TEACHING NON ZULU-SPEAKING MEDICAL STUDENTS TO COMMUNICATE WITH ZULU-SPEAKING PATIENTS IN THE OUT-PATIENTS' DEPARTMENT

THE FORMULATION AND RATIONALE OF A ZULU FOR SPECIFIC PURPOSES (ZSP) SECOND LANGUAGE SYLLABUS FOR THE MEDICAL CONSULTATION SETTING

BY JACQUELINE ANNE COCKERILL

A thesis submitted to the Faculty of Human Sciences
in fulfilment of the requirements for the Degree of Master of Arts,
in the Department of IsiZulu, University of Natal, Durban.

Supervisor: Mrs Beverley Muller

December 2002

ACKNOWLEDGEMENTS:

I would like to acknowledge, with thanks, the assistance of the following persons:

- Mrs Beverley Muller, for guidance and encouragement and for the many hours she devoted to the supervision of this thesis.

- Dr Chris Ellis, Professor Sihawukele Ngubane and Dr Thenjiwe Magwaza for their help in providing cultural information relating to Zulu perspectives on health and illness in the context of the medical consultation.

- Mr Francis Zungu for transcribing and translating twelve of the taped consultations observed during my field-work in the hospitals.

- The doctors (listed in Appendix D) who agreed to be interviewed by me or who allowed me to sit in on their consultations and observe their dealings with patients.

- The medical superintendents at McCords Hospital, Bethesda Hospital, Mseleni Hospital, Manguzi Hospital and Mosvold Hospital who facilitated my research in the hospitals.

- Red Cross and the staff responsible for their "flying doctor" service, for transporting me from Durban to the hospitals in northern Kwa-Zulu Natal.

- The syllabus designers and administrative staff at the University of Natal Medical School, particularly Professor Michelle Mclean, Mrs Jackie Van Wyk and Ms Veena Singaram, for their assistance in the planning and implementation of the first one-year introductory medical Zulu course introduced at the Medical School in 2001.

- My mother, Mrs Madeline Cockerill, for assistance with proof-reading and encouragement during the difficult phases of my research.

- My sister and brother-in-law, Karen and Jonathan Rundle, for guidance and support in the use of the computer.

With the exception of the above assistance, the work of this thesis is my own.

Jacqueline Anne Cockerill

December 2002

TABLE OF CONTENTS

Page No.

CHAPTER 1: INTRODUCTION 1

1.1 THE PROBLEM: THE LANGUAGE BARRIER BETWEEN DOCTOR AND PATIENT 1

1.2 HOW TO BRIDGE THE "LANGUAGE GAP": POSSIBLE SOLUTIONS 1

1.3 THESIS OBJECTIVES 3

1.4 DEFINING THE TERM "ZSP" 4

1.5 OUTLINE OF REMAINING CHAPTERS 5

CHAPTER 2: SETTING UP A THEORETICAL FRAMEWORK & CONTEXTUALISING THE RESEARCH 6

2.1 INTRODUCTION 6

2.2 MY APPROACH TO SECOND LANGUAGE LEARNING: 6

2.2.1 Communicative competency above grammatical mastery 7
2.2.2 The "Design Down" Principle 8
2.2.3 A learning-centred (ESP) approach to syllabus design 9

2.3 WHAT IS ESP? 10

2.4 KEY ELEMENTS OF DESIGNING A SPECIFIC PURPOSE LANGUAGE COURSE 11

2.4.1 Needs Analysis 11
2.4.1.1 Munby's needs analysis model 12
2.4.1.2 A shift in thinking about Needs Analysis 13
2.4.1.3 Target situation analysis vs. learning situation analysis 13
2.4.1.4 Hutchinson and Waters' approach to needs analysis 14
2.4.1.5 Application of needs analysis to my course design 17

2.4.2 Syllabus Design 17
2.4.2.1 Defining syllabus design 17
2.4.2.2 Selecting a syllabus type 18
2.4.2.3 Considerations of my eclectic syllabus design 22

2.4.3 Materials 26

2.4.4 Methodology 27
2.4.4.1 Learning is an active process 27
2.4.4.2 Learning is an emotional experience 28
2.4.4.3 Pitching the course at the right level 28

2.4.5 Evaluation 29

2.5 CONTEXTUALISING THE RESEARCH: A REVIEW OF EXISTING RESOURCES 31

2.5.1 Medical Zulu cources 31
2.5.2 General Zulu second language courses 32
2.5.3 Other relevant resources 34
2.5.4 Contribution to be made by my research 35

2.6 SUMMARY 36

CHAPTER 3: RESEARCH METHODOLOGY 38

3.1 INTRODUCTION 38

3.2 PARAMETER 1: RESEARCH APPROACH 38

3.3 PARAMETER 2: RESEARCH OBJECTIVES 39

3.4 PARAMETER 3: DEGREE OF FOCUS AND MANIPULATION OF CONTEXT 40

3.5 PARAMETER 4: DATA AND DATA COLLECTION 41

3.5.1 Interviews with doctors 42
3.5.2 Observations of doctor-patient consultations 43
3.5.3 Informal consultations with other syllabus designers 45
3.5.4 Workshops on cross-cultural communication in the medical consultation 45
3.5.5 Data collection: gathering texts 46
3.5.6 Course evaluations questionnaires, classroom observations and feedback from learners 46

3.6 ANALYSIS OF RESULTS OBTAINED 47

CHAPTER 4: RESEARCH RESULTS 48

4.1 INTRODUCTION 48

4.2 FINDINGS RELATED TO THE TARGET SITUATION 48

4.2.1 Why is the language needed by the learner? 48
4.2.2 With whom will the learner be communicating? 48
4.2.3 Where will the language be used? 49
4.2.4 How will the language be used? 49
4.2.5 When will the language be used? 50
4.2.6 What does the learner need to be able to express? 50

4.2.6.1 Language functions: 50

a. Greeting & Introducing 52
b. Asking after health 53
c. Questioning: Taking a patient's history 54
d. Instructing: Conducting a physical examination 57
e. Reassuring 57
f. Explaining 58
g. Suggesting further action 58
h. Saying goodbye/closing the conversation 59

4.2.6.2 Vocabulary: 59

a. Pain 60
b. Pregnancy/Birth/Mothering 61
c. Respiratory Problems 63
d. Nutrition 64
e. Skin infections 65
f. Hypertension 66
g. Diarrhoea and Dehydration 67
h. Diabetes 68
i. Eye complaints 69
j. Genital system 70
k. Sexually transmitted diseases 70
l. Nausea 72
m. Fever 72
n. Epilepsy 73
o. Broken limbs 73
p. Inability to sleep 74
q. Inappropriate vs. polite terminology 74
r. Days, time, numbers 75
s. Code-switching and borrowed words 76
t. Depression 77
u. Cancer 78

4.2.6.3 Grammatical structures: 79

a. Zulu noun class system..... 79
b. *-Na-* (to have) 80
c. *Nga-* (by means of/about) 80
d. Agentive prefixes *y-* and *ng-* 80
e. Locatives 80
f. Question words..... 81
g. Object concords 81
h. Statives..... 82
i. Passive mood..... 82
j. Present Tense (positive and negative)..... 82
k. Future Tense (positive and negative)..... 83
l. Recent & Remote Past (positive and negative)..... 83
m. Recent & Remote Past Compound tenses..... 83
n. Subjunctive mood..... 83
o. Imperatives..... 84
p. Dependent tense..... 84
q. *-nga-* (can) 84
r. Adjectives..... 85
s. Relatives..... 85
t. Possessives..... 85
u. Demonstratives & locative-demonstratives..... 85
v. Inclusive and exclusive pronouns: *-nke* (all) and *-dwa* (only)..... 85
w. *Se-* implication (meaning now) 86

