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Health, Culture and Language: Translation and Untranslatability in Selected English-to-Zulu Health Communication Messages in Rural KwaZulu-Natal

Mongezi Andrew Sikhakhane (201173251)

Supervisor: Prof. Nyasha Mboti
Co-supervisor: Prof. Pier Paolo Frassinelli

Thesis submitted to the Department of Communication Studies in the Faculty of Humanities, University of the Johannesburg, in fulfilment of the requirements for the degree of Doctor of Literature and Philosophy (DLitt et Phil) in Communication Studies.

June 2019
Dedication

To Fortunate, my wife and my daughter Sibusisiwe for their love, patience and support during the study and writing of this thesis.
Acknowledgements
The financial assistance of the National Institute for the Humanities and Social Sciences, in collaboration with the South African Humanities Deans Association towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the NIHSS and SAHUDA.

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Declaration
I, Mongezi Andrew Sikhakhane (201173251), declare that this thesis submitted for the degree of Doctor of Literature and Philosophy (Communication Studies) at the University of the Johannesburg, is my own original, unaided work. Where other people’s work has been used, I have cited it appropriately. The study has not been previously submitted for any other degree or examination at any other university.

_____________________
Mongezi Andrew Sikhakhane (201173251)
Abstract
In theory, all of South Africa’s 11 official languages are equal. But in reality, English has consolidated its position at the expense of the other 10. It remains the only language spoken across all ethnic groups in South Africa. English’s dominance as both a source and relay language has not only underdeveloped African languages but has also facilitated the emergence of a systematic yet lopsided translation culture. Translation, for instance, is a routine and central element in the South African Government’s communication with its citizens. This study examined this “translation culture” in the context of health communication. The translation of health communication messages from English into African languages is a common and taken-for-granted practice in South African public health communication. This study critiques the use and dependence by the Department of Health, in the dissemination of health messages to the broader South African population, on specific normative modes of “translation cultures”. I investigated the interplay of health, health communication, culture and language on the production and translation of health communication messages to establish how, if at all, translation interacts with health communication and messaging. Using qualitative interviews and focus groups, the study explored how translated health communication messages disseminated by the Department of Health are received and perceived in specific contexts of use by selected target audiences. The study findings suggest that normative assumptions about translation complicate health communication in unique and interesting ways. This is the case with terms such as Igciwane, Ingculaza, Umabhebeza and Inoni, among others. The examples show that meanings that are otherwise polysemic, deeply intralingual, intersemiotic and complex; emerge as simple and static through English words. Due to the presence of “untranslatable” terminology or medical terms, there emerges a very specific politics of untranslatability, tied to culture, worldview and identity, where it appears that some things are better left untranslated, or we have to reckon with the fact that we are actually never done translating. Rather, translation is always in a process of becoming. Participants in the study focus groups expressed strong views about the way certain English medical terms are left to police themselves in translations, and that such words drive out Zulu words from the health lexicon. The study looks more to the future than the past and leans on translation studies to make an original theoretical and empirical contribution to the field of African health communication. It insists on the importance of the design of culturally appropriate, culturally friendly, and culturally sensitive public health communication strategies, particularly when these are targeted at poor, rural, under-served and illiterate citizens. The current half-hearted interventions on the local translation scene are by and large detrimental to health communication. Translation must, in the end, be a dialogue and complex give and take between equally rich and equally expressive languages. This requires a ceaseless and continuous dialogue and interaction between Zulu and English, and English and Zulu. Such a dialogue and interaction must, however, be markedly different to the unsustainable current practice of translating normatively from English.
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CHAPTER ONE

INTRODUCTION

Setting the scene

The *language question* in South Africa is a complicated one. It dates to the time before the proclamation of the Act of Union of South Africa in 1910, and before Afrikaans got established as second official language from 1925 onwards. In 1910, following the Anglo-Boer war, the British and the Afrikaners accommodated each other at the expense of Africans, who were relegated to the status of invisible “natives”. Where language was concerned, natives were not even regarded as having languages. Rather, they were insultingly regarded as speaking “dialects”, mostly Nguni but also Sotho-Tswana. Whereas English was clearly the dominant hegemonic language, the Afrikaner elite sought to elevate Afrikaans to a similarly dominant status. Hence:

In the history of conquest, the first thing the victorious conqueror does is to attack people’s names and languages. The idea was to deny them the authority of naming self and the world, to delegitimize the history and the knowledge they already possessed, delegitimize their own language as a credible source of knowledge and definition of the world, so that the conqueror’s language can become the source of the very definition of being. This was true with the English conquest of Ireland, Wales, Scotland or the Japanese conquest of South Korea; or the U.S.A.’s takeover of Hawaii: to ban or weaken the languages of the conquered, and then impose by gun, guise or guile, their own language and accord it all the authority of naming the world. It was done with the enslaved. African languages and names were banned in the plantations; and later in the continent as a whole, so much so that African people now accept Europhonity to define their countries and who they are: Francophone, Anglophone or Lusophone (wa Thiong’o, 2017: 1)

In the colonial conception of “language as power”, there exists a priori “conception of the relationship of languages in terms of hierarchy, with the
officially sanctioned language, sitting at the top, as the language of power, law, justice, education, administration and economic exchange (wa Thiong’o, 2017: 4). The Soweto Uprising of 1976 arose partly due to the colonial, inflexible and arbitrary policy of attempting to artificially promote Afrikaans into a lingua franca. While translation is necessarily inherent in all languages and in all communication, it cannot exist as a case of hard imposition of language norms, as the Soweto Uprisings showed. That is, “while it is true that translation is the common language of languages; hierarchies of power and domination distort its full function as our common heritage” (wa Thiong’o, 2017: 8). The attempt to ram Afrikaans down the throats of Africans, in this latter case, led to a crisis of apartheid. What this episode showed, however, was the importance of language in the elaborate quest for hegemony.

The failure of the “artificial insemination” of Afrikaans before and after Soweto meant that only English was a truly hegemonic language in South Africa. This can be shown by the fact that the school children who were protesting against the imposition of Afrikaans in 1976 preferred English. The fact that English was also a colonial imposition had long been forgotten. The dominance of English has continued post-1994. Whereas Afrikaner elites feared that Afrikaans would disappear (cf. Giliomee 2003) with the coming of democracy (this fear has proved to be unfounded), no such fear was expressed with regards to English. Although Afrikaans tried as much as it could, by hook or crook, to elevate its status to be next to English, English is today clearly dominant and hegemonic in terms of its preferential usage nationally by most South Africans for whom it is not a mother tongue.

Wa Thiong’o (2017) argues that English is not just a lingua franca, but a language of power. Whereas a lingua franca “assumes the existence of co-equal languages” and “simply facilitates communication and dialogue among language equals”, a “language of power assumes that for it to be, other languages must cease to be. It desires to replace or silence all the other
languages” (wa Thiong’o 2017: 4). There is no doubt that English is, in South Africa, a language of power. However, this does not mean that a lingua franca is a priori, necessarily a good thing. I think a lingua franca can be as bad as a language of power, largely because in the nervous condition of the colonised, the two are the same thing. In South Africa English occupies an ambivalent space where it is both a language of power and a lingua franca. It facilitates and excludes, fosters and crushes, at the same time. Even more importantly, English got to be a lingua franca through being a language of power. It is nearly not so easy to separate the issues glibly. I thus think that wa Thiong’o is positing a false binary between lingua franca and language of power. English is both those things, and more.

The 2011 census shows that only 8.2% of South Africans speak English as a first language. Yet it remains the only primary “trans-ethnic” language spoken across all the country’s nine provinces. Most schools teach English and another South African language. Even more striking is the preferential usage of English by national government for government and communication purposes. This is happening despite the Constitution of the Republic South Africa, (Act No. 108 of 1996) granting equal status to all 11 (eleven) languages (isiZulu, isiXhosa, Tshivenda, English, SeSotho, isiNdebele, Northern SeSotho, Afrikaans, Setswana, isiSwati, Xitsonga). As Alexander (2004: 118) would say, English is treated by most South Africans as the first among the equals. There is no doubt, as per Humpty Dumpty’s famous injunction about mastery, that English is the “master”.

The master status of English is despite the best regulatory efforts of Act No. 12 of 2012: Use of Official Languages Act, 2012. This Act stands for the regulation and monitoring of the use of official languages for government purposes by national government; promotion of parity of esteem and equitable treatment of official languages of the Republic; facilitation of equitable access to services and information of national government; and the promotion of good language
management by national government, for efficient public service administration and to meet the needs of the public. The continued preferential usage of English by national government in all its official communications, and by most mainstream media, reflects a strong, pro-English reflex. Chapter 1 of the Founding Provisions of the 1996 Constitution states that:

The national government and provincial governments may use any official languages for the purposes of government, taking into account usage, practicality, expense, regional circumstances and the balance of the needs and preferences of the population as a whole or in the province concerned; but the national government and each provincial government must use at least two official languages (emphasis added).

The reality is that “usage, practicality, expense, regional circumstances and the balance of the needs and preferences” equals English. The exhortation that national government and each provincial government must use at least two official languages is also, to all intents and purposes, shorthand for only one official language: English. The implications in relation to the language rights enshrined in the 1996 Constitution are that language rights are being compromised either by inertia or convenience, or both.

These concerns notwithstanding, the fact of the matter is that English practically remains the only language spoken across all ethnic groups in South Africa. This situation is by no means a purely South African phenomenon, either. For instance, English remains the so-called lingua franca of the world, giving rise to the concept of English as the Global Lingua Franca (EGLF) (Christiansen, 2015). In some estimates, English is spoken in 101 countries, with over 335 million people speaking it as their first language, and 450 million as a second.

In fact, some scholars are convinced that, globally, the English language has “consolidated its position at the expense of the other languages” (Mesthrie 2006: 153). Others, however, are sceptical that English as the Global Lingua Franca is leading to a loss of language diversity or to a universal monolingualism (Christiansen, 2015). Instead, a “plurilingualism” is likely to emerge as English is indigenised and hybridised. A case in point would be Nigerian Pidgin English (NPE), or even “South African English”, both of which sound very different to unadulterated “Queen’s English”.

Most postcolonial African states openly prefer former colonial languages as official languages. Basically, the delegitimization of African languages that began in the colonial era was completed and normalised in the post-colonial era. “Where English was now equated with the gate to progress and modernity, African languages came to be seen as barriers to this glittering thing called progress and modernity” (wa Thiong’o 2017: 2). For instance, although Nigerian Pidgin English, or Naijá, is commonly used throughout the Nigeria, the government has not seen it fit to grant the language official status. Rather, it prefers English. Most African countries retain the coloniser’s language as the language of government. Alexander (2004: 122) has observed that with some notable but patchy exceptions in Tanzania, Somalia, Ethiopia and Eritrea, most of the countries in sub-Saharan Africa have promoted and entrenched a neo-colonial policy in which English, French and Portuguese continue to dominate the commanding of heights. For Bamgbose (2011: 1-2):

It is well known that colonial powers imposed their languages in each territory they governed as the language of administration, commerce and education... Even after independence, such languages remained as official languages in most countries and any proposal to empower the majority of the population by raising the status of African languages and extending the domains in which they are used failed largely because of two factors “elite closure”, i.e. monopoly of the language of power by the elites and resistance on the part to extend this jealously guarded power to other groups (Scotton, 1990: 27), and “inheritance situation” (Gellar, 1973: 385), i.e. how the policies and practices from the
colonial period continue to determine post-colonial policies and practices.

At least, this is the case in many African countries such as South Africa where English is the *de facto* lingua franca of government. This is happening even though English is originally of foreign origin and even though most citizens are unable to access information through this language.

The entrenchment of English in South Africa as *lingua franca* is a case study of colonialism. That is, the genealogy of the English language in the country can be traced to colonisation and the British imperial project (wa Thiong'o 1986). Basically, it was the language of the “master”, and thus was learnt by the colonised by default, not by choice. Whereas most Africans were limited to “kitchen kaffir” variants of English, mission-educated and other aspirational Africans tended to believe that English was indeed an elevated language – an instrument in the quest to be accommodated in the white man’s world.

Cultural theorist Ntongela Masilela (2013) makes the point that from as early as the 1800s, English was seen by “new African” intellectuals in South Africa as “a fundamental facilitator into the entryway into modernity”. Masilela quotes Gwayi Tyamzashe, a Xhosa intellectual writing in 1884, as saying:

> Of all modern languages, English is the noblest, fullest, deepest and most comprehensive. We natives of this country receive with thanks every inducement to learn that language. It is the language of the Arts and Sciences, the language of Law and Politics. It is the channel to all the benefits of civilisation (2013: 12).

Tyamzashe, who was the founder of the Native Society at Kimberley, a part of the influential Native Educational Association, hoped to “unite the different native tribes of this country by the English language and manners”. Hence:

> As we don’t understand each other in our various native languages, and as we differ in many respects from each other in our manner and habits of living, let us meet each other in our
manners and habits of living, let us meet each other somewhere, and try to understand each other through the medium of the English language (2013: 12).

For Tyamzashe, English was to be the default language of modernity, particularly in the project of “detribalisation”. It is interesting that the same motivation, cited by the likes of Tyamzashe in the 1880s, seems to be same one behind the present-day preference for English in governmental and other official circles.

At least, what Tyamzashe is saying seems to be a variant of the phrase, from the 1996 Constitution, citing “usage, practicality, expense, regional circumstances and the balance of the needs and preferences”. The use of English, then as now, is seen as practical, efficient, necessary, cost-saving, and politically desirable. For Tyamzashe, English served as a national integration tool, but this was a myth. On the contrary Bamgbose (2011: 4) argues that as far as language is concerned:

The concept of national integration is linked to multilingualism and myth of divisiveness, which is that one language, unites, and many languages divide. Given this myth, it is understandable why African languages are given low status in comparison with imported official languages, which are believed to unite different ethnic groups from the point of view of communication and government.

But it was not just the educated “natives”, however, who thought highly of English. Before the upsurge in Boer nationalism in the lead up to the Anglo-Boer war, leading Afrikaners at the time saw English as a superior language to Afrikaans. For instance, in a lecture given in 1876, exactly 100 years before the Soweto Uprisings, chief justice Sir Henry de Villiers described Afrikaans as being “poor in the number of its words, weak in its inflections, wanting in accuracy of meaning and incapable of expressing ideas connected with the higher spheres of thought”. de Villiers was in favour of Afrikaners appropriating English, which he described as “that rich and glorious language”, and that he
predicted English would become “the language of South Africa” (Meredith 2007: 88).

It can be argued that the attitude towards English just described, however complicated and ambivalent, continues to this day in a variety of forms and evolutions. Ironically, de Villiers was also right in predicting that English would become “the language of South Africa”. As already noted, the Soweto 1976 uprising was partly inspired by resistance to Afrikaans – and of course by a complex struggle for citizenship and contestation about who was to count as a South African (cf. Mboti 2013). It is doubtful that there would have been a similar uprising against the use of English. Essentially, English has continued to easily dominate other South African languages in terms of practical value, social capital, and credibility as *lingua franca*.

**Rationale and justification of study**

Despite South Africa having what has been described as “the most progressive constitution in the world, at least as regards language rights” (Wallmach 2006), English remains the language into which most local languages are readily translated to or translated from – so that most official translations are mediated via English. The National Language Policy Framework (NLPF), which stipulates that all national government structures and public institutions must adopt one or more working languages and that official government publications must also appear in all eleven languages, or failing this, in six languages on a rotational basis, has pretty much *not* been adhered to. Indeed, as wa Thiong’o observed:

> This linguistic picture confronts policy-makers as a nightmare, and they think that if they can ignore the nightmare long enough or frighten it away with more emphasis on European languages, the nightmare will vanish, and they will wake up to the bliss of a harmonious European language-speaking African nation. So, they engineer a massive transfer of resources from African to European languages. Ninety percent of the resources earmarked for language education go to European ones, a minuscule percent to African languages, if at all. But reality, however, is stubborn,
and they wake up to the same nightmare. European language speakers in any one of the African nations is at most 10% of the population only; the other 90% are African languages speakers (wa Thiong’o 2017: 2).

It is not common, for instance, for communication to be written in indigenous languages and to find stand-alone translations of texts from isiZulu to Tshivenda, Tshivenda to isiZulu, isiXhosa to Setswana, SeSotho to Afrikaans, and so on. Why not? Predictably, most South Africans are communicated to in English, except when the communiqué is translated into their first languages. It seems – to borrow Wallmach’s and Mesthrie’s (2006: 153) words – that despite the feel-good “Rainbowism” of the Constitution, it is English that has consolidated its position at the expense of other South African languages.

Whether we like it or not, English is the de facto language of power and the lingua franca of the state. This is despite the fact that most the “clients” (in fact, citizens) of the state are unable to access or utilise information through this language. Bamgbose’s (1991: 6) observation seems appropriate to describe the language problem in South Africa:

There is a general feeling that language problems are not urgent and hence solutions to them can wait. Language policies in African countries are characterized by one or more of the following problems: avoidance, vagueness, arbitrariness, fluctuation and declaration without implementation.

This study was motivated in part by the fact that, seemingly, nothing (or at least very little) is being done to address or change the situation. Alexander (2002: 122-123) also warns of the contradictions in language planning in South Africa today, caused by the interminable tension between what the governing elites are obliged to do constitutionally and what they prefer to do based on their interests and the convenience of inertia.

English’s dominance as a source or relay language has not only resulted in the under-privileging of African languages but has also led to the emergence of
what one could call ‘translation cultures’. Essentially, government seems most comfortable speaking directly to its citizens in English but, in order to fulfil a constitutional obligation, throws in a translator and a translation into the bargain. That is, translation of the “official word” has become a key element in the South African Government’s communication with its citizens. The Department of Health, for instance, has an obligation to “communicate effectively”. *Effective communication* in official government-speak in a major sense implies using a *de facto* lingua franca – in this case English – *and then* translating it into first languages. This is the phenomenon that this study grapples with: official communication that is not just normatively in English but is also *expected* to be *translatable* into other South African languages. This *expectation of translatability* is what this study found to be taken for granted and yet is far from given or simple. That is, translation is not merely a technical, linguistic task. Rather, it is a complex and complicated phenomenon that intersects in language (in all its verbal, mediated and embodied modes), culture, and identity.

This study was concerned with the *expectation of translatability* of health communication messages from English into African languages, something which has become a common practice in South African public health communication (cf. Lubinga and Jansen, 2008: 72). *Soul City*’s production of radio series in nine languages and printing of booklets based on the television drama in eleven languages, for instance, is one classical example of the practice of providing health communication messages in first languages. In addition, under the Khomanani Campaign and others, print materials have been produced by the South African National Department of Health in different first languages (Lubinga and Jansen, 2011: 467). Translation then figures as the *main*, go-to option if government, non-governmental organisations and the private sector, are to communicate *effectively* with all citizens across South Africa and across the 11 official languages. But what are the assumptions of effective communication? What are the features of the *expectation of*
translatability? Are all health concepts and messages translatable? Which parts are translatable; and which are not? What causes translatability and untranslatability? What can we learn from this phenomenon? Answers to these questions are revealed in Chapter five, a chapter that discusses findings of this study.

This study found that the expectation of translatability goes hand in hand with a dependence on translation – a matrix that factors into the very design of messages. That is, we are talking about a state-of-affairs of messages that are implicitly designed-for-translation due to dependence on translation rather than out of concern with citizens’ needs. The dependence on translation by health institutions often implies translation of messages from English to one or other of the 11 official languages, or from one or other of the 11 official languages into English. Most prevention and education health communication messages are available in first languages, in most cases translated from English. Already, there is a larger problem. Not only are the technical “registers” of African languages still to be fully understood by translators – most African languages are not yet fully standardised in the same sense that English is standardised (Wallmach 2006) – but the far more important matter of cultural context significantly and inevitably complicates things. Having observed that the production process of health communication messages by the Department of Health does not consider the cultural orientation and background of the audiences, this study strongly emphasises the design of culturally appropriate, culturally friendly and culturally sensitive public health communication messages and strategies; taking into consideration the intricate relationship between language and culture.

Language is a pillar of and produces culture (wa Thion’o, 1986). Being a pillar of and a producer of culture, language is inherently meaningful to its everyday users. Problems of meaning are therefore, bound to occur when a first language is translated into English and vice versa, particularly when “professional”
translators do not live the ordinary lives of those they target with their translations. The question of how readers of these messages experience and encounter translations in everyday settings is central to this study. To the best of my knowledge, such a question has not been systematically examined in literature on translations of health communication in African contexts. Reverting to the South African context, even the Department of Health, which is the producer of health communication messages does not or has never gone back to the target audiences to investigate how the messages are received and perceived. A core criticism of current official practice is that translation ends up being a tick-box exercise, to fulfil a constitutional obligation, rather than a living process of negotiation that intersects language, culture and identity. The ticking of boxes means that translation is rendered merely skin-deep. Inevitably, skin-deep translation is cited for criticism in this study.

The problem is that it is not just words that must be translated, but also the ideas, worldviews, cultural mores and moral values, fears, desires, triumphs and narratives that the words convey. In Spivak’s (1992) words, a language, *before translation*, is one of many elements that allow people to make sense of things and of themselves. Can we assume that, *after translation*, those ideas, worldviews, cultural mores and moral values have survived the translation? With practices of box-ticking, the answer has to be no. The question that arises is: can a lived culture be readily translated into another language? Chances of lived experiences and culture being “faithfully” translated are highly unlikely.

Nye (1998: 256) argues that “translation in the correct sense must refer therefore *not merely* to different linguistic uses but often to the different cultural realities behind the words” (emphasis added). For Baker and Saldanha (2008: xvii):

One of the most fascinating things about exploring the history of translation is that it reveals how narrow and restrictive we have been in defining our object of study, even with the most flexible of
definitions. When we read about how African interpreters regularly translated African drum language into actual words, for instance, we begin to realize that the current literature on translation has hardly started to scratch the surface of this *multifaceted* and all-pervasive phenomenon.

As with Nye, Malinowski (1935) opines that “when two cultures differ as deeply as that of the Trobrianders and the English”, “when beliefs, scientific views, social organisation, morality and material outfit are completely different,” then “most of the words in one language *cannot be even remotely paralleled* in the other” (emphasis added).

If this seems like it is overly pessimistic, the examples provided in this study will show that, in fact, *expectations of translatability* by government and other health service providers are overly optimistic. Malinowski’s reflections shed light on the South African context: the impossibility of translating culture may be behind the notion untranslatability. Let us take, for instance, *ukusoma*, a Zulu term for the cultural practice translated as “non-penetrative sex”. To a Zulu hearer, would saying “non-penetrative sex” simultaneously convey *ukusoma*? This seems impossible, since *ukusoma* is not just a word. Rather, it is a lived cultural and health practice that emerges out of given social and cultural contexts and is burdened by them. In other words, *ukusoma* resists simple substitution and transfer.

One can infer from this that a critical aspect of untranslatability and translatability is the at once *social, cultural, human, political, historical* nature of communication. The BBC\(^2\) in 2004 reported that the world’s most difficult word to translate was identified as *ilunga* from the Tshiluba language spoken in south-eastern DR Congo. *Ilunga*, which means “a person who is ready to

forgive any abuse for the first time, to tolerate it a second time, but never a third time”, was identified by 1 000 linguists as the hardest word in the world to translate. Clearly, ilunga resists transfer and substitution, and is untranslatable: one would need to be familiar with the social, cultural, human, political, historical context of south-eastern DR Congo to be able to “translate” ilunga in such a way that it means what it means in the Tshiluba language:

To speak of untranslatable in no way implies that the terms in question, or the expressions, the syntactical or grammatical turns, are not and cannot be translated: the untranslatable is rather what one keeps on (not) translating. But this indicates that their translation, into one language or another creates a problem, to the extent of sometimes generating a neologism or imposing a new meaning on an old word. It is a sign of the way in which, from one language to another, neither the words nor the conceptual networks can simply be superimposed (Cassin, 2004: xvii).

Some things are better left untranslated as they “travel’ from language to language, text to text, meaning to meaning. The untranslatable is always tethered “to the instability of meaning and sense-making” (Cassin 2004: vii), to the fact that we are never done translating.

The 24-word substitution for ilunga shows the rigid and problematic insistence by the 1 000 linguists that all words in language ought somehow to be inherently and naturally translatable and transferable into another language. This confirms Malinowski’s argument that “every language has words which are not translatable, because they fit into its culture and into that culture only, into the physical calling, the institutions, the material apparatus and manners and values of a people” (emphasis added). Hence:

The untranslatable as a construct makes a place for the private anguish that we as translators experience when confronted with material that we don’t want to translate or see translated. A certain density or richness or colour or tone in the source language seems so completely to defy rendering into another language that we would just as soon not try: the poverty of the result is too
distressing, makes us miss the first language as we miss a friend or a child (Apter, E., in Cassin, 2004: xiv).

Drawing on the Burkinabe context Drescher (2010: 201) avers, for instance, that “Faithfulness, one of the key concepts of HIV/AIDS education, has no direct equivalent in (such) traditionally polygamous societies”. Whether Drescher is right or wrong, the main finding ought to be that one cannot inevitably expect translation to result in effective communication. Jones and Norton (2007: 5) have, indeed, observed that “In African contexts in which ex-colonial languages are often official languages, the development of health literacy is seen to be a particular challenge particularly with reference to sexual health literacy”. If Wittgenstein (1953) is correct, then meaning is use. Wittgenstein claims that; “the concept of meaning is related to the public practice of utterance and all that makes this practice possible”. He argues that “meaning does not consist in the picturing relation between propositions and facts, but in the use of an expression in the multiplicity of practices which go to make up the language”.

Most studies of translation commonly focus on what Walter Benjamin (1923) has called “The Translator’s Task”. That is, there is a preoccupation with the translated text and the role and process of the translator in transforming the text. There has been no or little specific focus on what actual audiences in real world contexts bring to the translated messages. Questions about the extra-linguistic life, meaning and circulation of translated messages in communities of users have not been sufficiently subjected to any previous systematic study. This study seeks to contribute towards reducing paucity, the aim being to contribute to the debate about the relationship between culture, socio-cultural context, language and communication. Furthermore, no intensive systematic or in-depth research has been done focusing strictly on translation and untranslatability of communication in socio-cultural contexts or with regards to health messages. There is not enough work focusing on the translation of media from English into any of South Africa’s indigenous languages.
Additionally, this study contributes – though modestly – to the growing field of African translation studies. Normative translation studies have exclusively Eurocentric origins and “remains highly Eurocentric both in its theoretical explorations and its historical grounding’ (Hung and Wakabayashi 2005: 1). Indeed:

Translation studies has traditionally been strongly Eurocentric in orientation, and in some parts of the world continues to be dominated by theoretical paradigms that originated in the West and that are oblivious to the rich and substantially different experiences of translation outside Europe and North America (Baker and Saldanha 2008: xx).

I have thus written this study from a decidedly non-western perspective as a deliberate act of intervention in the field because I recognise the need for decolonising the theory and practice of translation studies.

Further, I did not seek to examine all the words there are in translated health communication, as it were. This was not my object. Rather, I took as my object the *theoretical* exploration of specific words and their uses, meanings, and contexts of use, in order to show what takes place at the frontier of translation and untranslatability. This exploration is not strictly located within translation studies. Instead, my study is much more comfortable with being located in what Baker and Saldanha (2008: xxi) refer to “interest in translation and interpreting *outside* translation studies” (emphasis in original). Finally, the research aims to contribute to efforts to craft approaches for designing culturally appropriate and culture-friendly public health communication strategies as will be depicted in Chapter five.

The location of the study is in rural KwaZulu-Natal (KZN). I chose rural KZN for a number of reasons. Firstly, because, in the 24-hour flow of everyday life, Zulus in this region predominantly speak isiZulu. They dream in the language. They tell stories and impart folk knowledge and morals in isiZulu. They voice their interactions with the natural and social environment in isiZulu, talked in isiZulu.
in their homes, in their work and everyday choice, in thirst and in hunger, in love and war. They give and take, and love, marry or divorce, and argue and settle disputes, in isiZulu. The Zulu language carries their identity. Secondly, KZN is where the Zulu language and culture are objects of an imagined purity and indigeneity, but also where the combination of poverty and illiteracy complicates the expectation of translatability.

The Zulu language is by far the dominant language spoken in rural KZN. However, even here English serves as the preferred medium of official written health communication. I found the disjuncture attractive for purposes of research, especially the tension between the expectation of translatability and the reality of uncertain translatability or even outright untranslatability. The cultural aspect is also magnified in rural KZN. While Zulus are found throughout South Africa, KZN is their so-called “stronghold”. There, Zulus are to be found not only in the majority but also in everyday social arrangements that encourage staunch preservation of isiZulu and Zulu “culture” and “values”. Additionally, the researcher is a native Zulu speaker and has a competent grasp and understanding of Zulu language and culture, on the one hand, and the rural health setting, on the other. Health communication has been chosen as the area of study because of the preponderance of translated material at and near clinics in rural KwaZulu-Natal.

**Research aims and objectives**

The study explored the relationship between language, culture and health by examining questions of “translation” and “untranslatability” in a selected corpus of English-to-Zulu health communication messages in a rural setting. By exploring the issues of translatability and untranslatability, the study ultimately investigated the relationship of content and meaning of translated English-to-Zulu messages, especially in situations where there might be no linguistic and cultural fits or equivalents to convey the intended messages in isiZulu. A core assumption is that translation is a site of deep contestation. Whereas the term
“translation” signifies language in a state of non-belonging (cf. Cassin 2004), hegemonic English seems to always belong. Indeed, it displaces and topples other languages wherever it goes. It is indigenous languages such as isiZulu that are made to feel foreign in their own country, to feel as if they did not belong. At least, this was seen to be the case in translated health communication.

The study is not a philological study of translation. Rather, it is a study of the life, meaning and circulation of selected translated messages in given communities of users and given contexts of use. The study traced the journey of the translated message from production to use in order to establish how end-users of translated messages use, understand, and make sense of these messages in specific socio-cultural contexts. As Airhihenbuwa and Webster (2004: 6) have asserted, “behaviour, particularly health behaviour, occurs in the context of cultures and, furthermore, is either reinforced or resisted through family, government and spiritual institutions”. The study sought to establish what sort of meaning(s) translated health messages convey. Using the supposed lack of equivalent terms between isiZulu and the English language as a starting point, the study questions whether the translation and untranslatability makes any difference in the socio-cultural lives, health choices and health beliefs of the target audiences, and whether the target audience uses the messages as they were intended.

The study has three objectives, which are to:

1. Establish how selected target audiences in the real-world contexts of rural KZN use, understand and make sense of selected health communication messages translated from English to Zulu;
2. Investigate why selected target audiences in rural KZN use [if they do], understand, and make meaning out of translated health communication messages in the way they do; and
3. Explore the nature of the “translatable” and the “untranslatable” in selected English-to-Zulu health messages and what it reveals about the relationship between language and culture, and between language, culture and health.

**Location of study**

The location of the study is rural KwaZulu-Natal (KZN) in clinics under the UThukela District and UMzinyathi District Municipalities (see Fig 1 below). These districts are constituted by several villages and each village has its own clinic.

![Map of UMzinyathi and UThukela District Municipalities](image)

*Fig 1.: UMzinyathi and UThukela District Municipalities*

**Delimitation and scope of study**

As noted, this is not a philological study of language but, rather, a study of the life, meaning and circulation of selected translated messages in given communities of users and in given contexts of use. The setting is rural clinics, where translated (English-to-Zulu) health communication messages are
plentifully communicated via posters, leaflets, pamphlets, booklets and billboards, but where English is the lingua franca. This study focused only on printed health communication messages. Broadcast health messages’ content will not be attended to. Although interpretation is an oral form of translation, little detailed attention was given to it. That is the focus is on written translation as opposed to oral translation. The focus of this study is investigating the relationship between translation, language, culture and health, and how these affect health communication, broadly. As such, it is beyond its scope to pay special attention to the health communication campaigns of specific kinds of diseases. That is, the study is not delimited to HIV/Aids, TB, cholera, or diabetes related messages, and so on. Rather, it concerns itself with health communication messages in general, and which are in use in KZN during the study. The focus is squarely on messages about different diseases that the various health departments want to “educate” and inform people about. The choice of messages was determined by availability and circulation.

Chapter outline
The study comprises six (6) chapters which follow a traditional thesis structure. **Chapter One** is the introduction to the study. It sets the scene for the study by outlining the state of language use by government, the reason why the study is being pursued, the aims and objectives of the study, the key questions that the study seeks to answer and location of the study. **Chapter Two**, which is the literature review on language, translation, culture, and health communication then follows. It contains the debates and discourses on Translation Studies and writings by pioneers on translation and translation studies, as a discipline. It discusses in detail key concepts such as translatability, untranslatability, translation, language, culture, and health communication. This if followed by **Chapter Three** which presents the theoretical framework of the study, which is based on the concepts of Skopos theory and functionalism theory, loyalty and fidelity, the cultural turn translation, theories of health communication and traditional translation theory. Next is **Chapter Four**, the methodology chapter
which presents methods used in collecting primary data, the research design and techniques used for recording data from the field as well as the analysis and interpretation of findings. The data are presented in Chapter Five where primary data collected through focus groups discussions, personal interviews, and content analysis of selected translated health communication messages are presented, analysed and interpreted. The penultimate chapter presents the researcher’s position in relation to the investigation. It also presents the researcher’s suggestions and recommendations towards remedying the situation. The final chapter is Chapter Six, which is the conclusion to the study.
CHAPTER TWO

LANGUAGE, TRANSLATION, CULTURE, AND HEALTH COMMUNICATION

Introduction
This chapter reviews previous studies on the four themes that are central to this study: language, translation, culture, and health communication. This first part begins at the very beginning: by looking first at the origin of language, how its evolution relates to its purpose in human lives, and how this purpose relates to communication. The chapter also reviews what we know about the state of the field of translation, the different contending schools of thought, and the debates that intersect the field. In the process, the chapter touches on the language situation and policy in the South Africa context, and concludes by exploring the concepts of translation, translatability and untranslatability in the context of health communication, and culture. The chapter anticipates Chapter 3, the theory chapter. More importantly, the key issues addressed here will be drawn on in the findings chapter.

The origins of language: Some perspectives
What is language? There is a plethora of definitions. Cassin (2004: xix) says that “each language is a vision of the world that catches another world in its net, that performs a world”. The online Dictionary.com has fourteen definitions of language, such as “a body of words and the systems for their use common to a people who are of the same community or nation, the same geographical area, or the cultural tradition” and “any set or system of such symbols as used in a more or less uniform fashion by a number of people, who are thus enabled to communicate intelligibly with one another”. David Crystal in How Language Works (2006: 3) links language with human communication and says that there

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are five modes of human communication, precisely because there are only five human senses which can act as channels of information: sound, sight, touch and smell, and taste. “The information we send and receive using these modes”, for Crystal, “is usually called the meaning of our communication”.

Wa Thiong'o notes (2009: 18) notes that his mother tongue, Gĩkũyũ, communally inherited and continually enriched through time, “was a storehouse of knowledge, attitudes, feelings and moods, and I drew from this granary of communal memory to understand my relations to the world around me”. Language says Fitch (2010: 2), “is hugely complex, and is so central to humanity that it infiltrates all aspect of human cognition, behaviour, and culture. Practitioners of many different disciplines can fairly claim insight into its workings. The diversity of perspectives can be bewildering”. What seems clear is that every human being and human culture uses language in one form or another to communicate. Critical to my study is the aspect that language in its many forms is a primary purveyor of meaning, sense-making, identity, and culture, yet it does so in ways that are not always easily translated.

Of some interest to me is the question of the uses of language. There are some scholars who regard language to be the most important faculty in the whole question of being human. Fitch (2010: 1), for instance, has asserted that:

Language, more than anything else, is what makes us human: the unique power of language to represent and share unbounded thoughts is critical to all human societies; and has played a central role in the rise of our species in the last million years from a minor and peripheral member of the sub-Saharan African ecological community to the dominant species on the planet today. Despite intensive researching, it appears that no communication system of equivalent power exists elsewhere in the animal kingdom…. Given its central role in human behaviour, and in human culture, it is unsurprising that the origin of language has been a topic of myth and speculation since the beginning of history (emphasis added).
On first view, the assertion that we are human because we speak seems to be an exaggeration. After all, we are human because we do other inevitably human things as well. For instance, we think. At least, this is the basis of the Cartesian cogito: *I think, therefore I am*. We also love, and bind ourselves to societies, rules, mores, cultures, ethics and laws.

All this seems crucial to what makes us human. However, Fitch is adamant that – above all – it is language that makes us inalienably human: *we use language; therefore, we are*. Studies by anthropologists such as Malinowski and linguists such as JR Firth have shown that *language use* is at the core of social organisation, and that without its social life would be *meaningless*. With language, on the other hand, social life is *meaningful*. In *Philosophical Investigations* (1953), Austrian philosopher Ludwig Wittgenstein goes as far as to state that human beings play in structured and elaborate “language games” as part of everyday life and, crucially, that “meaning is use”.

But how did language use itself come to be? Darwin (1859) believed that language was constructed from a *state without a language*, to a *state with language*. Beyond that, the split in opinion is broadly that language is either a conscious invention or a natural faculty. Fitch (2010: 2) states that “scholars appear evenly split concerning whether language evolved initially for its role in communication with others, or whether its role structuring thought provided the initial selective advantage”. Four major schools of thought in linguistics – namely, functionalism, structuralism, generativism and cognitivism – come to mind when one mentions the question of the *origins* of language. However, there is little consensus across and within camps, as the discourse is always shifting across the sands of time. Fitch (2010: 1, 2) notes that:

> Since the dawn of modern Darwinian evolutionary theory, questions about the evolution of language have generated a rapidly growing scientific literature. Since the 1960s, an increasing number of scholars with backgrounds in linguistics, anthropology, speech science, genetics, neuroscience, and evolutionary biology have devoted themselves to
understanding various aspects of language evolution. The result is a vast scientific literature, stretched across a number of disciplines, much of it directed at specialist audiences.

Most of these scholars come from different disciplines, and each has his or her own philosophy on the topic of language's evolution and purpose. Henle (1965:1, 2), cites Whorf, a famous student of Sapir, has always emphasised Sapir’s claim that language constitutes a sort of logic, a general frame of reference and so moulds the thought of its habitual users.

Whorf also claimed that, where culture and a language have developed together, significant relationships developed between the general aspects of the grammar and the characteristic of the culture, taken as a whole. Chomsky (1964), for his part, claimed that language is in-born: without a strong innate component, language cannot be learned. However, many culturalists such as Everett (2013) explicitly reject Chomsky’s innativism, and argue that human beings are capable of learning and creating, including learning and creating language. None of the contending philosophies about the origins and purpose of language, however, are sufficient on their own. Rather, each view must form a co-operating or contending layer on top of other layers, one building on the others until we achieve a broader and more satisfactory picture (Fitch, 2010: 3).

The sociological model asserts that language is not an autonomous system but is subordinate to, and dependent upon, social structures, social uses, and the child’s development in other areas (cf. Johansson 1991: 5). Theorists in the sociological school of thought see language as a tool that human beings use for different purposes in their lives, with communication being one of the uses. What is of primary interest for them “is not cognitive development, but the social development, the child’s growing need to communicate and interact with other beings. Language is regarded simply as means to an end, a tool developed by the child to solve its communicative needs” (Johansson 1991: 5). Language is seen in relation to social factors. Stages of development are central to this
vision of language as communication, as well as a broader investment in linguistic tools. Linguistic tools themselves are important in the formation of social identity. Intertwined with “sociology of language”, of course, is function. In certain respects, functionalist theories focus on phonological, semantic and syntactic aspects of language.

The second school of thought, structuralism, is based on the idea that language is made up of different units – structures – connected to each other in a fixed system. This school of thought was propagated by a Swiss linguist and semiotician Ferdinand de Saussure, well known for his Course in General Linguistics. For de Saussure language was a system of signs that was best looked at from the point of view of a semiotic system of signifiers and signified. Generativism, on the other hand, focuses on how human being acquired language in the first place. According to Johansson’s (1991: 2) reading of Chomsky’s “innateness”, ideology of language, there is a universal grammar which all human beings anywhere are capable of learning.

The “universal” argument insists, for instance, that language is made up of certain innate rules that apply to all human languages. Generativism insists that there is something in-born and innate in all of us that helps in language development skills. Finally, cognitivism is a reaction to the generativism theory. Unlike generativism, cognitivist theory was based on the notion that language acquisition skills come from the meaning that the mind creates from words. The idea behind the cognitivism is “that acquisition of the language to describe some concepts follows, by some unspecified mechanism, from the cognitive acquisition of the concept” (Johansson, 1991: 4). It suggests, “language does not automatically follow” from cognitive development, but instead the child uses its cognitive capacity to deduce the rules of the language it hears (Johansson, 1991).
Considering the mammoth nature of the topic of language, as well as the fragmentation and the complexity of the debate, I am quick to be persuaded by Fitch that no perspective is better than the other. Rather, I will creatively raid what I can from all or some of these schools of thought. My preference is to treat language in terms of both the notion of language as communication and in terms of its role as a facilitator and carrier of identity, culture and thought. Language will, in this study, be treated and looked at as a creative and cultural tool that humans have to use to communicate identity, thoughts, needs, desires, triumphs, anxieties, fears, aspirations and ideas.

Mutasa (1999: 85) has regarded the importance of language in human lives and actions in the following words:

Language is one of our most precious possessions and a quintessence of our humanity. It is the principal factor enabling individuals to become fully functioning members of the group into which they are born. Nations are able to develop because language provides an important link between the individual and his/her social environment.

It can be deduced from Mutasa’s argument that language is much more than a mere communication tool for its users. Rather, it enables humans to understand their contexts and surroundings and make sense of them. In this regard, without language, our everyday lives would be incomprehensible.

Henle (1965: 4) also concurs that the importance of language to humans lies in the way it helps us make sense of our surroundings. Hence:

In dealing with the relationship between vocabulary and the interests of a society there is enough direct evidence to indicate such correlation, but hardly so with any of the other relationships… Even in the case of the relationship between vocabulary and culture, this sort of evidence helps substantiate the direct correlation. We see every reason to believe, as part of our common-sense psychology, that a people should have words for objects with which they are concerned with and they should
lack words for objects with which they have fewer dealings… Sapir gives detailed evidence over a broader field in claiming that the vocabulary of a language clearly reflects the physical and social environment of a people. Indeed, the complete vocabulary of a language would be “complex inventory of all the ideas, interests, and occupations that take up the attention of the community… Status systems in various cultures, however, complex, and differentiations due to occupations are all mirrored in language (Henle 1965: 4).

Henle’s assertions are critical because they paint a seemingly clear picture of the relationship between language and its users, while showing – unequivocally – the connection between language and culture. The link between language, culture and society is fundamental and crucial to this study. Through language, it seems, one gets to begin not only to belong in a given society, but to be it, to name it, and to constitute it. In other words, it is through language that we become endowed with an identity, and that we emerge as human beings and as individuals. That is, it is through language that we get to know who we are. If this seems, again, like an exaggeration, I hope to show at least that language comes close to this ideal. I thus borrow Mutasa’s (1999) words and refer to language as quintessence.

**Language as communication**

There would be no need to have language if people did not need to communicate. Lewis (cited in Chomsky 1986: 19), defines language as:

A pairing of sentences and meanings (the latter taken to be set-theoretic construction in terms of possible worlds) over an infinite range, where the language is “used by a population” when certain regularities “in action or belief” hold among the population with reference to the language sustained by an interest in communication.

It seems clear from Lewis’s statement that the main purpose of language is to communicate. As a communication tool, language functions as cultural glue for a community. This concept of cultural glue is going to be critical in our analysis.
of interview data that emphasises culturally-inflected readings of health messages. It seems that most of the literature I consulted on the uses of language is in concert that language’s critical is that of communication. But, communication of what? In my study, I privileged the fact that language communicates culture.

Everett (2013), who spent nearly three decades studying different languages and their contexts of use, has come up with what he regards as a comprehensive description of what language exists to serve: as a tool. In *Language: The Cultural Tool*, Everett regards language as a tool that was part discovered and part invented to serve a set of purposes in human life:

> Language is in the first instance a tool for thinking and communicating and, though it is based in the human psychology, it is usually shaped from human cultures. It is a cultural tool as well as a cognitive tool. There are many such tools, including the concept heroes, scientific theories, and the wheel. And yet it seems clear that language is arguably the most important of tools, it is part of discovery and part invention. Languages are the imperfect outputs of thinking of bipedal primate, refined gradually by the task they perform. Language is a cobbled-together set of answers to different facets of the problems of communication and cooperation among humans (Everett 2013: 20).

This particular passage suggests, firstly, that language is first and foremost a *communication* tool and, secondly, that it is a *cultural* invention. This definition is crucial to positioning this study, in that it helps me to reflect on whether it matters *at all* if health messages are translated. If language is firmly imbedded in the *cultural life* of a community, then translation cannot go without saying. It is no longer just a question of seeing language as informing people in a mechanical way. Rather, one needs to evaluate the social and cultural *contexts of use* which I believe impinge *inevitably* on the translation.
The move away from a mechanical regard of language is at the heart of Everett’s argument about the heavily cultural nature of language origin and language use. For instance, he argues that:

A given culture has discovered a solution and way of organizing its grammar. And this solution is passed down to subsequent generations and descendant languages of the original mother tongue… If languages varied little from one another except in their vocabularies, then the idea that languages emerged principally from a common biological source would be appealing. On the other hand, the idea that language is a tool shaped by culture and communication demands would make sense if diversity than similarity was the hallmark of human language. When we look across the vast array of the thousands of languages spoken throughout the globe, the diversity of human languages is astounding (Everett 2013: 84, 85).

The far more important matter of cultural context is of significant interest in this study, largely because it complicates reception of health messages. Because the study is about translated messages and how they are received in a Zulu cultural context, cultural differences make the translation process more difficult. As this study shows, the cultural context is perhaps the single largest factor behind untranslatability.

Everett’s culture-oriented definition of language has utility in nullifying the notions propagated by Chomsky that language is innate or biological. The Chomskian view – based on the notion that children know things about language that they could have not learnt and that languages share fundamental similarities, meaning that there is common core all humans are born with – falls short because, as much as there are similarities amongst languages, the differences are also inevitably vast:

If Homo sapiens were born with a language organ, then it might not be considered unreasonable to ask where this organ resided. Language, in every society requires years of experience and exposure to data for any child to reach adult levels of fluency.
These are hallmarks of learning not of genetic determinism (Everett 2013: 91).

By asserting that language was invented or discovered as opposed to evolving, Everett turns his back on – indeed denounces – the Darwinists’ evolutionist, mentalist and innatism conceptions of language. Whereas the evolutionists and the mentalists like to assert that language is part and parcel of the Darwinian arsenal, Everett sees it as changeable, cultural, contextual and transformative.

I find Everett’s claim that language is a *cultural tool* to be broadly supportable in the context of the findings of this study, particularly in relation to *untranslatability*. Everett’s preferred formula for summarising his concept of language is useful in setting the scene for discussing *untranslatability* in complex cultural contexts:

\[
\text{Cognition + culture + concept of language = language.}
\]

This means that each normal human being has a brain, belongs to a community with values, and needs to communicate, and confluence of these states results in language. Communication sets up a problem to be solved.

Everett asserts that languages came into existence because there were problems *to be solved* and humans had to cooperate and find ideas and solutions to the problems. Therefore, language was created to communicate ideas and solve problems. At core, language use is *creative* and complex:

Language is the complex interaction of cultures, lots of different types of cognition, the need to communicate, the nature of communication, grammar, human sound production, and so on. It is our most complex behaviour... Culture is the field in which the mind grows and creates – the field fenced in by shared ideas and values. Constrained by these ideas and values, members of the culture create the perimeters of their existence and their means of survival (Everett 2013: 16).
After assessing the evidence from both sides, I tend to side with Everett more than with the evolutionists. The main reason for this is that the evolutionary paradigm takes away agency and subjectivity from human beings. In a context of colonisation, which regarded African languages as “dialects” and as mere grunting and collections of clicks (cf. what Chinua Achebe says in “An Image of Africa” about Joseph Conrad’s Heart of Darkness), it is a no-brainer which view is more attractive. This is aside from the fact that I find Everett’s argument that language is a cultural tool – part of the cultural arsenal – more logical, humanising and convincing.

For Everett (2013: 36) language “derives from a complex set of emotions, behaviours, and thinking patterns”. That is, the communication of ideas and information is not the sole purpose of language. Rather, it is crucial in the thinking process. Hence:

Looking more closely at the thinking itself, and the myriad functions of human reasoning, it is immediately obvious that the most important tool at our disposal, besides our brains, is not a calculator, a book, or a computer, but language. Without language, most concepts would be ineffable and unthinkable. No math. No technology. No poetry. Minimal transmission of thoughts from one mind to another. And without language it would be impossible to sequence our thoughts well. To review them in our minds, to engage in contemplation (Everett 2013: 50).

In my study, I wanted to suss out how far this function is sustained in health messages that are translated. Whose ideas are being communicated? Whose problems are being solved? Are health messages creative or merely crudely pragmatic and “propagandistic”?

