A data chart was created to depict the salient features of each article, thus extracting the pertinent information in the categories of the year of publication, type of publication, aims of the study, sample size, research design, results, country of origin, and healthcare setting. This structure assisted the researcher in creating a framework for the process of thematic analysis. From the data chart, it was noted that all the articles were published between 2013 and 2021, with 62% of these articles being published between 2016 and 2021, indicating a significant rising trend in the number of publications that focused on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities over the past ten years. The data charting results suggest that a significant proportion of the literature on this topic is empirical. Generally, there is a significant paucity of literature on the topic being investigated, indicating a need for further systematic inquiries on the topic to better understand this contemporary phenomenon.

The data chart also shows that the identified studies were conducted in both scenarios, where healthcare services are provided by doctors who do not speak the local language and where patients are migrants and therefore do not speak the same language as local

doctors.

However, most of the identified studies focused on language barriers. Only a limited number of studies have investigated the effects of cultural differences on the delivery of quality healthcare. This introduced bias in the results as there was more focus on the impact of language barriers and this suggested that more research is needed that focuses on the implications of cultural difference between patients and healthcare practitioners on the quality of healthcare provided healthcare facilities because it is an important aspect of communication in clinical care.

Furthermore, most studies were conducted in public hospitals, while the few remaining studies were conducted in tertiary hospitals, military hospitals, medical health centers, a multilingual hospital, and a hospital with non-Muslim staff. This suggests that further studies in different healthcare facilities are needed to examine whether the trends identified in this scoping review apply to the different types of healthcare settings where healthcare services are provided and consumed by patients and healthcare practitioners who do not share common cultural and linguistic backgrounds.

Another important aspect observed in the reviewed articles is the lack of global studies. Of the 23 articles, nine were conducted in the Middle East and Saudi Arabia. This result shows that, despite the rapid increase in migration and the associated global challenges, the topic remains under-researched in other geographical regions. This limits the ability to synthesize and identify gaps in research on the implications of language and cultural differences on the quality of healthcare in healthcare facilities where patients and healthcare practitioners do not share a common language and culture worldwide. Furthermore, there are few articles on studies conducted in other regions that are known to recruit masses of migrant health professionals to offer their services in various healthcare facilities.

Finally, the reviewed literature shows that in most of the identified studies, data was collected from nurses and healthcare professionals and only a few studies included patients. This suggests that there may be bias in the literature by marginalizing patients and excluding their experiences, disregarding their roles, and perspectives on the topic under study.

Thematic analysis

The researcher identified eleven themes that encapsulate the scope of the literature on

the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. They include poor communication, delayed diagnoses and treatments, failure to build rapport, decreased empathy, mistrust, poor patient compliance, increased stress and anxiety, increased patient frustrations, increased avoidance behaviour, non-disclosure of medically relevant information, and medical errors. In all the 23 articles that were included in the scoping review, it was noted that the complexities faced by patients and healthcare practitioners in these healthcare facilities influenced the delivery of subpar healthcare.

A prominent theme of poor communication was noted in two of the selected articles. The findings revealed that as a result of the presence of language and cultural differences, patients and healthcare practitioners are not able to communicate satisfactorily. When properly implemented, efficient communication in healthcare facilitates the development of relationships that are likely to lead to a therapeutic pact between the two parties (Chichirez & Purcărea, 2018). Effective communication between a doctor and a patient is of utmost importance and a prerequisite for building a healthy bond between them (Jahan & Siddiqui, 2019). When communication is inadequate, patients' ability to express themselves and doctors' ability to understand the patient during consultations becomes limited, which can lead to misdiagnoses and prescriptions of incorrect treatments. From the comparative prevalence of themes in the included research, it appears that poor communication was not only identified in the two articles in the scoping review but that all other themes identified were a consequence of its existence. However, Desmet *et al.* (2017) point out that culture consists of two components: visible aspects, which include language, clothing, music, and food, and non-visible aspects, which include beliefs, values, ethics, and the management of emotions. Most studies examined the visible aspects of culture, particularly language, paying little attention to the other points of the visible and invisible aspects of culture. It would therefore be imperative to examine how these other aspects of culture affect the delivery of quality healthcare in facilities where patients and healthcare professionals do not share a common language and culture, as this is likely to help healthcare providers determine how patients perceive health and illness and how they respond thereto, enabling them to develop interventions to mitigate the noted issues.

Delayed diagnoses and treatments were another identified theme in three of the twenty-three articles that were included in the scoping review. Findings suggest that language and

cultural differences between patients and healthcare practitioners result in lengthy consultations as it takes longer for the two parties to understand each other, leading to delays in patient diagnosis and the administering of treatments. Suneja (2022), points out that diagnostic delays are associated with morbidity and mortality. Mortality is defined as the number of deaths caused by a certain health event whereas morbidity is a state of being symptomatic or unhealthy (Kim & Hernandez 2022). The delays that occur as a result of the presence of language and cultural differences between patients and healthcare practitioners are likely to result in more disastrous consequences that elevate poor health outcomes. This points to a need for further research to explore how these delays affect morbidity and mortality rates in multicultural healthcare facilities. Findings from such studies will serve as a scale to understand the graveness of delays in patient diagnosis and treatments caused by the presence of language and cultural differences and guide the development of strategies that can be used to improve timely diagnoses in multicultural healthcare facilities. Holmboe and Durning (2014) reiterate that if a patient is diagnosed correctly and on time, their chances of attaining positive health outcomes increase because the clinical decisions made by practitioners in such circumstances are likely to be clear and correct.

Six of the twenty-three articles that were selected for the scoping review indicated that healthcare practitioners failed to build rapport with patients in healthcare facilities where both parties did not share a common language and culture. English *et al.* (2022) and Yinong *et al.* (2022) explain that the ability to build rapport is one of the most important skills that medical professionals must possess to establish effective communication, which consequently promotes the maintenance of a good patient-doctor relationship. These inconsistencies contribute to ineffective communication and result in healthcare professionals being more likely to be overwhelmed and unable to build a harmonious relationship with patients (Yinong *et al.*, 2022). It is important to note that harmonious relationships between patients and healthcare professionals are associated with improved patient compliance and patient satisfaction, highlighting the fact that the presence of language and cultural differences is likely to hinder the delivery of quality healthcare (Leach, 2005). According to Fernández (2010), there is non-verbal and verbal rapport in medical encounters. The first is related to the use of facial expressions, body gestures, and movements, smiling, direct eye contact, greater interpersonal distance, and a gentler tone of voice. The second is related to a situation where a conversation between a patient and a healthcare practitioner is characterized by backchanneling "*conversation*

that involves a speaker talking and interjection from a listener", using remarks that may include *("um," "I see," "Is that right?"),* concentration, engaging in small talks and repetitions. Further research is therefore required to distinguish if the presence of language and cultural differences between patients and healthcare practitioners that seemingly affect the delivery of quality healthcare contributes to failure to build verbal or non-verbal rapport in healthcare facilities. Establishing this information will facilitate the development of focused strategies that can be implemented to help build rapport between the two parties in multicultural healthcare facilities and ultimately improve health outcomes.

Two of the twenty-three selected articles reported that the presence of language and cultural differences was associated with decreased empathy of healthcare practitioners towards patients. Hojat *et al*. (2002) describe empathy in the context of healthcare as the ability of healthcare professionals to perceive the emotions, worldviews, and perspectives of patients without experiencing them first-hand, and to be able to communicate this cognizance correctly. In healthcare settings where healthcare professionals demonstrate empathy, numerous positive health outcomes often occur which include improved patient satisfaction, trust, better adherence to treatment, improved emotional health, symptom resolution, improved physiological measures, better pain management, prevention of stress and burnout, and the development of good communication links with patients (Kim *et al*., 2004; Thirioux *et al*., 2016). Evidence from the literature suggests that linguistic and cultural inconsistencies exacerbate misunderstandings during consultations, which then result in physicians failing to develop and convey sufficient empathy to patients. This indicates that the above positive health outcomes associated with physicians' ability to convey empathy are not achieved. The current analysis indicates that there are few articles with findings pointing to the presence of language and cultural differences contributing to the decreased empathy of healthcare practitioners toward patients. Therefore, additional research is needed to verify and determine the nature and strength of the association between the two because empathy appears to be crucial and a determinant for therapeutic change that occurs as a result of interactions and communication between a patient and a therapist during regular meetings in therapy sessions (Orlinsky, 2001). Findings from such studies will then help establish how language and cultural differences dissuade therapeutic changes and how they affect the attainment of positive health outcomes in multicultural healthcare facilities.

Four of the twenty-three articles in the scoping review point out that when patients and

healthcare practitioners do not share a common language and culture, mistrust ensues. The misunderstandings that result from the discrepancies leave patients uncertain about doctors' ability to properly diagnose and treat them. Saunders (2017) emphasizes that achieving positive health outcomes requires trust between patients and healthcare professionals. Yinong *et al*. (2022) further emphasize that trust is the foundation of an effective patient-doctor relationship. On the contrary, mistrust may be associated with reduced patient-physician interaction, poor clinical relationships, and reduced adherence and utilization of healthcare services, which all are inconsistent with the delivery of quality healthcare (Musa *et al*., 2009).

However, the conceptual framework of healthcare trust depicts that there are two levels namely; *micro and macro levels*. The former focuses on interpersonal trust between an individual patient and a healthcare practitioner and the latter focuses on trust between a patient and the institution providing healthcare to them (Rasiah *et al*., 2020). Most of the studies included in the review focused on this micro level (trust between patients and healthcare practitioners who do not share a common language and culture) pointing out numerous adverse effects which negatively affected the delivery of quality healthcare. There seems to be a scarcity of studies exploring the macro level of trust in multicultural healthcare facilities thus a need was identified to conduct such to investigate how the presence of language and cultural differences between patients and healthcare practitioners decreased/increased trust of patients in the healthcare institution as part of the larger health system and how these affect the delivery of quality healthcare. Findings from such studies can help provide a better understanding of patients' stance on mistrust or trust in multicultural healthcare institutions as the custodians of the delivery of quality healthcare, and how these impact their outlook on the healthcare system. They will also guide the development of strategies that these institutions can adopt to enhance patients' trust in the system if findings indicate reduced trust.

Three of the twenty-three articles that were reviewed indicated that language and cultural differences between patients and healthcare practitioners in healthcare were associated with patients' poor compliance with suggested treatments and medical procedures. It is important to note that patient compliance is an important element in providing quality healthcare, as non-compliance is likely to result in physical harm and may affect patients' well-being (Martin *et al*., 2005). Findings show that patients and healthcare practitioners did not communicate well during consultations, which resulted in patients not understanding the information provided to them, including diagnoses, recommended

lifestyle changes, and treatment instructions. As a result, patients were likely not to adhere to recommended treatment plans, putting themselves at risk of suffering the effects of non-compliance mentioned above. However, there appears to be a lack of research on this topic, as this theme was only identified in two articles. Therefore, further research should be carried out to examine the extent to which linguistic and cultural differences are factors that contribute to patient non-compliance, as they have serious consequences that impact not only the patient but also the healthcare system in general and are likely to have negative consequences not only for the patient, but also for the practitioners, and for the medical researchers working to determine the value of medication on the target population. In addition, Findings from such studies may inform the development of interventions that target this seemingly important phenomenon as "it relates to morbidity, mortality, and health care utilization" (Murphy & Coster, 1997).

Two of the twenty-three articles selected for the scoping review revealed that language and cultural differences between patients and healthcare practitioners resulted in increased stress and anxiety. This was a result of communication hurdles they were faced with. This, in turn, is likely to limit doctors' ability to carry out their work satisfactorily. Stress and anxiety negatively impact patients' health, contributing to delays in recovery and the development of other potentially life-threatening mental illnesses (Çelmeçe & Menekay, 2020; Kotrotsiuo *et al.*, 2001; Kumar, 2016). There seems to be no research conducted to explore the extent to which the life-threatening mental illnesses associated with the stress and anxiety suffered by patients and healthcare practitioners as noted in the studies conducted to explore the implications of language and cultural differences in multicultural healthcare settings further affect health outcomes. Søvold *et al.* (2021) point out that healthcare workers undertake a great role in maintaining the health of populations, therefore their psychological needs should be met to improve their well-being. On the other hand, Prince *et al.* (2007) indicate that mental illness is associated with an increased risk of communicable and non-communicable diseases and contributes to unintentional and intentional injuries for patients. This points to the importance of mental health in primary healthcare, thus the importance of further studies to explore the extent to which the presence of language and cultural differences in healthcare facilities affects the mental well-being of both patients and healthcare practitioners with the hope of developing multidisciplinary interventions that can help improve health outcomes.

Another theme identified in two of the twenty-three selected articles was the increased patient frustrations due to the communication hurdles they were met with. Findings

suggest that these are likely to lead to anger and discouragement in seeking immediate medical help, as well as depression and loss of interest in life (Alavi, 2013; Smith *et al.*, 2017). In addition, this is associated with patients' discouragement to continuing self-care activities and adopting practices that lead them to stopping to take prescription medications (Byren, 2008). Furthermore, these practices are associated with short-term and long-term health implications and trauma, loss of self-confidence, anger, or sadness. However, Peng (2021), points out that in the long term, they can be associated with positive behavioral effects. Tedeschi and Calhoun (1996) in Peng (2021) explain that researchers in positive psychology indicate that trauma experienced by an individual may assist them in developing post-traumatic growth (PTG), which is defined as a positive psychological change that often occurs after a person overcomes a traumatic experience. Further research is needed to establish long-term effects of such language differences and ensuing sub-par healthcare as well as PTG for patients in these healthcare settings.

Three of the twenty-three articles noted that avoidance behavior was one of the implications of the presence of language and cultural differences in healthcare facilities (Ali & Watson, 2018; Al-Kabani *et al.,* 2020; Naidoo, 2014). Findings suggest that when patients and healthcare professionals do not share a common language and culture, they avoid consultations due to communication difficulties. This is likely to lead patients to adopt certain health behaviors that could lead to delays in seeking timely medical care (Byren, 2008). Evidence points out that the avoidance behavior that patients adopt, results in diagnostic delays that are associated with morbidity and mortality (Suneja, 2022). Further research is therefore needed to explore the extent of morbidity and mortality rates that are associated with their avoidance behaviors due to the presence of language and cultural differences between patients and healthcare practitioners because failure to establish their relationship may result in extremely unfavorable health outcomes that may include late disease detection which may reduce patients' survival rate and increase their suffering.

Three of the twenty-three articles included in the review pointed out that patients' non-disclosure of medically relevant information during consultations is a relevant theme relating to implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. When patients are discouraged from disclosing some of their symptoms, health behaviors, thoughts, and feelings to doctors during consultations, patient care is compromised, resulting in poor healthcare outcomes

(Alrasheed *et al.*, 2022; Levy *et al.*, 2018). There is a relatively small number of studies that reported that the presence of language and culture differences between patients and healthcare practitioners resulted in the former failing to disclose some medically relevant information required by the latter to make the correct diagnosis. This points to a need to undertake studies to examine the relationship between the occurrences of cases of misdiagnoses and medical errors that are often associated with wrong diagnoses and with failure of patients to fully disclose medically relevant information during consultations due to the presence of language and cultural barriers. Conducting further studies may also help to identify ways to increase patients' comfort in reporting all relevant information in during consultations.

Three of the twenty-three selected articles pointed out that when patients and healthcare practitioners do not share a common language and culture in a healthcare setting there was an increase in the commission of medical errors. Findings suggest that language and cultural differences disrupt communication during consultations, resulting in inaccurate and inadequate health-related information being exchanged, thus the commission of medical errors, which in turn are likely to result in harm to the patient. This would likely result in increased mortality rates, higher rates of hospitalizations, and higher recovery costs, all of which indicate subpar health care (Fathi *et al.*, 2017). However, since the problem of medical errors is associated with negative consequences that include loss of life for patients and can also result in civil lawsuits for hospitals or medical professionals, this issue needs to be given additional scholarly attention to facilitate the development of interventions aimed at reducing such incidents. This is particularly salient given Oyebode's (2013) assertion that the role of poor communication in determining the likelihood of committing medical errors is poorly understood.

This review offered a broad and integrated overview of the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. Literature indicates that healthcare facilities are increasingly becoming multicultural, and as a result, numerous challenges face patients and healthcare practitioners in such facilities. Findings from the studies that were selected for this scoping review reveal that the presence of language and cultural differences in healthcare limited communication during consultations resulting in numerous implications that hindered the delivery of quality healthcare.

2.4 Limitations

Some articles were published in journals that were inaccessible even if efforts were made to obtain the full text. As a result, these studies could not be included in the data presentation and thematic analysis and could not contribute to the findings of the current scoping review.

Additionally, only studies written or translated into English were included in the review, suggesting that some relevant studies published in other languages were omitted. It is important to note that most studies on the impact of language and cultural differences have been conducted in Saudi Arabia, an Arabic-speaking country. Much of the available literature has not been translated into English and was therefore not included in the scope. This may have inadvertently resulted in important findings on this topic being excluded from the present review.

Another limitation of the study is that no quality control mechanism was implemented in the study. However, this step is not considered essential for scoping reviews (Levac *et al.*, 2010), and the study aimed to provide an overview of existing research on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. This limitation is further exacerbated by the fact that the researcher worked independently, processing each article individually and thus potentially exhibiting a biased perspective in interpreting information. Feedback from the readers and examiners will point to this and any quality issues that will be raised will be addressed accordingly. However, this quality control element of the study may have been minimized through a collaborative approach that offers different interpretations of the different themes.

Lastly, another limitation was the fact that the researcher has a personal interest in the implications of language and cultural differences on the quality of health care provided by physicians who do not share a common language and culture with patients in health care facilities. This limitation was addressed through strict adherence to the scoping review process of Arksey and O'Malley (2005) and Levac *et al.* (2010) and the frame analysis approach of Braun and Clarke (2006). Furthermore, the researcher sought to be mindful and ethically aware in considering the key features of the literature and to adopt a balanced and objective standpoint. For this reason, the scoping review structures were followed in detail, and reporting mechanisms such as the data chart were optimally utilized to standardize reporting and thus provide reproducible results (Munn *et al.*, 2018).

2.5 Recommendations

The included studies in the scoping review on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities focus on general healthcare facilities. Excluding studies conducted in other specialized healthcare facilities where healthcare services are provided by physicians who do not share a common language and culture with patients and where diagnosis and treatment of health problems rely more on linguistic communication than on objective tests and medications, e.g., mental health facilities (Sentell *et al.*, 2007) should be added in future scoping reviews.

The inclusion of such studies from such institutions in a scoping review may reveal various aspects of this phenomenon, which may contribute to the development of interventions to eradicate this problem in other types of healthcare facilities where linguistic and cultural differences exist between patients and healthcare professionals.

In addition, health warnings for several products (e.g., condoms offered in hospitals) have English instructions for use. Future research should aim to determine how language differences that exist between patients and such written instructions might affect the correct application of these preventative measures to patients and how this affects the delivery of quality healthcare.

This study also found that the vast majority of literature on the phenomenon under study is empirical (15 studies). Only six publications were theoretical, two others were expert opinions. Given the relatively small number of publications, it is obvious that not only the empirical but also the theoretical evidence and expert opinions on this topic are relatively limited and that additional theoretical and empirical work is required to verify and expand the existing results.

Lastly, future research should be conducted in other parts of the world as most of the available literature currently comes from studies conducted in Saudi Arabia. Similar studies should be conducted in other geographical regions. This is likely to bring to light different perspectives, views, and experiences from patients and healthcare professionals, creating a broader, more comprehensive, and multifocal view of the topic.

2.6 Conclusion

This study was aimed at scoping available literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. A scoping review was conducted following Arksey and O' Malley's framework (2005) where five database search platforms were utilized to find some inclusive search results from CINAHL, PUBMED, Google Scholar, APA, and PSYCHOINFO that are related to the research question. Using distinct inclusion and exclusion criteria, 23 articles were then retained for analysis. Data chart findings indicate that 15 studies of the identified publications were empirical. Only six publications were theoretical, and a further two were expert opinions. This points out a need for further theoretical and empirical research on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities to provide additional knowledge that is required to verify and expand upon the existing findings.

Additional results from the data chart show that most of the included research was conducted in the Middle East and Saudi Arabia within varying healthcare settings, sample sizes, and research designs, and also that research on the phenomenon being studied was approached from diverse viewpoints, by different interest groups. This indicates a need for further research in other regions and a more targeted and systematic inquiry on the topic to better understand how other communities in different areas who possess different languages, cultures, religions and unique patient-healthcare practitioner migration patterns perceive and experience the implications of language and culture difference on the delivery of quality healthcare.

Thematic analysis of the included studies yielded eleven themes. These themes suggest that the presence of language and cultural differences between patients and healthcare practitioners in healthcare settings that serve diverse populations resulted in numerous implications that hindered the delivery of quality healthcare. They included: poor communication, delayed diagnoses and treatments, failure to build rapport, decreased empathy, and mistrust, poor patient compliance, increased stress and anxiety, increased patient frustrations, increased avoidance behavior, non-disclosure of medically relevant information, and medical errors. These themes depict that when patients and healthcare practitioners do not share a common language and culture, communication problems

arise which lead to misunderstandings and failure for the two parties to build the harmonious relationships that are required in clinical interactions (Naidoo, 2014). The discordances further hinder or reduce patient satisfaction, and job satisfaction for the healthcare practitioner, and compromise patient safety which all are indicators of quality healthcare delivery (Almutairi, 2005).

Reference List

Abderahim, H., Elnashar M., Khidir, A., Killawi, A., Hamound, M. & Al-Khal, L. A. 2017. Patient perspectives on language discordances during healthcare visits: findings from the extremely high-density multicultural State of Qatar. *Journal of Health Communication*, 22(4).https://doi.org/10.1080/10810730.2017.1296507

Albagawi, B. S. 2014. *Examining barriers and facilitators to effective nurse-patient* communication *within a Saudi Arabic cultural context.* School of Health Sciences, College of Science, Engineering and Health, RMIT University (Thesis-PhD). https://researchrepository.rmit.edu.au/esploro/outputs/doctoral/Examining-barriers-and- facilitators-to-effective-nurse-patient-communication-within-a-Saudi-Arabic-cultural- context/9921861272601341 Date of access: 15 Jun. 2019.

Albougami, A. 2015. Role of language and communication in providing quality healthcare by expatriate nurses in Saudi Arabia. *Journal of Health Specialties*, 3(3). http://www.thejhs.org/article.asp?issn=2468-6360;year=2015;volume=3;issue=3;spage=166;epage=172;aulast=Albougami Date of access: 28 Jun. 2019.

Alhamami, M. 2020. Language barriers in multilingual Saudi Hospitals: causes, consequences and solutions. *International Journal Multilingualism*, 19(2). https://doi.org/10.1080/14790718.2020.1777134

Al-Harasis, S. 2013. Impact of language barriers on quality of nursing care at armed forces Hospitals, Taif, Saudi Arabia. *Middle East Journal of Nursing*, 7(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201401/#maincontent Date of access: 28 June 2022.

Ali, P. A. & Watson, R. 2018. Language barriers and their impact on provision of care to patients with limited English proficiency: Nurse's perspective. *Journal of Clinical Nursing*, 27(5-6). https://doi.org/10.1111/jocn.14204

Al-Kalbani, Al Mashrafi, Almutairi, A. G. & Alshamsi, H. 2020. Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal*, 35(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201401/ Date of access:03 June 2022.

Allen, S., Chapman, Y., O'Connor, M. & Francis, K. 2007. The impact of language on nursing: does it convey commonality of meaning and is it important to do so? *Australian Journal of Advanced Nursing,* 24(4). https://pubmed.ncbi.nlm.nih.gov/17682414/ Date of access:02 May 2022.

Allutis, C., Bishaw, T. & Frank, W. M. 2014. The workforce of health in a globalized context- global shortage and international migration. *Global Health Action*, 7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926986/#main-content Date of access: 18 July 2023.

Almutairi, K. M. 2015. Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal*, 36(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4404475/#ref21 Date of access: 16 April 2019.

Alrasheed, A. A., Alharbi, A. H., Alotaibi, A. F., Algarni, A. H., Alshahrani, A. M., Almigbai, T. H. & Batias, M. A. 2022. Prevalence, reasons and determinants of patients' non-disclosure to doctors in Saudi-Arabia: A community-based study. *Patient Prefer Adherence*, 16. https://pubmed.ncbi.nlm.nih.gov/35125866/ Date of access: 02 Jan. 2022.

Alshammari, M., Duff, J. & Guilhermo, M. 2019. Barriers to nurse-patient communication in Saudi Arabia: an integrative review. *Biomed Central Nursing*, 18. https://pubmed.ncbi.nlm.nih.gov/31827387/ Date of access: 16 Feb. 2021.

Alavi, N. 2013. Frustration: A challenge in chronic conditions. *Nursing Midwifery Studies*, 2(3). https://pubmed.ncbi.nlm.nih.gov/25414868/ Date of access: 20 Dec. 2022.

Arksey, H. & O'Malley, L. 2005. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1). https://doi.org/10.1080/1364557032000119616

Auwalu, I. A & Yunusa, M. 2015. *The meaning and theories of intercultural*

communication. Working paper. Faculty of social and management sciences. Department of mass communications. Bayero University, Kano. https://www.academia.edu/15920079/THE_MEANING_AND_THEORIES_OF_INTERCULTURAL_COMMUNICATION_AND_HOW_IT_PROMOTES_PEACE_AMONG_COUNTRIES_OF_THE_WORLD Date of access: 20 Jun. 2021.

Bellefontaine, S. P., & Lee, C. M. 2014. Between black and white: Examining grey literature in meta-analyses of psychological research. *Journal of Child and Family Studies,* 23. https://doi.org/10.1007/s10826-013-9795-1

Biyazin, T., Fenta, B., Yetwale, A., Taye, A. & Belay, Y. 2022. Patient-health care provider relationship during preoperative care in obstetric and gynecologic surgeries at Jimma medical center, Jimma, Ethopia: patient's perspective. *Perioperative Medicine*, 8. DOI:10.1186/s13741-022-00241-8

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in* Psychology, 3(2). http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised Date of Access: 02 Oct. 2019.

Burnett, A. 2002. Globalization, migration and health. *Journal of Medicine, Conflict and Survival*, 18(1). https://www.jstor.org/stable/45351936 Date of access: 29 Oct. 2020.

Butt, M. F. 2021. Approaches to building rapport with patients. *Clinical Medicine*, 21(6). Doi: 10.7861/clinmed.2021-0264

Byren, S. K. 2008. Healthcare avoidance: a critical review. *Holistic Nursing Practice*, 22(5). DOI: 10.1097/01.HNP.0000334921.31433.c6

Çelmeçe, N. & Menekay, M. 2020. The effect of stress, anxiety and burnout levels of healthcare professionals caring for COVID-19 patients on their quality of life. *Front Psychology,* 11. DOI: 10.3389/fpsyg.2020.597624

Chichirez, C. M. & Purcărea, V. L. 2018. Interpersonal communication healthcare. *Journal of Medicine and Life*, 11(2). PMCID: PMC6101690 PMID: 30140317

de Moissac, D. & Bowen, S. 2018. Impact of language barriers on quality of care and patient safety for official language minority francophones in Canada. *Journal of*

Patient Experience, 6(1). https://journals.sagepub.com/doi/pdf/10.1177/2374373518769008

Desmet, K., Ortín, O. & Wacziarg, R. 2017. Culture, ethnicity and diversity. *American Economic Review*, 107(9). https://www.aeaweb.org/articles?id=10.1257/aer.20150243 Date of access: 27 Oct. 2023.

English, W. Gott, M. & Robison, J. 2022. The meaning of rapport for patients, families and healthcare professionals: A scoping review. *Patient Education and Counselling*, 105(1). doi: 10.1016/j.pec.2021.06.003

Fathi, A. Hajizadeh, M., Moradi, K., Zandain, H., Dezhkameh, M., Kazemzadeh, S. & Rezaei, S. 2017. Medication errors among nurses in teaching hospitals in the West of Iran: what we need to know about prevalence, types and barriers to reporting. *Epidemiology Health*, 39. DOI: 10.4178/epih.e2017022 Date of access: 26 Nov. 2022.

Fernandez, I. E. 2010. Verbal and non-verbal concomitants of rapport in healthcare encounter: implications for interpreters. *The Journal of Specialized Translation*, 14. https://www.researchgate.net/publication/266201442 Date of access: 27 Oct. 2023.

Fong Ha, J. & Longnecker, N. 2010. Doctor- patient communication: A review. *The* Ochsner *Journal*, 10(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/ Date of access: 25 Apr. 2019.

Hojat, M., Gonnella, J. S., Nasca, J. T., Mangione, S., Vergare, M. & Magee, M. 2002. Physician empathy: definition, components, measurement and relationship to gender specialty. *American Journal of Psychiatry*, 159(9). DOI: 10.1176/appi.ajp.159.9.1563

Holmboe, E. S. & Durning, S. J. 2014. Assessing clinical reasoning: moving from in vitro to in vivo. *Diagnosis*, 1(1). https://doi.org/10.1515/dx-2013-0029

Jahan, F. & Siddiqui, H. 2019. Good communication between doctor-patient improves health outcomes. *European Journal of Medical and Health Science*, 1(4). DOI:10.24018/ejmed.2019.1.4.84

Kim, S. S., Kaplowitz, S. & Jaafari, N. 2004. The effects of physician empathy on patient

satisfaction and compliance. *Evaluation and the Health Proffessionals,27(3).* doi:10.1177/0163278704267037

Kim, Y. P. & Hernandez, B. R. 2022. *Epidemiology morbidity and mortality*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK547668/ Date of access: 28 Oct. 2023.

Kotrotsiuo, E., Theodasopoulou, E. & Papathanasiuo, I. V. 2001. *How do patients experience stress caused by hospitalization and how do nurses perceive this stress experienced by patients. A comparative study.* Corpus ID: 70942932 Date of access: 22 Oct. 2022.

Kumar, S. 2016. Burnout and doctors: prevalence, prevention and intervention. *Healthcare* Baseline, 4(3). doi: 10.3390/healthcare4030037 Date of access: 28 Nov. 2022.

Leach, M. J. 2005. Rapport: a key to treatment success. *Complementary Therapies in Clinical Practice*, 11(4). https://doi.org/10.1016/j.ctcp.2005.05.005

Levac, D., Colquhoun, H. & O' Brein, K. 2010. Scoping studies: advancing the methodology. *Implementation Studies,* 5(69). https://doi:10.1186/1748-5908-5-69

Levy, A., Scherer, A., Zikmund-Fisher, B., Larkin, K., Barnes, G. B. & Fagerin, A. 2018. Prevalence of and factors associated with patient non-disclosure of medically relevant information to clinicians. *JAMA Network Open*, 1(7). doi:10.1001/jamanetworkopen.2018.5293

Malik, P. A. & Khan, M. A. 2020. Bridging the gap: A review of communication skills challenges for expatriate doctors in the Arabian Gulf. *World Family Medicine Journal*, 18(10). DOI: 10.5742/MEWFM.2020.9381

Martin, L. R., Williams, S. L., Haskard, B. K. & Dimatteo, M. R. 2005. The challenge of patient adherence. *Therapeutic and Clinical Risk Management*, 1(3). PMID: 18360559 Date of access: 06 Jun. 2022.Mosadeghard, M. A. 2013. Healthcare service quality: towards a broad definition. *International Journal of Health Care Quality Assurance*, 26(3). https://www.ncbi.nlm.nih.gov/pubmed/23729125. Date of access: 02 Feb. 2019.

Munn, Z., Peters D. M. J., Stern, C., Tufanaru, C., McArthur, A. & Aromataris, E. 2018. Systematic review or scoping review? Guidance for authors when choosing

between a systematic or scoping review approach. *BMC Medicine Research Methodology*, 18. doi: 10.1186/s12874-018-0611-x

Murphy, J. & Coster, G. 1997. Issues in patient compliance. *Drugs*, 54(6). https://pubmed.ncbi.nlm.nih.gov/9421690/. Date of access: 24 Sep. 2023.

Musa, D. Schulz, R., Harris, R, Silverman, M. & Thomas, B. S. 2009. Trust in the healthcare system and the use of preventive health services by older black and white adults. *American Journal of Public Health*, 99(7). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696665/. Date of access: 09 Nov. 2022.

Naidoo, S. 2014. Transcultural and language barriers to care. *South African Dental Journal, 69(9).* http://www.scielo.org.za/sc ielo.php?script=sci_arttext&pid=S0011-8516201400090001385162014000900013. Date of access: 03 Mar. 2019.

Orlinsky, D. E. 2001. Psychotherapy Process research*. International Encyclopedia of the Social and Behavioral Sciences*. https://doi.org/10.1016/B0-08-043076-7/01334-6

Oyebode, F. 2013. Clinical errors and medical negligence. *Medical Principles and Practice*, 22(4). Doi: 10.1159/000346296

Paez, A. 2017. Grey literature: an important resource in systematic reviews. Journal of Evidence-based Medicine. https://pubmed.ncbi.nlm.nih.gov/28857505/ Date of access: 21 May 2019.

Peng, Y., Tang, J. & Li, H. 2021. Good deeds could come from frustrated individuals. *Frontiers in Psychology*, 12. Doi: 10.3389/fpsyg.2021.631711

Peterson, J., Pearce, P. F., Ferguson, L. A. & Langford, C. A. 2016. *Understanding scoping* reviews*: Definition, purpose and process.* School of nursing, Loyola University. https://onlinelibrary.wiley.com/doi/pdf/10.1002/2327-6924.12380. Date of access: 26 Apr. 2019.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R. & Rahman, A. 2007. No health without mental health. *Lancet*, 370(9590). https://pubmed.ncbi.nlm.nih.gov/17804063/. Date of access: 27 Oct. 2023.

Rasiah, S., Jaafar, S., Yusof, S., Ponnudurai, G., Yin Chung, K. P. & Amirthaliingam, S.

M. 2020. A study of the nature and level of trust between patients and healthcare providers, its dimensions and determinants: A scoping review. *BMJ Open*, 10. DOI: 10.1136/bmjopen- 2018-028061

Reiss, H. 2017. The science of empathy. *Journal of Patient Experience*, 4(2). DOI: 10.1177/2374373517699267

Rosky, M. 2015. Overcoming *language barriers in health care services in the medical tourism context: Health care companies' perspective.* School of Business, Aalto University (Thesis-Masters). www.aalto.fi: Date of access: 12 February 2019.

Russell, C. 2005. An overview of the integrated research review. *Progress in* Transplantation, 15(1). DOI: 10.7182/prtr.15.1.0n13660r26g725kj

Saunders, J. 2017. *Trust and mistrust between patients and doctors. Handbook of the philosophy of medicine*. Cardiff University. DOI:10.1007/978-94-017-8688-1_20

Schyve, P. M. 2007. Language differences as a barrier to quality and safety in health care: The joint commission perspective. *The Journal of General Internal Medicine*, 22(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2078554/ Date of access: 06 May 2022.

Sentell. T., Shumway, M. & Snowden, L. 2007. Access to mental health treatment by English language proficiency and race/ethnicity. *Journal of General Internal Medicine*, 2. Doi: 10.1007/s11606-007-0345-7

Sibblad, S., Macgregor, J. C. D., Surmacz, M. & Wathen N. 2015. Into the grey literature: a modified approach to citation analysis to better understand research impact. *Journal of Medical Library Association*, 103(1).https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279935/ Date of access: 29 Aug. 2019.

Smith, L. M., Bergeron, C. D., Adler, H. C., Patel, A., Ahn, S. D., Beim, M. & Ory, M. G. 2017. Factors associated with healthcare- related frustrations among adults with chronic illnesses. *Patient Education and Counselling*, 100(6). DOI: 10.1016/j.pec.2016.12.033

Sobane, K. M. E. 2013. Language *discordant HIV/AIDS interactions in Lesotho health care centers.* Stellenbosch University. (Thesis-PhD).

https://scholar.sun.ac.za/items/094b3f4f- 6925-4da9-a627-2af5e55bc878. Date of access: 21 Mar. 2018.

Sobane, K. M. 2015. Communication challenges experienced in Lesotho clinics where physicians speak both the community language and lingua franca. *Journal of Social Sciences,* 43(3). https://www.tandfonline.com/doi/abs/10.1080/09718923.2015.11893445. Date of access: 17 Apr. 2019.

Sɵvold, L. E., Naslund, A. J., Kousoulis, A. A., Saxena, S., Qoronfleh, M. W., Glober. C. & Mŭnter, L. 2021. Prioritizing the mental health and well-being of healthcare workers: an urgent global public health priority. *Frontiers in Public Health*, 9. 10.3389/ 10.3389/fpubh.2021.679397

Spencer-Oatey, H. 2012. What is culture? A compilation of quotations. GlobalPAD Core Concepts. https://warwick.ac.uk/fac/soc/al/globalpad/openhouse/interculturalskills_old/global_pad_-_what_is_culture.pdf Date of access: 12 Nov. 2019.

Suneja, M., Beekmann, S. E., Dhaliwal, G., Miller, A. C. & Polgreen, P. M. 2022. Diagnostic delays in infectious disease. *Diagnosis Berlin Germany*, 9 (3). doi: 10.1515/dx-2021-0092

Thirioux, B., Birault, F. & Jaafari, N. 2016. Empathy is a protective factor of burnout in physicians: new Neuro-Phenomenological hypotheses regarding empathy and sympathy in care relationship. *Front Psychol,* 7. *763.* doi:10.3389/fpsyg.2016.00763

Turner, L. W. & Hunt, S. B. 2004. Design and implementation of an osteoporosis prevention program using a health belief model. *American Journal of Health Sciences*, 19. https://www.proquest.com/openview/1c522faa57dabd5386cd22e3463fe5b9/1?pq-origsite=gscholar&cbl=30166 Date of access: 26 Jul. 2021.

Van den Berg, V. L. 2016. Still lost in translation: language barriers in South Africa health care remain. *South African Family Practices*, 58(6). https://medpharm.tandfonline.com/doi/full/10.1080/20786190.2016.1223795#.XKyEhIVjQU Date of access: 22 Jul. 2021.

Yeo, S. 2004. Language *barriers and access to care*. ResearchGate. https://www.researchgate.net/publication/8345471_Language_Barriers_and_Access_to_Care Date of access:18 Jul. 2019.

Yinong, T. Zhang, J. Haiyang, C. & Yonggang, S. 2022. *Weaving rapport: doctors' strategies towards patients' compliance*. Research Square. https://doi.org/10.21203/rs.3.rs- 1957932/v1

Zhang, D., Jiang, Z., Xie, Y., Wu, W., Zhao, Y., Huang, A., Li, T. & Ba-Thein, W. 2022. Linguistic barriers and healthcare in China: Chaoshan vs Mandarin. *BMC health Services research*, 22(376). https://doi.org/10.1186/s12913-022-07744-6

CHAPTER 3

Article 2

A qualitative exploration of the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals and strategies to reduce the noted implications.