4.2.6.4 Cultural elements: 86

a. Terms of address..... 86
b. The cross-cultural medical consultation..... 87
c. Culture bound syndromes..... 88
d. Traditional healers..... 90
e. Use of euphemism and metaphor..... 90
f. The "entry ticket" complaint..... 92

4.3 FINDINGS RELATED TO THE LEARNING SITUATION 93

4.3.1 Who are the learners? 94
4.3.1.1 Justification for selection of medical students as ideal target learners..... 94
4.3.1.2 Description of target learners..... 95

4.3.2 Why are learners doing the course? 97

4.3.3 How do learners learn? 99
4.3.3.1 An overview of a typical 2-hour lecture..... 99
4.3.3.2 Reading and writing activities..... 99

4.3.3.3 Emphasis on oral activities 99
4.3.3.4 Homework assignments & learner evaluation activities.... 101

4.3.4 What resources are available? 101
4.3.4.1 Handouts 101
4.3.4.2 WebCT 102
4.3.4.3 Certificates upon completion of course 103
4.3.4.4 Recommended resource for future use: audio tapes 103

4.3.5 Where do learners learn? 103

4.3.6 When does the ZSP course tale place? 104

4.4 SUMMARY 104

CHAPTER 5: APPLICATION OF RESULTS & RATIONALE FOR SELECTION OF SYLLABUS CONTENT 106

5.1 ANALYSING AND INTERPRETING THE RESULTS 106

5.2 DEFINING FEATURES OF THE INTRODUCTORY MEDICAL ZULU COURSE I HAVE DESIGNED 106

5.2.1 It is designed for a specific purpose 107
5.2.2 It has been designed with a specific group of target learners in mind... 107
5.2.3 The syllabus aims to promote oral competency 107
5.2.4 There are six mini-syllabuses comprising the eclectic syllabus 107
5.2.5 6O Contact hours between lecturer & learners 108

5.3 OUTLINE OF THE SYLLABUS I HAVE DESIGNED 108

5.3.1 How to interpret the summary table 108

5.3.2 Summary table of the syllabus I have designed for an introductory medical Zulu course 110

5.4 CRITERIA FOR SELECTING SYLLABUS CONTENT 112

5.4.1 Situational need 112
5.4.2 Frequency of occurrence 114
5.4.3 Linguistic knowledge already possessed 114
5.4.4 Time constraints 115
5.4.5 Emphasis on oral competency 115
5.4.6 Size of class 115
5.4.7 Facilities available 116
5.4.8 Learner motivation and enjoyment 116

5.5 ORDERING SYLLABUS CONTENT 119

5.5.1 Unit of organisation 119
5.5.2 Grammatical complexity 121
5.5.3 Cyclical / spiral syllabus 123
5.5.4 Dependence on previously taught structures 123
5.5.5 Priority of needs 124
5.5.6 Cohesion with other modules in the Medical School syllabus 125

5.6 DISCUSSION OF THE SIX SUB-SYLLABUSES INCLUDED IN THE SYLLABUS I HAVE DESIGNED 125

5.6.1 Themes/Topics 125
5.6.2 Language Functions 129
5.6.3 Vocabulary 131
5.6.4 Grammatical Structures 141
5.6.5 Cultural Input 143
5.6.6 Language Activities 144

5.7 SUMMARY & CONCLUSIONS 149

CHAPTER 6: SUMMARY & CONCLUSIONS 150

BIBLIOGRAPHY 154

APPENDICES 159

Appendix A Map showing hospitals where research was conducted 159
Appendix B Summary table of consultations observed 160
Appendix C Transcripts of 12 taped consultations 166
Appendix D Summary notes based on interviews with doctors 177
Appendix E Notes on weight loss (in Zulu and English) 180
Appendix F Medical Zulu course evaluation questionnaire 182
Appendix G Findings of Medical Zulu course evaluation questionnaire 189
Appendix H History Taking protocol 190
Appendix I Extract from a Zulu/English history-taking questionnaire 204
Appendix J The Culturally Sensitive Medical Consultation 210
Appendix K Seventeenth Century Man in the 21st Century 212
Appendix L Sample handout for Unit 1 215
Appendix M Extract from sample Unit 2 227
Appendix N Extract from sample Unit 3 230
Appendix O Extract from sample Unit 6 231
Appendix P Extract from sample Unit 8 234
Appendix Q Extract from sample Unit 9 236

CHAPTER 1
INTRODUCTION

1.1 THE PROBLEM: THE LANGUAGE BARRIER BETWEEN DOCTOR & PATIENT

"Asikwazi sonke uku-undastanda isiLungu" (We can't all understand the whites' language).

(Crawford, 1999: 28)

In an article addressing the issue of monolingual health services in a multilingual society, Crawford records the above sentiment expressed by a female patient in a hospital in the Cape. The language barrier identified by this woman and the implications it has when viewed in the context of the medical consultation is a serious problem not only in the Cape, but throughout the country and especially in Kwa-Zulu Natal. Zulu is the widest spoken African language in South Africa and in Kwa-Zulu Natal, Zulu speakers constitute 80% of the population. Many English-speaking doctors, however, are unable to communicate adequately in Zulu, the language of the majority.

The need for doctors to be able to speak and understand Zulu has been further intensified with the institution of the 1999 Community Service policy. This policy stipulates that all doctors must complete one year of community service before they are able to practice medicine in a private capacity. In many of these hospitals, especially those situated in rural areas, the language spoken by the majority of patients is Zulu.

1.2 HOW TO BRIDGE THE "LANGUAGE GAP": POSSIBLE SOLUTIONS

Bridging the communication gap in South Africa is a complex process, which must be addressed on a number of different levels – social, political and linguistic. One of the conclusions Crawford draws in his article is that there are no instant, ready-made international solutions to this *"uniquely South African problem"* (1999: 42).

One of the ways in which the language barrier is currently being addressed in hospitals is through the use of nurses as interpreters. On 11 July 1996 the University of Natal hosted a one-day conference on the theme of *Communication for the Health Professions in a Multilingual Society*. One of the major debates at the conference was whether doctors should be expected to communicate effectively in the language of the majority of their patients or whether the nursing profession should accept this as their responsibility.

It is often taken for granted that the Zulu-speaking nurse can, and will, act as an interpreter. However, this concept was challenged at the conference as speaker after speaker emphasised the deficiencies of this method. In her paper, Buthelezi (1996) says misinterpretation or inaccuracy may occur when a nurse shortens a patient's message. For example, when a patient's words such as "I am getting smaller, thin and I feel weak" are abbreviated to "loss of weight".

Dr Cairns, who served at Nkandla Hospital in Kwa-Zulu, agrees that the nurse-interpreter system is not ideal. During my interview with her (February 2002), she described an incident involving a similar kind of misinterpretation. Dr Cairns explained that her comprehension of Zulu was fairly good but that her ability to speak the language was quite limited and she was thus relying on the nurse present to interpret what she was saying to the patient. She recounted a situation where a patient had complained "something is moving inside my stomach". The nurse assisting Dr Cairns summarised the complaint as "stomach ache".