In this study I have put Everett’s notion of language as a cultural tool to work. For instance, we can consider its utility in the consideration of the concept of Ingculazi/za, the translation or neologism of AIDS in isiZulu. Ingculaza was coined by Nguni-speaking South Africans when the epidemic first announced
itself in the 1980s. People did not wait to be told what AIDS was, what it represented, or what it meant. Their own interactions with a disastrous new epidemic led them to exhibit linguistic agency, coining a word drawn from their everyday experiences. Translating AIDS would have not worked considering that AIDS is an acronym for Acquired Immune Deficiency Syndrome is combination of medical terms. Everett’s assertions about language as a cultural tool appear to support this process of using language to carry one’s experience:

At one level, all the meaning of every word is cultural, because the existence of a word in any language, from preposition to verb and nouns, is a cultural decision. The important thing is that if the information is important to the speakers of the language they will come up with a way of expressing it. Meaning can vary from language to language and different cultures can have symbols that embody different meanings not found as such in other cultures. Culture, cognition, and communication are the shaping forces of our language and, though all are necessary, none alone is sufficient to produce language. A primary building block would be the ability of humans to invent words. Without words, there is no language. (Everett 2013: 107).

The example of Ingculaza shows the ability of humans to “invent” words. Ingculaza does not directly translate to AIDS. Rather, in English, it would be loosely translated to “Isifo esibangwa yivayarasi/igciwane elithathelana ngoketshezi lwasemzimbeni, lapho kuba khona ukufa kwamasotsha omzimba okukhulu, okushiya umuntu onegciwane elula noma entekenteke ukuthi angenwe yizifo ezahlukene”. It would take 24 words to translate and acronym of four words!

At least, this 24-word IsiZulu translation is one of the possible translations that could be used if a direct translation of AIDS were to happen. The context of Ingculaza, in my view, supports the view that language was consciously created by humans. Hence:

There can be no culture without language, no language without culture, and no society without both. Language is the tool by
which we created our social world. But as we use a tool, we modify it and shape it to serve us more effectively. Language has been shaped in its very foundation by our socio-cultural needs. Languages are cultural tools, developed through a combination of invention and building (Everett 2013: 139).

Indeed, the example of Ingculaza shows that people affected by AIDS are not just faltering, diseased bodies. Rather, they are thinking beings. As Ulbaek (1998: 33) notes:

Language grew out of cognitive systems already in existence and working: it formed a communicative bridge between already-cognitive animals. Thus, I not only reject the seemingly natural assumption that language evolved out of other communication systems, but I adopt the far more radical assumption that cognitive systems were in place before language.

Basically, I would say that the invention of Ingculaza is proof of a cognitive system at work, rather than one waiting for imported words to carry a local experience. In this regard, translation needs to reckon with such cognitive systems. In concert with Ulbaek and Everett I would say that there is utility in putting cognition first. This is because emphasising the rationality of those living with a disease, for instance, forces those who create health messages to respect those they target with those messages. A selection of health messages dealt with in this study reflects a need to factor in a clear consideration that those that are targeted by communication messages are also rational beings.

The language question in South Africa
The use of language is complicated by the fact that some languages seem to be de facto lingua francas, preferred and used more than others. An example, which is central to this study, is English. English is seen as a privileged language of international communication (cf. Beukes 2009: 40). Accompanying the privileged status of English is the generalised notion that the grammar code of Standard English (SE) and, implicitly, native English pragmatic behaviours, are shared norms in intercultural transactions around the world. But what about
people who may speak the language and still not be fully acquainted with the norms and values of that language community?

In a treatise on problems in the immigration domain, Guido (2008: 21) questions the taken-for-granted lingua franca status of English. I shall quote at length:

It is a truth universally acknowledged that English is today’s global “lingua franca” for international communication. Statements like this are typical of historical periods and societies when the dominant ethnocentric beliefs of a ruling class with economic and political power determine what is true and can be taken for granted and what is not. Taken for granted, for instance, is the idea that the grammar code of standard English – and implicitly, also native-English pragmatic behaviours – are shared norms in intercultural transactions across the world ranging from the domains of economics and politics, to the fields of law, environment, social sciences and so on, until it encompasses every domain wherein Western culture exerts its influence over other non-Western civilizations.... Such unconditional recognition of the privileged status of the English language in the world does not in fact acknowledge the communicative needs of other non-native and crucially non-Western speakers of English. This lack of acknowledgement of other pragmatic modes of communication may have serious socio-political and personal consequences, particularly when domains of cross-cultural specialised communicated related to immigration are involved.

Although I would not go as far as saying that there is an “unconditional recognition of the privileged status of the English language”, I am persuaded by Guido’s assertion that the pervasive lack of acknowledgement of other pragmatic modes of communication in English-dominated contexts may have serious socio-political and personal consequences on what he calls non-Western civilizations.

Guido’s research, of course, focused specifically on problems in the immigration domain. However, what he evaluates in the passage above is also generalisable in other domains that include health communication. At least, my contention in this study would be that the question of lack of recognition of other
pragmatic modes of communication is also visible at the cultural level in respect of the work of translating or consuming translated health communication messages. Translation, for instance, is one other specialised domain that is also affected by the privileged status of English especially in societies where the majority population does not speak English or is not fully acquainted with the norms and values of that language.

As argued in Chapter One, the language question in South Africa is a complex and complicated one, historically, politically, and in practical terms. What concerns me in this study, specifically, is the reality that English has retained its “hegemony of use” by national government for official government-to-citizen communication purposes. As already noted, this is despite the Constitution of the Republic South Africa (Act No. 108 of 1996) formally granting equal status to all eleven languages. It appears that the meaning of “equal status” is meaningless in practice. Act No. 12 of 2012: Use of Official Languages Act further legislates the regulation and monitoring of the use of official languages for government purposes by national government, promotion of parity of esteem and equitable treatment of official languages of the Republic, facilitation of equitable access to services and information of national government, and the promotion of good language management by national government for efficient public service administration and to meet the needs of the public the language rights.

However, inertia and a seeming complicit preference for “convenience” has hindered any progress in mainstreaming languages such as IsiZulu, IsiXhosa, Sepedi or Tshivenda in government communications. In the words of Alexander (2004: 118), English is treated by most South Africans as the first among the equals. As already noted, English not only remains the only language spoken across all ethnic groups in South Africa but, globally, has “consolidated its position at the expense of the other languages” (Mesthrie 2006: 153). If we ask the question in the form that Humpty Dumpty put it, about which is to be master,
then it is clear that English remains the master language for South Africans with any investment or interest in official communication.

Bamgbose (1991) (cited in Phillipson 1996: 161-162) argues that language policies in African countries are characterised by one or more of the following five problems: avoidance, vagueness, arbitrariness, fluctuation and declaration without implementation. South Africa is a case in point. South Africa does not lack a language policy: its policy is clear and robust. Indeed, Batchelor (2014: 255) identifies South Africa as a “notable exception” stating that “language and educational policies favour the development of corpora of literature and other texts in all eleven languages”. South Africa also has unambiguous, enabling constitutional provisions where the language question is concerned. To my mind the problem lies elsewhere: in walking the talk. This is what Bamgbose (1991) has called the problem of *declaration without implementation*.

It appears that South Africa is following the same route as many post-colonial African states that entrench colonial languages either by wilful neglect and inertia or by pretending that European languages are convenient and provide for global competitiveness. As Alexander (2004: 122) has argued:

> With a few notable but nonetheless patchy exceptions in Tanzania, Somalia, Ethiopia and Eritrea, most of the countries south or east of the Sahara have promoted and entrenched a neo-colonial policy in which English, French and Portuguese continue to dominate the commanding of heights.

The *entrenchment* of English in South Africa is, again, a case in point. As noted in Chapter 1, the genealogy of the English language in the country (and on the African continent in general) can be traced to colonisation and the British imperial project (wa Thiong’o 1986). Basically, the language was and remains more or less an imposition, the language of the “master”, not a choice.
Still, some Africans – particularly from within the upwardly mobile, educated classes – have historically tended to believe that English is indeed an elevated language. In the words of cultural theorist Masilela (2013), English was seen by “new African” intellectuals in South Africa as “a fundamental facilitator into the entryway into modernity”. This is exemplified in the quote by Gwayi Tyamzashe, a Xhosa intellectual writing in 1884 who – as we have seen – said that “Of all modern languages, English is the noblest, fullest, deepest and most comprehensive. We natives of this country receive with thanks every inducement to learn that language”. For Tyamzashe, English was “the language of the Arts and Sciences, the language of Law and Politics. It is the channel to all the benefits of civilisation” (Masilela 2013: 12).

But it was not just an admiration of English as “the noblest, fullest, deepest and most comprehensive” that motivated the “New Africans”. English was also seen as, inevitably, a practical choice. Hence Tyamzashe, who was the founder of the Native Society at Kimberley, a part of the influential Native Educational Association, hoped to “unite the different native tribes of this country by the English language and manners” because “we don’t understand each other in our various native languages, and…we differ in many respects from each other in our manner and habits of living”. English thus provided a meeting place. As Tyamzashe would eloquently put it, “let us meet each other somewhere, and try to understand each other through the medium of the English language” (Masilela 2013: 12). Basically, he is arguing that there is something appealing about European languages from a practical point of view.

As noted, even some within the leading Afrikaner elite – at least before the upsurge in Boer nationalism in the lead up to the Anglo-Boer war – saw English as a superior language to Afrikaans. For instance, as late as 1876, chief justice Sir Henry de Villiers was in favour of Afrikaners appropriating English. De Villiers not only predicted that English would become “the language of South Africa”, but described it as “that rich and glorious language” (Meredith 2007: 38).
Although Afrikaners eventually turned their backs on English at the height of apartheid, it could be said that the ultra-nationalistic fervour in favour of Afrikaans in the 20th century functions as an acknowledgement of how dominant English was. That is, Afrikaans also wanted its proverbial place in the sun (cf. Giliomee 2003). Like Tyamzashe, de Villiers regarded English as convenient, practical and a meeting place, compared to Afrikaans which he regarded as “poor in the number of its words, weak in its inflections, wanting in accuracy of meaning and incapable of expressing ideas connected with the higher spheres of thought”. To this day, English has continued to easily dominate other South African languages in terms of value and credibility as a lingua franca.

Predictably, the majority of South Africans are officially communicated to in English, or in translation. This study, as we have noted, focuses on official communication to South Africans in the second instance: via translation. I have observed that official communication and messages are typically conceived in English and then translated into indigenous or first languages. That is, English is the de facto lingua franca of the state, despite the fact that the majority of citizens (‘clients’ of the state) are unable to access information through this language (cf. Wallmach and Mesthrie 2006: 153). What has motivated this thesis is the fact that nothing or very little is being done to address or change the situation. As Bamgbose (cited in Phillipson 1996: 161-162) says, “There is a general feeling that language problems are not urgent and hence solutions to them can wait”. Alexander (2002) (cited in Wallmach 2006) has gone as far as saying that language planning in South Africa today is surrealistic: there is tension between what the governing elites are obliged to do constitutionally and what they prefer to do based on their interests and convenience of inertia.

It is my considered view that the problem of walking the talk, or what Bamgbose has called declaration without implementation, explains much of the continued practice of translating communication to citizens, where such translations are normally from English, and conceived in English. This state of affairs where the
government is dependent on translation in order to communicate officially with its citizens is what this study, in Chapter 5 and 6, has called communication-by-translation, translated communication, or translation-for-communication. Were it not for translation from English, it is arguable that the government would not know how to communicate with most of its citizens. As we will have opportunity to see, this default translated communication is a clear characteristic of health communication from the South African health department, for instance.

The problem of walking the talk, or what Bamgbose has called declaration without implementation has interested scholars of language policy and planning. For instance, McKinney and Soudien (2007) (cited in Dimitriu, 2009: 181) have decried that:

> From the vantage point of 2007, we know that language policy has (had) disappointing little impact in practice. Rather, as is the case elsewhere in post-colonial Africa, the power and status of English is growing, witnessed in its widespread use in high status domains of politics, the media and education... The poor implementation of the language policy has, over the last decade, become a new kind of truism: ‘it has become passé to point out the huge gap between government policy that promotes additive bilingualism and practice in schools where English has become increasingly hegemonic in the post-apartheid era.

Although McKinney’s and Soudien’s research is slightly dated, there is little indication that this situation has changed a decade later. Government has uniformly failed to apply this policy in most of its departments. The default reliance on translation to communicate with the majority of the citizenry continues apace. Indeed, one does not see how, or at what point, it can be arrested. What is worrisome from a language rights, cultural rights, constitutional rights, human rights and social justice perspective is that, 25 years after democracy, the same marginalised and voiceless citizens whose languages were deliberately underdeveloped by successive minority governments during apartheid have nothing better than translation under a
majority black government. The underdevelopment and undervaluing of African language persist.

Basically, English’s dominance as a source or relay language has not only resulted in the underdevelopment of African languages, but also led to a fully developed official translation culture. That is, translation has become a key element in the South African Government’s communication with its citizens (cf. Lubinga and Jansen 2008). As argued in Chapter 1, the obligation to “communicate effectively” implies, for the Department of Health, using the de facto lingua franca – English – and translating it into first languages. Any other practice amounts to ineffective communication, an assertion that echoes Tyamzashe and de Villiers earlier.

The translation of health communication messages from English into African languages has become a common, accepted and axiomatic practice in South African public health communication (Lubinga and Jansen 2008: 72). A case in point is Soul City’s production of radio series in nine languages and printing of booklets based on the television drama in eleven languages: everything had to be translated from English. In the Khomanani Campaign on HIV, STI, AIDS and TB (2001-2004) (2007-2009), for instance, print materials produced by the South African National Department of Health in different first languages were by and large all translations (Lubinga and Jansen 2011: 467). Translation thus seems to be the best go-to option if government - and non-governmental organisations and the private sector – are to communicate effectively with all citizens across the 11 official languages.

The phenomenon of dependence on translation is yet to be systematically studied. Those few studies (cf. Kruger 2009) that have been done demonstrate that it is a quite complex issue; although the data collected and analysed in this study shows that the government has a pretty rigid and simplistic view of
translation. Kruger (2009: 171, 174) has asserted the following regarding the South African translation scene:

Due to the multicultural and multilingual nature of the South African society, the majority of readers in South Africa are, to some degree caught up in the cultural and linguistic multiplicity… Translations may therefore be regarded as hybrids, as complex, polyphonic blends of the domestic and the foreign, of the familiar and the strange, of otherness and selfness, created by the multiple writers and readers involved in the continual reshaping of the translation as discourse among other discourses.

Basically, the translation is a complex text that cannot simply be regarded as a matter of convenience (one-size-fits-all) based on a 1-to-1 correspondence of words in source and target languages: the so-called principle of equivalence (cf. Sakai 2006; Frank 2008; Bell 1991). It also cannot be a matter of responsible officials ticking boxes.

The linguistic multiplicity and hybridity that Kruger speaks of is further complicated by the fact that in South Africa translators are typically versed in both source and target languages but one of these is known as a second language and in some instances as a third language. Furthermore, South Africa not only has its own so-called South African English, but within that broad category there are multiple varieties of English. For instance, most racial groups (White-English, Afrikaner, Indian, Coloured, Black, etc.) speak differently-accented kinds of Engli...
translation faces what Ndhlovu (2014) has called “term-creation” difficulties. Ndhlovu (2014: 327, 328), in a wide-ranging discussion of “term-creation strategies” used by Ndebele translators in the Zimbabwean health sector, has asserted that:

It is a well-known fact that many African languages encounter problems of term scarcity, especially in technical and scientific arenas. Guaton, Taljard and de Schreyer (2003: 81) explain that the single biggest problem that translators who translate into African languages have to contend with is a lack of terminology in the majority of specialist subject fields.

Term scarcity and term creation already highlight potential problems with translatability. In addition to the problem of term paucity, most translators who translate from the lingua franca may not be skilled enough to adopt suitable translation strategies that will convey the messages effectively, efficiently, sensibly and sensitively.

As I found in this study, many translators who translate into African languages in South Africa are not native speakers of the languages they translate into. This becomes a problem when one considers that a translator should ideally be fluent in both the source and the target language. But even this linguistic fluency may not be enough: one also needs a kind of “cultural fluency” – a deeper knowledge of the culture of the target language. We will see this demonstrated in the case of Umabhebeza and Inoni in Chapter Five. The issue of non-mother tongue speakers of English becomes even more central in the context of translation. Dimitriu (2009: 187) states that “an interesting fact related to the ideal direction for translation is that an increasing number of translations are done by non-mother tongue speakers of English. This implies there is a need to improve English as a second language”.

In South Africa, where most people are non-mother tongue speakers of English, the existence of a default translation culture raises complex problems. The
issue of translations being done, as a matter of course, by non-mother tongue speakers applies to English and to other languages as well. For instance, in my work in the translation of school textbook manuscripts, I have observed some translations of English-to-Zulu translations are being done by isiSwati speakers for MacMillan on behalf of the Department of Education. Basically, *no one can be a mother tongue speaker of two languages*, although one can be “fluent” in more than one culture. No matter how eloquent and fluent one can be in two or more languages, only one language can be a mother tongue; the others will remain second languages. In the context of the methodology of this study, it compels us to assess one’s command of both SL and TL. What I observed in the course of this study is that the tendency of most local translators is to assume, normatively, the principle of *equivalence* (see next section) between the source language and the target language. This principle is the one that brings up the most controversy in relation to *untranslatability* and to cultural contexts.

If, as wa Thiong’o (1986) argues, that “language is a pillar of, and produces, culture”, then it follows, somewhat, that language is inherently *meaningful* to its users. This aspect has a latent relation to the growing problem of non-mother tongue translators cited above. Samuel (2007: 376) has argued that:

> The fact that each language conditions the way in which its speaker perceives and interprets reality presupposes that there will be terms which are specific to each linguistic community. It also implies that each linguistic community structures reality in a different way according to its own linguistic.

Basically, the *nexus* of language and culture appears to be one of the most important, but is not *the* most important, in the South African translation space. This was bound to happen considering the government’s default dependence on translation in its official communications with its citizens. If nuance is not brought into this space, the “crime scene” of translation not only remains but is *expanded*. 

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Translation by non-mother tongue speakers can only worsen the situation when one takes into account the interrelationship of culture and language. As with wa Thiong’o, di Almeida (1981: 24) (cited in Bandia 2008) has emphasised that:

Indeed, culture and language are closely interrelated, because languages do not operate in isolation but within and as part of culture, and cultures differ from each other in different ways. It is through language that culture is expressed, and on the other hand, a culture nourishes the language that carries it.

This means that the specificity of cultures and cultural contexts requires translators to be fluent both in the target language and the culture of the target language.

Nord (1997: 34) has argued that “A culture-specific phenomenon is thus one that is found to exist in a particular form or function in only one of the two cultures being compared”. Unfortunately, we have no adequate theory of “cultural fluency” that can accompany being fluent in the target language. Although in South African townships one can observe more or less homogenous township or kasi cultures, this is harder in rural areas. Rural areas are dispersed and fragmented, and tend to be culturally isolated and conservative. Needless to say, this study was carried out in the context of more or less remote, rural areas. The scope for generalisation was not big.

If we accept that language and culture are intertwined, the complexities of translation and untranslatability emerge precisely because it is not just words that must be translated but, rather, also the ideas, worldviews, cultural mores and moral values that the words convey. In Spivak’s (1992) words, “a language, before translation, is (only) one of many elements that allow people to make sense of things and of themselves”. As such, being “fluent” in the cultural context may involve an intimate knowledge of given “communicative situations”. Nord (1992: 7) states that:
Both the source and target texts are culture-bound linguistic signs that are determined by the communicative situation in which they are supposed to transfer meaning. Translation is thus closely linked with language and culture, given that language not only has semantic value, but also culture-bound meaning.

We can say with some certainty that problems of meaning are bound to occur when a first language is translated into English and vice versa. The question itself of how readers or consumers of these messages experience and encounter translations in everyday settings has not been systematically examined. In part, the current study intended to tackle this aspect of the problem. The question that arises is: Can a lived culture be readily translated into another language? The answers are obviously as will be depicted in Chapter Five.

Considering the linguistic and cultural differences between indigenous languages and cultures and the dominant English language and culture, it is apparent that translation inevitably invites complex challenges. Basically, chances of lived culture being translated are highly unlikely. Malinowski (1935) (in Nye, 1998: 256) has said that: “Translation in the correct sense must refer therefore not merely to different linguistic uses but often to the different cultural realities behind the words”. The concept of “behind the words” suggests that translation is more than meets the eye. The aspects that lie “behind the words” are also the same ones that are likely to cause untranslatability. As Malinowski (1935) says:

> When two cultures differ as deeply as that of the Trobrianders, and the English; when beliefs, scientific views, social organisation, morality and material outfit are completely different, most of the words in one language cannot be even remotely paralleled in the other (emphasis added).

For Malinowski, the gap between the Trobrianders and the English is unbridgeable. At least, it cannot be bridged by translation. The seeming
impossibility of translating culture is behind the notion *untranslatability*. This is the case with terms such as *ukusoma* and *Ingculaza*. These terms are not just words that can be substituted for others. Rather, they constitute lived cultural and health practice as well as existential states of disease and healing. In other words, the words and the practices *behind the words* resist simple substitution and transfer. Jones and Norton (2007: 5) have argued that “In the African contexts in which ex-colonial languages are often official languages [lingua franca], the development of health literacy is seen to be a particular challenge particularly with reference to sexual health literacy”.

We noted in Chapter 1 that the world’s reportedly most difficult word to translate is *ilunga* from DR Congo. In English, *ilunga* seemingly means “a person who is ready to forgive any abuse for the first time, to tolerate it a second time, but never a third time”. But is that what it really means? What is its context of use? If 1 000 linguists found it to be the hardest word in the world to translate, it seems rather clear that *ilunga* precisely resists transfer and substitution. The linguists, however, still insist that such a word is the hardest to translate – and not that it is *untranslatable*. The 24-word substitution for *ilunga* shows the rigid insistence by the 1 000 linguists that most words in most languages ought somehow to be inherently and technically translatable and transferable into another language.

If we defer to Malinowski, this is neither a reasonable, logical, nor practical attitude to take. Drescher (2010: 201), writing about Burkina Faso (a country with 60 different local languages), argues that a term such as “faithfulness” is lost in translation: “Faithfulness is one of the key concepts of HIV/AIDS education, which has no direct equivalent in traditionally polygamous societies”. In Malinowski’s view, therefore, “every language has words which are not translatable, because they fit into its culture and into that culture only, into the physical calling, the institutions, the material apparatus and manners and values of a people”. For this reason, I found it imperative for this study to
investigate and look at the effects of this translatability and untranslatability in the translation of health communication messages in South Africa with special focus on KZN.

Baker (1996: 81) defines *simplification* as involving “making things easier for the reader (but not necessarily more explicit), but it does tend to involve also selecting and interpretation and blocking other interpretations, and in this sense, it raises the level of explicitness by resolving ambiguity”. Is ambiguity simply contained in words and text? What about going *behind the words* as Malinowski encouraged? How does one resolve the ambiguity *behind words*? Ndlovu (2006), in a discussion of the “limits of simplification” in translated isiZulu health texts”, shows that while *simplification* is a universal practice of “simplifying the language used in translation”, the practice has shortcomings:

In their efforts to simplify health texts for their target readers, Zulu translators may produce texts that are difficult for some readers to understand… Translators employ simplification strategies to simplify problematic medical terms or expressions. These terms and expressions and other linguistic units have no equivalents in the target language. Because of this absence of equivalents, new problems arise where translations of health texts are attempted (Ndlovu 2006: 121, 122).

Some of the simplification process and strategies that Ndlovu looks at have been utilised in my own study in an attempt to understand the untranslatability and translatability of English to Zulu health messages. It appears that simplification raises as many problems as it solves. In the case of Burkina Faso, “the transfer of complex biomedical knowledge may be hindered or even threatened” (Drescher 2010: 201).

Translation and translation studies: Setting the scene
Snell-Hornby (2006) has asserted that the practice of *translating* is as old as the human language, an assertion that, if true, makes us realise that the academic approach to translation can hardly account for *all* that is involved in
translation. On the other hand, translation studies as a formal discipline is actually quite new, dating back to Holmes' 1988 essay entitled “The name and the nature of translation studies”. Because the practice of translation, whether formal or informal, has been around for millennia, the theory of translation has to play catch up. For instance, translation is difficult to define in a standard, universally accepted way: there is as yet no absolute, quintessential, or universally agreed definition of translation, whether such a standard definition is desirable, what the end-product of translation should be, or what constitutes the “perfect” translation. There is a wide gulf of opinion which is proving difficult to shift, and which ultimately needs to be acknowledged and respected. For instance, there is no agreement or clarity as to whether translation refers to the process or the end-product of the process (the finished, translated text). Some prefer the functionalist perspective, while others are wary of going beyond the equivalence perspective. Translation means different things to different people, and the expectations that a translation must satisfy are diverse too.

Translation is the expression, in another language (or target language), of what has been expressed in another, source language, preserving semantic and stylistic equivalence (Bell, 1991: 5). In other words, translation refers to new communication in a language different from the original communication. But, as we shall see, this normative definition represents a mere scratching of the surface. Baker and Saldanha (2008: xiv) contend that:

Translation studies is at a stage of its development when the plurality of approaches that inform it or are capable of informing it can be overwhelming, and the temptation for many has been to promote one approach with which they feel particularly comfortable and dismiss the rest.

For us to cut to the bone of the issue, we must dive deep into the definitional issues as well as foreground the different theoretical approaches. In this section, I shall evaluate three received definitions of translation and assess them in the context of this study. These three are by Bell (1991), Frank (2008)
and Sakai (2006). As will be seen, these definitions share significant similarities and differences.

The first definition we shall look at, by Bell (1991: 5, 6), regards translation as follows:

Translation is the expression in another language (or target language) of what has been expressed in another, source language, preserving semantic and stylistic equivalence. Translation is the replacement of a representation of a text in one language by a representation of an equivalent text in a second language (emphasis added).

Bell's definition regards translation as helping to preserve some of the original quality – semantic and stylistic – of the source text. We will call this the preservation principle; which Bell links the notion of equivalence. Interestingly, Bell uses the word replacement (as well as representation) in relation to equivalence, which seems to be a contradiction or, at least, increases the opacity of his definition. If something is being replaced, how is it equivalent? Bell believes that texts in different languages can be equivalent in different degrees (fully or partially equivalent) in respect of different levels of presentation, context, semantics, grammar, lexis, and at different ranks in terms of word-for-word, phrase-for-phrase and sentence-for-sentence.

The second definition we shall utilise is by Frank (2008: 6), who regards translation as:

A text derived from another text in another language, exhibiting qualities of equivalence to that source text, such that the derived text can be taken as a substitute for the original text. It is words arranged in sentences, and sentences arranged in larger structures, in non-arbitrary way according to the conventions of language, with the purpose of communicating something in particular (emphasis added).
Frank’s definition emphasises the *derivative* and *surrogate* nature of the translation: the translation is never the thing itself, even though some people may assume it is. Secondly, it emphasises the principle of *equivalence*, and finally, the critical issue of *communication* that we evaluated earlier in light of Everett’s views on the origin and purpose of language.

The third and final definition of translation is by Sakai (2006: 71, 72) who defines translation as:

> An *act of articulation* that takes place in the *social topos* of difference or *incommensurability*. The *topos of difference*, to which translation is a response, is anterior to the conceptual difference of species or *particularities*. Yet, translation is often represented as a process of *establishing equivalence according to the model of communication*. The misapprehension of translation derives from the confusion of the act of translation with its *representation*... The network of lexicographical connotations associated with the term translation leads to notions of *transferring*, *conveying* or *moving from* one place to another, or of *linking* one word, phrase, or text to another (emphasis added).

For Sakai, translation is a response – a response to what he calls a *topos of difference*. Basically, translation is *transitive*: a living, open, process of acting and being. Translation always inscribes itself in the *social topos* of *incommensurability* and difference.

Venuti (2000: 482) would seem to agree, in saying “The domestic inscription in the translation extends the appeal of the foreign text to a mass audience in another culture. But widening the domestic range of that appeal means the inscription cannot include much of the foreign context”. Further, argues Sakai, for translation to be understood, the ways in which it has been understood and practiced in modern societies needs to be historicised. Sakai believes that the conventional concept of translation as a process of homogenisation and of establishing *equivalence* is the most problematic and the most unsustainable. Translation articulates one text to another, it is true, but this does not mean that
translation merely establishes *equivalence* between two texts, two languages, or two groups of people. One must look for the salience of equivalence elsewhere.

All three definitions share a similarity in that they all normatively assume that for translation to happen there must be an expression or *transfer* of text from one language to another. The translation functions more or less as the replacement of *source text* by *target text*, with the latter expected to be an *equivalent* of the source text. However, there are also salient differences. For instance, Bell’s and Frank’s definitions look at translation singularly in terms of a *replacement* which *retains* both semantic and stylistic equivalence (what I am calling the principle of preservation).

Frank’s definition, in fact, also adds the need and the intention to communicate as a criterion, further asserted when he illustrates that:

> A speech actor, which in this case is a translator, constructs this text with a purpose. The translator is referencing another text and aiming to produce something perceived to be equivalent to the original text in some significant way. The translator perceives that an original author intended to *communicate* something to an original audience, and the translator aims to reproduce something from that original communication in a new context and with a new audience that was not reached by the original, source text (Frank, 2008: 6).

Sakai, however, is not only unsure about the status of equivalence in translation but also seeks to free translation from the metaphysics of communication. Furthermore, Sakai brings into the debate the salient issue of culture and cultural difference.

This last aspect brings Sakai closer to Everett (and Malinowski) in terms of foregrounding the role of culture in mediating translation. His articulation of the notions of *transitivity* and *incommensurability* proved valuable in how I
approached the questions of *translation* and *untranslatability*. Of the three definitions, Sakai’s appeals to me more as its frame of explanation is closest to the belief at the centre of this study that culture has a critical say in translation. That said, all three definitions, read together, provide a complex definition of translation that this study appreciates and consistently draws on.

Essentially, the justification for adopting a set of different definitions emerges from the fact that translation is necessarily acknowledged to be complex: it cannot be adequately covered or approached using one definition or theory. Venuti (2000: 5) has argued that the “changing importance of a particular theoretical concept, whether autonomy, equivalence or function, may be determined by various factors; linguistic and literary, cultural and social”. As a very contingent phenomenon, one that is determined transitively and discursively, translation is perhaps best read from the point of view of corpora of approaches and definitions.

As Frank (2008: 1) points out, “it is possible to have different co-existing theories each directed toward the same object of study, but each with a different approach and focus”. Indeed, in trying to answer the question “What kind of theory do we need for translation?” Frank asserts that a theory can be explained:

As a lens with which we can view something. It is a way of viewing what seems to be a coherent field of data calling for explanation. But because of our limited human perspective, our theories, like a lens, are only able to focus on certain parts of the object of study; and leave other parts out of focus. A theory might help one see some things clearly; and see other things fuzzily or not at all (Frank 2008: 1).

Tymoczko (2014: 20) has warned of the peril in “fixating on a specific definition of translation theory”, arguing that “rigid definitions may actually lead to closure on the question of what translations are, resulting in narrowing of research and exclusion of cultural products that are different from those dominant in Western
or globalized culture”. If Tymoczko is right, then various definitions and approaches will be necessary to undergird this study. It seems, also, that we should take Albert Einstein’s (cited in Frank (2008: 1) cogent suggestion: “Whether you can observe a thing or not depends on the theory which you use. It is the theory which decides what can be observed”.

‘Translation Studies’ emerges as part of the so-called pragmatic turn of the 1980s (Hornby, 2006: 47). In the words of Munday (2012: 27):

Translation was formerly studied as a language-learning methodology or as a part of comparative literature, translation workshops, and contrastive linguistics courses. This discipline as we know it owes much to the work of James S. Holmes, who proposed both a name and structure for the field.

But, if it was the pragmatic turn that made the emergence of Translation Studies as an independent discipline possible, it was what later became known as the cultural turn” of the 1980s that largely established its basic profile. The “cultural turn” is a name later given to a development that several of the various camps of the now generally (if grudgingly) accepted band of translation scholars like to claim as their own (Hornby, 2006: 47). The cultural turn established translation as more than just an inter-linguistic process. That is, it was much more complex than just replacing source language text with target language text. Rather, it must incorporate cultural non-imponderables and nuances that can shape the options and attitudes of recipients. In a word, translations are never produced in a cultural or political vacuum and cannot be isolated from the context in which the texts are embedded.

It is necessary, as Sakai (2006: 71) argues, to “historicise the particular ways in which translation has been understood and practised in modern societies” because of the “conceptual complexity of the term ‘translation’ and the difficulty in any attempt to define it”. Basically, translation has not been immune to paradigmatic movements in scholarship and in society in general. It has, rather, moved with the times and adapted itself. As Steigelbauer, Tirban and Banciu
(2012: 166) state, “the meaning and the means of communication have changed dramatically, and translators have found themselves moving in a new direction, adapting their goals and professional vision to reflect the coming of age of a new global community”.

The major debates that have animated translation studies are themselves relatively simply framed as the question of the translation’s “loyalty” to source text or fidelity to the spirit of the letter. Some theorists argue for the target text’s loyalty to the source text/original text, while others are propagators of the autonomy of the target text or translated text. As Venuti (2000: 5) has put it, “The history of translation theory can in fact be imagined as a set of changing relationships between the relative autonomy of the translated text or the translation actions, and two other concepts: equivalence, and function”. One can thus divide translation approaches into the traditional and functionalist.

Traditional translation theory argues for equivalence in meaning between the source and the translation. Hence “translating consists in producing in receptor language the closest natural equivalent to the message of the source language first in meaning and secondly in style” (Houbert 1998). The propagators of fidelity have always fought for prolonging the life of the source text as opposed to meaning-for-meaning translation. They also asserted that a translation should resemble the source text both in terms of structure (or form) and syntax, preferring that a translation should be accurate and reproduce the form of the original. Basically, traditional translation theory is married to the idea that a translation is a continuation of the life of the original in another language. Venuti (2000) has stated that equivalence has been understood “as accuracy, adequacy, correctness, correspondence, fidelity or identity; it is a variable notion of how the translation is connected to foreign text”. What this means is that the translated text should be identical to the original text in all aspects including linguistics, form, structure and meaning.
The attainability of *equivalence* is in question, considering that no two languages can have the same structure, irrespective of how closely related they are. Gasset (1937) (cited in Venuti 2000: 51), has asserted that, in fact, each language has its own linguistic style, a kind of “internal form” that distinguishes it from all the others. It is hard to believe that two words belonging to different languages, and which the dictionary gives us as translations of each other, refer to exactly the same objects. Since languages are formed in different landscapes, through different experiences, the incongruity is natural. Critics of equivalence argue that no translation can be an equivalent reproduction of the original text. Something must give in a translation: one or other aspect needs to *give in* for something to be achieved. The way I see it as that for *equivalence* to be achieved, other things will need to be *equal: ceteris paribus*. In reality, other things are never equal. Language and culture are very variable.

The functionalist approach to translation, on the other hand, emanating from Skopos theory (cf. Nye 1998; Venuti 2000), argues that the function of the translation should determine the strategies that will be employed during the translation process. It is much more lenient to “necessary changes” being made during the translation process in order to achieve the intended purpose. In the words of Nye (1998: 256) “Translation in the correct sense must refer therefore not merely to different uses but often to the different cultural realities behind the words”. The functionalist perspective presumes that any translation is complicated by the fact that it should serve a certain purpose. For instance, theorists such as Vermeer (1986) and Nord (1997) are of the opinion that a translation is only proper or successful when it serves the purpose or function it was intended for. Vermeer, in particular, sees translation as an action which has an aim or purpose which leads to a target text, the goal and the mode in which the action (translation methods and strategies) being determined by a *commission* set by the client or by the translator. Vermeer suggests that although the translator may have his own interpretation of the text, he or she is restricted by the nature of this commission. Hence, argue Vermeer and Nord, a
translation does not necessarily have to resemble the original text as long as it serves the intended purpose.

Amongst the functionalists, it does seem that equivalence is a kind of dirty word. At least, there is resistance to the idea that the original and the target text are in any way equivalent. Translation says Gasset (cited in Venuti 2000: 61), for instance, “is not a duplicate of the original text; it is not – it should not try to be”. Rather, as Nye (1998: 254) has argued, “Translation must always be the recreation of original into something profoundly different”. It is never a substitution of word for word but, invariably, “the translation of the whole context”. Nida (1964: 126) argues that, since no two languages are identical, “either in the meanings given to corresponding symbols or in the ways in which such symbols are arranged in phrases and sentences, it stands to reason that there can be no absolute correspondence between languages”. Bassnett (2014: 3) in concert argues: “No two languages share the same structures, syntax and vocabulary, so adjustments always have to be made to accommodate the black holes that yawn when there is no equivalent in the target language for a word or an idea expressed in the source text”. Basically, there can be no fully exact translations. While it may be granted that the total impact of a translation may be reasonably close to the original, there cannot be identity in detail.

In the context of this study, it is difficult not to agree with the functionalists since I deal with translations of text from ex-colonial European or Western languages into African languages. The “mastery” of English over, say, isiZulu, is one that needs to be decolonised. In this regard, the functionalist approach marks a useful entry point. Certainly, what became clear in writing this literature review is that there is a paucity of work written on translation involving translation from an African language into European or western language. Batchelor (2014: 253) argues that, despite the success of post-colonial literature originally written in English British and American publishers “have proved generally reluctant to
publish translations that display anything other than straightforward fluency”. Indeed, translation has been “the instrument for inscribing the European text in African languages, but the written languages of Africa have rarely been translated in return” (Ricard, 2011: 377).

The approach that prefers a more context-oriented reading of the act of translation seems more Africa-friendly if one considers the hegemony of orthodox Western approaches. Bandia (2008: 1) has stated that “European languages, a part of the colonial legacy in Africa, have had an enormous impact on modes of communication, competing with, and sometimes displacing indigenous languages in matters of literacy and intercultural communication”. Indeed:

The theorizing of African translation practice is still quite undeveloped, probably due to the fact a comprehensive history of translation in Africa is yet to be written. Most theoretical, pragmatic and descriptive statements on translation in Africa have been informed by models and approaches from other postcolonial situations (Bandia, 2012: 357).

The field of African translation studies still does not receive the attention it deserves. Batchelor (2014: 256) has contended that:

The argument for greater openness to other theoretical paradigms when analysing translation in the African context has relevance beyond the analysis of literary texts; and serves as an important reminder of the growing body of research that is driven by considerations other than Africa’s relationship with the West or in other words by interests that lie outside traditional postcolonial paradigms.

There has, in this regard, been consistent critical thought on the role of indigenous languages, particularly in decolonising projects targeted at the dominance of colonial languages such as English, French and Portuguese. Wa Thiong’o (1986: 5) has observed that:
Berlin in 1884 saw the division of Africa into the different languages of the European powers. African countries, as colonies and even today as neo-colonies, came to be defined and to define themselves in terms of the languages of Europe: English speaking, French speaking or Portuguese-speaking African countries.

A thread of sentiment running through the heart of this study is that the often English-centric, western bias of translation studies has resultantly not done the African translation studies project any favours.

Orthodox, pro-Western theories are an uneasy fit to a study of problems of translation in an African context. There is a need for theories that will look at translation from an African perspective and prioritise the contextualisation of translation theories in order to solve translation problems that relate to Africa. Kuhn (1970) (cited in Frank 2008: 1), in his argument about how, throughout history, one theory replaces another and how a “scientific revolution” takes place when old theories are trumped by a new one, observes that this happens “when it becomes obvious that the dominant theory (which might not be recognized as a theory at all) is not able to explain other important facts”.

Of course, the scale and depth of the problem goes beyond South Africa and Africa. Indeed, there is a consensus that much of translation theory has a western, Eurocentric bias (cf. Hung and Wakabayashi 2005; Hermans 2006; Cheung 2006; Kothari and Wakabayashi 2009; Inggs and Meintjes 2009), anchored in historic derivations in the study of Classical Greek and Latin, and from Biblical translation practices. Fortunately, this orthodoxy has started to be challenged and critiqued (cf. Tymoczko 2005, 2006, 2007, 2010) Hung and Wakabayashi 2005; Hermans 2006; Cheung 2006; Kothari and Wakabayashi 2009; Inggs and Meintjes 2009). Arguing for the need for a paradigm shift Tymoczko (2014: 13, 14) berates continued reliance on Western historical circumstances:
In the Eurocentric tradition, most statements about translation that date before the demise of positivism are relatively useless for current theorizing, because most encode the dominant perspectives of Western imperialism or respond to particular Western historical circumstances. There is a need in translation studies for more flexible and deeper understanding of translation, and the thinking on non-Western peoples about this central human activity is essential in achieving broader and more durable theories about translation.

Indeed, there has been an insistence that other, non-Western traditions, practices and definitions of translation need to be mainstreamed. Tymoczko (2005, 2006, 2007, 2010), for instance, has argued that other cultures may have very different cultural and conceptual orientations to “translation”, indicated in unique words and metaphors for “translation” and in different attitudes toward the goal of lexical fidelity to an original. The importation of interdisciplinary models from cultural studies and postcolonial studies, among others, has further enriched the discipline – while perhaps also further fragmenting it. It is these critiques of orthodox Western approaches that are behind the contention that, in the end, there can be no single agreed or prescriptive definition of translation.

The functionalist approach privileges contexts of use, which themselves are imbedded in culture. Venuti (2000: 5) argues that function cannot be separate from the needs and contexts of the target text, target culture and target audience:

Function has been understood as the potentiality of the translated text to release diverse effects, beginning with the communication of the information and the production of a response comparable to the one produced by the foreign text in its own culture...Function is a variable notion of how the translated text is connected to the receiving language and culture (emphasis added).

Vermeer (cited in Venuti 2000: 229), for instance, insists that one cannot prise the source text from the source culture, or the target text to the target culture.
“As its name implies,” says Vermeer, “the source text is oriented towards, and is in any case bound to the source culture”. It is this aspect – source text *glued* to the source culture, and target text *glued* to the target culture which ultimately defines adequacy.

In such a context, it will come as no surprise if source and target texts diverge from each other quite considerably, not only in the formulation and distribution of the content but also as regards the goals which are set for each, and in terms of which the arrangement of the content is in fact determined. Nida (cited in Venuti: 2000: 127, 128) argues that:

The particular purposes of the translator are also important factors in dictating the type of translation. Of course, it is assumed that the translator has purposes generally similar to, or at least compatible with those of the original author, but this is not necessarily so... A translator’s purposes may involve much more than information. He may, for example want to suggest a particular type of behaviour by means of translation. Under such circumstances, he is likely to aim at full intelligibility, and to make certain minor adjustments in detail so that the reader may understand the full implications of the message for his own circumstances.

Certainly, the purposes of the translator cannot be ignored in the final analysis. However, key to understanding the functionalist approach is the assertion that function is variable. In Venuti’s view, such variability is introduced in translation by the receiving language and culture.

Yet Venuti’s views are as problematic as those of the traditionalists who posit equivalence. For instance, what does it mean to insist on “the production of a response comparable to the one produced by the foreign text in its own culture”? What is a *comparable* response? What is the criterion for judging comparability? In this study, I found it unsustainable to assume that any translated text can produce the same response as the original text, taking into consideration that the isiZulu-speaking target audience of the translated text
differs in culture from the English target audience of the source text. As Gasset (in Venuti, 2000: 59) observes, “Languages separate us and dis-communicate, not simply because they are different languages, but because they proceed from different mental picture, from disparate intellectual systems – in the last instance, from divergent philosophies”.

Translation, of course, always takes place in the context of the original. For instance, the Department of Health in South Africa translates its health messages because someone in the department believes that the original text is so important that it needs to be passed to those who have no access to the original. Walter Benjamin (1923) (cited in Venuti (2000: 16) argued that translation is a mode, such that to comprehend it “one must go back to the original, for that contains the law governing the translation: its translatability” (emphasis added). Essentially, the act of going back to the original confers the “mode-ness” of translation. “If translation is a mode”, says Benjamin, then “translatability must be an essential quality of certain works”.

But what does it really mean to go back to the original? And what does this going back to the original confer, if anything, in terms of translatability? Benjamin clarifies that:

Translatability is an essential quality of certain works, which is not to say that it essential that they be translated; it means rather that a specific significance inherent in the original manifests itself in its translatability. It is plausible that no translation, however good it may be, can have any significance as regards the original. Yet, by virtue of its translatability the original is closely connected with the translation; in fact, this connection is all the closer since it is no longer of importance to the original.

Nida (1964), in fact, observes that “all translating, whether of poetry or prose, must be concerned also with the response of the receptor” (emphasis added). Essentially, “the ultimate purpose of the translation, in terms of its impact upon its intended audience, is a fundamental factor in any evaluation of translations”.

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A good translation, in the words of Forster (1958: 6), is therefore “one which fulfils the same purpose in the new language as the original did in the language in which it was written”. However, not all translations are the same and not all translations come equal. And, if Benjamin is correct, what drives the translation is the original text. And, if Frank (2008) is right, translations are also driven by communication: by the purpose to convey the message to a different audience than initially intended.

If the nature of the original text and communication are critical elements that diffract and refract the act of translatability, an equally significant factor is “need”, or the “so what” factor. The aspect of need is in some sense linked to intention and utility. Why does the Department of Health translate its health messages? So, what? For example, if a translation is done with a purpose to convey the message to the new audience in mind, there must a need for the original text to be reproduced for reception by the new audience. The questions that arise out of this are: Who needs this translation? Is it the target audience who feel they need the information? Or is it someone else thinking on behalf of the target audience that they need this information? Is it the original author who feels the need to expand the message? The “so what” of translation is crucial in unpacking the interests that lurk behind each translated text.

Essentially, the commissioning of a translation introduces complexity, as well as power dynamics, into the process of translation. We know, for instance, that translations are rarely commissioned by the author of the original text. If a translation is commissioned by someone else who is not original author, there are possibilities that this person wants this translation for a different function to that of the original author. Frank (2008) has identified four stakeholders who leave an impression on the translation: the translation team; the target audience; the original author; and third-party stakeholders. Whose view – and which stakeholder – therefore, determines the outcome of the translation? The biggest problem in relation to sticking with the function or purpose is that the
translator is also a stakeholder in the translation as he or she is the one who does the actual translation. Certainly, the process of translation cannot avoid a certain degree of interpretation by the translator (cf. Nida 2000). The translator will somehow interpret the text differently from what the original author intended to communicate. Vermeer (1989: 235), on the other hand, has argued that “The realisation of a commission [of translation] depends on the circumstances of the target culture, not on the source text. A commission is only indirectly dependent on the source culture to the extent that a translation by definition must involve a source text”.

Linked to utility, the Department of Health’s decisions are also influenced by availability of resources, human, technical, material and financial. Are there relevant resources and means to effectively make that translation? The question of resources is a crucial one politically and juristically, because the Department uses taxpayer money. For this reason, it has to account for each rand utilised in, and allocated for, translation. The imperative that arises due to the use of taxpayer money is parallel to the constitutional imperative which requires access to health for all South Africans as well as language rights. Decision-making also interacts with the power dynamics of the “so what”, considering that there are a handful of possible kinds of translations, making it imperative that a decision about which kind of translation is needed must be made before any translation process can take place. The existence of different kinds of possible translations that are available to a translator – literal, communicative, faithful, semantic, free, idiomatic, relevant equivalence, etc – also plays a significant part in translatability and untranslatability. The verdict on whether a translation is good or bad or a mistranslation can partly be informed by how much we know about what kind of translation was applied during the translation process.

Translatability (or lack of it) is reflected in the differences between one translation and another, such that one may seem better than other, or at least
that each translation reflects the different decisions that went into making it. The differences in translations may themselves be accounted for, according to Nida (1964: 127) by three basic factors of translating, namely (i) the nature of the message, (ii) the purpose of the author and, by proxy, of the translator, and (ii) the type of audience. Samuel and Samuel (2007: 375) attribute the problem of translatability and untranslatability generally to the complex nature of translation:

Texts of every kind are produced in the source language and translated into the target language. Since the process of translation is not a straightforward approach, many theories of translation have evolved with the purpose of applying a network of steps offered by translation theories in order to achieve a target text that will meet all the requirements of cross-cultural text adaptation. As a result of these problems some translation theorists have oscillated between the possibility and impossibility of translation of texts by postulating methodical theoretical approaches to translation.

Samuel and Samuel (2007) suggest that the possibility and impossibility of translation can be blamed on methodology but what exactly leads to failures and successes? It would seem to me that one’s methodological approach to translating plays second fiddle to larger questions that are thrown into relief when language meets culture. Is translatability between widely culturally and linguistically different texts at all possible? Is translatability at all attainable? These questions are pondered below.

Translatability, untranslatability, language and culture
Is translation possible or impossible? This is a question that has been repeatedly asked and debated among philosophers, linguists as well as translators and translation theorists. There are essentially two points of view from which the question of translatability has been traditionally approached: The Universalist one and the monadist one (De Pedro, 1999: 546). The Universalists argue that the existence of linguistic universals is what ensures translatability. In this regard, some scholars and artists believe that virtually
everything is translatable. Newmark (1989: 17), for instance, has stated that, “Every variety of meaning in a source language text can be translated either directly or indirectly into a target language, and therefore everything is translatable”.

Some of the most prominent twentieth-century linguists (such as Jakobson, Bausch, Hague, Nida and Ivir appear to accept the view that – at least in principle – everything can be expressed in any language. The likes of Pedro (1999: 547), von Humboldt’s words, a nineteenth century linguist, have stated that the structural differences which exist between languages are no obstacle for translation and that each linguistic community has the potential of expression which can generate resources for verbalising every extra-linguistic area, even those which go beyond its own social and cultural experience. The monadists, on the other hand, maintain that each linguistic community interprets reality in its own particular way and therefore translatability is more or less impossible.

Translatability refers to the property of being translatable or being able to be translated. But translatability in actual practice is much more than this simplistic dictionary definition. In practice, quite a number of things need to occur during the translation process in order for the text to be seen as translatable. Lewis (1985) (cited in Venuti 2000: 267, 268) has stated that:

The point is now also that translation, when it occurs, has to move whatever meanings it captures from the original into a framework that tends to impose a different set of discursive relations and a different construction of reality... For in fact the conventional view of translation puts the translator under pressure not simply to produce a version of the original that reads well or sounds right in the target language but also to understand and interpret the original masterfully so as to reproduce its message faithfully.