Abstract

This qualitative study explored the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. The secondary aim of this study was to explore their views on strategies that they recommend be employed to reduce any noted adverse implications. Purposive sampling was used to select two groups of participants (24 patients and 18 expatriate healthcare practitioners) in four Lesotho public hospitals (Queen 2 Hospital, Queen 'Mamohato Memorial Hospital, Berea Hospital, and Butha-Buthe Hospital). Semi-structured interviews were used to gather data, which were then analyzed through thematic analysis.

Findings revealed that language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals result in miscommunication between the two parties. As a result, expatriate healthcare practitioners fail to understand information related by patients during consultations. In reactions to all these, patients experience awkwardness and discomfort and they resort to eliminating vital health-related information during consultations. This leads expatriate healthcare practitioners to conduct poor assessments of patients' conditions. The discordance also triggers the negative emotional responses of both patients and expatriate healthcare practitioners. Expatriate healthcare practitioners experience frustrations while patients suffer from stress and anxiety. These feelings prompt mistrust of patients towards the capabilities of expatriate healthcare practitioners to attend to their health needs, perpetuating resistance of patients to undertake the suggested medical procedures and treatments. As a result, patients then develop avoidance behaviour that is associated with queuing of patients because they then wait in long lines for a lengthy time to consult practitioners who speak and understand their local dialect.

On strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences, patients and expatriate

healthcare practitioners point out that it should be ensured that expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual, that orientation of expatriate healthcare practitioners should be done, a medical interpreting curriculum should be developed in schools and that hospitals should hire professional interpreters.

It is hoped that the findings emanating from this study will inform the development of an intervention that can be employed to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals while also increasing the chances of attaining consequent healthcare-related outcomes.

Keywords: *language and cultural differences, expatriate healthcare practitioners, patients, quality healthcare, and public hospitals.*

3.1 Introduction

This study was conducted to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and to explore their views on strategies that could be employed to reduce the noted implications.

Globalization has coincided with increased migration, people move from their home countries to other parts of the world for a variety of reasons, including business, diplomacy, security, and to escape civil wars (Czaika & Reinprecht, 2022). Migrants often face communication problems in destination countries because they have a different linguistic and cultural background than the host population (Ahmed, 2018). This birthed the popular concept of *intercultural communication*. It is about understanding other people's linguistic and cultural backgrounds during interactions to achieve effective communication (Jhaiyanuntana & Nomnian, 2020).

The healthcare sector is no exception to this general trend. There is an increasing demand for healthcare professionals worldwide to address the increasing global demand for healthcare service practitioners (Ghorbani, 2021). This has led to a corresponding increase in the number of healthcare professionals migrating to offer their expertise in global healthcare institutions (Braimoh & Dimarco, 2021; Naicker *et al*., 2009). Many governments have been forced to recruit healthcare professionals from different parts of the world to provide healthcare services to their respective citizens due to severe shortages of staff in healthcare facilities witnessed in most countries (Aluttis *et al*., 2014;

Mandeville *et al.*, 2016). According to Downs *et al.* (2013), Lesotho has also been affected by these shortages and has therefore resorted to hiring expatriate healthcare practitioners from various countries to care for people in public hospitals.

This strategy has been shown to pose some communication challenges due to linguistic and cultural differences between expatriate healthcare practitioners and patients. As conceptualized in this study, *communication* is the exchange of information, ideas, meanings, and understanding from one person to another (Sharma, 2017). Effective communication between a doctor and a patient is of utmost importance and a prerequisite for building a healthy bond between them (Jahan & Siddiqui, 2019). Moreover, disruptions in their communication negatively impact on the delivery of quality healthcare in hospitals (Albougami, 2015; Almutairi, 2015; Schyve, 2007).

Like any other language, Sesotho is a medium through which people share history, customs, beliefs, values and practices (Mokuoane & Moeketsi, 2018). In public health facilities in Lesotho, it is mostly used in the dissemination, interpreting, influencing, and motivation of individuals in relation to important issues of health. However, in some instances multiculturalism and multilingualism of patients and healthcare practitioners in Lesotho public hospitals have resulted in the use of English language during consultations.

The relationship between a doctor and a patient is greatly influenced by language and culture as two important aspects of human interaction. Alshammari *et al.* (2019) and Mokuoane (2018) emphasize that these two aspects are fundamental and coexist for effective communication. They further indicate that language exists as a result of the presence of culture and that culture in turn reciprocally influences language. According to Spencer-Oatey (2012), *culture* is the shared and learned values, beliefs, and norms of a particular group of people that are passed from one generation to the next and guides and influence that group's thinking, behaviors, and decision-making. On the other hand, *language* refers to the sounds, signs, and codes established and used by a group of people to accurately exchange information, messages, or ideas (Mokuoane & Moeketsi, 2018). Language and culture are therefore two particularly important aspects related to effective communication, which is necessary in healthcare to ensure the delivery of quality healthcare (Schyve, 2007).

Mosadeghard (2013) and Hughes (2008) define *quality healthcare* as a standard of healthcare service delivery whereby individuals and populations receive healthcare that

can improve their health and well-being. Given the noted importance of language and culture, it is, therefore, crucial to ensure effective and efficient communication in the context of healthcare systems where there is an increasing interaction of culturally and linguistically diverse populations of healthcare practitioners and patients, to ensure the delivery of high- quality healthcare (Chiehi *et al.*, 2017:103).

Studies on this topic have been conducted in culturally and linguistically diverse healthcare settings, in regions including Qatar and Saudi Arabia in the Middle East, South Korea, and African countries such as Namibia, South Africa, Ghana, and Lesotho. The findings of these studies suggest that the presence of linguistic and cultural differences between patients and healthcare practitioners leads to numerous negative consequences that impact the delivery of quality healthcare. The literature suggests that these differences lead to communication difficulties, and misunderstandings that result in the commission of numerous medical errors, thus negatively affecting the delivery of quality healthcare (Alhamami, 2020: Almutairi, 2015; Alshammari *et al.*, 2019; Mlambo, 2017; Turner, 2015).

Intercultural encounters in healthcare are associated with disagreements on health issues between patients and healthcare professionals. Findings reveal that in such situations, especially when making decisions, the likelihood of conflicts arising between the two parties is increased (Van Keer *et al.*, 2015). This impairs their ability to develop functional and medically productive relationships (Brooks *et al.*, 2019; Givler *et al.,* 2019). Literature also points out that there is often a lack of companionship when doctors and patients have different cultural and linguistic backgrounds (Ahmed *et al.*, 2017; Fowler, 2008; Naidoo, 2014). Studies also indicate that many healthcare practitioners fail to build rapport with patients because of poor communication that occurs as a result of the presence of language and cultural barriers (Fong Ha & Longnecker, 2010; Wiener & Rivera in Sobane, 2015). In addition, Schouten and Meeuwesen (2006) add that linguistic inconsistencies hinder the development of good relationships between patients and healthcare practitioners. To add to this, Schouten *et al.* (2009) point out that the presence of these discrepancies could lead to misunderstandings, causing patients to feel judged and taken for granted. As a result, this negatively affects their willingness to attend future check-ups or seek timely medical attention if they feel unwell (Fong Ha & Longnecker, 2010; Jacobs *et al.*, 2006; Nourizinia *et al.*, 2016).

Findings from previous studies also show that the presence of linguistic and cultural

differences in healthcare settings results in healthcare practitioners often failing to ask about contextual, emotional, and mental factors associated with the patient's medical complaints. According to De Beer and Chips (2014) and Somnath and Catherine (2008), this contributes to patients feeling that the practitioners are incompetent, causing them to lose confidence in their abilities to assist them with their healthcare needs. In addition, findings also show that this uncertainty is due to patients' lack of confidence that they correctly and clearly described their illnesses and symptoms to the healthcare practitioner or that the practitioner clearly understood the information they provided during consultations (de Moissac & Bowen 2018; Van den Burg, 2016). These eventualities often lead to low patient satisfaction and reduce their chances of seeking readily available preventive care the next time they need medical attention (Schouten & Meeuwesen, 2006; Schouten *et al.*, 2009).

In addition, these barriers often result in misunderstandings, which often lead to patients not recognizing the seriousness of the illnesses they have been diagnosed with, as a result, they fail to follow treatment instructions given to them (de Moissac & Bowen, 2018; Fong Ha & Longnecker, 2010; Meuter *et al.*, 2015; Wagner *et al.*, 2015). In these instances, patients report that they pretend to understand what is being told to them when in reality they do not understand it (Meuter, 2015; Partida, 2007; Van ben Berg, 2016). This could lead to further disease complications and delays in disease treatment.

According to de Moissac and Bowen (2018) and Meuter *et al.* (2015), literature indicates that language differences between healthcare practitioners and patients lead to poor assessments and misdiagnosis as patients find it difficult to use the correct terms to communicate their symptoms and illnesses to the practitioners. On the other hand, practitioners may not be able to fully understand patients' symptoms and have limited opportunities to learn more about them due to these differences (Al-Shamsi *et al.,* 2020). This, in turn, leads to incorrect treatments being administered to patients, increasing incidences of medical errors, further disease complications, hospital readmissions, unnecessary use of resources on diagnostic testing, and at times, loss of lives (Auerbach *et al.*, 2010; de Moissac & Bowen, 2018; Wagner *et al.*, 2015).

Furthermore, language barriers in a healthcare setting have been identified as a contributor to delayed treatments because patients spend an extended amount of time undergoing assessments and in lengthy consultations due to the prolonged time spent in consultation rooms where healthcare practitioners try to comprehend what they are trying

to relate, meanwhile, patients are in pain and dire need of urgent medical treatment (de Moissac & Bowen 2018; Nourizinia *et al.*, 2016, O' Daniel & Rosenstein, 2008).

Additionally, the literature indicates that when language barriers exist, healthcare practitioners sometimes do not take the necessary precautions to prevent patients from becoming further ill. This is because the barriers hinder their ability to provide effective advice and patient education (Al-Khashan *et al.*, in Almutairi, 2015; Amoah *et al.*, 2018). This means that these patients are at risk of developing new or additional diseases because practitioners fail to warn them about the potential risks of certain behaviors or actions because of language barriers.

In addition, findings also reveal that sometimes patients become vulnerable to emotional distress caused by being unable to participate in discussions about their health (Alhamami, 2020; Alshammari *et al.,* 2019). This is exacerbated in situations where healthcare practitioners are not approachable for further clarifications after consultations, especially when a patient feels they did not clearly understand some issues or instructions due to language barriers (Aghabarari *et al.*, 2009; Amoah *et al.*, 2018; Li, Ang & Hegney in Norouzinia *et al.*, 2016). This is likely to contribute to the development of new stress-related illnesses or further illness complications for patients (Cohen *et al.*, 2007).

To add to the findings, the literature reveals that healthcare practitioners are most likely to become frustrated when faced with language barriers during consultations, which often leads to a lack of empathy toward patients (Amoah *et al.*, 2018; Van den Berg, 2016). For healthcare practitioners, this would likely lead to depression, burnout, and even death from depression-related illnesses. Moreover, findings point out that due to the existence of language barriers, consent issues are sometimes ignored, which can lead to ethical misconduct (Bowen, 2001; Wanjau *et al.*, 2012). This is likely to result in lowered patient satisfaction.

According to the literature, translator services have been used in some healthcare facilities to reduce the negative impact of language and cultural barriers. Findings show that the use of these services has proven to be only partially effective, as despite these strategic measures, communication gaps still exist (Sobane, 2013; White *et al.*, 2018). In addition, findings demonstrate that patients and healthcare practitioners who use these services are pessimistic about the competence of the interpreters and uncertain about their ability to correctly interpret and translate the information exchanged during consultations. Furthermore, the results indicate that many patients perceive the presence

of an interpreter in the consultation room as an invasion of their privacy (Klugah & Ansah, 2019). This indicates the limited efficacy of this strategy, which highlights the possibility of continued communication problems between patients and healthcare practitioners which may be associated with the non-disclosure of some pertinent information by patients during consultations, and misinterpretations that are likely to lead to misdiagnoses and multiple adverse downstream consequences in terms of medical treatment.

The above findings from the existing literature highlight the role and critical importance of language and culture in the context of effective communication, which is of utmost importance in clinical encounters. Due to their essential nature, these two constructs will be discussed in more detail in the next sections.

3.2 Culture

Culture refers to forms of traditional behavior or shared and learned values, beliefs, and norms of a particular group of people that are transmitted from one generation to another and that guide ways of thinking and acting and influence decision-making (Spencer-Oatey, 2012). It affects health and controls how people perceive health and illness, engages in health-promoting behaviors, and experience and express pain (Peacock & Patel, 2008).

Findings from several studies indicate that during consultations between patients and healthcare practitioners with different cultural backgrounds, misunderstandings often occur, leading to unhealthy relationships due to a lack of rapport (Alhamami, 2020; Brooks, *et al.*, 2019; Givler *et al.*, 2019; Naidoo, 2014; Schouten & Meeuwessen, 2006; Turner, 2015). This is likely to result in reduced patient engagement and increased anxiety, resulting in poor healthcare experiences for both parties. Research further indicates that these differences result in patients' lack of trust in healthcare practitioners (Al-Harasis, 2013; Van den Berg, 2016). When cultural differences are present, patients doubt that they have been correctly diagnosed, which leads to non-compliance with recommended treatment protocols (Kennedy *et al.*, 2017; Martin *et al.*, 2005; Mcquiad & Landier, 2018). Studies also reveal that when cultural differences are present, often there is a lack of comfort for the patients (Ahmed *et al.*, 2017; Fowler, 2008; Malik & Khan, 2020; Naidoo, 2014). Many lament that they do not feel sufficiently recognized when consulting with doctors who do not have a similar cultural background to theirs. This can lead to patients withholding some important health-related information during consultations, which can lead to misdiagnosis and poor disease management.

It is often assumed that healthcare practitioners are equipped with sufficient skills during their training to be culturally sensitive when dealing with patients from different cultural backgrounds. Such training typically aims to facilitate them with the relevant knowledge, attitudes, and skills required to respond effectively to sociocultural issues that arise during clinical encounters (Jongen, *et al.*, 2018). However, evidence suggests that some practitioners fail to interact with patients with expected cultural competence (Brooks *et al.*, 2019; Fleckman *et al.,* 2015; Marier-Lorentz, 2008). It seems reasonable to assume that this situation could be exacerbated if the healthcare practitioners in hospitals have a different cultural background than the patients they care for. Given the prevalence of this situation in public hospitals in Lesotho, it was considered important to explore how cultural differences affect the quality of healthcare provided by expatriate healthcare practitioners.

There is evidence that cultural differences between patients and healthcare practitioners represent a barrier to achieving desired health outcomes. This is because they lead to the practitioners not understanding the ethics, values, and customs of patients. According to Naidoo (2014), to avoid problems such as mistrust, conflict, and lack of patient enthusiasm, both the cultural perspectives and worldviews of the patient and the healthcare practitioner must be taken into account.

3.3 Language

Language is a communication medium and serves as the primary means of exchanging information between patients and healthcare practitioners (Partida, 2012). Patients use it to communicate their symptoms to healthcare practitioners, who in turn use it to learn about patients' symptoms, communicate diagnoses, discuss patients' health conditions, suggest treatments, and recommend health-promoting behaviors (Allen *et al.*, 2007; Yeo, 2004). The role of language in healthcare highlights its importance in communicating vital health-related information between the two parties who must work together to achieve positive health outcomes. Findings from some studies that were conducted to examine issues of language barriers in healthcare reveal that they lead to poor assessments and misdiagnosis as patients have difficulty finding the correct terms to communicate their symptoms and illnesses to healthcare practitioners (Alhamami, 2020; de Moissac & Bowen, 2018; Meuter *et al.*, 2015; Sobane, 2013). Consequently, these implications lead to increased incidences of medical errors, further disease complications, unnecessary hospital readmissions, the undertaking of unnecessary and costly tests, and sometimes deaths (Auerbach *et al.*, 2010; Wagner *et al.*, 2015). This clearly shows that the presence of language barriers in healthcare has a direct impact on the delivery of quality healthcare.

Research findings emanating from studies undertaken in Saudi Arabian hospitals reveal that the existence of language barriers contributes to delayed treatments (Almutairi, 2015; Alshammari *et al.,* 2019). This is because patients spend a lot of time undergoing examinations in consultation rooms since they find it difficult to communicate their symptoms to healthcare practitioners. At times, during this period, patients experience severe pain that requires urgent medical treatment or pain management (de Moissac & Bowen, 2018; Nourizinia *et al*., 2016; O'Daniel & Rosenstein, 2008). Healthcare practitioners also indicate that consultations with patients who speak a different language to theirs take longer because they spend time trying to understand what is being narrated, leading to delayed treatments (Alhamami, 2020). This situation can lead to further disease complications and failure to treat pain and illness in a timely and effective manner, and in some cases, it can also lead to loss of life. In addition, findings reveal that in healthcare situations where language barriers are present, patients often pretend to understand what is being communicated by healthcare practitioners to avoid lengthy conversations conducted in a language they do not understand (Alhamami, 2020; Mlambo, 2017). Such situations cause emotional distress for patients who are unable to freely engage and seek further clarity where they need it. This, in turn, would adversely affect patients' future health behaviors.

Language barriers in healthcare have been shown to contribute to patients' poor understanding of diagnoses, treatments, and the severity of the illnesses they are diagnosed with (Abderahim, 2012; de Moissac & Bowen, 2018; Fong Ha & Longnecker, 2010; Meuter *et al.,* 2015; Wagner *et al*., 2015). These eventualities result in patients not recognizing the importance of adhering to prescribed treatment plans. Furthermore, findings from a qualitative study conducted in Windhoek, Namibia, revealed that healthcare practitioners in multilingual healthcare centers stated that language barriers between themselves and patients lead to low job satisfaction and lower self-esteem as their ability to perform their jobs is limited (Mlambo, 2017). The low self-esteem subsequently causes patients to have reduced trust in them. On the other hand, low job satisfaction is likely to result in absenteeism, substandard care, and lower patient satisfaction.

Research findings further indicate that in the presence of language barriers, some healthcare practitioners become frustrated and do not show compassion, kindness, and empathy toward patients (Amoah *et al*., 2018; Fong Ha & Longnecker, 2010; Van den Berg, 2016). These are likely to reduce patient satisfaction. Sometimes doctors are forced to make decisions on the most appropriate medical procedures on behalf of patients (often

in critical medical situations) because of the presence of language barriers that hinder effective communication (Bowen, 2001; Malik & Khan, 2020; Wanjau *et al.*, 2012). This is associated with unethical conduct which could result in lawsuits. Healthcare practitioners further indicate that when language barriers exist, they are not able to provide effective counseling and patient education, which hinders their ability to ensure they limit the likelihood of further illness and achieve desired patient outcomes (Almutairi, 2015; Amoah *et al.*, 2018). As such, evidence from the literature suggests that language barriers can directly or indirectly lead to poor quality of healthcare through a variety of consequences. By contrast, findings from existing studies suggest that minimizing language barriers leads to a lower incidence of adverse health outcomes and increases trust between healthcare practitioners and patients (Albougami, 2015; Almutairi, 2015; Schyve, 2007), all of this is likely to contribute to improved quality healthcare.

3.4 The context of the present study: Lesotho

Lesotho has a complex cultural composition that includes unique ancestral beliefs, customs, identity, traditions, and language. The Basotho culture has remained relatively unchanged even after missionaries introduced modernization programs (Mokuoane, 2018). Makoa (2000) points out that Basotho's beliefs and customs include the use of traditional healers to cure and prevent disease which influences how they perceive health, illness, and disease. According to WHO (1976), traditional healing is the summation of all knowledge and practices, based primarily on experiences and observations passed down from one generation to the next. Furthermore, these can be verbal or written health practices, approaches, knowledge, and beliefs that include herbal, animal, and mineral medicines, spiritual therapies, manual techniques, and exercises. These are used to treat, diagnose, and prevent disease to maintain well-being, and to prevent or correct physical, mental, or social imbalances. A significant portion of the Basotho population still maintains this culture, which most likely influences their health beliefs and behaviours. Conversely, Possa and Khotso (2015) show that a significant proportion of the population can afford and have access to medical centers and therefore seek medical care in these facilities where Western medicine is used. The administrative tasks of these institutions include the provision of personnel for the management of these facilities that are tasked with hiring local and international healthcare experts to care for this culturally complex population. The aforementioned facts about Basotho culture, its health belief systems, and contemporary approaches to health in a country still dominated by traditional cultural health belief systems come together to provide a compelling rationale for examining the implications of language and culture differences on the quality of healthcare provided by

expatriate healthcare practitioners in public hospitals in Lesotho. Likewise, they provide a rationale for further exploration of their views on strategies that can be employed to reduce the noted implications.

Due to existing staff shortages, public hospitals in Lesotho are largely staffed by expatriate healthcare practitioners whose languages and cultures differ from those of patients (Downs *et al.*, 2013). In addition, there is a significant reliance on non-Basotho workers in the medical doctor labor market in Lesotho (Schwabe *et al.*, 2004). Despite this, thus far, only three studies by Sobane, (2013), Thuube (2015), and Sobane (2015) explored the implications of language and cultural differences on the delivery of quality healthcare in Lesotho hospitals and clinics (for a comprehensive discussion of these studies and their limitations, refer to Chapter 1.) Sobane (2013) conducted a qualitative study to investigate the organizational structure of medical communicative facilities and the related communicative experiences of healthcare providers and patients in HIV/AIDS care centers. The study mainly focused on HIV/AIDS patients and was conducted exclusively in clinics around Maseru. The findings of this study showed that patients and healthcare practitioners faced numerous challenges when interacting in consultation rooms due to language barriers. These differences were reflected in an imbalance in linguistic repertoires, which led to misunderstandings between the two parties. Thuube (2015) also conducted a study in Lesotho using qualitative methodological approaches such as discourse and conversation analysis to examine how the direct participation of ad-hoc interpreters (that included family members, nurses, and assistant nurses) influenced the cross-linguistic communication between patients and doctors who did not share a common language. The study was conducted in a public and a church hospital. Findings revealed that several errors occur due to misinterpretation during consultations between patients and doctors. The ad hoc interpreters made linguistic errors that resulted in ineffective communication on issues of diagnoses and negotiation of medical outcomes. Lastly, Sobane (2015) conducted a qualitative study to explore the challenges experienced by healthcare practitioners and patients in two clinics where physicians spoke both the community language (at a very basic level of competency) and the non-native lingua franca (English). The findings showed that participants faced significant challenges during the consultations as a result of language barriers. These included the lack of accuracy of information exchanged between the two parties. On the other hand, the interpreters reported that their job was difficult to undertake.

Of these three studies, only one tangentially addressed the issue of cultural differences

and their impact on the provision of quality healthcare services. Furthermore, only one study was conducted in a public hospital, even though Cohen *et al.*, (1999 in Sobane, 2013) indicate that 80% of doctors working in hospitals in Lesotho are foreigners who speak various native languages and have little knowledge of Sesotho and are mostly not fluent in English, a second language in Lesotho. In addition, these hospitals do not have nurses available to help with translations between healthcare practitioners and patients. Additionally, most of the studies were conducted in clinics that employed interpreters, which is not the case in most hospitals. Likewise, in the clinics, ad hoc interpreters, including Basotho nurses and family members, were readily available to assist with translations when patients and healthcare practitioners encountered communication problems due to language barriers.

Given the very high prevalence of culturally and linguistically diverse interactions between patients and expatriate healthcare providers in Lesotho hospitals, as well as the range and extent of potential adverse consequences that such differences could have on the delivery of quality healthcare, it was deemed necessary to conduct this study which aimed to qualitatively address and identify gaps in the literature regarding this phenomenon in Lesotho public hospitals. Language and culture are central to effective communication and play a central role in the interaction between healthcare practitioners and patients (Eckersley, 2006; Jongen *et al.*, 2018). Therefore, it is important to pay attention to these factors because if they are ignored, patients become at risk of delayed or inappropriate treatment, misdiagnosis, expensive and unnecessary tests, non-compliance with recommended health plans, and sometimes loss of lives. On the other hand, healthcare practitioners are likely to fail to provide care that complies with human rights principles, promotes patient equality, increases job satisfaction, and reduces work-related stress and anxiety (de Moissac & Bowen 2018; Röysky, 2015; Al-Shamsi; 2022). As such, the main aim that guided the present study was to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. A secondary aim was to explore their views on strategies that can be employed to reduce the noted adverse implications emanating from such linguistic or cultural differences. To answer the research question, an exploratory qualitative research design was used, as explained below.

3.5 Research Methodology

A research design specifies how the researcher intends to conduct a study. It is a logical and coherent overview of how key components of research work together to answer the

research question (Hofstee, 2006; Miller & Salkind, 2002). A research design maps out the methods to be used by the researcher, including sampling, methods of data collection, and methods of analysis that are relevant to the overall purpose and answer the research question (Babbie & Mouton, 2008; Creswell, 2014; Hofstee, 2006). In attempting to inductively explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and exploring their views on strategies that can be employed to reduce the noted adverse implications, the researcher employed an *exploratory qualitative research design*. This research design is used to expand knowledge and provide greater understanding in research where comparatively little is known about the phenomenon under study (Payne & Grey, 2014). Relatively little research has been undertaken on this phenomenon in the case of Lesotho, with only three studies having been conducted to date. As was the aim of the present study, an exploratory research design does not aim to provide conclusive answers to a research question but rather focuses on providing a better understanding of the problem (Burns & Groove, 2001; Creswell, 2014), which in this case is centered on the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and exploring their views on strategies that can be employed to reduce the noted adverse implications.

3.5.1 Sampling and Research Participants

Purposive sampling was used to find participants for this study in the following four selected public hospitals:

1. Queen 2 Hospital in Maseru district (public hospital)
2. Berea Government Hospital in Berea district (public hospital)
3. Butha-Buthe Government Hospital in Butha-Buthe district (public hospital)
4. Queen ‘Mamohato Memorial Hospital in Maseru district (public hospital)

These hospitals were selected because a significant number of the healthcare practitioners employed in these facilities are foreigners. In addition, they are state-owned and provide subsidized health services to the public, making them accessible to citizens and therefore highly utilized (Ministry of Health Lesotho, 2013). Additionally, these public hospitals serve urban, semi-urban, and rural populations, each with distinct socioeconomic backgrounds, cultural backgrounds, linguistic dialects, and communication patterns that make their health behaviors and experiences unique.

Purposive sampling was utilized to recruit participants for this study. This is a non-

probability sampling technique used in qualitative research to find information-rich participants who are well-informed about the topic being studied (Cozby & Bates, 2009; Creswell, 2014). This sampling method was considered optimal for this study because it allowed the researcher to select participants who were available, willing, and able to communicate their opinions and experiences in a manner that would best help the researcher understand the problem and answer the research question.

The sampling process was guided by a set of inclusion criteria established for each group of participants. In particular, the following inclusion criteria determined the selection of *patients*:

- Participants had to be Basotho out-patients (18 years and above) in one of the 4 selected public hospitals.
- Their primary language had to be Sesotho.
- Patients were selected on the basis that they had been attended to by an expatriate healthcare practitioner in one of the selected hospitals.
- Patients who took part in this research were selected on the basis that the supervising healthcare practitioner considered them fit to take part in this study and indicated that they were unlikely to be negatively affected by their participation.

The inclusion criteria for *expatriate healthcare practitioners* were that participants had to be:

- Non-proficient or had very low proficiency in Sesotho.
- Had attended to Basotho patients in the selected public hospitals.

The final sample consisted of 42 participants, comprised of 24 Basotho patients and 18 expatriate healthcare practitioners who were treated or worked in the selected public hospitals. The characteristics of the participants are tabulated in **Table 1** for patients and **Table 2** for expatriate healthcare practitioners.

Table 1. Characteristics of Patient Participants

Participant	Gender	Age	District	Hospital
1	Female	52	Maseru	Queen 2
2	Female	58	Maseru	Queen 2
3	Female	59	Maseru	Queen 2
4	Female	62	Maseru	Queen 2
5	Male	65	Maseru	Queen 2
6	Female	53	Maseru	Queen 2
7	Female	34	Berea	Berea Hospital
8	Male	48	Berea	Berea Hospital
9	Male	52	Berea	Berea Hospital
10	Female	28	Berea	Berea Hospital
11	Female	32	Berea	Berea Hospital
12	Male	34	Berea	Berea Hospital
13	Female	36	Butha-Buthe	Butha-Buthe Hospital
14	Female	57	Buthe-Buthe	Butha-Buthe Hospital
15	Female	29	Butha-Buthe	Butha-Buthe Hospital

16	Female	37	Butha-Buthe	Butha-Buthe Hospital
17	Female	21	Butha-Buthe	Butha-Buthe Hospital
18	Male	48	Butha-Buthe	Butha-Buthe Hospital
19	Female	53	Maseru	Queen 'Mamohato Memorial Hospital
20	Female	42	Maseru	Queen 'Mamohato Memorial Hospital
21	Female	61	Maseru	Queen 'Mamohato Memorial Hospital
22	Male	47	Maseru	Queen 'Mamohato Memorial Hospital
23	Male	52	Maseru	Queen 'Mamohato Memorial Hospital
24	Male	58	Maseru	Queen 'Mamohato Memorial Hospital

As shown in Table 1, the participant group consisted of 8 males and 16 females between the ages of 21 and 65 years. These participants were cared for by expatriate healthcare professionals in the various health departments of public hospitals, including gynaecology, dentistry, optometry, and general medicine.

Table 2. Characteristics of Expatriate Health Care Practitioner Participants

Participant	Gender	Age	Department	District	Hospital	Country of origin
1	Male	43	Dentistry	Berea	Berea Hospital	Nigeria
2	Male	47	OPD	Berea	Berea Hospital	Democratic Republic of Congo
3	Male	43	OPD	Berea	Berea Hospital	Democratic Republic of Congo
4	Male	38	Gynaecology	Butha-Buthe	Butha-Buthe Hospital	Malawi
5	Female	52	Dentistry	Butha-Buthe	Butha-Buthe Hospital	Senegal
6	Male	34	OPD	Butha-Buthe	Butha-Buthe Hospital	Nigeria
7	Female	40	Cardiology	Butha-Buthe	Butha-Buthe Hospital	Democratic Republic of Congo
8	Female	36	OPD	Maseru	Queen 'Mamohato Memorial Hospital	Bangladesh
9	Female	39	Optometry	Maseru	Queen 'Mamohato Memorial Hospital	Democratic Republic of Congo
10	Male	45	Oncology	Maseru	Queen 'Mamohato Memorial Hospital	Malawi

11	Female	33	Gynaecology	Maseru	Queen 'Mamohato Memorial Hospital	Democratic Republic of Congo
12	Female	54	Paediatrics	Maseru	Queen 'Mamohato Memorial Hospital	Scotland
13	Male	31	OPD	Maseru	Queen 2 Hospital	India
14	Female	39	ENT	Maseru	Queen 2 Hospital	Cuba
15	Male	52	ENT	Maseru	Queen 2 Hospital	Bangladesh
16	Male	47	OPD	Maseru	Queen 2 Hospital	Cuba
17	Female	43	OPD	Maseru	Queen 2 Hospital	Nigeria
18	Female	38	Optometry	Maseru	Queen 2 Hospital	Democratic Republic of Congo

Expatriate healthcare practitioners who participated in the study were from the four selected Lesotho public hospitals. The participants came from three continents across the globe: Africa, Asia, Europe, as well as from Cuba. Three healthcare practitioners were from Nigeria, six were from the Democratic Republic of Congo, two were from Malawi, one was from Senegal, two were from Bangladesh, one was from Scotland, one was from India, and two were from Cuba. This participant group consisted of 9 males and 9 females with an age range of 31 and 54 years. They were hired to contribute their expertise to a variety of departments in the selected public hospitals, as indicated in Table 2.

3.5.2 Data collection

Individual semi-structured interviews were used to collect data. These types of interviews are a focused data collection method that occurs conversationally and allows for two-way communication between a participant and a researcher (Cohen & Manion, 1994; Jamshed, 2014). This method of data collection was deemed appropriate to use in this study because they are flexible; the interviewee uses their own words to express themselves, which allows for more elaboration while also allowing the interviewer to formulate impromptu follow-up questions that help uncover additional important details about the topic being researched (Alshenqeeti, 2014; Newton, 2010:01). Interview guides were used to facilitate the interviews (Refer to Appendices 1 and 2). Typically, such guides contain a series of mostly open-ended questions about the topics that a researcher wants to cover in interviews with participants (Bird, 2016). In the case of the present study, the interview guide for *patients* was comprised of six questions aimed at exploring their views, experiences, and perceptions of how language and cultural differences affect the quality of healthcare provided by expatriate healthcare practitioners, as well as their views on strategies that can be employed to reduce these implications. The interview guide for *expatriate healthcare providers* consisted of five questions that centered on exploring the implications of language and cultural differences on the quality of healthcare they provide in Lesotho public hospitals and their views on strategies that can be employed to reduce associated adverse implications.

All interviews with participants were conducted by the researcher herself in small, private, distraction-free offices, which were available in all but one hospital. In the latter case, the researcher was provided with a secluded stretch tent to conduct interviews with the patients on the hospital premises, as all patients had indicated that they wanted to meet the researcher when they came for follow-up appointments. All interviews with the expatriate healthcare practitioners were conducted in their consulting rooms. Sesotho (the researcher's native language) was used for the interviews with patients, while English was used for the interviews with the expatriate healthcare practitioners.

3.5.3 Research Procedure

After ethical clearance was granted by the NWU Human Health Research Ethics Committee (NWU-02127-20-A7), the researcher contacted the Office of the Principal Secretary of the Ministry of Health in Lesotho to discuss the proposed study and request permission to conduct interviews in the four selected public hospitals. After permission

was granted (see Appendix 4), the researcher contacted the administrators of Queen ‘Mamohato Memorial, Queen 2, Butha-Buthe, and Berea hospitals to assist in identifying, contacting, and arranging individual meetings with the potential participants (expatriate healthcare practitioners), who met the inclusion criteria. The purpose of these meetings was for the researcher to explain to potential participants in more detail what the study entailed and to provide them with consent forms that, following the prescribed ethical mandate, had to be read at least 24 hours before they were signed. Appropriate dates, times, and locations for the interviews were then agreed upon with the participants. At the beginning of the interviews, the researcher reminded participants of the study's objectives and assured them that confidentiality would be maintained. The researcher used interview guides to facilitate the interviews (see Appendix 1), each lasting between 20 and 30 minutes, and recorded using an audio voice recorder with the participants' consent.

When selecting the second group of participants (patients), the researcher used the same strategy of contacting the hospital administrators at Queen' Mamohato Memorial, Queen 2, Butha-Buthe, and Berea hospitals for advice and assistance in identifying potential participants who met the study inclusion criteria by posting research notices on the hospital bulletin boards. The notices included information about the research, eligibility criteria, and researchers' contact details, which were to be used by potential participants to contact her and express interest in participating. After responding to the invitation to participate, potential participants were provisionally considered. The researcher was also provided with contact details of interested potential participants who, for various reasons, were unable to contact the researcher to inform her of their interest in participating in the research. Following the purposive sampling criteria, only patients deemed suitable by their physicians to participate in the study were included. Meetings were arranged with them at times and locations convenient to them. The purpose of these meetings was for the researcher to explain to them in more detail what the study entailed and to provide consent forms, which, per the required ethical mandate, had to be read at least 24 hours before they were signed. Appropriate dates, times, and locations where the interviews were to be carried out were set. At the beginning of the interviews, the researcher reminded them of the purpose of the study and assured them that confidentiality would be maintained. To facilitate the interviews, the researcher used interview guides (see Appendix 2). The interviews were audio recorded with the participant's consent and were audio recorded with the participant's consent. They lasted between 20 and 30 minutes.

3.5.4 Data analysis and interpretation

Thematic analysis (Braun and Clarke, 2006) was used to analyze the data derived from the interviews. This six-step framework was used to identify, analyze, and report patterns within the data collected relating to the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and their views on strategies that can be employed to reduce the noted adverse implications to provide meaningful insights and bring a better understanding of this research phenomenon. Following the recommendations of Braun and Clarke (2006), the following six steps were followed in the analysis.

Step 1 Familiarization with the data

This step involves the researcher becoming familiar with the data by repeatedly going through the entire data set (Byren, 2021). To familiarize herself, the researcher listened carefully and repeatedly to the audio recordings of the interviews. She then created verbatim transcriptions of the recordings and read through the transcripts several times to delve into the data and confirm that the transcribed information was accurate.

Step 2 Generating initial codes

This step involves systematically generating initial codes and then organizing them into meaningful groups (Maquire & Delahunt, 2017). Coding is about breaking data into meaningful chunks. This process is performed to create short, concise descriptive or interpretive labels for information that may be relevant to the research question (Byren, 2021). With this in mind, the researcher worked systematically through the entire data set, giving equal consideration to each data element in the set and identifying aspects of the data elements that were relevant and likely to influence the development of themes. She marked the identified text segments that were relevant to the research question and generated codes to describe their content.

Step 3 Searching for themes

In this step, the coded data is reviewed and analyzed to see how different codes can be combined according to their shared meaning so that they can form potential themes (Byren, 2021). The researcher examined the generated codes to identify patterns within them and began to develop broader themes that appeared to answer the research question. Some related initial codes were combined into a single theme, and some were found to be representative of an overarching narrative within the data and others formed subthemes, while other irrelevant initial codes were discarded.

Step 4 Reviewing themes

In this step, the researcher must review and refine the preliminary themes generated in step three to determine whether they were meaningful, useful, and represent an accurate representation of the data (Maquire & Delahunt, 2017). To ensure that the themes were coherent and clear, the researcher read through the data associated with each theme to determine whether they supported the generated theme. When necessary, some themes and subthemes were split, combined, or in some cases discarded to ensure that data within themes were clear, meaningful, and unambiguous.

Step 5 Defining and naming the themes

According to Braun and Clarke (2006), this step involves articulating what each theme means and identifying how it contributes to understanding the data. Furthermore, in this step, the researcher expresses how each identified theme and sub-theme is interconnected and related to the research questions. According to Patton (1990), each topic should be coherently and consistently supported by data and should be unrelated to other topics. To enable this final refinement phase, the researcher drew on the compiled data extracts of each theme and sub-themes to organize them into coherent and clearly defined themes.

Step 6 Producing the report

This step begins immediately after the researcher defines the themes, and involves writing a report that is coherent, logical, non-repetitive, and fully detailed, and contains the themes from the data set that are related to the phenomenon under study (Braun & Clarke, 2006). Following Braun and Clarke (2006), the report points out relevant themes previously built upon, then reports in a consistent manner that conveys their narrative. The researcher compiled a report that explained how the themes emerged and what they meant and included excerpts from the interviews as evidence.

