EXPLORING DIALECTAL VARIATIONS ON QUALITY HEALTH COMMUNICATION AND HEALTHCARE DELIVERY IN THE SISSALA DISTRICT OF GHANA

Abstract

This article explores the effects of dialectal variations on quality health communication and healthcare delivery using ethnomethodology design. The study revealed that healthcare providers and patients in the Sissala District of Ghana experienced significant difficulties in communicating health needs: misinterpretations and miscommunication characterised the interactions between patients and providers due to dialectal variations and cultural differences. This culminated into reliance on untrained interpreters to enhance communication. The paper recommended that Ghana Health Services should consider issues of linguistic abilities and cultural sensitivity when posting staff to areas that are characterised by multiple languages and dialectal variations.

Keywords: dialectal variations, intercultural and health communication, language socialization, healthcare delivery, interaction, cultural diversity

Abstract- Swahili

Makala hii inachunguza athari za tofauti za dialeta juu ya mawasiliano bora ya afya na utoaji wa huduma za afya kwa kutumia muundo wa ethnomethodology. Utafiti huo umebaini kwamba watoa huduma za afya na wagonjwa katika Wilaya ya Sissala ya Ghana walipata shida kubwa katika kuwasiliana na mahitaji ya afya: kutokuelezea na kutatanisha machafuko yalionyesha uingiliano kati ya wagonjwa na watoa huduma kwa sababu ya tofauti ya dialeta na tofauti za kitamaduni. Hii ilifikia kutegemea wakalimani wasiojifunza ili kuongeza mawasiliano. Karatasi ilipendekeza kuwa Huduma za Afya za Ghana (GHS) zinapaswa kuzingatia masuala ya uwezo wa lugha na uelewa wa kitamaduni wakati wa kuwasilisha wafanyakazi kwa maeneo ambayo yanajulikana kwa lugha nyingi na tofauti za dialeta.

Introduction

Competence in language and multilingualism are gradually becoming requirements for global engagement. Globalisation has brought the world and its people, languages, perspectives, services and goods more closer than ever, and Ghana is no exception. Ghanaians, their cities and villages have become close to each other due to migration in particular for work and education; information and communication technology (ICT); and a good road network. Usually, people migrate with their own cultural baggage: language, worldview, values, norms, beliefs, perspectives and are integrated or assimilated into their newfound homes (Alhassan, 2011). This, nevertheless, does not happen without consequences: they have to learn new local cultures including languages that often result into language shift. Indigenous languages that are similar are often maintained, but with some level of misunderstanding, and miscommunication during social interactions and actions. The challenges arising therefrom have a negative impact on the quality of communication between healthcare professionals and patients at the healthcare facilities.

On the global level, critical and empirical studies on health communication have revealed limited therapeutic nurse-patient interactions that affected quality healthcare delivery (Ojwang, Otugu & Matu, 2010; Korsah, 2011). In the case of Ghana, Prilutski (2010) and Korsah, (2011) observed that effective health communication, both nurse-patient and doctor-patient, are central to quality healthcare delivery. In particular, Korsah (2011) highlighted the problems of poor nurses-patients interaction in Ghanaian healthcare facilities. Multiculturalism, which is a reality in the Ghanaian society, is becoming a serious challenge in most healthcare settings as healthcare professionals, clients have different ethnic, cultural and linguistic backgrounds converge and interact with one another at the healthcare facilities.

While several studies have presented an informed overview of the challenges within health communication in Ghana (Prilutski, 2010; Korsa, 2011), there is a paucity of studies on the effects of dialectal variations on quality health communication and healthcare delivery in Ghana. It was for this reason this study was conducted in the Sissala District of Ghana. The main purpose of the study was to explore the effects of dialectal variations on quality health communication and healthcare delivery in Ghana. Specifically, the paper focused on the dialectal

variations within the Sissala[1] language of Ghana and explored its impact on health communication in the Sissala District.

Literature Review

It will be helpful to begin this brief review of literature with clarification of some key concepts - language, dialect and communication; and polysemy of signs among others as used in this article. These concepts (language and communication) play crucial roles in quality healthcare delivery in Ghana. Studies have shown that language, cultural differences, and low health literacy are key barriers to effective communication and must first be addressed if the safety and quality of health services are to be achieved (Schyve, 2007, Prilutski, 2010; Korsah, 2011).