Den Broeck and Lefevere (1979) (cited in Samuel and Samuel 2007: 376) would seem to agree in their assertion that “Translatability is greater when there
is a degree of contact between the source language and the target language; translatability is greater when the source language and target language are on an equal cultural level of development; and translatability can be influenced by the expressive possibilities of the target language”. Venuti (2000: 468), for his part, has asserted that translation “never communicates in an untroubled fashion” precisely because the translator is an active participant who “negotiates the linguistic and cultural differences of the foreign text by reducing them and supplying another set of differences, basically domestic drawn from the receiving language and culture to enable the foreign to be received there”.

A critical aspect of translatability that is acknowledged in the literature is the target audience. For Sakai (2006: 73): “The translator is summoned only when two kinds of audiences are postulated with regard to the source text, one for whom the text is comprehensible at least to some degree, and the other for whom it is incomprehensible. The translator’s work consists in dealing with differences between the two audiences”. Baker (1992: 243) appears to affirm this when he argues that “Translators are aware that the norms of the target language will not necessarily go in line with those of the source language. That is why a kind of accommodation (adjustment) in the target text is needed so as to arrive at a solution for the problem”. Forster’s (1958: 6) definition of a good translation as “one which fulfils the same purpose in the new language as the original did in the language in which it was written” allows us to posit that the target audience for which the translation is being made has a central place in assessing the success or failure of a translation. Nida (in Venuti, 2000: 131) argues that “all translating, whether of poetry or prose, must be concerned also with the response of the receptor, hence the ultimate purpose of translation in terms of its impact upon its intended audiences, is a fundamental factor in any evaluation of translations”. Basically, a translation should be meaningful to the target audience. The receptor of a translation must be able to apply and use the translation. This aspect of meaningfulness proved to be crucial in the
analysis for this study, as I assumed that the target audiences in rural KZN were the key arbiters of the translated health messages.

Untranslatability affirms the autonomy of the text from transference. Gorea in *Lost in Translation: Beyond Words* defines untranslatability as “a property of a text or any utterance, in one language for which no equivalent text or utterance can be found in another language when translated”. This is the base view of the monadists, who maintain that each language “conditions the way in which its speaker perceives and interprets reality presupposes that there will be terms which are specific to each linguistic community structures reality in a different way according to its own legitimate order” (Samuel and Samuel 2007: 376).

Two types of untranslatability have been formally identified in the literature, namely linguistic untranslatability and cultural untranslatability. Hence:

Linguistic untranslatability takes place in a situation in which the linguistic elements of the original cannot be replaced adequately in structural, linear, functional or semantic terms in consequence of a lack of denotation or connotation... Cultural untranslatability refers to the situation where the relation of expressing certain cultural terms in the source text does not find adequate rendering in the target culture. In other words, the relation between the creative subject and its linguistic expression in the original does not find functional cultural translation equivalent in the target language (Bassnett 1980, cited in Samuel and Samuel 2007: 377).

Because of linguistic and cultural differences across different communities, some terms or concepts can be rendered *untranslatable*, with culture being the most prominent factor that contributes to untranslatability of texts. In the words of Nida (1964), “in fact, differences between cultures cause many more severe complications for the translator than do differences in language structures”.

As with Nida, Cymbalista (2003: 22) agrees that there are “*culture-specific reasons* for untranslatability because the lack of one-on-one correspondence between languages as regards both lexical items, in particular, and at some
level of generalisation, even linguistic structures may be traced down to the difference source and target cultures”. Indeed, Nida (1964: 137) regards untranslatability as inevitable. Basically, it is “inevitable also that when source and receptor languages represent very different cultures there should be many basic themes and accounts which cannot be naturalized by the process of translation” (ibid).

For some functionalist scholars, untranslatability is a function of incomplete translatability. That is, translatability is possible but not completely. Venuti (2000: 22, 24) in Tymoczko’s words, argues that complete translatability is unattainable largely because of the difference in culture and language:

It is clear from theory and practice of translation that no text can ever be fully translated in all its aspects: perfect homology is impossible between translation and source... In source texts to be translated translators are presented with aspects of the source culture that are unfamiliar to the receiving audience – elements of the material culture (such as food, tools, garments), social structures (including customs and law), features of the natural world (weather conditions, plants, animals), and like, such features of the source culture are often encoded in specific lexical items for which there are no equivalents in the receptor culture or for which there are only extremely rare or technical terms.

The difference between a source language and a target language and the variation in their cultures, it seems, makes the process of translating a real challenge. Among the problematic factors involved in translation would be the form of the text, the meaning, style, proverbs, and idioms and so on. Of course, besides culture, one still needs to be aware of the problem of superficial similarities. Nida (1964: 130), for instance, also warns us of “the serious dangers consists of so-called ‘false friends’ i.e. borrowed or cognate words which seem to be equivalent but are not always so”. Gasset, in The Misery and the Splendour of Translation (1937: 59), states that “Not only do we speak, but we also in a specific language, and intellectually slide along pre-established rails prescribed by our verbal destiny”. This suggests that different linguistic
communities think differently and therefore communicate differently. This aspect makes the search for equivalents hopeless.

The nexus between culture and language – their inseparability – is thus the cause of untranslatability. It is difficult to penetrate that nexus in a way which ensures equivalence. Cymbalista (2003: 21) has asserted that “Due to the fact that different languages are inseparable from the culture and the different – sometimes dramatically different – cultures determine equally diversified culture-specific ways of perceiving the world there is no automatic equivalence between words in the source and target languages and apparently similar structures may have different uses and different connotations”. The difficulty caused by culture-specificity is expressed by Lefevere (1999: 76, 77) when he argues that:

Problems in translating are caused at least as much by discrepancies in conceptual and textual grids as by discrepancies in languages. This fact, which may be obscured to some extent in the process of translating between languages that belong to Western cultures (and most thinking and writing on translation, having been done in the West, relies on this kind of translating), becomes blatantly obvious when we are faced with the problem of translating texts from Western to non-Western cultures and vice versa.

Nye (1998: 3, 255, 256) citing Malinowski affirms the culture-specificity aspect by noting that:

In human language, different kinds of words must be ‘fitted’ together, and the correctness of the fit determines whether what is said is true or false…In brief, every language has words which are not translatable, because they fit into its culture and into that culture only, into the physical calling, the institutions, the material apparatus and manners and values of people…Translation in the correct sense must refer therefore not merely to different linguistic uses but often to the different cultural realities behind the words…When two cultures differ as deeply as that of the Trobrianders, and the English, when beliefs, scientific views, social organisation, morality and material outfit are completely
different, most of the words in one language cannot be even remotely paralleled in the other.

In the context of this study, therefore, I drew on the assertions of the impossibility of translating culture is behind the notion untranslatability. The example of *ukusoma* which we drew earlier illustrates this incommensurability. To a Zulu hearer, saying “non-penetrative sex” simultaneously fails to convey *ukusoma*. *Ukusoma* is a lived cultural and health practice which resists simple substitution and transfer.

**The problem of translation in the African context: A brief primer**

Carbonell (1996: 83) argues that “Translation as a bridge between cultures may also be a source of separation when it reaffirms received stereotypes…Therefore translation will be more difficult when there exists a tradition in which the source culture is not represented in the target culture”. Because colonialism instantiates a system of *unequal exchange* between societies that is fundamentally a relationship of coercive domination, this inequality is acted out culturally and linguistically in the production of “the relationship between ‘unequal’ languages” (Niranjana, 1992: 48). This inequality between languages is the root cause of the problems faced in translation especially the translation Western to non-Western languages. I opine that this inequality ultimately resulted in the non-Western languages being underdeveloped. The underdevelopment of non-Western languages contributes to *untranslatability* because of deliberate neglect: there are no formal lexical and formal equivalents of source languages in the target languages. This is evident in the South African context were English, as the *lingua franca*, alongside Afrikaans, was developed at the expense of indigenous languages. Essentially, apartheid and its *two languages policy* literally crippled the development of indigenous languages.

Wa Thiong’o and Kwesi Prah are some of the foremost proponents of the view that the status of English as a source language or relay language is *detrimental*
to African cultural development and expression. In the 1980s, wa Thiong'o made the choice to abandon English and write exclusively in Gikuyu. Other African writers such as Chinua Achebe, however, disagreed with wa Thiong'o’s stance. In Achebe’s view, English had already gained the status of an African language; and could be made to carry and convey African culture and experience. Achebe’s view was a bit short sighted in the sense that it overlooked what was happening to the African languages as a result of the dominance of English (cf. Prah). He also overlooked the fact that the majority of African people, in Nigeria and elsewhere, could not write in or read formal English. This was in a way creating a mode of dependence on a non-native language for information as well education purposes. Prah (2013), (in an interview by Alicia Mitchell) asserts that “No country can make progress on the basis of a borrowed language, understood only by a minority”. Niranjana (1992: 32) has further affirmed that:

The demand for English education on the part of the colonised is clearly not a simple recognition of “backwardness” or mere political expediency, but a complex need arising from the braiding of a loss of historical factors, a need produced and sustained by colonial translation (emphasis added).

This study, ultimately, assumes that translation is not an innocent practice of transferring meanings and substituting words. This view is ably supported in critical literature on translation.

In some instances, translations are used to promote certain ideologies. Schaffner, for instance, has pointed out that “any translation is ideological since the choice of a source text and the use to which the subsequent target text is put is determined by the interests, aims, and objectives of social agents”. Claramonte (2003: 23) remarks that language is “not innocent but always implies a vision of the world which is related... to the legitimacy of certain institutions and social practices and the power relations maintaining them”. As Lefevere (1999: 75) suggests, “the rules to be observed during the process of
decoding and reformulation depend on the actual situation, on the functions of the translation, and on who wants it made and for whom”. South Africa during apartheid is a good example that translation can be used for different purposes and ideologies.

South Africa’s apartheid government had a racist two-language policy that recognised only English and Afrikaans as official languages. Translation was predominantly from English and Afrikaans into “native”, “tribal” or “kaffir” languages. Predictably, indigenous languages were deliberately underdeveloped and neglected, particularly under racist Bantu education policies. Trew (1994: 74) indicates that:

Translation was equally significant during the apartheid era: not only was Afrikaans actively promoted, but the publication of government-approved translated textbooks in African languages was used to support the policy of ‘separate development’ – including separate (and unequal) education systems for different races and primary education in the mother-tongue. Translation into the African languages was also vital to state television broadcasting, as well as to the administration of the ‘homelands’ and the various courts of justice.

Translation under apartheid was a form of social control, designed to limit the education of the so-called Bantu to menial tasks and cheap labour. That Africans preferred to be taught in a language of their choice as opposed to one imposed on them was affirmed in the Soweto Uprising of 1976. As Kathryn Batchelor (2014: 246) has noted, inequalities of power did not of course disappear at the end of the apartheid and colonial eras. Rather, these continue in various guises in present day language policies and realities.

The irony of the South African Constitution regarding the 11 official languages is that the majority promptly become the minority when it comes to official language choice. The rest of the languages receive secondary attention whenever official preference is given to English. This act is a subtle continuation
of apartheid forms of language colonialism and domination. As wa Thiong’o asserts:

The choice of language and the use to which language is put is central to a people’s definition of themselves in relation to the entire universe. Hence language has always been at the heart of the two contending social forces in the Africa of the twentieth century. The contention started a hundred years ago when in 1884 the capitalist powers of Europe sat in Berlin and carved an entire continent with a multiplicity of peoples, cultures and languages into different colonies. It seems it is the fate of Africa to have her destiny always decided around conference tables in the metropolises of the western world (wa Thiong’o, 1986: 4).

Despite the constitutional provision that all eleven South African languages are official, English is still dominant because most communication from government is firstly written in English and then translated into indigenous languages.

Neville Alexander (2004: 122) reflects on the dominance of English in post-apartheid South Africa when he states that, “In the post-apartheid South African setting, the hegemonic position of English assumes an added significance because of very clear and explicit constitutional and legislative commitments to language equity and to the development of marginalised languages”. Government’s failure to communicate with the majority first hand in their mother tongues leads to dependency on translation. As this study repeatedly shows, the South African Government translates most of its communication from English into indigenous languages including health communication. Health communication appears to be the most challenging considering lack equivalent terms in target texts of the English versions. What is more confusing about health communication is that even when messages are created or written by indigenous isiZulu speaking people, these people still conceptualise and write them in English for later translation.

In translation practice, problems of translation and untranslatability are seemingly always created by cultural and language difference between the SL (in this case, English) and the TL (in this case, an indigenous language such as
As we observed in the previous sections, the difference between a source language and target language and the variation in their cultures makes the process of translating virtually impossible. Sontag (2007) puts it succinctly as follows:

The ethical understanding of the task of the translator originated in the awareness that translation is basically an impossible task, if what is meant is that the translator is able to take up the text of an author written in one language and delivers it, intact, without loss, into another language.

Translation, therefore, “always entails some loss of the original substance”. At risk of repeating myself, I find Malinowski (1998: 255) appropriate when writing, “Every language has words which are not translatable, because they fit into its culture and into culture only”. As noted, this is what is referred to as untranslatability.

Translation comes with peculiar problems for health communication. Alluding to Higgins and Norton (2010), Jones and Norton (2007: 5) have noted that:

In African contexts, in which ex-colonial languages are often official languages, the development of health literacy is seen to be a particular challenge, particularly with reference to sexual health literacy...Related to health communication between non-native and native speakers are the challenges of interpretation and translation.

While the South African Government “employs over 25 000 full-time court interpreters and numerous part-timers to cover the Department of Justice’s considerable language needs” (Wallmach 2006), there is no such provision for the Department of Health. When it comes to written health communication messages, the accommodation of African languages as official languages seems to be mostly cosmetic. Most health communication is still designed, created and written in English before being translated into other official languages.
The theoretical approach to be used in this study incorporates what Bassnett and Lefevere in *Translation, History and Culture* (1990) identified as the “cultural turn” in translation theory. The *cultural turn* reflects a turn away from language-based, linguistic, and positivistic approaches to translation that had dominated translation studies up to this point. The cultural turn in translation theory drawn on in this study incorporates the postcolonial translation theory of Niranjana (1992) and Spivak (“The Politics of Translation”), and the cultural studies-oriented analysis of Lawrence Venuti. In these theories culture is identified as a multifaceted, complicating factor in translation and as a contributing factor to untranslatability. In Venuti’s view the source text is always interfered with and what comes after the translation process is not the communication the source text intended. He argues that the foreign text is always inscribed with target text intelligibilities and interests which start at very choice of the text for translation influenced by certain discourses over others. Here foreign text is domesticated before it is further processed by the reader and made to bear other domestic meanings and to serve other domestic interests.

Venuti (2003) further argues that translation does something more than communicating the foreign text. “The source message”, he says, “is always interpreted and reinvented, especially in cultural forms open to interpretation, such as literary texts, philosophical treatises, film subtitling, advertising copy, conference papers, and legal testimony”. This interference with the source text raises the question: how can the source message be invariant if it undergoes a process of ‘establishment’ in a ‘certain’ target language and culture? Drawing on such questions, this study sought to find out, for instance, how much of the original messages “remain” in the English-to-Zulu translated health messages. Venuti’s (2003: 471) verdict, however, seems clear: “the foreign text is rewritten in domestic dialects and discourses, registers and styles, and this, results in the production of textual effects that signify only in the history of the domestic
language and culture”. Whether or not this is the case with English-to-Zulu messages is revealed later in this study.

**Translation and health communication in South Africa**

This chapter has touched on several issues that occur in the literature on translation. These issues will be of greater interest in the analysis of data collected, in Chapter 5. We discussed the importance of locating the origins of language in cultural contexts, and of seeing language as *cultural glue*. The chapter also discussed the dominance of English, and attitudes towards the language which for elites, is a convenient meeting place. We have seen how the *expectation of translatability* dominates and runs through the discourse of translation in government communications in South Africa, spawning a kind of translation-for-communication or communication-by-translation culture. This culture, however, is pervaded by assumptions that translation can achieve one-size-fits-all equivalence.

The examples of *ukusoma* and *Ingculaza* were used to show that such an assumption is problematic, partly because of the existence of complex cultural realities *behind the words* as well as the transitivity and incommensurability of meaning. The concept of *equivalence* which draws from one of the two main traditions in translation studies (the other one being functionalist) was rejected in much of the functionalist scholarship. A core assumption in the “equivalence” school is the *principle of preservation* which accepts that the original text can be preserved in the target text. Equivalence is fore grounded in *word-for-word* translations rather than *meaning-for-meaning*. The way I see it as that for *equivalence* to be achieved, other things will need to be *equal*: *ceteris paribus*. However, in reality, other things are never equal. Rather, language and culture are very variable. For some functionalist scholars, untranslatability is a function of *incomplete* translatability.
We conclude this chapter by setting the scene for the next chapters by looking at the contemporary situation in South Africa as it relates to government communication policies in general and to the dissemination of health messages in particular. As noted, in South Africa, the recognition of the indigenous languages as official languages on the national level is the declared goal of the policy. However, the government communication domain is dominated by English or translations (Mutasa, 1999: 86). In the past, this space was dominated by Afrikaans, but today English is almost unrivalled as the lingua franca. Benjamin et al (2016: 74) confirm this when they state that “English is only the fourth most-common home language in South Africa, but it is typically the preferred language of healthcare providers, resulting in more than 80% of medical interactions occurring across language and cultural barriers”.

As noted, the constitution of South Africa (Act 108 of 1996) protects the rights of all citizens to access healthcare services (Section 27), as well as to participate in all aspects of life, in the language of their choice (Section 6). The interlinked nature of these two basic human rights is emphasised in the National Health Act (Act 61 of 2003), which states that the healthcare provider must where possible, inform the user in a language that the user understands, and, in a manner, which takes into account the user’s level of literacy. The National Patients’ Rights Charter reiterates this idea by providing that patients should have access to healthcare and information, in a language that they understand (Van den Berg, 2016: 1).

The stipulations of the abovementioned constitutional and regulatory acts, however, have yet to take place in general practice. In most cases patients are still being communicated to in English when they visit to health institutions. Many doctors do not only not speak the languages of their customers/patients; but are not required to speak any other language except the normative language of medical school, which happens to be English. Indeed, communication in medical schools in South Africa happens predominantly in
English, and this is carried over to practice. Medical concepts in textbooks in medical schools are in English, and there has been no interest in indigenising these textbooks. How then can doctors be expected to use indigenous concepts to communicate with patients? There is thus no choice of language inside consultation rooms both in private and public health institutions: if a doctor breaks into isiZulu while talking to a patient they do so not because they are obliged to.

The unavailability of information to patients in the languages of their choice remains a widespread problem. As we will see in Chapter 5, the problem of language affects the quality of service that patients get considering that successful outcomes depend on effective communication. As Van den Berg (2016: 1) notes:

Successful outcomes for patients with chronic diseases rely on the rapport between the patient and the healthcare, the patient’s control of the dialogue, as well as the amount of information exchanged between the patient and healthcare provider, all of which require effective communication. Miscommunication due to the language barrier poses a threat of life-threatening misdiagnosis and mismanagement of diseases.

These concerns have, however, not led to any sea change in the language preferences in our health system. Current concerns about the endemic and deep-seated problems in South Africa’s health system do not include the issue of language. Often, the “large” issues, such as resources, service delivery and health epidemics hog the limelight. Yet, as this thesis hopes to show, language is as critical as the “large” issues.

The importance of language in health communication thus needs to be **mainstreamed**. Whilst language provision is protected in the constitution, the language barrier in South Africa’s health sector remains severe and worrisome. Van den Berg (2016: 1) highlights some of the salient issues:
Research in the United States, for example showed that persons
with limited English proficiency are less likely to receive regular
source of primary care and are less likely to receive preventive
care. Even in language-congruent situations, miscommunication
commonly occurs in the healthcare sector, because healthcare
professionals differ from their patients in terms of educational
level and knowledge regarding medical conditions. To complicate
matters further, language can never be separated from culture.
Whereas, healthcare professionals are trained in the biomedical
model of disease, their patients often hold very different culture-
specific models to explain origins of disease (emphasis added).

As we saw in the previous sections in this chapter, culture refers to the sum of
attitudes, customs, and beliefs that distinguishes one group of people from
another. Culture is transmitted, through language, material objects, ritual,
institutions, and art, from one generation to the next.

If Van den Berg is right and language can never be separated from culture, it
suggests that more needs to be done to mainstream culture-specific models
not only to explain origins of disease, but to name them and situate them
culturally. The current situation where healthcare professionals are trained
exclusively in the biomedical model of disease while most of their patients often
hold very different culturally-inflected views of health and disease seems
untenable. If, sociologically, culture consists of the “beliefs, behaviours, objects,
and other characteristics common to the members of a particular group or
society”, and if through culture, “people and groups define themselves, conform
to society’s shared values, and contribute to society” then the role of culture in
health communication cannot be overstated.

Certainly, there is evidence that culture affects health literacy skills in a
significant way (cf. Institute of Medicine 2004 [IOM]). Andrulis and Brach (2007)
in Singleton and Krause (2009) have argued that “Inter-relationships between
health, culture and language – culturally bound beliefs, values, and preferences
a person holds – influence how a person interprets health messages” One of
the main objectives is to investigate precisely how culture influences the
reception of selected translated health messages that are in use KZN clinics. Translation has emerged a solution to the problem of access to information, but the gains and losses have not been systematically studied. By translating health messages into indigenous languages government and provincial health departments try to provide for language and health rights as provided for by the constitution. Do translations work? If they do, how do they work? In this study I wanted the answers to these questions to come partly from the rural users themselves.

**Conclusion**
This chapter has dealt with some of the main strands of translation studies that are relevant to this study. It has examined definitions of translation and sought to define translatability, and untranslatability. The chapter has also shown how cultural and linguistic asymmetries create problems in the translation process, and indicated how orthodox, pro-Western translation theories are failing to address the translation problems facing Africa and other postcolonial settings, and also shown how the inequality between Western and non-Western languages and underdevelopment of the former gave birth to linguistic asymmetries that characterise translation today. It has also attempted to show how the South African language and translation context scene is similar and yet also different from other postcolonial settings.
CHAPTER THREE

THEORETICAL FRAMEWORK

Introduction

This chapter presents the theoretical framework of the study. The theoretical approach used in this study is twofold. Firstly, I expand on my evaluation of traditional translation theory from the previous chapter, with a view to assessing this theory’s overall (lack of) fitness for this study. Secondly, the chapter evaluates aspects of the functionalist and the “cultural turn” in translation studies, incorporating Skopos theory and descriptive translation studies (DTS). There seems to be more than one method or strategy for the translation of one particular source text. Translation itself is a decision process which must be guided by some kind of inter-subjective criterion or set of criteria (cf. Nida 2007: 1). The approaches adopted in this study, in my view, complement each other, more so where the efficacy of traditional approaches have been questioned.

Translation theory: A brief background

Since I have extensively treated the broader literature on translation in the last chapter, I shall only give a brief background here. Vallejo (2011) argues that what is termed translation theory comprises the study of “the proper principles of translation”, apparently “based on a solid foundation of understanding of how languages work” (emphasis mine).4 But how do languages work? Vallejo points out that translation theory recognises that different languages encode meaning in a variety of forms, yet, at the same time, guides translators to find “appropriate ways of preserving meaning, while using the most appropriate

4 http://www.translationdirectory.com/article414.htm
forms of each”. As has been noted, this study is preoccupied in large part with the issue of meaning, by whom it is made, how, why, and how and why it is deployed.

While translation theory broadly “includes principles for translating figurative language, dealing with lexical mismatches, rhetorical questions, inclusion of cohesion markers, and many other topics crucial to good translation”, the keywords for me appear to be contained in the notion of work and meaning. Firstly, we note that languages do a kind of work. How languages do this will be of interest in this study, in particular isiZulu. It might even be said that languages behave in a certain way. Secondly, the work of language is largely about meaning. Meaning, however, is not just a grammatical item. Rather, it is also social and cultural. It is this socio-cultural element of meaning that this study also seeks to tease out and elicit.

Pérez (n.d.) identifies what he regards as two competing theories of translation, both of which he says are equally valuable to the practice of translation, stating that:

In one, the predominant purpose is to express as exactly as possible the full force and meaning of every word and turn of phrase in the original, and in the other the predominant purpose is to produce a result that does not read like a translation at all, but rather moves in its new dress with the same ease as in its native rendering. In the hands of a good translator neither of these two approaches can ever be entirely ignored.5

Basically, the preoccupation with exactness is seen as competing with the preoccupation with giving a translation a new dress. This explication by Pérez continues the traditional banality in translation theory that we noted in Chapter

5 www.translationdirectory.com/article414.htm
2. Although Pérez suggests that both sides of the binary are equally important to the translator, he does not say much that suggests that there could be passage between them. One paradigm locks out the other. The conventional assumption, according to Pérez, is that, in order to perform their jobs successfully, translators should meet three important requirements, all involving a basic familiarity with: the source language; the target language; and the subject matter. Essentially, using the forms and structures of the target language, the translator discovers the meaning behind the forms in the source language and does his or her best to produce the same meaning in the target language. On the one hand, what needs to change is the form and the code. On the other hand, what should remain unchanged is the meaning and the message.

In as far as the goal of exactness is concerned; Western linguistic equivalence-based translation theory – “frequently associated with word-for-word fidelity to the source text even though the result may not be considered appropriate for the intended purpose” (Nord, 1997: 4) – suggests that any given translation must be faithful to the original text as much as possible. This is supposedly where the notion of equivalence originates from. In a more technical sense, equivalence-based translation theory stipulates that a translation must be a reproduction of the source text (ST) in the target text (TT), suggesting that

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6 Nida (cited in Bassnett, 2002: 30) states that there are, in fact, two types of equivalence: formal equivalence and dynamic equivalence. Formal equivalence focuses attention on the message itself, in both form and content. In such a translation one is concerned with such correspondence as poetry, sentence to sentence, and concept to concept. Viewed from the formal equivalence point of view, one is always concerned that the message in the receptor language should match as closely as possible, the different elements in the source language. A translation of dynamic equivalence aims at the complete naturalness of expression, and tries to relate the receptor to modes of behaviour relevant within the context of his own culture; it does not insist that he understand the cultural patterns of the source-language context in order to comprehend the message. Pragmatic equivalence, on the other hand, transfers source text according to the values that are familiar to the receiving language and culture so as to conceal the very fact of translation.
certain linguistic features and form of the source text must be preserved irrespective of what the intended purpose is. As Koller (1979: 187) points out:

There exists equivalence between a given source text and a given target text if the target text fulfils certain requirements with respect to these frame conditions. The relevant conditions are those having to do with such aspects as content, style and function. The requirement of equivalence thus has the following form: quality (or qualities) X in SL text must be preserved. This means that the source-language content, form, style, function, etc., must be preserved or at least that the translation must seek to preserve them as far as possible. Emphasis is on the original.

Such a theoretical paradigm in translation promotes ethics of sameness and faithfulness to the original text in translation. Any target text that is not equivalent (as far as possible to the corresponding source) is declared a non-translation. In the end, equivalence is a “static, result oriented concept describing a relationship of equal communicative value between two texts or, on lower ranks, between words, phrases, sentences syntactic structure and so on. In this context value refers to meaning, stylistic connotations or communicative effect” (Nord, 1997: 7).

In one specific sense, traditional translation theory (“Western linguistic equivalence-based translation theory”) can be understood as referring to the study of so-called “proper principles” of translation. Such proper principles would, for instance, incorporate “do’s and don’ts” of translation, some of which were documented as early as 1540 by Étienne Dolet (Firdaus, 2012: 293). These given principles specify that the translator:

1. **must** fully understand the sense and meaning of the original author; although he is at liberty to clarify obscurities;
2. **should** have a perfect knowledge of both SL and TL;
3. **should** avoid word-for-word renderings;
4. **should** use forms of speech in common use; and
5. *should* choose and order words appropriately to produce the correct tone.

These principles are important not so much for their theoretical import as for the methodological signposts. Indeed, as will be noted in the methodology and the findings chapters, I have drawn on these five principles to evaluate the actual translated material used in this study. However, lurking behind these do’s and don’ts is a specific attitude towards translation. In my reading, this attitude regards translation as a lens through which translation scholars and practitioners try to understand things that are unknown or difficult to understand – a reading that imbues translation with aspects of knowledge and sense-making. Above, all this, attitude to translation regards the practice as guiding the translator or even prescribing rules about how translation is to be done.

The prescription of translation schemes, while it assists translators with ready-made formulas, also complicates the role of the translator and of the reading public since meaning-making is not so much formulaic as contextual and socio-cultural. The inescapable facts at hand are that source texts are not from domains in which the use of African languages is currently well established. This reality cannot be wished away. The South African scenario will pose or poses many challenges to such a static theory considering that South Africa is not only culturally and linguistically diverse; it is a hybrid society both in terms of culture and language. As noted by Kruger (2009: 170):

> The domestic culture in South Africa may be regarded as a hybrid of various local subcultures and languages (in themselves mixtures of traditional and modern elements) that are sometimes separate, sometimes interwoven – and simultaneously strongly linked to the “foreign” usually American context through both language and cultural elements.

I observed – in this current study – many cases of non-equivalence in translation caused by the pragmatic differences between source and target cultures. The discovery of a lack of synonymy between languages should
perhaps not be surprising. Not only is there is no absolute synonymy between words in the same language, but the very act of shifting “from one language to another, is by definition, to alter the forms” (Bell 1991: 6). Furthermore, “contrasting forms convey meanings which cannot but fail to coincide totally” (Bell 1991: 6).

In any event, the discrepancies between English and indigenous languages continue to create a serious challenge in translation. Essentially:

Problems in translating are caused at least as much by discrepancies in conceptual and textual grids as by discrepancies in languages. This fact, which may be obscured to some extent in the process of translating between languages that belong to Western cultures (and most thinking and writing on translation, having been done in the West, relies on this kind of translating) becomes blatantly obvious when we are faced with the problem of translating text from western to non-Western cultures and vice versa (Lefevere 1999: 77).

In my study, for instance, I observed that traditional translation, based on the notion of direct equivalence upon a clear distinction between source and target language, complicates things in South Africa’s heavily multilingual and culturally plural society. A further complication of the prescriptive attitude is that multiple linguistic and cultural identities have continued to emerge in the post-apartheid dispensation, drawing on constitutional freedoms of expression and association but also on increasing urbanisation, globalisation, and Westernisation.

Essentially, there is something to be said about exploring organic new ways of looking at the translation scene in South Africa. In this regard, Dimitriu (2000: 183) has asserted that insight into the “complexities of post-apartheid identity formation around language issues (and the role of English)” is needed in the urgent task of navigating “the multifaceted translation scene in multicultural South Africa”. Established western assumptions “about various preconditions for proper translation” may need to be “carefully weighed up against a diverse
number of harsh realities”. Bermann (2005: 5) has argued that translators “have long agreed that the effort to render one language system into another requires a keen awareness of broad cultural as well as specific linguistic values. It also requires existential choices that are bound to have wide-ranging repercussions for the text and its audience”.

It is, for instance, unfair to apply translation theories, created in the West, with western preconditions and expectations for languages which are somehow related or have some affiliation, to languages that are so linguistically diverse and, in technical terms, underdeveloped. At the same time, while I find significant conceptual value in juxtaposing “western assumptions” against the “local translation scene”, I am also wary of setting up untenable binaries that assume that completely organic theories of translation – sealed off from the so-called “western” – are possible or even desirable. At any rate, my attempt to theorise and contextualise translation theory in a South African context will be shaped and informed by the basic concepts of the functionalist translation theory (cf. Chapter 2) and less by traditional theories that are dominated by rigid notions of equivalence.

One reason for this choice is that, in order to address the untranslatability that characterises translations from a lingua franca, such as English, into indigenous languages, there is a need for more flexibility. Rigid formulas seem like a bad fit for postcolonial contexts that are seeking new decolonised paradigms of communication. The impact of colonisation on the development of the languages of the colonised cannot continue to be ignored (cf. wa Thiong’o 1986; Prah 2013). As Bandia (2008: 227) puts it, “The coming together of these (industrialized and pre-industrialised world) two worlds during colonization brought about the imposition of the language and culture of the one group on the other”. South Africa’s colonial and apartheid history is replete with examples of one imposition after another, culminating in the Soweto 1976 uprising that rejected the imposition of Afrikaans. There is a need to carefully exorcise the
ghost of imposition from our methodologies of translation. In any event, it appears that traditional translation theory fails to recognise the impact that cultural and linguistic difference has in determining the outcome of the translation process. It also fails to fully recognise that African languages are different from western languages both in form and structure.

This study takes the perspective that the principles and expectations of traditional translation theory are *unrealistic* when applied to translation in the African context. The functionalist theory postulates that a translation does not have to read like a translation at all but must be more accommodative to the target culture. The theory does not emphasise similarity between source and target texts but, rather, maintains that meaning and sense need to be preserved in the target text. Taking into account that the translation comes from the source text, it must thus show some relationship to the source. Focus and emphasis is more on the *purpose* that the translation intends to serve, and the living context of the translation process. Hence, “the translation critic can no longer rely on features derived from source-text analysis but has to judge whether the target text is functional in terms of the translation context” (Nord 1997: 9). Functionality is central to this perspective since translation cannot be divorced from use. It is as if one is saying that *meaning is use* (cf. Wittgenstein 1956).

Nord (1997: 1) has, in this regard, asserted that a theory of translation ought in some sense to be “embedded in a theory of human action or activity”. This is because the act of communication never fails to take place “through a medium and in situations that are limited in time and place” (Nord 1997: 1). Given situations “are not universal but are embedded in a cultural habitat, which in turn conditions the situation” (Nord 1997: 1). Indeed, each “specific situation determines what and how people communicate, and it is changed by people communicating” (Nord 1997: 1). The conclusion is that language is an inherent and indivisible part of culture. Communication, meanwhile, “is conditioned by the constraints of the situation in culture” (Nord 1997: 1). Any given translation,
approached from the functionalist approach, can thus never be expected to be an equivalent of the source text or to be loyal to it or the original author taking into account that the original author might have been writing with a different purpose under a different situation from that of the commissioner of the translation. Ultimately, the role of the source text in functionalist approaches is radically different from assume for equivalence-based theories. This is because the source text is “no longer the first and foremost criterion for the translator’s decisions; it is just one of the various sources of information used by the translator” (Nord 1997: 25).

In order to further strengthen the functionalist theoretical lens, I incorporate, on the one hand, its other branch, Skopostheorie, and, on the other hand, concepts drawn from what has been called descriptive translation studies (DTS), a translation research tool that promotes the understanding of translation in context and as taking place within socio-cultural contexts. Skopostheorie, propounded by Hans Vermeer, is based on the premise that the purpose of the translation must determine the strategy to be used during the translation. Vermeer (1986: 33) does not regard translation as the “transcoding of words or sentences from one language to another,” but, rather, as “a complex form of action whereby someone provides information on a text (source language material) in a new situation and under changed functional, cultural and linguistic conditions, preserving formal aspects as closely as possible”.7 Nord (1997: 12)

7 Vermeer introduced two kinds of functions in translation. Those are a funktion kontang (unchanged function) and funktion verandering (changed function), whereby the text is adapted to meet specified need in the target text. Dan (2015: 211) (cited in Nord 2001: 32) points out that Vermeer put forward three rules of Skopostheorie namely, skopos rule, coherence rule and fidelity rule. Coherence rule stipulates that “a translation should be acceptable in a sense that it is coherent with the receiver’s situation. In other words, the TT should make sense in the target culture so that the TT receivers are able to understand it. Fidelity rules specifies that the TT should “bear some kind of relationship with the corresponding ST” since translation by definition is a translational action involving a ST. This rule might remind one of the concepts of faithfulness in equivalence-based translation theories; however, they differ from each other in that the former is a dynamic rule whose form and degree depend on the translator’s interpretation of the ST while the latter is a static concept. In other words, the fidelity rule may require either maximally faithful imitation of the ST or minimal relevance to the ST or anything
explains that Skopostheorie was developed “as the foundation for a general theory of translation able to embrace theories dealing with specific language and cultures”. The first and foremost principle of the functional approach of Skopostheorie is the *Skopos rule*, which stipulates that the *purpose* of the translation *determines* the choice of translation method and strategy.

Essentially, “what the translator can do, and should do, is to produce a text that is at least likely to be *meaningful* to target-culture receivers” (Nord 1997: 32) (emphasis added). This entails that the receiver of the translated message should be “able to understand it; it should make sense in the communicative situation and culture in which it is received” (Nord 1997: 32). Vermeer (cited in Nord 1997: 33) clarifies that:

> Every cultural phenomenon is assigned a position in a complex system of values. And every individual is an element in a system of space-time coordinates. If this is accepted, trans-cultural action or communication across culture barriers has to take account of cultural differences with regard to behaviour, education and communicative situation.

In one sense, one must focus on the *purpose* of the translation broadly, and all else will follow. Essentially, the theory does not turn on the prescriptive application of formulaic do’s and don’ts but, rather, on a consideration of context and culture.

But, since the purpose of a translation does not determine itself, a key factor determining the purpose of a translation is an evaluation of “who is the intended receiver or audience of the target text with their culture-specific world-knowledge, their expectations and their communicative needs” (Nord 1997: 12). Between these two extremes, whereas the concept of faithfulness requires maximal equivalence to the ST.
Translation is not just empty human action, but it an activity which is conditioned by an intention to communicate something in a given situation. Translating thus involves “aiming at a particular communicative purpose” (Nord 1997: 2). This purpose may or may not, of course, be identical with the one that other participants have in mind. Unlike equivalence, which turns on “fidelity”, Skopos theory draws on “loyalty”,\(^8\) instead.

Skopostheorie, as such, accounts for different strategies in different situations, in which the source text is not the only factor. The link between Skopostheorie and descriptive translation studies DTS, at this stage, seems obvious. This is because DTS eschews outcomes of previous speculative models in favour of a focus on the “actual facts of real life”. Accordingly, translations should be understood as occurring within a socio-political framework (cf. Toury 1980, 1982) and could in this regard be a means of observing societal norms. Broadly, DTS aims to “study, describe, explain and even predict translation outcomes in a systematic and controlled way” (Toury, 1982: 23). Hence:

Descriptive translation studies (DTS) is a translation research tool that promotes the understanding of translation in the context and translation as operating within socio-cultural contexts. DTS assumes an empirical science perspective as it focuses on actual facts of real life, rather than the merely speculative outcomes of previous important, but is integrated to the complete understanding of the norm-governed decision-making process of the translator. DTS can be function-oriented in the sense that it seeks to understand the function of the target in relation to other translators in the target system. DTS is a goal-oriented mechanism designed to understand translation beyond the

\(^8\) Nord (1997: 123) observes that the loyalty principle was first introduced into the Skopostheorie in 1989 in order to account for the culture-specificity of translation concepts. It set an ethical limitation to the otherwise range of possible skopos rules for the translation of one particular source text. According to Nord (2007), as an interpersonal category referring to a social relationship between individuals who expect not to be betrayed, in the process, loyalty may replace the traditional relationship of fidelity, a concept that usually refers to a linguistic or stylistic similarity between the source and the target texts, regardless of the communicative intentions and/or expectations involved (Nord, 2007: 3).
Building on the notion that (so-called) observable facts are not only important but are integrated to the complete understating of norms-governed decision-making process for the translator, DTS holds that in translation the system that matters is the target text system. This is because it is the system that initiates a cross-cultural interchange. In this regard, DTS assists us in making sense of power dynamics between the “target textual tradition” and the translation. Target textual traditions are used to determine what form the translation will take, and that form usually promotes the target textual tradition (Hermans, 1999: 118). DTS follows norms similar to the Skopos rule, where, in translation, the system that matters most is that of the target text because it is usually the system that initiates a cross-cultural interchange.

In the example given earlier of Ukusoma, a Zulu lived custom, which permits lovers to engage in non-penetrative sexual relationship but is not the equivalent of sexual abstinence; one can clearly see how traditional equivalence-based translation theory is likely to produce unsatisfactory results if it fails to consider cultural difference as a crucial element in translation. There was evidence in this study of a close social and cultural relationship in people’s lived cultures and their languages. Ultimate equivalence and resemblance between source language text and a translation, particularly if used rigidly without adjustments, produces hopeless results. Skopostheorie and DTS can provide a panacea not only to the rigid way in which traditional translation theory perceives translation but also to the way it sets up what I see as unrealistic expectations. For instance, traditional translation theory regards a translation as some way of prolonging the life of the original text, without which the original will die (cf. Berman, 2005: 6). Essentially, translation reinterprets the original for different audiences, and thus provides for the continued flourishing of the text and, in the process, for the future of national transnational cultures. This view, though plausible and attractive, seems too romantic for South African context. For
instance, how can a text’s originality survive the code-switching of the languages of the townships?

The translation of health communication messages, particularly as drawn on in this study, suggests that there are doubtful outcomes to attempting to translate in such a way that one prolongs the life of the originals. Health communication messages, in particular, are translated to provide target audiences with information that, in many cases, leads to healthier outcomes, save their lives, and generally keep people healthy. It seems, here, that purpose trumps stylistic prescription. Imposing or forcing equivalence does not produce good results especially where there is a huge difference between the target and source languages and cultures. For instance:

It is reported that when Pepsi-Cola entered the soft drink market in Thailand, it keyed its advertising campaign to its well-known American slogan, “Come alive, you’re in the Pepsi generation”. The campaign only later traced its slow initial sales to the problematical Thai translation of the slogan: “Pepsi brings your ancestors back from the dead”. The incident is a graphic reminder that translation across languages is translation across cultures. It is the act of translation as a commitment to cultural understanding that is at the heart of the discipline of anthropology (Bachmann, 2006: 33).

The quest for preserving and prolonging originality seems unrealistic and is the complete opposite of the functionalist and Skopostheorie where the original text is treated as just an offer of information which can be used by the translator to inform a different kind of audience, in a way he or she deems appropriate. That is, the intention of the person seeking the translation is not necessarily to prolong the life of the original. This perspective appeals to me because it offers the translator freedom and wiggle room, within context. One is not a prisoner to some prescriptive do’s and don’ts.

Equivalence-based theory broadly seems to ignore the existence of other cultures, while unrealistically expecting other cultures to shake off their own in
order to serve as a medium for conveying messages from other foreign cultures (cf. Bandia 2008). But we cannot disassociate language from culture, and vice versa. Lotman (in Bassnett, 2002: 22) has argued that:

No language can exist unless it is steeped in the context of culture, and no culture can exist which does not have at its centre, the structure of natural language. Language, then, is the heart within the body of culture, and it is the interaction of life-energy. In the same way that the surgeon, operating on the heart, cannot neglect the body that surrounds it, so the translator treats the text in isolation from the culture at his peril (emphasis added).

The “attempt to impose the value system of the SL culture onto the TL culture”, says Lotman “is dangerous ground”. This is because the translator “cannot be the author of the SL text, but as the author of the TL text has a clear moral responsibility to the TL readers”. These are strong words indeed. Whereas postcolonial notions of “hybridity, cultural syncretism, and linguistic creolization point to the significance of cultural translation” (Bandia 2008: 229), the problem of cultural untranslatability does not go away due to “the vast power differentials between the centre and the periphery”. Traditional or normative translation practice, which tends to emphasise the so-called ethics of sameness (cf. Derrida 1985, 1996), needs to be constantly confronted with an ethics of difference. Postcolonial translation practice “has to resist an assimilative quest for sameness by emphasizing the cultural differences it brings to the global literary space” (Derrida 1985).

I noted, above, that part of the reason the norms of traditional translation theory may be felt to be unrealistic in the postcolonial context is because of legacy of the colonial tradition (cf. wa Thiong’o 1986; Prah 2013). The imposition of the language and culture of the coloniser resulted in the underdevelopment of the language of the colonised. In “today’s global and geopolitical economy, some languages and cultures are more equal than others”, (Bandia 2008: 234). This inequality is reflected, more so, in translation where it is “not always possible to find parallel norms between cultures, particularly in the colonial or postcolonial
contexts where distant or alien cultures share the same space in an unequal power structure”. Many African languages today lack “global capital and are unknown or absent in the global market as they are oral in nature and have no written form, and thus do not benefit from any direct translation in the global space” (Bandia 2008: 234).

South African indigenous languages are no exception: the nine languages (isiXhosa, IsiZulu, Tshivenda, Sotho, isiNdebele, siSwati, Xitsonga, Sepedi, and Tswana), though now made official, were underdeveloped during colonisation and also under apartheid rule. Trew (1994: 77, 78) cited in Ndhlovu (2014: 328) states that the history of South Africa has been such that:

Indigenous South African languages have been less used in technical fields, in national politics or in economic management. If a source text is not from a domain in which the use of African languages is currently well established, then an accessible translation will require considerable resources of adaptation and explanation and no bilingual dictionary will provide much help.

Whereas only Afrikaans was developed to second official language status, after English, indigenous languages only existed to entrench the apartheid’s divide and rule or separate development policy which was engineered to entrench white hegemony.

African languages are not only struggling in terms of terminology, but also with regard to resource availability. For instance, they lack specialised dictionaries that support translations during the process of translating. The historical underdevelopment South African languages and current official neglect mean that many indigenous languages lag behind when it comes to finding culturally equivalent terms especially, particularly in the specialised domains such as health and science. As noted, it is unfair to apply translation theories, created in the West, with western preconditions and expectations for languages which are somehow related or have some affiliation, to languages that are not only
linguistically diverse but suffer from deliberate colonial and apartheid underdevelopment.

The choice to opt for the combination of functionalist theory, Skopostheorie and DTS is thus not only informed by the limits of equivalence,⁹ but also by the unique conditions that exist in the South African context. On the one hand, Cluver (1989: 254), notes, “translators who translate into African languages constantly find themselves caught between the process of translating and of term creation”. One the other hand, there is the problem of the viability of translating scientific and specialised terms. As already stated, my study is on health communication messages.

It so happens that South Africa boasts a very limited lexical terminology for scientific and specialised terms for indigenous languages. Dimitriu (2009: 183, 184) notes that:

The South African translation scene is significantly different from its western counterparts, which has relatively homogenous and prosperous population, able to offer satisfactory economic income for translators and interpreters, a financially accessible tertiary education for most translator trainees; and a small number of working languages. [....] Applied to South Africa, it is English that complicates matters, since it is more often than not, either source or target language in the translation process.

The fact that an increasing number of translations are done by non-mother tongue speakers of English not only implies the need to improve English as a second language (ESL), but it also affects the viability of the local translation

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⁹ Snell-Hornby (1988: 22) has specifically argued that equivalence is unsuitable as a basic concept in translation theory because the term equivalence, “apart from being imprecise and ill-defined (even after a heated debate of over twenty years), represents an illusion of symmetry between languages which hardly exists beyond the level of vague approximation and which distorts the basic problem of translation".
scene when it comes to lexical terminology for scientific and specialised terms. Cluver (cited in Ndhlovu (2014: 329) has pointed out that translators “become neologists when the translators who are working on a developing language actively participate in the elaboration or development of terminology”. Such neologist-translators appear to need “a deeper understanding of word-formation processes than their counterparts who work on so-called ‘developed’ languages”.

The main theoretical point here is that the concept of preconditions for a translation seems rather antiquated. Bassnett-McGuire (1988) (cited in Bandia 2008: 235) has argued that “sameness cannot even exist between two TL versions of the same text, let alone between the SL and TL version”. Critically, once we accept the principle that sameness cannot exist between two languages, “it becomes possible to approach the question of loss and gain in the translation process”. At any rate, no two languages “are ever sufficiently similar to be considered as representing the same social reality. The worlds in which different societies live are distant worlds, not merely the same world with different labels attached” (Bassnett 2002: 21).

Equivalence in translation, although perhaps desirable and even attainable in certain conditions, should not, to my mind, be the main feature of any given translation. After all, as Bassnett (2014: 3) has pointed out, languages are never identical and no two languages “share the same structures, syntax and vocabulary”. As such, adjustments “always have to be made to accommodate the black holes that yawn when there is no equivalent in the target language for a word or an idea in the target language for a word or an idea expressed in the source language” (Bassnett, 2014: 9). Basically, no translation can ever be the same as the original. Since even ordinary, everyday words may be used contextually in quite different ways, the quest for equivalence seems doomed.
Bassnett and Lefevere, in *Translation, History and Culture* (1990), have identified what they call the “cultural turn” in translation theory. The cultural turn in translation flows from the larger concerns in functionalist approaches with meaning, function and context; and reflects a turn away from language-based, linguistic, and positivistic approaches to translation that had dominated translation studies up to this point. It acknowledges that translation practice is caught in large socio-cultural, historical and power dynamics. In the words of Nord (2007: 2), “translation practice does not take place in a void. It takes place in specific situations set in specific cultures. Therefore, any application of the general theory, either to practice or training, has to consider the specific cultural conditions in which a text is translated”.

The concept of the *cultural turn* in translation theory used in this study incorporates the postcolonial translation theory of Spivak’s in “*The Politics of Translation*” (1993), and the cultural studies-oriented analysis of Venuti (2000). In these theories, culture is identified as a *multifaceted*, complicating factor in translation and as a contributing factor to untranslatability. Spivak (1992: 179) argues that translation: “is the most intimate act of reading”, that it is “a miming of the responsibility to the *trace of the other in the self*” and that “Language may be one of many elements that allow us to make sense of things and of ourselves. Making sense of ourselves is what *produces identity*”.