3.6 Quality and ethical considerations

3.6.1 Quality considerations

According to Nowell *et al.* (2017), it is necessary to ensure that qualitative studies are conducted rigorously and follow a set of procedures and protocols aimed at producing meaningful results that are robust and maintain the integrity of the conclusions. It is a way to reassure readers that the research results are valuable; it is about the degree of confidence in the data, interpretation, and methods used that confirm the quality of the study. Lincoln and Guba (1985) refined the concept of trustworthiness by introducing

transferability, confirmability, and credibility. Each of these concepts is explained below.

Transferability

Transferability is the degree to which the results of qualitative research can be transferred to other contexts with different participants. This is facilitated by a detailed description of the investigation and the use of appropriate sampling methods (Anney, 2014). This study, it was improved by using a purposive sampling approach and providing a clear description of study participants, inclusion criteria, interview guides, and a clear representation of the research setting.

Confirmability

Confirmability is about the neutrality of the data. According to Lincoln and Guba (1985), the interpretation of the results should not be based on the preferences of the researcher but should be based on the ideas and experiences of the participants. To facilitate confirmability, the researcher provided careful documentation of the data collection and analysis processes, detailing all steps undertaken. In addition, the researcher considered and explained the theoretical, methodological, and analytical decisions she made throughout the study. This decision path ensures confirmability in qualitative studies because it explains how and why these decisions were made (Koch, 1994).

Credibility

According to Bradley (1993: 436), credibility means ensuring the accuracy of results; that is, whether the results reflect the scenario being studied. In this study, this was ensured by only including participants who had insight into the topic under investigation and met the inclusion criteria. It was also ensured by using a well-established data collection method (semi-structured interviews), which allowed interactive questioning. According to Stahl and King (2020), this facilitates the collection of credible data and helps minimize the risk of misinterpretation by the researcher. To further ensure the credibility of this study, the researcher used interviewee transcript reviews. According to Hagen *et al*., (2009), interviewees are provided with verbatim transcripts of their interviews to allow them to verify accuracy, to correct errors or incorrectness, and to provide further clarifications. The researcher did this by reading the dialogue transcripts to the participants after conducting the interviews to determine whether the information captured matched what they had narrated.

3.6.2 Ethical considerations

Ethics are norms or standards of behaviour that distinguish between right and wrong. They help determine the difference between acceptable and unacceptable behaviour. According to the National Committee for Research Ethics in the Social Sciences and Humanities (2005), considering ethical issues when conducting a study helps a researcher promote social values and ensure that they are accountable to the public by avoiding conflict and harming human subjects. They also support the researcher in making morally acceptable decisions. For this study, the researcher sought and was granted ethical clearance from the NWU Ethics Committee for this study (see Appendix 3). Furthermore, the following ethical aspects will be considered:

Informed consent

According to Shahnazarian *et al.* (Undated), this is a voluntary agreement to participate in research. In conducting this research, it was ensured that potential participants understood the research in which they wished to participate. They were informed about the purpose of the study, the processes in which they would be involved, the duration, potential risks, etc., and possible benefits of their participation. Those who agreed to take part in the study were given the consent forms, which they had to read 24 hours before signing. Signing these forms was evidence that they fully understood what the study entailed and what role they would play. It was important to obtain consent from participants to avoid violating their privacy and thereby avoiding harm.

Voluntary participation

Voluntary participation implies that individuals participating in a study should exercise their free will in deciding whether or not to participate in a research activity (Smith, 2003:56). Therefore, participants must not be forced to take part in a study. Participation in this study was completely voluntary. Participants were informed of their right to refuse to answer certain questions or to withdraw from the study at any time if they wished, without facing any form of penalty.

Confidentiality

In this study, confidentiality was ensured by keeping the information provided by participants confidential, known only to the researcher, and therefore was not disclosed to anyone else without their consent. The identity of the participants was not reflected. It was important to maintain confidentiality in research because disclosing and disseminating incriminating information provided by other participants could harm the

subjects (Drew *et al.*, 2007:57).

Fidelity

Fidelity is about building trust between the researcher and the research participants, as it is a must to protect the participants and their well-being in the research situation (Garity, 1999, cited in Gelling, 1995:39). Fidelity in this study was ensured by honestly informing participants about the potential risks and burdens of participating in the study. In addition, the researcher ensured that the participants were not exposed to any harm. This was achieved by avoiding exerting any pressure on participants to reveal sensitive, private, degrading, or humiliating information. According to Drew *et al.* (2007:57), researchers must respect the privacy, dignity, and sensitivities of participants. This was done by avoiding manipulative, suggestive and instructive questions. This was also avoided by respecting participants' privacy, conducting honest research, and protecting participants' reputations, relationships, and well-being.

3.7 Findings

The thematic analysis of the data provided by patients and expatriate healthcare practitioners resulted in the identification of five themes related to the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. They included: **miscommunication, poor patient assessment, negative emotional responses, patients' resistance to undertaking suggested treatments and medical procedures, avoidance behaviour, and queueing of patients**. Furthermore, four themes were identified. They related to the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences. The themes included **ensuring that expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual, the orientation of expatriate healthcare practitioners, developing a medical interpreting curriculum in schools and hiring professional interpreters.**

The identified themes and subthemes are discussed in the remainder of this section.

3.7.1 The implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

Theme 1: Miscommunication

The most prevalent theme related to the implications of language and cultural differences

on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals was **miscommunication**. This relates to the assertion often expressed by participants that they often do not communicate as desired.

Several subthemes were identified relating to this theme, which include the failure *of expatriate healthcare practitioners to understand patients, awkwardness and discomfort,* and *the elimination of vital information.* They are discussed below.

Failure of expatriate healthcare practitioners to understand patients.

Language and cultural differences contribute to *the failure of expatriate healthcare practitioners to understand patients.* Findings suggest that the two parties do not communicate adequately during consultations, resulting in expatriate healthcare practitioners not being able to adequately understand certain important health-related issues that concern patients, such as discussions of a patient's medical situation, symptoms a patient is experiencing, and a patient's lifestyle.

Participant 7 (expatriate healthcare practitioner) from Butha-Buthe Hospital relates that:

> *"In instances where a patient is not fluent and engaging during consultations, it becomes difficult for me to understand and gather information that may help me diagnose them, making the designing of a treatment plan challenging."*

Similarly, participant 9 (expatriate healthcare practitioner) from Queen 'Mamohato Memorial Hospital indicates that:

> *"I use both Sesotho (with low levels of proficiency) and English languages during consultations with patients. The use of the two languages is efficient to some extent because at times we can communicate, and I can establish symptoms a patient is experiencing and some of the required information regarding the illness. However, at times I struggle to understand what the patient is relating to me. They sometimes fail to answer some of the questions I ask to establish information that may lead to a diagnosis…".*

The main focus of consultations is to obtain information about the patient's problems and concerns, provide information, discuss treatment options, and provide necessary support (Maguire *et al.*, 1999). However, the expatriate healthcare practitioners' responses

suggest that the presence of language and cultural differences limit their ability to reach the core of the consultations. This could potentially have a negative impact on health outcomes.

Illustrating this point, Participant 2 (expatriate healthcare practitioner Berea Hospital) narrates: *"…we sometimes serve people who come from villages where the way of living and languages used are primitive, this kind of people use deep Sesotho dialect which is very hard to understand. In such instances, it becomes difficult to understand them and to probe more to gather the necessary information…".* Participant 4 (expatriate healthcare practitioner Butha-Buthe Hospital) further points out that *"…In instances where a patient is not fluent and engaging during consultations which often occurs due to language barriers, it becomes difficult to understand information that may help diagnose them, deeming the designing of an appropriate treatment plan challenging."*

The presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals contributes to the practitioners not correctly interpreting and understanding important information from patients during consultations. This leads to misunderstandings of crucial facts necessary for an appropriate diagnosis, which increases the likelihood of numerous negative health consequences for patients, including misdiagnosis and incorrect prescriptions, which can lead to further disease complications and can result in loss of lives.

Awkwardness and discomfort

Another subtheme that was identified was *awkwardness and discomfort.* Findings suggest that patients in the Lesotho public hospitals become uneasy during consultations with expatriate healthcare practitioners due to communication challenges associated with the presence of language and cultural differences.

Participant 1 (patient) in Queen 2 Hospital relates that:

> *"I feel that the expatriate healthcare practitioners handle themselves in a way that portrays them as being unwelcoming and unfriendly during consultations. I do not feel free and often there is tension in the consultation rooms…".*

Similarly, participant 16 (patient) in Queen 'Mamohato Memorial Hospital mentions that:

> *"The expatriate healthcare practitioners are always keeping a serious*

face and never try to make conversation. They never try to initiate a conversation to ease up the tension…This creates an uncomfortable environment...".

The inability of patients and expatriate healthcare practitioners to communicate properly due to language and cultural differences creates displeasure for patients. The following excerpts from participants' (patients) responses depict this state of affairs.

> Participant 8 (patient) in Berea Hospital relates that: "…*Doctors are strictly focused on examining and writing they would rather be on their phones than talk to a patient to find out more information that could be leading to the illness, this behaviour makes me scared to speak or to ask questions. It becomes very awkward".*

It is apparent from the participants' accounts that the inability of patients and expatriate healthcare practitioners to communicate well due to language and cultural differences results in patients feeling uneasy and unwelcome. This can contribute to increased avoidance behaviours. The responses from the expatriate healthcare practitioners were not related to this theme. These frustrations caused by these discordances will be discussed in the sections below.

Elimination of vital information by patients.

An additional subtheme was the *elimination of information by patients*. Findings suggest that given language and cultural differences, patients choose to eliminate some health-related information that forces them to use English terms they do not know. They resort to free themselves from the anxiety associated with explaining themselves in a language they are not fluent in.

> Illustrating this, Participant 22 (patient) from Queen 'Mamohato Memorial Hospital relates that: *"…Sometimes I try to explain in detail my symptoms. But if I realize that even after applying effort to explain myself to the expatriate healthcare practitioner, they still fail to understand me, I decide to eliminate that issue in our discussion."*

> Echoing these sentiments, Participant 16 (patient) from Butha-Buthe Hospital points out that: *"…During consultations, some issues are easy to explain but some require the use of words that I do not know. When I come across such situations, I decide to address those that I can be able to explain, and I never attempt to explain those*

symptoms which require me to use difficult terminology."

Patients' decisions to limit the disclosure of critical health information during consultations with expatriate healthcare practitioners are also influenced by the presence of health-related cultural beliefs and values. This statement is supported by extracts from participants' (patients) responses.

> Participant 10 (patient) in Berea Hospital relates*: "As a Mosotho adult, it is not culturally appropriate to discuss certain issues with people of certain social characteristics. These beliefs force me to sometimes eliminate some sensitive information during consultations...".*

There is evidence that language and cultural differences between patients and expatriate healthcare practitioners influence patients' decisions not to fully disclose some important health-related information during consultations, sometimes because they lack the correct terms to convey this information and sometimes because they are hindered by their cultural values. Most of the customs and language restrictions that hinder patients from disclosing some information during consultations are only known to themselves, making it impossible for the practitioners to be aware that some information has been concealed. Such practices were likely to lead to the patient's resistance to undertaking the proposed procedures, knowing that the diagnosis was made based on incomplete information they provided.

Theme 2: Poor patient assessment

A second prevalent theme that was identified was **poor patient assessment.** The presence of language and cultural differences increases the likelihood that expatriate healthcare practitioners do not collect enough health-related information from patients regarding their illnesses. As a result, in some cases, the actual health challenges and needs of patients are not recognized.

> Participant 3 (expatriate healthcare practitioner) in Berea Hospital relates that:
>
> > *"...I struggle to properly communicate with patients and end up relying mainly on conducting tests for diagnosis. This denies me a chance to learn more about my patients, their lifestyles, and family history, making the selection of treatment plans that would best suit them challenging."*
>
> Resonating a similar account, Participant 5 (expatriate healthcare

practitioner) in Butha- Buthe Hospital indicates that:

> *"I use English mostly and Sesotho (low proficiency) ... sometimes I struggle to understand when patients narrate symptoms because every patient has a unique illness and ways of expressing themselves. In such instances where comprehending what the patient is relaying is challenging, the process of assessing their situation becomes difficult."*

The process of identifying and collecting information about a patient's physiological and psychological symptoms, reflecting on a patient's current and future needs, and enabling the formulation of a diagnosis is central to clinical care. However, the above evidence suggests that the presence of language and cultural differences in Lesotho public hospitals hinders the ability of the practitioners to carry out such.

> Participant 9 (expatriate healthcare practitioner) Queen 2 Hospital further relates that *"For me to be able to assess every patient's condition, I need to examine and ask them questions about their symptoms, but when there are language barriers then assessing their conditions through asking questions and holding discussions becomes difficult."* Participant 4 (expatriate healthcare practitioner in Butha-Buthe Hospital) also narrates that*: "…In normal situations, I must ask some questions to the patients to establish what symptoms they are experiencing so that I can be able to diagnose them. If communication is poor, then it means I may then fail to get the information I need from a patient to come up with a correct diagnosis."*

According to the responses of participants, the presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals causes the latter to fail to gather sufficient health-related information required to arrive at a reliable diagnosis. This is likely to increase the likelihood of expatriate healthcare practitioners misdiagnosing patients, a situation linked to subsequent illness complications and, in some cases, mortality. Patient assessment is a process undertaken by a healthcare professional that involves identifying a medical problem of a patient in a healthcare setting. As such, patients rely on healthcare practitioners to diagnose them as they are not equipped with skills that can enable them to correctly evaluate the accuracy of the conducted assessments thus their responses were not related to this theme.

Theme 3: Negative emotional responses

Another recurring theme that was identified was the negative **emotional responses.** During consultations, the presence of linguistic and cultural differences evoked negative emotions in patients and expatriate healthcare practitioners. Several sub-themes were identified that center on the experience of specific negative emotions, which include: *increased frustrations for expatriate healthcare practitioners, stress and anxiety,* and *mistrust.*

Increased frustrations for expatriate healthcare practitioners

Findings indicate that the presence of language barriers and cultural differences in Lesotho public hospitals results in *frustrations for expatriate healthcare practitioners*. They express dissatisfaction because of the emotional strain they undergo as a result of being unable to communicate effectively with patients.

> Participant 1 (expatriate healthcare practitioner) in Berea Hospital relates that:
>
> > *"I become very frustrated when I consult patients who barely speak English because I struggle with exchanging important information with them during consultations. Another factor that frustrates me is incidents where the clinical assistant placed in my clinic summarizes the information that patients narrate during consultations….I normally then must pester the assistant to try as much as possible to make them translate every piece of information a patient is relaying for me to diagnose them properly."*
>
> In a related manner, participant 10 (expatriate healthcare practitioner) at Queen 'Mamohato Memorial Hospital narrates that:
>
> > *"I get frustrated during consultations because at times patients fail to fully express themselves as they struggle to communicate due to language barriers. At times they begin to panic and become hysterical and unable to comfortably relate their illnesses and symptoms after realizing that I am not a Mosotho".*

Expatriate healthcare practitioners' responses acknowledge that language and cultural differences between themselves and patients in Lesotho public hospitals often cause incidents that leave them irritated. This is likely to lead to an exacerbation of distress, which is likely to result in frustration-related disorders, e.g., depression. Furthermore, this

is likely to reduce their job satisfaction. As indicated earlier, responses from patients pointed out that these discordances resulted in them being uncomfortable, a phenomenon associated with the theme of “awkwardness and discomfort”.

Stress and anxiety

Findings further indicate that patients suffer from *stress and anxiety* while waiting to consult expatriate healthcare practitioners. These are exacerbated by anticipation of the communication hurdles they are likely to encounter when interacting with these practitioners who speak a different language to theirs.

Participant 4 (patient) in Queen 2 Hospital relates that:

> *“When queuing up in the hospital I become agitated when I am not certain whether I will be attended to by a local or an expatriate doctor. This occurs because I am likely to face communication challenges should it happen that I am attended to by an expatriate healthcare practitioner because of the language they use to conduct consultations which is English”.*

Participant 23 (patient) 2 from Queen ‘Mamohato Memorial Hospital Maseru echoes the same sentiments and relates that:

> *“I undergo so much stress when queuing up to go consult an expatriate healthcare practitioner, I spend the entire time in the queue rehearsing what I will be saying in the consultation room, and I become anxious from all that and the fear that I might forget to mention some important information regarding my illness or symptoms.”*

Participants (patients) also point out that the stress, nervousness, and anxiety they feel increase even more when they finally find themselves in the consulting rooms where they are attended to by expatriate healthcare practitioners.

Participant 14 (patient) in Maseru Queen 2 Hospital mentions that:

> *“When I walk into a consultation and realize that the doctor who will be attending to me is not a Mosotho, my self-esteem immediately drops, and I start panicking because I begin to ask myself if the doctor will understand me due to language barriers. I begin to ask myself if I will understand him/her. I also ask myself if I will be able to remember to mention all my symptoms. Furthermore, I ask myself if I will be able*

to ask some follow-up questions as I am a very inquisitive person. These are all the questions that come to my mind and induce stress."

In addition, Participant 5 (patient) from Butha-Buthe Hospital relates that:

> *"At times I walk into a consultation room, seeing a fellow black woman/man doctor I relax with the belief that the doctor is a Mosotho and therefore will have an engaging consultation but all that often changes as we greet each other. The expatriate healthcare practitioners from African countries have an accent that is recognizable even if they greet in Sesotho. After realizing that the doctor is not Sotho, I become anxious because I begin to question my ability to converse with someone who does not speak the same language as me, especially when it comes to health issues."*

These excerpts from patients' responses indicate that the presence of language barriers and cultural differences between themselves and the expatriate healthcare practitioners in Lesotho public hospitals leads to fears of misunderstandings and miscommunication during consultations, which in turn leads to significant stress and anxiety. Components that can cause new stress-related illnesses or aggravate their illnesses resulting in further complications. The expatriate healthcare practitioners' responses were related more to the theme of increased frustration as mentioned in the sections above because it gave them a sense of dissatisfaction as a result of being unable to effectively communicate with patients and to accurately exchange health-related information with them during consultations.

Mistrust

Another identified subtheme related to the experience of negative emotional responses is *mistrust*. The presence of language barriers and cultural differences in public hospitals create uncertainty for vulnerable patients who rely on the expertise of expatriate healthcare practitioners. They lose confidence in these practitioners' ability to meet their healthcare needs.

Participant 5 (patient) in Queen 2 Hospital explains that:

> *"When consulting an expatriate healthcare practitioner, I always ask myself whether the doctor and I will be able to understand each other, whether the doctor will understand well my symptoms because if we fail to understand each other, I may be misdiagnosed and given the*

wrong treatments which may kill me".

In a similar vein, Participant 8 (patient) in Berea Hospital indicates that:

> *"…It becomes hard for me to trust I am diagnosed properly by someone who struggles to understand me. It also becomes difficult for me to ask questions so that I am sure we are on the same page".*

The participants' responses point out that these differences are associated with ineffective communication between patients and expatriate healthcare practitioners which prompts the former to develop uncertainties regarding the correctness of diagnoses made and prescribed treatments.

> Participant 3 (patient) in Queen 2 Hospital further relates that: *"…I always ask myself whether my language will enable the doctor to fully understand my symptoms since we fail to communicate satisfyingly. My worry is if he/she does not understand me properly then there is a high probability that he/she will fail to diagnose me correctly and therefore, I will not get healed."* Participant 13 (patient) in Butha-Buthe Hospital indicates: *"Another communication challenge that I face when consulting a non-Sesotho speaking doctor is that during consultations, it is not easy to determine if the doctor understands the information I am trying to relate because I always try to shorten the conversations because of language restrictions..."*

Extracts from the patients' responses reveal that in Lesotho public hospitals, patients' trust in the abilities of expatriate healthcare practitioners is reduced due to misunderstandings that occur as a result of language and cultural differences. This is likely to result in patients resisting the treatments and medical interventions suggested by these practitioners, as will be discussed next. The expatriate healthcare practitioners' responses were not related to this theme because, in the doctor-patient relationship, the patient is forced by the kind of relationship they have to rely on the expatriate healthcare practitioners' skills and expertise.

Theme 4: Patients' resistance to undertake the suggested medical procedures and treatments

An additional theme that was identified was *patients' resistance to undertaking the suggested medical procedures and treatments.* Findings indicate that the presence of language, and especially cultural differences in terms of beliefs, creates conflict that leads

to patients and expatriate healthcare practitioners consequently disagreeing on some issues regarding medical procedures and treatments and consequent patients' resistance to undertake the prescribed treatment regimens.

Participant 2 (expatriate healthcare practitioner) in Berea Hospital relates that*:*

> *"…Many Basotho patients whom I have diagnosed with cancer refuse to undertake suggested treatments because they believe that cancer can only be cured using certain Sesotho traditional herbs and not chemotherapy and other medications ..."*

Similarly, Participant 10 (expatriate healthcare practitioner) in Queen 'Mamohato Memorial Hospital indicates that:

> *"I work with people who have been diagnosed with HIV/AIDS and at times patients refuse to take ARV treatment because they point out that their beliefs do not allow them to take drugs, some indicate that they know of churches that cure HIV/AIDS while others state that they know of traditional healers that could cure the virus."*

As such, patients' resistance to undertaking medical procedures and treatments suggested by expatriate healthcare practitioners occurs because of their culturally anchored health beliefs that contradict the treatment methods used and prescribed in hospitals by the expatriate healthcare practitioners.

Participant 13 (expatriate healthcare practitioner) in Queen 2 Hospital in Maseru further relates that: *"I have come across a patient who needed a blood transfusion, but he refused and did not consent because he indicated that his religion did not permit him to carry a stranger's blood in his system, he indicated that he could inherit a lot of negative spirits by agreeing to a blood transfusion procedure. He refused and left the hospital."*

Extracts from the participants' responses reveal that the presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals hinder their ability to reach consensual agreements about the treatments and procedures to be performed, leading patients to resist them. Patients' responses did not address this theme because after refusing to undergo the suggested procedures and undertake the recommended treatment that clashed with their beliefs, they proceeded to go through with practices that fit their cultures and beliefs outside of the healthcare

establishment. This could lead to disease complications and poor management of the disease, which could lead to its progression and therefore loss of lives.

Theme 5: Avoidance behaviour and queueing of patients

An additional theme that was identified was **avoidance behaviour**. Findings point out that patients are reluctant to consult expatriate healthcare practitioners due to communication difficulties that are likely to occur due to the presence of language barriers. A particularly prominent phenomenon that was associated with avoidance behavior was *queuing patients in long lines*.

Findings indicate that in the hospitals, patients stand in long queues waiting to consult healthcare practitioners who speak and understand their local dialect. They disregard the length of the queues and wait to receive assistance from the practitioners of their choice with whom they can easily communicate.

Participant 18 (Patient) at Butha-Buthe Hospital narrates that:

> *"When queuing up in the foyer to go consult a healthcare practitioner, I avoid rooms that are manned by expatriate healthcare practitioners because the procedure here is to go into any vacant consultation room when it is your turn. If I see that I may be forced to go into such a consultation room, I ask others who queue behind me to proceed and go inside until I can go into a room where I will be attended to by a Mosotho doctor because I don't like the stress of having to communicate with a doctor who does not speak Sesotho."*

Similarly, participant 2 (patient) in Queen 2 Hospital narrates that:

> *"I queue up where I am told by other patients that the doctor in the consultation room is a Mosotho. I become patient and queue up because I know that going into a room where I will be attended to by an expatriate healthcare practitioner is going to bring me the stress of having to speak a language I am not comfortable expressing myself in (English)".*

For patients, consulting an expatriate healthcare practitioner who does not share a common language and culture with them is a traumatic experience.

Participant 10 (patient) in Berea Hospital shares the same sentiments and relates that:

> *"To avoid the stress of being attended by someone who speaks a language I barely understand, I have identified some expatriate healthcare practitioners who are proficient in Sesotho. They are not 100% fluent but at least with them, I know we will be able to understand each other to a certain extent. I have identified a few and I always wait to be attended by them even if queues to their consultation rooms are long."*

The participants' responses indicate that the presence of language and culture barriers in Lesotho public hospitals influence patients to be hesitant to consult expatriate healthcare practitioners to avoid encountering communication hurdles that regularly arise due to language discrepancies. This results in already sick patients queuing for extended periods to receive medical attention, leading to delays in diagnosis and treatment processes and increasing the likelihood of disease progression and further complications. There is no data relating to this theme from the expatriate healthcare practitioners because they are often seated in consultation rooms during working hours waiting for patients to walk in and it can be assumed that when they do not see patients sequentially walk in, they presume queues are finished; not being aware that patients have opted to queue to see other healthcare practitioners who understand their languages.

3.7.2 Patients and expatriate healthcare practitioners' views on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences

Four themes were identified that related to the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences. As will be discussed in the remainder of this section, the themes that were generated include: *Ensuring expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual; orientation of expatriate healthcare practitioners; developing a medical interpreting curriculum in schools; and hiring professional interpreters.*

Theme 6: Ensuring expatriate healthcare practitioners that are hired to work in Lesotho public hospitals are multilingual

A theme *that* was identified was ensuring expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual. Participants note that, in addition to the required academic qualifications, when hiring practitioners, bodies responsible for

recruitment should ensure that they specify multilingualism as a requirement for healthcare professionals applying for jobs in healthcare facilities in Lesotho; particularly those that require contact and communication with patients.

Participant 22 (patient) from Queen 'Mamohato Memorial Hospital states that:

> *"I understand there is a shortage of local doctors especially specialists in our hospitals and that the government has outsourced them from all over the world, however, the employer or recruiter needs to ensure that they recruit people who will be able to communicate with Basotho patients. They should at least be proficient in English language because it is one of the two official languages in Lesotho and this will facilitate understanding between us".*

In addition, Participant 6 (patient) from Queen 2 Hospital further relates that:

> *"I don't know how they advertise the vacancies for hiring doctors outside the country, but they should ensure that they recruit doctors who are multilingual and who are at least proficient in English to avoid the communication challenges that are occurring at the present moment."*

Participants (patients) in this study indicate that to avoid communication breakdown between themselves and expatriate healthcare practitioners in Lesotho public hospitals and consequent negative health outcomes, relevant authorities must ensure that they employ expatriate healthcare practitioners who are multilingual, especially those proficient in English, which, although not the official language of Lesotho, is reasonably well understood by many of its citizens. There is no data from expatriate healthcare practitioners relating to this theme mainly because the two parties hold different stances as consumers and service providers of healthcare in Lesotho public hospitals, hence different views on strategies that could be adopted.

Theme 7: Orientation of expatriate healthcare practitioners

Conducting an **orientation for newly hired expatriate healthcare practitioners** was another prevalent theme that was identified. Findings indicate that participants believe that upon their arrival in Lesotho, the newly recruited expatriate healthcare practitioners should be immersed in the dynamics of Basotho health beliefs, customs, health-seeking behaviours, and language use in healthcare via training programs that will be organized by different stakeholders to equip them with the information they need to provide culturally

sensitive healthcare services in the public hospitals.

Participant 3 (expatriate healthcare practitioner) in Berea Hospital narrates:

> *"…all we need to do as expatriate healthcare practitioners is to have the willpower to learn the language and culture of the people we serve. This can be achieved with the support of those who are responsible for the welfare of expatriate healthcare practitioners. It can be done with the assistance of the Ministry of Health whereby retreats can be organized for us where we could interact with people in linguistics and culture departments or NGOs where they will provide us with courses on the Sesotho language in medicine and the role of Sesotho culture in medicine. The government can engage consultants who can research and design programs that will assist us to be able to communicate and interact with Basotho patients in a more culturally competent way that could assist us to achieve the best healthcare outcomes."*

To add on, Participant 14 (expatriate healthcare practitioner) in Queen 2 Hospital in Maseru also relates that:

> *"The Ministry of Health should design and implement a learning course that every one of us will be mandated to undertake before we start working with Basotho patients to give us an idea of the culture and basic language of the people we will be serving. This will prevent culture shock and will help us to understand common practices and the language frequently used in healthcare to avoid conflict and the committing of errors in the process of serving their healthcare needs."*

Lastly, participant 9 (expatriate healthcare practitioner) in Queen 'Mamohato Memorial Hospital mentions that:

> *"When we are recruited to work in hospitals, it is often a matter of urgency, we engage in consultations with patients as soon as we get to the hospitals due to the serious human resource shortages in the hospitals, I would suggest that the Lesotho Government offers mandatory online courses that will orientate us as on Basotho cultures and languages they use, it should be mandatory to take this course for at least six months upon arrival in Lesotho."*

After acknowledging that the presence of language barriers and cultural differences adversely affects the delivery of quality healthcare in Lesotho public hospitals, the expatriate healthcare practitioners suggest that relevant authorities launch an introductory program introducing them to Basotho culture, norms, customs, and language. They believe that this strategy is likely to help improve their cultural sensitivity and thus better interactions with patients, which in turn will improve the delivery of quality healthcare. Responses from patients are not related to this theme because of the technicalities associated with the suggested strategy. Only the expatriate healthcare practitioners were cognizant of these as they have experience and knowledge of how healthcare systems operate.

Theme 8: Developing a medical translation curriculum in schools

Developing a medical translation curriculum in Lesotho tertiary institutions was identified as a theme related to strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences. Participants point out that education experts should design curriculums that will enable enrolled students to understand and translate clearly and accurately and to familiarize them with the intrinsic medical jargon used in consultations between patients and healthcare practitioners who do not share a common language and culture.

Participant 3 (patient) from Queen 2 Hospital relates:

> *"…the Ministry of Health should work hand in hand with the Ministry of Education to introduce medical translation courses where programs will be designed specifically to train individuals to be able to translate in hospitals to assist with communication between patients and healthcare practitioners who do not share a common language. These courses should be designed to upskill the trainees' ability to translate medical terms in languages used by patients and expatriate healthcare practitioners in Lesotho public hospitals."*

Furthermore, Participant 21 (patient) from Queen 'Mamohato Memorial Hospital states that:

> *"The Ministry of Education should introduce an educational program where Basotho youth who have completed their degree in languages can be trained for medical translating as a course to add to their*

degrees to enable them to work in hospitals…The government should then create jobs for them depending on the number of expatriate healthcare practitioners per hospital."

Participants' responses indicated that academia should work with the public sector (government ministries) to introduce the curricula in higher education institutions in Lesotho to train medical translators. Trainees should be equipped with specific skills and expertise that will allow them to correctly handle the specific terminology used in consultations between patients and expatriate healthcare practitioners to avoid incidents of miscommunication and misunderstandings that lead to numerous repercussions and thus poor healthcare delivery. Responses from the expatriate healthcare practitioners were not related to this theme.

Theme 9: Hiring Professional Interpreters

The hiring of professional interpreters was another identified prevalent theme. Participants note that hospitals should hire well-trained individuals and certified interpreting companies to work in hospitals where patients and healthcare professionals have difficulties communicating due to language barriers.

Participant 12 (expatriate healthcare practitioner) in Queen 2 Hospital in Maseru indicates that:

> *"Hospitals need to hire interpreters that are accessible to patients and to us any time they are needed because the people who are currently performing these duties are not reliable as they have other duties to perform in the hospitals. I also think they are not well trained for the role of interpreting thus they miss out on important information discussed between us and patients during consultations."*

In a similar vein, participant 6 (expatriate healthcare practitioner) from Butha-Buthe Hospital relates:

> *"Hospitals need to hire interpreters that are accessible to patients and to us to assist at any time their services are needed. They should be trained professionals to avoid problems that could occur if they mistranslate some information as this could put the lives of patients and our jobs at risk."*

Lastly, Participant 12 (patient) in Berea Hospital explains that:

> *"For me, there is not much that can be done because upon being recruited, doctors are expected to start work as soon as they get into the country because of the staff shortages in our hospitals. They, therefore, cannot afford to spend a week or two being taught the Sesotho language, rather the hospitals can engage private companies to offer interpreting services in hospitals for patients who may need such services".*

Patients and expatriate healthcare practitioners suggest that hospitals hire professional interpreters and private companies who have the necessary literacy and cultural mediation skills to increase patient satisfaction and the frequency of positive medical outcomes.

3.8 Discussion

This study aimed to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. The secondary aim of this study was to explore their views on strategies that can be employed to reduce the noted adverse implications. In line with the qualitative methodology that was adopted for the study, semi-structured interviews were used to collect data from 42 participants in four selected Lesotho public hospitals. Thematic analysis was used to analyze the data from the patients and expatriate healthcare practitioners. Five themes and seven sub-themes were identified which elucidate the implications. In addition, four themes were identified regarding the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the adverse implications associated with language and cultural differences.

Findings from this study indicate that the presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals results in **miscommunication**. As a result, *expatriate healthcare practitioners fail to understand patients* during consultations while having discussions on issues such as medical situations and other health-related topics. These findings are consistent with those from previous studies that showed that patients and healthcare practitioners who do not share a common language and culture fail to understand each other during consultations (de Mosaic and Bowen, 2018; Mustafa *et al*., 2023; Pytel *et al*., 2009;

Schlemmer & Mash, 2006). The current study further reveals that as a result of the failure of patients and expatriate healthcare practitioners to understand each other, the former experiences *awkwardness and discomfort.* Findings from previous studies also showed that patients often felt uncomfortable during consultations when they did not share a common language and culture with the attending healthcare practitioner (Almutairi, 2015; Mustafa *et al.*, 2023; Pandey *et al.*, 2021). In addition, findings from the present study also reveal that as a result, some patients decide to *eliminate vital information* regarding their health. These results are supported by the existing literature. Previous studies found that linguistic and cultural discrepancies lead patients to omit important information during consultations with doctors who do not share a common language and culture to avoid the burden of having to explain some symptoms in languages they are not fluent in (Al-Kabani *et al.*, 2020; Al Shamsi *et al.*, 2020; Kale & Syed, 2010; Sobane, 2013).

The current study further reveals that all the above-mentioned implications lead to expatriate healthcare practitioners **poorly assessing patients' health conditions**. These findings, in turn, echo those of previous studies that showed that linguistic and cultural differences in healthcare contribute to doctors' inability to gather enough important health information about patients to accurately assess their condition (Alshammari *et al.*, 2019; Pandey *et al.*, 2021).

In the present study, it was found that the presence of language and cultural differences between patients and expatriate healthcare practitioners is associated with several **negative emotional responses** for both parties. Expatriate healthcare practitioners suffer *increased frustration* due to being unable to efficiently interrelate with patients during consultations. This finding is consistent with those of previous similar studies, which found that when faced with language and cultural barriers, healthcare practitioners have difficulty communicating well with patients and become frustrated as a result (Alhamami, 2020; Alshammari *et al.*, 2019; Mustafa *et al.*, 2023; Naidoo, 2014; Pandey *et al.*, 2021). Furthermore, this study finds that patients suffer from *stress and anxiety* due to enduring communication hurdles whilst consulting expatriate healthcare practitioners. Findings from previous studies similarly revealed that language and cultural discordances resulted in communication complications that caused stress and anxiety for patients (de Moissac & Bowen, 2018; Meuter *et al.*, 2015; Naidoo, 2014; Turner, 2015). This study's findings further show that the anguish patients undergo elicits *mistrust*; they lose confidence in expatriate healthcare practitioners' capabilities to meet their healthcare needs. This finding is supported by existing literature which reveals that the presence of language

barriers and cultural differences between patients and healthcare practitioners often result in the two parties misinterpreting and misunderstanding each other, causing the former to be unsure whether the diagnosis had been made correctly (Alhamami, 2020; Al-Harasis, 2013; Al-Shamsi *et al.*, 2020; de Moissac & Bowen, 2018; Naidoo, 2014; Sobane, 2013; Van den Berg, 2016).

In addition, this study finds that the above-mentioned implications result in **patients resisting undertaking suggested medical procedures and treatments** due to misinterpretations, misunderstandings, and conflicting health beliefs. These findings are also backed up by existing literature indicating that the presence of language barriers and cultural differences creates conflicting beliefs that lead patients to resist medical interventions and treatments suggested by doctors who do not share a common language and culture with them (Alshammari *et al.*, 2019; Zhang *et al.*, 2022).

Furthermore, the findings of the current study reveal that language and cultural discordances in Lesotho public hospitals where expatriate healthcare practitioners serve patients with different language and cultural backgrounds commonly lead to **avoidance behaviours** among patients. They shy away from consulting these practitioners to avoid communication hurdles. Previous studies also found that patients avoid consulting healthcare professionals who do not share a common language and culture to avoid communication difficulties (Ali & Watson, 2018; Al-Kabani *et al.*, 2020; Naidoo, 2014). Findings from this study also indicate that this avoidance behaviour most commonly results in *prolonged queues*. Patients wait in long lines to see practitioners who speak and understand their local dialect, even when there are no lines in consulting rooms manned by expatriate healthcare practitioners. In contrast to this finding, a previous study found that queues are often long in consultation rooms with doctors who do not share a common language and culture with patients, as consultations are time-consuming and lengthy due to communication difficulties (Naidoo, 2014). The prolonged queues in Lesotho public hospitals can be explained by **communication accommodation theory** which indicates that people adapt various communicative behaviours to accommodate each other during social interactions by using different adjustments (Kuruthan & Kuruthan, 2019). The theory indicates that three communicative adjustments include: *convergence,* defined as a strategy in which individuals alter their communicative behavior to become more similar to the other person's behavior, decreasing communicative differences. *Divergence* is a strategy in which individuals adopt different communicative behaviors dissimilar to the other party’s and this reinforces

communicative differences. Lastly, *maintenance* is explained as a situation in which neither of the two interacting parties attempts to accommodate each other since neither party takes measures to reduce or increase the communicative differences (Elhami, 2020). The scenario in the case of Lesotho public hospitals can be associated with *maintenance*, as findings indicate that patients avoid consultations with expatriate healthcare practitioners and wait in long queues to consult practitioners who speak and understand their language, suggesting that both parties make no effort to improve or reduce the existing communicative differences that exist due to their differing cultural and linguistic backgrounds.

Regarding the second research question, which centered on the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences, patients suggested that **it should be ensured that expatriate healthcare practitioners hired to work in Lesotho public hospitals are multilingual**. This finding emerged in previous studies that indicated that hiring multilingual physicians to work in healthcare settings has proven to be a tactical strategy for ensuring that there is effective communication (Aqtash, 2017; Kamwendo, 2008).

In addition, participants in the present study pointed out **that expatriate healthcare practitioners should be orientated** to Basotho culture and language before they are permitted to interact with Basotho patients in public hospitals. Findings from previous studies conducted on a similar topic showed that physicians' orientation to the culture and linguistic dynamics of the patients they are going to care for would most likely equip them with the necessary cultural competence to provide quality healthcare despite existing language barriers and cultural differences (Alosaimi & Muayyad, 2016; Zakaria & Yusuf, 2022).