Language, Dialect and Communication

In defining language, Kuyini (2015) contends that it is any means or system of communicating ideas either expressively or receptively. In a similar vein, Hudson said it is a rule-based system of signs (1996, p.5), while Jandt (2004) added that it is a set of symbols shared by a community to communicate meaning and experience. Here, Hudson (1996) and Jandt (2004) are not dichotomous: They both employ symbols/signs, which could be words and gestures in making their experiences common to other people either expressively or receptively. In this study, however, language is considered as a means through which healthcare professionals, clients and relatives make themselves understood. The means could be signs, words, gestures, drawings among others, or a combination of them. For instance, in most healthcare facilities in Ghana, healthcare professionals and clients speak English language (the official language of Ghana) and/or one or several other indigenous languages including Akan, Dagbani, Dagaari, Ewe, Sissala etc. or a combination of two or many of those languages to make themselves understood.

Within the languages used in the health facilities in Ghana, there are dialects. Dialect is a geographical variety of a language, spoken in a certain area, and being different in some linguistic items from other geographical varieties of the same language (Hudson, 1996, p.4). The

[1] Sissala- Sissala is a tribe in the Upper West Region of Ghana.

important thing here is that, apart from dialect being socially or regionally marked version, it is characterised by differences in the use of vocabulary, grammar, and pronunciation or accent (Hartley, 2003). For example, the Sissala ethnic group of the Upper West Region of Ghana have different dialects, although the language is Sissala. Interestingly, all Sissalas from these geographical areas understand one another; but with significant communication challenges due to some variations in linguistic items: pronunciations, use of jargons, vocabulary, grammar and accent. In the context of the healthcare provider-patient relationship, such a situation could lead to misunderstandings, misinterpretation and misdiagnoses.

Moreover, the idea of communication has become a common, but critical feature of healthcare provision globally. Wiseman (1995) argues that communication is simply a process of exchanging and a creation of meaning. This suggests that the mere exchange of messages between healthcare providers (encoders) and the patients (decoders) or vice versa is not an end in itself, but a means to an end. The communicated messages, in this regard, could be meaningless unless a common understanding is reached between the encoder and the decoder of the message. For instance, the communication of healthcare providers and clients are characterised by sending and receiving messages from and to one another. In such situations, if common meanings are not attached to symbols/signs that are sent by the encoder to the decoder of the messages, there is high tendency that those messages will be misinterpreted and misunderstood, and may lead to medication errors. Therefore, the interrelationship between language, dialect and communication could be useful for analysing effects of dialectal variations on effective communication and healthcare delivery in Ghana.

Concerning the impact of effective communication skills to quality healthcare delivery, Schyve (2007) observed that treatment in healthcare facilities often involved data collection through conversations with patients and most often with the patients' relatives; observation of patients; a physical and mental examination; laboratory testing, and imaging as dissemination of information to patients. In all these processes, Schyve argued, oral communication/conversation often takes place between clinicians and the patients or relatives. In each of these processes, messages are conveyed from either the patients to clinician and vice versa. Without effective communication skills, messages and signals will be misinterpreted and misunderstood and can

lead to unmet needs of patients, medication errors and misdiagnoses (Croucher, 2017; Schyve, 2007). A similar study concluded that quality healthcare service was affected and did not lead to personal satisfaction due to deficiency in effective communication skills between healthcare professionals and patients (Norouzinia, Aghabarari, Shiri, Karimi & Samami, 2016).

Polysemy of signs

The concept of polysemy plays a central role in communication. The word polysemy comes from Greek word "poly" meaning "many" and "semy" stands for meanings. Therefore, polysemy means multiple or many meanings (Hartley, 2009). In light of this, polysemous signs are defined as signs that have the tendency of having more than one meaning (Jandt, 2004). For example, a word, a symbol or a phrase can have multiple meanings depending on the context it is used. The position of polysemous signs is that meanings of signs are created through differences of one sign from another, but not by referral to an essence (de Saussure, 1966). Similarly, de Saussure (1966) asserts that signs are polysemy because the relationships between its key components (signifier and the signified) are arbitrary. Thus, there is no natural relationship between the signifier and the signified. For example, a symbol for "no smoking" can mean a different thing to different people depending on the context it is used. Owing to the fact that a meaning(s) is/are not generated because an object or a referent has an essential meaning, rather, a meaning(s) is/are generated because signs are different from one another. This gives credence to Barthes' (1973) argument that signifiers are polysemous because they do not have stable denotative meaning. The implication is that every sign carries potential meanings. This explains why a signifier in a language may refer to several signified because conventions are culturally and contextually determined. Polysemy of signs, then, becomes a challenge in the context of healthcare communication and service delivery.

The polysemy of signs attracts attention in the study because the basic unit of communication between healthcare professionals in the Sissala District, as you will see later in the findings, involves the use of signs. Variations in the usage of signs, symbols, or gestures in the Sissala dialects may lead to miscommunication because different linguistic/dialectal groups attach different meanings to their signs, gestures or symbols. For example, a healthcare provider, who speaks Debin (a dialect of the Sissala), might attribute different meaning to the signs (gestures)

of a Pasaalin (another dialect of Sissala). In view of this, we argue that communication between healthcare professionals and patients cannot be meaningful if shared meaning (based on the signs or symbols used) is not created in the communication.