Following Spivak it seems that language is once again being assigned a new role in opposition to the perception that language is the determining factor of what a good translation is. For Spivak:

Language is not everything. It is only a vital clue to where the self loses its boundaries. The ways in which rhetoric or figuration disrupt logic themselves point at the possibility of random contingency, around language. Such dissemination cannot be under control. Yet in translation, where meaning hops into the spacey emptiness between two named historical languages, we are perilously close to it (1992: 180).
Spivak argues that language and translation are not about the transfer of bodies of meaning, but language and translation allow the agent [translator] to facilitate the love between the original and its shadow [translation], a love that permits fraying, hold the agency of the translator and demands of her imagined or actual audience at bay. My reading of Spivak’s statement is that a translator needs to break away the norm of retaining the language of the original and allowing the fraying of the original language in other to allow new possibilities. This we see in the statement that “The ways in which rhetoric and figuration disrupt logic themselves point at the possibility of random contingency around language.

Spivak postulates that the translator must not conform to the demands of both the agency and the imagined audience but instead must try to pay attention to the rhetoric of the original. But what is the rhetoric of the original and how can we know it? Real translation, according to Spivak, can only take place when there is interplay between rhetoric and logic. Hence:

Logic allows us to jump from word to word by means of clearly indicated connections. Rhetoric must work in the silence between and around words in order to see what works and how much… The jagged relationship between rhetoric and logic, condition and effect of knowing, is a relationship by which a world is made for the agent, so that the agent can act in an ethical way, in the world. Unless one can at least construct a model of this for the other language, there is no real translation (1992: 181).

Logic, it seems, is more technical, allowing us to follow a system (“to jump from word to word by means of clearly indicated connections”) in step by step ways. Rhetoric, on the other hand, is located more in the realm of feeling and intuition (“must work in the silence between and around words”). Together, the two allow an ethical act of translation to occur.

Whereas both traditional and functionalist theory centres language, the mode of the cultural emphasised by Spivak appears to turn away from language
altogether. Translation, as an ethical (as well as intimate) act, begins by exposing the “limits of language”:

The translator must surrender to the text. She must solicit the text to show the limits of its language, because that rhetorical aspect will point at the silence of the absolute fraying of language that text wards off, is a special manner… No amount of tough talk can get around the fact that translation is the most intimate act of reading. Unless the translator has earned the right to become the intimate reader, she cannot surrender to the text, cannot respond to the special call of the text. We have to turn the other into something like self in order to be ethical. To surrender in translation is erotic than ethical (1992: 183).

After exhorting the translator to proceed in ways that specifically expose the limits of language, Spivak provokes us to consider the opposite of what she considers ethical: the erotic. The text has a special call, which interpolates the self, and requires that translation be understood not as something mechanical but, rather, “the most intimate act of reading”. The rhetoric of the text becomes key to surrendering oneself to adopt the other’s identity.

Thus, translation is about communication, reaching out, and love, and is inherently humanising. This reading has echoes of Paulo Freire in the *Pedagogy of the oppressed* where the act of reading the word is both an act of reading the world and an act of love, which humanises the reader through literacy. I would therefore say that for Spivak translation is a mode of reading the word, humanising the world, and of literacy. It includes critique as well as love and intimacy. Spivak opines that:

In order to earn that right of friendship or surrender of identity, of knowing that the rhetoric of the text indicates the limits of language for you as long as you are with the text, you have to be in a different relationship with the language, not even only with the specific text. That takes a different kind of effort from taking translation to be a matter of synonym, syntax and local colour (ibid.)
In contrast to the technical notion of fidelity, which stresses that a translation must show some resemblance to the source text in terms of structure, meaning and syntax, Spivak embraces post-structuralism, which she claims is able to show that translation must be approached from a three-tiered notion of language i.e. rhetoric, logic and silence.

The act of translation, however, is not just personal and intimate. It is also political, critical and practical. Spivak, for instance, embraces the necessity of taking a historicised position and a gaze towards the world, of being gendered, and being bilingual in Third World translation:

I think it is necessary for people in the Third World translation trade now to accept that the wheel has come around, that the genuinely bilingual post-colonial now has a bit of an advantage… In my view, the translator from a Third World language should be sufficiently in touch with what is going on in that language to be capable of distinguishing between good and bad writing by women (1992: 187, 188).

That is, Spivak writes from both a postcolonial, feminist and a cultural (studies) perspective that involves being anchored in history, critiquing power and empire, having an identity and utilising bilingual postcoloniality. Hence, she draws on resistance and identity politics in showing her annoyance with writers who claim to have something in common with women from the Third World without even bothering to learn their languages and cultures.

Spivak appears to revise her earlier ambivalence towards language, where she downgrades language’s role in facilitating the intimacy of the act of translation, by suggesting that the intimacy of cultural translation has a lot to do with (the learning of indigenous) languages. Language is necessary for solidarity:

Rather than imagining that women automatically have something identifiable in common, why not say humbly and practically, my first obligation in understanding solidarity is to learn her mother tongue. You will see immediately what the differences are. You
will also feel the solidarity every day as you make the attempt to learn the language in which the other woman learnt to recognize reality at her mother’s knee. This is preparation for the intimacy of cultural translation… In other words, if you are interested in talking about the other, and/or in making a claim to be the other, it is crucial to learn other languages (1992: 191).

Indeed, learning the language of the other is a mode of preparation for solidarity. By emphasising the notion of solidarity, Spivak takes off where the functionalists left off. The functionalists, although more culturally committed than the traditional equivalence theorists, still did not commit themselves politically beyond saying that translation is determined have a distinct purpose. Spivak goes further and identifies the act of translation as being political, as having a political purpose: solidarity. As she says, “If you are going to bludgeon someone else by insisting on your version on solidarity, you have the obligation to try out this experiment and see how far your solidarity goes” (1992: 192).

Without subsuming difference, translation allows commonality if it is approached in terms of the intimacy between logic and rhetoric. In fact, difference is necessary to solidarity and commonality between the oppressed of the world:

Tracking commonality through responsible translation can lead us into areas of difference and different differentiations... There are differences that we must keep in mind. And we must honour the difference between ethnic minorities in the First World and majority populations of the Third World (Spivak, 1992: 193).

Spivak thus brings up not just the cultural turn but also the postcolonial turn to translation. That is, her theorising about translation is relevant to the global south and is of the global south. There is no distance imposed between the act of translation and the reception of the translated text by non-English speakers. Rather, her conception of translation centres “the ethnic minorities in the First World and majority populations of the Third World”.

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Venuti, like Spivak, regards translation as more than just an innocent act. For him, translation “never communicates in an untroubled fashion”. Rather, it is always bound up, implicated and inscribed with other acts, intentions, purposes and contexts. That is, the source text is always interfered with and what comes after the translation process is seldom, if ever, the communication the source text as intended. The translation, in the end, is the site of multiple determinations. For Venuti:

In contemporary theory informed by continental philosophical traditions such as existential phenomenology and poststructuralism, language is constitutive of thought, and meaning a site of multiple determinations, so that translation is readily seen as investing the foreign-language text with a domestic significance. Translation never communicates in an untroubled fashion because the translator negotiates the linguistic and cultural differences of the foreign text by reducing them and supplying another set of differences, basically domestic, drawn from the receiving language and culture to enable the foreign to be received there. The foreign text, then, is not so much communicated as inscribed with domestic intelligibilities and interests Venuti (2000: 468, 469).

Venuti sets up a binary between the domestic (context of reception) and foreign (source text), suggesting that the domestic always interferes with the foreign, and vice versa. That is, the foreign text is always inscribed with target text intelligibilities and interests which start at very choice of the text for translation, always a very selective and densely motivated choice, and continues in the development of discursive strategies to translate it, always a choice of certain discourses over others. Here, the foreign text is domesticated before it is further processed by the reader and made to bear other domestic meanings and to serve other domestic interests.

The notion of domestication is crucial to the cultural turn because it imbues the users of the translated message with agency. Domestication is the process of interfering with the foreign text. However, interference must not be taken in a negative light. Rather, it is simply proof that the translated text is a site of
multiple determinations. Indeed, translation does something more than communicating the foreign text. The source message is always interpreted and reinvented, especially in cultural forms open to interpretation, such as literary texts, philosophical treatises, film subtitling, advertising copy, conference papers, legal testimony.

This interference with the source text raises the question: how can the source message be invariant if it undergoes a process of ‘establishment’ in a ‘certain’ target language and culture? Drawing on such questions, this study sought to find out, for instance, how much of the original messages “remains” in the English-to-Zulu translated health messages. Venuti’s (2003: 471) verdict, however, seems clear: “the foreign text is rewritten in domestic dialects and discourses, registers and styles, and this results in the production of textual effects that signify only in the history of the domestic language and culture”. Whether or not this is the case with English-to-Zulu messages is revealed in the findings of the study.

Venuti is critical of “domestic inscription” which “never quite” becomes “cross-cultural communication”. He laments the absence of an ethics that counters simple domestication and blames this failure on the dependence on domestic dialects, registers, discourses, and styles. Hence:

Seen as a domestic inscription, never quite cross-cultural communication, translation has moved theorists towards an ethical reflection wherein remedies are formulated to restore or preserve the foreignness of the foreign text. Yet an ethics that counters the domesticating effects of the inscription can only be formulated and practiced primarily in domestic terms, in domestic dialects, registers, discourses, and styles. And this means that the linguistic and cultural differences of the foreign text can only be signalled indirectly, by their displacement in the translation, through a domestic difference introduced into the values and institutions at home (2000: 469).
Domestication is thus limited if it cannot cross over into being a genuine displacement of the foreign text that fosters authentic cross-cultural communication. Venuti, like Spivak, is critical of attempts by translators to create imagined communities abroad still using the same domestic tool and strategies. They are not simply critical of dominant strains in translation theory. Rather, both seem preoccupied with using translation as a tool, mode and instrument of cross-cultural communication. This also questions the extent to which health communication messages seen in rural KwaZulu-Natal constitute authentic cross-cultural communication.

As with Spivak, Venuti (2000: 469) is preoccupied with the ethics of translation and, further, with difference and solidarity. The “ethical politics of difference”, for Venuti, motivate a translator to solidarity.

When motivated by this ethical politics of difference, the translator seeks to build a community with foreign cultures, to share an understanding with and of them and to collaborate on projects founded on that understanding, going so far as to allow it to revise and develop domestic values and institutions. The very impulse to seek a community abroad suggests that the translator wishes to extend or complete a particular domestic situation, to compensate for a defect in the translating language and literature, in the translating culture... This translator knows that translations never simply communicate foreign texts because they make possible only a domesticated understanding, however, much defamiliarized, however, much subversive or supportive of the domestic (Venuti, 2000: 469).

In a technical sense, it seems that what Venuti is saying is that whatever attempt is made to preserve foreignness in foreign text is in vain, as long as there is domestic inscription in translation. This speaks to the issue of agency mentioned earlier. A broader point, however, is that translation is motivated by solidarity and the seeking of community. For Venuti, the fact of domestic inscription of the foreign, and the absence of cross-cultural communication unaffected by domestic intelligibilities and interests, cast doubt on the kinds of
communities that can be fostered through translations. He argues that domestic inscription limits and redirects the communicative aim of translation.

Toury’s (1980: 17) definition of translation, which regards translation as communication in translated messages within a certain cultural-linguistic system, considers that such communication must include “all relevant consequences for the decomposition of the source message, the establishment of the invariant, its transfer across the cultural-linguistic border and the re-composition” (emphasis added). Domestic inscription, it seems, makes the “establishment of the invariant” impossible. Spivak (1992: 191) considers what needs to happen in translation for translation to achieve its communication purpose but also notes the deficiency when she says that, “If you want to make the translated text to be accessible, try doing it for the person who wrote it. The problem becomes clear then, for she is not within the same history of style”.

Translators may try to preserve foreign text as much as possible in their translations, but domestic inscription always limits that. For Venuti the invariant is impossible because “it undergoes the process of establishment is a certain target language and culture. Source message is always reconstructed according to a different set of values and always variable according to different languages and cultures”. Venuti seems clear that there can be no total transfer of foreign text in translation, as is observed when he asks, “Can a translation ever communicate to its readers the understandings of the foreign text that foreign readers have?” (Venuti, 2000: 473) His answer is that “Yes, I want to argue, but this communication will always be partial, both incomplete and inevitably slanted towards the domestic scene”.

For Venuti, domestic inscription, at the level of the domestic scene, seems also to be linked to the problem of untranslatability. The fact that “communication will always be partial, both incomplete and inevitably slanted” seems, in fact, to define an aspect of untranslatability. Venuti outlines, in some detail, how he
thinks untranslatability or loss of meaning in foreign text occurs. As Venuti (2000: 472) puts it:

The remainder does not just inscribe a domestic set of linguistic and cultural differences in the foreign text, but it supplies the loss of the foreign-language differences which constituted that text. The loss occurs, as Alasdair Maclntyre (1988: 384) has observed, because in any “tradition-bearing community” the “language-in-use is closely tied to the expression of the shared beliefs of that tradition” and this gives a “historical dimension to languages which often fails to survive the translating process.

Maclntyre (1988: 384, 385) has argued that the problem of untranslatability “is most acute with ‘the internationalized language-in-use in late twentieth-century modernity’, like English, which ‘neutralize’ the historical dimensions of the foreign”. English translation appears to render “other” texts context less. By rendering such texts context less, they are turned into authorless texts which even addressed audiences struggle to recognise as belonging to particular authors.

Venuti’s conception of the “cultural turn” is crucial for my study because of its openness: it does not shut other possibilities out of the translation process. For Venuti, the purpose of a translation is to create heterogeneous communities. For him, the domestic inscription in translating constitutes

A unique communicative act, however, indirect or wayward. It creates a domestic community of interest around the translated text, an audience to whom it is intelligible and who put it to various uses. This shared interest may arise spontaneously when the translation is published; attracting readers from different cultural constituencies that already exist in the translating language… Any community that arises around a translation is far from homogenous in language, identity, or social position. Its heterogeneity might best be understood in terms of what Mary Louise Pratt calls a: “linguistics of contact”, in which language-based communities are seen as decentred across “lines of social differentiation” (Pratt, 1987: 60). A translation is a linguistic “zone of contact” between foreign and translating cultures, but also
within the latter. The interests that bind the community through a translation are not simply focused on the foreign text, but reflected in the domestic values, beliefs, and representations that the translator inscribes in it. And these interests are further determined by the ways the translation is used (Venuti, 2000: 477).

Whereas my analyses of health communication messages sought to find how intelligible the messages are to the target audiences (domestic inscription), and what uses the target audiences put the messages, attention will also be paid to how the translator presents issues and to the more “intangible” issues identity, social position, community and the linguistics of contact.

Conclusion
This chapter has presented a discussion of translation theories in general, in terms of a background and a critical evaluation, and examined the selected frameworks of the functional approach to translation, the Skopostheorie, DTS, and the “cultural turn”. Drawing on the theories explored in this chapter, I have argued for considering the importance of the interplay between language, culture and health communication. The choice to opt for the combination of functionalist theory, Skopostheorie and DTS was not only informed by the limits of equivalence, but also by the unique conditions that exist in the South African context. I take the position that traditional translation theory has not only run its course but is largely inadequate for purposes of recognising and acknowledging cultural “load” that characterises translation.

That is, traditional translation theory is regarded as incompatible with many translation scenarios that are relevant to the particular South African context selected for this study. It is made incompatible, in part, by the fact that it expects the target text to be an extension of the original text’s life. This is unattainable if we agree that a translation is an offer of information by the translator. The main theoretical point made was that the concept of preconditions for a translation seems rather antiquated and unrealistic. The chapter therefore
discussed functionalist theories, arguing that they are more relevant for postcolonial contexts. For instance, Skopostheorie, based on the premise that the purpose of the translation must determine the strategy to be used during the translation, was seen as a more nuanced alternative. The chapter concluded by appraising the cultural turn, which calls for a new attitude towards the act translation. This entailed evaluating the ideas about translation of Spivak and Venuti.
CHAPTER FOUR

RESEARCH METHODOLOGY AND DESIGN

Introduction
This chapter lays out the methodology and research protocol that was utilised in the study. I describe the methods and the techniques used to collect and analyse data, providing reasons for preferring these methods. I also describe the nature and size of the sample, where it was drawn from, and ethical considerations, centring on consent and confidentiality. This study, investigated the interplay of culture, language, translation and untranslatability on selected English-to-Zulu health communication messages in use at selected sites in rural KwaZulu-Natal, focusing on printed media such as posters, leaflets and pamphlets that are printed in Zulu after having been translated from English. The study was conducted in KwaZulu-Natal province, at nine rural clinics in the uThukela District Municipality, and one rural clinic in the uMzinyathi District Municipality.

As noted in Chapter One – whether we like it or not – English is the de facto lingua franca of the South African government and state. This is despite the fact that most the “clients” (in fact, citizens) of the state are unable to access or utilise information through this language. This is because the National Language Policy Framework (NLPF), which stipulates that all national government structures and public institutions must adopt one or more working languages and that official government publications must also appear in all eleven languages, or failing this, in six languages on a rotational basis, is not being adhered to. English’s dominance as a source or relay language has not only resulted in the underdevelopment of African languages but has also led to the emergence of what one could call “translation cultures”.

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Essentially, government seems most comfortable speaking directly to its citizens in English but, in order to fulfil a constitutional obligation, throws in a translator and a translation into the bargain. That is, translation of the “official word” has become a key element in the South African government’s communication with its citizens. I thus examined the relationship and interplay between of health, health communication, culture and language on the production and translation of health communication messages in order to establish how, if at all, the dependence on translation, and in particular the dependence on particular modes of translation, bears upon health communication and messaging.

The investigation, which is motivated in part by the fact that nothing (or at least very little) is being done to address or change the situation described above, sought to acquire an in-depth understanding of the lived processes of meaning, meaning-making in respect of health messages. This study posed the following three specific research questions:

1. How do selected target audiences in the real-world contexts of rural KZN use, understand and make sense of selected health communication messages translated from English to Zulu?

2. Why do selected target audiences in rural KZN use [if they do], understand, and make meaning out of translated health communication messages in the way they do?

3. What is the nature of the “translatable” and the “untranslatable” in selected English-to-Zulu health messages and what does it reveal about the relationship between language and culture, and between language, culture and health?
This exposition of my research question is important because the design of the whole methodology process draws from it. As Creswell, 2007: 39-41) points out:

The research problem or questions requires it, to better understand an area where little is known, to make sense of complex situations, contexts, and settings, to learn how participants construct their worlds, to gain deep, rich and detailed descriptions of cultural scenes, to help empower individuals to express their stories and enact meaningful social change and to generate theory where little exists.

Without a clearly defined research question, a study will lack one of the most important steps in research. The methodology I chose arose from my search for the most appropriate and rigorous way of addressing my research question. As noted repeatedly in the previous three chapters, this study is preoccupied in large part with the issue of *meaning*, by whom it is made, how, why, and how and why it is deployed.

As noted, in Chapter 1, most studies of translation commonly focus on what Walter Benjamin has called “The Translator’s Task”. That is, there is a preoccupation with the translated text and the role and process of the translator in transforming the text. There has been little specific focus on what actual audiences in real world contexts do with the translated message. Questions about the extra-linguistic life, meaning and circulation of translated messages in communities of users have not been subjected to any previous systematic study. Few studies investigate how the users or target audiences of the translated messages perceive, and what they feel about, these messages. This study sought to fill this research gap, the ultimate aim being to contribute to the debate about the relationship between health, culture, socio-cultural context, language and communication. There are as yet no previous studies focusing on the translation of media from English into any of South Africa’s indigenous languages. No intensive systematic or in-depth research has been done focusing strictly on translation and untranslatability of communication in socio-
cultural contexts or with regards to health messages. Additionally, this study contributes to the nascent field of African translation studies. Finally, this research aimed to contribute to efforts to craft approaches for designing culturally appropriate public health communication strategies.

The study utilised a qualitative methodology, for the reason that my main research question itself seeks to answer “what”, “how”, and “why”. As noted, I sought to examine the interplay of language, health and culture, and understand – in detailed ways – people’s experiences of translated messages, in rural contexts where not much is currently known. This kind of data cannot be quantified, it needs to be interpreted to get a deeper understanding of the participants' perspectives and reasoning in relation to health communication messages that they have access to. This necessitated the choice of a qualitative research design. Kothari (2004: 31) has defined a research design as:

> The arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with the economy in the procedure. In fact, research design is the conceptual structure within which research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data.

Broadly, my research design was informed by my preoccupation with going beyond the traditional “translator’s task”. The issue of meaning, by whom it is made, how, why, and how; and why it is deployed requires not just a bit more interpretive leeway, but to expand how we see the “essence” of translation. True, the translated text and the role and process of the translator in transforming the text is still important. However, I was also interested in giving specific focus to what actual audiences in real world contexts do with the translated message, including questions about the extra-linguistic life, meaning and circulation of translated messages in communities of users.
In light of the theoretical point made in Chapter 3, that the concept of preconditions for a translation seems rather antiquated and unrealistic, I also sought a research methodology that was light on “preconditions” – or at least one that allows flexibility. Such a methodology could only be qualitative. Bogdan and Biklen (2007: 274) have defined qualitative research as “an approach to social science research that emphasises collecting descriptive data in natural settings, uses inductive thinking, and emphasises understanding the subjects’ point of view”. Some of these elements were present in my study, such as collecting data in natural settings of rural KwaZulu-Natal, and the emphasis on understanding subjects’ point of view. Denzin and Lincoln (2005: 3) define qualitative research as:

A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world more visible. These practices transform the world. They turn the world into a series of presentations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them.

We noted in the last chapter that languages do a kind of work, and that it might even be said that languages behave in a certain way. How languages, in particular English and IsiZulu, do this is of interest in this study. Glesne (2011: 283), for their part, defines qualitative research as “a type of research that focuses on qualities such as words, or observation that are difficult to quantify and lend themselves to interpretation or deconstruction”. I feel that this definition applies to the data that I collected through interviews, and which I treated through an interpretive lens. It also echoes Venuti’s important conception of the “cultural turn”, which I cited as being crucial for my study because of its emphasis on openness. The “cultural turn” does not shut other possibilities out of the translation process.
Other definitions of qualitative research emphasise what is elemental to qualitative research, such as that it is “concerned with qualitative phenomena, i.e. phenomena relating to or involving quality or kind” (Kothari, 2004: 3). Hesse-Biber and Leavy (2004: 5) have noted that:

What distinguishes the field of qualitative research is its diversity. It encompasses a wide range of epistemological positions and theoretical framework while offering many distinct research methods. Qualitative inquiry, then allows researchers to ask different counterparts. Qualitative research allows for thick descriptions of social life, detailed explanation of social processes, and the generation of both micro and macro levels of analysis.

The term “thick description” is, of course, borrowed from Clifford Geertz refers to the eliciting of data that is in-depth and qualitative, and that allows us to read the social and the subjective. This preoccupation is critical to my study, shaped as it is by the functionalist paradigm in translation and, in particular, the “cultural turn”.

The benefits of employing a qualitative research methodology for a study such as mine are obvious, considering that my three research questions do not seek to generate numbers or quantities but, rather, reflect an interest with the broadly intangible and unaccountable which differ from individual to individual. In this study, I am largely attentive to the issue of meaning, by whom it is made, how, why, and how and why it is deployed. Creswell (2007: 39) argues that we conduct qualitative research because we need a “complex, detailed understanding” of a given issue. Such detail can only be established “by talking directly with people, going to their homes or places of work and allowing them to tell their stories unencumbered by what we expect to find or what we have read in the literature”. Hence:

Qualitative researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in a situation,
and generally sketching the larger picture that emerge. Researchers are not bound by tight cause and effect relationships among factors, but rather by identifying the complex interactions of factors (Creswell, 2007: 39).

As stated, my study is broadly interested with “meaning”. Meaning, however, is not just a grammatical item. Rather, it is also social and cultural. It is this socio-cultural element of meaning that this study also seeks to tease out and elicit. This, again, is more in line with the functionalist and cultural turn in translation, in contrast to equivalence which in Chapter 3 was described as a “static, result oriented concept describing a relationship of equal communicative value between two texts or, on lower ranks, between words, phrases, sentences syntactic structure and so on” (Nord 1997: 7).

The benefits of qualitative research are linked to the methodology’s peculiar characteristics. Creswell (1994) has outlined some of these characteristics. For instance, qualitative research is inductive, in that the researcher builds abstractions, concepts, hypotheses, and theories from details. Furthermore, it is descriptive, in that the researcher is interested in process, meaning, and understanding gained through words or pictures. By saying that qualitative researchers are interested in meaning is meant a preoccupation with how people make sense of their lives, experiences, and their structures of the world. Meanings and interpretations are negotiated with human data sources because it is the subjects’ realities that the researcher attempts to reconstruct (Lincoln and Guba 1985; Merriam 1988). The concern, primarily, with processes, means also that researchers are less preoccupied with outcomes, products, or hard deliverables. Miles and Huberman (1984) have considered four parameters that typify qualitative research designs: the setting (where research will take place); the actors (who will be observed or interviewed); the events (what the actors will be observed doing or interviewed about); and the process (the evolving nature of events undertaken by the actors within the setting).
Denzin and Lincoln (2005) have counselled that “the ideal approach to assessing knowledge, attitude and perception is qualitative and interpretive”. Because my study seeks to go beyond the traditional translator’s task to an investigation of the experiences, attitudes and perceptions of the users of translated messages, there is a preoccupation with the subjective dimension of the communication process that involves translated messages at rural clinics, and even an interest in “the various factors which motivate people to behave in a particular manner, or which make people like or dislike a particular thing”. Kothari (2004: 3, 5) expands on the benefits of qualitative research, stating that:

Qualitative research is especially important to the behavioural sciences where the aim is to discover the underlying motives of human behaviour. Through such research, we can analyse the various factors which motivate people to behave in a particular manner, or which make people like or dislike a particular thing. [...] Qualitative approach to research is concerned with subjective assessment of attitudes, opinions and behaviour.

Broadly, the diverse definitions of qualitative research sketched out in this introduction complement each other. This is because they all emphasise the use of the methodology in attempts to understand people’s belief system, perspectives, and experiences.

That is, seemingly the key thing in qualitative research is the participants’ perspective or points of view on issues. Whereas quantitative methods seek to measure something (and by so doing) generate numbers as data for analysis, qualitative methods typically generate words. But the definitions must not just stop at complementing each other. They must aid in understanding the phenomenon that this study grapples with: official communication that is not just normatively in English but is also expected to be translatable into other South African languages. This expectation of translatability, though taken for granted, is far from given or simple. Translation is not merely a technical, linguistic task. Rather, it is a complex and complicated phenomenon that
intersects in language (in all its verbal, mediated and embodied modes), culture, and identity.

Data collection and sampling
To collect data, I opted to combine an umbrella of primary and secondary methods for purposes of eliciting “thick” data (cf. Geertz 1978) and enriching the overall quality and depth of such data. For instance, I started the process by purposively selecting a sample of 20 translated health communication messages, as and when such material became available. But this was only the first phase of the data collection journey. This documentary selection raised obvious questions about uses and reception of that material that could only be addressed with data gathered in situ, mainly from focus groups discussions. But there was no way I could conduct focus groups without a selection of the translated text at hand. At the same time, had my study only been a desktop study, the initial phase of gathering documentary evidence of the translated messages would have sufficed, and I would not have needed to go out into the field and interview people. Rather, I would just have carried out desktop and documentary analysis of the material, as if it were a literature review or textual analysis.

Instead, the study of content and meaning of translated English-to-Zulu messages, especially in relation to situations where there may be no linguistic and cultural fits or equivalents to convey the intended messages in isiZulu, certainly required a degree of the researcher’s presence in situ. The task of going beyond the “translator’s task” required a lot more, methodologically. I fulfilled this by conducting set focus groups at selected sites. Finally, having gathered primary data about users’ experiences of the translated messages using focus groups, I also needed to fill some gaps here and there: additional information that I could not get via focus groups was gathered from key informants (namely, health professionals at some clinics, as well as key personnel those involved in translating messages or conveying the health
department’s translation policies). It is possible – and valid – that “purists” may consider these eclectic combinations to constitute a sort of methodological overkill, but I regarded this cocktail of data collection methods as necessary, because each method was invaluable in filling a gap that the others did not. Also, each of methods I applied could have been used in a preliminary or a follow-up role, without necessarily altering or reducing its efficacy. The larger and ultimate goal remained, as Morgan (1997) says, to strengthen the total research project, regardless of which method is the primary means of data collection.

In the end, each of the methods preferred had advantages and disadvantages, yet they also complement each other when used interchangeably. For instance, as Morgan (1997: 23) suggests, follow-up interviews with individuals can help provide depth and detail on topics that were only broadly discussed – and perhaps not made sufficiently clear – in group interviews. The larger issue is that I had the opportunity to practise some flexibility during the data collection process. That is, the methods I used tend to reflect how I reflexively dealt with fieldwork, within the limits and context of the overall qualitative research design. I concede that, had my study been quantitative, I would perhaps not have had the same empirical flexibility.

Essentially, a main observation I made about the process of data collection is that being out in the field is not the same as sitting at a desk and deciding in absolute terms how the data will be collected. Once “out there” one is confronted with a variety of situations that necessitate flexibility. Below I shall describe some of those problems encountered at the clinics that reflect the difficulties of “fieldwork” and of the overall data collection process. As Creswell (2007: 39) suggests, the research process for qualitative research is always in the process of emergence, which means that “the initial plan for research cannot be tightly prescribed, and that all phases of the process may change or shift after the researchers enter the field and begin to collect data”.

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The first, though not the main, method of data collection I used was desktop selection of translated messages. This material was gathered on my trips to selected sites or from the government health departments. As intimated above, my key focus was on printed media such as posters, leaflets and pamphlets that are printed in isiZulu after having been translated from English. There were, however, very few billboards at these rural clinics or at the Department of Health’s offices and in the communities where fieldwork was conducted. Messages used in the study were thus drawn mainly from the printed material.

I purposively collected 20 messages that were available at different clinics, and also from the KwaZulu-Natal Department of Health’s Communication Unit, and the Department of Arts and Culture’s translation unit (See Appendix for a list of these messages in abbreviated form).

Tesch (1990: 60) states that “when dealing with language as a communication, one (has to) be interested in the content of texts”. I thus selected those messages that not only contained translated content, but content that was on diverse health topics. All the messages sampled sought to inform and educate visitors to the clinics about the nature of different diseases, their signs, symptoms, prevention, and cure. I would have liked to use more health communication messages in my focus groups, but there were always time constraints on the side of focus groups participants. An immediate observation I made is the lack of messages in isiZulu at the clinics. In some cases, there was a total absence. Also, many of the messages contained in pamphlets, leaflets and posters were dated. Even the Central Health Information hub in Ladysmith, where most clinics under the uThukela District Municipality fall, get their health communication material from, has little up to date health communication material. The breadth of this problem is illustrated by the fact that the health messages available at this central hub in Ladysmith are severely outdated: staffers at that office informed me that their last supply of health communication material from central government was 10 years ago. Most
clinics have stopped expecting updated health communication material as a result. As a result, the only up-to-date messages that I used in my focus groups were procured directly from the departments involved.

The second method I used was face to face interviews. I did not use this method extensively or primarily, but only to fill gaps in information drawn from my main research instrument of focus groups. I included this instrument mainly in order to gather information from key informants from the KwaZulu-Natal Department of Health and the Department of Arts and Culture. In total, I gathered four such interviews, two from each department. The producers of the original or source messages were represented by selected key personnel from the Department of Health’s communication unit in Pietermaritzburg. The producers of the translated messages were represented by key personnel from the Department of Arts and Culture’s translation unit also based in Pietermaritzburg. I hoped to use this data to evaluate the “translator’s task”: the creative, design and planning processes behind the production, translation and dissemination of health communication contained on printed material. I sought to establish the context of design, production, translation and dissemination of these messages, and how they choose messages for translation. Did they the actively consider identity of the end-user at all? Did they consider literacy levels, and cultural orientation of the target audiences? Did the translators operate on the basis of equivalence or the functionalist paradigm? Did they, in their translations, have any sense of the “cultural turn”?

I formulated open-ended questions for these key informants, partly to get thick descriptions but also because my earlier attempts to ask them pointed questions were treated with suspicion, fear or even hostility. Most key personnel that I initially approached fobbed me off simply by informing me that they felt that they were not properly qualified to be included in my study, or that no one in their unit was designated, authorised or in a position to answer the questions I had. Thus, to get the some of the officials to speak to me at all I had to adapt
my line of questioning to make it more relaxed and less structured. I might add that the attitude of these key personnel in these government departments towards outside researchers took me rather by surprise. As suggested, the attitude ranged from mild suspicion to irrational fear to open hostility.

One identifiable positive in these personal interviews, apart from their being with key informants, is that I was able to use more subtle cues to negotiate the direction of the interview, in contrast to the focus groups where I only had "control" as a moderator. I was able to ask follow-up questions on interesting questions. Creswell (2007: 39) has noted that:

In a qualitative inquiry, we ask open-ended research questions; wanting to listen to the participants we are studying and shaping the questions…. Our questions change during the process of research to reflect an increased understanding of the problem. Furthermore, we take these questions out to the field to collect either words or images.

Certainly, focus groups required greater attention to my role as moderator and, in comparison, seemed to provide less depth and detail about the opinions and experiences of participants.

The third method I used was focus groups. This was my main data collection method, targeted at “users” of clinics. This method of data collection has been defined as follows:

As a form of qualitative research, focus groups are basically group interviews, although not in the sense of an alternation between a researcher’s questions and the researcher’s participants’ responses. Instead, the reliance is on interaction within the group, based on topics that are supplied by the researcher who typically takes the role of a moderator. The hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group (Morgan, 1997: 2).
To some extent, this method was forced on me because of limited time with clinic users who would have travelled long distances and were anxious to be in queues or to return to their homes. Certainly, focus groups seemed useful to kill many birds with one stone, when time to collect data was limited due to circumstances beyond my control.

Creswell (2007: 133) points out that focus group discussions are critical in that they facilitate the provision of “direct evidence about similarities and differences in participants’ opinions and experiences as opposed to reaching such conclusions from analysis of separate statements from each interview”. Morgan (1997: 8, 9) has argued that the main advantage of focus groups “is the opportunity to observe a large amount of interaction on a topic in a limited period of time”. This opportunity, however, is directly dependent on the researcher’s moderating skill and their ability to assemble and direct the focus group scenario. At the same time, argues Morgan, this control is also a disadvantage. This is because “it means that focus groups are in some sense unnatural social settings. Because the discussions in focus groups are controlled by the researcher, we cannot be sure of how natural the interactions are” Morgan (1997: 9). Because of the small number of participants, focus groups discussions data and interviews data also cannot be generalised. However, this is a limitation – or, rather, a constraint – that affects all qualitative studies.

My creatively adapting to time constraints aside, I found focus groups to be a useful instrument for gathering data partly because of the very nature and geography of my research site: rural clinics in remote KwaZulu-Natal. There is an integral baseline dimension to my study, because such research populations are not easy to access. I also wanted, in my focus groups, to allow my participants to say as little or as much as they like, in order to gather data that reflected more “authentically” the “meanings” of the participants themselves. Focus groups, as Smithson (2000: 105) says: “is not merely…a quick way to pick up relevant themes around the topic, but a social event that includes
performances by all concerned”. Saldanha and O’Brien (2013: 172) have enlarged on the benefits of this “free-flowing” process:

The interviewer uses a series guiding questions at their discretion so as to direct the required information in the manner that best suits the circumstances of the interview. The goal is generally to see the research topic from the perspective of the interviewee and to understand how and why they have come to a particular perspective. Interviewers are allowed to improvise, and open-ended questions allow participants to say as little or as much as they like, actively shaping the course of the interview. As a result, data collected tend to reflect more accurately the concerns of the participants themselves, although it is at the expense of comparability.

Apart from offering an efficient use of time (by allowing access to the perspectives of a number of people during the same time period), focus group scenarios can bring out multiple perspectives on a given topic. The researcher would use a focus group to better understand how a group would discuss the issue at hand and elicit multiple perspectives in the process (Glesne, 1992: 131).

In addition to learning about the research topic itself, focus groups interviews can be useful as exploratory research to help determine the line of questions that you want to pursue in individual interviews. I observed in my groups that individual participants were able to have their subjective opinions heard, despite the limitation of being interviewed in a group. A further advantage of using focus groups is that this method provides “direct evidence about similarities and differences in the participants’ opinions and experiences as opposed to reaching such conclusions from post hoc analyses of separate statements from each interviewee” (Morgan, 1997: 10). On balance, and despite the limitations discussed, the instrument of focus group discussions proved to be well suited to the task of eliciting participants’ experiences and opinions in their own words. This, for me, was one criterion of success for my study. If I was able to gather data that seemed to contain “authentic” perspectives of clinic users’ sense of
translation and untranslatability, I would have considered such data to be adequate for purposes of addressing the main aspects of my three research questions.

As intimated earlier, selecting participants for focus groups sessions was not easy. Since my samples had to come from clinic users (who are mainly patients), it was not always easy to convince them to stay for focus group discussions after their consultations because most of them had already spent a long time in the queues and always wanted to leave the clinics as soon as they were done. On the other hand, it was not easy to get them to leave the queues to participate in discussions before consultations because they were always concerned that their consultations would be delayed because of their participation. People go to the clinic when they are sick or to collect their medications, not to sit and talk with a stranger-researcher. After their business, they want to go back home immediately to rest or do planned chores. And, because some of them often stayed in queues for long periods, it becomes very difficult to keep them at the clinics once they get their turn to be assisted. Even some of those who had agreed to participate would leave the room once I informed them about the time they were likely going to spend in the sessions. An hour (sometimes more) proved too long for some of them. Other participants were expecting to be incentivised for participating in the focus group, and they would immediately show reluctance once they realised that there were to be no incentives.

In all, I conducted 12 focus groups, stratified according to the aggregate number of clinics (listed below) surveyed. Sampling was purposive. Saldanha and O’Brien (2013: 34, 180) state that:

Purposive sampling involves selecting a sample based on pre-defined critical parameters. This technique is commonly used in corpus-based studies and interview-based studies. Although it is possible, in theory to apply random sampling methods in large studies based on interviews, the aim is rarely to generalise to
wider populations but rather to provide rich and diverse information from key informants. To achieve this goal, purposive sampling, where participants are selected on the basis of principled criteria so as to cover the key aspects of the research question, is more effective.

Participants in each group were mixed in terms of gender and age and numbered between 6 and 10. This figure represents a standard range, constrained by the fact that the group cannot be too small or too big. Morgan (1997: 43) states that practical and substantive considerations are behind the rule of thumb size that specifies a range of 6 to 10, adding that “Below 6, it may be difficult to sustain a discussion, above 10; it may be difficult to control”. Numbers also depended on the availability and willingness of participants on a given day at a given site. The ages of the participants ranged between 16 and 55.

The following are the ten clinics at which the focus groups were conducted:

1. Limehill Clinic
2. Sgweje Clinic
3. Rockcliffe Clinic
4. Douglas Clinic
5. KwaMteyi Clinic
6. Gcinalishone Clinic
7. Tholusizo Clinic
8. Matiwaneskop Clinic
9. Ekuvukeni Clinic
10. St Chads Community Health Centre.

At two of the clinics (Limehill and Ekuvukeni) I conducted 2 focus groups each. Bachuk and Badiee (2010: in “Realising the Potential of Qualitative Designs: A Conceptual Guide for Research and Practice”) state that, unlike in quantitative designs, qualitative researchers “base purposeful selection criteria of sites,
individuals, and events on their relevance to advancing the understanding of the research problem or question rather than on achieving population representativeness”. This rationale partly influenced my choice of sites of research. In hindsight, the number of clinics sampled need not have been so high, since 5 or 6 groups allowed me to reach saturation. However, I found that there were still subtle differences in the answers I got, even after so-called “saturation”. Ordinarily, a higher number in a sample population, if it is not going to alter the findings, is not a problem. It is merely overkill. In any event, researchers strive to keep going with data collection until their intuition tells them to stop or until they feel comfortable that they have achieved saturation or have a fairly comprehensive understanding of the phenomenon. There is no hard and fast formula in qualitative research.

The actual focus groups, once assembled, themselves proceeded with relatively few glitches. I structured the focus group interviews to be participant- and content-oriented. Essentially, my role in these focus group discussions was limited to directing the conversation and encouraging participation. Participants were selected on the basis that they are able to read the media in both English and Zulu or have someone who can read the printed media on their behalf. They were also expected to be able and willing to discuss and answer questions relating to the content of the media that they were presented with. Considering the approach used in “picking up” participants (they were not at the clinic for social reason, but they had all visited the facility for health-related reasons), most of them did not know each other, although I assumed that a few did. After

10 Saturation is the point at which additional data collection no longer generates new understanding (cf. Morgan, 1997: 43). Dörnyei (2007: 126), cited in Saldanha and O’Brien, states:

Ideally, the iterative process of analysing and collecting data should go on until a saturation point is reached, which occurs when additional data do not seem to develop the concepts any further but simply repeat what previous informants have already revealed.
briefing the participants about the study, its aims and objectives, I would hand out, to each of the participants, excerpts or extracts of selected health messages in original and translated versions so that they could quickly read (or at least scan) and assess their readability and comprehensibility. This mode of operation (giving selected extracts only, as opposed to the whole message) was dictated by time constraints and the unwillingness of some participants to stay too long at the clinic. The size of extracts from each sample was also determined by the size of the entire message. The English and IsiZulu versions were typed or written side by side. For example, extracts from the original version were typed on the first column and the translated isiZulu version on the opposing column parallel to the English. Participants were given approximately 10 to 15 minutes to familiarise with both extracts.

After having read the extracts, participants were then given an opportunity to discuss the intelligibility or the ease of understanding or difficulty of understanding the content of the messages. Could they read what was there? Did they comprehend it? Did it mean anything to them? Although respondents had to read both English and Zulu messages, the main purpose of the discussions was to investigate the intelligibility of Zulu messages which are a translation. The logic behind the 15-minute “reading exercise” was to allow the messages to sink in so that I could, in my questions, establish whether the translated messages conveyed the same message as the original version. In my questioning I would inquire about cultural attitudes to the health issues or diseases mentioned in the extract, particularly how the message came across culturally, as we ask the participants to rate the “translator’s task” and competence. Was the translation successful?

Consideration was given to lines of questioning that tended to promote conversation within each group, constrained by my three main research questions. The four themes of language, translation, culture, and health communication, as identified in Chapter 2, broadly informed the kinds of
questions that I asked the participants. To get the discussion going, I always started each session with an experimental question that each individual participant had to answer to create a starting point and make everyone comfortable in talking. An example of such a question would be: “Out of both versions of the messages that you have read, which ones were more intelligible and why?” I would also ask “What made unintelligible messages unintelligible?” and “Would you effectively be able to pass the messages you have read from translated messages to another person? Please explain”. The overall discussions sought to find out what meanings, if any, the participants made from each version, and revolved around whether the translation succeeded or not.

Data from the focus groups discussions was recorded on a voice recorder, although I also took written notes. These notes were not just back-up, helped but generate new and follow-up questions for subsequent interviews should the need for more clarity arise. The language used in all the focus groups was IsiZulu. (Saldanha and O’Brien, 2013: 46) have noted that “The language used in the research design might contribute to an exclusion effect since those who do not speak the language or who are less competent in its use, will either select not to participate or will automatically be excluded”. To prevent these kinds of exclusions and to also avoid misinterpretations during the sessions I encouraged participants to communicate in a language that they were comfortable in. Recorded data was then transcribed verbatim soon after, in preparation for analysis. The recording devices provided a complete and accurate record of what was said during the interviews and discussions.

I interviewed key informants at the Corporate Communications Unit of the KwaZulu-Natal Department of Health in order to gather insight into the creation, production, translation and dissemination of health messages. This Unit of the KwaZulu-Natal Department of Health is responsible for the design and production, including graphic design and typing, of health communication
messages that go out to the public. They informed me, however, that they do not conceive or write or create the original messages. Rather, health communication messages are written or created by creatives at different units or programmes within the Department of Health, such as the TB Programme, Communicable Disease Programme. These are the units, departments or programmes that initiate and generate original content and then send it to the Corporate Communications Unit for design and production. I was told that the assumption is that these programmes, because they are the ones which are directly involved in diseases management, know best what messages need to go out to the public. I was informed that they have experts who have been working on different diseases for a very long time and who know all the facts about the diseases they are working on. The Corporate Communications Unit, however, collaborates closely with these diseases’ management programmes.

In terms of the workflow management, all content development is done by the disease’s management programmes in the KZN Health Department. Each of the diseases’ management programmes put together the messages that they want to send out to the public and then forward them to the Communications Unit for production design, layout and typing. That is, the messages are already complete by the time they get to the Communications Unit. At this stage, they are mostly in English. The conception of messages in English, therefore, is done by the diseases’ management people. The Communications Unit initially just receives and forwards the English versions of the health messages to the Department of Arts and Culture for translation. After translation, the messages then return to the Communications Unit for production design and layout.

**Ethical considerations**

Standard ethical protocol specifies that I have an obligation to respect the rights, needs, values and desires of the participants. Specific safeguards were thus provided. These include formal ethical clearance from my university (the University of Johannesburg). The letter confirming ethical clearance is provided
as part of the Appendices. I also obtained formal, written gatekeeper clearance for each research site, prior to carrying out interviews. Permission to do research at the clinics was obtained from UThukela District Municipality, while permission to do research in the province including interviews with government departments’ personnel was obtained from the KwaZulu-Natal Department of Health. Arrangements were made in advance with the gatekeepers at different clinics that were used as sites to conduct focus groups discussions. Prior to beginning interviews, I articulated the research objectives so that they were clearly understood by each participant. I also described how the data collected would be used, preserved and destroyed after five years, in accordance with my university’s guidelines.

Participants were informed and assured that verbatim transcriptions and written interpretations and reports would be made available to them should they need them. They were also informed that their rights, interests and wishes were considered first when choices are made regarding reporting the data. Participants were also informed and assured that the final decision regarding their anonymity rested with them. I then provided each participant with a consent form, in IsiZulu and/or English, and explained what was in it and what it was for, in such a way that this was clearly understood. The form detailed everything about the study and the participants’ rights, including their freedom, choice and right to cease participating in the process whenever they felt they wanted to do so, and for whatever reason. I thus only collected after each participant had understood, consented and signed the consent forms. Needless to say, informed consent is one of the core principles in ethically-designed research, and it was my responsibility to ensure that participants fully understand what they are consenting to participate in (Saldanha and O’Brien, 2013: 43).
Data analysis
I have already indicated, of course, that data in this study is not going to be expressed in numerical form. Numbers cannot speak for themselves: they must be interpreted somehow. We saw that Chapter 2, the literature review, was organised and structured according to the four themes of language, translation, culture, and health communication. This same structure informs the thematic analysis adopted in Chapter 5. That is, the specific data analysis method chosen for this study is thematic analysis. Since data cannot interpret themselves, this is the specific method I shall use to attach meaning to the data.

Marshall and Rossman (1990: 111) explain that data analysis “is the process of bringing order, structure and meaning to the mass of collected data. […] Qualitative data analysis is a search for general statements about relationships among categories of data”. Hitchcock and Hughes (1995: 295) add that it represents “the ways in which the researcher moves from a description of what is the case to an explanation of why what is the case is”. Creswell (2007) states that:

Qualitative data analysis generally consists of preparing and organising the collected data for analysis, reducing the data into themes or patterns through a process of labelling, coding and abstraction, and representing these data visually in figures, tables, and in narrative form (cited in Babchuk and Badiee, n.d.)¹¹

Essentially, data analysis requires the researcher to develop categories and make comparisons and contrasts, and to “be open to possibilities and see contrary or alternative explanations for the findings” (Creswell, 1994: 153). This involves the researcher taking a large amount of information and reducing it to certain patterns, categories, or themes and interprets this information by using some schema.

¹¹ https://msu.edu/~mwr2p/Babchuk%26Badiee-MR2P-2010.pdf
In thematic analysis, the researcher focuses analytical techniques on searching through the data for similar themes and patterns. One of the important aspects of this process is data coding, wherein one reads through all the pieces of data coded in the same way and tries to figure out what is at the core of that code (Glesne, 1992: 187). I tagged and coded answers from the transcriptions according to the broad themes of translatability and untranslatability, and according to a coding tree predicated on the keywords in all the four research questions. In the coding tree, attribute codes were described in as far as they conveyed demographic information, while substantive codes reflected the actual rich content of each respective focus group session. Using the qualitative analysis software, N-Vivo 11, to do the tagging, coding and categorising of themes, I then inductively searched for patterns among the themes, and to consider relationships between themes.

Tesch (1990: 56, 60) asserts that when language is studied as communication, there is more than one way of doing so. For instance, it can be studied as an art form or as information, or the researcher can be mostly interested in “meaning”. When the researcher is mostly interested in “meaning”, she or he interprets and looks for “themes”, some of which might not be directly expressed in the data but emerge from them upon intensive analysis. In my study, translated health communication messages were checked against the originals to evaluate if social constructions and cultural aspects play any role in the meaning of translated messages. It also helped in identifying translatability and untranslatability issues (that were there) in the selected messages. Particular attention was paid to the meanings and usage of language in translated messages in order to establish whether the selected corpus of translated messages communicated what was intended by the original version.