The pitfalls of using a nurse to interpret is even more evident in the following example. Dr Cairns recounted an incident where she was counselling an adult male patient on sexually transmitted diseases and safe sex. When she explained to the patient that abstinence was the only foolproof way of avoiding contracting sexually transmitted diseases, the nurse did not translate the concept of abstinence. She simply told the man that the doctor recommended the use of condoms. When I asked Dr Cairns why she thought the nurse had left this information out, she suggested that the nurse probably felt that it was impossible or unlikely that the patient would even consider abstinence as an alternative and thus didn't feel it was necessary to translate this information.

Also on the subject of nurse-interpreters, Professor Loening, Director of Medical Education Development at the University of Natal Durban, states that:

"Not only can one not readily assume that [the nurse] has the necessary competence but it must also be recognised that there is seldom acknowledgement of this function or any reward."

(Prof. Loening, SAMJ Volume 87:1997)

Addressing the debate on who is responsible for facilitating communication in the medical consultation, Professor Loening explains that overcoming the language barrier should be the shared responsibility of both doctors and nurses. Furthermore, he encourages the institution of a second language course aimed at equipping medical students with the necessary linguistic knowledge and skills to be able to consult patients who speak African languages:

"these options should not be mutually exclusive; rather, the undergraduate medical curriculum as well as the vocational training programme for doctors should ensure that these requirements are met. It is patently obvious that much more than a 6-month course in an African language is essential."

(Prof. Loening, SAMJ Volume 87: 1997)

The obvious and immediate need for a specialised course aimed at equipping doctors with the basic linguistic skills and knowledge necessary to communicate in Zulu to their patients was the motivation behind my thesis topic. One of the factors influencing the choice of my thesis topic was when the University of Natal Medical School requested the UND Zulu Department to design and implement a medical Zulu second language course for the first year medical students as part of the new Problem-Based Learning (PBL) Curriculum 2001. Professor Ngubane, HOD of the Zulu Department, and Beverley Muller, senior lecturer in the Zulu Department and my supervisor, asked me to design and lecture this introductory medical Zulu course.

1.3 THESIS OBJECTIVES

I realise that the scope of a research project such as the one I have chosen is extensive and it would be an impossible task to cover every aspect of a medical Zulu second language course within the confines of a Masters thesis. After doing

some preliminary investigation into this field of study, I chose to focus on two specific areas, needs analysis and syllabus design.

In other words, the two-fold objective of my thesis was to:

- Investigate what kinds of things doctors need to be able to say and understand in the medical consultation (Needs Analysis).

- Design a syllabus for an introductory medical Zulu course aimed at teaching non Zulu-speaking medical students training to become doctors how to communicate with their future patients in Zulu (Syllabus Design).

The results of my needs analysis are presented in chapter four and a discussion of the introductory medical Zulu syllabus I designed can be found in chapter five.

The exact nature of the syllabus I have designed is discussed in detail in chapter five but I would like to comment briefly on it here. As stated above, the course that I have designed is an *introductory* medical Zulu course. In other words, it aims to introduce learners to the more common and useful communicative exchanges, which I recommend doctors should *begin* by learning. This course is designed with medical students in mind, rather than doctors who are already practicing in hospitals. My reasons for selecting medical students as my target learners will be discussed in greater detail in chapter four (section 4.3.1).

1.4 DEFINING THE TERM "ZSP"

Throughout this thesis I make use of the term "ZSP", "Zulu for Specific Purposes". Many people will be familiar with the term ESP, meaning "English for Specific Purposes". ESP is a branch of language teaching where a learner is taught to communicate in English for a specific (as opposed to general) purpose. An ESP course may, for example, be aimed at teaching German car manufacturers how to discuss matters relating to the automobile industry while the objective of another ESP course might be to assist French Canadian telephone operators to deal with customer inquiries in English. As these examples show, the target learners and target situation are clearly defined and that is why these courses are identified as having a specific purpose. The proposed course has the defining features of a "specific purposes" course as it has the explicit aim of teaching medical students

whose mother tongue is not Zulu to communicate with Zulu-speaking patients in the designated setting of a hospital Out-Patients Department (OPD). I have, therefore, chosen to refer to my course as a "Zulu for Specific Purposes" (ZSP) course.

1.5 OUTLINE OF REMAINING CHAPTERS

In chapter two I outline the theoretical framework upon which my thesis is based and comment on some of the existing Zulu resources that have been used by doctors trying to learn medical Zulu. Chapter three offers a detailed explanation of my research methodology and a list of my data sources while chapter four reports and discusses the main findings of my needs analysis. In chapter five I interpret and analyse those results and it is in this section that I make suggestions and recommendations about what should be included in the syllabus of an introductory ZSP course aimed at medical students, training to be doctors. The final chapter consists of a summary and conclusions.

CHAPTER 2
SETTING UP A THEORETICAL FRAMEWORK & CONTEXTUALISING THE RESEARCH

2.1 INTRODUCTION

Having studied a Zulu Honours module, *Teaching IsiZulu as an Additional Language* (DZU710M) in 1999, I was familiar with the general trends, developments and schools of thought in the field of second language learning. Furthermore, my experience lecturing Zulu as a second language at the University of Natal, Durban from 1999 - 2002 had equipped me with an understanding of the practical aspects of teaching Zulu as a second language. The general topic of my thesis was, therefore, suited to my interests and experience. However since the medical Zulu course I wanted to design fitted the profile of a "Specific Purpose" language course, I set out to research ESP (English for Specific Purposes) as this particular area of second language teaching was fairly new to me.

The major part of chapter two deals with the general second language learning theories upon which my theoretical framework is based and those aspects of ESP which are relevant to my syllabus design. In the final section I discuss some of the resources doctors have used in the past to learn to speak Zulu and how I feel my thesis can contribute towards the existing body of knowledge in this field.

2.2 MY APPROACH TO SECOND LANGUAGE LEARNING

"Through studying the history of language teaching we can find perspective on present-day thought and trends and find directions for future growth. Knowing the historical context is helpful to an understanding of language teaching theories."

(Stern, 1983: 76)

As Stern correctly states, a historical perspective on the subject of second language teaching is extremely useful for someone involved in the field of second language teaching, particularly when they intend to design a syllabus. Over the years, there have been a number of significant "approaches" to second language teaching, each with its own defining characteristics and contributing in some way to the existing body of knowledge on second language teaching.

"By approach is meant a commitment to particular, specified points of view – to an ideology, one might say – about language teaching."

(Strevens, 1977: 23)

Some of the best-known approaches or movements include: the Grammar-Translation approach, the Reform movement, the Natural/Direct approach, the Structuralist approach, the Communicative approach, Learning-Centred method, the Outcomes-based model and the list goes on. It is not my intention to review the merits and demerits of each approach in this chapter. Rather I will draw on principles from the Communicative approach, Outcomes-based teaching theory and the Learning-centred approach as outlined by Hutchinson and Waters (1987), to explain my approach to second language learning. Below I explain the basic tenets of the approach to second language learning that I have adopted:

2.2.1 Communicative competency above grammatical mastery

Before the advent of the communicative movement, many syllabus designers started out by drawing up lists of grammatical, phonological, and vocabulary items, which were graded according to difficulty and usefulness. The learners' aim was seen as gaining mastery over these grammatical, phonological and lexical items.

"Learning a language, it was assumed, entails mastering the elements or building blocks of the language and learning the rules by which these elements are combined, from phoneme to morpheme to word to phrase to sentence".