Furthermore, findings from the present study further revealed that participants indicate that **a medical interpreting curriculum** be introduced in institutions of higher learning to train eligible individuals to be interpreters and translators in hospitals. According to participants, this curriculum should aim to provide candidates with the ability to interpret medical jargon used during consultations when patients and healthcare practitioners do not speak a common language. Previous studies conducted on the same topic also highlighted recommendations for hiring medical interpreters to mitigate the impact of linguistic and cultural differences in various multicultural healthcare environments, as an

efficient way to facilitate communication between patients and physicians who do not share a common language and culture (Pandey *et al.*, 2021; Squires, 2018; Tokin, 2017).

Lastly, participants advised that **trained interpreters** be hired to assist with communication in the hospitals. Existing literature concurs with this finding and suggests that the delivery of quality healthcare improves significantly when professional interpreters are available to support communication between patients and healthcare professionals when language barriers exist (Heath *et al.*, 2023; Karliner *et al.*, 2007; Woll *et al.*, 2020).

3.9 Limitations of the study

The current study was not without limitations. Due to administrative issues, the Principal Secretary of the Ministry of Health granted the researcher permission to conduct the study about four months after the application was submitted, resulting in delays in the data collection processes. When approval was finally granted, the country imposed a one-and-a-half-year total lockdown due to the COVID-19 pandemic, which was then gradually lifted. In the first stage, the movement of most of the population was restricted, which prevented the researcher from contacting the hospital administration as planned. As lockdown restrictions were further lifted, the researcher was able to meet the hospital administration. However, the potential participants who met the inclusion criteria were not accessible as only critical patients were allowed to enter the hospital premises.

Furthermore, the researcher had originally planned to interview 24 expatriate healthcare practitioners and 24 patients, and although she managed to interview the intended number of patients, she was only able to interview eighteen expatriate healthcare practitioners because their jobs in the understaffed and overburdened public hospitals which included attending to emergencies and COVID-19 patients as the infection rate was still high rendering them unavailable to participate in the scheduled interview sessions. Some had to reschedule several times while others withdrew from participating in the study entirely.

In addition, in some instances, the expatriate healthcare practitioners were reluctant to share some information regarding sensitive issues during interviews. This included information relating to the commission of medical errors. This was evident as some doubted that the study was purely academic, despite the researcher providing a letter explaining the research and its objectives, which were endorsed by the Lesotho Ministry

of Health.

Another limitation was that some expatriate healthcare practitioners had difficulties expressing themselves during the interviews and understanding the researcher because they had limited knowledge and understanding of English, the language used to conduct the interviews.

Patients were also hesitant to meet with the researcher due to their fear of contracting COVID-19. In addition, during interviews some of the patients hid their emotions and avoided discussing their views and experiences regarding their encounters with expatriate healthcare practitioners in the public hospitals because they were not entirely convinced that their responses would not implicate the expatriate healthcare practitioners. They feared their comments would lead to victimization and jeopardize the jobs of the expatriate healthcare practitioners. However, they were reassured that any information they provided would be treated confidentially and would not be disclosed to third parties without their consent.

3.10 Recommendations for future research

As this study was undertaken, it was apparent that a similar study should be conducted in Lesotho public hospitals during a non-pandemic period, as this will increase the likelihood of the collection of sufficient data on this topic because more information-rich participants (patients and expatriate healthcare practitioners) will be accessible, thereby contributing to the attaining of more reliable results regarding this topic in the context of Lesotho.

Future research on a similar topic should be undertaken and anonymous self-administered questionnaires should be used to collect data from the expatriate healthcare practitioners. This will allow them to answer the research questions at a time convenient for them based on their work schedule and to respond anonymously, which is likely to reveal some important and sensitive information that they did not disclose during the interviews due to their sensitivity. In addition, focus group discussions, along with semi-structured interviews, should be used to collect data from patients to obtain multiple perspectives and allow the researcher to observe emotional processes within a group context to gain a deeper understanding of their views and experiences on the subject being studied.

When conducting similar future studies, multilingual interpreters should be hired to

support communication between researchers and expatriate healthcare practitioners, as some of them are not proficient in English which was used to conduct interviews.

In the future, longitudinal research on this topic should be undertaken to allow the exploration of key sequences of events, identify changes over time, and provide insight into other factors that play a role concerning the implications of language and cultural differences for the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

Given the ethical sensitivity of some information that is likely to come to light during data collection, researchers in future studies on a similar topic should take more reassuring measures to convince participants of the study's goal, such as an additional letter from the hospital manager addressed to an identified individual who is a potential participant, stating the aim of the study. This will help participants answer research questions more freely and openly, without fear of prejudice. Additionally, it could help increase the number of participants showing interest in taking part in the study.

3.11 Conclusion

The main aim of this qualitative study was to explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. The secondary aim of this study was to explore their views on strategies that can be employed to reduce the noted adverse implications resulting from the presence of linguistic and cultural differences. The overall findings from this study suggest that the presence of language barriers and cultural differences results in miscommunication between patients and expatriate healthcare practitioners. The inability of the two parties to exchange health information sufficiently results in practitioners failing to understand vital information that is related by patients during consultations. Findings further indicate that this causes awkwardness and discomfort for patients and as a result, they resort to not disclosing all the vital information required by the practitioners to conduct a diagnosis. In addition, findings from the current study show that the presence of language and cultural differences increases the chances of expatriate healthcare practitioners poorly assessing patients' presenting health conditions. Another point that was revealed in the findings was that language and cultural discordances bring about misunderstandings that evoke unpleasant emotions for patients and practitioners. In particular, practitioners were prone to experience increased frustration. Patients, on the other hand, experience stress and anxiety. Furthermore,

these differences prompt patients to have reduced trust in expatriate healthcare practitioners' ability to correctly diagnose them and to make appropriate health-related recommendations. Another point that was noted was that the differences in health beliefs between patients and expatriate healthcare practitioners in Lesotho public hospitals are a source of conflict and disagreements that often result in patients' resistance to undertaking the medical procedures and treatments suggested to them. Finally, findings suggest that these eventualities lead to patients deciding to shy away from consultations with these practitioners to avoid the adversities of communicating with them therefore they wait in long queues to receive care from doctors with whom they can communicate without any problems.

Regarding the views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce these adverse implications, participants suggested that it should be ensured that expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual. In addition, they noted that expatriate healthcare practitioners should receive an orientation to Basotho cultures and language before interacting with patients in public hospitals. They further suggested that a medical interpreting curriculum be introduced in institutions of higher learning to train eligible individuals to be translators and interpreters. Lastly, participants recommend that professional interpreters be hired to assist with communication between patients and expatriate healthcare practitioners during consultations and in daily hospital operations when patients and healthcare practitioners do not share a common language and culture.

These findings underscore the fact that language and culture are fundamental in the interactions of patients and expatriate healthcare practitioners in Lesotho public hospitals. It appears that clinical interactions primarily rely on these two factors. Findings emanating from the study suggest that the success of the meetings between patients and expatriate healthcare practitioners depends on their ability to understand each other as these forms a foundation of their relationship and paves the way for the undertaking of other processes that are required for the attainment of quality healthcare delivery. Attention should be paid to the implications of cultural and language differences between patients and healthcare practitioners in multicultural healthcare settings that are increasingly becoming widespread due to globalization, as is the case of Lesotho public hospitals. When the importance of language and culture is ignored, healthcare systems are at great risk of failing to deliver quality healthcare services to populations that are increasingly faced with pandemics such as HIV/AIDS and COVID-19 which are leading causes of death and

which create significant social and economic disruptions that affect the well-being of the majority population who receive medical treatment in these accessible and affordable healthcare facilities.

Reference List

Abderahim, H., Elnashar M., Khidir, A., Killawi, A., Hamound, M. & Al-Khal, L. A. 2017. Patient perspectives on language discordances during healthcare visits: findings from the extremely high-density multicultural State of Qatar. *Journal of Health Communication*, 22(4). DOI: 10.1080/10810730.2017.1296507

Aghabarari, M., Mohammadi, A. & Varvani- Farahani, A. 2009. Barriers to application of communication skills by nurses in nurse-patient interaction. Nurses and patients' perspective. *ResearchGate*, 8(1). www.researchgate.net Date of access: 26 Jan. 2019.

Ahmed, R. 2018. Challenges of migration and culture in a public health communication context. *Journal of Public Health Research*, 7(2). DOI:10.4081/jphr.2018.1508

Ahmed, S., Lee, S., Shommu, N. & Rumana, N. 2017. Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal*, 4(1). DOI:10.35680/2372-0247.1181

Albougami, A. 2015. Role of language and communication in providing quality healthcare by expatriate nurses in Saudi Arabia. *Journal of Health Specialties*, 3(3). DOI:10.4103/1658- 600X.159898

Alhamami, M. 2019. Language barriers in multilingual Saudi hospitals: causes, consequences and solutions. *International Journal of Multilingualism,* 19(2). DOI:10.1080/14790718.2020.1777134

Al-Harasis, S. 2013. Impact of language barriers on quality of nursing care at Armed Forces Hospitals, Taif, Saudi Arabia. *Middle East. Journal of Nursing*, 7(4). https://www.semanticscholar.org/paper/Impact-of-Language-Barrier-on-Quality-of-Nursing- at-Al- Harasis/6da06cd9bc70f02646b5cd3419963343b96ab2ec Date of access: 28 May 2022.

Ali, A. P. & Watson, R. 2018. Language barriers and their impact on provision of care to patients with limited English proficiency: nurses' perspectives. *Journal of Clinical Nursing*, 27(5-6). DOI: 10.1111/jocn.14204

Al-Kalbani, Al Mashrafi, Almutairi, A. G. & Alshamsi, H. 2020. Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal* 35(2). DOI: 10.5001/omj.2020.40

Allen, S., Chapman, Y., O'Connor, M. & Francis, K. 2007. The importance of language for nursing: does it convey commonality of meaning and is it important to do so. *Australian Journal of Advanced Nursing*, 24(4). https://pubmed.ncbi.nlm.nih.gov/17682414/ Date of access: 16 Oct. 2022.

Almutairi, K. M. 2015. Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. Saudi Medical Journal, 36(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4404475/#ref21 Date of access: 16 Apr. 2019.

Alosaimi, D. N. & Muayyad, M. 2016. The challenges of cultural competency among expatriate nurses working in the Kingdom of Saudi Arabia. *Research and Theory for Nursing*, 30(4). https://pubmed.ncbi.nlm.nih.gov/28304260/ Date of access: 21 May 2021.

Alshammari, M., Duff, J. & Guilhermino, M. 2019. Barriers to nurse- patient communication in Saudi Arabia: an integrative review. *Biomed Central Nursing*, 18(61). https://doi.org/10.1186/s12912-019-0385-4

Al-Shamsi, H., Almutairi, G. D., Al-Mashrafi, S. & Alkabani, T. 2020. Implication of language barriers for healthcare: a systematic review. *Oman Medical Journal*, 35(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201401/. Date of access: 22 Apr. 2022.

Alshenqeeti, H. 2014. Interviewing as a data collection method: A critical review. *English Linguistics Research*, 3(1). DOI:10.5430/elr.v3n1p39

Aluttis, C., Bishaw, T. & Frank, W. M. 2014. The workforce for health in a globalized context- global shortages and international migration. *Global Health Action*, 7(1). https://doi.org/10.3402/gha.v7.23611

Amoah, V. K. M., Anokye, R., Boakye, D. S. & Gyamfi, N. 2018. Perceived barriers to effective therapeutic communication among nurses and patients at Kumasi South Hospital. *Cogent Medicine*, 5(1).

https://www.tandfonline.com/doi/full/10.1080/2331205X.2018.1459341

Anney, V. N. 2014. Ensuring the quality of findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trend in Educational Research and the Policy Studies,* 5. https://www.researchgate.net/profile/Vicent-Anney/post/How-are-validity-and- reliability-issues-dealt-with-in-qualitativ Date of access: 27 Jun. 2022.

Aqtash, S., Robb, F. W., Brownie, M. S., Hamad, A., Hunter, H. L. & Almuhtasib, M. 2017. Self-assessed competence of experienced expatriate nurses in a rural and remote setting. *SAGE Open Nursing*, 3. https://doi.org/10.1177/2377960817702382

Auerbach, A. D., Karliner, L. S., Kim, S. E. & Meltzer, D. O. 2010. Influence of language barriers on outcomes of hospital care for general medicine inpatients. *Journal of Hospital Medicine*, 5(5). https://www.journalofhospitalmedicine.com/jhospmed/article/128310/languagebarriers-and-hospital-care Date of access 10 Apr. 2019.

Babbie, E. & Mouton, J. 2001. *The practice of social research*. South African ed. Oxford University Press, Cape Town. https://www.oxford.co.za/book/9780195718546-practice-of- social-research Date of access:24 Mar. 2021.

Bird, C. 2016. *Perspectives on data science for software engineering*. https://www.sciencedirect.com/book/9780128042069/perspectives-on-data-science-for- software-engineering Date of access: 12 Jan. 2022.

Bowen, S. 2001. *Language barriers in access to health care. Health Canada*. Government of Canada. https://www.canada.ca/en/health-canada/services/health-care Date of access: 19 Apr. 2019.

Bradley J. 1993. Methodological issues and practices in qualitative research. *Library Quarterly*, 63(4). https://eric.ed.gov/?id=EJ471251 Date of access: 03 Jan. 2019.

Braimoh, T. & Dimarco, M. 2021. *There is a global shortage of nurses. COVID-19 is making it worse*. Clinton Health Initiative.https://www.clintonhealthaccess.org/blog/there-is-a-global- shortage-of-

nurses-covid-19-is-making-it-worse/ Date of access: 03 Jun. 2022.

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. Qualitative *Research in Psychology*, 3(2): http://dx.doi.org/10.1191/1478088706qp063oa

Brooks, L. A., Manias, E. & Bloomer, M. J. 2019. Culturally sensitive communication in healthcare: a concept analysis. *Collegian*, 26(3). https://doi.org/10.1016/j.colegn.2018.09.007

Burns, N. & Grove, S. K. 2003. *The practice of nursing research: conduct, critique and utilization*. 5th Ed, Elsevier Saunders, Missouri. https://www.scirp.org/(S(351jmbntvnsjt1aadkposzje))/reference/ReferencesPapers.aspx?Re ferenceID=1895024 Date of access: 18 Mar. 2022.

Byren, D. 2021. A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quality*, 56. https://doi.org/10.1007/s11135-021-1182-y

Chiehi, L., Abdulkerim, N., Jordans, C. A., Ga Eun Son, C. 2017. Overcoming communication barriers to healthcare for culturally and linguistically diverse patients. *North American Journal of Medicine and Science*, 10(30). https://www.exeley.com/exeley/journals/north_american_journal_of_medicine_and_science/ 10/3/pdf/10.7156_najms.2017.1003103.pdf Date of access: 11 Feb. 2019.

Cohen, L. & Manion, L. 1994. Research *methods in education*. London: Longman. https://www.academia.edu/37378137/research_methods_in_education_book_by_Cohen_a nd_Manion_pdf Date of access: 04 Sep. 2019.

Cohen, S., Denise, J. D. & Gregory, E. M. 2007. Psychological stress and disease. *The Journal of America Medical Association, 298(14)*. DOI: 10.1001/jama.298.14.1685

Cozby, P. C. & Bales, S. C. 2009. *Methods in behavioural research*. 12th ed. McGraw Hill Education. http://students.aiu.edu/submissions/profiles/resources/onlineBook/Y8M8y6_Methods%20in%20Behavioral%20Research.pdf Date of access: 08 May 2023.

Creswell, J. W. 2014. *Research Design; qualitative, quantitative and mixed methods*

approach. University of Nebraka- Lincon. SAGE. https://in.sagepub.com/en-in/sas/research- design/book237357 Date of access: 03 Jun. 2019.

Czaika, M. & Reinprecht, C. 2022. Migration *drivers: Why do people migrate? Introduction to migration studies. An interactive guide to the literatures on migration and diversity.* Imiscoe, Open Access. Springer. https://doi.org/10.1007/978-3-030-92377-8_3

De Beer, J. & Chipps, J. 2014. A survey of cultural competence of critical care nurses in Kwa Zulu Natal. *Southern Africa Journal of Critical Care*, 30(2). https://www.ajol.info/index.php/sajcc/article/view/114977 Date of access: 18 Oct. 2019.

de Moissac, D. & Bowen, S. 2018. Impact of language barriers on quality of care and patient safety for official language minority francophones in Canada. *Journal of Patient Experience*, 6(1). https://journals.sagepub.com/doi/pdf/10.1177/2374373518769008

Downs, S., Montagu, D., da Rita, P., Brashers, E., Feachem, R. 2013. *Health System Innovation in Lesotho: Design and Early Operations of the Maseru Public Private Integrated Partnership. Healthcare Public-Private Partnerships Series, No.1.* San Francisco: Global Health Sciences, University of California, San Francisco and PwC. United States of America. https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/pshi- lesotho-ppip-report-exec-summary.pdf Date of access: 17 Jan. 2023.

Drew, C. J., Hardman, L. M. & Hosp, J. L. 2007*. Ethical issues in conducting research. Overview of research*. SAGE Publications. https://www.sagepub.com/sites/default/files/upm-binaries/26094_3.pdf Date of access: 23 Dec. 2018.

Eckersley, R. 2006. Is modern Western culture a health hazard? *International Journal of Epidemiology*, 35. https://pubmed.ncbi.nlm.nih.gov/16303804/. Date of access: 26 Mar. 2022.

Elhami, A. 2020. *Communication accommodation theory: a brief review of the literature.*

A brief review of *literature.* https://www.researchgate.net/publication/341252455. Date of access: 24 Feb. 2022.

Fleckman, J. M., Dal Corso, M., Ramirez, S., Begalieva, M. & Johnson, C. C. 2015. Intercultural competency in public health education. *Frontiers in Public Health*, 3. https://www.frontiersin.org/articles/10.3389/fpubh.2015.00210/full. Date of access:02 Oct. 2019.

Folwer, J. D. 2008. Cultural *and structural barriers that affect the doctor- patient relationship: A Bolivian perspective.* Oregon State University. (Thesis-Honors). https://ir.library.oregonstate.edu/concern/honors_college_theses/sf268942g. Date of access: 17 Apr. 2022.

Fong Ha, J. & Longnecker, N. 2010. Doctor-patient communication: A review. *The Oschsner Journal*, 10(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/. Date of access: 25 Apr. 2019.

Gelling, L. 1999. Ethical principles in healthcare research. *Nursing Standard*, 13(36). http://journals.rcni.com/doi/pdfplus/10.7748/ns1999.05.13.36.39.c2607

Ghorbani, A. 2021. Demand for health and healthcare. *Healthcare Access.* DOI:10.5772/intechopen.98915

Givler, A., Bhatt, H. & Maani-Fogelman, P. A. 2023. *The importance of cultural competence in pain and palliative care.* University Health- Conway Geisinger Medical Centre, Stata Pearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK493154/. Date of access: 01 Nov. 2023.

Hagens, V., Dobrow, M. J. & Chafe, R. 2009. Interviewee transcript review: assessing the impact on qualitative research. BMC Medical Research Methodology, 9(47). doi: 10.1186/1471-2288-9-47

Heath, M., Hvass, F. M. & Wejse, M. C. 2023. Interpreter services and effect on healthcare - a systematic review of the impact of different types of interpreters on patient outcome. *Journal of Migration and Health*, 7. https://doi.org/10.1016/j.jmh.2023.100162

Hofstee, E. 2006. Constructing *a good dissertation. A practical guide to finishing a Master's, MBA or PhD on schedule.* www.exactica.co.za Date of access: 19 May

2022.

Hughes, R. G. 2008. *Patient safety and quality: an evidence-based handbook for nurses*. AHRQ publication No.8. Agency for healthcare research and quality. Rockville,MD. https://books.google.co.za/books?hl=en&lr=&id=QFg_YnoXR6IC&oi=fnd&pg=PA1&dq=Hug hes+(2008)+define+quality+healthcare&ots=F5Nav7LFhD&sig=zSj3Kvy_MUwC7rd1SjHXm_X0-XM#v=onepage&q=Hughes%20(2008)%20define%20quality%20healthcare&f=false Date of access: 15 Feb. 2023.

Jacobs, E., Chen, A. H. M., Karliner, L. S., Agger-Gupta, N. & Mutha, S. 2006. The need for more research on language barriers in health care: a proposed research agenda. *A Multidisciplinary Journal of Population, Health and Health Policy,* 84(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690153/ Date of access: 04 May 2019.

Jahan, F. & Siddiqui, H. 2019. Good communication between doctor-patient improves health outcome. European *Journal of* Medical *and Health Sciences*, 1(4). https://doi.org/10.24018/ejmed.2019.1.4.84

Jamshed, S. 2014. Qualitative research method- interviewing and observation. *Journal of Basic Clinical Pharmacy*, 5(4). doi: 10.4103/0976-0105.141942

Jhaiyanuntana, A. & Nomnian, S. 2020. Intercultural communication challenges and strategies for the Thai undergraduate hotel interns. *PASAA*, 59. https://www.researchgate.net/publication/352741906_Jhaiyanuntana_A_Nomnian_S_2020_Intercultural_communication_challenges_and_strategies_for_the_Thai_undergraduate_hotel_interns_PASAA_591_204-235 Date of access: 17 Apr. 2022.

Jongen, C., McCalman, J. & Bainbridge, R. 2018. Health workforce cultural competency interventions: a systematic scoping review. *Biomed central Health Services Research*, 18(232). https://doi.org/10.1186/s12913-018-3001-5 Date of access: 03 March 2022.

Kale, E. & Syed, H. R. 2010. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Education Counselling*,

81(2). https://pubmed.ncbi.nlm.nih.gov/20542656/ Date of access: 22 Mar. 2022.

Kamwendo, G. H. 2008. Language proficiency testing and the expatriate medical practitioner in Malawi. *Current Issues of Language Planning*, 9 (3). https://www.researchgate.net/publication/249025183_Language_Proficiency_Testing_and_the_Expatriate_Medical_Practitioner_in_Malawi Date of access: 15 July 2022.

Karliner, S. L., Jacobs, E. A. & Chen, H. M. A. 2007. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review. *Health Services Research*, 42(2). https://pubmed.ncbi.nlm.nih.gov/17362215/ Date of access:17 September 2022.

Kennedy, B. M., Rehman, M., Johnson, W. D., Magee, B. M., Leonard, R. & Katzmarzyk, P. 2017. Healthcare providers versus patients' understanding of health beliefs and values. *Patients' Experience Journal*, 4(3). https://www.ncbi.nlm.nih.gov/pubmed/29308429 Date of access: 08 Mar. 2019.

Klugah, M. A. & Ansah, A. M. 2019. Language barriers in healthcare delivery. A focus on expatriate healthcare providers in Ghanaian hospitals. *An Interdisciplinary Journal of Healthcare, Ethics and Society, 16(3).* DOI: https://doi.org/10.1558/cam.39671

Koch, T. 1993. Establishing rigour in qualitative research: the decision trail*. Journal of Advanced Nursing*, 53 (1). https://doi.org/10.1111/j.1365-2648.2006.03681.xopen_in_new

Kuruthan, C. & Kuruthan, A. 2019. Communication accommodation in healthcare provider- patient exchange. American Society of Microbiology Journal, 13(5). https://www.akademisains.gov.my/asmsj/?mdocs-file=5129 Date of access: 27 Jun. 2022.

Lincoln, Y. S., & Guba, E. G. 1985. *Naturalistic Inquiry*. Beverly Hills, CA: Sage. http://dx.doi.org/10.1016/0147-1767(85)90062-8

Maguire, P. 1999. Improving communication with cancer patients. *European Journal of Cancer*, 13(4). https://doi.org/10.1016/S0959-8049(99)00301-9Get rights and content

Maier-Lorentz, M. M. 2008. Transcultural nursing: its importance in nursing practice.

Journal of Cultural Diversity, 15(1). https://www.ncbi.nlm.nih.gov/pubmed/19172978 Date of access: 02 Oct. 2019.

Makoa, E. T. 2000. *Collaboration between* traditional *healers and nurse practitioners in primary health care in Maseru health service area-Lesotho.* University of South Africa. (Thesis- PhD). https://uir.unisa.ac.za/handle/10500/17307 Date of access: 22 March 2022.

Malik, P. A. & Khan, M. A. 2020. Bridging the gap: A review of communication skills challenges for expatriate doctors in the Arabian Gulf. *World Family Medicine Journal*, 18(10). DOI: 10.5742/MEWFM.2020.9381

Mandeville, K. L., Lagarde, M., Hanson, H. & Mills, A. 2016. Human resources of health: time to move out of crisis mode. *Lancet Journal*, 388(10041). DOI: https://doi.org/10.1016/S0140- 6736(16)30952-7

Maquire, M. & Delahunt, B. 2017. Doing a thematic analysis: a practical, step by step guide for learning and teaching scholars. *All Ireland* Journal *of Higher Learning,* 9 (3). https://ojs.aishe.org/index.php/aishe-j/article/view/335 Date of access: 17 May 2023.

Martin, L. R., Williams, S. L. & Haskard, K. B. 2005. The challenge of patient adherence. *Journal of Therapeutics and Clinical Risk Management*, 1(3). https://www.ncbi.nlm.nih.gov/pubmed/18360559 Date of access: 13 Feb. 2019.

Mcquaid, E. L. & Landier, W. 2018. Cultural issues in medication adherence: disparities and directions. *Journal of General Internal Medicine*, 33(2). https://www.ncbi.nlm.nih.gov/pubmed/29204971 Date of access: 11 May 2019.

Meuter, R. F., Gallois, C., Segalowitz, N. S., Ryder, A. G. & Hocking, J. 2015. Overcoming language barriers in health care: A protocol for investigating safe and effective communication when patients or clinicians use second language. *Health Services Research*, 15. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4566365/ Date of access: 08 Jan. 2019.

Miller, D. C. & Salkind, N. J. 2002. Handbook *of research design and social measurement.*6th ed. SAGE Publications. https://doi.org/10.4135/9781412984386

Ministry of Health Lesotho. 2013. National *multi-sectoral integrated strategic plan for the*

prevention and control of non-communicable diseases (NCDS): 2014-2020. Government of Lesotho. https://www.iccp-portal.org/system/files/plans/LSO_B3_Endorsed%20NCD%20Stratergic%20Plan%20-%20Copy.pdf Date of access: 27 Mar. 2022.

Mlambo, N. 2017. *Multilingualism in healthcare: communicative experiences of expatriate healthcare providers* with *varying linguistic repertoires in Windhoek Namibia*. (Thesis- Masters). Department of general linguistics. University of Stellenbosch. http://hdl.handle.net/10019.1/102832 Date of access: 22 Mar. 2022.

Mokuoane, M. C. N. & Moeketsi, V. S. M. 2018. The role of Sesotho language and culture in shaping identities of speakers: A case of Basotho in Free State and Lesotho. *Interdisciplinary Journal*, 17(1). https://journals.co.za/content/journal/10520/EJC- 14f2cd35f0. Date of access: 30 Mar. 2019.

Mokuoane, M. C. N. 2018. *The* reflection *of language in culture and identity: A case of Basotho in the Free State and Lesotho*. Faculty of Humanities. Central University of Technology, Free State. (Thesis-Masters). http://hdl.handle.net/11462/1917 Date of access: 29 May 2022.

Mosadeghard, M. A. 2013. Healthcare service quality: towards a broad definition. *International Journal of Health Care Quality Assurance*, 26(3). https://www.ncbi.nlm.nih.gov/pubmed/23729125. Date of access: 02 Feb. 2019.

Mustafa, R., Mahboob, U., Khan, R. A. & Anjum, A. 2023. Impact of language barriers in doctor-patient relationship: A qualitative study. *Pakistan journal of medical science*, 39(1). DOI: https://doi.org/10.12669/pjms.39.1.5805

Naicker, S., Plange-Rhule, J., Tutt, C. R. & Eastwood, J. B. 2009. Shortages of healthcare workers in developing countries-Africa. *Ethnicity and Disease*, 19(1). https://pubmed.ncbi.nlm.nih.gov/19484878/ Date of access: 22 Jun. 2022.

Naidoo, S. 2014. Transcultural and language barriers to care. *South African Dental Journal,* 69(9). http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S001185162014000900013 Date of access: 03 Mar. 2019.

Newton, N. 2010. *The use of semi- structured interviews: strengths and weaknesses. Exploring qualitative methods*. https://www.academia.edu/1561689/The_use_of_semi_structured_interviews_in_qualitative_research_strengths_and_weaknesses Date of access: 21 Dec. 2018.

Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M., & Samami, E. 2015. Communication Barriers Perceived by Nurses and Patients. *Global Journal of Health Science*, 8(6). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954910/ Date of access: 17 Feb. 2019.

Nowell, S. L. Nor ris, M. J., White, D. E. & Moules, N. J. 2017. Thematic analysis: striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16. DOI:10.1177/1609406917733847

O' Daniel, M. & Rosenstein, A. H. 2008. *Patient safety and quality: An evidence-based handbook*. Agency for healthcare research and quality. Rockville. https://www.ncbi.nlm.nih.gov/books/NBK2637/ Date of access: 09 Apr. 2019.

Pandey, M., Maina, G. R., Amoyaw, J., Li, Y., Kamrul, R., Michael, R. & Maroof, R. 2021. Impact of English language proficiency on healthcare access, use and outcomes among immigrants: a qualitative study. *BMC Health Services Research*, 21 (741). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06750-4 Date of access:16 Jul. 2022.

Partida, Y. 2007. Language barriers and the patient encounter. *American Medical Association Journal of Ethics*, 9(8). https://journalofethics.ama-assn.org/article/language- barriers-and-patienthttps://journalofethics.ama-assn.org/article/language-barriers-and- patient-encounter/2007-08encounter/2007-08 Date of access: 25 Apr. 2019.

Patton, M. Q. 1990. *Qualitative evaluation and research methods*. 2nd ed. Newbury Park, CA: Sage. https://psycnet.apa.org/record/1990-97369-000 Date of access: 23 Apr. 2022.

Payne, K & Grey, L. 2014. *Quantitative Methodologies. An Introduction to Health Services Research*. Sage Publications Ltd. https://www.research.manchester.ac.uk/portal/en/publications/quantitative-methodologies(29ffffd1-c73f-4e57-8aa9-06504424a0af)/export.html Date of

access: 24 May 2022.

Peacock, S. & Patel, S. 2008. Cultural influences on pain. *Reviews on Pain*, 1(2). Doi: 10.1177/204946370800100203

Possa, R. & Khotso, P. 2015. Naming of Basotho medicinal plants: semantic connection to their remedies. *South African Journal for Folklore Studies*, 25(1). https://journals.co.za/doi/pdf/10.10520/EJC186416

Pytel, C., Fielden. N. M., Meyer, K. H. & Albert, N. 2009. Nurse-patient/visitor communication in the emergency ward. *Journal of Emergency Nursing*, 35(5). https://pubmed.ncbi.nlm.nih.gov/19748019/ Date of access: 18 Jul. 2022.

Resnik, D. B. 2015. *What is ethics in* research *and why is it important.* National institute of environmental health sciences.https://www.niehs.nih.gov/research/resources/bioethics/whatis/. Date of access: 17 Oct. 2023.

Rösky, M. 2015. *Overcoming language* barriers *in health care services in the medical tourism context: Health care companies' perspective.* Aalto University, School of Business. (Thesis- Masters). https://aaltodoc.aalto.fi/handle/123456789/18267 Date of access: 12 Feb. 2019.

Schlemmer, A. & Mash, B. 2006. The effects of language barriers in a South African district hospital. *South African Medical Journal*, 96(10). https://pubmed.ncbi.nlm.nih.gov/17164941/ Date of access 28 Aug. 2022.

Schouten, B. C. & Meeuwesen, L. 2006. Cultural differences in medical communication; a review of the literature. *Patient Education Counselling*, 64(1-3). https://www.ncbi.nlm.nih.gov/pubmed/16427760 Date of access: 29 Aug. 2019.

Schouten, B. C., Meeuwesen, L. & Harmen, H. A. 2009. GP's interactional style in consultations with Dutch and ethnic minority patients. *Journal of Immigrant Minor Health*, 11(6). https://link.springer.com/article/10.1007/s10903-008-9131-9. Date of access: 29 Aug. 2019.

Schwabe, C., Lerotholi, K. & McGrath, E. 2004. *Human Resources Development & Strategic Plan 2005- 2025*. Ministry of Health and Social Welfare. Kingdom of Lesotho.

https://www.socialserviceworkforce.org/system/files/resource/files/Kingdom%20of%20Lesot ho%20HR%20Development Date of access: 23 November 2023.

Schyve, P. M. 2007. Language differences as a barrier to quality and safety in health care: The joint commission perspective. *The Journal of General Internal Medicine*, 22(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2078554/ Date of access: 17 May 2022.

Shahnazarian, D., Hagemann, J., Aburto, M. & Rose, S. s.a. *Informed consent in human subjects research*. Office for the protection of research subjects. University of Southern California. http://oprs.usc.edu/files/2013/04/Informed-Consent-Booklet4.4.13.pdf Date of access: 02 Jan. 2019.

Sharma, R. 2017. Communication: The lifeline. *World-wide Journal of Multidisciplinary Research and Development*, 3(9). https://wwjmrd.com/archive/2017/9/437/communication- the-lifeline Date of access:03 May 2022.

Smith, D. 2003. Five principles for research ethics. *American Psychology Association,* 34(1). http://www.apa.org/monitor/jan03/principles.aspx Date of access: 26 Feb. 2019.

Sobane, K. M. 2015. Communication challenges experienced in Lesotho clinics where physicians speak both the community language and lingua franca. *Journal of Social Sciences,* 43(3). https://www.tandfonline.com/doi/abs/10.1080/09718923.2015.11893445 Date of access: 17 Apr. 2019.

Sobane, K. M. E. 2013. Language *discordant HIV/AIDS interactions in Lesotho health care centres*. Stellenbosch University. (Thesis-PhD). https://scholar.sun.ac.za/items/1edf661b- 7083-4cde-85b0-ede0ce2664c5 Date of access: 21 Mar. 2018.

Somnath, S. & Catherine, M. 2008. Patient centeredness, cultural competence and health care quality. *Journal of the National Medical Association*, 100(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2824588/ Date of access: 01 Mar. 2019.

Spencer-Oatey, H. 2012. *What is culture? A compilation of quotations*. *Core Concept Compilation.* Global People. DOI:10.13140/RG.2.2.29603.37925

Squires, A. 2018. Strategies for overcoming language barriers in healthcare. *Nursing Management*, 49 (4). https://pubmed.ncbi.nlm.nih.gov/29528894/ Date of access:18 Jun. 2022.

Stahl, N. A. & King, J. R. 2020. Expanding approaches for research: understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*. https://eric.ed.gov/?id=EJ1320570 Date of access: 18 Jun. 2022.

The National Committees for Research Ethics in Norway. 2005. *Guidelines for research ethics in the social sciences, law, and* the *humanities*. https://graduateschool.nd.edu/assets/21765/guidelinesresearchethicsinthesocialscienceslawhumanitiespdf Date of access: 23 Feb. 2019.

Thuube, M. R. 2015. Communicative problems of interpreting during cross linguistic interactions between non-Sesotho speaking Doctors and monolingual Basotho patients in Lesotho hospitals. *Journal of Humanities*, 2(3). https://journals.nul.ls/index.php/tsebo/article/view/5 Date of access: 27 Jun. 2022.

Tokin, E. 2017. The importance of medical interpreters. *American Journal of Psychiatry*, 12(8). https://doi.org/10.1176/appi.ajp-rj.2017.120806

Turner, L. L. 2015. Lived experiences of service members' medical care *rendered by culturally different caregivers*. University of the Rockies. (PhD-Thesis). https://www.proquest.com/openview/b6ab3983e3a524e93850f49d247c3293/1?pq-origsite=gscholar&cbl=18750 Date of access: 06 Mar. 2023.

Van den Berg, V. L. 2016. Still lost in translation: language barriers in South Africa health care remain. *South African* Family *Practices*, 58(6). https://medpharm.tandfonline.com/doi/full/10.1080/20786190.2016.1223795#.XKyEhIVjQU Date of access: 09 Apr. 2019.

Van Keer, P., Deschepper, R., Francke, A. L., Huyghens, L. & Bilsen, J. 2015. Conflicts between healthcare professionals and families of a multi-ethnic patient population during critical care: an ethnographic study. *Journal of Critical Care*, 19(44). https://www.ncbi.nlm.nih.gov/pubmed/26694072 Date of access: 23 May 2019.

Wagner, C., Van Rosse, F., De Bruijne, M., Suurmond, J. & Essink- Bot, M. 2015. Language barriers and patient safety risks in hospital care: A mixed methods study. *International Journal of Nursing Studies*, 54(45-53). http://www.ncbi.nlm.nih.gov/pubmed/?term=25840899 Date of access: 16 Apr. 2019.

Wanjau, K. N., Muiruri, W. B. & Ayobo, E. 2012. Factors affecting provision of service quality in the public health sector: A case study of Kenyatta National Hospital. *International Journal of Humanities and Social Sciences*, 2(13). http://karuspace.karu.ac.ke/handle/20.500.12092/1873 Date of access: 13 Jan. 2019.

White, J., Plompen, T., Osadnik, C., Tao, L., Micallef, E. & Hines, T. 2018. The experience of interpreter access and language discordant clinical encounters in Au. *International Journals for Equity in Health,* 17(1). https://www.ncbi.nlm.nih.gov/pubmed/30249270 Date of access: 13 Mar. 2019.

Woll, A., Quick, K. K., Mazzei, C., Selameab, T. & Miller, J. L. 2020. Working with interpreters as a team in health care (WITH Care) curriculum tool kit for oral health professionals. *The Journal of Teaching and Learning Resources*, 16. https://doi.org/10.15766/mep_2374-8265.10894open

World Health Organisation. 1979. *African traditional medicine: African technical report series no. 1.* Congo Brazaville: WHO regional; Office for Africa. https://www.afro.who.int/health-topics/traditional-medicine Date of access: 28 Mar. 2023.

Yeo, S. 2004. *Language barriers and access to care.* ResearchGate. https://www.researchgate.net/publication/8345471_Language_Barriers_and_Access_to Care Date of access:18 Jul. 2019.

Zakaria, N. & Yusuf, B. N. M. 2022. Sacrifices from relocation to a foreign land: Multifaceted challenges experienced by self-initiated expatriate female nurses during cross-cultural adjustment. *Current Psychology,* 42(1). https://link.springer.com/article/10.1007/s12144-022-02745-4 Date of access:29 January 2023.

Zhang, D., Jiang, Z., Xie, Y., Wu, W., Zhao, Y., Huang, A., Li, T. & Ba-Thein, W. 2022.