**Conclusion**

This chapter outlined and discussed the different methods and techniques that were used to collect and analyse data. It also touched on sampling and ethical
considerations. In the chapter reasons for choosing specific methods are given and defended. For instance, I have discussed both the advantages and disadvantages of focus groups discussions. I have also shown why the combination of approaches is in the best interests of the study and how they complement each other. This chapter is a prelude to the most important chapter in the study, the findings chapter, which comes next.
CHAPTER FIVE

ENGLISH-TO-ZULU HEALTH COMMUNICATION MESSAGES IN RURAL KWAZULU-NATAL

This chapter presents data collected on the basis of the protocols and procedures outlined in Chapter Four, and analyses and discusses it. It is, to all intents and purposes, the most important chapter of the study. It precedes the conclusion to the study. The study investigated the interplay between health, culture and language by exploring translation and untranslatability in a selected corpus of English-to-Zulu health communication messages that circulate or are disseminated in rural settings in KwaZulu-Natal. The study began with the observation that the expectation of translatability of health communication messages from English into African languages, has become a common practice in South African public health communication (cf. Lubinga and Jansen 2008: 72). Translation figures as the main, go-to option if government, and also non-governmental organisations and the private sector, are to communicate effectively with all citizens across South Africa and across the 11 official languages. However, the assumptions behind the notion of “effective” communication have never really been fully teased out.

The study thus explored the possibilities for meaningfulness – or, its opposite, meaningfulness – of translated messages in the lived, social, and cultural contexts of target audiences in rural KwaZulu-Natal. From these participants, the study sought to establish a sense of those elements which are translatable and those which are not, and why. What causes translatability and, also, untranslatability? What can we learn from this phenomenon? Below, the study breaks down its findings and discusses them in light of the three research
questions. The chapter is organised in such a way that it addresses the following three broad thematic issues:

1. How selected target audiences in the real-world contexts of rural KZN use, understand and make sense of selected health communication messages translated from English to Zulu?
2. Why selected target audiences in rural KZN use [if they do], understand, and make meaning out of translated health communication messages in the way they do?
3. What the nature of the “translatable” and the “untranslatable” in selected English-to-Zulu health messages is, and what it reveals about the relationship between language and culture, and between language, culture and health?

An unsurprising finding of my study confirmed the master status of English – of English as being translatable as-a-matter-of-course or as not needing translation at all. This hegemony of English relegated isiZulu to being the only source of all translation problems and, more importantly, of untranslatability. In South Africa, as Dimitriu (2009: 183, 184) points out, it is English that complicates matters, since it is more often than not, either source or target language in the translation process. The Department of Health and the Department of Arts and Culture normatively expect health messages to be conceived in English, and then translated to indigenous languages such as IsiZulu. There is, in government, a strong, pro-English reflex. Act No. 12 of 2012: Use of Official Languages Act, 2012, regulates and monitors the use of official languages by government and government departments and agencies and seeks to promote parity of official languages in the country, facilitate equitable access to services and information of national government, and promote good language management by national government, for efficient public service administration and to meet the needs of the public.
The continued preferential usage of English by national government in all its official communications reflects a strong, pro-English reflex. Interestingly, the preference for English seems to be justified in Chapter One of the Founding Provisions of the 1996 Constitution which states that:

The national government and provincial governments may use any particular official languages for the purposes of government, taking into account usage, practicality, expense, regional circumstances and the balance of the needs and preferences of the population as a whole or in the province concerned; but the national government and each provincial government must use at least two official languages (emphasis added).\(^\text{12}\)

When scrutinised, the above paragraph is a shortcoming in the South African Constitution in relation to the provision of language rights. In my interviews with key personnel from the Department of Arts and Culture’s translation unit, it was clear that “usage, practicality, expense, regional circumstances and the balance of the needs and preferences” equal English. That is, the normative use of English as a starting point for the health communication translation process is considered to be a foregone conclusion because it is simply practical. Starting with IsiZulu as the origin of the translation is considered complicated, impractical, and expensive.

Ironically, most people in KZN use IsiZulu, and regional circumstances and the balance of the needs and preferences should favour their contexts and should favour IsiZulu as the origin point of meaning-making. So, what is going on? I decided to examine the interplay of language and culture. As MacIntyre (1988: 384) has observed, in any “tradition-bearing community” the “language-in-use is closely tied to the expression of the shared beliefs of that tradition” and, as

such, gives a “historical dimension to languages which often fails to survive the translating process”. The issue, at the outset, therefore is not so much English as the issues thrown up by English’s, systemic dominance. What became immediately clear was that master status of English was merely a proxy for what was going on under the surface. Scratch under the surface of English’s hegemony in translation and what came out were layers of tradition-bearing communities where “language-in-use” reflected strains of cultural domain that made mockery of the translating process.

The master status of English led me to the observation that what takes precedence in the end are the circumstances and the balance of the needs and preferences of the translators themselves. The needs of the users in real-world contexts were not taken into consideration in how messages were translated. But this is where things become interesting. We observed in Chapter 3 that meaning-making is not just a grammatical item. Rather, it is also social and cultural. The translators at the Department of Arts and Culture seem to have little regard for the socio-cultural element. At least, for them practicality is the overriding concern. As argued in Chapter 1, most official translations are mediated via English as a rule. But practicality is code-word for convenience. This goes against Spivak’s statement that a translator needs to break away the norm of retaining the language of the original thus allowing the fraying of the original language in order to allow new possibilities.

Starting with English seems convenient for the translators, even if – as we will see – it is largely inconvenient for the rural clients of clinics. As Nord (1997: 32) has stated what the translation can do and should do is “to produce a text that is at least likely to be meaningful to target-culture receivers”. This entails that the clients of the clinics in rural KZN should be able to understand the message and that the message should “make sense in the communicative situation and culture in which it is received”. Certainly, communicative interaction can only be regarded as successful if the receiver “interprets it as being sufficiently coherent
with their situation”. The prescription of translation schemes, while it assists translators with ready-made formulas, also complicates the role of the translator and of the reading public since meaning-making is not so much formulaic as contextual and socio-cultural. In the “real world”, outside the cubicles of the translation unit, culture is multifaceted, complicates translation, and contributes to untranslatability. We will see this demonstrated succinctly in the example of Inoni and Umabhebeza further below.

Here, at the outset, I would like to argue that it is Zulu culture itself that it untranslatable. Our analysis has to necessarily see translation in a variety of modes. One such is inflected by what we observed in Chapter 2 and 3 to be the cultural turn. The cultural turn established translation as more than just an inter-linguistic process. That is, it was much more complex than just replacing source language text with target language text. Rather, it must incorporate cultural non-imponderables and nuances that can shape the options and attitudes of recipients.

In a word, translations are never produced in a cultural or political vacuum and cannot be isolated from the context in which the texts are embedded. Thus, translation performs a crucial role in our understanding of the cultural ‘other’ (cf. Dingwaney and Maier, 1995, cited in Bernacka 2012). As Tymoczko (2014: 14) has asserted, there is need for a paradigm shift of sorts in translation studies – a shift that moves away from the Eurocentric tradition and its alienating scaffolding of positivism. Precisely, there is a need in translation studies for “more flexible and deeper understanding of translation, and the thinking on non-Western peoples about this central human activity is essential in achieving broader and more durable theories about translation” (Tymoczko 2014: 14).

We can start that de-scaffolding by looking at an example. Despite many decades of health communication by various means – for instance, about HIV – the persistence of stigma points to an enduring failure or at least to superficial
gains. An HIV positive participant in the focus group at Limehill Clinic related how her family relationships took a turn for the worse when she went for an HIV test and found that she was HIV positive. Whereas her family had always taken care of her when she was sick and receiving treatment prior to the diagnosis, everything changed after she confirmed her HIV-positive results. She reported that:

When I first got sick, my father took me to a traditional healer who told us that I was bewitched because my ancestors want me to become a sangoma. He said this was their way of telling us what they wanted me to do. He said they wanted me to help other people by becoming as sangoma. My father believed this and I underwent training as a sangoma, but the problem was that I was not getting better. I stayed in training until I completed my training. I was still sick and not getting better, but one good thing is that my family was taking care of me and even washed me when I could not. My father is a staunch traditionalist and he still believed I was going to get better after completing training as a sangoma. I also could not start practising as a sangoma as I was very sick. I then decided to go on my own to the clinic to take an HIV test and the results came back positive. I told my family the bad news, but my father was still in denial. He said what I have is not HIV/Aids and it is not a new disease. He even suggested that I should get some traditional concoction and I would recover. When I told him that I want to continue with HIV treatment, he expelled me from home. I do not have a place to stay as we speak. I have a child and they expelled my child too.

The larger issue here seems to be health literacy – but health literacy as an aspect that emerges in the interplay of language and culture. The take-away from the quotation above is that health literacy that ignores the persistence of complicated, complex and problematic cultural beliefs is likely to keep running up against the same cocktail of deep-seated cultural beliefs that involve Umbhulelo, providence, God, ancestors, misfortune, spells, evil spirits, witchcraft, sorcery, tokoloshes, or bad luck. Participants pointed out that although some of these beliefs might be looked at negatively in educated circles, they were constrained from turning their backs on culture and tradition. The reason they proffered for this is that this is how they were raised.
At the intersection of language and culture – at the point of interplay – is where I see the untranslatability of Zulu culture located. That is, health communication has to come to terms in the first instance with **contending forms of health literacy**. Untranslatability produces not a single, monolithic healthy literacy to the hegemony of English, but health literacy in the plural. These forms of health literacy are shot through with contradictions and are saddled with the burden of an isiZulu that is itself burdened by Zulu culture. A nurse I interviewed at Limehill Clinic had this to say about these contending forms of health literacy:

Cultural beliefs affect our work a lot. A while ago, when I used to work at the hospital, I had a problem when I was preparing another old woman for theatre. That woman was from the rural areas in uMzinyathi Municipality District. When you prepare a person for theatre there are certain procedures that you need to follow. One of the procedures of preparing her for the operation she was going to undergo was that I had to clean and sanitise her private parts. Normal hospital procedure specifies that I was not supposed to insert a catheter inside her without cleaning the vagina. I told her about this and that is where the problem began. She told me that I was not going to clean or wash her private parts unless I had money or a cow to pay damages. I asked the woman what the damages were for. She then told me that she does not wash her vagina because when her husband comes back from Johannesburg, **he must be able to smell her** even when she is in the other room. The husband must smell her scent and know she is there even before or without seeing her. Nothing else is supposed to touch her vagina until her husband returned. What she was going to say to her husband when he discovered that her vagina did not smell the way he expected it to? Her husband would be angry and would interrogate her about who she was with in his absence and accuse her of promiscuity or having a lover. When I tried to explain to her why it was important for her to be cleaned before the operation, she started telling me that, because I was educated, I considered myself better than her and I was looking down upon her and her culture. She got very upset and I had to apologise, and I ended up putting the catheter without cleaning her. **She refused even when I told her that she might get an infection.** I was forced to proceed without her being cleaned. I had to write a note describing her refusal to follow procedures. I had to do that because I could not stop her from undergoing an
operation and at the same time I could not force to do things that seemed like a violation of her culture and tradition to her.

The Limehill nurse is, at one level, describing the role and persistence of cultural beliefs. Others might interpret the woman from uMzinyathi’s actions as irrational. But this is only an aspect of it. The extreme clarity of the woman’s refusal to have her vagina cleaned (whether she is right or not, whether we agree with her or not), her invocation of damages, the power of an absent husband (or absent patriarchy, perhaps), and the woman’s firmness in her convictions are all aspects of what I am calling cultural untranslatability. Whereas this individual might not be health literate according to the norms of Western medicine and its style of healthcare, she seems to be health literate in her own culture (cf. Neilsen-Bohlman, Panzer and Kindig 2004). It is not that the woman’s refusal does not make sense or is irrational. Rather, it is that it is untranslatable. She is invoking a health literacy that the nurse finds ineffable and untranslatable.

The functionalist approach, detailed in Chapter 2 and 3, privileges contexts of use, which themselves are imbedded in culture. If function is understood as the potentiality of the translated text to release diverse effects, beginning with the communication, followed by the production of a response (Venuti 2005: 5), then the back and forth between nurses and their Zulu patients who either refuse to be treated or negotiate how they are treated has to be located in the interplay of culture and language. Neilsen-Bohlman, Panzer and Kindig (2004: 117) observe that “People with diverse cultural experiences may differ on how a fever is defined or described how pain is expressed, and how body parts are identified, such as whether there is a different name for each finger”. Translation never communicates in an untroubled fashion. The source text is always interfered with (Venuti). The “foreign” text is always rewritten in domestic dialects and discourses, registers and styles, and this, results in the production of textual effects that signify only in the history of the domestic language and
culture. After all, it is not just words that must be translated, but also the ideas, worldviews, cultural mores and moral values that the words convey.

A key informant, a nurse at Ekuvukeni Clinic, indicated that Zulu men, in particular, are difficult to attend to when it comes to sexually transmitted infections (STIs). She said:

Men are very reluctant to work with female nurses when it comes to their private parts. Unfortunately, most nurses are women. As a nurse you must first see the condition of the private parts before you can treat a person. You cannot just go by what he is saying; you might think it is a minor thing from what he is telling you, but in actual fact find that the damage is too bad. You see, the problem with sexually transmitted infections (STIs) is that someone will tell you or describe something as if it something else, when the actual ailment is totally different from what he is telling you. Seeing is very important when you treat STIs: it is important to see what you are treating. Men, however, are reluctant to undress before a woman and show you their privates. They would rather prefer only to describe it; it becomes a struggle and a waste of time to convince them to undress. Recently, I had to treat a young man who had sores on his penis, but he was refusing to show me how they looked. It took me a long time but, I finally won after telling him that after he leaves the consultation room, I will not even remember him or what his penis looked like. I warned him that I could not help him or give him any treatment if I did not see or know what I was treating.

This reluctance to undress before a woman nurse and be examined by her is partly because STIs affect genitalia and involve discussing sensitive sexual histories. But there is also Vermeer (1989: 229) insists that one cannot prise the source text from the source culture, or the target text to the target culture. “As its name implies,” says Vermeer, “the source text is oriented towards, and is in any case bound to the source culture”. It is this aspect – source text glued to the source culture, and target text glued to the target culture – that I find interesting in relation to untranslatability. This is a point at which the nurse accepts that she will not be able to convince the young man that it is proper to
see his genitals, even if he is in pain and wants to be treated. This is not just patriarchy at work. There is something untranslatable at work.

This point of the untranslatable is the same point that the nurse who wanted to clean the vagina of the woman from uMzinyathi also reaches when she decides to go ahead with the procedure minus the cleaning. It is not that they have reached an impasse. Rather, they have reached the point of the untranslatable. The woman wanted to keep her unique smell, for her husband’s sake, even if this meant getting an infection. At the same time, she wanted to be treated. Henle (1965: 3) says this about culture: “All those historically created design for living, explicit and implicit, rational, irrational and non-rational, which exist at any given time as potential guides for the behaviour of men”. Everett (2013: 49) on culture avers: “Is the field in which the mind grows and creates – the field fenced in by shared ideas and values. Constrained by these ideas and values, members of the culture create the perimeters of their existence and their means of survival”. The woman who refused to have vagina sanitised or cleaned knew how to survive and maintain her marriage.

The untranslatable is the same point reached in the belief that health problems can be caused by witchcraft. A clinic matron that I interviewed at Sgweje Clinic explained that it was difficult, when talking to patients, to always separate an objective biomedical diagnosis from cultural, spiritual and mythological explanations involving God, ancestors, misfortune, spells, evil spirits, witchcraft, sorcery, tokoloshes, or bad luck. Patients must accept the nurse’s diagnosis, but they still believed that, over and above that diagnosis, those other forces were also at work. The nurse pointed out that there was always a reluctance to believe in single, empirical causes of diseases. Rather, they felt better if they believed that there was more to the diagnosis. The nurse pointed out that the most problematic patients tended to be those with cancer, gangrene, TB and HIV:
Cancer is one good example where indigenous and western knowledge clash. Sometimes a person will be diagnosed with cancer and when you tell him the bad news, he will come up with a cultural or traditional explanation to the condition, which he expects you to believe. He will tell you that it is impossible that he can have a growth out of the blue. The same thing will happen with people who have gangrene on their feet. They will tell you that gangrene has been caused by Umbhulelo, which means that he jumped over some spell on the ground which was set by a witch to make him sick. Once a person starts thinking that he was bewitched, there is no way that you can completely alter his line of thinking. Such people tend to prefer substituting western medicine for traditional medicine. They may also default on treatments. Other patients when they suffer a stroke, they will go as far as telling you that they were kicked by some evil bird that was sent by a witch. When you tell them that their stroke was caused by high blood pressure, they will want to know where the high blood pressure is coming from. If you can’t answer every question, they tell you do not know what you are talking about. As a result, some of them will refuse to take certain medication because they prefer using traditional concoctions. I am not saying traditional or cultural stuff does not work, there are cases where they are right and making sense.

Participants in the focus groups indicated that there are cultural or traditional explanations for every single sickness. As Gasset (1937: 59) observes, “Languages separate us and dis-communicate, not simply because they are different languages, but because they proceed from different mental picture, from disparate intellectual systems – in the last instance, from divergent philosophies”. It emerged in the focus groups that many rural people straddle two worlds: they are comfortable taking western medicine as far and as long as it works, while also observing their “culture and tradition” as far and as long as it works.

Consulting traditional healers or spiritual healers and going to the clinic or to the doctor are part of a menu of options. A participant in the Gcinalishone Clinic focus group even thought that “It is only when a person is very sick that they go to clinics or doctors”. The participants live and move in a world where they seek explanations and solutions for ailments both from western medicine and
traditional medicine. Another participant in the Gcinalishone Clinic focus group contended that:

Many people have died because they wasted a lot of time going to traditional healers for ailments that cannot and have never been solved by cultural and or traditional medicine. Many people have been killed after being accused of witchcraft when the sick people have been suffering from diseases that have nothing to do with witchcraft, such as HIV/AIDS and TB. But, also, there are other times when you will find that sometimes someone wastes a lot of time going to doctors, hospitals and clinics when the problem could have been solved through tradition. We need both western medicine and tradition. For example, I know someone who could have had her foot amputated, but something kept on coming when she needed to go for amputation, this kept on happening three times and the foot did not get worse; one day she went to a traditional healer and a solution was found and she was saved from amputation. We must have both.

Neilsen-Bohlman, Panzer and Kindig (2004: 109) note that cultural health beliefs affect how people think and feel about their health and health problems, when and from whom people seek healthcare, and how they respond to recommendations for lifestyle change, healthcare interventions and treatment adherence.

The expectation of translatability itself – the fact that official communication that is not just normatively in English but is also expected to be translatable into other South African languages – presumes another expectation: that people are literate in a certain normative sense. Translations of health communication are done in order to make information accessible to users who would otherwise not be able to read and comprehend it if it was not translated. There is thus a clear assumption that translations are targeted at people who can read, or who have access to people who can read. There is such an assumption of literacy, that people are literate. There is, however, a further assumption embedded in this first assumption.
This is the assumption that people are literate only in one language, and that this one language is not the *lingua franca*. The translation is thus targeted at people who can read but are likely unable to read the *lingua franca*. In South Africa lingua franca, this would be English. This situation appears to be the one happening in UThukela District Municipality. Statistics SA, which keeps national statistics on such things as poverty and education, defines literacy as “the ability to read and write in at least one language”. The World Bank defines literacy as people who are aged 15 and above, who can read and write with understanding a short simple statement on their everyday life. Many of the people in rural KwaZulu-Natal can be considered literate on these criteria, since an average of 75% can read and write in isiZulu.

However, being able to read and write in one language, IsiZulu still leaves most of the people at a disadvantage because they cannot read or write in English. Also, being able to read and write with understanding a short simple statement on one’s everyday life is not enough to read and understand a health message. My study found that translations are made on the assumption that the majority of people in KZN are literate but forgetting that such literacy is problematic if it means an ability to read and write in at least one language or being able to read and write with understanding a short simple statement on their everyday life. As Neilsen-Bohlman, Panzer and Kindig (2004, 39) stated, possessing the skills needed for basic literacy does not guarantee that one can read and comprehend all types of written text. After all, not all texts are equally readable and comprehensible to every person, regardless of that person’s reading ability.

Apart from knowing and understand the individual words and terms used in the texts, readers must be familiar with the concepts addressed in the texts. This disjunction between the expectation of literacy and the reality that people’s literacy is inadequate for dealing with English as a *lingua franca* was behind some of the frustration expressed by participants. The *bilingual post-coloniality* cited by Spivak is a missing link in the translation environment in rural KZN.
because people mainly read and write in only one language: IsiZulu. However, as we saw in Chapter 3, for translation to work it must partly be seen as an intimate act of reading. I observed that some participants struggled to understand messages that were in IsiZulu because the language and the translation, while grammatically correct, seemed wrong in everyday usage.

For instance, I encountered a sentence such as the following from a message about MDR TB: “Decentralized MDR TB sites have been established in all districts to make it easier for patients to be initiated onto treatment and retained in care closer to their homes”. An isiZulu translation for this was: Kunezizinda ezisatshalaliswe kuzo zonke izifunda okulashelwa kuzo i-MDR TB ukuze kube lula ukuthi iziguli zithole ukwelashwa esigabeni sokuqala kanye nokuthola ukunakekelwa ezindaweni eziseduze namakhaya azo. While the translation appears to directly convey the message contained in the English text, it is somehow distorted by the use of esigabeni sokuqala as opposed to the English “to be initiated”. Esigabeni sokuqala can be interpreted to be saying “at initial/beginning stage”, which is the opposite of the English which translates as “to be started” or “to start”. Participants in the focus groups stated that esigabeni sokuqala is almost always gives the isiZulu audience an impression that there are other treatments stages to follow. Participants pointed out that the use of esigabeni sokuqala in the existing translation instead of, say, ukuze baqale ukwelashwa, tended to create a degree of unnecessary confusion and difficulty for them.

Other participants blamed themselves. They felt inferior to the translations, stating that they felt that their difficulty with the translations was because the isiZulu used by the translators was some kind of high-brow IsiZulu that was above their level of understanding. Some participants who struggled to understand the translation even though they were composed in isiZulu suggested that, rather than reading the messages themselves, they would prefer to ask someone more knowledgeable to read and explain messages to
them. This led focus group participants to express concern at what they perceived as their low level of education compared to the “highly educated” creators of health communication messages. The translation, although in IsiZulu, made readers feel *linguistically inferior* and stripped them of their agency and subjectivity. Whereas some regarded reading messages that they did not understand as a waste of time, and thus resisted the message as a whole, some participants pointed out that they felt that the messages were not meant for people like them; people with low levels of education. How terms are used in different contents relate to other contexts in multilingual societies like South Africa. Translators need to select terms with caution to retain the correct messages.

Other participants just dismissed the whole enterprise of health communication as so much “toilet paper”, as illustrated by the participant in the Gcinalishone Clinic focus group who revealed that:

> Paper like these pamphlets can contain good messages, but we rural people, when we see paper, what also comes to mind is not communication, but we see it as wasting a paper that one can use when he goes to the toilet, or that I can use to wrap tobacco. You are not always keen to read these papers.

Neilsen-Bohlman, Panzer and Kindig, (2004: 110-111) have asserted that beyond the differences of languages:

> Culture gives significance to health information and messages. Perception and definitions of health and illness, preferences, language and cultural barriers, care process barriers, and stereotypes are all strongly influenced by culture and can have a great impact on health literacy and health outcomes... Differing cultural and educational backgrounds among patients, and providers, as well as among those who create health information and those who use it, contribute to problems with health literacy... Individuals, families and communities have belief systems, religious and cultural values, and group identity that serves as powerful filters through which information is received and processed.
In concert with the above, (O’Neil 2006) argues that: “The cultural environment that people grow up in can have surprising effects on how they interpret the world around them”. Health literacy is thus a much deeper and more complex construct than mere literacy as defined by the World Bank. If we are to accept that the wheel has come around, that the genuinely bilingual post-colonial now has a bit of an advantage, then translators at the Department of Arts and Culture cannot just proceed on the assumption that being able to read and write in only IsiZulu is adequate for them to go ahead and translate rigidly. Participants pointed out that the intelligibility of translated health communication messages in general is made difficult by rigid translations. Some of the participants did not realise that the messages were translated: they just thought that these were examples of writers with a terrible command of IsiZulu. The participants themselves have difficulty with translations because they domesticate the translations, using their own cultural and prior beliefs to do so.

The study made a finding about the existence of a broader problem of health literacy. Moyo and Salawu (2017: 103), citing the US Healthy People Report (2010), define health literacy as “the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health”. The definition of health literacy suggests that the ability of the recipient to understand and use the health information is important. This is what this study sought to establish. However, before people even use information, they need to be able to obtain it and have access to it first. The study found that health communication in the form of printed and visual material was not systematically provided at the 10 clinics surveyed. At some clinics such as Gcinalishone, Rockcliffe and Limehill, there was a total absence of printed material. There were also no notable

13 https://www2.palomar.edu.anthro/language/language_5.htm
billboards displaying prominent health information or health education, as is the case in the cities. The Central Health Information hub in Ladysmith, where most clinics under the uThukela District Municipality fall, get their health communication material from, itself has little up to date health communication material.

The severity of the problem is illustrated by the fact that staffers at that office informed me that their last supply of health communication material from central government was 10 years ago! Clinics have generally stopped expecting updated health communication material as a result. I had to obtain some of the material I used in my focus groups from the communication and translation units based far away, in cities. One participant in the Sgweje Clinic focus group stated, “I also think that when a new disease breaks out, instead of just handing out or distributing pamphlets, the Department of Health must start with awareness campaigns and road shows, then distribute pamphlets thereafter”. This speaks to the issue of the larger health delivery system in the province and in South Africa in general, which participants unanimously felt was poorly resourced, disorganised, and was letting them down. Participants felt that access to health and health literacy were not just a one-off thing or even an occasional or episodic event. Rather, people were always learning about health and diseases, gaining and sharing new information and interrogating and replacing outdated information. Health communication on its own cannot do the job of informing people. Rather, there needs to be a cocktail or armamentarium of interventions, of which such written communications are only one aspect.

I noted that the available printed material was mostly in English and was outdated. The lack of messages in IsiZulu at the clinics shows that the question, at one level, should not even be posed as one of the expectations of translatability. Rather, the Department of Health (and the Department of Arts) is either not sending any reading material at all to rural areas or is sending material in English! Sending material in English to areas where there is high
illiteracy and where IsiZulu is mostly spoken and English is hardly spoken suggests that the Department of Health is violating a specific constitutional provision to translate materials into vernacular. The sending of printed health material to KZN in English appears to show a lack of sensitivity to the language and literacy situation. Health literacy enables the patient to make informed judgements about when, for example, it is advisable to seek expert advice from a health professional, knowledge of how to find the appropriate professional, and the ability to explain the health problem and personal concerns that made the consultation necessary (Schulz, and Nakamoto 2013, in Moyo and Salawu, 2017: 104).

Health messaging must, at the very least, be adequately simplified and accessible. But what does simplification mean? Berry (2007: 97) believes that:

In general, there is a consensus of opinion that the extent to which prose is comprehended is determined largely by the complexity of the sentences and familiarity of the vocabulary. Thus, when producing written information material, technical terms should be replaced by everyday counterparts, non-essential information should be eliminated, words and sentences length should be reduced, language structures should be simplified, and information and information reordered to enhance coherence.

The translators I interviewed generally subscribe to these norms when translating. Baker (1996: 181) (cited in Ndlovu 2006) defines simplification as involving “making things easier for the reader (but not necessarily more explicit), but it does tend to involve also selecting and interpretation and blocking other interpretations, and in this sense, it raises the level of explicitness by resolving ambiguity”. But who says ambiguity has been resolved? Is ambiguity simply contained in words and text? What about going behind the words, as Malinowski encouraged? How does one resolve the ambiguity behind words?
Ndlovu (2006), in a discussion of the “limits of simplification” in translated isiZulu health texts, shows that while simplification is a universal practice of “simplifying the language used in translation”, the practice has shortcomings:

In their efforts to simplify health texts for their target readers, Zulu translators may produce texts that are difficult for some readers to understand... Translators employ simplification strategies to simplify problematic medical terms or expressions. These terms and expressions and other linguistic units have no equivalents in the target language. Because of this absence of equivalents, new problems arise where translations of health texts are attempted (Ndlovu, 2006: 121, 122).

Some of the simplification process and strategies that Ndlovu looks at have been utilised in the translated English to Zulu health messages. It appears that simplification raises as many problems as it solves, such as non-equivalence between the simplified term and the complex biomedical term.

Non-equivalence in translation, caused by the pragmatic differences between source and target cultures, and by a lack of synonymy between languages, is rife in translation. However, the observed practice in the examples I sampled for my study seemed to veer away from the theory. For instance, I observed that in a preponderant amount of the printed material, medical jargon was rendered in English, while the surrounding text would be in isiZulu. We will call this the use of non-translated or non-translated terms. A key question in this regard is whether the preference for the use of non-translated or untranslatable terms constitutes the same thing as untranslatability or is simply a reflection of translators’ “laziness” in breaking away from traditional “preservation” norms in translation.

The key informants that I interviewed at the Corporate Communications Unit of the KwaZulu-Natal Department of Health stated quite openly that most of the health communication messages are written first in English before they are translated into indigenous languages such as isiZulu. This is done by various
diseases management programmes within the larger KZN Department of Health. I was told that the assumption is that these programmes, because they are the ones which are directly involved in diseases management, know best what messages need to go out to the public. They have experts who have been working on different diseases for a very long time and who know all the facts about diseases they are working on. As noted in the previous chapter, it is these diseases management programmes that conceive the health communication messages in English.

The study found that the use of medical terms or medical jargon without translation and detailed explanations constitutes one of the biggest challenges for users/target audiences of health messages. The original, foreign, English medical terms are often preserved in the isiZulu text – that is, lifted as they are from the original English version – without further explanation. Below is the first example:

Table 5.1 Use of medical terms or medical jargon without translation

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<td>1. <strong>Nucleoside analogues and non-nucleoside analogues</strong> prevent HIV from copying itself onto a person’s DNA.</td>
<td><strong>Ama-nucleoside analogue</strong> nama-non-nucleoside analogue anqanda igciwane lesandulela-ngculaza lingangeni kw-DNA yomuntu.</td>
</tr>
<tr>
<td>2. A microorganism called a dinoflagellate is generally regarded as the source of the toxins that cause CFP.</td>
<td><strong>Igciwane okuthiwa i-dinoflagellate ngokuvamile libhekwa njengomthombo wobuthi obubangela i-CFP.</strong></td>
</tr>
<tr>
<td>3. Staphylococcus bacteria, which often causes wound infections, used to be eliminated easily by penicillin derivatives.</td>
<td><strong>Igciwane i-staphylococcus</strong>, elibangela izilonda, lalivame ukuqedwa kalula ngemikhqizo ye-penicillin.</td>
</tr>
<tr>
<td>4. Reye’s syndrome is an acute neurological illness that can develop in children following a viral infection.</td>
<td><strong>I-Reye’s syndrome</strong> yisifo sobuchopho esiyingozi esingangena ingane ngemva kokuba iye yangenwa igciwane loholo lwe-virus.</td>
</tr>
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Participants in general complained that nearly all diseases that the messages educate them about are unfamiliar or English terms, which causes them not to know what it is they are really reading about. They indicated that in most cases the symptoms of the diseases would be clear, but the remaining question would be what the name or definition of the disease is. In the Zulu worldview, diseases are not just named for flippant reasons (Ngubane 1977). Rather, the names of diseases have an intimate link with the nature of the disease and its perceived seriousness. Cancer is one disease that is named according to its nature and its perceived seriousness. Umdlavuza is the Zulu name for cancer. Dlavuza, the stem in them umdlavuza means to destroy; this links the behaviour of the disease with name. Partly, this is because disease is not just caused by Igciwane. Rather, diseases can also be caused by ubuthakathi (sorcery) and malign spirits (for instance, tokoloshes). One’s ancestors can also cause disease either as warning or punishment, or to deliver a message. The names of diseases are thus crucial in understanding the disease.

A few participants even felt offended and disrespected by the translated messages that kept using non-translated scientific terms, feeling that the Zulu language was not being treated seriously by the translators. One rather irate participant at the Ekuvukeni Clinic focus group remarked that:

Zulu messages should be written in proper Zulu and there should be no mixing of terms. We do not see the mixing of terms in English messages. It is because English is superior to Zulu? English messages are written in English only; we expect the same treatment for our languages (emphasis added).

Phrases such as “proper Zulu”, “no mixing”, “same treatment” and “our languages” speak to deep-seated and strongly held cultural concerns about the
perceived continued colonial mastery of English over indigenous languages. At the same time, they hint at a belief that there is such a thing as “proper Zulu”, “our language”, and pure Zulu culture. But is this necessarily the case? A participant in the Matiwaneskop Clinic focus group angrily queried, “When you are writing messages in Zulu, you must write them in Zulu. I have never seen English messages with Zulu words. You can go all over South Africa and you will never find that. Why is it done to our language?” The sense that translators treat indigenous languages as second-class languages was strong.

A caregiver\textsuperscript{14} from one of the local “clubs”\textsuperscript{15} near Ekuvukeni Clinic commented that: “A problem we have seen is that when people see some English words in the messages they get de-motivated and stop reading”. Another participant in the focus group at Ekuvukeni stated that: “Here at Ekuvukeni, most people are uneducated, so when you use English terms in the Zulu messages, you are even confusing the readers even further. Keeping English terms in Zulu messages defeats the purpose”. Generally, most participants lamented that English terms should not be found in both the English versions and the Zulu versions. They reported that the reason they picked Zulu messages to read was specifically to avoid reading in English, which they could not understand. Thus, when they kept encountering English terms in the Zulu communication, they felt put off and short-changed.

\textsuperscript{14} A person who goes house to house checking on patients that are on chronic medication ensuring that they take their treatment and help the very sick people by cleaning their houses, cooking for them, explaining issues that they might have and even bathing them if they are very sick. They fetch medication for those patients that cannot go to clinics on their own because they are very sick. Even when patients struggle with reading and understanding health literacy material, caregivers are supposed to be there to help.

\textsuperscript{15} Club refers to a group of patients who are receiving chronic medication and are under the care of the caregiver who always ensures that they continue taking treatment and that they eat well.
Participants in most of the focus groups would also point out that in some instances certain diseases represented in the health messages have many similar symptoms but different names in isiZulu or English. When that happens, patients get even more confused. The preservation of English terms manifests, in my view, *uncritical* attempts to impose the value system of the SL culture onto the TL culture. This, as Lotman (cited in Bassnett, 2002: 22), says, “is dangerous ground”. This practice also reflects the fact that, as Trew (1994: 77, 78) (cited in Ndhlovu 2014: 328) states, that “The history of South Africa has been such that indigenous South African languages have been less used in technical fields, in national politics or in economic management”. Although the translator cannot be the author of the SL text, as the author of the TL text they have a clear moral responsibility to the TL readers. Traditional or normative translation practice, which tends to emphasise the so-called ethics of sameness (cf. Derrida 1985, 1996), needs to be constantly confronted with an ethics of difference.

Based on the extracts that I gave the participants in the focus groups to read, and in response to my questions about usage and meaning, most participants indicated that such messages are only partially intelligible because of the usage of English terms or medical jargon in the Zulu messages. An example of this admixture of isiZulu and English in the same message would be a sentence such as: *ama-nucleoside analogue nama-non-nucleoside analogue anqanda igciwane lesandulela-ngculaza lingangeni kwidNA yomuntu* (Nucleoside analogues and non-nucleoside analogues prevent HIV from copying itself onto a person’s DNA). Another example is *lgciwane i-staphylococcus, elibangela izilonda, lalivame ukuqedwa kalula ngemikhiqizo ye-penicillin* (Staphylococcus bacteria, which often causes wound infections, used to be eliminated easily by penicillin derivatives) or *lgciwane okuthiwa i-dinoflagellate ngokuvamile libhekwa njengomthombo wobuthi obubangela i-CFP* (A microorganism called a dinoflagellate is generally regarded as the source of the toxins that cause CFP). Another example of the admixture of isiZulu and English in the same
Individuals who felt that they were struggling to understand the translations not only complained that the use of English terms complicated the things even further, but, as already noted, went further to suggest that, rather than reading the messages themselves, they would prefer to ask someone more knowledgeable to read and explain messages to them. The use of non-translated terms might have served to make some within the rural setting feel linguistically inadequate and inferior. The retention of English medical jargon, as we will see, illustrates that the translators in the Department of Arts and Culture feel that there is no equivalent term in IsiZulu, or assume that “everyone” knows the term.

Most of the participants in the focus groups discussions felt that the use of medical jargon in the Zulu messages was a major hindrance in their health literacy. One participant at the Rockcliffe Clinic focus group, in particular, pointed out that for her the addition of English terms in the Zulu messages functioned as a brick wall that made her want to stop reading right there. Another participant in the Rockcliffe Clinic focus group rejected both the source text and the target. She said, “In my opinion there is no difference between the two versions. They are both not helpful to the average reader. How does it help the reader if you translate something into their language and still use the same terminology that he had been struggling to understand in the original version? Anyway, I do not see how it helps me to complain. I can see that some of these medical terms are untranslatable, perhaps because they were not meant for isiZulu speakers”.

Such exasperated statements from the participants helped me to reflect on what Spivak says about translation-as-rhetoric, located more in the realm of
feeling and intuition ("must work in the silence between and around words"). An ethical act of translation must not lock out participants from meaning and understanding like this. As I argued above, the translator, as the author of the TL text, has a clear moral responsibility to the TL readers. The historical underdevelopment South African languages and current official neglect mean that many indigenous languages lag behind when it comes to finding culturally equivalent terms especially, particularly in the specialised domains such as health and science. The problem of the viability of translating scientific and specialised terms looms large. This problem is plugged-in into an even larger and concerning problem: the viability of the local translation scene itself when it comes to lexical terminology for scientific and specialised terms. It means the historical underdevelopment of indigenous languages continues apace.

As it was, participants pointed out that once they saw unfamiliar English terms in the messages, they quickly concluded that such messages were not or are not meant for them. The reading behaviours of these participants, particularly the one who stopped reading once she saw an English word in a Zulu translation, reflects the mode of the cultural, emphasised by Spivak, which turns away from language altogether. This reflects that translation, as an ethical (as well as intimate) act, begins by exposing the "limits of language". Stopping reading the moment one sees an English word exposes the limits of language and expresses resistance to the translation. The isiZulu text interspersed with English reflects a failure of "domestication" – a lack of a genuine displacement of the foreign text. Interestingly, participants who were bilingual, and could read both English and isiZulu competently, stated they would rather read the messages in the original English because it was where everything explained clearly. They felt that some of the original English messages made better sense than the translated version and complained that, when reading the Zulu messages, they were not sure at all if they were reading the same messages that they had been reading in English.
The study found that the problem of the use of non-translated terms reflects, on the one hand, what I gathered to be the hierarchical norms and elitism of the translation process. A kind of communicative schizophrenia is created. The use of specialised medical jargon means that specialists know what they are talking about, but the people they are talking to do not. This problem does not only affect patients or facility users, but, rather, also the health professionals such as nurses and educators who have to explain things to patients. One key informant who worked at the Limehill Clinic as an educator and facilitator told me that:

After reading both versions of these health messages, I am convinced that the English versions explain things better than the translated messages. I work for the Department of Health, but I can tell you now that the translated messages are not helpful in the sense that if you did not read the English version, it would be very difficult to understand what the message is about. Some of the terms have been taken from the English version and dropped in the Zulu version as they are without a detailed explanation about what they mean. As a result, the whole message will be lost because you will find that the English terms that have been used in the Zulu versions without being translated are very important to understanding the whole message and failure to understand these terms means that you have achieved nothing with your reading. Not knowing what those non-translated terms mean, results in the reader not benefiting from the message, which also means that the message cannot be passed to other people, especially those who cannot read. As a health literacy educator here at the clinic, I can frankly tell you that we have a big challenge trying to educate patients using translated health messages that still contain non-translated terms. Just imagine if I am also struggling with these terms, what happens to a lay person who is reading these messages on his/her own (emphasis added).

Again, the issue of translated health messages that still contain non-translated terms looms large. What is critical here is that the issue is being raised not by “rural illiterates” but by key informants who – we suppose – have little or nothing to lose. On the other hand, the rigid preference for non-translated terms reflects
Drescher's (2010: 201) fear that “the transfer of complex biomedical knowledge may be hindered or even threatened”.

A verdict such as the one given in the quote above, that the translated messages are not helpful, is an indictment of the norms of translation process in as far as they seek to take care of the needs and preferences of the translators before those of the target users. Although this key informant should have been happy with the status quo, she is not at all pleased because she realises that translation is a two-way process. Translated messages that address only the needs of translators miss the most important ingredient of the translation process: purpose. The statement that the translated messages are not helpful is critical because it takes us back to the main claim of Skopostheorie that translations succeed only if they take cognisance of the balance of needs of the target culture. Essentially, a key factor determining the purpose of a translation is an evaluation of “who is the intended receiver or audience of the target text with their culture-specific world-knowledge, their expectations and their communicative needs” (Nord 1997: 12). Translation is not just empty human action, but it an activity which is conditioned by an intention to communicate something in a given situation. Translating thus involves “aiming at a particular communicative purpose” (Nord 1997: 2).

We noted in Chapter 3 that fidelity stipulates that the target text should bear some kind of relationship with the corresponding source text since translation by definition is a translational action involving a source text. Fidelity seeks a close relationship between the target text and source text. This clashes with the notion of loyalty, within functionalist theories, which has more to do with the needs of the target audience. Readers must, as far as possible, be able to establish analogies with their own worlds. This became clear in the comment of another key informant, also a health worker, who remarked that:

I agree that there is a huge problem with the usage of difficult terms in the translated health messages. This problem does not
affect patients only; it also hinders the way we do our work. For example, every morning after praying with patients we always make sure that we teach them something different every day. Using the same material, we conduct health lessons before starting with consultations. The problem is that we use the same pamphlets or health material to teach. The problem is that as you teach, it sometimes happens that you come across these terms that have not been translated into Zulu and you find yourself in a position where you cannot explain what it means to the patients. When this happens, you end up looking as if you do not know what you are talking about to patients. Other patients will even ask you how it happens that you are teaching them about something that you do not know or understand yourself? Those are some of the embarrassing moments that we face when we use these pamphlets. Sometimes this embarrassment does not end here at the clinic. It follows you to the area where you come from. You know there is something about rural people. When they know that you work at the clinic, they do not mind coming to your home with pamphlets to ask for clarity in case there is something they do not understand. You sometimes find yourself reliving the same experience in your own home. It is very difficult to explain something to another person if you do not have proper Zulu terms for that. Health jargon is a serious problem especially when you must explain things to old people like grandmothers. Old people like grandmothers are so important in health literacy because they fall sick often and use clinics most, and they are the ones who look after grandchildren when their parents are at work. When you explain ailments that have difficult unknown terms, you end up describing the symptoms, but you will notice that the old woman is not satisfied because you did not clearly explain what the condition or the disease is called (emphasis added).

The health workers are themselves victims of an unresponsive translation process that dumps specialist English terminology on them and expects them to convey the message to an audience of rural, non-expert clientele. Either the health workers repeat the English term as is, or they become another ad-hoc, make-shift layer of translation that was not intended in the first place. The health professionals, however, confessed to me that they often found themselves out of their depth as make-shift translators. This was mainly due to the translations’ lack of differentiation in the use of terms in the Zulu messages. Some of the terms are used interchangeably in the translated Zulu messages. For instance,
the terms *viruses* and *bacteria* were sometimes *preserved* in English, as did those relating to cancer such as *radiotherapy* and *chemotherapy*.

We saw in Chapter 2 Bell’s (1991) and Frank’s (2008) definitions of translation that regard translation singularly in terms of a *replacement* which *retains* both semantic and stylistic equivalence (what I have called the principle of preservation and is closely linked with the notion of equivalence). In Frank’s (2008: 6) view, translation “is a text derived from another text in another language, exhibiting qualities of equivalence to that source text, such that the derived text can be taken as a substitute for the original text”. Bell’s (1991) definition regards translation as helping to preserve some of the original quality – semantic and stylistic – of the source text. Bell, we must remember, believes that texts in different languages can be *equivalent* in different degrees (fully or partially equivalent) in respect of different levels of presentation, context, semantics, grammar, lexis, and at different ranks in terms of word-for-word, phrase-for-phrase and sentence-for-sentence. In Bell’s (1991: 5) own words, translation “is the expression in another language (or target language) of what has been expressed in another, source language, *preserving* semantic and stylistic *equivalence*” (emphasis added). The preservation of English terms in isiZulu texts contradicts some of the central tenets of functionalist theory which postulates that a translation does not have to read like a translation at all but must, rather, be more accommodative to the target culture. Emphasis is not on similarity between source and target texts but, rather, on the fact that meaning, and sense need to be preserved in the target text.

The statement that this situation *also hinders the way we do our work* reflects a larger problem of health and service delivery. As the key informant states, old people such as grandmothers are central to health literacy because i) they fall sick often, ii) use clinics most, and iii) are the ones who look after grandchildren. To these old people, the name of the disease is key. Yet the specialists end up describing only a set of symptoms. But it is not just old people who struggle to
comprehend the messages adequately. Even young people who have completed grade 12 reported that a large amount of the health messaging is not intelligible to them either. A term such as Staphylococcus cannot be found even in traditional English dictionaries, or in English-Zulu thesauruses. The poor translation practices cascade and end up affecting the effectiveness and efficiency of health delivery itself. A participant in the Sgweje Clinic focus group stated that: “When they use difficult or untranslatable terms, you end up jumping words that you are struggling with but sometimes those words are key to understanding the messages.

The view of most participants in the focus groups was that Department of Health must use language that can be understood by everyone more or less at once, without for instance needing to use dictionaries. Messages must be understandable to both highly educated and uneducated people alike”. A nurse at the Rockcliffe Clinic mentioned to me, for instance, that things such as CD4 count are almost untranslatable and unexplainable to rural HIV patients. When this happens, patients end up suspecting that the nurses themselves are not sure about what the CD4 count is. Why can they not explain things to them in their own languages? The concern that the health workers themselves end up looking as if (they) do not know what you (they) are talking about is clearly detrimental to health access matrix. For instance, patients miss out because they cannot make follow up questions or ask questions that relate to the existing medical jargon. There are also complications about medicines and dosages.

The distinction between bacteria and virus, as we will see, is complicated by the term igciwane. Should one therefore take antibiotics or not? When medication is not taken as directed, its likely therapeutic effect is reduced. Igciwane refers to many things in Zulu translations ranging from bacteria to germ, etc. Below, is one example:
Some participants informed me that sometimes it comes down to pronunciation. During health classes, some patients choose not to ask follow-up questions because they cannot pronounce the technical terms. Fear of embarrassment or losing face in front of other people forces patients to shy away from asking questions or seeking clarity on the issues they do not understand in the messages. The statement by the informant that it is very difficult to explain something to another person if you do not have proper isiZulu terms for that, however, suggests that the broader issue might be untranslatability. In this case, untranslatability is linked to interchangeability.

Terms such as virus and bacteria, and radiotherapy and chemotherapy, for instance, are used interchangeably. A key informant indicated that:

We (need to) deal with the problem of the interchangeable use of same terminology for different medical terms. Radiotherapy and chemotherapy, for instance, are used interchangeably in isiZulu. In isiZulu, we refer to these two different therapies as Ukushisa,
(to burn), when these therapies are done differently procedurally. It is not easy at all to explain the difference to a lay person when you are actually using the same terminology for two different procedures.

The interchangeable use of words such as virus and bacteria, and radiotherapy and chemotherapy, in isiZulu health messages is regarded by health workers as a specific barrier to health. At the very least, it creates a wall of confusion when health professionals have to explain these to patients.

A health worker pointed out that the interchangeable use in translations of these bacteria and virus, for instance, posed a particular challenge when giving health classes to patients, particularly old people. She indicated that:

Some of the Zulu messages refer to both the bacteria and the virus as igciwane, as if they are the same. The virus and the bacteria are different. This is a problem when one is teaching because the effects of the two are different on the body of the patient and that in many cases there is no cure for conditions that are caused by the virus, as opposed to the bacteria although both resultant conditions can be kill if left untreated.

The old people have only one word for bacteria, germ, fungus, microbe, pathogen, protozoa, infection, and virus: Igciwane. However, in biomedical literature and in the pamphlets, the likes of virus, germ, infection and bacterium are not only quite distinct, but it is always important to always distinguish them.

The health workers are thus faced with at least ten words: virus, germ, bacterium, infection, protozoa, fungi, pathogen, biological agent, microorganism, and igciwane. Not knowing how to distinguish these ten, the specialists treat them sometimes as if they are the same, and other times as if they are not. Created is veritable linguistic mess. Any given translation, approached from the functionalist approach, can never be expected to be an equivalent of the source text or to be loyal to it or the original author, taking into account that the original author might have been writing with a different purpose.
under a different situation from that of the commissioner of the translation. In the end, *virus, germ, infection, bacteria, protozoa, microorganism* and *igciwane*, among others, seem to be either the same thing or ten distinct things to the old people.

If we cease treating the source text as the first and foremost criterion for the translator’s decisions, then we dispense with *virus, germ, infection, microbe*, and *bacteria* and remain with *igciwane*. But if we use equivalence, or simplification, we have choice but to take a decision based on convenience: we would have to decide if *igciwane* is either virus or germ or microbe or infection or bacteria. It cannot be all of these at the same time. A solution would be to just call of these microorganisms, or microbes, or organisms. But this solution has its problems, because viruses, germs and bacteria are not just microorganisms. Also, *igciwane* does not even mean microorganisms: it is not a reference to size at all, but to the *action* of the microorganism. The translation, thus, is never resolved.