(Richards and Rodgers 1986: 49)

During the 1970's, communicative ideas about language teaching began to be affect syllabus design. Instead of focussing on the mastery of linguistic elements, syllabus designers began to ask, "What does the learner want/ need to do with the target language?" The idea of designing a course based on what the learner needs to be able to do with the language is obviously one of the most important features of ESP theory. With specific purpose courses, time is often a limited resource and there is an imminent and pressing need for learners to be able to communicate in their chosen field as soon as possible. Therefore communicative competency rather than grammatical mastery seems to be a much more realistic aim.

However, this is not to suggest that grammar no longer has an important role to play in the learning of a second language. While Littlewood states that effective communication relies on more than just knowledge of language forms, he also stresses that knowledge of grammar remains one of the essential ingredients for successful communication. The key is to be able to relate these structures to their communicative functions in real situations and real time.

"The most effective communicator in a foreign language is not always the person who is best at manipulating its structures. It is often the person who is most skilled at processing the complete situation involving himself and his hearer, taking account of what knowledge is already shared between them (e.g. from the situation or from the preceding conversation), and selecting items which will communicate his message effectively. Foreign language learners need opportunities to develop these skills, by being exposed to situations where the emphasis is on using their available resources for communicating meanings as efficiently and economically as possible. Since these resources are limited, this may often entail sacrificing grammatical accuracy in favour of immediate communicative effectiveness."

(Littlewood, 1981: 4)

2.2.2 The "Design Down" Principle

The "design down" principle is one of the key concepts of Outcomes-based education and also forms part of the backbone of the theoretical framework for learning upon which my course design is based. Basically, this principle suggests that syllabus designers should *start* their curriculum and teaching planning where they want learners to ultimately *end up* and then work back from there. In a South African manual addressing the theme of Outcomes-based education, William Spady describes the concept as follows:

"At its core, the process requires staff to start at the end of a set of significant learning experiences – its culminating point – and determine which critical components and building blocks of learning (enabling outcomes) need to be established so that students can successfully arrive there."

(Spady, in Lubisi, 1995: 28)

One of the greatest challenges to the design-down principle is gaining the co-operation and willingness of the teacher and/or syllabus designer to eliminate *"familiar, 'favourite', but unnecessary curriculum details"* (Spady, 1995) simply because that's the way it's always been done. But if we are to meet learners' needs, in any discipline, syllabus designers need to commit themselves to a thorough investigation of these needs in order to identify a set of outcomes, which will assist them in designing a course that is practical, relevant and grounded in reality. This is particularly crucial for a specific purpose course where the target situation is well defined and can be investigated. Conducting a target situation analysis is the concrete expression of the design-down principle. Needs analysis is examined further in section 2.3.1.

2.2.3 A Learning-centred (ESP) approach to syllabus design

Too often second language courses do not seem to cater adequately for learners' needs. This may be due to a number of reasons. Sometimes it is because the syllabus being used was never designed with these learners in mind. Sometimes it is as a result of an old syllabus not being updated or modified to suit the changing needs of learners. And sadly, sometimes it is because the teacher or syllabus designer is not committed to investigating learners' needs and is not prepared to invest the time necessary to locate or create materials which match these needs.

It is for this reason that I find Hutchinson and Waters' learning-centred approach so appealing because it takes the learner into consideration at every stage of the course design process. After identifying learners and the target situation for which they are preparing themselves, the syllabus design process begins with a thorough investigation of both target situation and learning situation dynamics. This reflects an understanding that, while the overall aim of the course is to prepare learners for the target situation, their immediate needs in the learning environment (e.g. their need to be involved in enjoyable, interesting activities and to be presented with aesthetically pleasing and relevant resources) also need to be considered.

Furthermore, this approach recognises that syllabus design is not a once-for-all activity. It is a dynamic process that requires ongoing needs analysis and careful attention to the evolving needs of learners. It encourages the institution of

feedback channels and a constant re-evaluation of the syllabus in light of new findings. Hutchinson and Waters' learning-centred approach is depicted in the figure below:

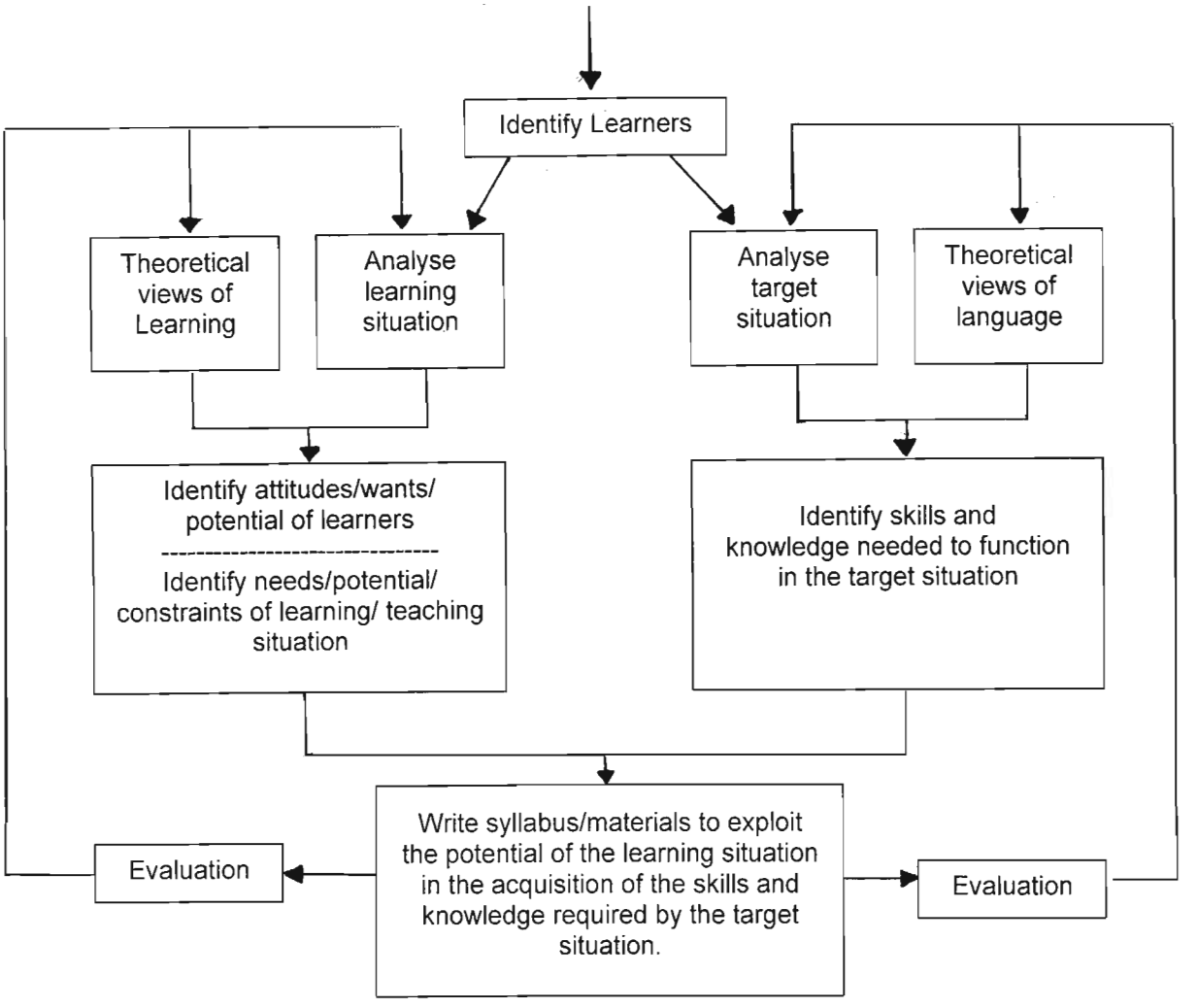


Figure 1: Hutchinson and Waters' model: A learning-centred approach to course design (1987:74)