Language socialization and culture

Given the challenges with the ways in which dialectal variations and polysemy of signs are conceptualised, what barriers do language socialisation and culture present to quality healthcare delivery? Language, socialisation and culture, as Schieffelin and Ochs (1986) posit, are interlinked. Language is a powerful tool of socialisation; it is through language human beings are able to pass on socio-cultural values from one generation to another. Researchers acknowledge that language socialisation examines how a group of people organises its language practices to shape the life of people to become active participants in the communities they find themselves (Schieffelin & Ochs, 1986; Ochs, 2000; Orosco, 2010). The community here may include, but not limited to: households, neighbourhoods, peer groups, schools, professions, religious organizations and other institutions (Ochs, 2000). In essence, language socialization views language learning as the process of becoming a member of a socio-cultural group through participation in the socio-cultural practices (Orosco, 2010). Here, language socialisation and culture, as we posit, are inseparable since language learning, and its practices are rooted in the culture of the people. Language socialization and culture are interwoven since the processes of acquiring language is deeply rooted in the process of transferring cultural values to members of the society.

Our conception of culture reflects what Holiday, Hyde and Kullman (2004, p.64) coined as a "small culture". These authors defined a small culture as any cohesive social groupings with no necessary subordination to large cultures (p.64). They argued that a small culture is "non-essentialist" since it does not relate to the essence of national, ethnic and international entities, but rather relates to how behaviours of individuals are negotiated, constructed and discursively formed within any cohesive social groupings.

In addition, Sarangi (2009) observed, "individuals are seen as living in their culture and the culture lived by the individual" (p.84). This is in line with Geertz's (1973) definition of culture as a web that people spin themselves (p.5). Thus, it is a web created by members of the society

for several purposes. Firstly, it confines members to their social realities they have created and facilitate their functioning in these realities. Secondly, culture is both a product and a process; and thirdly, culture provides contexts, which then defines the behaviour of the people. One of the ways members of the society create a web for themselves is through language. Language, as in Schieffeli and Ochs' (1986) classic formulation, is a powerful medium of socialization. In view of this, language is a channel through which socio-cultural values are passed on from generation to generation. Therefore, the analytic focus of language socialization rests on socially and culturally organised interactions that bring together both experienced, and less experienced persons in shaping the structuring of knowledge, emotions and social actions (Ochs, 2000). Through these socially and culturally organised practices, people practise language and learned the appropriate use of the language (what, when, where and how) in different settings.

Xingsong (2007) argued that people go through secondary socialization the very moment they are exposed to new socio-cultural contexts, communities of practice, a workplace, and educational program. In the case of this study, healthcare professionals who come from other parts of Ghana to work in the Sissala District have to go through secondary socialization process to be able to work effectively in their new environment. Language socialization and culture are relevant in this study because the theory posits that effective health service delivery requires effective language skills and cultural competence.

To sum up, there is an intrinsic relationship between language socialization and culture. Language socialization and culture are interlinked because the process of acquiring language is deeply rooted in the processes of transferring culture to members of a community. Hence, the process of becoming a competent member of a society is achieved through language.

Health communication and effective healthcare delivery

Another important concept, which is used in this study, is health communication. Croucher (2017) defines health communication as a field of communication that investigates and provides information about how we communicate issues in healthcare situation. This implies that the purpose of health communication is to design communication strategies to influence and promote healthcare knowledge and conditions of individuals and communities. Further, NCI (2002) defines health communication as the study and use of communication strategies to inform and influence individual and community decisions that enhance health (p.2). In light of this, health

communication is a tool that is critical to addressing healthcare problems, promoting and improving healthcare delivery (Freimuth & Quinn, 2004). That is not all: healthcare research and practice found that health communication is capable of increasing knowledge on the use of communication to inform and influence individuals and community decisions on health through media advocacy, education, and interpersonal communication (Freimuth & Quinn, 2004; NCI, 2002). Findings that are more recent suggest that effective healthcare communication requires good interactions between the healthcare providers and patients: nurse-patient interaction, doctor-nurse interactions, doctor-doctor interactions, and patient-pharmacist interaction (Crewick et al. cited in Mensah, 2013). This means that, a good communication relationship between the healthcare providers and patients are essential for effective health communication.