Linguistic barriers and healthcare in China: Chaoshan vs Mandarin. *BMC Health Services Research*, 22(376). https://doi.org/10.1186/s12913-022-07744-6

Chapter 4

Article 3

Development of an intervention outline to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

Abstract

This chapter reports on an intervention outline that was developed to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. To achieve this aim, the researcher used intervention mapping, a six-step framework for theory and evidence-based health promotion program planning. In step one, the researcher undertook needs assessment. This step aimed to analyze the problem faced by the target population which were patients and expatriate healthcare practitioners in Lesotho public hospitals. Step two entailed the formulation of change objectives; the main objective was to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. Five performance objectives were specified, they included: enabling expatriate healthcare practitioners to carry out self-assessments, increasing their ability to accommodate patients' traditions and collect culturally appropriate information from patients, equipping them with the ability to interact with patients from multicultural backgrounds, improving their knowledge and proficiency in Sesotho and English to enable them to interact and communicate effectively with patients in the public hospitals and encouraging them to engage in the processes of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with the cultural backgrounds of their patients. For the third step, which entails the selection of theory-based methods and practical strategies, the researcher selected the Campinha-Bacote theory. The model consists of five constructs which the researcher translated into practical strategies and they included: equipping expatriate healthcare practitioners with cultural awareness, enhancing their cultural knowledge, improving their cultural skills, invigorating their cultural encounters, and increasing their cultural desires. The fourth step was the development of an intervention outline. The researcher developed an intervention outline aimed at providing expatriate healthcare professionals working in Lesotho hospitals with the opportunity to acquire basic communication skills and improve their cultural competencies, with the goal of improving the quality of healthcare delivery. The

fifth step was the adoption and implementation plan and the sixth step, evaluation planning which were both not undertaken because the researcher was only able to develop an outline due to time constraints. It only details activities, their purpose, and the range of participants. Implementing the program proved to be difficult because of the lengthy procedures that were required. These included requesting the health cluster in the Parliament of Lesotho to evaluate the proposed program, discuss it, invite specialists to assess its viability, and then, should they find it viable, instructing the relevant ministry to include it in the budget for the next financial year after its approval. These processes could take years. On the other hand, the time allotted for the study was not sufficient, making it impossible for the researcher to wait for the lengthy legislative processes. (However, the researcher intends to undertake these stages in her post-doctoral phase to complete the study to have the intervention implemented and evaluated as it is likely to help in the cultivation of positive health outcomes in Lesotho public hospitals.)

Based on the above, the researcher developed a culture immersion program outline for expatriate healthcare practitioners that she proposes to be used to provide them with an opportunity to acquire basic skills in languages used in Lesotho public hospitals and improve their cultural competencies to ensure the delivery of quality healthcare services.

4.1. Introduction

Globalization influences the movement of people as they leave their countries of origin to relocate to new countries; a phenomenon referred to as migration. With their new statuses, migrants are often challenged during interactions with the domestic ethnic majority who possess different languages and cultures in the host countries (Oucho & Williams, undated). Treatment Improvement Protocol (2015) explains *culture* as a conceptual system developed by a community to shape the way they view the world. It is also explained as a collection of shared and learned values, beliefs, and norms developed by a community and passed down from one generation to another, guiding ways of thinking and acting and influencing decision-making (Spencer-Oatey, 2012). On the other hand, *language* is an essential aspect of human interaction where sounds, signs, and codes are set and used by a group of people to communicate with precision (Mokuoane & Moeketsi, 2018). These two aspects mutually influence each other and are important because they facilitate human interaction (Mokuoane, 2018).

In the host countries, migrants are usually compelled to interact with local communities who possess different cultures and languages; a concept known as *intercultural*

communication, which centers on understanding other people's linguistic and cultural backgrounds to attain effective communication (Jhaiyanuntana & Nomnian, 2020). Healthcare sectors have not been exempted from the patterns of migration and the resultant requirement for intercultural communication. Many countries are experiencing an influx of expatriate healthcare practitioners due to shortages in the local supply of human resources. These practitioners are often faced with challenges in the new countries where they serve populations of dissimilar cultural and language backgrounds. This often adversely affects communication (de Moissac & Bowen, 2018) which, in turn, is likely to lead to negative healthcare outcomes (Roysky, 2015:02).

Lesotho, like many other countries, suffers from a severe shortage of human resources and specialists in the health department (Downs *et al*., 2013). To address this, the Government of Lesotho has resorted to hiring healthcare practitioners from across the globe to meet the healthcare needs of citizens. However, this decision has been shown to pose several challenges that significantly affect the ability of healthcare systems to fulfill their mission of providing quality healthcare. These practitioners tend to have languages and cultures that differ from those of the patients they care for in Lesotho hospitals, leading to a wide range of negative health outcomes (as reported in Chapter 3, based on an empirical study conducted by the researcher to explore the implications of language and cultural differences on the healthcare quality provided by expatriate healthcare practitioners in Lesotho public hospitals). Findings from this study (as reflected in Chapter 3) serve as additional confirmation of those made by others. Sobane (2013), Sobane (2015) and Thuube (2015) found that when patients and healthcare practitioners did not share a common language and culture in healthcare facilities, they struggled to accurately communicate health-related information during consultations and this affected the delivery of quality healthcare.

To mitigate such inimical consequences, there is evidence in the literature that suggests that several approaches have been used to improve cultural competence in healthcare settings. These include cultural competency training programs for healthcare practitioners, which aim to improve healthcare professionals' knowledge, understanding, and necessary skills that they need to treat patients from culturally and linguistically diverse backgrounds (Vella *et al*., 2022). These intervention programs are considered to represent some of the most credible models for addressing cultural competency issues in healthcare and establishing culturally responsive healthcare services (Al-Ansary, 2017).

In the case of Lesotho, there are noticeable staff shortages in public hospitals. Consequently, the Government opted to hire expatriate healthcare practitioners to provide their expertise and services. The practitioners have languages and cultures that are different from those of patients (Downs *et al.*, 2013). However, except for a provision in the constitution designating English and Sesotho as official languages, Lesotho lacks a written language strategy (Sobane, 2012). This may indicate that different healthcare facilities custom-make and adopt strategies that may seem practicable to achieve effective communication. Sobane and Anthonissen (2013) undertook a description of multilingual practices in two HIV-care centers in Lesotho to acquire an understanding of the kinds of interventions developed to promote communication in multilingual healthcare settings. Findings indicated that these centers adopted two types of strategies to respond to language diversities and to facilitate language effectiveness during physician and patient interaction. The first consists of institutionally driven initiatives that include interpreting services and availing printed material. The second is informally developed communication strategies for the transfer of information that may include non-verbal communication, checking understanding, re-organizing and retelling explanations, visual illustrative support material, soliciting assistance from others, and corrective measures after the consultations. The interventions that are currently used are informal, and unmethodological, and are therefore likely to lack enforcement measures because they have been devised within the organizations with no advice from experts. However, findings from the studies of Sobane (2013), Thuube (2015), and Sobane (2015) point out that communication problems that are associated with poor healthcare delivery persist in healthcare settings where patients and healthcare practitioners do not share a common language and culture despite the interventions that are put in place. Thus, a need exists for an intervention to be developed following recognized intervention development frameworks, that will incorporate expert guidance, and that will be used as a clear policy guide towards managing culture and language differences in Lesotho public hospitals. Therefore, the present study aimed to develop an intervention outline to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

4.2 Methodology

4.2.1 Intervention mapping

The six steps of intervention mapping include:

(1) Needs assessment.
(2) Formulation of change objectives.
(3) Selection of theory-based methods and practical strategies.
(4) Development of the intervention.
(5) Adoption and implementation plan.
(6) Evaluation planning.

This framework provides a systematic process and detailed protocol for effective, step-by-step decision-making for intervention development, implementation, and evaluation. However, for this study, as will be discussed in the remainder of this section, only four steps were executed because time constraints barred the researcher from implementing the program. As such, she developed an intervention outline that only details activities, their purpose, and the range of participants.

4.2.1.1 Step 1: Needs assessment

The purpose of this step is to analyze the problem faced by the target population (Olive *et al.,* 2020), which in this case is represented by the patients and expatriate healthcare practitioners in Lesotho public hospitals. To carry out this step, the researcher undertook empirical research (as reflected in article 2 chapter 3) to qualitatively explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals, as well as their views on strategies that could be employed to reduce the noted adverse implications. Purposive sampling was used to select two groups of participants (24 patients and 18 expatriate healthcare practitioners) in the four selected Lesotho public hospitals (Queen 2 Hospital, Queen 'Mamohato Memorial Hospital, Berea Hospital, and Butha-Buthe Hospital).

Findings (see Table 3) revealed that the presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals resulted in miscommunication. As a result, expatriate healthcare practitioners fail to understand information related by patients during consultations. This leads to the practitioners conducting poor assessments of patients' conditions. The discordances also elicit negative emotional responses among both patients and expatriate healthcare practitioners. Expatriate healthcare practitioners experience frustrations while patients suffer from stress and anxiety. These feelings prompt mistrust of patients towards the capabilities of expatriate healthcare practitioners to effectively attend to their health needs, which in turn engenders resistance of patients to undertake the suggested medical

procedures and treatments. As a result, patients then develop avoidance behaviour, which becomes the reason they wait in long lines to consult practitioners who speak and understand their local dialect.

In terms of strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences, patients and expatriate healthcare practitioners pointed out that it should be ensured that only multilingual healthcare practitioners are hired to come work in Lesotho public hospitals, that orientation of expatriate healthcare practitioners should be done, that a medical interpreting curriculum ought to be developed in schools, and that hospitals should hire professional interpreters.

Table 3. Summary of empirical research findings

Main theme and subthemes	Units of meaning
Miscommunication	
Failure of expatriate healthcare practitioners to understand patients	*"In instances where a patient is not fluent and engaging during consultations, it becomes difficult for me to understand and gather the information that may help me diagnose them, making the designing of a treatment plan for them challenging."* *"I use both Sesotho (with low levels of proficiency) and English languages during consultations with Basotho patients. The use of the two languages is efficient to some extent because at times we can communicate to establish what symptoms a patient is experiencing and some of the required information regarding the illness. However, more often, I struggle to understand what the patient is relating to me. They sometimes also fail to answer some of the questions I ask to establish information that may lead to a diagnosis…"*
Awkwardness and discomfort	*"I feel that the expatriate healthcare practitioners handle themselves in a way that portrays them as being unwelcoming and unfriendly during consultations. I am not free and there is tension in the consultation rooms…"* *"The expatriate healthcare practitioners are always keeping a serious face and never make an effort to make conversation. They never try to initiate a conversation to ease up the tension…This creates an uncomfortable environment..."* *"…Sometimes I try to explain in detail my symptoms. But if I*

Elimination of vital information	*realize that even after applying more effort to explain myself to the expatriate healthcare practitioner, they still fail to understand me, I decide to eliminate that particular issue in our discussion.”* *“…During consultations, some issues are easy to explain but some require the use of words that I do not know. When I come across such situations, I decide to address those that I can be able to explain and I never attempt to explain those symptoms which require me to use difficult terminology.”*
Poor patient assessment	*“...I struggle to properly communicate with patients and end up relying mainly on conducting tests for diagnosis. This denies me a chance to learn more about my patients, their lifestyles, and family history, making the selection of treatment plans that would best suit them challenging.”* *“I use English mostly and Sesotho (low proficiency)... sometimes I struggle to understand when patients narrate symptoms because every patient has a unique illness and ways of expressing themselves. In such instances where comprehending what the patient is relaying is challenging, the process of assessing becomes difficult.”*
Negative emotional response *Increased frustrations for expatriate healthcare practitioners*	*“I become very frustrated when I consult patients who barely speak English because I struggle with the exchange of important information with them during consultations. Another factor that frustrates me is incidents where the clinical assistant placed in my clinic summarizes the information that patients narrate during consultations.… I normally then have to pester the assistant to try as much as possible to make them translate every piece of information a patient is relaying for me to diagnose them properly.”*

	"I get frustrated during consultations because at times patients fail to fully express themselves as they struggle to communicate due to language barriers. At times they begin to panic and become hysterical and unable to comfortably relate their illnesses and symptoms after realizing that I am not a Mosotho".
Stress and anxiety	*"When queuing up in the hospital I become agitated when I am not certain whether I will be attended to by a local or an expatriate doctor. This occurs because I am likely to face communication challenges should it happen that I am attended to by an expatriate healthcare practitioner because of the language they use to conduct consultations which is English".* *"When I walk into a consultation and realize that the doctor who will be attending to me is not a Mosotho, my self-esteem immediately drops and I start panicking because I begin to ask myself if the doctor will understand me due to language barriers. I begin asking myself if I will understand him/her. I also ask myself if I will be able to remember to mention all my symptoms. Furthermore, I ask myself if I will be able to ask some follow-up questions as I am a very inquisitive person. These are all the questions that come to my mind and induce my stress."*
Mistrust	*"When consulting an expatriate healthcare practitioner, I always ask myself whether the doctor and I will be able to understand each other, whether the doctor will understand well my symptoms because if we fail to understand each other, I may be misdiagnosed and given the wrong*

	treatments which may kill me". *"…It becomes really hard for me to trust I am diagnosed properly by someone who struggles to understand me. It also becomes difficult for me to ask questions so that I am sure we are on the same page".*
Patients' resistance to suggested medical procedures and treatments	*"…Many Basotho patients whom I have diagnosed with cancer refuse to undertake the suggested treatments because they believe that cancer can only be cured using certain Sesotho traditional herbs and not chemotherapy and other medications ..."* *"I work with people who have been diagnosed with HIV/AIDS and at times patients refuse to take ARV treatment because they indicate that their beliefs do not allow them to take drugs, some indicate that they know of churches that heal HIV/AIDS while others indicate that they knew of traditional healers that could cure the virus."*
Avoidance behaviour *Patients queuing in long lines*	*"When queuing up in the foyer to go consult healthcare practitioners, I try by all means to avoid rooms that are manned by expatriate healthcare practitioners because the procedure here is to go into any vacant consultation room when it is your turn. If I see that I may be forced to go into such a consultation room, I ask others who queue after me to proceed and go inside until I can go into a room manned by a Mosotho doctor because I avoid the stress of having to communicate with a doctor who does not speak Sesotho."* *"I queue up where I am told by other patients that the doctor in the consultation room is a Mosotho. I become patient and queue up in those long lines because I know that going into an expatriate healthcare practitioner's consultation room is going to bring me the stress of having to speak a language I am not comfortable expressing myself in (English)".*

Hiring professional interpreters	*"Hospitals need to look into hiring translators that are accessible to patients and to us any time they are needed because the people who are currently performing these duties are not reliable as they have other duties to perform in the hospitals. I also personally think they are not well trained for the role of translating and miss out on important information discussed between us and patients during consultations."* *"Hospitals need to look into hiring translators that are accessible to patients and to us to assist at any time their services are needed. They should be trained professionals to avoid problems that could occur if they mistranslate some information as this could put the lives of patients and our jobs at risk."*
Developing a medical translation curriculum in Schools	*"The Ministry of Education should introduce an educational program where Basotho youth who have completed their degree in languages can be trained for medical translating as a course to add to their degrees to enable them to work in hospitals…The government should then create jobs for them depending on the number of expatriate healthcare practitioners per hospital."* *"…the Ministry of Health should work hand in hand with the Ministry of Education to introduce medical interpreting courses where programs will be designed specifically to train individuals to be able to translate in hospitals between patients and healthcare practitioners who do not share a*

	common language. These courses should be designed to upskill the trainees' ability to translate medical terms in languages used by patients and healthcare practitioners in Lesotho public hospitals."
Ensuring expatriate healthcare practitioners who are hired to work in Lesotho public hospitals are multilingual	*"I understand there is a shortage of local doctors especially specialists in our hospitals and that the government has outsourced them from all over the world, however, the employer or recruiter needs to ensure that they recruit multilingual people who will be able to communicate with Basotho patients in the languages they speak. They should at least know and understand Sesotho and English because if they don't, then there is no point in having them here because we will not be able to understand them and they will fail to understand us as well."* *"I don't know how they advertise the vacancies for hiring doctors outside the country but they should ensure that they recruit doctors who are multilingual more especially those proficient in English, this should be stated in the job requirements."*
Orientation of expatriate healthcare practitioners	*"When we are recruited to work in hospitals, it is often a matter of urgency, we engage in consultations with patients as soon as we get to the hospitals due to the serious human resource shortages in healthcare, I would suggest that the Lesotho Government offers mandatory online courses that will orientate us as expatriate healthcare practitioners on Basotho culture and language, it should be mandatory to take this course for at least six months upon arrival in Lesotho."* *"The Ministry of Health should design and implement a learning course that every one of us will be mandated to undertake before we start working with Basotho patients to give us an idea of the culture and basic language of the*

	people we will be serving. This will prevent culture shock and will help us to understand common practices and the language frequently used in healthcare to avoid conflict and the committing of errors in the process of serving their healthcare needs."

Findings derived from the needs assessment were aimed at producing an empirically based description of the health problems faced by the target group to enable the development of a working model for health that will be used to guide the planning of a health intervention.

4.2.1.2 Step 2: Formulation of proposed change objectives

The second step of intervention mapping involves formulating the proposed intervention objectives. In this step, it is required that the overall objective of the program be split into several performance objectives that are task-specific (Olive *et al.,* 2020). The proposed overall objective of this phase of the study was to develop an intervention outline that can be put in place to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. To achieve this, it was split into five performance objectives. For the first performance objective, expatriate healthcare practitioners will be guided on reflecting and assessing their biases in daily interactions with patients in Lesotho public hospitals and how these may influence stereotypes they hold regarding Basotho patients. They will also be guided to reflect on how these affect their ability to deliver quality healthcare. The second performance objective will focus on equipping expatriate healthcare practitioners with knowledge and understanding that will enable them to be more accommodating of Basotho patients' cultural beliefs and norms. These beliefs may be an influencing factor in how patients experience health and illness, access to healthcare, and relationships with healthcare practitioners. The third performance objective will focus on strengthening the expatriate healthcare's ability to gather culturally relevant information from patients in the consultation rooms, to know patients' cultural beliefs, and therefore select culture-appropriate assessments for them. The fourth performance objective will focus on encouraging expatriate healthcare practitioners to interact more with patients for them to familiarize themselves with the patients' cultures as this is likely to reduce stereotypes that may otherwise develop. This performance objective will also focus on encouraging

expatriate healthcare practitioners to evaluate the linguistic needs of patients. Furthermore, the practitioners will be encouraged to strive to identify the linguistic resources needed by patients to ensure that they feel included during consultations and understand all information exchanged regardless of the language differences that exist. This will be done to avoid the occurrence of misunderstandings and errors. The fifth performance objective will focus on motivating expatriate healthcare practitioners in Lesotho public hospitals to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with the cultural backgrounds of the patients.

Table 2 summarizes the performance objectives that were formulated after the performing needs assessment in step 1.

Table 4. Summary of proposed performance objectives

Performance objectives	Determinants	Change objectives
Equip expatriate healthcare practitioners with cultural awareness to enable self-evaluation of biases	Self-efficacy	Enabling expatriate healthcare practitioners to be able to assess the Possible implications of their biases on the delivery of quality healthcare.
Enhance the expatriate Healthcare practitioners' cultural knowledge	Enthusiasm	Increase their ability to Comprehend and be accommodative of patients' cultural beliefs and norms
Improve Expatriate Healthcare practitioners' cultural skills	Requisite knowledge of Basotho culture	Enable them to collect Culturally appropriate information from patients to Enable the selection of appropriate physical assessments that were acceptable, ideal, and conforming to their cultures

Invigorate expatriate Healthcare practitioners' cultural encounters	Intention	Capacitate them with the Ability to interact with Patients from different Cultural and linguistic Backgrounds to reduce disparities, misunderstandings, and errors and to access their lived experiences of health and illness
Increase the desire of expatriate healthcare practitioners to want to be culturally competent	Determination	Encourage them to engage in the processes of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with the cultural backgrounds of patients.

4.2.1.3 Step 3: Selection of theory-based methods and practical strategies

In the third step, the researcher identifies and selects relevant theoretical methods that could facilitate the translation of the program objectives into practical strategies (Fernandez *et al.*, 2019). According to Olive *et al.* (2020), the use of theory-based methods increases the effectiveness of the intervention. The proposed change objectives identified in step two were subsequently linked to a theory that will guide the development of an intervention outline that can be used to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

For this purpose, the researcher used the Campinha-Bacote theory. Introduced in the 1960s, it was established as a framework for healthcare providers to use to develop and implement culturally appropriate healthcare (Al-Ansary, 2017). It is considered by scholars to be an effective model that promotes cultural competence and takes into account the characteristics associated with culturally competent care (Albougami *et al.*, 2016; Bauer & Bai, 2018; Wall-Bassette & Hedge, 2018). The theory underscores the importance of healthcare systems, particularly healthcare providers, being mindful of

patients' cultural backgrounds and perspectives (Betancourt, 2002). In the context of this study, the notion of culture is conceptualized as encompassing everything about people, their way of life, their worldviews, and their ways of communicating (Bearskin, 2011). On the other hand, cultural competence is a collection of behaviours, attitudes, policies, and structures that enable an individual to be fully capable of functioning in multicultural situations (Flaskerud, 2017). Meany *et al.* (2008) stated that cultural competence is a skill that a person can acquire through academic, interpersonal, and clinical teachings. Culturally competent healthcare providers can provide high-quality healthcare services because they have the skills to overcome cultural barriers. Campinha-Bacote (2002) views cultural competence as an ongoing process in which healthcare providers continuously strive to achieve the ability to function fully in patients' diverse cultural contexts. The model suggests that healthcare practitioners should view themselves as being in a continuous learning process of being culturally competent, rather than viewing themselves as either culturally competent or not (Caminha-Bacote, 2002).

This model is based on five major constructs which the researcher proposes be translated into practical strategies. These include *cultural awareness, cultural knowledge, cultural skills, cultural encounters,* and *cultural desires*. They are discussed in the next section.

The first construct of *cultural awareness* focuses on the assessment of one's own biases to see whether these could impact their stereotypes and consequently, healthcare delivery to patients from different cultural backgrounds (Al-Ansary, 2017). This construct will guide the development of strategies aimed at enabling expatriate healthcare practitioners to assess the potential impact of their biases on their ability to deliver quality healthcare. The second construct is *cultural knowledge*, which is concerned with healthcare practitioners' understanding of patients' worldviews, as well as the extent to which they take them into account; and how their cultural beliefs and norms may influence their experiences of health and illness, access to health care, and relationships with healthcare practitioners (Al-Ansary, 2017). Drawing on this construct, expatriate healthcare practitioners will be supported in improving their ability to understand and accommodate patients' cultural beliefs and norms. The third construct is *cultural skills,* which is defined as the ability to gather culturally relevant information from patients in the consultation room and select an assessment that is culturally acceptable to them (Al-Ansary, 2017). Informed by this construct, strategies will be developed to train expatriate healthcare practitioners to be able to collect culturally appropriate information from patients and select suitable physical assessments that are acceptable, ideal, and

conforming to their patients' cultures. The fourth construct is *cultural encounters* which is defined as the process of encouraging healthcare practitioners to engage directly in cross-cultural interactions with patients from different cultural backgrounds, as this helps break down stereotypes (Al-Ansary, 2017). With this construct, expatriate healthcare practitioners will be guided on how they can enhance their ability to interact with patients from different cultural and linguistic backgrounds to reduce disparities, misunderstandings, and errors, and to gain an understanding of their lived experiences of health and illness as this will direct them on how to assess their linguistic needs and then provide the necessary assistance. The fifth construct is *cultural desire* which is related to the healthcare practitioner's motivation to engage in the process of becoming culturally aware, culturally knowledgeable, culturally competent, and familiar with the patients' cultural backgrounds (Al-Ansary, 2017). In line with this construct, it is proposed that strategies be developed to motivate expatriate healthcare practitioners to cultivate an earnest desire to become culturally aware, culturally knowledgeable, culturally skillful, and familiar with the cultural backgrounds of the patients.

The findings emanating from the empirical research (article 2 chapter 3) strongly suggest that that the presence of language and cultural differences between patients and expatriate healthcare in most Lesotho public hospitals was a cause of the noted adverse healthcare outcomes. It is due to the above-mentioned reasons that the selection of Campinha-Bacote theory was proposed to facilitate the achievement of the change objectives.

4.2.1.4 Step 4 Development of an intervention outline

In step four, the focus is on developing a framework that successfully meets and translates the practical applications outlined in step three to achieve the proposed change objectives identified in step two. The researcher decided on the kind of program to adopt and designed the overall outline of the program, channels, and delivery methods. She designed and produced intervention material that conveyed the intention of the program and all the activities that she proposed be undertaken in developing the intervention. Intervention materials are the instructional resources that are used to remediate an issue that is addressed by an intervention (Echanes *et al.*, undated).

The researcher deemed the use of a cultural competency training intervention framework appropriate to achieve the aim of the program, in particular, a cultural immersion training program. These training interventions are often used to educate and train healthcare

practitioners on the relevant knowledge, attitudes, and skills needed to respond effectively to sociocultural issues that arise during clinical encounters (Betancourt *et al*., 2003). They equip them with strategies that enable them to effectively use culturally appropriate and culture-specific practices. In addition, they aim to continually develop awareness of healthcare practitioners' cultural influences and reduce prejudices and biases that may occur during interactions with patients who possess a different cultural background to theirs (Hark *et al*., 2009). Several training programs have been used to increase the cultural competence of healthcare professionals, although they vary in content, length, framework, frequency, and delivery method. They have been regarded as a key strategy used to address racial and ethnic disparities in healthcare in Canada, Australia, New Zealand, and the United States among other places (Jongen *et al*., 2018).

For healthcare practitioners to be able to deliver culturally appropriate care, they should be allowed to gain a deep understanding of patient's diverse cultural backgrounds through meaningful interactions with them. This phenomenon is referred to as cultural immersion (Brock *et al.,* 2019). According to Onosu (2020), numerous studies indicate that these interactions lead to a significant increase in participants' cultural tolerance, which according to Verkuyten *et al.* (2019) is the ability to respect, accept, and appreciate cultural diversity, which promotes global awareness and intercultural communication. For these reasons, cultural immersion programs are popular and offered to medical and health sciences students to improve their cultural competency. They have been shown to have a positive impact on their ability to function effectively in diverse cultural healthcare contexts. They have been proven to promote a level of self-confidence and awareness of students' attitudes to cultural differences and to encourage the building of relationships with communities (Thackrah *et al*., 2014). According to Ogunsiji *et al*., (2022), cultural immersion is important because it offers them the opportunity to acquire knowledge that will allow them to participate directly in the learning process, challenge their cultural assumptions, and enable behavioral and cognitive changes that are likely to lead to higher levels of awareness. These programs are important because they promote understanding and development of appropriate responses when interacting with populations from diverse cultural backgrounds. Additionally, they challenge students to engage in situations with which they are unfamiliar with to access and understand other people's cultures and worldviews.

Engaging students in real-world contexts outside the classroom through mixing theory and practice has proven to increase empathy, which is associated with heightened cultural

awareness. It is also associated with increased cultural competence and decreased ethnocentrism (de la Cruz, 2019). Additionally, it is noted that students who participated in these programs reported that interacting with patients who spoke a language that they were unfamiliar with contributed to their cultural awareness and thus increased their confidence (de la Cruz, 2019). According to Ryan *et al*. (2000) and Smith-Miller *et al*. (2010), another point to consider was that these programs strengthened students' communication skills and provided them with the opportunity to learn different languages.

In addition, findings from studies that were conducted following students' participation in cultural immersion training programs stated that they reported reduced anxiety when consulting with patients who had a different cultural background to theirs (de la Cruz, 2019). This outcome is of particular significance because according to Çelmęçę and Menekay (2020), Kotrotsiuo *et al*. (2001), and Kumar (2016), anxiety among healthcare providers exacerbates distress and is likely to negatively impact their effectiveness in their work.

4.3 Program: Culture immersion program outline for expatriate healthcare practitioners

4.3.1 Proposed Program objective:

To allow expatriate healthcare practitioners who work in Lesotho public hospitals to achieve basic competence in Sesotho, enhance their cultural competency, and ensure that quality healthcare services are delivered in these hospitals. This aim is in line with those of a similar program that was used to allow medical professionals (nurses, doctors, and students) to improve their Spanish language skills, enhance cultural awareness, and learn about the medical profession in Costa Rica by the Central American Spanish Academy (ACCE Costa Rica, undated).

4.3.2 Program goals:

- Improving the Sesotho language skills of expatriate healthcare practitioners.
- To improve/provide specific vocabulary and communication methods that can be used when working with Basotho patients.
- To enhance cultural awareness by offering lectures about the Basotho culture.
- To enable expatriate healthcare practitioners to interact with various communities in Lesotho who have diverse educational, sociocultural, socioeconomic, and socio-political backgrounds to enhance their cultural understanding, perceptions of health and illness, health behaviours, and beliefs.

These interactions will concurrently also promote the goal of language acquisition.

- To enable the practitioners to learn about the healthcare system in Lesotho by scheduling visits to local clinics and healthcare centers and observing real consultations between Basotho patients and Basotho healthcare practitioners.
- To enable them to interact with Basotho communities by participating in field trips to local clinics in areas around the four public hospitals that were selected for the empirical study.

4.3.3 Duration

It is proposed that this immersion program will entail 60 hours of participation and be carried out over a two-week period. This includes a 40-hour workshop to train expatriate healthcare practitioners in the Sesotho language (with a specific focus on terms commonly used in basic healthcare conversations). The remaining 20 hours will be used for professional practice in the selected clinics or health centers.

4.3.4 Settings

For the classes, it is proposed that suitable locations (hospital or community center halls) will be identified near the four public hospitals that previously participated in the empirical study. Simulation consultations will take place in nearby clinics and health centers.

4.3.5 Participants

The researcher suggestes that simulation participants (expatriate healthcare practitioners) will be selected through purposive sampling while patients will be selected through convenience sampling in the areas near the selected clinics and healthcare centers.

4.3.6 Inclusion criteria

It is proposed that expatriate healthcare practitioners will be included in the program provided they are available and willing to participate and the relevant divisions in the hospital management allow them to take part in the training. Immersion patients will be selected provided they can express themselves clearly and are available and willing to participate in the exercises.

4.3.7 Facilitators

It is suggested that language and culture specialists will be engaged to facilitate these

exercises. These professionals have the ability to understand the importance of heterogeneity of language and culture (University of Jyväskylä, 2019). Furthermore, they are often fluent in several languages and are therefore able to diversify and use them flexibly, especially in this scenario where findings from the qualitative research conducted in Lesotho public hospitals indicate that some of the expatriate healthcare practitioners originate from non-English-speaking countries and thus struggle to understand English (which is the second official language in Lesotho). It is further mentioned that these specialists have the expertise to act with practicality in different communicative situations.

4.3.8 Delivery methods

4.3.8.1 First Week

In the first week, it is proposed that the participants have classes during the morning hours and that the training workshop be delivered through classroom sessions which will be divided into three lesson categories:

Lesson 1: The first lesson will focus on highlighting the following key areas of language analysis: which a morphology (rules governing changes in meaning at the level of a word), syntax (rules governing the order of words to form clauses, phrases and sentences), semantics (rules governing the meaning and context of words or grammar units), pragmatics (rules governing the use of languages within a communication context) and phonology (rules governing the structure, distribution and sequence of speech sound patterns) in a Sesotho discussion because they contribute to the language in various ways. These areas contribute significantly to the understanding of language and communication (Masyhur, 2023) They all work together, and that is what is needed for communication between patients and expatriate healthcare practitioners. When these rules are understood, communication becomes smooth between two individuals.

Lesson 2: Learning vocabulary specifically focused on the area of healthcare and medicine.

Lesson 3: Introducing activities to educate expatriate healthcare practitioners on the everyday needs of Basotho patients in public hospitals.

In the afternoon, the participants will be made to watch films produced in Lesotho that depict Basotho’s way of living, cultures, and the languages spoken. According to Champoux (1999), films are distinctively rich mediums of teaching and studying culture because they are communicative and reflective.

4.3.8.2 Second Week

In the second week, the researcher proposes that expatriate healthcare practitioners get an opportunity to take part in various excursions throughout the day where they will participate in the simulation exercises in the selected clinics and health centres located not far from the selected public hospitals. According to Maran and Glavin (2003), simulation exercises are educational strategies that enable intensive interactions by partially or completely replicating a clinical experience without exposing the patient to risk. They enable people to carry out their roles and functions and help health systems assess their readiness and ability to respond to public health issues (Brock *et al.,* 2017). San (2015) also notes that they are associated with numerous positive impacts on student nurses because they equip them with strategies to apply during clinical encounters.

It is further proposed that the simulation session will be divided into three phases which include: pre-briefing, simulation scenario, and debriefing.

4.3.8.2.1 Pre-briefing

This phase involves relaying information to participants before the simulation begins in order to provide an orientation to the process. During these sessions, details will be discussed with the simulation participants such as the goals and objectives of the session, relevant Sesotho terms and phrases that will be used during the simulation exercise, arrangements, logistical details of the session, and assurance will be given that they will be psychologically safeguarded as this reduces their fears and anxieties (Hughes & Hughes, 2023).

4.3.8.2.2 Simulation scenario

Here the expatriate healthcare practitioners will interact with the simulated patients at the selected health facilities and are expected to greet them, ask questions about the symptoms they are allegedly experiencing, check vital signs, and conduct a physical examination in Sesotho.

4.3.8.2.3 Debriefing

Participants will then be debriefed. According to Guerrero *et al.* (2022), debriefing participants is important and constitutes a critical element of a successful simulation exercise. This will help participants understand the learning objectives through reflection, feedback, and discussions that are expected to stimulate thoughts about appropriate interventions and clinical thinking patterns that can contribute to improving healthcare

systems (Tanoubi *et al.*, 2019). These sessions use therapeutic communication skills to attend to and provide emotional support to participants, as feelings are likely to be triggered in the process (Horsfall, 1990).

4.4 Limitations

A significant limitation is that the program has not been implemented and tested.

4.5 Conclusion

This chapter presented the proposed intervention outline that the researcher proposes be employed to limit the adverse effects of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in public hospitals in Lesotho. Intervention mapping was used to guide this process, which is a six-step framework for theory and evidence-based health promotion program planning that addresses challenges by providing systematic and clear phases necessary in planning the intervention.

The steps include needs assessment, formulation of change objectives, selection of theory-based methods and practical strategies, development of the intervention, adoption and implementation plan, and evaluation planning. However, due of time, bureaucratic, and political barriers and constraints, the researcher only developed an intervention outline which only details activities, their purpose, and the range of participants.

In the first step, the researcher carried out a needs assessment. This enabled a description of the problems faced by patients and expatriate healthcare practitioners in public hospitals in Lesotho caused by linguistic and cultural differences between them, which hinder the provision of quality healthcare services. In the second step, the proposed intervention objectives were formulated, which were based on the breakdown of the overall aim into several performance objectives and determinants. The first proposed practical strategy centered on raising expatriate healthcare practitioners' cultural awareness. The focus will be on improving the practitioner's ability to assess their biases, to see whether they influence their stereotypes and the healthcare provided to patients from different cultural backgrounds, and this requires self-efficacy. The second strategy is improving the practitioner's cultural knowledge. The focal point will be on improving their ability to engage with patients' worldviews and to understand how their cultural beliefs and norms may influence their experiences of health and illness, access to healthcare, and relationships with healthcare professionals and it requires them to have a certain level of

eagerness or enthusiasm to gain the knowledge. The third strategy is focused on improving practitioners' cultural skills which are aimed at enhancing their ability to gather culturally relevant information from patients in the consultation rooms and select an assessment that is culturally acceptable to them, which requires them to have the requisite knowledge of Basotho culture. The fourth strategy centers on the facilitation of cultural encounters which focuses on encouraging the practitioners to engage directly in cross-cultural interactions with patients from different cultural backgrounds as this helps break down stereotypes and this requires self-efficacy. The fifth strategy centers on cultural desire, which focuses on motivating practitioners to want to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with the cultural backgrounds of the patients which requires determination from them. Step three was the selection of theory-based methods. The researcher selected the Campinha-Bacote theory which serves as a framework for healthcare providers to develop and implement culturally responsive healthcare. The theory is based on five major constructs that are translated into practical strategies to guide the achievement of the aims of the program. They include cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires. These constructs will be conjoined with intervention objectives formulated in step two. Step four entails the development of a cultural immersion program outline for expatriate healthcare practitioners, which aims to provide practitioners with the opportunity to acquire basic skills in the Sesotho language, healthcare-specific vocabulary, and communication methods necessary for working with Basotho patients. In addition, this will strengthen their cultural awareness and provide them with the opportunity to interact with different communities in Lesotho who have different educational, socio-cultural, socio-economic, and socio-political backgrounds to improve their cultural understanding of how Basotho perceive health and illnesses as well as their health behaviors and beliefs in an attempt to build on their cultural competence, which is likely to lead to improved delivery of quality healthcare in Lesotho's public hospitals.

Reference List

Albougami, S. A., Pounds, K. G. & Alotaibi, J. S. 2016. Comparison of four cultural competence models in transcultural nursing: A discussion paper. *International Archives of Nursing and Healthcare,* 2(4). DOI: 10.23937/2469-5823/1510053

Al-Ansary, N. F. S. 2017. *The effect of cultural competency training programs on expatriate nurses' levels of cultural competence in Saudi Arabia as measured by the inventory for assessing the process of cultural competence (IAPCC-R).* The University of Alabama. (Thesis- PhD). https://www.proquest.com/openview/34e5b5e5db74956cee75f389fcc78ea7/1.pdf?pq- origsite=gscholar&cbl=18750 Date of access: 26 Mar. 2023.

Baur, K. & Bai, Y. 2018. Using a model to design activity-based educational experiences to improve cultural competency among graduate students. *Pharmacy Baseline*, 6(2). Doi: 10.3390/pharmacy6020048

Bearskin, B. L. S. 2011. A critical lens on culture in nursing practice. *Nursing Ethics*, 18 (4). Doi: 10.1177/0969733011408048

Betancourt, J. R. 2002. *Cultural competence in health care: emerging frameworks and practical approaches.* Massachusetts general hospital-Harvard medical school. https://www.researchgate.net/publication/238623089_Cultural_Competence_in_Health_Car e_Emerging_Frameworks_and_Practical_Approaches Date of access: 18 Mar. 2023.

Betancourt, J. R., Green, R. A., Carrillo, J. E. & Firempong, O. A. 2003. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Report*, 118(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/ Date of access: 13 Jun. 2022.

Brock, M. J., Fowler, L.B., Freeman, J. G., Richardson, D. C. & Barnes, L. J. 2019. Cultural immersion in the education of healthcare professionals: a systematic review. *Journal of Educational Evaluation of Health Professions*, 16(4). https://doi.org/10.3352/jeehp.2019.16.4

Campinha-Bacote, J. 2002. The process of cultural competency in the delivery of quality

healthcare services: a model of care. *Journal of Transcultural Nursing*, 13(3). Doi: 10.1177/10459602013003003.