2.3 WHAT IS ESP?

According to linguists, English Language Teaching can be divided into two broad categories: General English (GE) and English for Specific Purposes (ESP). What distinguishes ESP from GE is that it aims to prepare learners for communication in a well-defined target situation as opposed to a number of general settings that the

learner may encounter. Hutchinson and Waters (1987) offer the following description of ESP:

"ESP must be seen as an approach not as a product. ESP is not a particular kind of language or methodology, nor does it consist of a particular type of teaching material. Understood properly, it is an approach to language learning that is based on learner need. The foundation of all ESP is the simple question: Why does this learner need to learn a foreign language?"

(Hutchinson & Waters, 1987: 19)

In other words, ESP is not a specialised variety of language but language that is used for a specific purpose. In order to determine the communicative purposes, for which a learner needs the language, it is necessary to conduct a needs analysis.

2.4 KEY ELEMENTS OF DESIGNING A "SPECIFIC PURPOSE" LANGUAGE COURSE:

The creation of a specific purpose language course can be roughly divided into three broad stages namely, a planning phase, an implementation phase, and an evaluation phase. The planning stage involves all activities that result in the course design and includes needs analysis, syllabus design and the selection or creation of materials. Aspects relating to teaching methodology, the way in which resources and materials are introduced and the classroom activities employed fall under the implementation phase. The final phase concerns itself with learner assessment and course evaluation.

As explained in chapter one, my research focuses on designing the syllabus for a specific purpose medical Zulu course. Therefore, my comments focus on aspects relating to the planning phase. I refer to methodological and evaluation issues only when they are relevant to my discussion on syllabus design.

2.4.1 Needs Analysis

Needs analysis is one of the defining features of ESP. Hutchinson and Waters describe needs analysis as the starting point of planning and designing a specific purpose language course.

"Given that the purpose of an ESP course is to enable learners to function adequately in a target situation... then the ESP course design process should proceed by first identifying the target situation and then carrying out a rigorous analysis of the linguistic features of that situation. The identified features will form the syllabus of the ESP course."

(Hutchinson & Waters, 1987: 12)

2.4.1.1 Munby's needs analysis model

One of the most elaborate applications of needs analysis to language syllabus design is to be found in the work of John Munby (1978). Munby's model identifies nine parameters that he maintains the syllabus designer should investigate:

A Participant

Information related to the learner's identity and language skills including factors such as age, sex, nationality, mother tongue, command of target language, experience learning other languages etc.

B Purposive domain

The purposes for which the language is required

C Setting

The environment in which the target language will be spoken.

D Interaction

With whom the learner will be interacting

E Instrumentality

The medium, channel and mode of the language to be used: Spoken or written, receptive or productive, monologue or dialogue, face-to-face or indirect (e.g. telephone) encounters

F Dialect

This relates to instances where the variety or dialect needs to be specified (e.g. understand and produce standard English/ General American)

G Target level

The degree of mastery which the learner will need to gain over the target language

H Communicative event

The type of communicative encounter/event the learner will be faced with as well as the chief productive and receptive skills the learner will need to master in order to function adequately in the specified target situation

I Communicative key

The interpersonal attitudes and tones the learner will need to master

2.4.1.2 A shift in thinking about Needs Analysis

Munby made a valuable contribution to the general development of needs analysis with his system. As Nunan points out, it is well suited to the design of ESP courses for example, 'English for Motor Mechanics', where *"it is assumed that there are certain structures, functions, topics, vocabulary items, conceptual meanings, and so on that are particular to the world of the motor mechanic and which are not found in 'general' English"* (Nunan, 1988: 21). Munby's model provides us with a thorough and well-considered perspective of the learner's target situation needs.

Other researchers criticised Munby's approach, saying that it is too mechanistic and does not pay enough attention to the learning needs of the learner. They say that target situation needs are only part of the picture. Criticisms of such early needs analysis work led to a shift in focus toward a more humanistic approach, based on the belief that learners should have a say in what they learn and how they learn it.

2.4.1.3 Target situation analysis vs. learning situation analysis

In his discussion of needs analysis, Nunan identifies two areas of investigation, which fall under the umbrella term of needs analysis, namely *"task analysis" and "learner analysis"* (1988:14). Task analysis focuses on what the learner needs to be able to do with the language in the target situation. Learner analysis looks at how the learner learns and examines what needs he experiences during the learning process.

Hutchinson and Waters (1987) also distinguish between target situation needs and learner needs. They adopt Chambers' (1980) term of *"target situation analysis"* to refer to an investigation of the environment in which the learner will ultimately be using the language. Target situation analysis helps the course designer to verify what skills or knowledge should constitute the content of the course. What the target situation analysis cannot do, however, is show *how* the learner should learn the language items, skills and strategies that he will need in the target situation.

"It is naïve to base a course design simply on the target objectives, just as it is naïve to think that a journey can be planned solely in terms of the starting point and the destination. The needs, potential and constraints of the route (i.e. the learning situation) must also be taken into account if we are going to have any useful analysis of learner needs."

(Hutchinson & Waters, 1987: 61)

Therefore, in addition to investigating the target situation, it is important to consider the dynamics of the learning situation and the learning needs of target learners.

2.4.1.4 Hutchinson and Waters' approach to needs analysis

Hutchinson and Waters' outline a simple yet comprehensive approach to needs analysis. They suggest using Rudyard Kipling's 'honest serving men' (1987: 21) as a guideline for the kinds of questions which need to be answered before one can begin the task of designing an ESP course.

"I keep six honest serving-men.
(They taught me all I knew.)
Their names are What and Why and When
And How and Where and Who."

(Rudyard Kipling in Hutchinson & Waters, 1987: 21)

By using Kipling's "honest serving-men", we are able to identify the key areas that should be addressed by a thorough needs analysis in order to address both target situation needs and learning needs.

A target situation analysis framework (Hutchinson and Waters, 1987: 59)

Why is the language needed?

- for study;
- for work;
- for training;
- for a combination of these;
- for some other purpose, e.g. status, examination, promotion.

How will the language be used?

- medium: speaking, writing, reading etc.;
- channel: e.g. telephone, face to face etc.;
- types of text or discourse: e.g. academic texts, lectures, informal conversations, technical manuals, catalogues.

What will the content areas be?

- subjects: e.g. medicine, biology, architecture, shipping, commerce, engineering;
- level: e.g. technician, craftsman, postgraduate, secondary school;

Who will the learner be using the language with?

- native speakers or non-native;
- level of knowledge of receiver: e.g. expert, layman, student;
- relationship: e.g. colleague, teacher, customer, superior, subordinate.

Where will the language be used?

- physical setting: e.g. office, lecture theatre, hotel, workshop, library;
- human context: e.g. alone, meetings, demonstrations, on telephone;
- linguistic context: e.g. in own country, abroad.

When will the language be used?