What we will never know is what an old woman is referring to when she says *igciwane*. Is she referring to bacteria or germs or microbes or virus, or just to *igciwane*? Is *igciwane* virus or bacteria or germs or microbes? Is it all of them at once? The latter seems impossible. If we are talking *untranslatability*, it is also possible that *igciwane* is neither bacteria nor virus, neither germ nor microbe. To know what it really is one has to be fully and intimately *immersed* in the culture that uses *igciwane*. One has to know the word, the organism and the culture together, not separately. Unfortunately, normative translation culture only admits knowledge of these things separately. The problem with *igciwane* extends to different forms of translations and renderings in health communication. As noted, in isiZulu, any of bacteria, germ, fungus, microbe, pathogen, protozoa, infection, and virus could be *igciwane*. 
Below are some examples and instances of *igciwane*. The first six instances are translations of *igciwane* as a virus. These instances showcase different contexts of use of *igciwane* as a virus. The first two instances are the equivalent translations of virus as *igciwane*. In the first case, the medical term Ebola is left non-translated, whereas Hepatitis is.

*Table 5.2: Six translations of igciwane as a virus*

<table>
<thead>
<tr>
<th>1.</th>
<th>Ebola virus</th>
<th><em>Igciwane</em> le-Ebola</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Hepatitis B Virus (HBV)</td>
<td><em>Igciwane</em> Sokusha Kwesibindi Lohlobo B (HBV)</td>
<td></td>
</tr>
<tr>
<td>3. When HIV invades the human body...</td>
<td>Lapho <em>igciwane</em> lesandulela-ngculaza ihlasela umzimba womuntu....</td>
<td></td>
</tr>
<tr>
<td>4. In some lands, other mosquitoes, such as the Aides albopictus, may also carry the dengue virus.</td>
<td>Emazweni athile, ezinye izinhlobo zomiyane, njenge-Aedes albopictus, nazo zingase zibe nalo <em>igciwane</em> lodenga.</td>
<td></td>
</tr>
<tr>
<td>5. In almost all cases, the body clears itself of the virus within weeks or months</td>
<td>Cishe kuzo zonke izimo, umzimba ulibulala ngokwawo <em>igciwane</em> phakathi namasonto noma izinyanga ezimbalwa</td>
<td></td>
</tr>
<tr>
<td>6. The flu virus, which attacks the respiratory system, is passed from one person to another primarily in droplets of bodily fluids expelled when the infected person sneezes, coughs, or even talks.</td>
<td><em>Igciwane</em> lomkhuhlane, elihlasela imigudu yokuphefumula, lidluliselwa komunye umuntu ngamaconsi oketshezi lomzimba lapho umuntu ogulayo ethimula, ekhwehlela, ngisho noma ekhuluma.</td>
<td></td>
</tr>
</tbody>
</table>

The translators simply add the noun prefix “*i*” to “Ebola” to make “*i*-Ebola”. The same happens with terms such as Zika (rendered as *i*-Zika), botulism (*i*-botulism), anthrax (*i*-anthrax), thrush (rendered *i*-thrush), DNA (*kuyi*-DNA) candida (*i*-candida), Marburg (*igciwane leMaburg*), Lyme (*igciwane lesifo saseLyme*), black death (*i*-black death) and CD4 count (*i*-CD4 count), and so on. We thus cannot call a simple addition of a noun prefix a translation. It is a rendering in the original, seemingly because the translation could not find
indigenous equivalents. Such mere additions of noun prefixes are important because they help readers of translated health messages familiarise themselves with the medical terminology, but do not do much to help readers understand what Ebola, Zika, botulism, anthrax, thrush, candida, or CD4 count is.

In the case of Hepatitis, a translation is preferred, although the letter “B” is retained, as is the abbreviation HBV. We know hepatitis is an inflammation of the liver caused by a virus or a toxin. The translation echoes this definition since *Igciwane Lokusha Kwesibindi Kohlobo* translates to “the virus that burns up part of the liver”. What is notable in the case of the translation of Hepatitis is that the isiZulu term is not really a term, but a sentence-like description of Hepatitis. Other health pamphlets did not do this (i.e. did not name Hepatitis via a description) but merely called it *i-Hepatitis*, much as we saw translations call Ebola as *i-Ebola*. The same applies to other pamphlets that preferred *i-HIV* to the longer *igciwane lesandulela ingculaza*.

In the third instance, *igciwane* is translated as “virus”, but this is done slightly differently to the case of Ebola and Hepatitis. We saw that Ebola is not translated (it is merely rendered as *i-Ebola*, by adding a noun prefix), and Hepatitis is fully translated into an indigenous form (through a descriptive phrase). In the case of the dengue virus, it is “translated” as “lodenga”. This is the same way Zulus would, for instance, render “percentage” as *Amaphesenti*, “soldiers” (antibodies) as *amasosha*, school as *esikoleni*, number as *inombolo*, moto car as *imoto*, and science as *isayensi*. This is “Zulification” or “Zulu-ising” of the medical term, because the foreign spelling is altered and domesticated, but retains enough of the original phonetic structure to make any listener tell that the term is English (or foreign). The terms are helped to sound even more Nguni because of the noun prefixes “lo” and “Ama”.

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The term “denga” for dengue is a neologism in isiZulu, because there is no such term in the language. The scientific name of the mosquito, Aedes albopictus, is also retained, with the addition of the simple prefix “njenge”, to become njenge-Aedes albopictus. My participants informed me that such Zulu-isising does not do much to help them understand the Zika virus, the dengue virus, the mosquito, Aedes albopictus or, say, the notion of percentage. The problem is complicated by the fact that the neologism “denga” sounds a little like “dinga” (transitive verb for “need” or intransitive verb for a homeless person) or “tenga” (intransitive verb for swaying back and forth) or “thenga” (intransitive verb for “buy”). Because “denga” is a neologism, people tended to associate it phonetically with other words they knew, even though the word bears no relation at all with needing, swaying back and forth or purchasing things. Rather, dengue is a fever. Even “Zika” exists in isiZulu only as a possessive concord (as in the sentence “izandla zikaMongezi” – Mongezi’s hands).

I gathered in my interviews that the translation of Hepatitis, via the sentence-like description – “the virus that burns up part of the liver” – communicates the concept much more effectively for readers than either the addition of noun prefixes (i-; ama-; u-; o-; isi; um(u)-; ubu-; uku-) or the “Zulu-isation” of the word. This form of translation seemed to be preferred by most participants. One participant in the St Chad Community Health Centre focus group, who had stated that she struggled with the English terminology in the Zulu messages, indicated that she “would be happy if the terminology could be defined in detail”. This applies to other diseases such as Hantavirus (igciwane lomkhuhlane elitholakala emagundaneni), SARS (kanye nohlobo olubi kakhulu lwenyumoniya) and tuberculosis (igciwane lesifo sofuba). Even though it is not really a name of a disease, but rather a full definition, the description gets the point across. In fact, the description shoots two birds with one stone: it gives the disease a name and a description/definition at the same time. That is, if an indigenous variant cannot be found, it is better to substitute a sentence-like description or definition of the disease in isiZulu.

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Of course, we also note that the problem of retaining scientific names in the translations also occurs in the isiZulu translation of Hepatitis B, in the form of the letter “B” and the abbreviation HBV, or SARS, or TB. Such abbreviations are clearly untranslatable (you cannot translate the alphabet). However, they introduce a complicated problem in that the abbreviation HBV, retained in the isiZulu translation, bears no relation to the sentence-like name “the virus that burns up part of the liver” (that is, “Igciwane Lokusha Kwesibindi Kohlobo B”). SARS, as an abbreviation, bears no relation to kanye nohlobo olubi kakhulu lwenyumoniya or TB to isifo sofuba or HIV to Igciwane lesandulela ngculazi. Participants in all the focus groups found acronyms to be confusing and empty of meaning, particularly were they were given without a breakdown or definition of what each letter stood for. When I put it to the participants that acronyms, being letters of the alphabet, cannot be translated or transferred, they merely shrugged their shoulders, pointing out that there is no point in bombarding “half-educated” old people from the rural areas with terms that only educated people could understand.

So, is there a solution to the acronyms? Suppose that the longer sentence-like descriptions of disease are to be abbreviated, it would be ILKK B (“Igciwane Lokusha Kwesibindi Kohlobo”) rather than HBV, KNOKL (“Kanye nohlobo olubi kakhulu lwenyumoniya”) rather than SARS, ILS (“Igciwane lesifo sofuba”) rather than TB, and ILN (“Igciwane lesandulela ngculazi”) rather than HIV. However, ILKK B, KNOKL, ILS and ILN would take the translation of HBV, SARS, TB and HIV in a completely different direction. There is a fear here, as Drescher’s (2010: 201) points out, that “the transfer of complex biomedical knowledge may be hindered or even threatened”. At least, to South African medical students, who are taught in English and taught to recognise foreign medical terms and taxonomies, the acronyms ILKK B, KNOKL, ILS and ILN would be unrecognisable in mainstream literature. This may suggest that African medical schools need to be decolonised so as to introduce isiZulu medical terms and
isiZulu medical dictionaries from top to bottom. The Zulu-derived acronym of Hepatitis B (that is, ILKK B) would be the same for Hepatitis A (HAV), which would in this case be ILKK A. Such acronyms would be as consistent as HBV and HAV if medicine were taught in isiZulu. What these problems show is the heavy dominance of the trace of the foreign original term in the translation. There is clearly a limit to domestication of the terms.

The fifth and sixth examples of the use of Igciwane, unlike the first four examples, are all in isiZulu. The flu virus has an indigenous equivalent (flu = *mkhuhlane*), as does terms such as respiratory system (*imigudu yokuphefumula*). This is the same with terms such as smallpox (*Ingxibongo*), Herpes (*izilonda zomkhuhlane*), intravenous drug use (*Ukuzijova ngezidakamizwa*), toxins (*ubuthi*) and Tsetse flies (*Izimpukane*), which have what seem to be adequate isiZulu variants. Some translators, as we will see, have domesticated terms such as ART treatment (*ukwelashwa ngemishanguzo*), AIDS (*ingculaza*) and HIV. These last examples come closest to adequate translations that leave little trace of the English original. At the same time, it is also clear that some of these latter usages (i.e. example 5 and 6) are themselves pretty simple sentences and usages, within which *Igciwane* fits seamlessly. Interestingly, for term such as flu, which is translated to *lomkhuhlane*, this isiZulu term does not always render well since *mkhuhlane* can mean any illness or infection.

What seems clear is that the introduction of scientific and medical terms often causes problem for some translators at the Department of Health and the Department of Arts and Culture. One of the two translators at the Department of Arts and Culture that I interviewed told me that she had “a serious problem when it comes to scientific and medical terminology. The terminology is not there”, a claim supported by the other translator. When I asked her how she typically translates health messages, particularly in the context of a perceived lack of indigenous scientific terminology, she stated that: “I write the word as it
is. I will just put an “i-” (the noun prefix) before the name or object or a disease. Otherwise, I would be forced to write an explanation which might be one or two sentences or even more. *The best way is to leave it as it is*’ (emphasis added). In a few cases the translator says she “will rephrase or naturalise (the text)”. It is evident in the translators’ statement that the process of translation is their choice considering that they get no translation commission.

I gathered that the reluctance to render scientific and medical terms in their indigenous forms is partly because these translators are preoccupied with *fidelity*. They would rather reproduce Hepatitis as i-Hepatitis rather than as *Igciwane Lokusha Kwesibindi Kohlobo B*. This is because, as we saw, the new indigenous term, if it becomes normative, would lead to *indigenised* acronyms such as ILKK B (for HBV), ILKK A (for HAV), KNOKL (for SARS), ILSN (for TB) and ILN (for HIV). These acronyms would seem, to the translators, too be far removed from HBV, HAV, SARS, TB and HIV to be recognisable to (Western) biomedical discourse. In such cases translators err on the side of caution and would rather just add a noun prefix. Some (cynical) translators have concluded that subjects such as (Western) medicine cannot be taught in indigenous languages. Furthermore, sentence-like forms such as *Igciwane Lokusha Kwesibindi Kohlobo B*, if they are used too frequently, make the translations longer and, in the opinion of the translators (and some participants), unwieldy. Participants noted that the Zulu translations were often much longer than the English versions of the messages, making them suspect that the translated Zulu messages were not the exact equivalent of what has been communicated in English. The term *i-HIV* is clearly shorter than *Igciwane lesandulela ngculazi*, and TB is shorter than *Igciwane lesifo sofuba*. Clearly, their preference is for brevity and to-the-point translations. Pamphlets and billboards are not, after all, textbooks. Granted, but what do the users prefer?

The second instance that we will look at is the translation of *igciwane* as infection. Treating *igciwane* as infection means that the sense and meaning
changes from a specific organism such as a virus to something closer to an illness or a disease.

**Table 5.3: Translation of Igciwane as infection**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. X died from a bacterial infection.</td>
<td>U-X wabulawa yisifo esibangwa igciwane.</td>
</tr>
<tr>
<td>2. Reye’s syndrome is an acute neurological illness that can develop in children following a viral infection.</td>
<td>I-Reye’s syndrome yisifo sobuchopho esisingangena ingane ngemva kokuba iye yangenwa igciwane loholo lwed-virus.</td>
</tr>
<tr>
<td>3. The patient, whose jaw had been destroyed by a bone infection, can now eat, breathe, and speak normally.</td>
<td>Le siguli, umhlathi waso owawudliwe igciwane elihlasela amathambo, sesiyakwazi ukudla, ukuphefumula nokukhulum a kahle.</td>
</tr>
<tr>
<td>4. Blood-Borne Infection</td>
<td>Igciwane elithwalwa yigazi</td>
</tr>
<tr>
<td>5. The whole system works so well that often you do not even realize that you have been infected and effectively defended.</td>
<td>La masosha asebenza kahle kakhulu kakhulu ngokuvamile awuqapheli nakuqaphela ukuthi uye wahlasela igciwane elithile futhi alibulala.</td>
</tr>
</tbody>
</table>

This is clearly seen in example 1 and 2 of Table 5.3 where the terms “bacterial infection” (isifo esibangwa igciwane) and “viral infection” (igciwane loholo lwed-virus) are used. This use of igciwane as infection is complicated by the use of igciwane as virus (as we just saw) and as bacteria (as we shall see below). In other words, a sentence such as “X died from bacterial infection” (U-X wabulawa yisifo esibangwa yigciwane) or a phrase such as “a viral infection” (igciwane loholo lwed-virus) both confuse the meaning of igciwane. Is igciwane a virus, infection, or bacteria? These terms are not exactly equivalent but can refer to qualitatively different things. Referring to them as if they meant the same thing caused confusion in some of the readers of translated health messages at the clinics.

We can see that virus, infection, and bacteria are not the same if we consider the 4th example. The old woman’s jaw had been destroyed by a bone infection (say osteomyelitis), thus could have been caused by bacteria rather than a
virus. As is commonly known, bacterial infections are caused by bacteria, while viral infections are caused by viruses. The difference between viruses and bacteria is thus quite clear, the most important distinction being that antibiotics usually kill bacteria, but they are not effective against viruses. Health practitioners and health workers need to make this distinction clear in order to avoid getting patients taking the wrong medicines. Such a distinction might be understood easily by pharmacists but may not be so easy to separate to rural users of clinics. The sentence in #5 does not specify whether the infection is viral or bacterial: it is just an infection (*ukuthi uye wahlaselwa yigciwane*). It seems clear from the examples that *igciwane* as infection can refer to infections-in-general or to infections-in-particular (bacterial, viral, blood-borne, and so on). The third instance regards *igciwane* as microorganisms, as example 1 and 2 below shows.

**Table 5.4: Examples of translation of microorganism as igciwane**

<table>
<thead>
<tr>
<th>Example</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A microorganism called a dinoflagellate is generally regarded as the source of the toxins that cause CFP.</td>
<td><em>Igciwane</em> okuthiwa i-dinoflagellate ngokuvamile libhekwa njengomthombo wobuthi obubangela i-CFP.</td>
</tr>
<tr>
<td>2. Tiny amounts of a microorganism are lethal enough to ravage a field of crops, a herd of animals, or a city of people, assuming the pathogen is delivered precisely to the target.</td>
<td><em>Igciwane</em> elincane elibonakala ngesibonakhu lingakwazi ukushaya liqothule izitshalo emasimini, umhlambi wezilwane, nomabonce abantu edolobheni, uma lelo gciwane lisakazwa ngokuqondile kulokho okuhlaselwayo.</td>
</tr>
<tr>
<td>3. Once a biological agent has been dispersed into the atmosphere, it is exposed to sunlight and varying temperatures, which can cause the microorganism to die.</td>
<td>Uma nje <em>igciwane</em> selidedelwe emoyeni, lithola ilanga namazinga okushisa nawokubanda ahlukahlukeni, okungalibulala.</td>
</tr>
<tr>
<td>4. The organism that caused cholera.</td>
<td><em>Igciwane</em> elibangela ikholera.</td>
</tr>
<tr>
<td>5. Tell us, what happens when a microbe enters our body?</td>
<td>Ake usitshele ukuthi kwenzekani lapho <em>igciwane</em> lihlasela umzimba?</td>
</tr>
</tbody>
</table>
However, a microorganisms (or microbe, as in example 5) are merely a very small organism, and this translation does not distinguish between virus and bacteria (and protozoa and germs). That is, this use of igciwane is merely a reference to the size of the organism, and not to its behaviour or different means of preventing or treating it. As example 2, shows, the microorganisms can affect crops, animals or people. Thus, the meaning of microorganism is not limited to the consideration of human diseases only, or even just to diseases. At any rate, treatment and prevention do not typically target the size of the organism but, rather, its behaviour. In the third example, the word microorganism is used, but in this instance the translation for igciwane is given not as microorganism but as “biological agent”. The terms are used as if they were interchangeable. However, this can be confusing, since a microorganism is not necessarily a biological agent. These various uses introduce important imprecision into the translation.

In example 4 igciwane is not a microorganism as such, but merely an organism. There might be a justification for referring to igciwane merely by reference to size, as a microorganism, as this will eliminate concerns about nuance: whether igciwane is bacteria, virus, germ, fungus or protozoa. That is, all these examples are microorganisms – just as they are organism. However, microorganism and organism might be too broad and imprecise, particularly in medicine where the slightest technical nuance might mean the difference between life and death. We also note, in example 1, that – in keeping with the standard of preserving technical, medical and scientific terms in translations – the term dinoflagellate and the abbreviation CFP are retained, without translation.

The fourth case below refers to igciwane as bacteria. We saw earlier that the distinction between viruses and bacteria is important, particularly as it refers to the dispensing of antibiotic drugs. Such drugs are not effective against viruses and cannot be used as if they were. While some of the distinctions between
viruses and bacteria (for example, that viruses are as much as 10 to 100 times smaller than bacteria, or the RNA and DNA of viruses are enclosed in protein, while the genetic material of bacteria is found in cytoplasm) are of relevance only to specialists, explaining the difference between TB and HIV is important to ordinary people. TB is caused by bacteria, while HIV is cause by a virus. Chicken pox is caused by bacteria, while common colds are caused by viruses.

To make things even more complicated, infections such as diarrhoea, pneumonia and meningitis can be caused by either bacteria or viruses. There are also many kinds of different bacteria. For instance, in example 5, the translation uses bacillus (a type of bacteria) instead of the general term bacteria, as does example 1 (Staphylococcus). There are even different types and subtypes of bacillus. Translations that treat igciwane as bacteria (or microbes) are thus broad and imprecise as those that treat igciwane as viruses. The examples below also preserve terms such as penicillin, bacillus, staphylococcus, Lyme, and Black Death.

**Table 5.5: Examples of translations of bacteria as igciwane**

<table>
<thead>
<tr>
<th>Example</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staphylococcus bacteria, which often causes wound infections, used to be eliminated easily by penicillin derivatives.</td>
<td>Igciwane i-staphylococcus, elibangela izilonda, lalivame ukuqedwa kalula ngemikhiqizo ye-penicillin.</td>
</tr>
<tr>
<td>2. In 1882, Robert Koch identified tuberculosis bacteria and developed a test for the disease.</td>
<td>Ngo-1882, Robert Koch wakwazi ukuthola igciwane lesifo sofuba futhi wasungula nendlela yokuxilonga lesi sifo.</td>
</tr>
<tr>
<td>3. The bacterium that causes Lyme disease may have come to North America a hundred years ago with rats or livestock on ships from Europe.</td>
<td>Kungenzeka ukuthi igciwane lesifo seLyme lafika eNyakatho Melika eminyakeni eyikhulu edlule namagundane noma nemfuyo eyayisemikhunjini evela e-Eyurophu.</td>
</tr>
<tr>
<td>5. Alexandre Yersin isolated the bacillus causing the plague</td>
<td>U-Alexandre Yersin owathola igciwane elibanga lesi sifo</td>
</tr>
</tbody>
</table>
The fourth instance treats *igciwane* as germ. Such a use shows how broad the application of *igciwane* can be, since germ can be any of bacteria, virus, fungi, or protozoa.

**Table 5.6: Examples of translations of germ as igciwane**

<table>
<thead>
<tr>
<th>1. In 1882, Robert Koch identified the germ that causes tuberculosis, described by one historian as “the greatest killer disease of the nineteenth century.”</th>
</tr>
</thead>
</table>
| Ngo-1882, uRobert Koch wathola *igciwane* elibangela isifo sofuba, esichazwa esanye isazi-mlando ngokuthi “isifo esingumbulali omkhulu ekhulwini le-19”.

2. In 1882, Robert Koch identified the germ that causes tuberculosis, described by one historian as “the greatest killer disease of the nineteenth century.” |
| La masosha omzimba “azofuna” igciwane alaziyo, futhi azohlasela indawo ebalulekile *egciwaneni*.

3. These antibodies will “seek” the germ they recognize and will strike a vital site on the germ |

4. An army of cells immediately goes into action, with but one purpose—elimination of the invading germ and consequent recovery from illness. |

| Ibutho lamangqamuzana ngokushesha liqala ukulwa, linenjongo eyodwa vó – ukuqeda *igciwane* elihlasele futhi likululamise. |

Finally, we have an assortment of examples where *igciwane* is used variously as protozoa, fungus, and so on. Below is an example:

**Table 5.7: Example of protozoa translated as igciwane**

<table>
<thead>
<tr>
<th><em>Tsetse flies transmit the protozoa that cause sleeping sickness.</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Izimpukane zingadlulisela <em>igciwane</em> elibangela isifo sobuthongo.</td>
</tr>
</tbody>
</table>
Regrettably, the relation between untranslatability interchangeability of igciwane is difficult to tease out only by talking to patients and health workers on the ground. Only the translators at the closed translation environments of the Department of Health and the Department of Arts and Culture could be in a position to shed light on whether or not they found terms truly untranslatable or they merely chose the line of least resistance by preserving technical medical jargon.

As stated in Chapter Four, I could not manage to interview any of the personnel from the diseases management programmes. The explanation was that they were working on tight schedules and had no time for me. One of the key informants from the Corporate Communications Unit admitted that she was not sure at all if the factors of a deeper health literacy and translation cultures ever get considered by the experts at the diseases management programmes. She stated that:

I do not know how much thought is put in relation to levels of education and cultures of target audiences. I think because they are so busy, they just want to send the message across. If we had an in-house translation unit, we would be able to target-specific messages. In most cases we try to have the English and Zulu messages running parallel to each other. Also note that not all messages are translated. From my personal observation, I do not think that this get considered when these messages are written. I think what they have in mind is getting the message out there and

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16 In terms of the workflow management, content development is done by the diseases management programmes in the KZN Health Department. Each of the diseases management programmes put together the messages that they want to send out to the public and then forward them to the Communications Unit for production design, layout and typesetting. That is, the messages are already complete by the time they get to the Communications Unit. At this stage, they are mostly in English. The conception of messages in English, therefore, is done by the diseases management people. The Communications Unit initially just receives and forwards the English versions of the health messages to the Department of Arts and Culture for translation. After translation, the messages then return to the Communications Unit for production design and layout.
that is it. I think they just stick to the facts about the disease, but I cannot guarantee that because I am not part of their team. *Because we are short staffed now and everything is done in a bit of a rush*, I do not think that larger issues such as levels of education and cultural orientation get considered. *People are just concerned with drafting messages based on facts about the disease and to send the message out there.* I do not think people have time to think who is going to read this message. Most messages that we produce here are at the same education level (emphasis added).

End users at the clinics cannot be expected to invest in translating terminology which health communicators, specialists, and translators themselves seem to want to “preserve” in the original language or seem not to want, or to be able, to translate. As we noted in the reference to grandmothers who visit the clinics, what the old woman wants is the name of the disease in isiZulu, and a *culturally competent* clear biomedical explanation of the nature of the condition or the disease. This suggests that the old people are more comfortable with *igciwane* than virus, germ, microbe or bacteria. After all, the act of communication never fails to take place “in situations that are limited in time and place” (Nord 1997: 1). Theories of translation, as we saw, ought in some sense to be embedded in a theory of human action or activity.

What is noticeable is that, when the Corporate Communications Unit receives the messages from the diseases management units to forward to the Department of Arts and Culture for translation into isiZulu, there is no translation brief of any sort. This seems to be just a mechanical exercise. What this means is that it is up to the translator to decide *how* to translate. The translator sitting in his cubicle at national headquarters has no idea what the proposed translation seeks to achieve or what its purpose is. The Department of Health itself is not concerned; its only objective is that the message *be sent out*. How that message is received, or issues of health literacy, are not considered. The translation commission procedure, as reported by my key informants, is that the Department of Health is a *client* of the Department of Arts and Culture and thus just sends out documents “to those folks” without any proper translation briefs.
We are reminded of Nord’s (1997: 12) contention that, in the framework of the Skopostheorie, one of the most important factors determining the purpose of a translation is the addressee. In the workflow of the Department of Health and the Department of Arts and Culture, the intended receiver or audience of the target text, with their culture-specific world knowledge, their expectations and their communicative needs, is missing. This is a huge unacceptable oversight in health communication in South Africa. Corcoran (2007: 31) argues: “It is no longer acceptable that health promotion campaigns are planned and implemented on an ad hoc basis and the application of theory to practise interventions cannot be ignored. In order to promote health successfully and reduce ill-health, health promoters should design all interventions using theoretical concepts for successful health promotion campaigns”.

Asked about the criteria for translating and for not translating, the key informant from the Communications Unit replied that “The key factors are events and outbreaks of diseases. Let us say the MEC has an event on TB. They create brochures or flyers so that they can disseminate to the public. For such events, translations into Zulu are always done. Another factor would be a crisis, such as an outbreak of a disease. We always make sure that we get information out there”. What is noticeable in this statement is that the Department of Health only has a part-time interest in the deeper issues of translation and health literacy. Whatever translations get put out there are done to fulfil the contingent requirements of episodes, events, crises and disease outbreaks and, indeed, to please high-ranking officials such as the MEC. There is no evidence of a long-term commitment to health communication as a practice. There is also no evidence of theory building about translation, or investment in creative policy making or best practices. Wright (1998) argues that, as a general rule, information design needs to be reader-based rather than text based. Imparting information for the sake of imparting it will not make any difference in the lives of target audiences.
The translators I spoke to at the Department Arts and Culture confirmed that they do not receive any translation brief. Rather, they do what they think is appropriate. The end result is that translators end up with translations that are only loyal to the source text. The word client pops out at me. The Department of Health is a client of the Department of Arts and Culture. The relationship seems corporatised, which – not surprisingly – accords well with the stated aim of meeting the requirements of occasional crises are events and pleasing the MEC. As Nord (1997: 30) fears clients “do not normally bother to give the translator an explicit translation brief; not being experts in intercultural communication, they often do not know that a good brief spells a better translation”. While the Department of Health cannot be faulted for its commitment to getting information out there and providing information to the public in their mother tongues, the neglect of the translation process amounts to gross dereliction. Nord (2007: 2) has argued that translation practice “does not take place in a void”. Rather, it takes place “in specific situations set in specific cultures”. Vermeer (1989) cited in Venuti asserts: “The realizability of a commission depends on the circumstances of the target culture, not on the source text. A commission is only indirectly dependent on the source culture to the extent that a translation by definition must involve a source text”. This does not happen in translation of health messages.

It seems that the Department of Health’s translation practice does take place in a void. In fact, it is not clear if there is any translation practice at all. The commissioning process itself (see also footnote 11) sheds light on the lack of properly thought out translation practice. I was informed by my key informants that the Translating Unit at the Department of Arts and Culture receives a request from the Department of Health in an email. The two departments then communicate about the timeframes before the translations start. Once an agreement on timeframes has been reached, and the target language specified, the translation process begins. The translator is not even briefed what the target
audience is or whether the document is for internal use in the Department of Health. When the document arrives, it is up to the translator at the Department of Arts and Culture to decide how to translate the document. There is no other exchange. Essentially, it is up to the translator to decide how to go about translating the documents received within the timeframes. The most important consideration, therefore, seems to be deadlines! There is no negotiation of the Skopos between the client and translator. The informants stated that they receive work in this way at least once every month, with the majority of translations happening during outbreaks of diseases and when there are events roadshows. This confirmed what the informant from the Corporate Communications Unit had stated.

Nutbeam (2000) (cited in Neilsen-Bohlman, Panzer and Kindig 2004: 109) contends that a conception of health literacy “that does not recognize the potential effect of cultural differences on the communication and understanding of health information would miss much of the deeper meaning and purpose of literacy for people”. This, unfortunately, is what seems to be going on in the KwaZulu-Natal Department of Health. They need to centre health literacy as part of a wider translation culture and translation practice. What seems to be shocking is that, although translation culture is widespread in the official government communications of South Africa, this takes place artificially, superficially and mechanically, without any real creative reflection on what it means and how to do it better in terms of communication praxis and being people friendly. This is what Bamgbose (1991) has called the problem of declaration without implementation. I would go further and call it implementation without reflection.

The case of igciwane constitutes a clear case of non-equivalence and lack of synonymy in translation, caused by the pragmatic differences between source and target cultures. Ndhlouvu (2014: 327-8), in a discussion of “term-creation strategies” asserts that “many African languages encounter problems of term
scarcity, especially in technical and scientific arenas”. Ndlovu (2014) refers to these as “term-creation” difficulties. Guaton, Taljard and de Schreyer (2003: 81) explain that the single biggest problem that translators who translate into African languages have to contend with is “a lack of terminology in the majority of specialist subject fields”. As argued in Chapter 3, term scarcity highlights potential problems with translatability. However, I do not think that the use of igciwane to mean 10 different things (virus, germ, bacterium, infection, protozoa, fungi, pathogen, biological agent, and microorganism) reflects on the term scarcity of isiZulu. As the examples of smallpox (Ingxibongo), ART (ukwelashwa ngemishanguzo), HIV (igciwane lesandulela-ngculaza), AIDS (Ingculaza), Herpes (izilonda zomkhuhlane), DNA (uhlolofuzo) and malaria fever (umalaleveva) show, adequate terminology does not seem to be the problem.

Rather, the problem seems to be the rigidity of the source culture itself in refusing to reveal itself fully to the needs of indigenous languages. Were Africans allowed adequate epistemic space to creatively build language that marches in step with their everyday cultures, I am certain that they would find no problems with efficacious words for botulism, anthrax, thrush, candida, and so on, even for CD4 count. If the Chinese can translate anthrax as tānjū bìng or just tānjū, botulism as ròu zhòngdú, thrush as niánzhū jùn zhèng, and DNA as tuōyǎng hétānghésuān why can the same not happen in isiZulu? A nurse at Limehill Clinic had this to say:

We are just unfortunate that we no longer have people like Mandlenkosi Nene who could coin terms when new things and diseases arrive. For example, Ingculaza for AIDS was coined by him as there was no name for it, but today everyone including children know what it stands for. Ingculaza was coined; it is not a translation. I think if we can have more people like Nene the situation can improve. There will be no need for translation if Zulu terms can be coined for different diseases and for people to be taught in their language at their level of understanding.
Dr Thokozani Mandlenkosi Ernest Nene (b. 1944 – d. 2008), also known as “Gxaba Lembadada”, was a well-known South African translator, interpreter, linguist, newsreader, academic and wordsmith – a former Interpreter at the Supreme Court and former member of the then Pan South African Language Board – who spent much of his working and academic life in the project to invent creative, new lexicon in isiZulu.

Nene, who was also a playwright, famously “invented” isiZulu translations for such words as AIDS (Ingculaza) and “infrastructure” (Ingqalasizinda). He also famously referred “Police” as Imbokod’ebomvu and “handcuffs” as amasongo kasigonyela. Nene, who was a radio newsreader at the South African Broadcasting Corporation (SABC) during apartheid, began to test his hand at “inventing” Zulu words while translating from Afrikaans and English to isiZulu for the then Radio Bantu station. Using his knowledge of isiZulu, Zulu cultural norms, and Zulu idioms, proverbs, literature, poetry and oral history, Nene embellished his translated news broadcasts in ways that meant he often “invented” new terminology. Elements taken from praise poems of the Zulu Kings such as Shaka, Dingane, Cetshwayo and others found their way into his translations. Nene did not really invent words that did not exist – but excavated Zulu words that were not in common usage, or combined existing words in fresh new ways, which he brought into modern, popular usage.

The example of “Gxaba Lembadada” shows that culturally relevant, yet popular, words can be incubated. Just as the Chinese tànjū for anthrax, ròu zhōngdú for botulism, niānzhū jūn zhèng for thrush, and tuòyǎng hétânghēsuān for DNA, “Gxaba Lembadada” was able to “invent” Ingculaza (AIDS), Ingqalasizinda (infrastructure), Imbokod’ebomvu (Police) and amasongo kasigonyela (handcuffs), among dozens of other words. One key informant in the study stated:

I think we need people who are fluent in both languages to write health communication in Zulu, from scratch, rather than translate.
It would be interesting to see what will happen if health communication were to be translated from indigenous languages into English. Writing messages in indigenous languages from scratch will benefit us black people. We will be able to understand messages clearly and our languages will also be developed because such an initiative will lead to coining of terms, which lead to the growth and development of our languages.

As the examples of Hepatitis B, Hepatitis A, HIV, SARS and tuberculosis showed, it is possible to create a vocabulary, but only if there is adequate space for Africans to build on language innovation from the ground up. The existence of a default translation culture raises complex problems for the availability of such an epistemic space. It is no longer just a question of seeing language as informing people in a mechanical way. Rather, one needs to evaluate the social and cultural contexts of use without translation are always going to be mechanical.

There is no question of an absolute synonymy between words in the same language. Contrasting forms convey meanings which cannot but fail to coincide totally, and the very act of shifting from one language to another, is by definition, to alter the forms (Bell 1991: 6). It is important that we acknowledge, after Malinowski, that when two cultures differ as deeply as that of the Zulu and the English, when beliefs, scientific views, social organisation, morality and material outfit are fundamentally different, “most of the words in one language cannot be even remotely paralleled in the other” (emphasis added). On a positive note, I was informed – during my interviews with the key informants – that a unit has been established in the Department of Arts and Culture to work on coining terms (I surmise that such coining work would be after the tradition of “Gxaba Lembadada”). The unit, of course, is not focused on the Department of Health’s messages, but works with rest of other government departments.

The study found that the interchangeable use of virus and bacteria, on the one hand, and radiotherapy and chemotherapy, on the other, leaves patients and the health workers in a situation where they are both not sure if the
communication transaction was successful. Both radiotherapy and chemotherapy, for instance, are referred to in isiZulu as *Ukushisa* (to burn). Inferring from the above, it is clear how important it is to ensure that the other party understands everything in the communication transaction. It was suggested by some key informants that the Department of Health employ the services of language experts, such as Zulu linguists and professors (people in the mould of “Gxaba Lembadada”), to deal with this problem. However, misunderstanding or misinterpretation can also take place even when people belong to the same ethnic group, such as Zulus. This is because isiZulu itself is a living language that is always in a process of becoming. There is no pure Zulu identity, and different forms of isiZulu are spoken in different parts of KZN.

Regional terminology means that there can never be total and absolute agreement of which standard terms to apply. One participant in the focus group at Tholusizo Clinic, for instance, made reference to a plant (or living organism) that lives or thrives in water, which goes by different names such as *Umabhebeza* and *Inoni*, depending on which region you come from in KwaZulu-Natal. Whereas people from the inland region of KZN call this organism *Umabhebeza*, people from the coastal regions such as Umzinto call it *Inoni*. This example was drawn on simply to show that standardisation is neither completely achievable nor desirable. That is, different parts of KZN may use different terms to name the same thing. When two individuals are talking, there is just the possibility that they might, or might not, be talking about the same thing. The larger issue here is about cultural fluency (see Chapter 3). As the discussion of *Umabhebeza* and *Inoni* below will demonstrate, being “fluent” in the cultural context may involve an intimate knowledge of given “communicative situations”. After all, it is not just words that must be translated but, rather, also the ideas, worldviews, cultural mores and moral values that the words convey. Language, as Nord (1991: 7) states, not only has semantic value, but also *culture-bound* meaning. The example was also drawn on in order to show, to a
lesser extent, that some concepts and uses fit into a specific culture and into that culture only, into the material apparatus and values of a people.
The use of different terminology to refer to the same thing is greatly magnified when it comes to the complicated process of the translation of health messages. At a practical level, the use of region-specific terms may result in the exclusion of people from other regions. It is these complex problems, I was told, that partly cause translators at the Department of Health to prefer preserving English medical terms in isiZulu health messages. Trying to standardise the use of igciwane to refer to either virus or bacteria will not completely solve the problem. Whether or not we are talking about Umabhebeza and Inoni is never completely certain. It is not even absolutely certain that Umabhebeza and Inoni refer exactly to the same thing. If we agree that language is a form of communication as well as a facilitator and carrier of identity, culture and thought, a creative and cultural tool that humans have created in order to communicate identity, thoughts, needs, desires, triumphs, anxieties, fears, aspirations and ideas, then standardisation will only be useful in the traditionalist, equivalence frame of reference.

But the example of Umabhebeza and Inoni is even more significant than that posed by igciwane because it sheds light on the problem of culture, use, perception, translation and untranslatability, all in one. Following is the reason why. People from the two regions, inland and coastal, consume Inoni or Umabhebeza for different purposes, and even believed that it had qualitatively different benefits. That is there are region-specific good and bad (interpretations of) benefits attached to the consumption or use of this medicine. Whereas people usually harvest this organism from its natural habitat and put it jars with water and after a while they will start drinking that solution, people from the inland region regarded Umabhebeza as meaning that a woman found using it could be expelled from her home by her husband – since it was believed that women use it to make themselves very strong and attractive in bed.

Inland women who used Umabhebeza were regarded, medically, socially and culturally, as harbouring the intention of controlling men or keeping certain
(promiscuous or polygamous) men for themselves. Ironically, the use of *Umabhebeza* to control men and to be strong in bed was attached to the belief that women who used it were themselves promiscuous. On the other hand, in the coastal region (Umzinto, for instance), *Inoni*, though it is believed to be the same organism as *Umabhebeza*, does not carry the same social, cultural and medical meanings. In Umzinto, everyone can take *Inoni*, as it is called there, even little children. Adults allow their children to consume *Inoni* or even administer it to them because they believe it has important health benefits for the whole family. People can and do drink or consume *Inoni* in the open, without any fear of stigma.

Certainly, it seems clear that the use or consumption of *Inoni* is perceived differently down the coast compared to inland: the knowledge, culture and perception around *Inoni* and *Umabhebeza* is completely different. People on the coastal region use *Inoni* openly for its perceived health benefits (it is not clear what those benefits are), while those inland use it — under the name *Umabhebeza* — privately for some perceived medical (and mystical) benefits. As Malinowski (1935) (in Nye, 1998: 256) has pointed out, translation must contend not merely with different linguistic uses but often with “the different cultural realities behind the words” (emphasis added). The concept of “behind the words” not only suggests that translation is more than meets the eye, but that the aspects that lie “behind the words” are also the same ones that are likely to cause untranslatability.

It seems that even the differential naming carries meaning. For instance, calling the medicine *Umabhebeza* gives it a sinister ring, and condemns it to private (sometimes harmful or at least taboo) use. Calling the medicine *Inoni*, on the other hand, gives it an openness and social acceptance that it might otherwise not have. The name thus seems to carry both the meaning and the unique form of empirical medical benefit. While calling the medicine *Umabhebeza* condemns it to private use, and to stigma and taboo, calling it *Inoni* removes
the harmfulness and secrecy. What fascinates me about this example is that we are talking about the same plant/organism, found in the same province (KZN), amongst the same people (Zulus). It is clear that Umabhebeza and Inoni are untranslatable. To translate them, one has to translate the culture as well. But this seems highly impossible.

The example of Umabhebeza and Inoni may, on the one hand, lay to rest the debate about Chomsky’s “innativism” ideology of language, whether there is a universal grammar which all human beings anywhere are capable of learning. Umabhebeza and Inoni are hard to comprehend even amongst Zulus separated by geography of inland and littoral. That is, there is not even a universal grammar for Zulus living in one province. There is no universality within the same indigenous languages. On the other hand, Umabhebeza and Inoni allow us to consider contexts of use that are unique to the inland regions and the coastal regions of KwaZulu-Natal.

We saw in Chapter 1 and 2 the example of Ilunga, a word that 1 000 linguists found to be the hardest word in the world to translate. I argued that it seems rather clear that ilunga precisely resists transfer and substitution. The linguists, however, somehow continue believe that such a word is the hardest to translate – not that it is untranslatable. The 24-word substitution for ilunga shows the rigid insistence by the 1 000 linguists that most words in most languages ought somehow to be inherently and technically translatable and transferable into another language. In Malinowski’s view, “every language has words which are not translatable, because they fit into its culture and into that culture only, into the physical calling, the institutions, the material apparatus and manners and values of a people”. Umabhebeza and Inoni, I would say, are untranslatable.

Berry (2007: 58) has argued that the way people react to illness “is rooted in their broader health belief systems which in turn are culturally determined”. The untranslatability of Umabhebeza and Inoni shows us how complicated the task
is of trying to comprehend health messages on site in rural KwaZulu-Natal. Language is much more than a mere communication tool for its users. Rather, it enables humans to understand their contexts and surroundings and make sense of them. In this regard, without language, our everyday lives would be incomprehensible. The untranslatability of Umabhebeza and Inoni takes us back to Mutasa (1999: 85), who has regarded the importance of language in human lives and actions in the following words:

Language is one of our most precious possessions and a quintessence of our humanity. It is the principal factor enabling individuals to become fully functioning members of the group into which they are born. Nations are able to develop because language provides an important link between the individual and his/her social environment.

Given the apparent untranslatability of Umabhebeza and Inoni, we perhaps now see what (Henle 1965: 4) means when he says that language gives us “every reason to believe, as part of our common-sense psychology, that a people should have words for objects with which they are concerned, and they should lack words for objects with which they have fewer dealings”. If terminology in the context of health literacy, present a complex challenge when it comes to a lingua franca such as English and indigenous languages in the case of igciwane, the challenge is even greater in the case Umabhebeza and Inoni. Language is not just a pairing of sentences and set-theoretic constructions. Rather, language functions also as cultural glue that for community.

The study confirmed that cultural beliefs go a long way when it comes to deciding on important health decisions, including interpreting and understanding day to day medical ailments. To rural folks, interpretations about what causes certain medical conditions are not just made on the linguistic, grammatical or semantic plane, but also the socio-cultural. Certain cultural explanations may coincide or clash with biomedical western explanations. I gathered that most rural people prefer whatever works, but cultural
explanations seem to have an important, spiritual place in their worldview. Berry (2007: 58) argues that:

Many cultures encompass different religious beliefs. Such religious beliefs and other culture-specific beliefs often strongly influence how illness and treatment are perceived and will affect healthcare and health communication in different ways.

The example of Umabhebeza and Inoni suggests the value and importance of cultural beliefs for health literacy and health communication. Language is firmly imbedded in the cultural life of a community. As Everett (2013) shows, cognition + culture + concept of language = language. We must be alive to what Sakai (2006) calls a topos of difference, which considers contexts in which translation is transitive: a living, open, process of acting and being.

Participants who felt that some of the translated messages were “too much” for them had a solution. They stated that they would prefer, for instance, that health communication material carries a lot of visuals, graphics, photographs and other pictorial resources. It was felt that a picture was worth a thousand words. One participant in the Gcinalishone Clinic focus group commented:

I am talking from experience; as I do not like reading. For me to read something, it must capture my attention and have something very interesting. I think most communication material must contain more pictures than words. If you put a pamphlet in front of me and put a magazine on the other hand I will pick up a magazine not the pamphlet. They need to put some more pictures in the messages. You do not have to be educated to understand health communication material if it is presented in pictures. Pictures can make things much easier for uneducated people. For example, look at the road signs, most people including uneducated ones are able to figure out what is expected of them without a struggle.

The use of visuals suggested an important intervention to supplement, or supplant, the translation. Considering that we live in a hyper-mediated environment, often logged-in to the internet, the power of images cannot be
overstated. That said, visuals are language, and have got a semiotics and a grammar of their own that requires as much orientation and skill as written language (Kress and van Leeuwen 1996). Translations that are visuals-heavy will add an important and interesting layer to translation studies but may not necessarily remove the current problems of translation. They will just reintroduce it in new forms, such as those of the male gaze (Mulvey 1975) or the racist gaze (cf. Demirtürk 2009).

Some participants tended to question the Zulu language skills of translators, while others questioned their morality. For instance, some participants felt that it is taboo to pronounce words like *anus* in isiZulu. Most would prefer one to use some euphemism or other when you are talking about private parts in public. At the same time, they recognised that euphemisms dilute messages and may even change the meaning. Failure to call things by their names, even if these are taboo, means that sensitive subjects such as sexually transmitted infections are sometimes sidestepped. On the question of skill, a participant in the KwaMteyi Clinic focus group stated: “Not only I am struggling with English terms in the Zulu messages; there are also Zulu terms that I do not understand”. Participants felt that the quality of the translations was, at times, questionable. When I asked the participants what they thought was behind these questionable translations, they said that they suspected that the professionals who translated the messages were not first-language or native Zulu speakers, were not fluent in both languages (English and Zulu), or were poorly attuned to the cultural contexts within which the Zulu language lived and circulated. A participant in the Douglas Clinic focus group, for instance, queried that “When you compare some of the Zulu messages to the English, you sometimes think that the people who did these translations are not original Zulu speakers”.

I observed that the participants were very opinionated about this issue. I will call this the “Gxaba Lembadada” phenomenon, because Thokozani Mandlenkosi Nene fits the *ideal* of a “pure” Zulu speaker who draws on an “authentic” Zulu
cultural database of praise poetry, oral literature, idioms, folklore and proverbs. Few South Africans, perhaps except those from rural KZN, can expect to be Gxaba Lembadadas. As one participant in the Limehill Clinic focus group stated, “I think we need people who are fluent in both languages to write health communication in Zulu, from scratch, rather than translated” (emphasis added). Only a “Gxaba Lembadada”, I feel, can write health communication in isiZulu, from scratch. Being from rural KZN, my participants were not used to hearing tsotsi-taal spoken in urban areas. Theirs was a “deep” and supposedly “pure” Zulu. They said that they spoke isiZulu as it was supposed to be spoken and felt offended to see isiZulu “brutalised”. Interestingly, the case of Umabhebeza and Inoni suggests that this is a simplification. Even in rural KZN there is also slang, which tends to be regional. People in rural KZN themselves, who speak so-called deep, unadulterated Zulu, did not always understand each other. They tended to consider isiZulu from other parts of KZN not to be as pure as the one they spoke. Also, Zulus from different regions tend to use different terminology for same objects.

All this, I felt, is to be expected because, historically, the notion of “Zulu” itself is a construct. There was no Zulu nation before Shaka came onto the scene in the late eighteenth century. Shaka recruited young men from all over the kingdom and trained them in his own novel warrior tactics. His military campaign resulted in widespread violence and displacement, and after defeating competing armies and assimilating their people, Shaka established his Zulu nation. Within 12 years, he had forged what is largely acknowledged to be one of the mightiest empires the African continent has ever known. Long ago, before the Zulu were forged as a nation, they lived as isolated family groups and partly nomadic northern Nguni groups. These groups moved about within their loosely defined territories in search of game and good grazing for their cattle. As they
accumulated livestock and supporters, family leaders divided and dispersed in
different directions, while still retaining family networks.¹⁷

¹⁷ https://www.sahistory.org.za/article/zulu
CHAPTER SIX

CONCLUSION

This study investigated the *interplay* of health, language and culture by exploring questions of “translation” and “untranslatability” in a selected corpus of English-to-Zulu health communication messages that are disseminated in a rural setting. By exploring the issues of translatability and untranslatability, the study ultimately investigated the relationship of content and meaning of translated English-to-Zulu messages, especially in context-sensitive situations where there might be no linguistic and cultural fits or equivalents to convey the intended message in Zulu. This was a study of the life, meaning and circulation of selected translated messages. It investigated how the target audience see, understand and use the translated messages. I sought to understand if the target audience is benefitting from the information provided by translated messages. The production process and journey of the health messages was also traced in order to understand whether the socio-cultural circumstances and levels of education of the target audiences are considered during the creation and production of health messages. The study revealed that the initial production process is mainly concerned with getting the message *across* and the translators on the other hand are concerned with being loyal to the *source text*.

In the first chapter, the study provided the background to the issues to be investigated. I argued that the government’s preference of English results in the language rights enshrined in the constitution being compromised by inertia or convenience, practicality, usage and expense. The reality is that usage, practicality, expense, regional circumstances and the balance of needs and preferences leads to the dominance of English as government’s preferred
language of communication. This resulted in default dependence on translation. I also pointed out that English remains the language into which most local languages are readily translated from. It is not common for communication to be written in indigenous languages and to find standalone translations of text from one indigenous language to another. The study found that the expectation of translatability goes hand in hand with a default dependence on translation. Most prevention and educational health communication material is available in first languages, in most cases translated from English. The problem with dependence on translation is that not all messages are readily translatable. *Ukusoma*, a Zulu term for the cultural practice translated as “non-penetrative sex” was used as an example.