In the context of the effects of culture on health and health communication, most recently Piacentini, O'Donnell, Phipps, Jackson and Stack Teresa (2018) have argued that health, and our understanding of health are shaped and informed by our cultural backgrounds. In light of this, cross-cultural understanding and effective communication lie at the core of healthcare delivery. However, differences in cultural values and medical literacy affect providers-patients effective communication. For instance, a study by Van den Berg (2016) on the impact of language barriers on effective rendering of healthcare services in South African healthcare sector highlighted that language barriers continue to compromise large proportion of the South African population`s quality of, and access to healthcare services. The study further noted that, in most clinical settings in South Africa, healthcare providers and their patients do not share the same first language, which is a major barrier to effective communication between healthcare providers and patients. Similarly, Piacentini et al. (2018) analysed the experiences of immigrant-patients, healthcare providers and interpreters' relationship in Scotland. They concluded that healthcare providers and other stakeholders should move beyond the "language problem" in addressing multiple hidden inequalities in healthcare access and provision in both at the clinical and home-based settings, and focused on how other migratory trajectories intersect with language to reproduce and maintain inequalities at the clinical settings.

Finally, Van Wieringen, Harmsen, & Bruijnszeels, (2002) observed that the inability to communicate effectively within healthcare consultations could have negative consequences on

patients visit to healthcare providers, longer consultations, poorer mutual understanding leading to non-compliance with medication and treatment. In support of this view, Croucher (2017) observed that misunderstanding caused by different cultural and linguistic backgrounds can lead to increase rate of illness and death among members of indigenous and minority groups. Besides, Ulrey and Amason (2001) noted that in the patient-provider relationship, intercultural issues play an important role, and intercultural awareness of patients by healthcare providers can improve the quality of healthcare services and the effectiveness of treatments. In the context of this study, healthcare providers in the Sissala District of Ghana will require effective communication and cross-cultural competence skills in order to provide quality healthcare services to patients from different linguistic and cultural backgrounds.

Methodology

This study is located in the paradigm of social constructionism. This approach posits that the world in which we live is constructed by us, and that once constructed, it is not open to change very easily (Bryman, 2004; Kuada, 2012). Thus, patients and the healthcare providers, who speak different dialects, constructed the reality about the dialectal variations and its effects on quality communication and healthcare delivery in the Sissala District, and once the reality is constructed, it cannot easily be deconstructed.

Again, the study adopts a research design derived from ethnomethodology. Ethnomethodology examines the classifications of social actions of individuals within groups through drawing on the experience of the groups directly without imposing the researcher(s)' values on the research setting (Lynch, 1993). In this regard, the study made use of the practices healthcare providers and patients employed in dealing with the dialectal variations and its effects on healthcare delivery and communication in the Sissala District. Ethnomethodological design is employed in this study for two reasons. First, to focus on how patients from the Sissala ethnic groups with dialectal variations describe how healthcare providers in the Sissala District communicate with them about their health needs and vice versa. The second concern was not only to investigate how the research participants engaged in everyday practical social actions, but also how the research participants saw each other engaged in every day practical social actions at the Sissala District. This design provided us with methodological resources to explore, in detail, the effects

of dialectal variations on the quality of communication and healthcare delivery in the Sissala District.

The Sisaala ethnic group of the Upper West region of Ghana speaks the Sissala language with dialectal variations such as Debin, Galebaglin, Debibesin, Pasaalin and Tumuulung/Isaalin among others. The language is mainly spoken in four districts; Wa East, Lambussie, Sisaala West and East Districts in the Upper West region. These districts share common borders and lie within the same geographical area. The Tumu District shares boundary with Burkina Faso; Kassena Nankana and Builsa Districts; West Mamprusi District; Wa East and Nadowli Districts (Population & Housing Census, 2010).

Data collection procedures

Preparation for data collection started by gaining institutional agreement from the University for Development Studies (UDS), Ghana. Again, in order to gain access to the research site and participants, a letter of intent was written to the management of a hospital in the Sissala District requesting for a study to be carried out at the hospital on dialectal variations within the Sissala language of Ghana, and explore health communication between patients and healthcare providers.. Besides, the letter stated the extent of time to be used for the study, and the impact of the research for national development. Approval for the study was granted by the management of the hospital. Also, for the study to achieve confidentiality, anonymity, honest and respect for participants in the study, the rationale for the study was explained to all the participants. All the participants were assured that the data was to be used for research purposes. The consents of all participants were sought. Furthermore, participation in the study was on voluntary basis. Raw data in the form of conversation transcripts were treated in a way that protected the confidentiality and anonymity of the participants.