- concurrently with the ESP course or subsequently;
- frequently, seldom, in small amounts, in large chunks;

A framework for analysing learning needs (Hutchinson and Waters, 1987: 62)

Why are learners taking the course?

- compulsory or optional;
- apparent need or not;
- Are status, money, promotion involved?
- What do learners think they will achieve?
- What is their attitude towards the ESP course? Do they want to improve their English or do they resent the time they have to spend on it?

How do the learners learn?

- What is their learning background?
- What is their concept of teaching and learning?
- What methodology will appeal to them?
- What sort of techniques are likely to bore/alienate them?

What resources are available?

- number and professional competence of teachers;
- attitude of teachers to ESP;
- teachers' knowledge of and attitude to the subject content;
- materials;
- aids;
- opportunities for out-of class activities.

Who are the learners?

- age / sex / nationality;
- What do they already know about English?
- What subject knowledge do they have?
- What are their interests?
- What is their socio-cultural background?
- What teaching styles are they used to?
- What is their attitude to English or to the cultures of the English-speaking world?

Where will the ESP course take place?

- Are the surroundings pleasant, dull, noisy, cold etc.?

When will the language be used?

- time of day;
- every day / once a week;
- full-time / part-time;
- concurrent with need or pre-need.

2.4.1.5 The needs analysis considerations of my research design

I chose to examine both the target situation and the learning environment of my target learners and based my investigation on Hutchinson and Waters' (1987) approach to needs analysis as outlined above. Chapter three explains the research methodology I employed in order to conduct my needs analysis. The results rendered by these research activities are then discussed in chapter four.

2.4.2 Syllabus Design:

Once the needs analysis has been conducted and all the data collected, the course designer must ask himself the question, "What do I do with the information I have gathered?" First, data must be interpreted and translated into a syllabus to meet the needs of the learner which have been identified. In this section I will define what is meant by the term 'syllabus design' and give a brief summary of the different types of syllabuses, which one can choose from. Finally I will give a motivation for the syllabus type I have chosen for my course design.

2.4.2.1 Defining "syllabus design"

There are a number of conflicting views on exactly what distinguishes syllabus design from methodology. Some theorists draw a clear distinction between the two, stating that syllabus design is concerned solely with the selection and grading of content while methodology refers to the selection of learning tasks and activities i.e. how content is taught. Language specialists such as Allen and Stern support this perspective:

"Syllabus, on the other hand, refers to that subpart of curriculum which is concerned with a specification of what units will be taught (as distinct from how they will be taught which is a matter for methodology)".

(Allen, quoted in Brumfit, 1984: 6)

"... I would like to draw a distinction... between curriculum or syllabus, that is its content, structure, parts and organisation, and, ... what in curriculum theory is often called curriculum processes, that is curriculum development, implementation, dissemination, and evaluation. The former is concerned with the WHAT of curriculum: what the curriculum is like or should be like; the latter is concerned with the WHO and HOW of establishing the curriculum."

(Stern 1984: 10-11)

Other linguists, such as Candlin, suggest that syllabus design and methodology are not really separate matters but rather two inter-related and inseparable features of the larger activity of syllabus or curriculum design.

"We might ... ask whether it is possible to separate so easily what we have been calling content from what we have been calling method or procedure, or indeed whether we can avoid bringing evaluation into the debate?"

(Candlin, 1984: 32)

In order to restrict myself to the focus of my thesis, i.e. syllabus design, and for the purpose of clarity, I have chosen to deal with syllabus design and teaching methodology as separate issues. However, I readily acknowledge that methodological issues do impact on syllabus design and as such they did influence my decisions when drawing up my syllabus.

2.4.2.2 Selecting a syllabus type

Anyone who has conducted research into the field of second language acquisition, will be familiar with the multiplicity of syllabus types available to the syllabus planner. The following are some of the better-known distinctions: synthetic vs. analytic, grammatical/structural, functional-notional, task-based (or procedural), communicative, outcomes-based and the list goes on. Below is a discussion of the syllabus types that contribute in some way to the syllabus type selected for the medical ZSP course I have designed.

- **The synthetic vs. analytic distinction:**

Nunan (1988) suggests that one way of categorising the various types of syllabuses is by locating them somewhere along the synthetic-analytic continuum. Syllabus planning can be described as *synthetic* where language is broken down

into manageable units to be taught in a pre-determined order (like most functional-notional syllabuses) or *analytic,* where learners are exposed to language that has not been linguistically graded, and can even incorporate elements of both. Wilkins offers the following definition of the synthetic syllabus:

"A synthetic language teaching strategy is one in which the different parts of language are taught separately and step by step so that acquisition is a process of gradual accumulation of parts until the whole structure of language has been built up."

(Wilkins, 1976: 2)

Nunan defines an analytic syllabus approach as follows:

"In an analytic syllabus, learners are presented with chunks of language which may include structures of varying degrees of difficulty. The starting point for syllabus design is not the grammatical system of the language, but the communicative purposes for which language is used."

(Nunan, 1988: 28)

According to Wilkins, analytic syllabuses:

"are organised in terms of the purposes for which people are learning language and the kinds of language performance that are necessary to meet those purposes."

(Wilkins, 1976: 13)

- **Grammatical/Structural Syllabus**

The grammatical syllabus is perhaps one of the most well utilised syllabus types and will be familiar to many learners who have sat in a Zulu second language classroom. In spite of the growing popularity of communicative learning methods since the 1980's, many second language syllabuses are still based on the perception that certain grammatical structures must be learnt before others can be assimilated. As a result, the syllabus is organised around grammatical structures beginning with the basics and progressing on to more complex structures. Nunan defines a structural syllabus as follows:

"The assumption behind most grammatical syllabuses seems to be that language consists of a finite set of rules which can be combined in various ways to make meaning. It is further assumed that these rules can be learned one by one, in an additive fashion, each item being mastered on its own before being incorporated into the learner's pre-existing stock of knowledge. The principal purpose of language teaching is to help learners to 'crack the code'."

(Nunan, 1988: 29)

- **Functional-Notional Syllabus**

To understand a functional-notional syllabus, one must first define what is meant by "functions" and "notions":

"In general, functions may be described as the communicative purposes for which we use language, while notions are the conceptual meanings (objects, entities states of affairs, logical relationships, and so on) expressed by language."

(Nunan, 1988: 35)

A functional-notional syllabus is organised according to language functions (e.g. greeting, identifying, warning etc) and notions (e.g. time, cause, size etc) that the syllabus planner thinks learners need to know in order to be able to achieve the specified communicative act.

- **Task-based/Procedural Syllabus**

As the name suggests a task-based syllabus is built around a list of activities or tasks which the syllabus designer thinks the learner should be able to carry out. This syllabus type is not dissimilar from the functional-notional approach and is described by Richards, Platt and Weber (1985) as:

"... a syllabus which is organised around tasks rather than in terms of grammar and vocabulary. For example the syllabus may suggest a variety of different kinds of tasks which the learners are expected to carry out in the language, such as using the telephone to obtain information; drawing maps based on oral instructions; performing actions based on commands given in the target language; giving orders and instructions to others, etc."

(Richards, Platt & Weber, 1985: 289)

- **Multi-dimensional/ Eclectic syllabus**

An eclectic syllabus type can be described as one, which draws on elements from more than one syllabus type. A number of writers on the issue of syllabus planning suggest that the various syllabus designs are not mutually exclusive. Johnson, for example, explains that an eclectic syllabus is more flexible and sensitive to learners' language needs than a uni-dimensional syllabus:

"There is no reason why only one of the inventory item types needs to be selected as the unit of organisation. It would be possible to develop a syllabus leading to lesson of varying orientation – some covering important functions, others dealing with settings and topics and yet others perhaps with notions or structures."