The first chapter also outlined the research questions, aims, and objectives of the study, as well as stating its rationale and justification. The question of how readers of health communication messages experience and encounter translations in everyday settings was central to the study. To the best of my knowledge, such a question had not been systematically addressed in literature on translations of health communication messages in the African contexts. Most studies of translation commonly focus on what Walter Benjamin (1923) called “The Task of the Translator”. Prior to this study, there had been little specific focus on what actual audiences in real world situations bring to and do with translated messages. Many research methods in translation tend to focus on examining and understanding problems and the process of translation with a source-text oriented view. Questions about the extra-linguistic life, meaning and circulation of translated messages in communities of users have not been subjected to any previous systematic study.

This study fills this research gap, the aim being to contribute to the debate about the relationship between culture, socio-cultural context, language and communication. Furthermore, no intensive systematic or in-depth research has been done focusing strictly on translation and untranslatability of
communication in socio-cultural contexts or with regards to health messages. There are yet no previous studies focusing on the translation of media from English into any of South Africa’s indigenous languages. Additionally, this study contributes – though modestly – to the nascent field of African translation studies. Finally, the research aims to contribute to efforts to craft approaches for designing culturally appropriate and culture-friendly public health communication strategies.

The second chapter of the study provided a discussion of debates and discourses on Translation Studies and writings by pioneers on translation and translation studies, as a discipline. I discussed in detail key concepts such as translatability, untranslatability, translation, language, culture and health communication. Having discussed what language is I then discussed various perspectives and arguments on the evolution of the language. Out of a plethora of definitions of language, what seemed common was that every human being and human culture uses language in one form or another to communicate. Critical to my study is the aspect that language in its many forms is a primary purveyor of meaning, sense-making, identity and culture, yet it does so in ways sometimes not easily translated. The “bewildering diversity of perspectives” about the evolution of language includes the views of the likes of Malinowski, Firth, Chomsky, Tomasello, Fishman, Sapir, Whorf, Lieberman, Piaget, Halliday Markman, Steels, Deacon, Sinclair, Arbib, Goffman, Bickerton, Hewes, Wray, Tallerman, Jackendoff, Pinker and Miller.

Four major schools of thought in linguistics – namely, functionalism, structuralism, generativism and cognitivism take centre stage when it comes to the question of the origins of language. There is little consensus across and within camps as the discourse is always shifting across the sands of time. I examined literature on innativism which argues that language is in-born and without a strong innate component, language cannot be learned. Culturalists such as Everett (2013) reject innativism and argue that human beings are
capable of learning and creating including language. I also examined literature that says language use is at the core of social organisation, and that without its social life would be meaningless. Theorists in the sociological model see language as a tool that human beings use for different purposes in their lives, with communication being one of them. Functionalists focus on phonological, semantic and syntactic aspects of language. Structuralism is based on the idea language is made up of different units; structures connected to each other in a fixed system. The generativists focus on how human beings acquired language in the first place.

Cognitivism on the other hand is based on the notion that language acquisition skills come from the meaning that the mind creates from words. The idea behind cognitivism is “that acquisition of the language to describe some concepts follows, by some unspecified mechanism, from the cognitive acquisition of the concept” (Johansson: 1991: 4). Considering the mammoth nature of the topic of language, as well as the fragmentation and the complexity of the debate, I was persuaded by Fitch that no perspective is better than the other. I creatively raided what I could from some of these schools of thought. I treated language in terms of both the notion of language as communication and in terms of its role as a facilitator and carrier of identity, culture and thought. Language, in this study, was treated and looked at as a creative and cultural tool that humans have used to communicate identity, thoughts, needs, desires, triumphs, anxieties, fears, aspirations and ideas.

To be able to understand the nature of translatability and untranslatability in the health communication messages, I first had to understand what translation is. I searched for a better definition of translation and like in the case of language quite I had to contend with a number of definitions. Translation is difficult to define in a standard, universally accepted way. There is as yet no absolute, quintessential, or universally agreed definition of translation, whether such a standard is desirable, what the end-product of translation should be, or what
constitutes the “perfect translation”. There is also no agreement or clarity as to whether translation refers to the process or the end-product of the translation process (the finished, translated text). Translation means different things to different people and the expectations that a translation must satisfy are diverse too. I then focused on three definitions which I found relevant to this study.

Bell (1991: 5, 6) regards translation as “The expression in another language (or target language) of what has been expressed in another, source language, preserving semantic and stylistic equivalence. Translation is the replacement of a representation of a text in one language by a representation of an equivalent text in a second language”. Bell contradicts himself because he regards translation as a replacement and at the same time as a representation in relation to equivalence. If something is replaced, how is it equivalent? Frank (2008: 6) sees translation as “Text derived from another text in another language, exhibiting qualities of equivalence to that source text, such that the derived text can be taken as a substitute for the original text”. Frank’s definition emphasises the derivative and surrogate nature of the translation: the translation is never thing itself, even though some people may assume it is. Secondly, it emphasises the principle of equivalence, and finally, the critical issue of communication that we evaluated earlier in light Everett’s on the origin and purpose of language.

Sakai (2006: 71, 72) defines translation as an act of articulation that takes place in the social topos of difference or incommensurability. The topos of difference, to which translation is a response, is anterior to the conceptual difference of species or particularities. The network of lexicographical connotations associated with the term translation leads to notions of transferring, conveying or moving from one place to another, or of linking one word, phrase, or text to another. For Sakai, translation is a response to what he calls a topos of difference. He sees it as a living, open, process of acting and being. Translation always inscribes itself in the social topos of incommensurability and difference.
Sakai believes that the conventional concept of translation as a process of homogenisation and of establishing equivalence is the most problematic and the most unsustainable.

All three definitions share a similarity in that they all normatively assume that for translation to happen there must be an expression or transfer of text from one language to another. The translation functions more or less as the replacement of source text by target text, with the latter expected to be an equivalent of the source text. However, there are also salient differences. For instance, Bell’s and Frank’s definitions look at translation singularly in terms of a replacement which retains both semantic and stylistic equivalence (what I am calling the principle of preservation). Unlike Bell and Frank, Sakai brings into the salient issue of culture and cultural difference. There is some commonality between him, Everett and Malinowski regarding the role culture in mediating translation. Of the three definitions, Sakai’s appeal to me more because it relates to the central belief of this study that culture has a critical role in translation. All three definitions, read together, provide a complex definition of translation that this study appreciates and draws on. The reason for adopting a set of different definitions emerges from the fact that translation is acknowledged to be complex: it cannot be adequately covered or approached using one definition or theory.

Tymoczko (2014: 20) has warned of the peril in “fixating on a definition of translation theory”, arguing that “rigid definitions may actually lead to closure on the question of what translations are, resulting in narrowing of research and exclusion of cultural products that are different from those dominant in Western or globalized culture”. If Tymoczko is right, then various definitions and approaches will be necessary to undergird this study. In order to understand translations, it is imperative that we understand translatability. But what creates or leads to translatability. Translatability can be viewed from two points of view, namely the Universalist and monadist points of view argue (De Pedro, 1999:}
Universalists believe that virtually everything is translatable. Newmark (1989: 17) argues: “Every variety of meaning in a source language text can be translated either directly or indirectly into a target language and therefore everything is translatable”.

The monadists, on the other hand, maintain that each linguistic community interprets reality in its own particular way and therefore translatability is more or less impossible. While on surface, translatability refers to the property of being translatable or being able to be translated, I argued that translatability in actual practice is much more than this simplistic dictionary definition. In practice, quite a number of things need to occur during the translation process in order for the text to be seen as translatable. Venuti (2000: 468) avers translation is: translation “never communicates in an untroubled fashion” precisely because the translator is an active participant who “negotiates the linguistic and cultural differences of the foreign text by reducing them and supplying another set of differences, basically domestic drawn from the receiving language and culture to enable the foreign to be received there”.

In agreement with Gorea in Lost in Translation: Beyond Words, I defined untranslatability as “a property of a text or any utterance, in one language for which no equivalent text or utterance cab be found in another language when translated”. Two types of untranslatability have been formally identified in the literature and they are linguistic untranslatability and cultural untranslatability. This study has shown that while linguistic untranslatability affects the meaning of messages, cultural untranslatability leads to total failure. Examples of ukusoma, umabhebeza, and inoni were used to indicate total cultural untranslatability.

The importance of locating the origins of language in cultural contexts and seeing language as cultural glue was also discussed. The dominance of English and attitudes towards the language, which for elites is a convenient meeting
place, was also discussed. I also touched on how the expectation of
translatability dominates and runs through the discourse of translation in
government communications in South Africa, spawning a kind of translation-for-
communication or communication by translation culture. I showed how the
concept of equivalence collapses or is refuted by the functionalists’ scholarship.
The chapter also discussed how cultural and linguistic asymmetries create
problems in the translation process, and indicated how orthodox, pro-Western
translation theories are failing to address the translation problems facing Africa
and other post-colonial settings.

The third chapter presented a discussion of translation theories in general, in
terms of a background and critical evaluation, and examined the selected
frameworks of the functional approach to translation, the Skopostheorie, DTS
and the cultural turn. I argued that the traditional translation theory has run its
course and is inadequate for purposes of recognising and acknowledging
cultural load that characterises translation. Traditional translation theories are
incompatible with many translation scenarios that are relevant to the particular
South African context selected for this study. I made a theoretical point that the
concept of preconditions for a translation is antiquated and unrealistic. I also
argued that the quest for preserving and prolonging originality seems unrealistic
and is the complete opposite of the functionalist and Skopostheorie where the
original text is treated as just an offer of information which can be used by the
translator to inform a different kind of audience, in a way he or she deems
appropriate. The functionalist perspective appeals to me because it offers the
translator freedom and wiggle room, within context. One is not a prisoner to
some prescriptive do's and don'ts.

In the fourth chapter, I outlined the methodology of the study, detailing the
methods used to collect and analyse data, including sampling and ethics. I
stated that few studies investigate how the users or target audiences of the
translated messages perceive them and what they feel about these messages.
I also justified why a qualitative methodology was used; the being that it sought to answer the “what”, “how” and “why” part of the main research question. As noted, I sought to examine the interplay of language, health and culture; and to understand in detailed ways – people’s experiences of translated messages in rural contexts where not much is currently known. The fact that this kind of data cannot be quantified but needs to be interpreted to get a deeper understanding of the participants’ perspectives, and reasoning in relation to health communication messages that they have access to, a qualitative research design became appropriate. Data collection techniques and sampling were also discussed in detail in this chapter. I justified why a combination of primary and secondary methods of data collection were used. I also indicated the method and the software that was used in analysing data. N-Vivo, a qualitative data analysis was used to code thematically collected data. This qualitative research software helps the researcher code, tag and group data according recurring themes and patterns in the data. I also discussed both the advantages and disadvantages of the methods that were used in collecting data, such interviews versus focus groups. I also pointed out how they interchangeably complement each other such asking questions that were not asked in the other vice versa.

The most important chapter of the study is chapter 5. In this I presented and discussed findings. The key findings of my study are that the master status of English has relegated isiZulu to being the only source of all translation problems and more importantly, of untranslatability. I have argued that the Department of Health and the Department of Arts and Culture normatively expect health messages to be conceived in English and be translated to indigenous languages such as isiZulu. This becomes a source of all translation and untranslatability problems. In my interviews with key personnel from the Department of Arts and Culture’s translation unit, I found that “usage”, “practicality”, “expense”, regional circumstances and the balance of the needs and preferences amount to or equal English. That is, the normative use of English as a starting point for the health communication translation process is
considered to be a foregone conclusion because it is simply practical. Starting with isiZulu as the origin of the translation is considered complicated, impractical and expensive. The irony is that most people in KZN use isiZulu and regional circumstances and the balance of needs and preferences should favour their contexts and should favour isiZulu as the origin point of meaning-making. The study revealed that the needs of the users in real-world contexts are not taken into consideration in how messages are initially conceived and later translated, as long as the messages have been sent out. Translators also concerned with preserving and producing the messages as they are in the original disregarding the socio-cultural element in meaning making.

I argued that at the intersection of language and culture – the point of interplay – is where untranslatability of Zulu culture is located. Health communication has to come to terms in the first instance with contending health literacy in different forms. Untranslatability produces not single, monolithic health literacy to the hegemony of English, health literacy in plural. These different kinds of health literacy are shot through with contradictions and are saddled with isiZulu that is itself burdened by Zulu culture. I also indicated that health communication messages contend with untranslatable traditional beliefs that some health problems are caused by witchcraft. A clinic matron that I interviewed at Sgweje Clinic explained that it was difficult when talking to patients, to always separate an objective biomedical diagnosis from cultural, spiritual and mythological explanations involving God, ancestors, misfortune, spells, evil spirits, witchcraft, sorcery, tokoloshes, or bad luck.

Patients, it would seem, generally accept the biomedical diagnosis, but they still believed that over and above that diagnosis, those other mysterious spiritual forces were also at work. The matron pointed out that there was always a reluctance to believe in single, empirical causes of diseases. I also showed that many rural people straddle two worlds: they are comfortable taking western medicine as far and as long as it works, while also observing their culture and
tradition as far and as long as it works. Consulting traditional healers or spiritual healers and going to the clinic or to the doctor are part of a menu of options.

With regard to intelligibility of translated messages, I argued that little has been achieved in terms of producing communication guided by theory. I observed that in a preponderant amount of the printed material, medical jargon was rendered in English, while the surrounding text would be in isiZulu. The use of non-translated medical terms or medical jargon constitutes one of the biggest challenges for users/target audiences of health communication messages. I also gave a couple of examples where medical jargon is put as it is in translated messages without being explained. In response to my question about the intelligibility of translated messages, most participants in the focus groups indicated that messages are partially understood because of the medical terminology that they are unfamiliar with. The isiZulu text interspersed with English reflects a failure of domestication – a lack of genuine displacement of the foreign text. Through examples of untranslatable words such as virus, bacterium radiotherapy and chemotherapy, I was able to show how untranslatability hinders health communication which is done via a default translation culture.

This study attempted to introduce a politics of the untranslatable to trouble the hegemony of the translatable represented by English. I showed in the findings chapter that the translation procedure or process that is followed by the Department of Health and the Department of Arts and Culture is itself flawed because they do not use translation briefs. A translation brief is very important if the translation has to achieve a certain purpose. Failure to provide translators with translations briefs, allows translators to translate as they deem fit, at the expense of the target audience. No one can blame translators for translating as they deem appropriate. If someone has to be blamed, it is the person who commissions the translations. The study also found that while health communication messages are written in English for translation to indigenous
languages such isiZulu, distribution is also poorly organised. The study revealed that health communication in the form of printed and visual material was not systematically provided at the 10 clinics that I visited.

In order to show the difficulty of translating culture, norms, beliefs, values, cultural mores, moral values, etc., I used the example of Umabhebeza and Inoni. This example was also used to show that standardisation of terms is neither completely achievable nor desirable for various reasons, with regional colloquial preferences as one of them. It also served to indicate that cultural fluency is contingent upon a given communication situation. After all, it is not just words that must be translated, but rather, also the ideas, worldviews, cultural mores and moral values that the words convey. This example of Umabhebeza and Inoni was also used to show that some concepts and uses fit into the material apparatus and values of a people. The use of different terminology to refer to the same thing is greatly magnified when it comes to the complicated process of the translation of health communication. The example of Umabhebeza/Inoni was critical in shedding light on the problem of culture, use, perception, translation and untranslatability simultaneously. It was also used to show that the concept of “behind the words” by Malinowski (1935), not only suggests that translation is more than meets the eye, but that the aspects that lie “behind the words” are also the same ones that are likely to causes untranslatability. It suggests the value and importance of cultural beliefs for health literacy and health communication.

To portray the complexity of the interchangeable use of terms and the confusion it creates in health communication, I used the example of the words Igciwane. In translated isiZulu messages Igciwane refers to both the virus and the bacterium, to say the least. A good example relates to diseases such as AIDS and TB. AIDS is caused by a virus, whereas TB is caused by bacteria. The problem with the isiZulu translations is that both diseases are translated as if they had the same cause, which is normatively translated as Igciwane. This is
because isiZulu appears to refer to many causes of diseases or sickness as *igciwane*. This is the same way, for instance, that isiZulu appears to forego differentiation of some colours, such as blue and green. In isiZulu blue and green are *luhlaza*. It is only when you ask for detailed explanation that someone will differentiate by saying: *Kuluhlaza okotshani*, (It is green like grass) or *Kuluhlaza okwesibhakabhaka*, (It is blue like a sky). With *igciwane*, there is no space for such differentiation in translation.

I observed that, in translations, *igciwane* can be any one of micro-organism, microbes, virus, germ, bacterium, infection, protozoa, fungi, pathogen and biological agent. All these are used or translated as *igciwane*, *without* distinction. I also noted that *igciwane* is used in singular form in translations, even if it is plural in English versions. The interchangeable use of *igciwane* might prove to be hazardous for patients because diseases caused by viruses and bacteria may need different medication. For instance, prescribing antibiotics for something caused by a virus might not be efficacious. Considering that people sometimes do self-medicate, it is in my view really important to differentiate between the virus and bacterium.

There is a need for coining distinct names for different micro-organisms that are currently referred to as *igciwane* and consensus must be reached as to what microorganism should be referred to as *igciwane*. This is important because different microbes cause different diseases; hence cause and effect need to be clearly defined. While I suggested in the findings that normative terminologies could be useful to deal with the problem of interchangeable use of terms such as *igciwane*, I also pointed out that problems might be encountered, because isiZulu is a living a language. Any norms in translation need to reckon with cultural specificity. I noted, for instance, that understanding target culture can also play a significant role since naming is also attached to meaning making as we saw in the case of untranslatability of *Umabhebeza* and *Inoni*. 
In sum, translation never communicates in an untroubled fashion. The source text is always interfered with (cf. Venuti). The “foreign” text is always rewritten in domestic dialects and discourses, registers and styles, and this, results in the production of textual effects that signify only in the history of the domestic language and culture. After all, it is not just words that must be translated, but also the ideas, worldviews, cultural mores and moral values that the words convey. In what way can a lived culture be readily translated into another language? The culturally rich and ethnically diverse population of South Africa, home to 11 official languages, creates unique challenges for researchers and healthcare workers alike. This study has shown that successful outcomes depend on effective communication (Van den Berg 2016), but also on leaving that which is untranslatable to be untranslatable. As Van den Berg (2016: 1) points out, “language can never be separated from culture”. Healthcare professionals may be trained in the biomedical model of disease, but their patients “often hold very different culture-specific models to explain origins of disease”. How can these two sit together? How can the translatable to live with the untranslatable?

One way of looking at it is that there is already constitutional provision for the translatable to live with the untranslatable. In the Constitution of South Africa, (Act 108 of 1996) the rights of all citizens to access healthcare services (Section 27) are protected. Also protected is the right to participate in all aspects of life in the language of choice (Section 6). The interlinked nature of these two basic human rights is emphasised in the National Health Act (Act 61 of 2003), which states that the healthcare provider must where possible, inform the user in a language that the user understands, and, in a manner, which considers the user’s level of literacy. The National Patient’s Charter reiterates this by stating that patients should have access to healthcare and information in a language that they understand (VL Van den Berg, 2016: 1). Despite all these lofty provisions, the state of health communication in South Africa is far from ideal.
This is despite the efforts and the money spent government and the Department of Health in relation to health messaging.

The institutions saddled with the constitutional duty to ensure health literacy as an aspect of access to healthcare, such as the KwaZulu-Natal Department of Health and the Department of Arts and Culture, are regrettably doing too little or nothing in this regard. These institutions need to centre health literacy as part of a wider translation culture and translation practice. Although translation culture is widespread in the official government communications of South Africa, this takes place artificially, superficially and mechanically, without any real creative reflection on what it means and how to do it better in terms of communication praxis and being people friendly. This situation is what Bamgbose (1991) has called the problem of declaration without implementation. I went further and called it implementation without reflection.

The study found that the problem of translated health communication messages does not only start and end with translation. Rather, it can be traced to two things. On the one hand, it can be traced to the creation and design process of the original messages. On the other hand, it can be traced to the socio-cultural plane. The subjects who participated in my study felt that they are still being communicated to in English or English with a thin coating of isiZulu translation, when they try to access healthcare. The hegemony of the translatable still rules over health communication and therefore health access. We note, for instance, that many doctors still prefer to speak to patients in English. As a nurse at Gcinalishone Clinic stated:

We experience communication problems with doctors who cannot speak Zulu. We as nurses must intervene as interpreters. The doctor will look at the patient as he or she describes the problem or ailment. In most cases their descriptions are long and winding because they do not know the scientific terms or short terminology for the condition. When it is your turn to explain to the doctor, sometimes the doctor looks at you in disbelief when you shorten the patient’s description. Sometimes even patients will doubt that
you are telling the doctor what they just told you. Others will even shake their heads to indicate that they disagree with you. This confuses the doctor even more.

There is also no choice of language inside consultation rooms both in private and public health institutions. Information is not always available in the languages of the patients’ choice.

The provision of health information pamphlets in hard copy to assist in teaching patients about health-related topics is a well-known practice, particularly in resource-restricted health systems such as South Africa (Wasserman et al. 2010 cited in Krige and Reid, 2017: 114). But such written health information can only be used in full if its certain communicative conditions are met (Krige and Reid, 2017: 120). Van den Berg (2016) has made reference to research that showed that persons with limited English proficiency are less likely to receive regular source of primary care and are less likely to receive preventive care. Aleligay et al. (2008) found that most educational health material is written at a grade 10 level, which means the reader must have completed at least 10 years of schooling to be able to understand the material. They recommend that health material should, rather, be prepared at a fifth to sixth grade level.

The Department of Health needs, in as far as health communication goes, to initiate an intellectual culture which is built on recognising difference – a *topos* of difference (cf. Mboti 2015) – and to move away from the current “instant noodles” culture of translation. It needs to develop and deepen effective health communication interventions that recognise and reckon with the status of isiZulu as a living language. Investment in a clear and comprehensive communication strategy relating to translation is overdue. This will entail a nuanced description of each intended audience, with audiences segmented according to feedback drawn from these audiences. The commissioning process for translation by the department needs to be revisited. Translators must not be left to decide how they want to translate a given message. They
must be given proper translation briefs which will guide them as to what are the circumstances of the target audience, its culture as well as their education levels and their reading skills. As Vermeer (1989) asserts, “the realizability of a commission depends on the circumstances of the target culture, not on the source text”. This is certainly not the case with the current translation scene.

The study found, from key translator informants, that translations are guided by loyalty to the source irrespective of who the target audience is. They are not supposed to fiddle with the source text. A commission is only indirectly dependent on the source culture to the extent that a translation by definition must involve a source text. It must be borne in mind that a translation is done to achieve or fulfil a specific Skopos or purpose, which in many instances is making information available to a different target audience, with different characteristics and needs. A translation should be a source for new information, not slavishly prolong or preserve the life of the source text. As De Pedro (1999: 552) asserts, the question of how the target audience may interpret cultural issues in the source text also forms part of the considerations which have to be borne in mind when approaching the question of translatability.

The diseases management unit is not a communication department. Their expertise is on controlling and management the health of the public. While it is within their job description to create or conceptualise health messages, the Corporate Communications Unit must be given more agency to influence messaging. It would be ideal for the Corporate Communications Unit to have a translation unit in-house, so that they might more effectively influence how translations are designed and produced. As it stands the Corporate Communications Unit is just a static “middle man” between the Centre for Disease Control (CDC) and the Department of Arts and Culture’s translating unit. The Corporate Communications Unit, as communicators should be more proactive in the production of health communication messages than they are at present. Considering that not everyone can read among the target audiences,
suggestions for improvement including incorporating more creative visuals which might play a significant role in communicating with “non-illiterates” about diseases. An example would be roads signs, which effectively convey their message through visuals.

Finally, participants voiced persistent dissatisfaction with the Department of Health, which they said does not treat rural areas the same way that it treats people from urban areas. For instance, there are no big, colourful billboards with evocative visual material and graphics in rural communities. There are tenacious systemic problems with access to health and health equity in KZN. These, however, can only be effectively tackled at national level, through a broad-based intervention at the level of the national health system. The burden of illness historically affects South Africa’s poor disproportionately. Disparities abound. This is still the case today in the 10 clinics I surveyed in my study.

The situation that faces us, then, in the words of Cassin (2004: xvii), is a problem of languages. This problem leads us to envisage two kinds of solution. We could choose a dominant language in which exchanges will take place from now on, a globalized Anglo-American. Or we could gamble on the retention of many languages, making clear on every occasion the meaning and the interest of the differences - the only way of really facilitating communication between languages and cultures.

In terms of policy recommendation, this study belongs in the second bracket. I concur with wa Thiong’o (2017: 7) that “You could have, at the very least, a three-language policy for every child: their mother tongue; the lingua franca; and whatever is the most useful language of global reach that is the reach beyond their communities”. However, this is already happening in townships, were anyone who has ever lived and grown up in a South African Kasi easily knows five or more local languages. Our local translation space needs to
harness this *Kasi* flexibility and *Kasi* culture – a kind of creative *heterolinguism*.

Our point of departure, then, is a radical politics of the *untranslatable*. This politics recognises that the supremacist ontology and global hegemony of English is unimaginative and outdated. But my study looked more to the future than the past. I thus established, as far as possible, unlike other conventional theorists of untranslatability (cf. Cassin 2004), that untranslatability is rendered more acute not just in language and linguistic but by *culture*. If we are to dismantle the supremacist ontologies encoded in our pragmatic dependence on translations from English, we must reckon with the fact that Zulu is not just a language but an irreducibly meaningful culture, identity, historical experience and worldview. But what I imagine to be Zulu culture is not something dried, static and reified. Rather, it is a proud culture that is creative, is richly expressive, and is always in the process of becoming. It is a state of affairs: a Zulu-ness, as it were. Zulu-ness is always already a multiplicity and a hetero-plurality. The multiplicity is to be found *around* and *within* isiZulu, expressing that being Zulu is necessarily caught up with the corpora of social history, social being, being-human, complex worldview, and cultural experience. When we are talking translation and untranslatability, one needs to reckon with the fact that isiZulu is a natural language: a language in a domain of a living culture of a proud African people.

These contexts, contests, uses, contexts of use, possibilities, opportunities, meanings, and extra-linguistic factors constitute a field of enquiry in their own right. This study sought to trace the outlines of this field. In this field, the relevance and irreducibility of isiZulu holds the status of a first principle. We must see not just what we are missing when we continue to impose translations that are of dubious efficacy, but the immense socio-cultural havoc that we are causing. What is lost in translation is often lost not because of language factors, but because of meaning and meaning in context. We must rescue South African
translation culture from the domain of the mechanical, the mathematizable and the purely functionalist to the domain of everyday life and socio-cultural contexts. The point is not to confer some special, essentialist or reified status for isiZulu. It is rather, to urge us to face issues of translation with renewed interest and courage. The current half-hearted participation is detrimental to the communication domain of South Africa as a whole.

We saw how the participants in the study were decidedly unhappy with the way English words seemed to chase around and chase out isiZulu words from the health lexicon. They were bemused and could not understand why English words could be left to police themselves, to call the shots, and to decide where to go or not to go. This status quo is injurious to communication and to language rights and self-determination. We noted in Chapter 1 that whereas the term “translation” signifies language in a state of non-belonging, hegemonic English never suffers from that particular problem. It always belongs. It belongs everywhere. Indeed, English displaces and topples other languages wherever it goes. It is indigenous languages such as isiZulu that are made to feel foreign in their own country. As wa Thiong’o (2017: 7) says, a “meaningful and practical policy has to start with the assumption that every language has a right to be”. Translation must be a dialogue and complex give and take between equally rich and equally expressive languages. This requires a ceaseless and continuous dialogue and interaction between isiZulu and English, and English and isiZulu. Such a dialogue and interaction must, however, be markedly different to the unsustainable current practice of translating normatively from English. However, it is important to first reverse the gaze (cf. Mboti 2010, 2014) and “secure the base”, as it were, to borrow the phrase by wa Thiong’o (2017: 1).

The base that needs to be secured is isiZulu. After all, African languages have always been sources of legitimate knowledge, meaning and communication. This is not going to change any time soon, if ever. As wa Thiong’o (2017: 1) says, “The security of one’s base, even when two armies are cooperating to
achieve a jointly held tactical or strategic end against a third, is necessary”. The condition of the existence of English must be the existence of isiZulu and isiXhosa and SeSotho, and so on. “In more equitable relations of wealth, power and values,” says wa Thiong’o (2017: 8), “translation can play a crucial and ultimate role of enabling mutuality of being and becoming even within a plurality of languages”. The hegemony of English is unimaginative and outdated. The future lies in a creative *heterolingualism*. 
REFERENCES


[https://www.tandfonline.com/doi/abs/10.1080/02687030701415872](https://www.tandfonline.com/doi/abs/10.1080/02687030701415872).


[https://msu.edu/~mwr2p/Babchuk%26Badiee-MR2P-2010.pdf](https://msu.edu/~mwr2p/Babchuk%26Badiee-MR2P-2010.pdf)


Gorea, L. “Lost in Translation: Beyond Words”. An interactive lecture workshop with several examples and hands-on activities”.


Appendix A

Some sample questionnaire questions

1. What are the most easily accessible kinds of health communication messages in this area?
2. Where are they accessible?
3. In what language are these health communication messages available?
4. Are these messages discernible to an average person?
5. What to do you make of them? Do they make any sense to you and your fellow community members? If not, why?
6. As a healthcare professional, are you able to use them in your real-life situations? If not, why?
7. Do you think these messages were initially meant for you or other people? Why do you think so?
8. Are concepts or terms used in these messages understandable and clear?
9. Let us say you were to explain a particular messages or health advertisement to a person who is uneducated and cannot read, will you be able to effectively do that? How difficult or easy will it be to do that?
10. Do you have some advertisements that come to your mind, which might give you some problems understanding and explaining them to someone?
11. What do you think needs to be done to make health communication messages more discernible?
12. How do selected target audiences in the real-world contexts of rural KZN use, understand and make sense of selected health communication messages translated from English to Zulu?
13. Why do selected target audiences in rural KZN use, understand, and make meaning out of translated health communication messages in the way they do?
14. What is the nature of the “translatable” and the “untranslatable” in selected English to Zulu health messages?
15. What do the “translatable” and the “untranslatable” in selected English-to-Zulu health messages reveal about the relationship between language and culture, and between language, culture and health?
16. How does untranslatability affect the meaning of translated messages? Are the messages that result from this the intended messages?
17. What do you think of the unfamiliar and non-translated terminology that characterise some of these messages?
Appendix B

Sample Cover letter and consent protocol

Department of Communication Studies
School of Communication & Media Studies
B-Ring 6, Kingsway Campus
University of Johannesburg
Cr. Kingsway & University Road, Auckland Park

January 2017

To the Faculty of Humanities Ethics Committee Chair

RE: Ethical Clearance Cover Letter for Mongezi Andrew Sikhakhane (student number: 201173251), Department of Communication Studies

The prospective title of my masters/doctoral study is:

Health, Culture and Language: Translation and Untranslatability in Selected English-to-Zulu Health Communication Messages in Rural KwaZulu-Natal

Broadly stated, the objective of my study is to investigate the relationship between language, culture and health by exploring questions of “translatability” and “untranslatability” in a selected corpus of English-to-Zulu health communication messages in selected rural settings in KwaZulu-Natal.

My main research objective is to question the social, health and communicative “impact” that translatability and untranslatability are likely going to have on the content and meaning of English-to-Zulu messages to rural audiences, especially in relation to situations where there are no cultural and linguistic fits or equivalents to convey the intended messages in Zulu.

The data collection method that I will use is a qualitative approach. The intention is to collect and analyse data from focus groups and in-depth interviews with clinic attendees and users, health workers at clinics and by extension producers of both original and translated messages. Participants will be drawn from selected KwaZulu-Natal clinics in UThukela District Municipality and UMzinyathi District Municipality communities over six weeks. The ages of participants are 18 to 55. A minimum of six people and a maximum of 10 people in each focus group will form participants and gender
representation will be determined by availability. Each interview will last for 45 to 90 minutes.

A formal letter (gatekeeper letting) giving me permission will be sought and made available to all potential 60 respondents. The autonomy of participants will be protected through the use of an informed consent form (please find a generic example of this form in English [p.3]. I will also translate it into in Zulu. This form specifies the nature and purpose of the research, the identity and institutional association of the researcher and their contact details, the fact that participation is voluntary, that anonymity will be ensured where appropriate, that participants are free to withdraw from the research at any time without any negative or undesirable consequences to themselves and that responses will be treated in a confidential manner. The informed consent form will clearly state that pseudonyms may be used by participants should they wish. No one will be interviewed without their informed consent or against their will. This will be reiterated at the start of every interview or focus group discussions. This will protect the identities of participants eternally. Once they have voluntarily signed these letters, I may then begin working with them.

Below is a list of the examples of structured and semi-structured questions that I intend to ask the participants:

1. What are the most easily accessible kinds of health communication messages in this area?
2. Where are they accessible?
3. In what language are these health communication messages available?
4. Are these messages discernible to an average person?
5. What do you make of them? Do they make any sense to you and your fellow community members? If not, why?
6. Are you able to use them in your real-life situations? If not, why?
7. Do you think these messages were initially meant for you or other people? Why do you think so?
8. Are concepts or terms used in these messages understandable and clear?
9. Let us say you were to explain a particular messages or health advertisement to a person who is uneducated and cannot read, will you be able to effectively do that? How difficult or easy will it be to do that? Do you have some advertisements that come to your mind, which might give you some problems understanding and explaining them to someone?
10. What do you think needs to be done to make health communication messages more discernible?
All the research data and instruments (recordings, interview transcripts etc.) will be handed to the supervisor for safe storage at the University for a period of up to 5 years. Thereafter, the data will be safely disposed of according to institutional norms and regulations.

The UJ Ethics Protocol Form is appended at the bottom of this letter.

Yours faithfully

Mr. Mongezi Andrew Sikhakhane

Personal email: mongezis@mtnloaded.co.za
Mobile: 078 182 0163

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**Consent for Participation in a Research Interview**

I agree to participate in this study titled "Health, Culture and Language: Translation and Untranslatability in Selected English-to-Zulu Health Communication Messages in Rural KwaZulu-Natal" being carried out by Mongezi Andrew Sikhakhane from the University of Johannesburg.

The purpose of this document is to specify the terms of my participation in the project through being interviewed. I can confirm that:

1. I have been given sufficient information about this research project. The purpose of my participation as an interviewee in this project has been explained to me and is clear.
2. My participation as an interviewee in this project is voluntary. There is no explicit or implicit coercion whatsoever to participate.
3. Participation involves being interviewed by (a) researcher(s) from the European University Institute. The interview will last approximately 45 to 90 minutes. I allow the researcher(s) to take written notes during the interview. I also may allow the recording (by audio/video tape) of the interview. It is clear to me that in case I do not want the interview to be taped I am at any point of time fully entitled to withdraw from participation.
4. I have the right not to answer any of the questions. If I feel uncomfortable in any way during the interview session, I have the right to withdraw from the interview.
5. I have been given the explicit guarantees that, if I wish so, the researcher will not identify me by name or function in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure. In all cases subsequent uses of records and data
will be subject to standard data use policies at the University of Johannesburg (Data Protection Policy).

6. I have been given the guarantee that this research project has been reviewed and approved by Prof. Nyasha Mboti, by the Department of Communication Studies, and by the Faculty of Humanities Ethics Committee at the University of Johannesburg. For research problems or any other question regarding the research project, the Faculty of Humanities Ethics Committee at the UJ may be contacted through [information of the contact person at the Ethics Committee].

7. I have read and understood the points and statements of this form. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

8. I have been given a copy of this consent form co-signed by the interviewer.

________________________  ______________________
Participant's Signature    Date

I have explained the study and the implications of being interviewed to the interviewee and I believe that the consent is informed and that he/she understands the implications of participation.

________________________  ______________________
Researcher's Signature     Date
# Research Ethics Protocol Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Mongezi Andrew Sikhakhane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department</td>
<td>Communication Studies</td>
</tr>
<tr>
<td>Degree</td>
<td>MA Fundamental Communication/PhD</td>
</tr>
<tr>
<td>Title of project</td>
<td>“Health, Culture and Language: Translation and Untranslatability in Selected English-to-Zulu Health Communication Messages in Rural KwaZulu-Natal”</td>
</tr>
</tbody>
</table>

**Legal aspects regarding consent**

- **(a)** Are participants in an institutional or specific organisational setting (e.g. a school, corporate organisation, prison)?
  - If so, please give the name of the institution/organisation:
  - If yes, permission will be obtained from the management of the institution/organisation.
  - **Yes**

- **(b)** Are any participants minors (i.e. under the age of 18)?
  - If yes, consent will be obtained from legal guardians.
  - **No**

- **(c)** Will the research be carried out on private property (e.g. shopping centre or business premises)?
  - If yes, permission will be obtained from property owners (or their managers).
  - **No**
### Information and informed consent

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Participants in a qualitative project will be provided with a letter/form asking for their informed consent. The consent form will state that participation in the study is voluntary, that the data will be treated in a confidential manner, that the participants will remain anonymous (where applicable), and that their privacy will be respected.</td>
<td>Yes  Yes</td>
</tr>
<tr>
<td>(b) Participants in a quantitative project will be provided with information pertaining to the nature of the project. They will also receive a written document (e.g. a cover page to a questionnaire) assuring them that participation in the study is voluntary, that the data will be treated in a confidential manner, that the participants will remain anonymous, and that their privacy will be respected.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Declaration by researcher/principal investigator

I, the undersigned, declare that the standard practice of ethical professionalism will be upheld in the proposed research project. I undertake to bring to the attention of the Humanities Academic Ethics Committee any changes to this project which may affect ethical matters pertaining to this project. Furthermore, I understand, acknowledge and undertake to adhere to the stipulations in the University document called *Code of Academic and Research Ethics*, which can be obtained on the intranet.

MA Sikhakhane

Signature of Researcher/Principal Investigator

Date: 29/09/2016

Signature of Supervisor(s)/Promoter(s)

Date: 30-10-2016

BoF Approved Nov 2014
APPENDIX C

Some examples of terms which resist translation and substitution.

- Chromosomes,
- Cox2,
- Down Syndrome,
- Ebola,
- Itrisomy,
- Hydrotherapy,
- Piriformis,
- Hypotonia,
- Levaton Scap,
- Legionnaire’s Disease,
- Methotrexate,
- Physio,
- ROM,
- Praziquantel,
- Scalenes,
- Dr Needling,
- VIP Curl Up,
- Occupational Therapy,
- Electrotherapy
- Synovial
- Zika
- SARS
UPHIKO OLUQONDENE NOKWELASHWA KWBANOKUKHUBAZEKA ESIBHEDLELA IBHETHESDA
UKUKHUBAZEKA OKUBIZWA NGE-DOWN SYNDROME
IYINI I-DOWN SYNDROME?
I-down syndrome ukuxoveka kwezakhi zofuzo okubonakala ngezimpawu ezithile. Kubangwa ukungahambi ngendlela kwemithambo ethile ephathelene nofuzo kanti futhi ithalitha kuzonke izinhlanga, abacebile kanye nabampofu ngokulinganayo.

IBANGELWA YINI I-DOWN SYNDROME?

IZIMPAWU ZE-DOWN SYNDROME
Izingane ezinezezima ezimbelezelezelezelelezelezele zibukheka zehlukile, ngaleyo ndlela-le zihlonzwa zizalwa nje ukuthi izihluka zukhubeke. Izimpawu ezejwayelelekile.

UBUSO
• Amehlo ayingxemu, abheke phezulu
• Izingane ezihluma ngaphakathi esweni
• Ikhala elincane elinombombo obanzi futhi oyisicaba.
• Umlomo omnbian, owenza ukuthi ulimi lubukeke lulukhulu.
• Izindlebe ezincane

IZANDLA
• Umugqa owowda entendeni yesandla
• Izandla ezinkulu neminwe emifushane
• Ucikicane ogobile
• Isikhala phakathi kukaqukuku nomunwe wesibili

APPENDIX D
SOME EXAMPLES OF ENGLISH AND ISIZULU HEALTH MESSAGES

BHETHESDA HOSPITAL OCCUPATIONAL THEERAPY DEPARTMENT
DOWN SYNDROME

WHAT IS DOWN SYNDROME?
Down syndrome is genetic disorder that is characterized by typical features. It is caused by an abnormality in the genetic material and it affects all races and all economic groups equally.

WHAT IS THE CAUSE OF DOWN SYNDROME?
Down Syndrome is caused by an excess of genetic material. The genetic material is present in every human body cell and is arranged in tiny structures called chromosomes. They are arranged in pairs and human have 46 chromosomes or 23 pairs of chromosomes.

People with Down Syndrome have an extra chromosome 21. Down Syndrome is therefore also called trisomy 21. Trisomy 21 refers to the presence of three copies of chromosomes.

THE TYPICAL FEATURES OF DOWN SYNDROME
Babies with Down Syndrome look different and they can therefore usually be identified at birth.

The most common features:

FACE
• eyes that slant upwards (up slanting palpebral fissures)
• folds on the inside of the eyes (epicanthal folds)
• small nose with a broad, flat nose bridge.
• small mouths, making the tongue appear large.
• Small low set ears

HANDS
• Single line on the palm of the hand
• Broad hands with short fingers
• Inclining pinkie (clinodactyly)
• Gap between the big toe and second toe (sandle gap)

OTHER
• Low muscle tone (hypotonia)
• Unusual looseness of joint
• Loose skin folds at the neck
• Heart defects occur in about 50% of cases.
• Eye defects occur in about 60% of cases
OKUNYE

- Ukungasebenzi kahle kwemisipha.
- Ukuxega okungajwayelekile kwalapho kuhlangana khona amalunga
- Izinyama ezilengayo emqaleni
- Ukungasebenzi kahle kwenhliziyo kulinganiselwa kuma- 50%.
- Ukungaboni kahle kwenzeka ezimweni ezingama- 60%.
- Inkinga yokungezwa nayo ibakhona kanti futhi ingaphamisa ukukhulu ama kanye nolimi olusetshenziswayo.
- Ukungasebenzi kahle kwendlala yegilo kanye nomdlavu womnkantsha, yizifo ezejwayelekile kubantu abanalokhu kukhubazeka.

INGQONDO

- Ukungakhuli ngezinga elilindelekile (ukungasebenzi kahle kwengqondo kushiyana ngamazinga, okunye ukuthi kakhulu okungasebenzi kakhulu)
- Izici eziningi ezikumuntu akuzona eziveza izingo lokungakhuli kumbe amandla omuntu.

NGAKUBE LIKHONA NA IKHAMB? I


Sezikhona izinhlelo zokungenelela ngokwesicelo futhi izikhetha umntwana kanye nokwenza okuningi. Izinkhithetha umntwana kunjalo nemidlalo ekhuthaza umntwana.

QAPHELA:


Abantu abane-Down syndrome bangaphila impilo ephelele futhi baphila kahle uma bengaphansi kwesimo lapho bethola khona uthando kanye nokunakekelawela. Ukuyisa umuntu onalokhu

INTELLECT

- Developmental delay (intellectual disability varies from mild or moderate to severe)
- The numbers of common features present in an individual however is not an indication of the level of developmental delay or the potential of the person.

IS THERE A CURE?

There is currently no cure for Down syndrome. However, there is much that can be done to help a baby with the condition. Early referral for the detection of complications (heart, hearing and eye defects) is encouraged.

Early intervention and stimulation programmes have been developed to encourage the child to reach his/her full potential.

Occupational therapy intervention plays a vital role in facilitating the stimulation program and developmental play.

NOTE:

It is very important to realize that children with Down syndrome are born with many abilities and qualities. It is up to the parents and caregiver to see that these are developed to fullest. It is also important that the health practitioners advise the parents or caregivers on stimulation required or refer to Occupational therapist as early as possible.

People with Down syndrome can live a full life and will prosper in a loving, caring environment. Placing a person with Down syndrome in an institution is therefore not the only option.

WHERE TO GET MORE INFORMATION

For further advice and support you can contact
DEPARTMENT OF HEALTH
HUMAN GENETICS
Private bagX828
Pretoria
0001
Ungaluthola Kuphi Ulwazi Oluthe Thuthu?

Uma ufuna ezinye iziyalo nokwesekwa ungaxhumana no:

Umnyango Wezempilo

Uphiko oluqondene Nokufuzisana Kwabantu

Private bagX828

Pretoria

0001

Ucingo: (012) 312 0000

Ifeksi: (012) 326-2740

Down Syndrome South Africa

PO Box 12962

Harfield

0028

Ucingo: (012) 664 8871

Ifeksi: (012) 664 8349

DSA KZN

Nks. B A Higgins

Ucingo: (031) 28-7338

Ifeksi: (031) 52-7468

Ihlanganiswe nguMnu. D M Mpanza

EsiBhedlela iBethesda, uPhiko Lwezokwelashwa

Kwabanokuhubazeka

Kukhubazeka esikhungweni sabo akusisona isisombululo sokucincina

Ukuvoca voca umzimba kanye nokuthathwa kwesiguli esinesifo sokuqaqamba kwamathambo (I-Arthritis)

Isifo sokuqaqamba kwamathambo: ukuqaqamba kwamalunga".

Zimbili izinhlobo zesifo sokuqaqamba kwamathambo: Isifo Samalungu Amathambo (Rheumatoid Arthritis) kanye neSifo Sokukhumuzeka Kwamathambo (Osteoarthritis).

Isifo Samalungu Amathambo: yisona sifo esejwayelekile sokuqaqamba kwamalunga. Uketshhezi olubizwa ne-Synovial luyanda bese kuthi isikhumba esilulweli isivuvuka sidaile izinhlungu, ukushisa kanye nomanakalo welungu lomzimba.

Isifo Sokukhumuzeka Kwamathambo: kwalapho quanta oluselungwini lomzimba luvodloka, lube maholo futhi luvendlezeka

Exercises and management of the arthritic patient

Arthritis: "inflammation of the joints".

Two specific types of arthritis are: Rheumatoid Arthritis and Osteoarthritis

Rheumatoid Arthritis is a common inflammatory disease of the joints. Synovial fluid increases, and membranes become swollen causing pain, heat and destruction to the joint.

Osteoarthritis is when the cartilage in a joint becomes pitted, rough and brittle causing the bone underneath to thicken and broaden. Joints can become deformed and painful when moved.

Arthritis effects daily life:

It can cause discomfort, pain, weakness, stiffness, fatigue, frustration and can result in varying degrees of physical impairment. These symptoms may vary in intensity from day to day.

The pain experience for each individual is unique; subjective. Some may complain of stabbing pain; whereas others of an ache; and others will experience referred pain (i.e.: in an area other than the affected joint).

Weakness and fatigue can range from a minor inconvenience to a major loss of function. Arthritis thus may have a psychological impact as activities of daily life, work and hobbies can be limited, which may be difficult to accept.

The extent of its affect depends on the type of arthritis, the stage of the disease and the management. Although there is no cure for
ldrile ukuba ithambo eiqiniso futhi futhi libe banzi. Amalungu omzimba angabe esekhubazeka futhi abe buhlungu uma enyakaziswa.

**Isifo Sokuqaqamba Kwamathambo sithikameza impilo yansuku zonke:**

Singadala ukungaphatheki kahle, izinhlungu, ubuthakathaka, ukugongoba, ukukhathala, ukudikibala kanti lokhu kungaholela ekutheni kucincise sekunokukhubazeka komzimba ngokwamazinga ahiukene. Lezi zinkomba zingehluka ngokwamazilinga usuku nosuku.

Izinhlungu eziiziwi ngumuntu ngamanye zehlukile; ziziwi ngumuntu lowo. Abanye bangakhala ngezinhlungu eziyiminjunji; kanti abanye ngobuhlungu; kanjalo abanye bangaziza benezinhlungu kwenywe nje indawo (okungaba sendaweni okungelela iluntu elithintekile).

Ubuthakathaka kanye nokukhathala kungaqala ngokuthi kube yinto engatheni kuye ngokuya kube kube umuntu uggcina engasakwazi sampela ukusebenza. Ngakho-khe, iSifo Sokuqaqamba Kwamathambo singaba nomthelela ekusamukela, lezi zinkomba zingehluka, okuyisimo esingaba nzima ukusamukela.

Izinga lokuthikamezeka okudalwa yilesi sifo inya ngohlobo lwevesi sokuqaqamba kwamathambo olukuphethe, isigaba osukuso, kazi kanye nokudalwa ukuvuvuka; ukunqanda ukuphelela ngamandla kanti nokusiza igcine izikhweto, izikhale nokubiza, izikhakhe ezintsha zokuqala, ikakhulu athikameza ulwelwesi lwangaphakathi esizwini (?) (Isibonelo: i-Methotrexate).

**Physiotherapy Role**

Physiotherapy and Occupational Therapy, in addition to this, medication such as **DMARD's** (Disease Modifying Anti-Rheumatic Drugs) and **NSAID's** (Non-steroidal Anti-inflammatory Drugs) can help to limit the joint destruction caused by inflammation.

**Drugs:**

In addition to this, medication such as **DMARD's** (Disease Modifying Anti-Rheumatic Drugs) and **NSAID's** (Non-steroidal Anti-inflammatory Drugs) can help to limit the joint destruction caused by inflammation.