Çelmeçe, N. & Menekay, M. 2020. The effect of stress, anxiety, and burnout levels of healthcare professionals caring for COVID-19 patients on their quality of life. *Front Psychology,* 11. Doi: 10.3389/fpsyg.2020.597624

Central American Spanish Academy. s.a. *A language and cultural immersion program for medical* professionals. https://www.acce.co.cr/programs/medical-professionals/ Date of access: 16 Jun. 2023.

Champoux, J. E. 1999. Film as a teaching resource. *Journal of Management Inquiry*, 8(2). https://journals.sagepub.com/doi/epdf/10.1177/105649269982016

de la Cruz, K. H. 2019. Assessing *the long-term effects of a cultural immersion experience on nursing practice*. UNVL. (Thesis-PhD). http://dx.doi.org/10.34917/15778427

de Moissac, D. & Bowen, S. 2018. Impact of language barriers on quality of care and patient safety for official language minority francophones in Canada. *Journal of Patient Experience*, 6(1). https://journals.sagepub.com/doi/pdf/10.1177/2374373518769008

Downs S., Montagu, D., da Rita, P., Brashers, E., Feachem, R. 2013. *Health System Innovation in Lesotho: Design and Early Operations of the Maseru Public Private Integrated Partnership. Healthcare Public-Private Partnerships Series, No.1*. San Francisco: Global Health Sciences, University of California, San Francisco and PwC. Produced in the United States of America. First Edition. https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/pshi- lesotho-ppip-report-exec-summary.pdf Date of access: 18 Oct. 2022.

Echanes, Javil, O., Alaska, Reyzle, P., Armeza, Jenny Loren, M. (undated). *Development and validation of strategic intervention materials (SIM) for grade eleven earth and life* science *in Quezon National High School Senior High School*. https://www.scribd.com/document/397949160/DEVELOPMENT-AND-VALIDATION-OF- STRATEGIC-docx Date of access: 28 Aug. 2023.

Fernandez, E. M., Ruiter, R. A. C., Markham, M. C. & Kok, G. 2019. Intervention

mapping: theory and evidence-based health promotion program planning: perspectives and examples. *Front Public Health*, 7(209). doi: 10.3389/fpubh.2019.00209

Flaskerud, J. H. 2007. Cultural competence: What is it? *Issues in Mental Health Nursing*, 28, 121–123. DOI:10.1080/01612840600998154

Guerrero, G. J., Tungpalan- Castro, G. M & Pingue- Ranguini, M. 2022. Impact of simulation debriefing structure on knowledge and skill acquisition for post-graduate critical care nursing student: three-phase vs multiphase. *BMC Nursing*, 21(318). https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-022-01100-z Date of access:16 Oct. 2023.

Hark, L., DeLisser, H. & Morrison, G. 2009. *Achieving cultural competency: A case-based approach to training health professionals*. Vol. 1. Chichester, UK: John Wiley and Sons Ltd. https://www.wiley.com/en-us/Achieving+Cultural+Competency%3A+A+Case+Based+Approach+to+Training+Health+ Professionals-p-9781405180726 Date of access: 18 May 2023.

Horsfall, J. 1990. Clinical placement: pre-debriefing and debriefing as teaching strategies. *Australian Journal of Advanced* Nursing, 8(1). https://pubmed.ncbi.nlm.nih.gov/2091680/ Date of access: 16 Oct. 2023.

Hughes. P. G. & Hughes. K. E. 2023. *Briefing prior to simulation activity*. Stat Pearl Publishing. https://www.ncbi.nlm.nih.gov/books/NBK545234/ Date of access: 28 Sep. 2023.

Jhaiyanuntana, A. & Nomnian, S. 2020. Intercultural communication challenges and strategies for the Thai undergraduate hotel interns. *PASAA*, 59. https://files.eric.ed.gov/fulltext/EJ1240001.pdf Date of access: 18 Mar. 2023.

Jongen, C., McCalman, J. & Bainbridge, R. 2018. Organizational system’s approaches to improving cultural competence in healthcare: A systematic scoping review of the literature. *International Journal for Equity in Health*, 16(78). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-017-0571-5 Date of access: 17 Jun. 2023.

Kim, J., Jang, J., Kim, B. & Hee Lee, K. 2022. Effect of the PRECEDE-PROCEED

model on health programs: a systematic review and meta-analysis. *Systematic Reviews*, 11(213). https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-022-02092-2 Date of access: 08 Nov. 2023.

Kotrotsiuo, E., Theodasopoulou, E. & Papathanasiuo, I. V. 2001. *How do patients experience stress caused by* hospitalization *and how do nurses perceive this stress experienced by patients?* A comparative study. https://www.researchgate.net/publication/215477754_How_do_patients_experience_stress_caused_by_hospitalization_and_how_do_nurses_perceive_this_stress_experienced_by_patients_A_comparative_study/link/07331bd2298e4fe0094423f3/ Date of access: 22 Oct. 2022.

Kumar, S. 2016. Burnout and doctors: prevalence, prevention and intervention. *Healthcare Baseline*, 4(3). doi: 10.3390/healthcare4030037

Maran, N. J & Glavin, R. J. 2003. Low-to high- fidelity simulation- a continuum of medical education? *Medical Education*, 37. https://pubmed.ncbi.nlm.nih.gov/14641635/ Date of access: 29 September 2023.

Masyhur, M. 2023. Exploring language analysis: a comprehensive analysis of linguistic structures and communication dynamics. English Study Program.

Mokuoane, M. C. N. 2018. *The reflection of* language *in culture and identity: A case of Basotho in the Free State and Lesotho*. (Thesis Masters). Faculty of Humanities. Central University of Technology, Free State. http://hdl.handle.net/11462/1917 Date of access: 29 May 2022.

Mokuoane, M. C. N. & Moeketsi, V. S. M. 2018. The role of Sesotho language and culture in shaping identities of speakers: A case of Basotho in Free State and Lesotho. *An Interdisciplinary Journal*, 17(1). https://journals.co.za/content/journal/10520/EJC- 14f2cd35f0. Date of access: 30 Mar. 2019.

Meaney, K. S., Bohler, H. R., Kopf, K., Hernandez, L., & Scott, L. S. 2008. Service-learning and pre-service educators' cultural competence for teaching: An exploratory study. *Journal of Experiential Education*, 31(2), 189-208. DOI:10.5193/JEE.31.2.189

Ogunsiji, O., Ogbeide, A. E., Mukuria, V., Olugbemiro, F., Workman, A. & Dune. T. 2022. From the world to western: A community-engaged teaching strategy to enhance students' learning of cultural issues relevant to healthcare. International Journal of Environmental *Research and Public Health*, 19 (9). https://www.mdpi.com/1660-4601/19/9/5114. Date of access: 30 March 2019.

Olive, L., Parker, R., Dober, M., Drake, C., Keith, M. & Telford, R. 2020. *Global Journal of Community Psychology Practice*, 11 (2). http://www.gjcpp.org/. Date of access: 23 May 2023.

Onosu, G. O. 2020. Cultural immersion: a trigger for transformative learning. *Social Science*, 9 (2). https://doi.org/10.3390/socsci9020020

Oucho, L. A. & Williams, D. A. s.a. Challenges and solutions to migrant integration, diversity and social cohesion in Africa. World Institute for Development Economics Research. https://www.wider.unu.edu/sites/default/files/OUCHO,%20Linda%20Adhiambo_paper.pdf Date of access: 22 Nov. 2023.

Rosky, M. 2015. *Overcoming language barriers in health care services in the medical tourism context: Health care* companies' *perspective*. Aalto University, School of Business, Thesis. www.aalto.fi:. Date of access: 12 February 2019.

Ryan, M., Twibell, R., Bringham, C. & Bennet, P. 2000. Learning to care for clients in their world not mine. *Journal of Nursing Education*, 39 (9). https://doi.org/10.3928/0148-4834- 20001201-06

San, E. O. 2015. Using clinical simulation to enhance culturally competent nursing care: A review of the literature. *Clinical Simulation in Nursing*, 11 (4). DOI:10.1016/j.ecns.2015.01.004

Smith-Miller, A. C., Leak, A., Harlan, A. C., Dieckmann, J. & Sherwood, G. 2010. "Leaving the comfort of the familiar": fostering workplace cultural awareness through short-term global experiences. *Nursing Forum*, 45 (1). https://doi.org/10.1111/j.1744-6198.2009.00163.x

Sobane, K. & Anthonissen, C. 2013. Linguistic resources and strategies used in multilingual communication in HIV/AIDS care centres. *Stellenbosch Papers in*

Linguistics Plus, 42. doi: 10.5774/42-0-173

Sobane, K. M. E. 2013*. Language* discordant *HIV/AIDS interactions in Lesotho health care centres.* Stellenbosch University. (Thesis-PhD). https://scholar.sun.ac.za/items/1edf661b-7083-4cde-85b0-ede0ce2664c5. Date of access: 21 March 2018.

Sobane, K. M. 2015. Communication challenges experienced in Lesotho clinics where physicians speak both the community language and lingua franca. *Journal of Social Sciences,* 43(3). https://www.tandfonline.com/doi/abs/10.1080/09718923.2015.11893445. Date of access: 17 April 2019.

Spencer-Oatey, H. 2012. *What is culture? A compilation of quotations.* Global PAD Concepts.https://warwick.ac.uk/fac/soc/al/globalpad/openhouse/interculturalskills_old/gl obal_pad_-_what_is_culture.pdf Date of access: 12 November 2019.

Tanoubi, I., Labben, I., Guêdira, S., Drolet, P., Percon, R., Robitaille, A. & Gêorgescu M. 2019. The impact of a high-fidelity simulation-based debriefing course on the debriefing assessment for simulation in healthcare (DASH)© score of novice instructors. *Journal of Advances in Medical Education and Professionalism*, 7. https://doi.org/10.30476/jamp.2019.74583.0

Thackrah, R. D., Thompson, S. C. & Durey, A. 2014. "Listening to the silence quietly": Investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice. *BMC Research Notes*, 7(1). DOI:10.1186/1756-0500- 7-685

Thuube, M. R. 2015. Communicative problems of interpreting during cross linguistic interactions between non-Sesotho speaking Doctors and monolingual Basotho patients in Lesotho hospitals. *Journal of Humanities*, 2(3). https://journals.nul.ls/index.php/tsebo/article/view/5 Date of access: 27 Jun. 2022.

Treatment improvement protocol. 2014. *Centre for substance abuse and mental health services administration (US).* Series no. 59. https://www.ncbi.nlm.nih.gov/books/NBK248433/. Date of access: 10 September 2023

University of Jyväskylä. 2019. Language specialist. Department of language and communication studies. https://www.jyu.fi/hytk/fi/laitokset/kivi/en/studies/areas-of-specialization-for-language-students/language-specialist. Date of access: 18 September 2023.

Van Mol, M., Nijkamp, M., Markham, C. & Ista, E. 2017. Using an intervention mapping approach to develop a discharge protocol for intensive care patients. *BMC Health Services Research,* 17(837). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2782-2. Date of access: 27 August 2023.

Vella, E., White, M. V. & Livingston, P. 2022. Does cultural competence training for health professionals' impact on culturally and linguistically diverse patient outcomes? A systematic review of literature. *Nurse Education Today*, 118. doi: 10.1016/j.nedt.2022.105500.

Verkuyten, M., Yogeeswaran, K. & Adelman, L. 2019. Intergroup toleration and its implications for culturally diverse societies. *Social Issues Policy Review*, 13 (1). doi: 10.1111/sipr.12051

Wall-Bassette, E. D. & Hedge, A. V. 2018. Using Campinha-Bacote's framework to examine cultural competency from an interdisciplinary international service-learning program. *Journal of International Studies*, 8 (1). doi: 10.5281/zenodo.1134303

Chapter 5

Conclusion, limitations, and recommendations

5.1 Introduction

This chapter provides a summary of the thesis, after which the main conclusions drawn from the study are outlined and discussed based on the research objectives that guided the study. Following this, the associated limitations of the study, and recommendations for practice and future research are also explained. The study's main objective was to explore the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities, with an emphasis on Lesotho.

In support of the overall objective, the following secondary research objectives were formulated:

- To provide a scoping review of existing literature about the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities.
- To qualitatively explore the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals as well as strategies that they recommend be employed to reduce the noted adverse implications in these facilities.
- To develop an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals.

These objectives were addressed through three separate studies, as reflected in Chapters 2, 3, and 4. The remainder of this section is devoted to providing a brief recapitulation of the methodology that was followed with each of these aims/studies.

For article one, which addressed the first secondary research objective, the researcher undertook a scoping review following the Arksey and O'Malley (2005) framework. It incorporates six stages, of which the first five were relevant to this study:

(1) Identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, (5) collating, summarizing, and reporting the results, and (6) engaging in a consultation exercise. (The 6th stage was omitted because the aim of the study was merely to provide an overview of existing literature on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities).

The research question that guided the scoping review was: *What does the existing literature* reveal *about the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?*

Guided by the research question, the researcher conducted an electronic database search and identified five relevant databases which included: CINAHL, PUBMED, Google Scholar, APA, and PSYCHOINFO. To conduct the search, several Boolean operators were used, which included*: language* AND *culture differences, healthcare practitioners, patients,* AND *quality healthcare* as well as related word variations, such as "*barriers*", which produced the most effective results in the context of the stated research objective. Furthermore, reference lists were consulted to gather grey literature. According to Paez (2017), it includes diverse documents such as government reports, policy statements, theses and dissertations, fact sheets, and research reports that are typically distributed outside of peer-reviewed publications and distribution channels. In addition, it is produced from outside the traditional publishing and distribution channels which allows for the inclusion of information that may have been omitted due to publication bias and which often serve as valuable sources of data as they often include more recent studies that may be more detailed as they have not been restricted by the editors in terms of length or scope (Bellefontaine & Lee, 2013; Sibbald *et al.*, 2015).

The studies that were included in the scoping review were selected using defined inclusion and exclusion criteria. In particular, studies were included if they were concerned with the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities; they were written in English or have been translated into English; they were conducted in the last decade (as such articles revealed current trends and evidence on the phenomenon being studied and as this period enabled

tracing of scholastic progression in the field).

Studies that were excluded were those that were duplicate reports or focused on a specific illness.

Studies were also excluded if the study's full text was not available even when efforts were made to obtain the full text, if it was written in a language other than English and was not translated into English, was undertaken over a decade ago, and was not conducted within a healthcare facility.

After this process, a total of 23 publications were identified and included in the review. A data charting form was then developed to allow the researcher to extract and document variables that expounded on the research question. The following key variables were charted: *Year of publication, type of publication, aims of the study, sample size, research design, results, region, and healthcare setting.* The researcher then proceeded to collate, summarize, and report the results. Data collected from the selected articles were then analyzed through a six- step framework approach to thematic analysis as proposed by Braun and Clarke (2006). In the first phase, the researcher familiarized herself with the data intensively by repeatedly reading through the selected articles with the aim of understanding and finding meanings and patterns. The second phase entailed generating initial codes. In the third phase, codes that emerged from the data set were collated and sorted into sub-themes and main themes. In the fourth phase, the researcher refined the themes to establish whether they formed a coherent pattern that reflected a valid account of the data set or whether there was a need for some themes to be merged or broken down further into new themes. In the fifth phase, the researcher reflected on each theme thus far captured and narrated the topic under study, and then named the themes accordingly to demonstrate the key findings that emerged from the data. In the last phase, a write-up of a report was done which fully detailed what the themes from the data set indicated concerning the phenomenon that was being studied.

For article 2 which addressed the second secondary research objective, the researcher undertook a qualitative exploration of the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and further explored their views on strategies that could be employed to reduce the noted adverse implications. She employed a qualitative methodology and adopted an exploratory qualitative design. Purposive sampling was used to find participants for this study and they were selected based on several inclusion criteria. For

patients, participants had to be Basotho out-patients (18 years and above) in one of the four selected public hospitals, their primary language had to be Sesotho, and they were selected on the basis that they had been attended to by an expatriate healthcare practitioner in one of the selected hospitals and were considered fit by the supervising healthcare practitioner to take part in this study and that they were unlikely to be negatively affected by their participation. Expatriate healthcare practitioners were selected on the basis that they were non-proficient or had very low proficiency in Sesotho and that they had attended to Basotho patients in the selected public hospitals.

For article 3, which addressed the third secondary research objective, the researcher developed an intervention outline aimed at limiting the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. Intervention mapping (IM) was used to guide the development of a culture immersion program outline for expatriate healthcare practitioners. IM is a protocol that guides decision-making for intervention development, implementation, and evaluation of problems that may occur within healthcare settings (Van Mol *et al.,* 2017). This framework provides a systematic process and detailed protocol for effective, step-by-step decision-making for intervention development. It uses theory and evidence-base health promotion program planning to assess and intervene in health problems and it also involves community participation (Fernandez *et al*., 2019). It consists of the following six steps:

(1) Needs assessment.
(2) Formulation of change objectives.
(3) Selection of theory-based methods and practical strategies.
(4) Development of the intervention.
(5) Adoption and implementation plan.
(6) Evaluation planning.

However, for this study, as discussed in the previous chapter, only four steps were undertaken because developing, implementing and evaluating a program would require the health cluster in the Parliament of Lesotho to discuss the proposed intervention, invite specialists to assess its viability, then instructing the relevant ministry to include it in the budget for the financial year after approval, etc. all of which which could take years, and could not be completed in the time alloted for the study.

5. 2 Findings

This section presents findings reached during the study concerning the three research questions that were formulated at the outset of the study.

Research question 1

The first research question was: *What does the existing literature reveal about the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities?*

To address this, the *researcher* conducted a scoping review of existing literature on the topic being investigated (reflected in article 1 chapter 2).

Findings derived from the scoped literature indicated that the presence of language and cultural differences between patients and healthcare practitioners who do not share a common language and culture contributed to **poor communication** (Albougami, 2015; Alshammari *et al*, 2019). Findings further revealed that as a result of this, consultations became lengthy, causing **delays in diagnoses and consequently the administering of treatments** to patients (Alhamami, 2020; Ali & Watson, 2018; Naidoo, 2014). In addition, the scoped literature indicates that these discordances brought about a sense of being overwhelmed for the healthcare practitioners which resulted in them **failing to build rapport** with patients (Abderahim *et al.*, 2017; Albagawi, 2014; Almutairi, 2015; Malik & Khan, 2020; Naidoo, 2014; Sobane, 2013). Furthermore, findings indicated that these differences often resulted in healthcare practitioners failing to relate to and understand patients' situations, **decreasing their ability to be empathetic** (Naidoo, 2014; Van den Berg, 2016). Also, it was established in the literature that these discordances were associated with increased **mistrust** of patients in the healthcare practitioners' capabilities to correctly diagnose, and prescribe appropriate treatments for them (Alhamami, 2020; Al-Harasis, 2013; Sobane, 2013; Van den Berg, 2016). As a result, patients failed to subscribe to some of the suggestions reached by healthcare practitioners during consultations, which resulted in **poor patient compliance** (Alshammari *et al.*, 2019; Zhang *et al.*, 2022). It was also revealed that these differences resulted in communication hurdles that caused **stress and anxiety** for both parties (Alhamami, 2020; Alshammari *et al.*, 2019). The struggle to communicate properly with healthcare practitioners was a major source of **frustration** for patients (Naidoo, 2014; Turner, 2015). Findings also revealed that these differences resulted in **increased avoidance behavior** for both

patients and healthcare practitioners. They shied away from interacting with each other in order to minimize the communication adversities they experienced (Ali & Watson, 2018; Al-Kabani *et al.*, 2020; Naidoo, 2014). To add to the above-mentioned, the literature also indicated that language and cultural differences led to communication hurdles that discouraged patients from **fully disclosing some medically relevant information** (Al-Kabani *et al.*, 2020; Sobane, 2013). Another point to be considered within the findings was that the breakdown of communication between patients and healthcare practitioners contributed to the potential occurrence of misunderstandings and the insufficient collection of health-related information which resulted in the commission of **medical errors** (Albougami, 2016; Al-Harasis, 2013; Almutairi, 2015).

This section answered the first research question of the thesis. The literature revealed that the presence of language and cultural differences between patients and healthcare *practitioners* resulted in the two parties experiencing numerous unpleasant encounters that were driven by a lack of effective communication which is arguably one of the most important variables associated with quality healthcare delivery. Findings confirmed that these differences between patients and healthcare practitioners hindered the delivery of effective healthcare and led to inequalities and disparities within healthcare settings. The discordances also have a negative impact on the patient-healthcare practitioner relationships which are seemingly the basis of patient care. In conclusion, the literature clearly illustrated that the delivery of quality healthcare was hindered in facilities where healthcare practitioners did not share a common language and culture with patients.

Research question 2

The second research question was: *What are the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners to Basotho patients in Lesotho public hospitals? What strategies do they recommend be employed to reduce the noted adverse implications in these facilities?*

To address this, the *researcher* undertook an exploratory qualitative study (reflected in Article 2).

Several themes were identified. The first of these indicates that the presence of language and *cultural* differences between patients and expatriate healthcare practitioners in Lesotho public hospitals results in **miscommunication**. Responses from the participants indicate that these practitioners *fail to understand* information related by patients during

consultations. Furthermore, it was revealed that consequent to expatriate healthcare practitioners failing to adequately understand patients in clinical interactions, the latter experiences *awkwardness and discomfort.* Findings further illustrate that as a result of the discomfort owing to communication struggles in the consultation rooms, some patients decide to *eliminate some vital information* regarding their illnesses and symptoms. In addition, findings suggest that as a result of the aforementioned implications, expatriate healthcare practitioners **poorly assess patient's** conditions.

In addition, the communication struggles that ensued between patients and expatriate healthcare practitioners triggered **negative emotional responses**. In particular, *expatriate* healthcare practitioners experience *increased frustrations* due to being unable to efficiently interrelate with patients. On the other hand, findings reveal that the unpleasant experiences patients undergo due to the presence of language barriers and cultural differences cause them to suffer from *stress and anxiety*. Furthermore, findings show that the anguish patients experience due to misunderstandings that occur as a result of the presence of language barriers and cultural differences between themselves and expatriate healthcare practitioners results in them having *reduced trust* in the practitioners' capabilities of meeting their healthcare needs. Consequently, patients **resist undertaking the suggested medical procedures and treatments**. The findings further point out that the discordances lead to misinterpretations and conflicting beliefs and views regarding health- related issues which prompt patients' **avoidance behaviours** which in turn results in patients *queueing* in long lines to be attended to by healthcare practitioners who can communicate in their mother tongue.

Regarding participants' views on the strategies that can be employed to reduce the noted implications, findings reveal that the patients and expatriate healthcare practitioners suggest that it should be ensured expatriate healthcare practitioners that are hired to work in Lesotho public hospitals are multilingual. *Findings* further reveal that participants suggest that **the orientation of expatriate healthcare practitioners** on Basotho culture and language is done upon arriving in Lesotho. The current study also reveals that the respondents suggest an introduction of a **medical interpreting curriculum in schools** to train eligible individuals to be interpreters who will be equipped with the ability to translate and interpret the medical jargon used during consultations. Lastly, participants point out that **professional interpreters should be hired** to assist with communication in consultation rooms.

The findings of this study serve to answer the second research question proposed in this thesis. In summary, findings from this empirical study indicate that language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals adversely affect the overall patient experience, and serve to harm the healthcare reputation of Lesotho public hospitals because the mission statement of the Ministry of Health is to establish *a system that will deliver quality health services efficiently, effectively, and equitably to all Basotho* (NHSP, 2016*)*. This study reveals that the strategy (of employing expatriate healthcare practitioners) adopted by the Government of Lesotho to counteract the noted shortage of human resources in public hospitals which serve the majority of the population has inadequacies that need urgent attention to ensure the delivery of safe and high-quality healthcare to Basotho who seek services in these hospitals. In response to this, the researcher developed an intervention outline that she proposes be used to guide the development of a program that will be used to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals.

5.2.1 Discussion and theoretical contextualization of the findings

The health belief model (HBM) proposes that messages produce optimal behavior change when they successfully target perceived barriers, benefits, self-efficacy, and threats (Jones *et al.*, 2015). However, findings indicate that in the presence of language and cultural barriers between patients and healthcare practitioners, messages exchanged between the two parties failed to correctly target and promote optimal behavior modification in healthcare situations because they failed to communicate efficiently. This resulted in a series of adverse events that hindered the delivery of quality healthcare. In addition, Champion and Skinner (2008) point out that HBM posits that certain environmental circumstances can have an impact on an individual's final action. Findings from the current study indicate the presence of these language and cultural differences between patients and healthcare practitioners are cues that influence their behaviours and actions during clinical interactions and healthcare processes.

First of all, they influence perceptions of *susceptibility* among patients. This is a construct of HBM that explains that people take preventative measures only when they have a subjective assessment of the risk of developing a disease (Rosenstock, 1974). In *healthcare* facilities where patients and healthcare practitioners do not share a common language and culture, misunderstandings occur which often result in messages that are

being exchanged during interactions being misinterpreted or misunderstood. This is said to result in patients subjectively appraising themselves as being at low-risk of developing illnesses. As a result, preventive health education often fails to meet the targeted behavior modification, resulting in patients failing to adopt preventative measures, thus resulting in poor health outcomes. It is worth noting that in this scenario where individuals have taken upon themselves to seek healthcare assistance, that language and cultural differences between themselves and healthcare practitioners alters their ability to correctly assess the risk of developing new illness or further illness complications following their diagnosis. This is explained in the findings from the current study that indicate that the presence of these differences between patients and expatriate healthcare practitioners resulted in the former tending to avoid consultations. This indicates that they fail to assess the importance of consultations where they get insightful information that will help them correctly evaluate their susceptibility. Findings further detail that in public hospitals where healthcare services were provided by expatriate healthcare practitioners, patient at times eliminate some vital information during consultations. This points to the fact that the language and culture barriers not only hinder their ability to communicate important information related to their health (signs and symptoms, reactions to prescribed medications, issues of adherence etc.) but also that they hinder their ability to understand information that will help them assess the importance of such.

Findings further point out that in these healthcare settings, language and cultural differences were factors that negatively impacted patients' perceptions of the *severity* of their conditions. This construct of HBM explains that individuals only act when they believe an illness would have potentially serious consequences (Rosenstock, 1974). In the current study, it was found that there was often insufficient communication between patients and expatriate healthcare practitioners (as they were not able to properly explain some important health-related information to patients e.g., the seriousness of an illness they are diagnosed with, the importance of adhering to suggest medications, required lifestyles changes, required medical procedure). In turn, patients fail to comprehend the severity of the illness they have been diagnosed with because they miss out on important information e.g. explanations of further complications that this illness could have or the likeliness of health deterioration should certain health regimens not be followed.

In addition, this was likely to facilitate failure of patients to adhere to the recommended treatments because they do not understand the graveness of the illness they have been diagnosed with, and consequently fail to recognize the importance of undertaking

suggested corrective measures. This construct of HBM, *benefits,* explains that individuals act by adopting health- safe behaviors or taking proposed remedies only if they believe that the actions would be worthwhile (Rosenstock, 1974). Findings from the current study point out that it was difficult for patients to understand information related to them regarding the recommended behaviours, lifestyles changes and how to correctly take prescribed medicine due to language and cultural differences. Consequently, they failed to understand the benefits associated with complying with such. This placed them at risk of receiving healthcare services that failed to attain the expected positive health outcomes.

The last construct of HBM is barriers, and refers to an individual's perception of potential obstacles that could prevent them from taking the recommended remedial action (Rosenstock, 1974). Findings from the current study indicate that the in presence of *language* and cultural differences between patients and expatriate healthcare practitioners, some patients held certain cultural beliefs that inhibited them from informing the healthcare practitioners of some symptoms they were experiencing, from undergoing certain physical exams, undergoing suggested medical procedures, and undertaking certain treatments. This was likely to result in negative healthcare outcomes. Language was another barrier that hindered them from exchanging of some important information which was required for the diagnosing and prescribing of treatments for patients in healthcare. This is highly likely to result in more serious issues such as further disease complications and poor disease management, resulting in illness progression, and at times, loss of lives.

In the context of this study, HBM is a lens that points out that the presence of language and cultural differences in healthcare facilities exacerbates miscommunication. In turn, this leads to misunderstandings and misinterpretations of healthcare related information and situations that play out between patients and healthcare practitioners during consultations that are meant to assist *them* to reach medical decisions that will yield positive health outcomes and reduce occurrences of incidents which conspire to produce sub-par healthcare.

Uncertainty Reduction Theory (URT)

The theory aims to explain the communication processes that occur when two people meet. It posits that capturing, processing, retaining, and retrieving information is critical to the growth and maintenance of personal and social relationships (Gudykunst, 2005). It

further posits that relationships can be viewed as systems of information exchange that must reduce uncertainty in order to survive (Berger, 1988). Findings suggest that the presence of language and cultural differences between patients and expatriate healthcare practitioners in Lesotho public hospitals causes uncertainty especially among patients who point out that their inability to communicate effectively with the practitioners contributes to the development of feelings of doubt towards the practitioners'' ability to properly diagnose and prescribe correct treatment plans for them. The doubt patients have stimulates feelings of awkwardness, discomfort and frustrations which are associated new stress related illnesses which are likely to cause delayed recovery hence declination of health for the already ailing patients. For the expatriate healthcare practitioners, the uncertainty that was as a result of their inability to predict the outcomes of their interactions with patients due to ensuing communication difficulties was associated with failure to build rapport which results in reduced patient compliance and satisfaction. It also results in stress and anxiety which are likely to lead to the development of new stress related illnesses that may affect the quality of the healthcare services they give to patients.

For this study, URT was a framework that helped predict how the presence of language and cultural differences between patients and expatriate healthcare practitioners resulted in both parties failing to reduce uncertainty in situations that ensued due to communication challenges. Failure to reduce uncertainty *between* patients and expatriate healthcare practitioners in Lesotho public hospitals hindered both parties' ability to retrieve information from each other for the growth and maintenance of the patient-doctor relationship, which is a prerequisite to attaining quality healthcare.

Communication accommodation theory (CAT)

Communication accommodation theory was developed by H. Giles in 1971 as a general theoretical framework for interpersonal and cross-group communication (Kuruthan *et al.*, 2018). It aims to explain how people adapt their communicative behaviours to accommodate each other in social interactions, and it also focuses on what consequences these adaptations have for social differences (Kuruthan & Kuruthan, 2019). In the context of the theory, "accommodation" is used as a metaphor that represents a barometer indicating the level of social distance (Giles & Ogay, 2007). The theory further explains that individuals can control social differences by adapting different communicative approaches in different situations (Mlambo, 2017). In the context of the current study,

findings point out that the presence of language and cultural differences between patients and expatriate healthcare practitioners who exchange information during consultations in a clinical setting, leads to their failure to adopt communicative approaches that decrease social differences because of communication difficulties they meet owing to the language and cultural discordances. In addition, it theorizes that a communicator accommodates those they admire, like, respect, and trust (Giles & Farazadnia, 2015). Contrary to this tenet, findings emanating from the present study indicate that because of the presence of language and cultural differences in healthcare facilities, patients and expatriate healthcare practitioners fail to adapt their communicative behaviors and to accommodate each other, and this results in numerous adverse effects that include mistrust and failure to build rapport. In turn, this results in failure to reduce both communicative and social differences.

In particular, the theory focuses on three types of adaptations that can occur during interactions. They are convergence, divergence, and maintenance (Gasiorek *et al.,* 2021). The current study found that in the presence of language and cultural discordances, in some public healthcare facilities, patients and expatriate healthcare practitioners adopted a maintenance strategy. Patients avoided consultations with healthcare practitioners who did not share a common language and culture with them. Instead, they resorted to seeking healthcare assistance from those they would be able to communicate with easily. They did this in an attempt to evade the ensuing frustrations that occur as a result of the two parties failing to accommodate each other. They therefore make no effort to reduce or increase chances of social integration which is fundamental in the receiving and giving of care. Furthermore, the numerous instances of avoidance behaviours of patients to consult expatriate healthcare practitioners in Lesotho public hospitals could also be viewed as divergence. It is a type of adaptation whose consequences increase communicative differences and result in greater social disintegration (Elhami, 2020). When patients dodge consultations with expatriate healthcare practitioners due to evidently existing communication challenges, no effort is made to ensure they accommodate each other and this decreases social integration. Consequently, the two parties fail to build therapeutic relations. Maintenance and divergence were likely to result in extremely unfavorable health outcomes that may include late disease detection which may reduce patients' survival rate and increase their suffering. This stands in contrast to seeking convergent solutions, which are communication adjustments made during interactions that are likely to result in reduced

communicative differences (Elhami, 2020). However, some findings do point out that some patients consult expatriate healthcare practitioners despite the communication challenges they were likely to face. In such cases the effort taken by these patients to consult the expatriate healthcare practitioners could be viewed as convergence because some practitioners pointed out that at times, they resort to asking for assistance from their fellow colleagues to translate for them when they encounter problems while consulting some patients. This can be viewed as an effort from both parties to reduce social differences and encourage integration despite the existing language and cultural differences.

Communication accommodation theorists propose that accommodation can be achieved via five sociolinguistic strategies (Coupland *et al*., 1988; Giles *et al*., 2015 in Giles & Farazadnia, 2015). Three of the five strategies were expressed in the participants' views on strategies that could be adopted to mitigate the implications of language and cultural. The first strategy is *approximation*, which refers to making one's language and communication patterns more similar or dissimilar. Findings point out that participants suggest that it should be ensured that multilingual expatriate healthcare practitioners especially those proficient in English are hired to work in the public hospitals. This would assist in making communication patterns more similar because English is a second language in Lesotho, suggesting that the practitioners will be able to communicate with a larger population even when they are not proficient or have low proficiency in Sesotho. The second strategy centres on *interpretability*, which refers to accommodating another's perceived or expressed ability to understand what is going on in the conversation. For the application of this strategy, participants point out that professional interpreters should be hired to facilitate communication in clinical interactions between patients and expatriate healthcare practitioners. Secondly, they indicate that medical interpreting curriculums should be developed in schools to train medical interpreters who will be able to interpret medical jargon during consultations. These will assist the two parties to be able to accommodate each other by being enabled to express themselves consequently understanding each other during consultations. The third strategy is *emotional expression*; it has to do with responding to the other's identified or reported emotional and relational needs. In congruence with this last strategy, participants point out that the orientation of expatriate healthcare practitioners to the dynamics of Basotho health beliefs, customs, health-seeking behaviours, and language use in healthcare upon arrival in Lesotho would enable the practitioners to be able to accommodate their patients during

consultations because the orientation programs will facilitate their ability to assess emotional and relational needs of patients. Therefore, they believe that inducting expatriate healthcare practitioners into Basotho culture could enable them to better relate to the needs of patients and improve communication (and also accommodation) and the consequent delivery of quality healthcare. The fourth strategy is *interpersonal control*, which refers to how individuals adjust communication based on role relationships, relative power, and status, and the fifth strategy entails *discourse management*, which pertains to the adjustment of communication based on the perceived or stated conversational needs of the conversational partner. These two strategies were not reflected in the participants' views and thus this suggests a potentially fruitful avenue for future research.

Research Question 3

The third research question was: *What type of intervention can be developed to address the adverse implications of language and cultural differences on the quality of healthcare provided by* expatriate *healthcare practitioners to Basotho patients in Lesotho public hospitals?*

To answer this research question, the researcher developed a culture immersion training program outline guided by the Camphina-Bacote model of cultural competency. The proposed program's objective was to enable expatriate healthcare practitioners who work in Lesotho public hospitals to achieve basic competence in Sesotho and to enhance their cultural competency to increase the probability that quality healthcare services are delivered in these hospitals. Its proposed objectives included: improving their Sesotho language skills; providing them with specific vocabulary and communication methods that they can use effectively when working with Basotho patients; enhancing their cultural awareness by offering lectures about the Basotho culture; enabling them to interact with various communities in Lesotho who have diverse educational, sociocultural, socioeconomic, and socio-political backgrounds to enhance their cultural understanding, perceptions of health and illness, health behaviours, and beliefs. These will concurrently also promote the goal of language acquisition, enabling them to learn about the healthcare system in Lesotho by scheduling visits to local clinics and healthcare centers and enabling them to interact with Basotho communities by participating in field trips to local clinics around the four public hospitals that were selected for the empirical study.

The program is hoped to be carried out for two weeks with 60 hours of participation. This is inclusive of a 40-hour workshop to train expatriate healthcare practitioners on Sesotho

language terms commonly used in basic healthcare conversations and 20 hours of professional practice in the selected clinics or health centers.

It is proposed that suitable locations (hospital or community center halls) be identified for the classes in close vicinity of the four public hospitals that previously participated in the empirical study. It is suggested that simulation consultations take place in nearby filter clinics and health centers because they are easily accessible, less congested, provide primary care, and can diagnose, treat, and prevent a wide variety of conditions. Furthermore, it is proposed that participants should include expatriate healthcare practitioners who will be selected through purposive sampling and simulation patients will be selected through convenience sampling. Expatriate healthcare practitioners will be selected provided they are available and willing to participate and have permission from relevant departments to participate in this exercise. Immersion patients will be selected provided they can express themselves clearly and are available and willing to participate in this exercise.

It is proposed that in the first week, the participants (expatriate healthcare practitioners) will have classes during the morning hours that will be divided into three lessons. The first lesson will focus on highlighting morphology, syntax, semantics, pragmatics, and phonology in a Sesotho discussion. The second lesson will focus on teaching them vocabulary specifically focused on the area of healthcare and medicine. The third lesson will focus on introducing them to activities that will educate them on the everyday needs of Basotho patients in public hospitals. In the afternoon, the participants will be made to watch films produced in Lesotho that depict Basotho's way of living, cultures, and the languages spoken. In the second week, they will take part in various excursions throughout the day. These will include simulation exercises in the selected clinics and health centers. The simulation session will be divided into three phases which will include: pre-briefing, simulation scenario and debriefing for all participants.

5. 3 Limitations

As with all research, there were some limitations in the present study. In the context of the scoping review, a significant limitation of the current study was that some articles were published in journals that were inaccessible even if efforts were made to obtain the full text. As a result, these studies could not be included in the data presentation and thematic analysis and could not contribute to the findings of the current scoping review.

Additionally, only studies written or translated into English were included in the review, suggesting that some relevant studies published in other languages were omitted. It is important to note that most studies on the impact of language and cultural differences have been conducted in Saudi Arabia, an Arabic-speaking country. Much of the available literature has not been translated into English and was therefore not included in the scope. This may have inadvertently resulted in important findings on this topic being excluded from the present review.

Another limitation of the study is that no quality control mechanism was implemented in the study. However, this step is not considered essential for scoping reviews as the study aimed to provide an overview of existing research on the implications of language and cultural differences on the quality of healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities. With that said, this limitation is potentially compounded by the fact that the researcher worked independently (which was necessitated by the process of completing a post-graduate degree), and thus potentially exhibiting a biased perspective in interpreting information. Quality control of the study might have been enhanced through a collaborative approach that offers different interpretations of the different themes.