(Johnson, 1982: 67)

Littlewood also comments on the validity of a multidimensional syllabus:

"It is not necessary to opt for only one form of organisation for a course as there are several ways in which different organisational principles can be combined. For example, different forms of organisation can be 'nested' inside each other."

(Littlewood, 1981:79)

- **Most suitable syllabus type for the syllabus design I have chosen: Multi-dimensional / Eclectic syllabus**

There are pros and cons to each of the syllabus types mentioned above. They all have something valuable to offer the ZSP course I have designed and I have, therefore, chosen to adopt elements from more than one syllabus type and incorporate them into a *multi-dimensional*, or *eclectic* syllabus. My ZSP syllabus is organised around a number of different sub-systems, or mini syllabuses, which are identified in the section below.

2.4.2.3 Considerations of my eclectic syllabus design

In his document, entitled *Threshold Level English* (1975), Van Ek lists the following eight aspects as essential components of a language syllabus:

1. the situations in which the foreign language will be used, including the topics which will be dealt with;
2. the language activities in which the learner will engage;
3. the language functions which the learner will fulfil;
4. what the learner will be able to do in respect to each topic;
5. the general notions which the learner will be able to handle;
6. the specific (topic-related notions) which the learner will be able to handle
7. the language forms which the learner will be able to use;
8. the degree of skill with which the learner will be able to perform.

(Van Ek, 1975: 8-9)

Van Ek's list provides a useful framework for outlining the various aspects, which should be considered when designing a syllabus. Furthermore it complements the principle of an eclectic syllabus as it encourages the syllabus designer to arrange the syllabus in a dynamic way, incorporating a number of "sub-syllabuses" within the overall syllabus. Based on Van Ek's theory, and considering the specific needs of my target learners', I have selected the following six elements as core components, or sub-syllabuses, in my medical ZSP syllabus:

A. Themes/Topics:

The overall target situation for which this ZSP syllabus is preparing learners, is clearly defined as doctor-patient consultations in the OPD. Within the general context of the medical consultation, there are a number of more specific themes and topics. For example each theme could relate to the nature of the patient's presenting complaint e.g. back pain, diabetes, TB, AIDS etc.

B. Vocabulary/Lexis:

The aspect of lexis is particularly important when dealing with a specific purpose language course as each target situation has its own specific terminology.

C. Grammatical structures:

With the advent of the "communicative" approach to language learning, grammatical syllabuses have become less popular in second language teaching world-wide. However, in order to achieve communicative competency, grammatical instruction is still necessary. As Littlewood explains:

"A communicative approach to the content of a course need not involve abandoning the use of structural criteria for selection and sequencing... mastery of the structural system is still the basic requirement for using language to communicate one's own meanings. However... a communicative approach encourages us to go beyond the structures and take account of other aspects of communication. It can therefore help us to match the content more closely with the actual communicative uses that the learner will have to make of the foreign language."

(Littlewood, 1981: 77)

If the target learners understand Zulu grammar they will be able to manipulate grammatical structures in order to generate their own utterances and interpret sentences they have never heard before. If learners only possess phrasebook skills i.e. if they have memorised phrases but have no understanding of the underlying structures, they have what Widdowson refers to as "restricted competence". This limits the learners to:

"the acquisition of a particular repertoire of formulae, which can be applied directly to the solution of a predictable range of problems: that is to say, that the learner's purpose can be met by his being provided with a restricted competence."

(Widdowson, 1983: 13)

The main disadvantage of "restricted competence", as Widdowson points out, is that one is rarely able to accurately predict all of the learner's communicative needs in the target situation. Furthermore, since learners will be involved in interactive speech with their patients, they need to be flexible and confident enough to adapt their speech according to the patient's unique responses. When learners are able to manipulate the grammatical system of a language and combine structures to create their own unique sentences they possess generative capacity. As Widdowson explains:

"The situations of language use which simply call for the automatic application of formulae and the submissive conformity to established rules are relatively rare... generally speaking, effective language use requires the creative exploitation of the meaning inherent in language rules – requires, in other words, what I have called communicative capacity."

(Widdowson, 1983: 13)

The cultivation of "communicative capacity" involves the development of something Widdowson refers to as linguistic competence, which he defines as:

"the generative mechanism of grammar which allows for the production and reception of sentences never previously attested."

(Widdowson 1983:8)

In the introduction to his Zulu second language course, Asizwane, Jeff Thomas refers to the skills underlying communicative capacity as "sentence-building skills" (Thomas, 1992). It is not enough for a doctor to memorise a list of standard history-taking questions and answers as this will not assist him in understanding each patient's individual and unique responses nor will he be able to adapt the routine questions he has memorised to suit the individual nature of each consultation. Therefore he should be familiar with how the Zulu grammatical system works so that he can to "unravel" the patient's message even if it is a sentence he is hearing for the first time and adapt his speech according to the demands of the target situation.

D. Cultural elements:

I decided to include a cultural syllabus in my eclectic syllabus design for two main reasons. Firstly, I share the view held by a number of linguists that language and culture are inseparable.

"Culture is really an integral part of the interaction between language and thought. Cultural patterns, customs, and ways of life are expressed in language: culture-specific world views are reflected in language."

(Brown, 1980:141)

Secondly, culture plays an important role in the perspective held by a large number of Zulu speakers in both rural and urban settings and their beliefs

concerning well-being and illness often differ from Western beliefs. Since many of the target learners are from a more Western background, learners are not only learning a new language but are also being exposed to new cultural beliefs. During his research into the language barrier between Xhosa-speaking patients and non Xhosa-speaking doctors in the Cape, Crawford highlights how cultural differences can further compound the linguistic differences:

"An illness constellates a whole network of meanings for the ill person – social, emotional, psychological – and there is always a gap between this lived experience of the sufferer and the medical construction of that experience. However instead of seeking to understand the dimensions of that gap and negotiate a shared understanding with the patient, biomedicine tends to focus narrowly upon the cure or control of the disease to the neglect of the meaning of it for the sufferer. This is true for a patient operating in the same language and cultural paradigm as the doctor, but it is greatly exacerbated when the doctor and patient are sealed off from each other in their respective monolingualisms."

(Crawford, 1996)

South Africa's National Education Policy Investigation (NEPI), conducted in 1992, also reiterates the importance of cultural understanding in the process of learning a language:

"Developing communicative competency in a country like South Africa would also entail learning to understand that different cultures have different taboos, different ways of expressing politeness, respect, anger. This approach equips people to be more sensitive to and tolerant of differences."

(NEPI, 1992: 72)

E. Language activities:

This refers to the kinds of language activities that learners will be engaged in e.g. oral/conversational vs. written exchanges. In this case, target learners are preparing themselves for a specific kind of communicative exchange namely, being able to conduct a face-to-face interview with patients in the Out-Patients' Department. The two primary language activities involved in the target situation are speaking and listening. The language activities performed in the classroom

should, therefore aim to develop the productive and receptive skills needed by learners to be able to communicate orally in the target situation.

I do not discuss the aspect of language activities in great detail in chapter five since I feel that this is principally a matter for methodology. However I will comment on language activities where they have affected my choices regarding syllabus design.