Selection of informants

The research participants for this study were purposively selected. Purposive sampling is used when the researcher selects the research participants based on his/her own judgement (Bryman, 2004 & Creswell, 2009). In terms of the inclusion criteria, healthcare providers who had more than two years work experience in the hospital in question were selected. In the case of the

patients, years of experience in the hospital were not part of the selection criteria; rather, the dialect and culture of patients were considered. Again, in terms of exclusion criteria, healthcare providers who had less than two years work experience were not considered for the study. Besides, the hospital administrators who had no direct contact with patients were also excluded from the study.

Interviews

Eighteen personal interviews were carried out with every research participant using a semi-structured interview guide. This was to ensure coverage of all topics/themes to be investigated. The interviews were conducted at two levels. The first level of the personal interviews was conducted with seven healthcare providers who were native speakers of Sissala with dialectal variations. The healthcare providers who were interviewed were given copies of the interview guide because they could read and write in English language. Researchers asked questions based on the topics in the interview guide, while research participants responded accordingly. The research participants were not forced to follow the interview guide strictly; they could switch from one topic to another, but always returned to follow the trajectory. Every interview session took between 45 minutes and 1 hour. The interviews were conducted at different days and time in the month of June 2017. All the conversations were recorded with an audio recording device.

The second levels of the interviews were conducted with eleven patients with dialectal variations. The second part of the interviews were conducted in Sissala and later translated into English language. This was because not all the patients could speak English language. In this context, the interview guide was used, but it was not shared to the research participants. As stated earlier, every interview session took between 45 minutes and 1 hour. All the interviews were conducted at different days and time in the month of June, 2017. All the conversations were recorded with an audio recording device.

Data Analysis

All the interviews were transcribed exactly what they interviewees said including the nonverbal communication such as laughter, pauses etc.. To enhance the data quality, we used an external expert who reviewed the transcribed data with the original recordings so that inaccuracies were

resolved. Concerning data analysis, our attention was directed towards the interactions and communication between the healthcare providers, and the Sissala ethnic groups, and how these interactions and communication facilitated or impeded the quality healthcare delivery. Our focus was on how the processes of interaction between healthcare providers and patients from the Sissala ethnic groups shaped and are shaped by the social context. The data was coded using Strausss & Corbin's (1990) three systems of coding (open, axial and selective coding). Open coding was done by reading through the entire data and categorized the data into preliminary analytical categories. In order to enhance the credibility of the study, we independently coded the data, and compared the codes for inter-codal validity. The second coding technique used was axial coding. This coding technique was used to link the preliminary analytic categories into concepts. Finally, selective coding was used to select the core categories and related them to other categories (Bryman, 2004). In term of the themes' identification, the classic technique of content analysis was used (Creswell, 2007). In this regard, the number of times each descriptive code occurred was ranked and the most important concepts were identified as the themes.

Data Interpretation

This study adopts the hermeneutic or interpretative approach in interpreting the data. The term 'hermeneutic' refers to research that engages in interpreting texts and other organizational artefacts (Prasad, 2002).It also means the art or science of interpretation (Bryman, 2004). In this regard, we conducted detailed readings of the entire data and offered rich and thick descriptions of the data in order to discover the deeper meanings within the research participants' responses.

Findings and Discussion

Analysis of our interview data on the effects of dialectal variation on health communication and healthcare delivery in the Sissala District found linguistic variations, and cultural differences as barriers to health communication and healthcare delivery. The findings and discussions are presented below.

Linguistic variations as barriers to health communication and healthcare delivery

Communication is used as a vehicle to exchange information between patients and healthcare providers in hospitals in the Sissala District. However, miscommunication and misunderstanding due to dialectal variations often characterized healthcare providers and patients' communication. In view of this, one patient was asked to explain how they communicate with healthcare providers who speak different dialects from their own. In response, an interviewee C2, a patient stated:

> Hmmm.. in most cases we communicate like the deaf and dumb using sign language. When I came here the first day, after I had registered for a folder, I was asked to see a medical doctor. The medical doctor physically examined me, and asked me how I was feeling. It was not easy communicating with the doctor because I cannot speak English and the nurse too does not understand my accent. So, ee... eeh…, it was a difficult moment (Field data).

The views expressed by interviewee C2, have not only illuminated the communication difficulties between the healthcare providers and the patients, but it has also revealed the challenges in the use of sign language as a means of communication to create shared meaning between patients and healthcare providers who do not speak a common dialect or language. What is analytically interesting is that, the signs or symbols used by some patients and healthcare providers who do not speak the same dialect or language in exchanging messages to create shared meanings are arbitrary. This is because signs or words are not only abstract, or a simplification of what they stand for, but in most cases, they are not the same as those ideas and things they represent. In view of this, the use of signs to communicate with patients, healthcare providers and vice versa could easily be misinterpreted since the relationship between the signifier and the signified can be arbitrary. In the context of healthcare delivery, administering health services based on the interpretations and understanding of signs, gestures could pose danger to the lives of patients since such practices could lead to wrong diagnoses, prescriptions and even death. This finding is in harmony with the postulation of (Barthes, 1973; de Saussure, 1966) that signifiers are polysemous because they have multiple meanings, and are socially and culturally constructed.