**Physiotherapy Role**

The management of pain is vital and is our first role in order to decrease patient discomfort. This often coincides with the treatment for swelling:

<table>
<thead>
<tr>
<th>Heat or Ice:</th>
<th>15-20 minutes over painful/swollen area (+elevation for swelling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electro therapy:</td>
<td>US, Infra-red, laser, PSWD for inflammation and injured joints, muscles and tendons</td>
</tr>
<tr>
<td>Hydrotherapy:</td>
<td>Warm water eases the pain and allows movements while taking weight off painful joints</td>
</tr>
<tr>
<td>Relaxation:</td>
<td>learning how to pace daily life is VITAL, creating balance between exercise and rest</td>
</tr>
<tr>
<td>TENS:</td>
<td>Pain control-electrical currents are transmitted into the skin which stops the nerves transmitting pain messages to the brain</td>
</tr>
<tr>
<td>Mobilization:</td>
<td>to increase ROM and prevent stiffness (only used if no inflammation)</td>
</tr>
<tr>
<td>Dry Needling:</td>
<td>Pain relief</td>
</tr>
</tbody>
</table>

*Drugs:*

- New Cox2 inhibitors have least side-effects
- Others include aspirin (not used in gout), naproxen, indomethacin, ibuprofen, diclofenac.

In later, chronic stages, joint replacement is also considered, but this is generally in large, weight-bearing joints such as the hips and knees.

**Physiotherapy Role**

The management of pain is vital and is our first role in order to decrease patient discomfort. This often coincides with the treatment for swelling:

<table>
<thead>
<tr>
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<td>learning how to pace daily life is VITAL, creating balance between exercise and rest</td>
</tr>
<tr>
<td>TENS:</td>
<td>Pain control-electrical currents are transmitted into the skin which stops the nerves transmitting pain messages to the brain</td>
</tr>
<tr>
<td>Mobilization:</td>
<td>to increase ROM and prevent stiffness (only used if no inflammation)</td>
</tr>
<tr>
<td>Dry Needling:</td>
<td>Pain relief</td>
</tr>
</tbody>
</table>
Eminye imithi yokwelapha kubalwa kuyo I-aspirin (engesetshenzelwa i-gout), i-naproxen, i-indomethacin, i-ibuprofen, i-diclofenac.

Uma lesi sifo sesize safinyelela esigabeni lapho umuntu esegula njalonjalo, kungabekelelewa ukuba afakelwe elinye ilungu lomzimba (joint replacement), kepha lokhu kuvamise ukuba kwenzwe kumalungu omzimba amakhulu, athwala isisindo, njengenqulu kanye namadolo.

**Umsebenzi we - Physiotherapy**

Kusengqoka ukulawulwa kwezinhlungu futhi kungumsebenzi wethu wokugqala ukuze kudambe ukungaphatheki kahle esigulini. Lokhu kuvamisa ukuhambisana nokokwelashwa kokuvuvuka:

**Ukushisana noma Iqhaywa:** Amaminithi ayi-15-20 endaweni ebuhlungu/evuvukele (+ukuphakama kokuvuvuka)

**I-Electrotherapy:**


**I-Hydrotherapy:** Amanzi afudumele adambisa izinhlungu futhe enza ukwazi ukuyakaza ngesikhathi kunciphisa isisindo esikumalungu omzimba abuahlungu

**Ukuziphumuzwa:** KUBALULEKILE ukufunda ukulinganisa impilo yansuku zonke, uholele isikhathi sokuzivocavoca kanye nesokuphumula

**I-TENS:** Kuthunyelwa umfutho wokuhamba kukagadi okwenza ngendlela eyi kwehlisa inzi izinhloso ezinhloso efuthe enza ukwazi ukuyakaza kungabhekelelwa ukuba afakelwe elinye ilungu lomzimba (joint replacement), kepha lokhu kuvamise ukuba kwenzwe kumalungu omzimba amakhulu, athwala isisindo, njengenqulu kanye namadolo.

**Walking aids:** to relieve weight-bearing on joints and improve quality of life

**Posture:** corrected on relieve stress on joints and muscles

**Exercise programme:**

Exercises are given for different purposes: to maintain general fitness and cardiovascular endurance, to keep lungs strong, to strengthen individual muscles or to mobilize individual joints. As mentioned above, exercise in a hydrotherapy pool has the additional analgesic effects of heat and decreased weight-bearing, but if this is not possible a general strengthening programme with some cardiovascular or aerobic exercise can be used.

**Some general rules:**

- Begin with 15 minutes flexibility exercises prior to aerobic activity
- Start off with no more than 5 reps.
- Gradually work up to no more than 10 reps. Of 8 to 10 exercises
- Work slowly: muscle soreness and stiffness usually presents 24hrs-48hrs after exercise
- Repeat exercises on your left and right
- Breathe naturally. Do not hold your breath (count to ensure that you do not).
- Exercise 2-3 times a week for strengthening exercises. On rest days do resistance exercises.

**Flexibility exercises:**

**Neck:**

- side flex, forward flex, rot.

**Shoulder:**

- elev/depr, rot., circ., alternate flex/ext

**Elbow:**

- flex/ext

**Wrist:**

- flex/ext, circ.

**Finger:**

- flex/ext

**Back:**

- rot, side flex

**Ankle:**

- PF/DF, circ.

**Stretching:**

- LevatorScap
- SCM and scalenes
- Traps
- Rhomboids

<table>
<thead>
<tr>
<th>Stretching:</th>
<th>LevatorScap</th>
<th>SCM and scalenes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Traps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rhomboids</td>
</tr>
</tbody>
</table>
kungsatsheziswa uhlelo olujwayelekile lokuziqinisa
olubandakanya ukuvocavoca imithambo ephathelene nokushaya kwenhliziyo (cardiovascular) noma ama- aerobic.

Eminye imithetho ejwayelekile:
- Qala ngezinhlelo zokuzivocavoca zokwelula umzimba amaminiithi ayi– 15 ngaphambi kokuqala ukwenza ama- aerobic
- Qalisa ngokuphindaphinda uhlobo oluthile lokuzivocavoca kungeqi kokuhlanu (5 reps)
- Kancane zivocavoce ngokuphindaphinda uhlobo oluthile lokuzivocavoca kungeqi kokuyishumi (10 reps) Okungaba ukuzivocavoca ka-8 kuya kokuyishumi
- Zivocavoce ungasheshi: ubuhlungu nokubopheka kwamamasela kuvamise ukuba khona emahoreni angama- 24 kuya kwangama-48 emva kokuzivocavoca
- Phinda ukuzivocavoca kwasokudla nakwesokunxele
- Phefumula ngokujwayelekile. Ungakubambi ukuphefumula (bala ukuze uqinisekise ukuthi awukwenzi lokho).
- Zivocavoce kablyi kuya kokuthathu (2-3) evikini ngokwenza izinhlelo zokuzivocavoca zokuziwinisa. Ngezinsuku zokuphumula ungazivocavoca ngezinhlelo zokuzivocavoca zamandla.

Izihlelo zokuzivocavoca zokwelula umzimba:

**Intamo:** i-side flex, i-forward flex, i-rot.

**Ihlombe:** i-elev/depr, o-rot., i-circ., i-alternate flex/ext

**Indololwane:** i-flex/ext

**Isihlakala:** i-flex/ext, circ.

**Umunwe:** i-flex/ext

**Uqolo:** i-rot, side flex

**Iqakala:** I - PF/DF, i-circ.

**Ukuzela:**
- L-Levator Scap
- L-SCM kanye ne-scalenes
- Ama- Traps
- Ama - Rhomboids
- I-Cat stretch
- Umsipha wetsweba

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat stretch</td>
<td>Hamstring</td>
</tr>
<tr>
<td>Glut stretch and Piriforms</td>
<td>Calf</td>
</tr>
</tbody>
</table>

**Strengthening:**

**Upper limbs:**
Use weights to strengthen upper limbs:
- Bicep Curl
- Tricep Press
- Upright Row
- Lateral Lift
- Horizontal Pull
- Grip Strength

**Back: in prone with arms at sides**
- VIP back-up: Lift head shoulders and arms. Keep looking down and chin tucked in. Hold for 10secs and relax.
- Leg Up: Lift one leg at a time. Bend the knee slightly if you wish. Keep ankle and foot relaxed to avoid cramping.

**Abdomen: in crook lying**
- VIP curl up: Do pelvic tilt to get pelvis in neutral. Slowly curl up and raise head and shoulders. Hold for 10secs and curl back down SLOWLY.
- Roll-out: Bring one knee to chest. Do pelvic tilt holding lower back firmly on the floor. Slowly move leg away from chest as you straighten knee, BREATHING OUT. Move leg only until you feel your lower back begin to arch.
- Tuck leg back into chest and reset pelvic tilt.
- Repeat.

As you get stronger, your leg will be able to straighten further.

**Lower Limbs:**
Use ankle weights if strong enough:
- Back Kick: Hold onto counter for support and keep pelvis straight and steady.
- Move leg back and up.

**Ups and downs:** Stand in front of chair with arms at sides, legs slightly apart and keep knees turned
I- Glut stretch kanye ne-Piriformis
Izihluzi

Ukuziqinisa:

Izitho zomzimba zangenhlia:
Sebenzisa izinsimbi ukuqinisa izitho zomzimba zangenhlia:

Ukugobisa Izinkonyane
Ukucindezelwa Umsipha Ombaxanthathu
Ukugwedlela Phezulu
Ukuphakamiselwa Izandla Emaceleni
Ukudonsa Uqonde Thwi
Ukuxhakathisa Ngamandla

Umhlane: ulele phansi uvuze izingalo emaceleni

I-VIP back-up: Phakamisa amahlombe nezingalo. Bhekela phansi bese uthonisa phansi isilevu. Ima kanjalo imizuzwana eyi-10 bese uyahumula.


Isisu: ulele ugoqene

I-VIP curl up: Tshekisa isinye ukuze isinye sibe phakathi nendawo. Gqana kancane bese uphakamisa ikhanda namahlombe. Ima kanjalo imizuzwana eyi-10 bese uphinda ugoqana KANCANE.


UPHEFUMULA. Nyakazisa unyawo kuphela umhlane wakho seliqlana ukugoba.

Fingqa umlenze uye esifubeni bese uphinde uthsekise isinye.
Phinda.

Uma uqala ukuba namandla, umlenze wakho uzobe sewukwazi ukuleka kakhulu.

Izitho zomzimba zangezansi:

Sebenzisa izinsimbi uma unamandla ngokwanele:

I-Back-kick: Babambela phezu kwekhabethe ukuze uzeseka bese uqondisa isinye futhi unghathi.

Nyakazisa umlenze uye emuva nephazulu.

Ama-Ups and Downs: Ima phambi kwesitulo izingalo zibe semaceleni, g xmaxalazisa kancane

out. Slowly bend knees as if you are going to sit. Lower yourself only halfway and return to standing. Knee strengthening: straighten knee in sitting position

To increase resistance, pick up other leg and repeat

Sidekicks: inside lying/standing with support

Toe raises using support

Cardiovascular:
20-minute walk of moderate intensity, 3 times weekly

Occupational Therapy Role

OT will analyze all patients’ daily tasks in great detail. Activities of daily living are broken down into the components and demands of the activity and environment is analysed. In order to manage the arthritic patient, the OT needs to simplify and relieve pressure on joints, maintain optimal posture and conserve energy during activities. This is done through changes in the patient’s environment or method of performing activity and specific assistive devices necessary.

The best way to understand this method of management is through example.

Here is an example of activity analysis.

Sindiswe is a 45-year-old woman who is a mother to 2 children. She lives with her husband, children and mother. She has been struggling with pain in her joints, and tiredness while trying to prepare meals at home. A common food which she makes daily is Phutu.

1. First look at the environment.

Inside/Outside
Height of Cooker
Where are items kept e.g.? Maize water, salt, pot or utensils
She is cooking inside her home, on a waist height two plate cooker. The bag of maize is under the table by her cooker. She has a tap outside her kitchen where she fetches water in a jug. Her pots and utensils are in a cupboard across the kitchen from the cooker.

2. Next look at the components needed to perform the activity. Look from beginning to end.

Postures/positions of body and hands throughout the activity

E.g. While picking up 5kg bag of maize, getting pot, holding spoon while stirring.
imilenze bese ubhekisa ngaphandle amadolo. Gobisa kancane amadolo kube sengathi uhlahla phansi. Ehla kancane ube phakathi nendawo bese uphinde uyama futhi.

Ukuqinisa amadolo: qondisa amadolo uhezi phansi
Ukuze wenyuse ukuba namandla, thatha olunye unyawo bese uyaphinda

Ama-Side kicks: ulele ngecalu/umile ubambelele
Uphakamisa izinzwane uzisekelile

Ukuvocavoca okuqinisa imithambo ephathelene nokushaya kwenhliziyo:
Hambare amaminithi ayi- 20 ngomfutho olingene, kathathu ngosonto

Umsebenzi we - Occupational Therapy (i-OT)


Nasi isibonelo socwaningo lomsebenzi.

1. Qala ubheke isimo sendawo.
Ngaphakathi/ Ngaphandle
Ukuphakama kwenhloso yokulawula isibonelo.

2. Where in the activity are there problems? I.e. where is there strain being put on joints or extra energy being used. What can be done to conserve energy and protect joints?
Let’s look at the 5kg bag of maize.
Place it on a counter at waist height to prevent excess bending
Teach correct lifting technique- bending at the knees
Use a cup inside the bag to avoid having to lift the bag to get maize.

Turning Tap for water
Tap turner to change position of hand- decrease lunar deviation
Connect pipe to tap to avoid bending with jug to fetch water, putting strain on back

Fetching pot and utensils
Conserve energy by keeping pots and utensils close to cooker or cooking area
Keep frequently used items close to waist height- decrease bending incorrectly.

Spoon
Build up handle to decrease strain on joints in hand and fingers.

Careful individual look at each individual’s lifestyle and activities is necessary in order to protect the joints of the arthritic patient. Occupational Therapists must work closely with the patients, and often home visits assist with a better application of suggestions and fuller assessment and understanding of the individual’s circumstances.

Bilharzia: What is Bilharzia?
Bilharzia is a disease caused by parasitic worms that are found in some rivers and dams in South Africa
How does one get Bilharzia?

Isibonelo, ngesikhathi equkula isaka lempuphu elingama - 5kg, ethatha ibhodwe, ebamba iphini ngesikhathi egovuza.


Ake sibheke isaka lempuphu elingama - 5kg.

Lebeke phezu kwetafula lilingane nokhalo ukuze ugweme ukugoba ngokweqile

Funda indlela okuyiyo yokuphakamisa impahlia – ngokuguqa ngamadolo

Sebenzisa inkomishi ukukhuna ngaphakathi esakheni ukugwemwa ukuba uze uphakamise isaka uma ufuna ukuthatha impuphu.

Ukuvula umpompili wamanzi

Isibambo sokuvula umpompilo ngendlela: Shintsha indlela yokubamba – kwemuhla ukuchezuka kwethambo elingaphakathi kugalo

Xhuma iWAYi umpompili ukuze ugweme ukugoba nojeke uma ukha amanzi, kuthwalisa iqolo ubunzima

Ukuthatha ibhodwe kanye nezitsha

Yonga amandla ngokuba ubeke amabhodwe kanye nezitsha eduze kwesitofo nomphelo nemende umzimba

Beka izinto ozisebenzisa njalo endaweni eseduzane, ubude bayo buthi abilingane nasokhalweni – lokhu kuzoncipha ukuphela

Uphini

Lakhle libe nesimambo esithi xasa ukuze kuze kuzoncipha ukugqilazeka kwamalunga esandla kaye naweminiwe. Ukuqaphelisisa indlela yokuphila nemisebenzi yomuntu ngamunye kuyadingeka ukuze kube nokuvikeleka kwamalunga amathambo esiguli esinesifile sokuqaqamba kwamathambo. Kufanele ama -Occupational Therapist asebenzisa nezigtiti, futhi ukuvama ukuthumela isiguli ekhaya kuyaiswa ekuqinisekiseni ukuthi imiyalelo okuthiwa ayisetshenziswa iyhalwe kanjalo nasekhuoleni ngokuphulelelelo kanye nokuqonda isimo somuntu.

Through inadequate hygiene and contact with infected water by:

- Swimming
- Bathing
- Washing clothes
- Water sport
- Fishing

How does one know that you have Bilharzia?

- Blood in urine
- Tiredness
- Abdominal pain
- Bloody diarrhoea
- Painful urination

How to prevent and control Bilharzia?

- Large – scale treatment of at-risk populations with Praziquantel
- Access to safe water
- Improved sanitation
- Hygiene education
- Snail control

How to stop Bilharzia?

- Use a toilet
- Teach others about Bilharzia
- Go to the nearest clinic for treatment

BURNS

A BURN is an injury to the skin that is caused by heat or chemicals, which damages the tissue.

What to do when someone gets burnt

- remove the thing that is burning the person
- hold the burnt body part into cold water for 30 minutes, or use a cold, wet cloth
- if the burn is very bad, take the person to a doctor/hospital for treatment
- bees’ honey is very good to help healing burns – wash the burn wound with water that has been boiled and cooled and then put on fresh honey 2-3 times a day
Isichenene

Yini isichenene?
Isichenene yisifo esidalwa yizibungwana ezitholakala emifuleni nasemadanyini athile eNingizimu Afrika.

Umuntu usithola kanjani isichenene?
Ngokusebenzisa amanzi angahlazekile ngokwanele futhe analezi zibungwana, lapho:
- ebhukuda
- egeza
- ewasha izingubo
- edlala imidlalo yasemanzini
- edoba

Ubona kanjani ukuthi unesichenene?
- Umchamo onegazi
- Ukukhathala
- Ubuhlungu besisu
- Ukukhishwa isisu okunegazi
- Ubuhlungu uma uchama

Singavikelwa futhi silawulwe kanjani isichenene?
- Ukwelapha imiphakathi esengcubeni yokuthola lesi sifo nge- Praziquantel
- Ukusebenzisa amanzi ahlanzekile
- Ukuba nezindlu zangase ezizesimweni esihle
- Ukufundisa ngenhlanzeko
- Ukunqanda ukuba khona kweminenke

Ungasinqanda kanjani isichenene?
- Sebenzisa indlu yangasese
- Fundisa abanye abantu ngalesi sifo sesichenene
- Hamba uye emtholampilo oseduzane ukuze uthole ukwelashwa

IZILONDA ZOKUSHAZILINDANA ZOKUSHA

Isilonda sokusha ukulimala kwezikhumba okudalwa ukushisa kumbe akakhemikhali, alimaza izicubu zomzimba.

- it is important to keep the joints straight while the burn is healing
- protect the burn wound from flies by putting a clean gauze over it or lying under a mosquito net/blanket

Prevention of burns is very important!!
- Do not leave a fire or candle burning without anyone watching
- Never leave a little child alone with fire/dangerous chemicals
- Make sure children cannot reach any matches or cleaning chemicals
- Make sure that pot handles are turned away from the front of the stove, so a child cannot pull pots off the stove, and the kettle cord is not hanging off the cupboard, so a child cannot pull the kettle from the cupboard
- Put things in front of electricity sockets so that a small child cannot stick his/her fingers into it

Treatment of Burns
- Pain prevention before therapy by ensuring the patients has taken their pain medication
- Prevention of contractures by making use of activities to maintain ROM, by using pressure garments to decrease scarring, by making use of splint.

Compiled by: Community Service Therapists, Bethesda Hospital

References: “Disabled Village Children” by D. Werner, 1988
Yini okumele yenziwe uma umuntu esha:

- susa leyo nto eshisa lowo muntu
- leso sitho somzimba esishile sifake emanzini abandayo
  imizuzu engama-30 nomu usebenzise indwangu
  abandayo kumbe emanzi
- uma kunguthi ushe kakhulu, yisa lowo muntu
  kwadokotela kumbe esibhedlela ukuze ayokwelashwa
- uju lwenzinyosi lusiza kakulu ekwelapheni izilonda
  zokusha- geza isilonda sokusha ngamanzi akade ebilile
  abe esepholiswa bese usigcoba ngoku olungakadulelwa
  yisikhathi, izikhawu ama-2 kuya kwama-3 ngosuku
- kusemqoka ukugcina amalunga omzimba ehlale eqondile
  ngesikhathi Upholisa isilonda sokusha
- vikela isilonda sokusha ezimpukaneni ngokufaka
  ibhandisi elihlanzekile noma ulale ngaphansi kwenethi
  evimbela omiyane kumbe wembathe ingubo yokulala

Kusemqoka kakulu kukuvikeleka ekusheni!!!

- Ungalokothi ushiye umlilo nomu ikhandlela livutha
  kungakho oligadile
- Ungalokothi ushiye ingane encane iyodwa kunomlilo
  kumbe kunamakhemikhali ayingozi
- Qinisekisa ukuthi izingane azifinye lele eduze komentshisi
  nomu amakhemikhali okuhlanza
- Qinisekisa ukuthi izibambo zamabhodwe azibekiwe
  zabheka engxenyeni engaphambili yesitofu ukuze ingane
  ingeke ikwazi ukudonsa amabhodwe esitofini, futhi
  nentambo yeketela ingalengeli phansi ekhabetheni ukuze
  ingane ingeke ilidonse iketela ekhabetheni
- Beka okuthile phambi kwamapulaki kagesi ukuze ingane
  encane ingeke ikwazi ukufaka iminwe yayo kuso
Ukwelashwa kwezilonda zokusha

- Qanda ubuhlungu ngaphambi kokuthola ukwelashwa ngokuba uqinisekise ukuthi iziguli ziphuzza imithi eqeda izinhlungu

- Vimbeli ukufinyela kwemisipha ngokuba usebenzise izinsiza ezizolekelela ukuba kungabi nokudabuka kwesikhumba (i-ROM), sebenzisa amabhandishi okubopha unciphise ukuba khona kwezibazi.

Ihlanganiswe ngama-Community Service Therapists, asesibhedlela iBethesda, ngonyaka wezi-2013

Icashunwe: “kwi-Disabled Village Children” ebhalwe ngu-D. Werner, yangonyaka yowe-1988
### Ebola Virus Disease (EVD)

**I-Ebola yisifiso esiyingozini futhi ngakovumile esibalalayo**

Izimpawu kanye nezinkomba ze-Ebola

I-Ebola idala imifa ekubamba ngamandla, ukukhathala ngokweqile, ubuhlungu bekhandla, ukuqaqamba kwamalunga omzimba kanye nokungakuthandla ukudla. Lokhu kuyaye kulandelwe ukubuyisa, ukukhishwa yisisu (uhudo), ukuphuka, ukwehluleka ukusebenza kweziniso nesibindi kanye nokophila ngaphakathi nangaphandle emzimbeni.

**Isabalala kanjani i-Ebola?**


Isidumbu somuntu obulawe yilesi sifo se-Ebola uyaqhubeka nokusakaza lesi sifo futhi akumele sithintwane.

**Umakhe umuntu ephethwe yile Eb- yabe**

**seylelapheka ayibe isaphinde imphathe**

**Khumbula:** I- Ebola ayilona igciwane elibhebhethekiiswa ngumoya. Angeke wayithola i-Ebola ngokubha ukhulumaba nabantu, uhamba emgwqweni noma uthengha enxanatheleni yezitolo noma emakele nje.

Ungazivikela kanjani ku-Ebola?

- Ungamthinti umuntu ogulayo okusoleka ukuthi une-Ebola
- Ungazithinti izimphala zokugqoqo, amathawula nezimpahla zokwezulondla umbhede okumoshelnwe, kumbe yinoma yiluphi uketshezi lomzimba lomuntu ogulayo okusoleka ukuthi une-Ebola
- Ngesikhathi kubheduke i-Ebola, ungalokothi uthinti yinoma ngubani uma singekho isidingo
- Uma ungumsebenzi wezempi lo noma ubandakanye ekungcwabenzi izidumbu kumele uqoqo izimpahla zokuzivikela ngesikhathi uthinti izigisi kanye nezidumbu zabashonile
- Ungalokothi uye ocansini olungaphefe;phile
- Jwayela ukuhlele ugeza izandla zakho ngensipho

**Ebola Virus Disease (EVD)**

**Ebola is a serious and often deadly disease**

**Signs and symptoms of Ebola**

Ebola causes sudden high fever, extreme tiredness, headache, body pain and loss of appetite. This is followed by vomiting, diarrhoea, a rash, damaged kidney and liver and internal and external bleeding.

**How does Ebola spread?**

Ebola enters your body through your mouth, nose and eyes, or a break in the skin. To catch Ebola, you must touch the bodily fluids of a person with Ebola and then with dirty hands touch your eyes, nose or mouth. Bodily fluids include sweat, stools, vomit, urine, semen, vaginal fluid and blood.

A person who has died from Ebola is still highly infectious and should not be touched. Once a person has recovered from Ebola they will never get it again.

**Remember: Ebola is not an airborne virus. You cannot get Ebola by talking to people, walking in the street or shopping in malls or markets.**

How can you protect yourself from Ebola?

- Do not touch a sick person with suspected Ebola
- Do not touch the soiled clothes, towels and bed linens or any bodily fluids of a sick person with suspected Ebola
- During an Ebola outbreak, do not touch any people if it is not necessary
  - If you are a health worker or are involved in burying bodies, you should wear protective clothing when you handle patients and dead bodies
  - Do not have unprotected sex
  - Wash your hands with soap and water often

**What is the treatment for Ebola?**

There is currently no approved treatment or vaccine for Ebola. People suffering from Ebola are treated for their symptoms.

If you or someone you know have been in contact with someone with Ebola and have the symptoms, contact your nearest health facility immediately.
WORLD HEPATITIS DAY 28 JULY

Think you’re not at risk of HEPATITIS?
THINK AGAIN.

Hepatitis virus types A, B, C, D and E cause infection and inflammation of the liver that can lead to severe disease and death.

HEPATITIS A & E
Spread by poor food hygiene, unsafe water and lack of sanitation

The risk is higher in rural areas of developing countries, but you catch it anywhere

WAYS TO PROTET YOURSELF
Talk to your healthcare provider about the hepatitis A vaccine

Cook food well and eat it while it’s hot. Avoid raw shellfish and raw meat

Always wash your hands with soap and water after using the toilet, changing a baby’s nappy and before preparing food and eating

Peel fruit and vegetables, wash salads in clean water

Only drink safe water

An estimated 20 million people are infected with hepatitis E and 1.4 million with hepatitis A every year

Legionnaire’s Disease

What is Legionnaires’ disease?
Legionnaires’ disease is an infectious disease caused by Gram-negative bacilli called Legionella.

Mode of Transmission

Persons become infected by breathing in water droplets containing the Legionella bacteria through:

- Hot and cold-water systems (e.g. showers and taps)
- Cooling towers and evaporative condensers of air conditioners
- Spa baths (Jacuzzis), whirlpool baths and natural pools or thermal springs
- Ornamental fountains (particularly indoors) and sprinklers
- Humidified food display cabinets
- Respiratory therapy equipment

Susceptible groups
The following groups of people are at higher risk:

- Men (2-3 times more susceptible than women)
Abantu bathola lesi sifo ngokuba bahogele amaconsana amanzi analawa magciwane e- *Legionella*, atholakala:

- Emayipini amanzi ashisayo nabandayo (isb. emashaweni nakompopmi)
- Kumathwa okupholisa nakuziguqulimhwamuko zama- air conditioners (*Cooling towers and evaporative condensers of air conditioners*)
- Kobhavu basezindaweni zokuzibhucunga (Spa baths) (kuma-Jacuzzi), kuma-whirlpool baths nasemadamini okubhukuda ajwayelekile nje noma emadamini ashisayo okubhukuda (thermal springs)
- Emithonjaneni yokuhlobisa (ikakhulukazi esendlini) nakuzinkasa zokunisela
- Emakhabetheni anomswakama okubeka ukudla
- Kuzinsizakuphefumula

### Abantu abasemathubeni okuthola lesi sifo

Lezi zinhlobo zabantu ezilandelayo zisebungozini bokuthola lesi sifo:

- Abesilisa (basemathubeni ama-2 kuya kwama-3 kunabesifazane okuthola lesi sifo)
- Abantu abadala, ikakhulukazi esebevile eminyakeni yobudala engama-50
- Ababhemayo
- Abaphuza utshwala
- Abantu abanamasosha omzimba antekenteke, ikakhulukazi labo abaphila nezifile ezingelapheki (esingabala umdlavuza, isifo sikashukela, isifo esingelapheki samaphaphu noma sezinso) kanye nalabo abagcibisa noma abathatha imishanguzo eyenza amasosha omzimba abe ntekenteke.

### Lezi zimo ezilandelayo zingawandisa amathuba okuba sebengozini bokuthola lesi sifo:

- Ukunganakekelwa ngendlela kwendawo okwenza kube namaxhaphozi amanzi amgahambi
- Ukuhlala ezindaweni ezinamapayi asemadala amanzi
- Ukuhlala eduze nezinsizakupholisa nomwa nemithombo yamanzi
- Ukusebenzisa izinsizakushiza zikagese ezisebenza ngamanzi, ama-whirlpool, amadanyana asezindaweni zokuzibhucunga nomwa amadanyana anamanzi ashisayo asezindaweni zokuzibhucuka

### Isikhathi sokuchamuseleka kwalawa magciwane

Kuthatha izinsuku ezi-2 kuya kweziyi- 10

---

- People of increasing age, particularly over 50 years old
- Smokers
- Alcoholics
- Person with weakened immunity, especially those with chronic illnesses (such as cancer, diabetes mellitus, chronic lung or kidney diseases) and those taking corticosteroids or drugs that suppress body immunity.

**The following situations may also increase the risk of infection:**

- Poor maintenance leading to stagnant water in water system
- Living in areas with old water distribution or plumbing systems
- Living near cooling towers or fountains
- Using electric water heater, whirlpool, spas or hot water spring spas

**Incubation period**

About 2-10 days

**Clinical picture**

Symptoms are non-specific and may include a flu-like illness. Can present with:

- dry cough
- fever
- shortness of breath
- tiredness
- headache
- muscle & abdominal pain
- diarrhea
- confusion

**Management**

- It can be treated with antibiotics
- Seek medical attention if Legionella is suspected
- There are currently no vaccines to prevent Legionnaires disease.

**Prevention**

It is important to observe the following advice to reduce the risk of infection:

- Observe personal hygiene
- Smoke less and excessive drinking
IZIMPAWU ZOKUBA NALESI SIFO

IZIMPAWU KUBA UKUGULA ONGEKE WASHO UKUTHI YINENYE KALE FUTHI OKUBANDAKANYA NOMKHUDULANE NJE. ONGBA:

- nokukwhelela okomile
- nemfiva
- nephika
- nokukhathala
- nokuphathwa yikhanda
- nobuhlungu bemisipha kanye nesisu
- nokuhanjiswa yisisu
- nokudideka emqondweni

UKWELASHWA KWSAOSO

- Singelashwa ngamaphilisi kumbe imithi yokubulala amagciwane (antibiotics)
- Bonana nodokotela uma usola ukuthi una - Legionella
- Okwamanje ayikho imijovo yokuvikela lesi sifo i - Legionnaires.

UKUVIKELWA KWSAOSO

Kumqoka ukulandela le miyalelo elandelayo ukuze unciphise amathuba okuthola lesi sifo:

- Zwana nenhlanzeko
- Gwema ukubhema nokuphuza ngokweqile
- Izinga lokushisa lamanzi owasebenzisayo kumele lingabi ngaphezu kuka- 60°C kanti lawo aphuma empompiro
- Izinga lokubanda kwamanzi o owasebenzisayo kumele lingabi ngaphansi kuka- 20°C.
- Amapayipi amanzi kumele ahlale evulelwa futhi kugwenywe ukuba amanzi ahambe kancane kwephuma.
- Hlanza amapayipi amanzi, amadamu okubhukuda kanye namadanyana asezindaweni zokuzibhucunga ngokuhulu ukucophisele.
TB IS AN AIRBORNE DISEASE CAUSED BY BACTERIA THAT MOST OFTEN AFFECTS THE LUNGS BUT CAN AFFECT ANY BODY PART.

<table>
<thead>
<tr>
<th>TB CATEGORY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG SENSITIVE TB</td>
<td></td>
</tr>
<tr>
<td>MDR TB</td>
<td></td>
</tr>
<tr>
<td>Drug sensitive means the TB can be cured by first line TB medication.</td>
<td></td>
</tr>
<tr>
<td>XDR TB</td>
<td></td>
</tr>
<tr>
<td>Multi drug-resistant (MDR) is a form of TB caused by bacteria that does not respond to, at least, isoniazid and rifampicin, the two most powerful, first-line anti-TB drugs. MDR is mainly a result of patients not taking TB medication as prescribed. However, people can also contract MDR TB without having had TB before.</td>
<td></td>
</tr>
</tbody>
</table>

Extensively drug-resistant TB (XDR-TB) is a form of multi-drug resistant tuberculosis that responds to even fewer available medicines, including the most effective second-line anti-TB drugs. TB can be cured with 6 months treatment. Intensive phase medication for the first 2 months and continuation phase medication for the next 4 months. The number of tablets is dependent on the patient’s body weight.

MDR TB can be cured; however, the treatment period is for 24 - 36 months with daily injections for six months.

XDR TB is very difficult to cure and involves treatment for 24 - 36 months or longer.

SCREENING: The Department has massive TB screening campaigns implemented in all districts. All people visiting health facilities regardless of the reason for their visit must be screened for TB. In 2017 in health facilities, 76% of the 4,744,233 headcount per quarter was screened for TB. In 2017 in health facilities, 76% of the 4,744,233 headcount per quarter was screened for TB.

At community level health care workers collaborating with developmental partners and other departments within Operation Sukuma Sakhe continue to play a pivotal role in ensuring that TB screening takes place and also offer support to patients on treatment.

DIAGNOSIS

Once screening has taken place and a patient answers “yes” to any of the signs and symptoms, the patient will be asked to cough into two small plastic bottles. This gets sent to the laboratory for diagnosis.

GENEXPERT MACHINES

Our country has the largest number of the revolutionary GeneXpert machines in the world:

- 289 GeneXpert Machines Nationally
- 90 GeneXpert Machines in KZN and distributed to all districts
I-TB ENGAZWELI EMITHINI (MDR)

I-TB elapheka kalula isho i-TB elapheka usathole ukwelashwa esigabeni sokuqala.


I-MDR TB ingelapheka, nokho ukwelashwa kuthatha isikhathi esiyizinyanga ezingama-24 kuya kuma-36 lapho ujovwa khona nsuku zonke izinyanga eziyisithupha.

Kungenzeka nokho abantu bathole i-MDR TB noma bengakaze babe nayo i-TB phambili.

UKUHLOLWA: U姆nyango unemikhankaso eminingi eqhubekayo yokuhlolela i-TB kuzo zonke izifunda. Bonke abantu abahambela lezi zikhungo zezempilo kungakhathalekile ukuthi banye ngaziphi izithathu, kumele bahlolelwe i-TB. Ngonyaka wezi-2017 ezikhungweni zezempilo kwabalwa abantu abanga- 76% kwabayi-4 744 233 abahlolelwe i-TB.

Emphakathini kunonompilo abahlangana nabanye abasebenzisana nabo kwemininye iminyango ababhakele ezentuthuko ngaphansi kohlelo lwe-Operation Sukuma Sakhe bayaqhubeka nokumbamba iqhaza ekuqinisekiseni ukuthi i-TB iyahlolelwa nokuthi iziguli zithole ukwesekwa ngokwelashwa.

UKUHLONZWA KWESIFO

Uma sekwenziwe ukuhlolsa kwathi impepulo yesiguli yaba u-“yebo” kunoma yiluphi uphawu nezhinkomba, sizobeka sesicelwa leso siguli ukuba sikhehlulele emabhodyelele amabili amancane eplastiki. Lokho kubo sekuthunyelwa elabhorethi ukuze kuyoohlola kabanzi.

IMISHINI EBIZWA NGE-GENEXPERT

Izwe lethu linesibalo esiphuzulu kakulu semishini sesizengeni lomhlaba ebizwa nge-GenExpert:

- 289 GeneXpert Machines kuZwelonke
- 90 GeneXpert Machines KwaZulu-Natali futhi isatshalaliswe kubo zonke izifunda

These machines have greatly assisted in the early diagnosis of TB and MDR-TB which allow for the initiation of TB treatment within 24-48 hours.

TB SERVICES

All Hospitals, Community Health Care Centres, Clinics and mobile clinics provide a TB service.

Decentralized MDR TB sites have been established in all Districts to make it easier for patients to be initiated onto treatment and retained in care closer to their homes.

HOSPITAL

Madadeni

Provides both in and out-patient MDR-TB care

Murchison

Provides both in and out-patient MDR-TB care

Estcourt

Provides both in and out-patient MDR-TB care

Doris Goodwin

Provides both in and out-patient MDR-TB care

Greytown

Provides both in and out-patient MDR-TB care

Thulasizwe

Provides in-patient MDR-TB care for the whole district

Benedictine

Provides out-patient MDR-TB care

Ceza

Provides out-patient MDR-TB care

eDumbe

Provides out-patient MDR-TB care

Isthelejuba

Provides out-patient MDR-TB care

Nkonjeni

Provides out-patient MDR-TB care

Vryheid

Provides out-patient MDR-TB care

St Margaret
Le mishini seyibe wusizo kakhulu ekuhlonzwe
ni kwesifo se-
TB kanye ne-
MDR -TB kusenesikhathi ukuze kuqaliswe ukwelashwa
esigabeni sokuqala esikhathini esingamahora angama-24-48.

IZINSIZA ZE-TB
Zonke izibhedlela, iziKhungo Zomphakathi Zakonakekelwa
Kwezempiilo, iMitholampilo kanye nemitholampilo
engomahambanendlwana ihlinzekwa ngezinsiza ze-TB.

Kunezizinda ezisatshalaliswe kuzo zonke iziFundu okulashelwa
kuzo i-MDR TB ukuze kube lula ukuthi iziguli zithole ukwelashwa
esigabeni sokuqala kanye nokuthola ukunakekelwa ezindaweni
eziseduze namakhaya azo.

ISIBHEDLELA
EMadadeni
Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe nalezo eziske
zingalalisiwe eziphethehe yi-MDR-TB

EMurchison
Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe nalezo eziske
zingalalisiwe eziphethehe y-MDR-TB

E-Scotsbay: Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe
nalezo eziske zingalalisiwe eziphethehe y-MDR-TB

I-Doris Goodwin
Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe nalezo eziske
zingalalisiwe eziphethehe y-MDR-TB

I-Greytown
Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe nalezo eziske
zingalalisiwe eziphethehe y-MDR-TB

I-Thulasizwe
Sihlinzeka ngokunakekelwa kweziguli ezialalisiwe eziphethehe y-MDR-
TB esifundeni sonkana

I-Benedicite
Sihlinzeka ngokunakekelwa kweziguli eziske zingalalisiwe
eziphethehe y-MDR-TB

KwaCosa
Sihlinzeka ngokunakekelwa kweziguli eziske zingalalisiwe
eziphethehe y-MDR-TB

EDumbe
Sihlinzeka ngokunakekelwa kweziguli eziske zingalalisiwe
eziphethehe y-MDR-TB

ITshelejuba
Sihlinzeka ngokunakekelwa kweziguli eziske zingalalisiwe
eziphethehe y-MDR-TB

Provides both in and out-patient MDR-TB care
Montebello
Provides out-patient MDR-TB care. In-patient care will commence in
September 2018.

Hlabisa
Provides both in and out-patient MDR-TB care
Manguzi
Provides both in and out-patient MDR-TB care
Charles James
Provides both in and out-patient MDR-TB care
Don McKenzie
Provides both in and out-patient MDR-TB care
King Dinuzulu
Provides both in and out-patient for complicated MDR-TB and XDR-
TB. All children under 15 years of age are admitted to KDH for care.
There is a school on site to prevent the child missing out on
schooling.

Phoenix CHC
Provides out-patient MDR-TB care
Inanda C CHC
Provides out-patient MDR-TB care
Kwamashu CHC
Provides out-patient MDR-TB care
Tonga CHC
Provides out-patient MDR-TB care
Catherine Booth
Provides both in and out-patient MDR-TB care
EMbongolwane
Provides out-patient MDR-TB care
Eshowe
Provides out-patient MDR-TB care
DISTRICT
Amajuba
UGu
UThukela
ENkonjeni
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-Vryheid
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-St Margaret
Sihlinzeka ngokunakekelwa kweziguli ezilalisiwe nalezo ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-Montebello
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe eziphethwe yile-MDR-TB


KwaHlabisa
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe eziphethwe yile-MDR-TB

EManguzi
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe nalezo ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-Charles James
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe nalezo ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-Don McKenzie
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe nalezo ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-King Dinuzulu
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe nalezo ezisuke zingalaliwe eziphethwe yile-MDR-TB

I-Phoenix CHC
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalaliwe eziphethwe yile-MDR-TB

UMgungundlovu
UMzinyathi
Zululand
Harry Gwala
ILembe
UMkhanyakude
Ethekwini
King Cetshwayo

DOING MORE TOGETHER:

To strenghthen the fight against the scourge of TB, the KZN Department of Health has embarked on strategic public private partnerships and targeted community outreach interventions:

• Community outreach through Operation Sukuma Sakhe, which is led by the KZN Office of the Premier.

Established a partnership with hardware store Build It, which is helping us to drive a vigorous awareness campaign about Tuberculosis through distributing information and communications material at their stores throughout the province.

Targeting high transmission areas like schools, correctional facilities; churches; taxi ranks and informal settlements.

Have nurses training through the John Hopkins University to initiate MDR-TB treatment throughout the Province. To date the province has 40 trained nurses to initiate patients on TB Treatment.

Set up TB tracing teams and TB/HIV outreach teams who visit households to provide Directly Observed Treatment support.

To date there are 98 TB tracing teams.

TB Ambassador, HRH Prince Nhlanganiso Zulu, a TB survivor creates awareness about the importance of TB prevention and treatment compliance throughout the province.

TB infection can be prevented in the following ways:

• Cover your mouth and nose with tissue paper or your hands when coughing or sneezing. Do not cough / sneeze / spit on other people. Do not let other people cough, sneeze or spit on you.

Wash hands with soap and water after coughing or sneezing, before and after eating, after going to the toilet, before and after changing baby’s nappies.

Keep your windows open in your home and public transport - fresh air blows the TB germs away and sunshine kills the TB germs.

Immunize all babies at birth with BCG vaccine.

Keep your body healthy by: eating balanced meals, consisting of food like meat, fish, eggs, beans, mills, amasi, brown bread, maize meal, vegetables, and fruits.
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalalisiwe eziphethwe yi-MDR-TB

I-Tongaat CHC
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalalisiwe eziphethwe yi-MDR-TB

I-Catherine Booth
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalalisiwe nalezo ezisuke zingalalisiwe eziphethwe yi-MDR-TB

EMbongolwane: Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalalisiwe eziphethwe yi-MDR-TB

EShowe
Sihlinzeka ngokunakekelwa kweziguli ezisuke zingalalisiwe eziphethwe yi-MDR-TB

ISIFUNDA
Amajuba
UGu
UThukela
UMgungundlovu
UMzinyathi
I-Zululand
I-Harry Gwala
ILembe
UMkhanyakude
EThekwinini
I-King Cetshwayo

SENZA OKUNINGI NDAWONYE:
Ukuqinisa impi yethu yokulwa nesihlava se-TB, uMnyango Wezempilo KwaZulu-Natali sewuqhamukenesu lokusebenzisana nabasebenza ngokuzimzela kanye nemiphakathi ukuze kube
nezinhlelo zokungenelela:

• Ukufinyelela emphakathini ngaphansi kohlelo lwe-Operation Sukuma Sakhe, oluholwa yiHhovisi likaNdunankulu waKwaZulu-Natali

ukwakha ubudlelwano nemiphakathi ukuthi abantu
batheleke kuzo okungaba okukhulu abantu
batholeleke kuzo okungaba yizikole, izikhungo zokuhlunyelelisa
kwezimilo, amasonto, amarenki amatekisi kanye nasemjondolo.

Alcohol should be avoided because it lowers the body's resistance
to sickness and affects the treatment.

INxusa, HRH uMntwana uNhlanganiso Zulu, owasinda ku-TB uqwashisa ngokubaluleka kokuvimbela nokwelapha i-TB esifundazweni.

Ukungenwa yi-TB kungavimbele ka ngalezi zindlela ezilandelayo:

- Vala umlomo namakhala ngepepha elithambile (tissue paper) uma ukhwehlela noma uthirumila. Ungakwehlelele/ungathimulele/ungaphimisele abanye abantu. Ungavumeli abanye abantu bakukwehlelele, bakuthimulele noma bakuphimi sele.

- Geza izandla ngensipho nangamanzi emva kokukwehlelela noma kokuthimila, ngaphambi nangemuvu kokuthi udle, ngemuvu kokuya endlini encane, ngaphambi nangemuvu kokushintsha inabukeni.

- Gcina amafasitela ekhaya kanye nakwezokuthuthwa komphakathi evulwe – umoya ohlanzekile uyawaphetha amagcwane e-TB kanti nokukhanya kwelanga kuyawabulala amagcwane e-TB.

- Zonke izingane kumele zithole umgomo we-BCH uma zizalwa.

- Gcina umzimba wakho wakho wakho wakho wakho wakho napumelo nokuthi uzivocacocelo. Zijwayeze ukuya ocansini oluphephile. Yazi isimo sakho maqondana ne-HIV. Zijwayeze njalo ukuylolwelela umfutho wegeza, izinga likashukela egazini, izinga lamafutha egazini, i-HIV, i-TB.

- Lala ngokwanele. Gwema ukulala endlini enabantu abaningi ngokweqile.
APPENDIX E: Ethical Clearance letter

Ms Karin du Plooy
kardin@uj.ac.za
011 559 2373

From: Prof A.D. van Breda and Prof T. Guse
To: MA Sikakhane (201172251)
Cc: Prof N Mboti, Prof PP Frassinelli and Prof Nyasha Mboti
Date: 20 October 2016
Re: Research Ethics Committee and Higher Degrees Committee Proposal Approval

<table>
<thead>
<tr>
<th>Student Name</th>
<th>MA Sikakhane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Number</td>
<td>201172251</td>
</tr>
<tr>
<td>Title of Study</td>
<td>Health, Culture &amp; Languages: Translation &amp; Untranslatability in Selected English-to-Zulu Health Communication Messages in Rural KwaZulu-Natal</td>
</tr>
<tr>
<td>Department</td>
<td>Communication Studies</td>
</tr>
<tr>
<td>Degree</td>
<td>DLIR at Phil</td>
</tr>
<tr>
<td>Supervisor(s)</td>
<td>Prof N Mboti and Prof PP Frassinelli</td>
</tr>
<tr>
<td>Ethics Approval #</td>
<td>02-107-2016 (20 October 2016)</td>
</tr>
<tr>
<td>Approval Date</td>
<td>20 October 2016</td>
</tr>
</tbody>
</table>

The Faculty of Humanities Research Ethics Committee has scrutinised your research proposal and confirms that it complies with the approved ethical standards of the Faculty of Humanities of the University of Johannesburg.

The Research Ethics Committee recommends that you attend to the following suggestions: No confidentiality in focus groups; explain to participants; address prospective participants; permission letter from clinics; possibly even Ministry of health will be required; simplify consent form; give contact details of supervisor, not ethics committee; complete ethics protocol form; not ‘I agree’; give a choice.

In addition, the Faculty of Humanities Higher Degrees Committee (Humanities) approves your proposal if it is a Masters dissertation and recommends your proposal to the Senate Higher Degrees Committee if it is a Doctoral thesis.

The HDC recommends that you attend to the following suggestions: * Consider the bilingual and literacy requirements of participants in the rural KZN.

Kindly provide a signed copy of your final, corrected proposal to Mrs Karin du Plooy at the Faculty of Humanities as soon as possible.

Warm regards

(PROF A.D. VAN BREDA)
CHAIR; FACULTY OF HUMANITIES HIGHER DEGREES COMMITTEE (HUMANITIES)

(PROF T. GUSE)
CHAIR; FACULTY OF HUMANITIES RESEARCH ETHICS COMMITTEE
APPENDIX F: Permission to do research from UThukela District Municipality

TO: MONGEZI ANDREW SIKHAKHANE  
86 Monte Carlo  
Valleymead Park  
1709

FROM: DR NT ZULU  
DISTRICT DIRECTOR  
UTHUKELA HEALTH

DATE: 16 SEPTEMBER 2017

PERMISSION TO CONDUCT RESEARCH AT UTHUKELA HEALTH DISTRICT

RE: Health, Culture and Language: Translation and Untranslatability in Selected English-to-Zulu Health Communication Messages in Use in Rural KwaZulu-Natal

1. Your request received on the 08 September 2017 refers.  
2. Uthukela District must adhere to all the policies, procedures, protocols, and guidelines of the Department of Health with regards to this research.  
3. Your research will only commence once this office has received confirmation of the approval by Head of Health from the provincial Health Research Committee in the KZN Department of Health.  
4. However your research is hereby supported.  
5. I trust that you will find all to be in order.

Yours faithfully,

DR NT ZULU  
DISTRICT DIRECTOR  
UTHUKELA DISTRICT
APPENDIX G: KwaZulu-Natal Department of Health approval

Date: 7 November 2017

Dear Dr N.A. Sithakane
University of Johannesburg

Approval of Research

1. The research proposal titled ‘Health, culture and language: Translation and untranslatability in selected English to Zulu health communication messages in rural KZN’ was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby approved for research to be undertaken at Ladysmith Gateway clinic, Douglas, Ekwulukini, Limhiil, Mihlumlo, Sigwete, Rockcliff, Tholusizwe, Stedville, Melinwenskop, KwaMeyi clinic and St. Jude Community Health Centre. Data will also be collected at the Communications Unit of the Provincial Department of Health.

2. You are requested to take note of the following:
   a. Make the necessary arrangements with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr. X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee

Date: 7 November 2017

Fighting Disease, Fighting Poverty, Giving Hope