Furthermore, another limitation was the fact that the researcher has a personal interest in the implications of language and cultural differences on the quality of health care provided by physicians who do not share a common language and culture with patients in health care facilities. This limitation was addressed through strict adherence to the scoping review process of Arksey and O'Malley (2005) and Levac *et al.* (2010) and the thematic analysis approach of Braun and Clarke (2006). In addition, the researcher sought to be mindful and ethically aware in considering the key features of the literature and to adopt a balanced and objective standpoint. For this reason, the scoping review structures were followed in detail, and reporting mechanisms such as the data chart were optimally utilized to standardize reporting and thus provide reproducible results (Munn *et al.*, 2018).

Finally, the scoping review was not subject to a quality assessment. However, this phase is not considered crucial for scoping reviews (Levac *et al.*, 2010). Particularly because the main objective of the study was to obtain a general overview of the literature on the implications of language and cultural differences on the quality of healthcare provided by practitioners who do not share a common language and culture with patients in healthcare facilities.

For the qualitative study (Chapter 3), owing to administrative issues, permission to conduct the study was granted to the researcher by the Principal Secretary of the Ministry of Health after approximately four months after the application was submitted. This resulted in delays in data collection processes. When the application was finally approved, the country went into a one-and-a-half-year-long total lockdown due to the COVID-19 pandemic, which was then lifted gradually. In the first level, the movement of the majority of the population was restricted. This prevented the researcher from contacting the hospital administration regarding the recruitment of the potential participants. As lockdown restrictions were further lifted, eventually the researcher met the hospital administration. However, the potential participants who met the inclusion criteria were not accessible because access to hospital premises was limited only to critically ill patients. Furthermore, the researcher had originally planned to interview 24 expatriate healthcare practitioners and 24 patients. However, although she managed to interview the intended number of patients, only eighteen expatriate healthcare practitioners were interviewed, because, during the pandemic, their jobs in the understaffed and overburdened public hospitals which included attending to emergencies and COVID-19 patients as the infection rate was still high rendered them unavailable to participate in the scheduled interview sessions. Some rescheduled numerous times while others were compelled to withdraw from their participation in the study entirely. Furthermore, some expatriate healthcare practitioners were hesitant to share sensitive information during interviews that included information relating to the committing of medical errors and issues of malpractice. This was evident as some did not believe that the study was a requirement for the doctoral degree of the researcher despite her providing all the necessary documents that supported the cause of the study. Another limitation was that some expatriate healthcare practitioners were not fluent in English and struggled to respond to some questions during interviews because they had limited knowledge and understanding of English which was used to conduct the interviews.

Lastly, patients were in some cases also reluctant to make physical contact with the researcher due to their fear of contracting COVID-19. In addition, during interviews some of the patients concealed their emotions and avoided relating their views and experiences regarding events they encountered that were related to healthcare delivery by expatriate healthcare practitioners in public hospitals. They were skeptical because they did not believe that their responses would not incriminate the expatriate healthcare practitioners, which they believed was likely to result in victimization and the compromising of the

expatriate healthcare practitioners' jobs. However, they were continuously reassured that any information they provided would be treated confidentially and would not be disclosed to third parties without their consent.

For Chapter 4, which entailed the development of an intervention to limit the adverse implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals, a significant limitation is that the program has not been implemented and tested.

5.4 Recommendations

The included studies in the scoping review focus on non-specialist healthcare facilities, excluding studies that were undertaken in other specialized healthcare facilities where healthcare services are provided by healthcare practitioners who do not share a common language and culture with patients and where diagnosis and treatment of health problems rely more on linguistic communication than on objective tests and medication e.g., mental health institutions (Sentell *et al.*, 2007). Including such studies in a scoping review may reveal different aspects of this phenomenon that may contribute to the development of interventions to mitigate this issue in other types of healthcare facilities where language and cultural differences exist between patients and healthcare practitioners.

In addition, health warnings for several products (e.g., condoms that are normally put in hospital toilets) have instructions for use written in English. Future research should seek to establish how language differences that exist between patients and such written instructions might be affecting the correct use of these preventive measures for patients and how this affects the delivery of quality healthcare.

This study also noted that the preponderance of the literature on the phenomenon being studied is empirical (15 studies). Only six publications were theoretical, and a further two were expert opinions. Given the relatively small number of publications involved, it is evident that not just the empirical, but in particular the theoretical evidence and expert opinions relating to this topic are relatively scarce and that additional theoretical and empirical work is required to verify and expand upon the existing findings.

Lastly, future research should also be undertaken in other parts of the world because currently most of the available literature is from studies that were conducted in Saudi Arabia. Similar studies should be conducted in other geographic regions. This is likely to surface different perspectives, views, and experiences of patients and healthcare

practitioners, thus generating a more comprehensive, inclusive, and multifocal view of the implications of language and cultural differences on the delivery of healthcare.

Regarding article 2 chapter 3, it was apparent that a similar study should be conducted in Lesotho public hospitals during a pandemic-free period, because this will increase the likelihood of the collection of sufficient data on this topic. More information-rich participants (patients and expatriate healthcare practitioners) will be accessible, thereby contributing to the attaining of more trustworthy results regarding this topic in the context of Lesotho. In future research on a similar topic, anonymous self-administered questionnaires should be used to collect data from expatriate healthcare practitioners. This will enable them to respond to the research questions anonymously and at their convenience. This might help reveal some vital and sensitive information that might have been withheld during the interviews conducted in the current study. In addition, focus group discussions, along with semi-structured interviews, should be used to collect data from patients to obtain multiple perspectives and allow observation of emotional processes within a group context to gain a deeper understanding of their views and experiences on the subject being studied. When conducting similar future studies, multilingual translators should be hired to support communication between researchers and expatriate healthcare practitioners, as some of them are not proficient in English. In the future, longitudinal research on this topic should be undertaken to allow the exploration of key sequences of events, to explore changes over time, and to provide insight into other factors that might play a role concerning the implications of language and cultural differences for the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals. Given the ethical sensitivity of some information that is likely to come to light during data collection, researchers in future studies on a similar topic should use more reassuring measures to convince participants of the study's goal, such as an additional letter from the hospital manager addressed an identified individual who is a potential participant and states the aim of the study. This will help participants answer research questions more freely and openly, without fear of prejudice or hidden agendas on the part of the researcher. Additionally, it could help increase the number of participants showing interest in taking part in the study.

5.5 Recommendations for practice and policy

Despite all the problems emanating from the existence of language and cultural differences noted in this study, this issue has not received adequate attention at both

policy and practice levels in Lesotho. The mission statement of the Ministry of Health is to establish a system that will deliver quality health services efficiently, effectively, and equitably to all Basotho (Government of Lesotho, 2006). However, findings from the qualitative study that explored the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals (as reflected in Chapter 3) indicated that these discordances resulted in miscommunication, poor patient assessment, negative emotional responses, patients' resistance to undertaking suggested treatments and medical procedures, avoidance behaviour, and queueing of patients. All these eventualities contribute to the delivery of poor healthcare to patients in a country where the primary causes of death are HIV/AIDS, tuberculosis, strokes, lower respiratory infections, ischemic heart disease, diarrheal diseases, diabetes, neonatal disorders, road injuries and interpersonal violence (CDC, 2019). These are likely to cause significant social and economic disruptions that may affect the population's well-being, and speak to the high need for adequate healthcare delivery in Lesotho public hospitals. It is however important to note that there is presently an absence of specific public regulations which clearly indicate the right to access healthcare in one's own language in Lesotho. The researcher suggests that the issues of language and cultural differences between patients and expatriate healthcare practitioners should receive urgent attention among healthcare policymakers and healthcare administrators at the central government level to enhance healthcare access and effectiveness, and to increase patient satisfaction and job satisfaction among expatriate healthcare practitioners. A political will is needed from the government of Lesotho to address the language and cultural differences in Lesotho public hospitals.

Furthermore, this study makes a practical contribution in the form of a culture immersion program that was developed by the researcher with the aim of equipping expatriate healthcare practitioners who work in Lesotho public hospitals to achieve basic competence in Sesotho and to enhance their cultural competency in order to increase the likelihood that quality healthcare services are delivered in these hospitals.

In addition, views of patients and expatriate healthcare practitioners on strategies that can be employed to reduce the noted adverse implications resulting from the presence of language and cultural differences pointed out that English proficiency be a minimum requirement when recruiting expatriate healthcare practitioners, expatriate healthcare practitioners be orientated, medical interpreting curriculum should be developed in schools, and that professional interpreters should be hired.

5.6 Conclusion

This study has shown that the presence of language and cultural differences between patients and healthcare practitioners adversely affects the delivery of quality healthcare in healthcare facilities. A range of unfavorable outcomes that result from the presence of these discordances in healthcare settings demonstrate this. The study points out that language and culture constitute two vital aspects of the interaction between a patient and a healthcare practitioner. The nature of the relationship between the two parties requires them to communicate to facilitate healthcare processes. However, the presence of these discordances is associated with the failure of the two parties to communicate satisfactorily. Efficient communication between the two parties is important because it facilitates the exchange of vital health-related information. Patients communicate the following information to healthcare practitioners: symptoms of an illness, illness history, existing illnesses, current medication plan, and lifestyle. In turn, healthcare practitioners rely on such information to diagnose patients. Findings indicate that the presence of the discordances hindered this. Practitioners often fail to correctly assess patients' condition when they do not receive sufficient information from the patients. The inability of the two parties to communicate efficiently results in delayed diagnoses and the administration of treatments to patients. What was also evident is that the parties failed to build rapport which resulted in dire consequences that included healthcare practitioners' decreased empathy towards patients which in turn resulted in reduced trust of the latter in the capabilities of the former. These are associated with the noted poor compliance of patients to the suggested treatments and medical procedures. The study also points out that the presence of these discordances between patients and healthcare practitioners is linked to negative emotional responses: increased stress and anxiety for healthcare practitioners and increased patient frustrations. Furthermore, the study reveals that the presence of language and cultural barriers brings about avoidance behavior in patients, which results in queuing of patients in long lines to be attended to by practitioners who can understand and speak their language. In instances where patients finally consult healthcare practitioners who do not share a common language and culture with theirs, they do not disclose fully medically relevant information to these practitioners which could potentially result in the latter committing medical errors. To address these issues, respondents identified possible solutions to the challenges posed by these differences and suggested that it should be ensured that English proficiency is a minimum requirement when recruiting expatriate healthcare practitioners, expatriate healthcare

practitioners are orientated, medical interpreting curricula in schools are developed, and professional interpreters are hired.

The findings from the qualitative study and the scoping review subsequently guided the development of a cultural immersion program for expatriate healthcare practitioners. This program aims to equip practitioners with basic skills in the Sesotho language, specific vocabulary, and communication methods necessary for working with Basotho patients. The researcher hopes that it will be utilized by the Ministry of Health to limit these adverse impacts while also increasing chances of attaining consequent enhanced healthcare-related outcomes during encounters between patients and expatriate healthcare practitioners in Lesotho public hospitals.

The program is aimed at contributing to the development of intercultural communication competency among expatriate healthcare practitioners within Lesotho public hospitals. When intercultural communication is enhanced, healthcare practitioner and patients' relations will be improved as evidence suggests. A good relationship between a healthcare practitioner and a patient fosters better physician-patient communication, which ultimately improves diagnoses (Meuter *et al.,* 2015). The program also intends to minimize the potential malpractices that occur as a result of language and cultural differences between patients and healthcare practitioners in Lesotho public hospitals and to enable patients to make informed decisions regarding their health.

Hopefully, this research contributes to an understanding of how the presence of language and cultural differences affects through a stream of negative consequences, the delivery of quality healthcare provided by healthcare practitioners who do not share a common language and culture with patients in healthcare facilities, and that its findings and recommendations can serve as a basis for future research.

It is also hoped that the experiences of patients and expatriate healthcare practitioners In Lesotho public hospitals could be used to guide the formulation of policies and procedures that could contribute to the improvement of the quality of healthcare delivered.

There is a considerable reliance on non-Basotho medical doctors in Lesotho public clinics and hospitals and the Government of Lesotho intends to continue to extensively recruit these medical officers and specialists in the foreseeable future as this protects the country from significant potential losses in human capital investments (Schwabe et al., 2004). In addition, they point out that the expatriate healthcare practitioners are currently the

backbone of the Lesotho healthcare system and will be in foreseeable future yet this strategy has proven to carry consequences that hinder the delivery of quality healthcare because of language and cultural differences between patients and these practitioners in public healthcare facilities are not given the attention it deserves. This points to a need for urgent attention to be paid to this issues that has proven to promote negative healthcare outcomes for populations of Basotho from the middle and low classes who rely on public hospitals for subsidized healthcare services.

Reference list

Abderahim, H., Elnashar M., Khidir, A., Killawi, A., Hamound, M. & Al-Khal, L. A. 2017. Patient perspectives on language discordances during healthcare visits: findings from the extremely high-density multicultural State of Qatar. *Journal of Health Communication*, 22(4). https://doi.org/10.1080/10810730.2017.1296507

Albagawi, B. S. 2014. *Examining barriers and facilitators to effective nurse-patient communication within a Saudi Arabic cultural context.* School of Health Sciences, College of Science, Engineering and Health, RMIT University. (Thesis-PhD). https://researchrepository.rmit.edu.au/esploro/outputs/doctoral/Examining-barriers-and- facilitators-to-effective-nurse-patient-communication-within-a-Saudi-Arabic-cultural- context/9921861272601341. Date of access: 15 Jun. 2019.

Albougami, A. 2015. Role of language and communication in providing quality healthcare by expatriate nurses in Saudi Arabia. *Journal of Health Specialties*, 3(3). http://www.thejhs.org/article.asp?issn=2468-6360;year=2015;volume=3;issue=3;spage=166;epage=172;aulast=Albougami. Date of access: 28 Jun. 2019.

Al-Harasis, S. 2013. Impact of language barriers on quality of nursing care at Armed Forces Hospitals, Taif, Saudi Arabia. *Middle East Journal of Nursing*, 7(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201401/#maincontent. Date of access: 28 Jun. 2022.

Alhamami, M. 2020. Language barriers in multilingual Saudi Hospitals: causes, consequences and solutions. *International Journal Multilingualism*, 19(2). https://doi.org/10.1080/14790718.2020.1777134

Ali, P. A. & Watson, R. 2018. Language barriers and their impact on the provision of care to patients with limited English proficiency: Nurse's perspective. *Journal of Clinical Nursing*, 27(5-6). https://doi.org/10.1111/jocn.14204

Al-Kalbani, Al Mashrafi, Almutairi, A. G. & Alshamsi, H. 2020. Implications of language barriers for healthcare: A systematic review. Oman Medical Journal, 35(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7201401/ Date of access: 03 Jun. 2022.

Almutairi, K. M. 2015. Culture and language differences as a barrier to the provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal*, 36(4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4404475/#ref21 Date of access: 16 Apr. 2019.

Alshammari, M., Duff, J. & Guilhermo, M. 2019. Barriers to nurse-patient communication in Saudi Arabia: an integrative review. *Biomed Central Nursing*, 18. https://pubmed.ncbi.nlm.nih.gov/31827387/ Date of access: 16 Feb. 2021.

Arksey, H. & O'Malley, L. 2005. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1). https://doi.org/10.1080/1364557032000119616

Bellefontaine, S. P., & Lee, C. M. 2014. Between black and white: Examining grey literature in meta-analyses of psychological research. *Journal of Child and Family Studies, 23*, 1378- 1388. https://doi.org/10.1007/s10826-013-9795-1

Berger, C. R. 1988. Uncertainty and information exchange in developing relationships. Handbook of Personal Relationships: Theory Research and Interventions. *Journal of Family and Marriage*, 60. https://www.semanticscholar.org/paper/Handbook-of-personal- relationships%3A-Theory%2C-and-Duck-Hay/6a16144520c0d9. Date of access: 14 Nov. 2023.

Berger, C. R. & Calabrese, R. J. 2006. Some exploration in initial interaction and beyond: Towards a developmental theory of interpersonal communication. *Human Communication Theory*, 1, 99-122. https://doi.org/10.1111/j.1468-2958.1975.tb00258.x

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2):77-101. http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised Date of Access: 02 Oct. 2019.

Butraporn, P., Pach, A., Pack, R., Masngarmmeung, R., Maton, T., Sri-aroon, P., Nyamete, A. & Chaicumpa, W. 2004. The health belief model and factors relating to potential use of vaccine for shigellosis in Kaeng, Koi Province Thailand. *Journal of Health, Population, and Nutrition*, 22(2):170-181. http://www.bioline.org.br/pdf?hn04022 Date of access: 13 Jan. 2019.

Centre for Disease Control. 2019. Global *health*. https://www.cdc.gov/globalhealth/countries/lesotho/default.htm Date of access: 16 Nov. 2023.

Champion, V. L. & Skinner, C. S. 2008. *The health belief model. Health behavior and health education: Theory, research, and practice.* Jessey-Bass, San Francisco: 45-65. https://www.researchgate.net/publication/332446988 Date of access: 18 May 2023.

Elmelegy, O. I. A. & El Madhy, N. F. 2018. Application of the health belief model-based educational intervention on hand hygiene performance of intensive care units' nurses. *Journal of Health, Medicine, and Nursing*, 47. https://pdfs.semanticscholar.org/efa0/14a1760c09d82f01185f4f2789d91452e9f7.pdf Date of access: 26 Apr. 2019.

Fernandez, E. M., Ruiter, R. A. C., Markham, M. C. & Kok, G. 2019. Intervention mapping: theory and evidence-based health promotion program planning: perspectives and examples. *Front Public Health*, 7(209). doi: 10.3389/fpubh.2019.00209

Giles, H & Farazadnia, S. 2015. Patient- provider interactions: A communication accommodation theory perspective. *International Journal of Society, Culture and language*. https://www.researchgate.net/publication/283148020 Date of access: 14 Nov. 2023.

Government of Lesotho. 2016. *National Health Strategic Plan- Ministry of Health*. https://www.childrenandaids.org/sites/default/files/2018-05/Lesotho_Nat%20Health%20Strat%20Plan_2017-2022.pdf Date of access: 28 Jun. 2022.

Gudykunst, W. B. 2005. *An anxiety/* uncertainty *management (AUM) theory of effective communication making the mesh of the net finer: theorizing about intercultural communication*. Thousand Oaks, California: SAGE Publications. https://psycnet.apa.org/record/2005-01619-013 Date of access: 08 Jan. 2021.

Jones, C. L., Jensen, J. D., Weaver, C. L., Scherr, N., Brown, R. & Christy, K. 2014. The health belief model as an explanatory framework in communication research: exploring parallel, serial and moderated mediation. *Health Communication*, 6(30).

www.ncbi.nlm.nih.gov Date of access: 03 Apr. 2019.

Levac, D., Colquhoun, H. & O' Brein, K. 2010. Scoping studies: advancing the methodology. Implementation *studies,* 5(69). https://doi:10.1186/1748-5908-5-69 Date of access: 01 Feb. 2021.

Malik, P. A. & Khan, M. A. 2020. Bridging the gap: A review of communication skills challenges for expatriate doctors in the Arabian Gulf. *World Family Medicine Journal*, 18(10). DOI: 10.5742/MEWFM.2020.9381

Munn, Z., Peters D. M. J., Stern, C., Tufanaru, C., McArthur, A. & Aromataris, E. 2018. Systematic review or scoping review? Guidance for aurthors when choosing between a systematic or scoping review approach. *BMC Medicine Research Methodology*, 18. doi: 10.1186/s12874-018-0611-x

Naidoo, S. 2014. Transcultural and language barriers to care. *South African Dental Journal, 69 (9).* http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0011http://www.scielo.org.za/s cielo.php?script=sci_arttext&pid=S0011- - 85162014000900013851620140009000013 Date of access: 03 Mar. 2019.

Rosenstock, I. M. 1974. *Historical origins of the health belief model*. School of Public Health, University of Michigan. https://journals.sagepub.com/doi/10.1177/109019817400200403

Rosky, M. 2015. *Overcoming language barriers in health care services in the medical tourism context:* Health *care companies' perspective*. School of Business, Aalto University (Thesis-Masters).www.aalto.fi: Date of access: 12 Feb. 2019.

Schyve, P. M. 2007. Language differences as a barrier to quality and safety in health care: The joint commission perspective. *The Journal of General Internal Medicine*, 22(2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2078554/ Date of access: 18 Oct. 2022.

Schwabe, C., Lerotholi, K. & McGrath, E. 2004. *Human Resources Development & Strategic Plan 2005-* 2025. Ministry of Health and Social Welfare. Kingdom of Lesotho. https://www.socialserviceworkforce.org/system/files/resource/files/Kingdom%20of%

20Lesot ho%20HR%20Development Date of access: 23 Nov. 2023.

Sentell, T., Shumway, M. & Snowden, L. 2007. Access to mental health treatment by English language proficiency and race/ethnicity. *Journal of General International Medicine*, 22. https://link.springer.com/article/10.1007/s11606-007-0345-7 Date of access: 25 Aug. 2019.

Sibblad, S., Macgregor, J. C. D., Surmacz, M. & Wathen N. 2015. Into the grey literature: a modified approach to citation analysis to better understand research impact. *Journal of Medical Library Association*, 103(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279935/ Date of access: 29 Aug. 2019.

Sobane, K. M. E. 2013. Language *discordant HIV/AIDS interactions in Lesotho health care centers.* Stellenbosch University. (Thesis-PhD). https://scholar.sun.ac.za/items/094b3f4f- 6925-4da9-a627-2af5e55bc878 Date of access: 21 Mar. 2018.

Kuruthan, C. & Kuruthan, A. 2019. Communication accommodation in healthcare provider- patient exchange. American *Society of Microbiology Journal*, 13(5). https://www.akademisains.gov.my/asmsj/?mdocs-file=5129 Date of access: 27 Jun. 2022.

Turner, L. W. & Hunt, S. B. 2004. Design and implementation of an osteoporosis prevention program using a health belief model. *American Journal of Health Sciences*, 19. https://www.proquest.com/openview/1c522faa57dabd5386cd22e3463fe5b9/1?pq-origsite=gscholar&cbl=30166 Date of access: 26 Jul. 2021.

Turner, L. L. 2015. Lived experiences *of service members' medical care rendered by culturally different caregivers*. University of the Rockies. (PhD-Thesis). https://www.proquest.com/openview/b6ab3983e3a524e93850f49d247c3293/1?pq-origsite=gscholar&cbl=18750 Date of access: 06 Mar. 2023.

Van den Berg, V. L. 2016. Still lost in translation: language barriers in South Africa health care remain. *South African Family Practices*, 58(6). https://medpharm.tandfonline.com/doi/full/10.1080/20786190.2016.1223795#.XKyht tps://m edpharm.tandfonline.com/doi/full/10.1080/20786190.2016.1223795 - .XKy-

EhIVjQUEhIVjQU Date of access: 17 Jul. 2022.

Van Mol, M., Nijkamp, M., Markham, C. & Ista, E. 2017. Using an intervention mapping approach to develop a discharge protocol for intensive care patients. *BMC Health Services Research,* 17(837). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2782-2 Date of access: 27 Aug. 2023.

Zhang, D., Jiang, Z., Xie, Y., Wu, W., Zhao, Y., Huang, A., Li, T. & Ba-Thein, W. 2022. Linguistic barriers and healthcare in China: Chaoshan vs Mandarin. *BMC health Services research*, 22(376). https://doi.org/10.1186/s12913-022-07744-6

Appendix 1

The questions in the interview guide for expatriate healthcare practitioners specifically focused on the following;

- What language/s do you use to communicate with Basotho patients? To what extent do (or don't) these languages allow you to effectively communicate with the patients? How so?
- What is the greatest communication challenge you experience in interacting with Basotho patients? How is this a challenge? Please explain more and give examples. What is the second biggest communication challenge? Please explain why this a challenge? Please explain and give examples. (Question was repeated 2 to 5 times.)
- How do you then respond to these challenges, if at all?
- How do you handle situations whereby a medical procedure/ treatment you propose is in contradiction with a patients' cultural beliefs? Please explain with examples.
- What strategies do you believe can be employed in healthcare settings to reduce the adverse impacts of language and cultural differences between yourself as an expatriate healthcare practitioner and Basotho patients in order to enhance effective and efficient communication needed in providing quality healthcare?

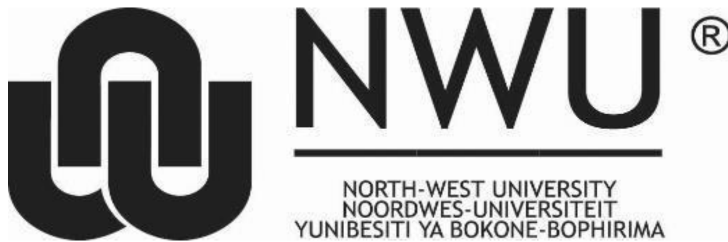
All interviews for expatriate healthcare practitioners were conducted in their respective work spaces because of their busy schedules. This enabled them to be accessible in cases of emergency. During the interviews, the participants provided their distraction free offices for interviews to take place.

Appendix 2

The interview guide that was used to guide the interviews for patients mainly focused on the following;

- Do you have any concerns about being attended to by a non- Sesotho speaking healthcare practitioner? Explain your answer.
- During consultations, do you always understand what the healthcare practitioner is communicating to you? If not, what are the reasons behind you failing to understand what the healthcare practitioner is communicating to you?
- What measures do you take to ensure that you fully understand what is being said to you?
- Have you ever had trouble understanding what the expatriate healthcare practitioners were saying in regards to what illness you have, or how you should take your medication, or what lifestyle changes you should make? If yes, what did you do in that situation?
- Have you ever experienced any behaviours or practices (on the part of the healthcare practitioner) during consultations that made you feel uncomfortable because you felt they were culturally unacceptable? What was the experience? How did you handle the situation?
- What do you think could be done to make encounters between you as a patient and expatriate healthcare more satisfying and comfortable?

Appendix 3



PO Box 1174, Vanderbijlpark
South Africa, 1900

Human and Social Sciences Research

Ethics Committee

Tel: +27(16) 910-3441

Web: http://www.nwu.ac.za

Email: Chrizanne.VanEeden@nwu.ac.za

15 December 2020

Dear Prof Nell and Ms Ramothamo

APPROVAL OF ETHICS APPLICATION

Implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospital: Development of an intervention.

The Human and Social Sciences Research Ethics Committee (HSSREC) has reviewed your feedback and reached the conclusion that the above ethics application can be *approved with no further changes*.

Kindly send copies of the final informed consent forms to Daleen Claasens (Daleen.Claasens@nwu.ac.za) to be stamped and signed for use during your research.

The HSSREC administrator will forward your application to SRCE, requesting your Ethics Clearance Certificate.

Yours sincerely

C. van Eeden

Prof C van Eeden Chairperson: HSSREC

Appendix 4

LESOTHO

Ministry of Health
P.O. Box 514
Maseru 100

REF: **ID 143-2021**
Date: August 10, 2021
To
Mamello Ramothamo (Ms.)
Student #: 25807862
North-West University

Category of Review:
[x] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other ______

Dear **Ms. Ramothamo**

RE: Implications of Language and Cultural Differences on the Quality of Healthcare Provided by Expatriate Healthcare Practitioners in Lesotho Public Hospitals: Development of an Intervention

This is to inform you that the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments.
[x] Protocol
[x] **Informed Consent Form**: English and Sesotho
[x] **Data Collection Tool**: Interview Guide for patients and Healthcare Practitioners
[x] Participant materials: *Participant Information Leaflet*
[x] Other materials: Letter of permission to conduct a study dated 09th July 2021, *Confidentiality Agreement-Translator*. Letter from Human Sciences Research Ethics Committee (*HSSREC*) dated 15th December 2020, CV_ Ramothamo

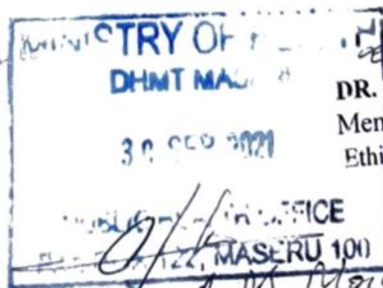
This approval is **VALID** until August 10, 2022.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expir[y] date. All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethi[cs] Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior [to] implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questio[ns] please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 59037919/58800246.

Sincerely,

DR. 'NYANE LETSIE
Director General Health Services



DR. LLANG BRIDGET MAAMA-MAIMI
Member of National Health Research Ethics Committee (NH-REC)

Appendix 5

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
VAAL TRIANGLE CAMPUS

PO Box 1174, Vanderbijlpark

South Africa, 1900

Web: http://www.nwu.ac.za

08 June 2021

HSSREC Authorization

PARTICIPANT INFORMATION LEAFLET AND

INFORMED CONSENT

FORM FOR

Expatriate healthcare practitioners in Lesotho public hospitals.

TITLE OF THE RESEARCH PROJECT: Implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention

REFERENCE **NUMBERS: NWU-02127-20-A7**

PRINCIPAL **INVESTIGATOR:** Mamello Ramothamo

ADDRESS**:** PO Box 8067, Khubetsoana Maseru, Lesotho 106

CONTACT **NUMBER:** +266 59976943

You are being invited to take part in a research project that forms part of my research study on the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research is about and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to

participate. If you decline, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you had initially agreed to take part.

This study has been approved by the **Human and Social Science Research Ethics Committee (HSSREC) of the Faculty of Humanities of the North-West University (NWU-02127-20-A7)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records to make sure that I (the researcher) am conducting research in an ethical manner.

What is this research study all about?

- The goals of this research are to investigate the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and to develop an intervention to improve communication between Basotho patients and expatriate healthcare practitioners.
- This study will be done in two urban districts of Lesotho namely Maseru and Teyateyaneng and in two rural districts namely Mokhotlong and Qacha's Nek.
- Interviews will be used to get the information needed for the study. Participants will be asked around 5 questions about the research topic. The researcher has been trained to conduct interviews like these.
- The duration of the interviews will be between 40 minutes to 1 hour.
- Approximately 40 participants will be included in this study.
- All interviews will be recorded with the informed consent of the participants, as this would allow the research to capture all important data without any omissions, and thus contribute to the trustworthiness of the data.

Why have you been invited to participate?

You have been invited to participate because you are an expatriate healthcare practitioner who has been working in a Lesotho public hospital for at least six months, attending to Basotho patients, and are unable to speak Sesotho.

What are you expected to do?

- You will be invited to take part in an 40 minutes to 1 hour session where 5 questions shall be asked to you and you shall be expected to honestly answer each question as best as you are

able to. The session will be recorded so that I can easily get the information you have given me later and only I and my supervisor, Prof. Werner Nell, will listen to these recordings.

- You will also be contacted again after the initial interviews (with your consent) for purposes of member checking (which will be adopted as strategy to enhance the credibility of the findings).

Will you benefit from taking part in this research?

- There are no direct benefits associated with taking part in the study.
- The indirect benefits include the following: this study will serve to make known the implications of language and cultural differences between you the expatriate healthcare practitioners and Basotho patients.
- If you take part in the study you will get an opportunity to contribute to an intervention that will be put in place in order to limit the adverse implications of language and cultural differences and also enhance communication during encounters between you and Basotho patients and consequently improve the quality of healthcare delivered in Lesotho public hospitals.

Are there risks involved in your taking part in this research and how will these be managed?

The risks in this study, and how these will be managed, are summarised in the table below:

Probable/possible risks/discomforts	***Strategies to minimize risk/discomfort***
Exposure to COVID 19 infections.	The researcher will provide hand sanitizer and three-ply masks for you and shall ensure that in setting up the interview rooms, social distance is maintained by ensuring that there is a 2 metre space between you and the interviewer during the conducting of interviews. The researcher will also ensure that places selected for conducting interviews are properly cleaned and fumigated.
There is also a possibility that some of the questions that the researcher might ask you may be sensitive in nature or may cause some discomfort.	You are free to answer only the questions that you feel comfortable with answering and if you are not comfortable in answering such questions then they can be skipped.
There is a possibility that you may not be available for the interviews or the interview may be disrupted due to your work on the set date for conducting interviews.	The researcher will postpone or reschedule the interview with you if you are not available on the selected day or if you need to attend to a work-related matter.
Some of the questions to be asked during interviews may cause you some distress.	The researcher will engage a qualified counsellor Miss Seipati Rafoneke to provide counselling for you if the need arises.

However, the benefits (as noted above) outweigh the risk.

Who will have access to the data?

- Anonymity (that is, in no way will your results be linked to your identity) will be ensured in the study by de-identifying participants during the data evaluation process. You not will be referred to by name during the data evaluation process and your personal details will also not be published in the final report (dissertation). During the data collection process, you will not be addressed by name, instead an assigned number (P1) or pseudonym of your choice will be used.
- Confidentiality (that is, I assure you that we will protect the information we have about you) will also be ensured. Some of your privacy might be lost during this study (e.g., you will be asked to provide your name and contact details) but your name will never be made known and your data will be handled with confidentially as much as possible. No individuals' identifiers will be used in any publications resulting from this study and only the team of researchers will

work with the information that you shared.

- In cases where translators are engaged, they will sign a confidentiality clause that binds them not to divulge any information discussed during interviews. Only I, the researcher, and my supervisor, Prof. Werner Nell, will have access to your personal information and the answers that you provide. Data will be kept safe and secure by locking hard copies in the researcher's home. Electronic data it will be saved in the researcher's personal laptop which is accessible only to her.
- Audio-recorded data will be sent to a transcriber who will sign a confidentiality clause (i.e., he will not be allowed to talk to anyone about any aspect of the data). As soon as data has been transcribed, the researcher will delete the recordings. The transcripts will be stored on a password-protected computer. Data will be stored electronically for a period of 5 years. Your real name will not be included on the transcript.

What will happen to the data?

- The findings of the study shall be compiled into a dissertation that will be available as hardcopies and online. The researcher also hopes to get the research report published with reputable journals. A research report will be also sent to relevant bodies such as the Ministry of Health in Lesotho and other NGOs e.g. ICAP and Workaway which focus on issues of patient advocacy and some associations that include Lesotho Association of Doctors who may find report useful in their daily duties in hospitals.
- Participants who are interested in receiving feedback on the findings will be given copies of the report after the study is concluded.
- The data produced for the current study could be used for future comparative studies but will not be used for any other non-academic purpose.

Will you be paid or compensated to take part in this study and are there any costs involved?

You will not be paid to take part in this study and but if it happens that you incur any extra cost due to participating in this study you will be reimbursed.

How will you know about the findings?

If you would like to know about the findings, the general findings of the research and the proposed program will be shared with you through a summary report.

Is there anything else that you should know or do?

- You can contact me, Mamello Ramothamo, at 59976943 or mhramothamo@yahoo.com if you have any further queries or encounter any problems.
- Alternatively, you can contact my supervisor, Prof. Werner Nell at 016 910 3427 or Werner.Nell@nwu.ac.za.
- You can contact the chair of the Human and Social Science Research Ethics Committee Prof Jacques Rothmann (21081719@nwu.ac.za) if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

Declaration **by participant**

By signing below, I______________________ agree to take part in a research study entitled: the impact of language barriers and cultural differences between patients and expatriate healthcare practitioners on healthcare delivery in Lesotho public hospitals: Development of an intervention.

I declare that:

- I have read and understood this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher (if this is a different person), and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I understand that what I contribute (what I say) could be reproduced publicly and/or quoted, but without reference to my personal identity.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20

_____________________________ _____________________________

Signature of participant **Signature of witness**

- You may contact me again **Yes** ☐ **No** ☐
- I would like a summary of the findings of this research **Yes** ☐ **No** ☐
- I would like feedback on my functioning/wellbeing as reflected in the questionnaires I completed **Yes** ☐ **No** ☐

Participant Age _(you may decline to provide your age)

The best way to reach me is:

Name & Surname:

Postal Address: _______

Email: _______

Phone Number: ______________ Cell Phone Number: ______________

In case the above details change, please contact the following person who knows me well and who does not live with me and who will help you to contact me:

Name & Surname: _______

Phone/ Cell Phone Number /Email: _____

Declaration by person obtaining consent

I *(name)* _____declare that:

- I explained the information in this document to ______________________________
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) ________________________ on (*date*) ______________ 20 _________

______________________________ ______________________________

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(name)* ______declare that:

- I explained the information in this document to ______________________________
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) ______________________________ on (*date*) ____________________ 20 ________

______________________________ ______________________________

Signature of participant **Signature of witness**

Declaration by researcher and participant

Personal face-to-face interviews during Covid-19 restrictions

Additional **declaration by participant in those instances where the participant requests to participate in a personal face-to-face semi-structured interview:**

By signing below, I ____, acknowledge the following information related to the required measures regarding Covid-19:

	Yes	No
• It is my personal choice and preference to participate in a personal face-to-face semi structured interview with the researcher	☐	☐
• This requires that I consent to the following strict measures to safeguard the personal health and safety of myself and that of the researcher/interviewer/primary investigator	☐	☐
• I consent to the researcher taking my temperature before the interview using a thermometer	☐	☐
• I confirm that my temperature measured at _degrees.	☐	☐

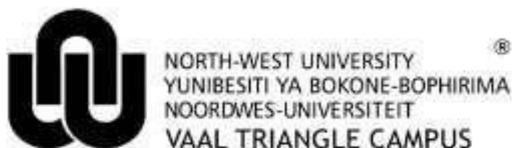
- I consent to use the tree ply mask provided by the researcher ☐ ☐
- I consent to wear the three-ply mask for the full duration of the interview ☐ ☐
- I consent to the researcher sanitising the interview context using a sanitiser with an 80% alcohol content before the commencement of the interview. ☐ ☐
- I consent to the researcher using a sanitiser with an 80% alcohol content before and during the interview if required ☐ ☐

Signed at (*place*) ________________________ on (*date*) _______________ 20 _________

________________________ ________________________

Signature of participant **Signature of researcher**

Appendix 6



PO.Box 1174, Vanderbijlpark South Africa, 1900

Web: http://www.nwu.ac.za

08 June 2021

PARTICIPANT INFORMATION LEAFLET AND

INFORMED CONSENT

FORM FOR

Basotho **patients who are attended by expatriate healthcare practitioners in Lesotho public hospitals**

TITLE OF THE RESEARCH PROJECT: Implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention.

REFERENCE **NUMBERS: NWU-02127-20-A7**

PRINCIPAL INVESTIGATOR: Mamello Ramothamo

ADDRESS: PO Box 8067, Khubetsoana Maseru, Lesotho 106

CONTACT NUMBER: +266 59976943

You are being invited to take part in a research project that forms part of my research study on the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals: Development of an intervention. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research is about and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to

participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you had initially agreed to take part.

This study has been approved by the **Human and Social Science Research Ethics Committee (HSSREC) of the Faculty of Humanities of the North-West University (NWU-02127-20A7)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records to make sure that I (the researcher) am conducting research in an ethical manner.

What is this research study all about?