In addition, to support the claim of interviewee C2, an interviewee C6, a patient added:

> eeh..eeh…It is always a problem when you meet a health professional who speaks a dialect or language you do not understand. I was consulted by a Nurse who spoke "Wale"[2] to me. I told her I understand basic "Wale" and didn`t understand all the information she shared with me. She called a health assistant in the hospital who understands "Wale", and my dialect. The health assistant helped and interpreted the information to me (Field data).

This revelation suggests an ineffective communication between the patient and the healthcare providers due to a language barrier. On the one hand, language fluency and skills could be an effective tool for influencing individuals and community's decisions and promotion of quality healthcare delivery. On the other, the lack of communication and language skills may be a barrier to effective health communication and healthcare delivery. This argument is in consonance with Sarez and Savez (2009) where skills and fluency in languages were considered as prerequisites for effective global engagement in every healthcare community. Similarly, the difficulty of healthcare professionals to communicate in a language that the patient understands is not in keeping with the language socialization theory, which focuses on learning and using the language of the community to become a competent member of the community (Schieffelin & Ochs, 1986).

Besides, when a question was asked to ascertain whether there were variations in the use of "Sissala Grammar, and symbols in communication", in an interview A2, a healthcare provider, revealed:

> Yes, some of the symbols used in communication are not the same. There are variations in accent, grammar and pronunciations (Field data).

This implies that, variations in the usage of communication symbols, grammar, and accent by the healthcare providers and some of the patients have illuminated how language barriers might result into cultural barriers at the clinical settings. What is analytically interesting is that language and culture are inextricably linked because language is often used to reflect the world

[2] Wale- It is a local Ghanaian language spoken in the Upper West Region, Ghana.

view of a society (Sapir, and Whorf in Holliday et al., 2004, p. 74-75). Both Sapir and Whorf argument mirrors the relationship between language and culture. Therefore, the inability of some of the healthcare providers and patients to create shared meaning with the symbols used in communication at the clinical settings could be due to the differences in acculturation process between the healthcare providers and patients. In this regard, the difficulty in creating a common understanding of the symbols used in communication could result to life-threatening mistreatment and mismanagement of diseases. This argument is in consonance with the postulation of Croucher (2017) that misunderstanding caused by different cultural and linguistic backgrounds can lead to increase rate of illness and death among members of indigenous and minority groups at the clinical settings.

Furthermore, concerning the strategies adopted at the hospital to deal with the effects of dialectal variations on quality healthcare delivery in the Sissala District, an interviewee A4, an administrator, was asked about the mechanisms they have put in place to minimise the effects of dialectal variations on patients and healthcare providers' interactions. In response, she stated:

> Eee, ... eeh ... we do not have a fixed style of managing the dialectal varieties we are faced with in the hospital, but in most cases, we use untrained interpreters, signs and gestures to facilitate communication between our patients who do not speak English language or a common dialect (Field data).

The views expressed by interviewee A4, cast light on the flexible management style on the issues of dialectal varieties in the hospital. Again, it has also highlighted the use of untrained or unprofessional interpreters who are often multilingual family members, other patients, health administrators, and the use of signs, gestures and other sign language (known in the Pasaali dialect of the Sissala language as – 'gania wibasi') for communication between healthcare providers and patients. While this way could be a step towards minimising the communication difficulties between healthcare providers and patients, it raises communication and professional ethical issues. First, the transfer of information from the patient to the physician by the untrained interpreters will depend on the communication abilities of the untrained interpreters to convey the exact messages to the patients, and from the patients to the physicians. Second, it will also

depend on the medical knowledge of the interpreters (known in the Pasaali dialect of the Sissala language as-niwie akankibirime) to transfer the exact medical terms from the physicians to the patients and from the patients to the physicians. In this regard, the lack of medical knowledge and professional communication skills on the part of the untrained interpreters could lead to medication errors and wrong treatments. Third, the use of untrained interpreters raises an ethical issue, as it is most likely that interpreters may disclose health information of patients to third parties, which could affect patients` confidentiality. Besides, this sort of communication engagement between healthcare providers, patients and interpreters could be arbitrary (de Saussure, 1966 & Barthes,1972) for various reasons: there could be no natural relationship between the sign used by the untrained interpreters, healthcare providers and the patients. It could lead to distortions of information, wrong diagnoses, and negative health outcomes. To buttress the point, interviewee Al, a nurse, expatiated:

> .....in most cases patients do not understand what the doctor tells them, and only get the information through an interpreter and that procedure delays the health delivery system, and the patients are affected (Field data).