- The goals of this research are to investigate the implications of language and cultural differences on the quality of healthcare provided by expatriate healthcare practitioners in Lesotho public hospitals and to develop an intervention to improve communication between Basotho patients and expatriate healthcare practitioners.
- This study will be done in two urban districts of Lesotho namely Maseru and Teyateyaneng and in two urban districts namely Mokhotlong and Qacha's Nek.
- Interviews will be used to get the information needed for the study. Participants will be asked around 5 questions about the research topic. The researcher has been trained to conduct interviews like these.
- The individual interviews should take around 40 minutes to 1 hour.
- About 40 people will be included in this study.
- All interviews will be recorded with the informed consent of the participants, as this would allow the research to capture all important data without any omissions, and thus contribute to the trustworthiness of the data.

Why have you been invited to take part in this study?

- You have been invited to take part in this study because you are a patient in this public hospital who has been attended by an expatriate healthcare practitioner who has been in Lesotho for at least six months.
- You are a Mosotho who is between the ages of 18 years to 65 years.

What are you expected to do?

- You will be expected to take part in 40 minutes to 1 hour session where 5 questions shall be

asked to you and you shall be expected to honestly answer each question as best as you are able to. The session will be recorded so that I can easily get the information you have given me later and only I and my supervisor, Prof. Werner Nell, will listen to these recordings.

- You will also will be contacted again after the initial interviews (with their consent) for purposes of member checking (which will be adopted as strategy to enhance the credibility of the findings).

Will you benefit from taking part in this research?

- There are no direct benefits associated with taking part in the study.
- The indirect benefits include the following: this study will serve to make known the implications of language and cultural differences on the quality of healthcare that you receive as a patient and how these may have affected your wellbeing.
- If you take part in the study you will get an opportunity to contribute to an intervention that will be put in place in order to limit the adverse implications of language and cultural differences and enhance communication during encounters between you and expatriate healthcare practitioners and consequently improve the quality of healthcare delivered in Lesotho public hospitals.

Are there risks involved in your taking part in this research and how will these be managed?

The risks in this study, and how these will be managed, are summarised in the table below:

Probable/possible risks/discomforts	***Strategies to minimize risk/discomfort***
Exposure to COVID 19 infections.	• The researcher will provide hand sanitizer and three-ply masks for you and shall ensure that in setting up the interview rooms, social distance is maintained by ensuring that there is a 2 meter space between you and the interviewer during the conducting of interviews. • The researcher will also ensure that places selected for conducting interviews are properly cleaned and fumigated.
There is also a possibility that you may not be well on the date set for interviews.	The researcher will reschedule the interview with you if you do not feel fit to participate
Some of the questions to be asked by the researcher during the interviews may bring about some traumatic memories to you.	The researcher will engage a qualified counsellor Miss Seipati Rafoneke to provide counselling for you if the need arises.

There is also a possibility that some of the questions that the researcher might ask you may be sensitive in nature or may cause some discomfort.	You are free to answer only the questions that you feel comfortable with answering and if you are not comfortable in answering such questions then they can be skipped.

However, the benefits (as noted above) outweigh the risk.

Who will have access to the data?

- Anonymity (that is, in no way will your results be linked to your identity) will be ensured in the study by de-identifying participants during the data evaluation process. You not will be referred to by name during the data evaluation process and your personal details will also not be published in the final report (dissertation). During the data collection process you will not be addressed by name, instead an assigned number (P1) or a 'fake' name of your choice will be used.
- Confidentiality (that is, I assure you that we will protect the information we have about you) will also be ensured, no information provided by you will be discussed with your doctor or anyone including the hospital. Some of your privacy might be lost during this study (e.g., you will be asked to provide your name and contact details) but your name will never be made known and your data will be handled as confidentially as possible. No individuals' identifiers will be used in any publications resulting from this study and only the team of researchers will work with the information that you shared.
- Only I, the researcher, and my supervisor, Prof. Werner Nell, will have access to your personal information and the answers that you provide. Data will be kept safe and secure by locking hard copies in the researcher's home. Electronic data it will be saved in the researcher's personal laptop which is accessible only to her.
- Audio-recorded data will be kept save in the researcher's password locked laptop and will later be sent to a transcriber who will sign a confidentiality clause (i.e., he will not be allowed to talk to anyone about any aspect of the data). As soon as data has been transcribed, the researcher will delete the recordings. The transcripts will be stored on a password-protected computer. Your real name will not be included on the transcript.
- Data will be stored electronically for a period of 5 years.

What will happen to the data?

- The findings of the study shall be compiled into a dissertation that will be available as hardcopies and online. The researcher also hopes to get the research report published with reputable journals. A research report will be also sent to relevant bodies such as the Ministry

of Health in Lesotho and other NGOs e.g. ICAP and Workaway which focus on issues of patient advocacy and some associations that include Lesotho Association of Doctors who may find report useful in their daily duties in hospitals.

- Participants who are interested in receiving feedback on the findings will be given copies of the report after the study is concluded.
- The data produced for the current study will be used for future comparative studies, but will not be used for any other non-academic purpose.

Will you be paid or compensated to take part in this study and are there any costs involved?

You will not be paid to take part in this study and you shall not incur any expenses during this study.

How will you know about the findings?

If you would like to know about the findings, the general findings of the research and the proposed program will be shared with you through a summary report or a brief discussion, depending on your preference.

Is there anything else that you should know or do?

- You can contact me, Mamello Ramothamo, at 59976943 or mhramothamo@yahoo.com if you have any further queries or encounter any problems.
- Alternatively, you can contact my supervisor, Prof. Werner Nell at 016 910 3427 or Werner.Nell@nwu.ac.za.
- You can contact the chair of the Human and Social Sciences Research Ethics Committee Prof Jacques Rothmann (21081719@nwu.ac.za) if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ___________________agree to take part in a research study entitled: The impact

of language barriers and cultural differences between patients and expatriate healthcare practitioners on healthcare delivery in Lesotho public hospitals: Development of an intervention.

I declare that:

- I have read and understood this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher (if this is a different person), and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurized to take part.
- I understand that what I contribute (what I say) could be reproduced publicly and/or quoted, but without reference to my personal identity
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ______________________________ on (*date*) _____________ 20 ________

____________________________________ ____________________________________

Signature of participant **Signature of witness**

- You may contact me again **Yes** ☐ **No** ☐
- I would like a summary of the findings of this research **Yes** ☐ **No** ☐
- I would like feedback on my functioning/wellbeing as reflected in the questionnaires I completed **Yes** ☐ **No** ☐

Participant Age (you may decline to provide your age) The best way to reach me is:

Name & Surname: _______

Postal Address: _______

Email: _______

Phone Number: _______

Cell Phone Number: _______

In case the above details change, please contact the following person who knows me well and who does not live with me and who will help you to contact me:

Name & Surname:

Phone/ Cell Phone Number /Email: _______

Declaration by person obtaining consent

I *(name)* _____declare that:

- I explained the information in this document to ____________________________________
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) ____________________________ on (*date*) ____________ 20 _______

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(name)* ______declare that:

- I explained the information in this document to______________________________
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) ____________________________ on (*date*) ____________ 20 ________

Signature of participant **Signature of witness**

Declaration by researcher and participant

Personal **face-to-face interviews during <u>Covid-19</u> restrictions**

Additional declaration by participant in those instances where the participant requests to participate in a <u>personal face-to-face semi-structured interview</u>:

By signing below, I _____, acknowledge the following information related to the required measures regarding Covid-19:

I declare that:

It is my personal choice and preference to participate in a personal face-to-face semi structured interview with the researcher	**Yes**	☐	**No**	☐

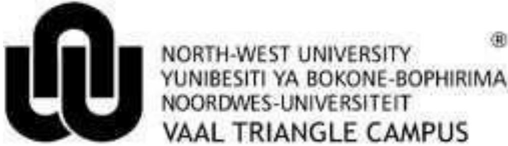
This requires that I consent to the following strict measures to safeguard the personal health and safety of myself and that of the researcher/interviewer/primary investigator

• I consent to the researcher using a sanitiser with an 80% alcohol content before and during the interview if required	**Yes**	☐	**No**	☐
• I consent to the researcher taking my temperature before the interview using a thermometer	**Yes**	☐	**No**	☐
• I confirm that my temperature measured at degree	**Yes**	☐	**No**	☐
• I consent to use the three-ply mask provided by the researcher for the full duration of the interview	**Yes**	☐	**No**	☐
• I consent to the researcher sanitising the interview context using a sanitiser with an 80% alcohol content before the commencement of the interview	**Yes**	☐	**No**	☐

Signed at (*place*) on (*date*) 20

Signature of participant	Signature of researcher

Appendix 7



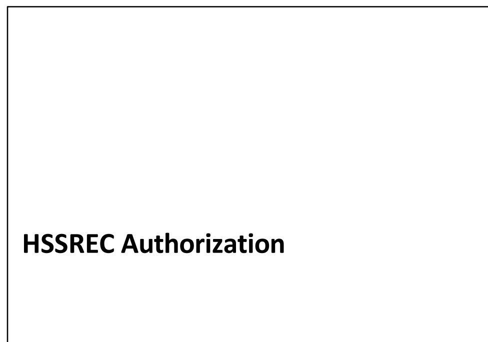
PO Box 1174,

Vanderbijlpark

South Africa,

1900

Web: http://www.nwu.ac.za



08 June 2021

HSSREC Authorization

FOROMO EA LINTHLA LE

TUMELLO EA HO NKA

KAROLO EA

Bakuli ba sebeletsong ke basebeletsi ba tsa bophelo ba tsoang kantle ho naha.

SEHLOHO SA BOITHUTO: Ho batlisisa ka mathata a ka hlahang a bakoa ke puo le bochaba tse fapaneng tsa basebelatsi ba tsa bophelo lipetleleng tsa 'Muso ba tsoang kantle ho naha le hore na mathata ana a ama boleng ba phano ea lits'ebeletso tsa bophelo tseo ba fanang ka tssona ka tsela efeng. Ho aha leano la tharollo

REFERENCE **NUMBERS: NWU-02127-20-A7**

Ralipatlisiso**:** Mamello Ramothamo

Aterese: PO Box 8067, Khubetsoana Maseru, Lesotho 106

Linomoro tsa mohala : +266 59976943

O memeloa ho nka karolo boithutong ba ho batlisisa ka tse ka tsoaloang ke phapano ea puo le bochaba lipakeng tsa bakuli le basebeletsi ba tsa bophelo ba tsoang kantle ho naha mabapi le phano ea lits'ebeletso tsa bophelo e ntle litsing tsa mmuso tsa bophelo. Le hore tharollo eka fungoana joang. O kotpjoa ho honka nako o bale linthla tsohle tse hlalositsoeng mona tse mabapi le boithuto bona. O kotpjoa hape ho botsa ralipatlisiso lipotso tsohle tseo o kabang le tsona mabapi le boithuto bona. Ho bohlokoa hore o botse

ralipatlisiso ka nthla efeng kapa efeng eo osa e utloisising malebana le boithuto bona. Ho bohlokoa hape hore o be le kotlouisiso e feletseng ea seo boithuto bo batlang hose fihlela le hore na oena o nka karolo efeng. Ha hona motho ea tlameletsoeng ho nka karolo boithutong bona, ona le tokelo ea ho hana ho nka karolo hao sa batle. Haeba o hana ho nka karolo, ha hona se sebe se kao etsahallang. O boetse hape o lokolohile hore o nyahlatsa ho nka karolo hoa hao nako eohle le haeba one ose o kentse letsoho.

Boithuto bona bo lumeletsoe se molao ke **Human and Social Science Research Ethics** Committee **(HSSREC) of the Faculty of Humanities of the North-West University (NWU02127-20-A7)** mme bo tla etsoa ho ipapisistsoe lipehelo le litsamaiso tsa international Declaration of Helsinki le lipehelo tsa boitsoaro tsa National Health Research Ethics Council. Ho bohlokoa hore komiti ea boitsoaro le liphuputso kapa banang le seabo ho etsa bohlahlobi ele ho etsa bonnete ba hore ke etsa liphuputso ke ipapisitse le melaona ea boitsoaro.

Sepheo sa boithuto bo ke se feng?

- *Sepheo sa boithuto bona ke ho batlisisa ka tse* ka tsoaloang ke phapano ea puo le bochaba lipakeng tsa bakuli le basebeletsi ba tsa bophelo ba tsoang kantle ho naha mabapi boleng ba phano ea lits'ebeletso tsa bophelo e ntle litsing tsa mmuso tsa bophelo. Ho aha leano tharollo le thusana ho ntlafatsa mekhoa ea ho buisana lipakeng tsa bakuli ba Basotho le baoki ba tsoang kantle ho naha.
- Boithuto bona bo tla etsoa literekeng tse nne tsa Lesotho. Ho fumana litaba tse hlokahalang,
- ho tlaba Mokhotlong le Qacha's Nek le tsepeli mabalane eleng Maseru le Teyateyaneng.
- Batho batlang ho nka karolo batla araba lipotso tse hlano tse mabapi le sehloho sa boithuto bona. Ralipatlisiso o fumane koetliso e lekaneng ho tsamaisa lipuisano tsena.
- Lipuisano le motho ka bo mong litla nka metsotso e mashome a mane ho isa ho hora Batho ba bonyane mashome a mane ba lebeletsoe ho nka karolo boithutong bona.
- Lipuisano tsa rona litla hatisoa ka tumello ea hao molemong oa hore mofuputsi atle a se lebale tseling tsa linthla tsa bohlokoa tse *tlang ho buuoa moo.*

Hobaneng o mengoe ho nka karolo boithutong bo?

- *O mengoe ho nka karolo boithutong bona hobane o Mosotho ea lilemo li 18 ho ea 65 ae kileng oa* alafshoa ke *ngaka kapa mooki ea tsoang kantle ho naha ena ea Lesotho.*

O lebeletsoe ho etsa eng?

- *O lebeletsoe ho nka karolo lipuisanong tse tlang ho nka metsotso 40 ho isa horeng moo teng o*

tlang ho botsoa lipotso tse hlano 'me o tla lebelloa ho li araba ka nnete eohle. Lipuisano *tsena litlahatisoa ele ho bebofatsa mokhoa oa ho* fumana *likarabo tse fanoeng ha morao. Ke nna le mosupisi oaka Prof. Werner Well fela batlang ho mamela likhatiso tsena.*

Na hona le molemo o tla o thola boithutong bo?

- *Ha hona* melemo *eo o tla e thola ka kotloloho* boithutong *bona.*

Ana **hona le kotsi e ka hlahelang ba nkang karolo boithutong bo, mme eka laoloa joang?**

- *Kotsi e ka hlahang boithutong bona e tla laoloa 'me ho hlakisitsoe ka bokhutsoane tafoleng e latelang:*

Kotsi tse ka hlahang kapa mathata	***Se tlang ho etsoa ho fokotsa likotso kapa mathata***
Ho ba kotsing ea ho fuamane tsoaetso ea Covid 19	O tla fumantsoa mask le sanitizer, mme ralipatlisiso otla etsa bonnete nah ore ha le atamelane nakong eo a ntseng ao botsa lipotso, otla siea sebaka sa limetara tse peli pakeng tsa lona. Ralipatliso otla boaela a etsa bonnete bah ore libaka tse khethiloeng hore lipotso li botsetsoa teng li hloekisitsoe tsa futheloa.
Tseling tsa lipotso tse tla botsoa mona li kanna tsa o hopotsa liketsahalo tse seng monate tseo kileng oa kopana tse tsona sepetlele mme o alafshoa ke ngaka kapa mooki ea tsoang kantle ho naha mme li kanna tsa o bakela khathello e itseng ea maikutlo.	O tla fuwa tlhabollo ho Mohlabolli Seipati Rafoneke haeba o utloa eka oka ona le tlhoko e joalo.
Hona le khonahalo a hore tseling tsa lipotso tse tla botsoa lio bakele hose lokolohe.	O lumeletsoe ho araba lipotso tseo o utloang ona le bolokolohi ba ho li araba feela, haeba o utloa hona le lipotsa tseo osa phuthuloheleng ho li araba, o lumeletsoe hose li arabe ho sena kotlo ea letho.
Ho kaba le khonahalo ea hore ka letsatsing le beiloeng bakeng sa liphuputso ebe hao ikutloe hantle mmeleng kapa kelellong.	Raliphuputso otla hlophisetsa hore ho be letsatsi le leng le tla shejoa moo otla nne o botsoe li potso mabapi le boithuto bona ha oso o ikutloa hantle. Raliphuputso otla boetsa a nka boeletsi ho mooki oa hao hore na o bona ole boemeng bo lokileng bakeng sa ho ka karolo boithutong bona.

- *Le haole joalo, melomo eo otlang ho e una e feta mathata aka hlahang.*

- *Boitsibiso ba hao e tlaba* lekunutu *boithutong bona. Batho ba* nkileng karolo boithutong bona ba keke ba bitsoa ka mabitso a bona kapa hona ho ngoloa ka hara sephetho sa moshoelella. Ha ho ntse ho fuputsoa litaba, batho ba tlang ho nka karolo batla fuoa linomoro kappa ho

rehoa lebitso la nakoana(beo eseng ba nnete) ele boitsibiso ba bona ho qoba ho sebelisa mabitso, sena se tlo etsoa ho netefatsa hore boitsibiso ba hao eba lekunutu. Tse ling tsa litaba tsa lekunutu tsa motho li kanna tsa hlokoa nakong ea boithuto empa lebitso lona le keke la sebelisao kapa hona ho tsejoa ke mang kapa mang mme litaba tsa hao li tsa tsoaroa ka lekunutu. Bafuputsi ke bona feela batla sebetsana le litaba ele hona ho netefatsa taba ea ho li etsa lekunutu. Litaba tsa bohlokoa litla bolokoa ka hara mechini e sebelisoang fela ke raliphuputso.

- Ke mofuputsi le motsamaisi oa hae Prof. Werner Nell, batla ba le tumello ea ho sebelisa litaba tse fanoeng. Litaba tse fanoeng litla koallo mme lits'ireletsoe ka ho behoa le haeng la raliphuputso.
- Litaba tse fanoeng lipuisanong le mofuputsi tse hatisitsoeng li tla fetoleloa Sesothong se ngotsoeng ke setsibe se tla tekena foromo ea boitlamo ba ho boloka lekunutu litaba tseo tse hatisitsoeng. Hang ha litaba lise ngotsoe fatshe likhatiso tsa lipuisano litla hlakoloa ebe lingoliloeng tsa litaba li behoa ka hara mochini oa mofuputsi o bulang ke eena a le mong.
- Litaba tse fanoeng litla behoa kahara mochini ho fihlela lilemo tse hlano li fela.

Ho tla etsahala eng ka litaba tse fanoeng?

Tse tla fumanoang boithutong bona li ngoloa fatshe ele repoto etla fumaneha marang rang le mooetla tholoa ele sengoliloeng. Mofuputsi o labalabela hore sephetho sa liphuputso tsena se kengoe li ngoliloeng tse kholo tse hlomphehang. Sephetho se tla boela se romelloa Lekala la Bophelo Lesotho le mekhatlo emeng e ikemetseng joalo ka ICAP le Workaway eleng mekhatlo e sebetsanang le ho buelella bakuli and mekhatlo e meng joalo ka Lesotho Association of Doctors moo ba kannang ba fumane sephetho sena sele bohlokoa ho tataisa ts'ebetso ea bona ea letsatsi le letsatsi.

Oena o le motho ea nkileng karalo boithutong bona, otla fuoa sephetho ke mofuputsi ea tlang hotla ho oena hoo hlalosetsa likateng tsa teng.

Litaba tseo o faneng ka tsona li kanna tsa sebelisoa hape liphuputsong tse ling tse nang le sepheo se ts'oanang le sena fela eseng ho sebelisetsoa hohong.

Na o tla patala kapa hona ho fumana mats'eliso ka ho nka karolo boithutong boo hona na hona le tjeo tse tla tsoa ho oena?

Che ha hona hoba le patala le oena o keke oa kena lits'enyehelong tsa letho.

O tla tseba joang ka sephetho sa liphuputso tse?

- Sephetho sa liphuputso se tla arolelanoa le oena ka lipuisano tse tlaba lipakeng tsa mofuputsi le oena hang ha sephetho se le teng.

Na hona le ho hong hoo o hlokang hoo tseba?

- O ka ntetsetsa nna Mamello Ramothamo, 59976943 kapa oa ngola ho mhramothamo@yahoo.com haeba o hloka litlhakisetso kapa o ka fumana mathata a mofuta ofe kapa ofe.
- O ka boetse hape oa bua le mosupisi oaka, Prof. Werner Nell ho 016 910 3427 kapa Werner.Nell@nwu.ac.za.
- O ka buoa hape le molula setulo oa Human and Social Science Research Ethics Committee Prof Jacques Rothmann (21081719@nwu.ac.za) haeba ona lingongoreho kapa lipelaelo tseo mofuputsi asa li arabelang hantle.
- O tla fumana tokomane enang le litaba tsena le foromo ea tumello molemong oa polokelo ea hao.

Boitlamo ba ea nkang karolo

Ka ho tekana mona, ‘na____________________ke lumela ho nka karolo boithutong ba ho batlisisa ka tse ka tsoaloang ke phapano ea puo le bochaba lipakeng tsa bakuli le basebeletsi ba tsa bophelo ba tsoang kantle ho naha mabapi le phano ea lits’ebeletso tsa bophelo e ntle litsing tsa mmuso tsa bophelo. Ho thoma tharollo.

Ke paka hore:

- Ke balile ebile ke utloisisitse litaba tsena le foromo ea tumello e ngotsoe ka puo eo kee utloisisang ebile kee tseba.
- Ke fuoe sebaka sa ho botsa lipotso ho motho a neng a nkopa ho nka karolo boithutong le he ho mofuputsi ‘me ke ile ka arajoa ka bokhabane.
- Kea utloisisa hore ho nka karolo boithutong bona ha ho tlame ’me ha kea tlamelloa ho nka karolo.
- Kea utloisisa hore seo ke se fanang se ka phatlalatsoa kapa sa qotsoa empa ho se boleloe na ke mang.
- Ke tla tlohela ho nka karolo boithutong bona ka nako eohle eo ke utloang ho hlokahala ’me ha kea labella ho thola kotlo ea letho ke hona
- Nka koptjoa ho tlooela ho nka karolo boithutong pele ho qetoa haeba raliphuputso a fumana

hole bohlokoa kapo haeba ke sa tsamae ka lipehelo tsa boithuto joale ka ha ho boletsoe.

Ho tekenetsoe (*sebaka*) _________________ ka (*letsatsi*) _______________20____

______________________________ ______________________________

Tekeno ea ea nkang karolo **Tekeno ea paki**

- O ka tla bua le nna hape? **Eya** ☐ **Che** ☐

- Nka rata ho fumana kakaretso ea tse fumanoeng liphuputsong **Eya** ☐ **Che** ☐

Lilemo tsa motho ea nkang karolo (o lumeletsoe hose bolele lilemo haeba o sa thabele ho fan aka tsona)

Mokhoa o bobebe oa ho mphumana ka:

Lebitso & Fane: _______

Aterese:_______

Email: _______

Nomoro ea fats'e: _______

Nomoro ea thekeng:

Haeba lintlha tse ka holimo li ka fetoha, ke kopa o letsetse motho enoa, ke eena ea ntsebang ea sa phelang lenna empa ea ka tsebang moo ke teng, o tla le thusa ho nfumana:

Lebitso & fane: ____

Nomoro ea mohala/ Nomoro ea mohala oa thekeng /Email: _____________________

Boitlamo ba ea kopang tumello

'Na *(lebitso)* ____ke tiisa hore:

- Ke hlalositse litaba tse tokomaneng ena ho ________________________________
- Ke mokhothalelitse ho botsa lipotso 'me ka nka boikhathatso le nako ho li araba.
- Ke khotsofetse hore o utloisisa lintlha tsohle tsa boithuto bona joalo ka ha ho bonts'itsoe ka holimo.
- Ke sebelisitse/ ha kea sebelisa mofetoleli oa lipuo.

Ho tekennoe (*sebaka*) ______________________ ka (*letsatsi*) _____________________20____

________________________________ ____________________________________

Tekeno ea ea fuoang tumello **Tekeno ea paki**

Boitlamo ba mofuputsi

'Na *(lebitso)* ____ke itlama hore:

- Ke hlalositse litaba tse tokomaneng ena ho ________________________________
- Ke mokhothalelitse ho botsa lipotso ka nka nako le boikhathatso ba ho mo araba.
- Ke khotsofetse hore ona le koutlisiso e felletseng ea lintlha tsohle tsa boithuto bona joale kaha ho hlalositsoe ka holimo.
- Ke sebelisitse/ Ha kea sebelisa mofetoleli oa lipuo.

Ho tekennoe (sebaka) ka (*letsatsi)* 20

_________________________________ ______________________________

Tekeno ea mofuputsi **Tekeno ea paki**

Appendix 8

Data Chart Form							
Authors and Year of Publication	Type of publication	Aims of the study	Sample	Research Design	Results	Region	Healthcare setting
Abalo-Fabai *et al.*, 2018	Journal	To assess the cultural diversity experience, cultural competence behavior and cultural awareness and sensitivity of Healthcare practitioners in a hospital setting of Saudi Arabia.	104 HCPs Doctors 76 nurses 4 laboratory technologists	Quantitative/ cross-sectional study	The HCPs were considered highly culturally competent especially in the behavioral aspect. However, crucial interventions should be performed to improve their awareness and sensitivity while working with diverse patients	Saudi Arabia	A government hospital situated in Riyadh Province
Abderahim, H., Elnashar M., Khidir, A., Killawi, A., Hamound, M. & Al-Khal, L. A 2017	Journal	To explore patients' perspectives about language discordance, and the strategies used to overcome language barriers during patients' visits.	84 Patients (Arabic = 24, English = 20, Hindi = 20, and Urdu = 20)	Qualitative inquiry	-Patients indicated that they were not able to have meaningful relationships with their doctors, they reported that they felt as if the doctors and themselves were from 2 different worlds due to the language barriers. The patients felt that the discussions they	Qatar	Public Hospital

					have with their doctors during consultation were of no use because they do not understand what the Doctors are communicating with them and they sometimes end up agreeing to things they did not understand.- Patients fail to follow correctly the Doctors' instructions because they do not understand the information communicated to them-Patients end up losing interest in consulting healthcare practitioners		
Alahammari, A. Y. 2016	Thesis	To explore the cultural communication barriers between non-Saudi nurses and Saudi patients when performing patient health care.	93 Surgical nurses	Quantitative descriptive survey	-There was miscommunication between expatriate nurses and their Saudi patients in the health care environment due to cultural discrepancies.	Saudi Arabia	A tertiary health care centre in Riyadh
Albagawi, B.	Thesis	To examine	32 Nurses	Mixed methods	-Some the	Saudi Arabia	5 Public

S. 2014		barriers and facilitators to effective nurse-patient communication within a Saudi Arabic cultural context		study	patients' beliefs made it difficult for nurses to be able to give them the quality healthcare they needed e.g. patients believed in traditional medicine hence they refused to take medication prescribed by the nurses. -Cultural differences between the nurses and patients resulted in poor communication -Patients and nurses failed to build good relationships due to their cultural differences and there was conflict between them		Hospitals
Albougami, A. 2016	Article	To examine the language and communication barriers within the KSA healthcare systems and how such barriers have the potential to compromise the quality of care	n/a	n/a	-Language barriers and miscommunication . -medical errors	Saudi Arabia	Kingdom of South Arabia healthcare systems

Alhamami, M. 2020	Journal	To explore language barriers in a multilingual Saudi hospital	37 Participants Physicians, nurses, other healthcare workers, and patients	Qualitative study	-Patients and healthcare practitioners did not understand each other during consultations due to language barriers and this caused stress to both parties - Patients developed mistrust in their healthcare practitioners and did not believe they were diagnosed properly and therefore did not believe in the treatments they were give and thereby did not get the satisfaction they needed in the hospitals - Healthcare practitioners indicated that when there is a language barrier between themselves and patients, consultations takes a longer time because it	Saudi Arabia	A multilingual Saudi hospital

					takes longer for them to understand patient history, symptoms of the patient, thus delayed diagnosis and treatment. -Language barriers between healthcare practitioners' results in excessive use of hospital resources e.g. running of unnecessary tests, unnecessary hospitalization		
Al- Harasis, S. 2013	Journal	To assess the impact of language barriers on quality of nursing care at Armed Forces Hospitals, Taif, Saudi Arabia and to suggest possible interventions to overcome the effect of language barriers on quality of nursing care	612 Nurses+ 227 Patients	Quantitative study	-Majority of the nurses reported that communicating with patients was difficult due to language barriers. -Language barriers affected understanding of patients' needs -Misunderstandings that occurred as a result of language barriers resulted into medical errors. - Patients' level of trust was reduced.	Saudi Arabia	3 Armed Forces Hospitals, Taif Region

Ali, P. A. and Watson, R. 2018	Journal	Language barriers and their impact on provision of care to patients with limited English proficiency	59 registered nurses 32 female and 27 male	Qualitative study	-patients found it very hard to book dr.'s appoints because they struggled to communicate - patients failed to understand reasons for suggested medical procedures - patients failed to understand instructions during procedures and to comprehend treatment regimen and side effects of medication	England	Tertiary care hospitals
Al Kalbani, Al Mashrafi, Almutairi, A. G. & Alshamsi, H. 2020	Journal	To investigate the impact of language barriers on healthcare and to suggest solutions to address the challenges.	14	A systematic review	-Physicians indicated that where language barriers existed between themselves and patients, then they caused misunderstandings that led to wrong diagnosis of patients and administering of wrong treatments. -Physicians also realized that patients withheld	Articles from USA, Saudi Arabia, South Africa, Norway, Canada, Switzerland, Germany and England.	n/a

					some information during consultations when they were barred by language to explain themselves. -Patients also had difficulties in understanding medical instructions, situations, labels and instructions for use on their medications and this led to complications and further illnesses. -Findings also revealed that patients sometimes opted to missing their Dr.s appointments in fear of going undergoing strenuous consultations again. where they struggle to express themselves and also struggle to hear what the Doctor is saying,		

					sometimes they did not go the consult the doctor because they failed to book appointments for themselves because of the language barriers		
Almutairi, K. M 2015	Journal	To examine culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia	12 articles on issues and challenges related to the culture and language differences of the health workforce in Saudi Arabia	Comprehensive systematic review	- Culture and language differences caused miscommunication differences -Patients resorted to violence towards healthcare practitioners when they failed to understand them -Patients failed to understand discharge info, health education, use of medication and medical terms -Nurses failed to build rapport between themselves and their patients -Patient felt that being treated by non-Muslim nurses was not satisfying because	Saudi Arabia	Saudi Arabian Healthcare

					they failed to observe Muslim practices that includes medical and food taboos		
Alosaimi, D. N & Ahmad M. M 2016	Journal	To explore the cultural challenges facing expatriate nurses working in the Kingdome of Saudi Arabia (KSA)	20 non-Muslim nurses	Descriptive qualitative approach	-Expatriate nurses were not able to give quality healthcare to the patients because of cultural, religious and language barrier - Patients' religion discouraged them from undertaking some of the nurses' recommendations	Saudi Arabia	A hospital in Al-Riyadh at KSA served by 80% non-muslim nurses
Alshammari, M., Duff, J. & Guilhermino, M. 2019	Journal	To identify and synthesize quantitative and qualitative evidence on the communication practices among nurses and patients in Saudi Arabia and their effect on patient satisfaction, quality of care and safety.	20 Papers	An integrative review	-The findings revealed that there was lack of therapeutic communication between nurses and patients due to language barriers - Finding further indicated that language barriers that existed limited communication between nurses and patients this compromised the quality of	Saudi Arabia	Papers about the Saudi Arabian health system published in English and Arabic languages between 2000 and 2018

					healthcare the patients received. -The language barriers between nurses and patients resulted in difficulties in communication and the nurses reported that this resulted in stress for them -Differences in cultural backgrounds between patients and nurses resulted in patients failing to adhere to the nurses' instructions thereby threatening patients' safety -Patients were less satisfied with the interpersonal communication between themselves and the nurses.		
Ansah, A. M. & Klugah, M. 2019	Journal	To investigates the nature of language barriers that result from language	16 expatriate doctors 3 nurses 3 patients.	Qualitative study	- Findings revealed that the expatriate doctors employed convergence strategies	Ghana	Three state-owned hospitals in Ghana

		discordance, the measures that expatriate doctors employ to bridge communication gaps and the effectiveness of their methods,			such as ad hoc interpreters, gestures, picture charts and electronic dictionaries to deal with language barriers		
Gerchow, L., Burka, R. L., Miner, S., Squire, A. 2021	Journal	To explore how research has examined the nursing workforce with respect to language barriers.	48 studies from 16 countries	A scoping review	-Nurses indicated that they failed to get crucial information about patients during consultations. -Nurses felt that they sometimes also misinterpreted patients -Language barriers affected the relationship between themselves and their patients	Global perspective	n/a
Malik, P. A. & Khan M. A. 2020	Journal	To explore the discourse surrounding communication challenges between doctor and patient, through the medium of Arabic language,	n/a	Literature review	- Participants in the study reported a hindrance in the doctor-patient relationship, and a lack of information preventing informed decision-making	Arabian Gulf	Arabian Gulf healthcare systems

		with Arabic-speaking patients, in the Arabian Gulf			-This study found that most patients had experienced language barriers during their visits to clinics. -Among the reasons reported for these barriers were the dominance of English language in the hospital setting		
Mlambo, N. 2017	Thesis	To explore Communicative experiences of expatriate healthcare providers with varying linguistic repertoires in Windhoek Namibia	19 Healthcare practitioners	Qualitative research design	-Expatriate HCPs with many languages in their repertoire working in a multilingual context found the linguistic diversity among colleagues and patients to be challenging to a lesser extent, and enriching to a greater extent. -The study further found that the expatriate HCP respondents experience the use of many languages to be an engagement	Namibia Windhoek	Private healthcare sector

					that broadens their professional, social and cultural views and this ultimately results in improved work relations and improved HCP-patient relationships -he use of English as well as indigenous Namibian and foreign languages was found rather to improve than prohibit efficient interactions with the patients, and multilingualism was found to be a resource, especially within a context like Windhoek, Namibia.		
Schouten, B. C., Cox, A., Duran, G., Kerremans, K., Banning, L., Lahdidioui, A., Van den Muijesenberg	Expert opinion	How can language barriers in intercultural health communication be mitigated? Which	60 participants from Amsterdam Center for Health Communicati on (ACHC)	n/a	To enhance intercultural health communication and care for migrant and ethnic minority patients both the language and cultural barrier	Amsterdam	n/a

h, M., Schinel, S., Sungur, H., Suurmond, J., Zendel,R. & Krystallidou, D. 2020		innovations can contribute to improving intercultural health communication?			should be addressed simultaneously, by using a combination of communication strategies, depending on the specific purposes one strives to achieve in a certain healthcare situation.		
Sobane, K. M. 2013	Thesis	To investigate the Local medical centers organizational structure of medical communicative facilities and the related communicative experiences of health care providers and patients in HIV and AIDS care centres where there is language discordance between physicians and patient	23 Physicians 5 Nurses 4 Counsellors 1 Interpreters 3 Patients 10	Qualitative study	-Patients fail to understand what doctors are saying during consultations and they also fail to narrate adequately their illness and symptoms to the doctors. -Patients sometime decide to eliminate some information during consultations because they are not able to express themselves due to language issues -Inability to communicate well between healthcare	Lesotho Maseru	HIV/AIDS Healthcare centres

					practitioners and patients had a negative impact on the Doctor- patient relationship --The healthcare practitioners failed to build rapport and gain trust of their patients.		
Squire, A. 2018	Expert opinion	The aim of the article is to provide background information about language barriers between nurses and patients, and how these barriers affect patient outcomes. To offer practice-based strategies to improve outcomes and reduce readmissions	n/a	Qualitative study	-To enhance communication between nurses and patients, priority should be given to staff who speaks the same language as patients. -Recruitment of staff should be based on their ability to speak other languages fluently and engage them into medical interpreter training. -Patient's understanding of medication management should be prioritized.	United States	n/a
Turner, L. 2015	Thesis	To explore the lived	8 service members	Qualitative study	-Patients had trouble	Seoul South Korea	Local medical centers in

		experiences of American service members who received medical care at local medical centers from South Korean healthcare providers in Seoul, South Korea	who received medical care in the last 8 months		understanding and talking to healthcare practitioners due to language barriers -Patients failed to understand treatment and prescriptions -The inability to communicate and understand each other caused frustrations for both parties -The cultural differences between patients and healthcare practitioners resulted into further miscommunication and misunderstandings -Failure of healthcare practitioners to be culturally sensitive and considerate of the patient's beliefs and practices caused conflict -Conflict between the 2 parties		Seoul South Korea

					resulted in patients not following treatment plans		
Zhang *et al.*, 2022	Journal	This study aimed to describe the dialect competence and usage, communication difficulty, impact of linguistic barriers, and subjective experience in healthcare.	234 Healthcare providers 483 healthcare consumers	A quantitative/ cross-sectional study	Incompetence and variation in the accents of the standard as well as local dialects impose significant linguistic barriers to healthcare in China. The dialect barriers, however, appeared to have impaired effective health communication not only between the healthcare providers and consumers but among the healthcare colleagues as well in this study. Health outcomes were adversely affected by poor compliance from unpleasant clinical encounters if patients feel their voices are not heard or they are not respected. The	China Guangdong	Two tertiary teaching hospitals in Shantou, Chaoshan region

					communication barrier impacted clinical encounters at emergency, ambulatory, and inpatient care in this study. The monolingual speakers of Mandarin or Chaoshan had significant communication difficulties in delivering or consuming healthcare due not only to discordant dialects.		
Naidoo, S 2014	Article	To explore transcultural and language barriers to patient care	n/a	n/a	-transcultural and language barriers decrease work efficiency -Decrease provision of holistic treatment -Increase frustration levels due to communication which is time consuming -decrease empathy and approachability -increases avoidance	South Africa	n/a

					behaviour		
Van den Berg, V. L. 2016	Literature review	To explore the impact of the language barrier on the effective rendering of healthcare services in South Africa, and to raise awareness that studies regarding language barriers within the South African healthcare sector are currently limited to isiXhosa in the context of English and Afrikaans, and has been conducted almost exclusively in the Western Cape	n/a	n/a	- healthcare providers felt that the inability to understand isiXhosa had a negative impact on their ability to be empathetic, kind and approachable; to resolve psycho-social problems; and to give effective counselling and patient education. -language barriers interfered with work efficiency and the provision of holistic treatment, negatively influenced the attitudes of patients and staff towards each other, decreased the quality of, and satisfaction with care, and led to cross-cultural misunderstandings - patients	South Africa	n/a

					expressed shame and blamed themselves for not being able to communicate effectively with healthcare providers.		