This clearly indicates that the use of untrained interpreters and nonverbal communication symbols as alternative forms of communication in cases of dialectal and languages barriers to facilitate communication between healthcare providers and patients could lead to negative health outcomes. As mentioned earlier, words, phrases and symbols have no inherent meanings. They have only the meaning(s) people ascribe to them based on the context. As a result, the meaning(s) the interpreters may assign to the exchanged messages between the healthcare providers and the patients may not be fixed or related to the essence of the study subjects, but would be negotiated, discursively and socially constructed within the context of the cohesive social groupings (Holliday, 1999).

Effects of cultural differences on health communication and healthcare delivery

The second theme generated from the interview data is cultural differences and their effect on healthcare delivery. This theme seeks to examine the effect of cultural differences on provider-patient interactions, and its effect on health communication and healthcare delivery. When we

communicate, we attach meaning(s) to messages we construct, transmit to others, and interpret the messages we received based on our cultural values. In relation with the effect of dialectal variation on the creation of shared or common meaning between patients and healthcare providers, an interviewee C6, a patient, had this to say:

> hmm… eeh… I am not always comfortable, in fact sometimes I become confuse because I don't know whether the doctor understands or not (Field data).

The views articulated by interviewee C6 has not only highlighted uncertainty, confusion, and discomfort in terms of the communication between patients and healthcare providers, but has also revealed the dual challenge of limited health literacy and cultural differences between them. On one hand, the inability of the patients to understand the physicians' messages could be attributed to the limited health literacy of the patients to understand the shared values and practices of the physicians. On the other, misunderstanding in relation with information exchanged between the patients and the healthcare providers might be linked to the cultural differences between the healthcare providers and the patients. These dual challenges of limited health literacy and misunderstanding due to cultural differences could lead to negative health outcomes.

Also, an interviewee A2, a healthcare provider added:

> even though I used sign language some of the times, I am not quite certain if the intended messages are clearly understood by the patients (Field data).

Here, the subject has cast light on communication challenges between healthcare providers and patients on two levels, thus, linguistic variation and cultural differences. On the level of cultural differences, the fact that the patient was not certain if sign language could help convey what he meant could be culturally influenced. This is because the language we are raised with influences the way we communicate and see the world. This understanding is compatible with the theoretical postulation of Geertz (1973) that culture is a web that people themselves have spun (p.5). Firstly, as a web, culture confines members to their social realities, and facilitates their

functioning in these realities; secondly, culture is both a product and a process; and thirdly, culture provides a context for behaviour. Therefore, the perceptions of the provider and the patient that if sign language could help convey what they meant may be due to the fact that both the provider and patient had been confined in their own symbols used in communication and social reality which they have created, socialised and interpreted based on their own contextual cultural filters. On the linguistic level, the uncertainties between the patient and the provider might be due to the arbitrariness of the relationship between the signifier (object) and the signified (the hidden meaning) (de Saussure, 1966). Interestingly, assigning meaning(s) to signs and symbols are socially and culturally determined. In this context, the patients and healthcare providers are not able to create common meaning(s) because they are both socialised in different cultural and linguistic backgrounds.

In addition, in connection with how patients and healthcare providers dealt with doubtful messages, an interviewee C1, a patient, stated:

> Eeh…day in day out, I get a lot of ambiguous information from the health professionals. Eee….eeh, it is difficult to cope with it, but with the help of sign language I am managing with the communication difficulties (Field data).

The above submission by an interviewee C1 did not only reveal how hard it is to understand messages expressed in different dialects within Sissala, but also stated how sign language had helped in information sharing between healthcare providers and patients. As mentioned earlier, using sign language as a means of communication between healthcare providers and the patients and the vice versa is not an end in itself, but a means toward minimizing communication challenges between patients and healthcare providers from different dialectal backgrounds.

Furthermore, the interviewee continued:

> Most of our patients speak the local languages with dialectal varieties. Eeeh,…eeh , I am not a Sissala, and I don't understand any of the languages spoken over here. I only speak English

language and Twi[3], but most of the patient do not understand English language and Twi" (Field data).

The view expressed by interviewee A2 has shed light on the linguistic diversity of Ghana. In Ghana, there are several tribal languages spoken in different districts and regions. In the case of interviewee A1, she can only speak English language and Twi, and cannot make herself understood in Sassala language. This could mean that respondent A1 might not be able to effectively communicate with patients who cannot speak either English language or Twi. The inability of the study subjects to communicate in the language and dialects used in the community is in tension with the philosophy of language socialization, which focuses on how a new member or a person becomes a competent member of a social group using language as a medium or tool in the socialization process (Schieffelin & Ochs, 1986). Besides, it is also contradicts the Sapir-Worf hypothesis, which states that the real world is to a large extent unconsciously built upon the language habits of the group (Sapir, 1949, p.162). In view of this, the difficulty of the healthcare providers to communicate in the language or dialects of the patients might not offer the healthcare providers the opportunity to understand the thoughts, perceptions and assumptions of the patients. This could lead to ineffective communication and negative health outcomes.

Similarly, patients were asked about how they managed cultural unfamiliarity with the healthcare providers. Interviewee C9 responded:

> Hmmm.., it has not being easy communicating with a doctor you cannot express yourself well with to get the right treatment, cultural variations are affecting our communications (Field data).

Extracts from the interview data above has not only underlined effects of cultural variables on communication between healthcare providers and patients, but it has also cast light on how that could influence quality healthcare delivery. The difficulties in creating shared meaning during interactions between the healthcare providers and patients to get the right treatment may be due

[3] Twi-Twi is a Ghanaian Language spoken by Akans in the southern part of Ghana.

to the different cultural backgrounds of patients and healthcare providers. It is important to note that understanding of cultural difference is an important step in effective patient-healthcare provider communication, and development of effective treatment procedures. Neglecting issues of cultural differences between healthcare providers and patients could lead to dangerous health outcomes.

Finally, in relation with the same issue, a question was posed to another interviewee (patient, C4) on how cultural familiarity affects health care delivery and in response, the interviewee expressed:

> Ee...ee cultural familiarity can enhance communication between us and the doctors ,you will be able to express yourself well to the doctor as compared to meeting someone from a different cultural background. If I were to respond to these questions in different language or dialect, for example, Galebaglin or Pasaalin, I might not have expressed myself this well as compared to Debin which is my own dialect.(Field data).

The above interview data provides ample demonstration of effective communication under the usage of the same cultural variables. In this context, cultural familiarity between healthcare providers and patients could enhance common understanding in the messages encoded and decoded. In view of this, mutual understanding of the cultural and linguistic knowledge of patients by healthcare providers, and at the same time, the ability of patients to understand the linguistic and cultural knowledge of healthcare providers could minimize miscommunication and misunderstanding (known in the Pasaali dialect of the Sissala language as 'Wikan birimee akikpa ngania') between healthcare providers and patients.

Conclusion

The paper has explored the effects of dialectal variations on quality health communication and healthcare delivery in a hospital in the Sissala District of Ghana. The study revealed that misinterpretations, misunderstanding and miscommunication due to cultural and linguistic barriers between healthcare providers and patients were pervasive. Untrained interpreters and sign languages were used to enhance patients and healthcare providers' communication. The

study concludes that understanding of cultural differences and linguistic variations between patients and healthcare providers is an important step in health communication and quality healthcare delivery. We recommend a broad interpretation of culture because the meanings patients, healthcare providers and interpreters attached to symbols used in communication were not related to the socially conventional meanings of the symbols used in communication, but were negotiated, socially and discursively constructed. Ghana Health Services and hospitals in the Sissala District could provide intercultural training to its staff focusing on how to improve on quality healthcare delivery through effective intercultural communication between healthcare providers and patients. Again, Ghana Health Services and hospitals in the Sissala District should consider issues relating to linguistic ability and cultural sensitivity when posting staffs to districts and regions that are characterized by multiple languages and dialectal variations. Finally, professional language interpretation centres could also be created in the Sissala District to support and enhance effective health communication between the healthcare providers and patients.

This study has one major limitation. It did not cover the entire hospitals in the Sissala District of Ghana and that forms a major limitation of the study. Healthcare professionals, specifically, medical doctors and nurses and all those who work in the clinical settings have the tools, approaches and opportunities to take the study of dialectal variations in health communication in new directions.

Future Directions

The study suggests the following future research directions in relation to the effects of dialectal variations on healthcare communication and delivery : first, we encourage researchers in the rural clinical settings in Ghana to conduct research on healthcare professionals and interpreters' intercultural and multilingual communicative competence since Ghana is characterised by linguistic and cultural diversity. Specifically, healthcare professionals' inabilities to speak indigenous languages in some clinical settings in the rural areas deny patients quality health service. Second, we suggest that more research be conducted on Ghanaian physicians' communication culture and its effects on quality healthcare delivery. There seem to be incompatible cultures of communication between Ghanaian physicians and service users in

Ghanaian hospitals. Third, our research on the effects of dialectal variations on health communication and quality healthcare delivery is a major step for researchers in this field to broaden their understandings of dialectal variation across different contexts and clinical settings in Ghana.

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