F. Language functions:

This aspect looks at the functions learners need to be able to express in order to successfully conduct a consultation. For example, learners should be able to ask after health, express sympathy, or instruct on the administration of medication etc.

2.4.3 Materials

Once the syllabus designer has completed his needs analysis and designed the syllabus, he needs to turn his course design into actual teaching materials. Hutchinson and Waters (1987: 106) suggest three possible ways to do this:

A. **Materials evaluation**: This is when the syllabus designer selects from existing materials. Basically, the syllabus planner matches the needs of the learners to available solutions.

B. **Materials design**: Materials design, or development, calls for the course designer to write his own materials.

C. **Materials adaptation**: This is when existing materials are modified.

According to Hutchinson and Waters (1987: 106), materials design is one of the most characteristic features of ESP in practice. Unlike with General English teaching where resources are plentiful, the ESP teacher often has to invest a large portion of his time writing materials. In their discussion of the purpose of materials, Hutchinson and Waters state that *"Materials provide models of correct and appropriate language use"* (1987: 108). In other words, the vocabulary, grammar, level of politeness, language functions etc. used in the materials (e.g.

handouts, audio tapes etc) should approximate as closely as possible the language they will be using in the target environment.

Littlewood also reminds us that relevant, realistic materials are not only effective in achieving communicative competency but also ultimately the most stimulating and motivating learning aids:

"...students learn better if they practise the foreign language through vocabulary and topics that are relevant to their interests. Such practice is not only more efficient in terms of their learning goals but also more motivating."

(Littlewood, 1981: 77)

2.4.4 Methodology

As explained in chapter one, I have chosen not to comment on methodology in great detail but I would like to emphasise the three cornerstones of my classroom methodology, which influenced my choices in selecting syllabus content:

2.4.4.1 Learning is an active process

"Language learning is an active process. It is not enough for learners to have *the necessary knowledge to make things meaningful, they must also* **use** *that knowledge."*

(Hutchinson & Waters, 1987: 128)

When a syllabus designer views language as an active rather than a purely academic activity, this is expressed in methodology. It is not enough for learners to have head knowledge of the Zulu language, nor is it enough that they are able to reproduce the grammar and vocabulary taught in class. They need to be able to apply what they know and communicate in real-life situations.

I hear and I forget.
I see and I remember.
I do and I understand.

(Chinese proverb)

The sentiment of this Chinese proverb parallels one of the principles of the functional-notional syllabus which is to engage learners in activities which simulate

'real' communication in the classroom. Nunan describes classroom activities as a *"dress rehearsal"* (1988:53) for real-life encounters. The ZSP course that I am designing relies on classroom activities such as role-play to encourage learners to become actively involved. The aim of these activities is to help learners to understand, adapt and practice what they have been taught within the context of the target environment.

2.4.4.2 Learning is an emotional experience

"Learning is an emotional experience. Our concern should be to develop the positive emotions as opposed to the negative ones..."

(Hutchinson & Waters, 1987: 129)

Part of the teacher's responsibility is to make the learning environment one in which the learners feel comfortable and confident enough to practice and experiment. Since learners participating in this ZSP are preparing themselves for oral communication, they need to be encouraged to speak without fear of humiliation or undue pressure to respond faster than they are able to. Learners must be made to feel that communication, and not perfection, is the goal. The syllabus designer should make:

"*'interest', 'fun', 'variety' primary considerations in materials and methodology, rather than just added extras."*

(Hutchinson & Waters, 1987: 129)

2.4.4.3 Pitching the course at the right "level"

"Language learning is not just a matter of linguistic knowledge. The most fundamental problem of second language learning is the mismatch between the learners' conceptual/cognitive capacities and the learners' linguistic level... This is a particular problem in ESP, where the learners' knowledge of their subject specialism may be of a very high level, while their linguistic knowledge is virtually nil."

(Hutchinson & Waters, 1987: 129)

In this case, the target learners are medical students and know a great deal about the human body, the conditions that affect it and the specific medical terminology

used to describe these things in their mother tongue. Thus they are conceptually and cognitively mature but in the target language, they are beginners. It is important to find a balance between these two elements. One cannot pitch the content of the Zulu course at the conceptual level of the learners' subject knowledge. But it is also important not to aim the course below their capabilities, which may result in their feeling like they are being taught "infantile" language. I will discuss my target learners in more detail in chapter four (section 4.3.1).

2.4.5 Evaluation

Evaluation can be grouped into two broad categories:

A. **Learner evaluation**: The purpose here is to assess what the learner has understood and mastered and to identify those areas which still need to be worked on.

B. **Course evaluation**: The aim of this activity is to see if learners' needs are being met and whether the course can be improved in any way.

While learner assessment is generally accepted as an integral part of language teaching, course evaluation activities are often neglected. I feel that assessing the effectiveness of a course, especially one with a specific purpose, is a crucial stage in course development.

Specific purpose language courses can be evaluated using various different techniques, such as looking at learners' assessment results, administering questionnaires, or by having informal discussions with learners. Rivers and Melvin (1981: 85) suggest that a questionnaire on learners' perceived needs is a good start to discovering what the needs of learners are. However Rivers, Melvin and Richterich caution that opinion polls, surveys and questionnaires also have their limitations.

"Experience shows that a person learning, or on the point of learning, a foreign language has only a very vague idea, if any, of his future needs. Techniques other than surveys of adult learners or prospective learners are therefore needed."

(Richterich, 1980: 47)

Rivers and Melvin suggest that one of the limitations of questionnaires is inherent in the actual construction of the questionnaire:

"The questionnaire construction begins with certain assumptions which determine the questions the students will address. Even a section on free response may not provide sufficient information because not all students can articulate a clear idea of what they would like the language course to provide. There are many possibilities that do not occur to them."

(Rivers & Melvin, 1981: 85)

Rivers offers a possible solution to this problem, suggesting that questionnaires should be supplemented by teacher observation and attentive listening to both learners and the community.

"Some language teachers will have to abandon the authoritarian approach of 'designing *the program to meet their students needs,' as they see them, in favour of discovering first how students perceive their own needs and then considering what contributions they can make, as teachers and course designers, to meeting these needs. We must stop thinking that we know and start finding out."*

(Rivers, 1981: 84)

In conclusion, course evaluation questionnaires are useful for determining learner's perceived needs and discovering which classroom activities are well received and which are not. However this information should be supplemented with other sources of information (such as teacher experience and classroom observations) and the course should be re-evaluated as learning needs change and as new material or research becomes available.

2.5 CONTEXTUALISING THE RESEARCH: A REVIEW OF EXISTING RESOURCES

"The excavator should be familiar with the work of his precursors and his contemporaries; he should know where to fit his new data into the total picture..."

(W.F. Albright: The Archeology of Palestine)

An important aspect of my preliminary investigations was to establish whether a medical Zulu course similar to the one I intended to design was already in existence. There is no need to "re-invent the wheel" and I wanted to be sure that the work I was about to do was not a repetition of someone else's efforts. Seliger & Shohamy refer to this practice as contextualising the research (1989: 65).

"The process of contextualisation helps the researchers to generate and select a research topic, expand their understanding, and broaden their knowledge and perspective of that topic, and at the same time arrive at a researchable and well-defined question for the research. The literature review helps them realise that the problem they are interested in is part of a larger body of knowledge. The review will also indicate whether there have already been important findings within this research area, whether there are still areas to be investigated, and whether the research that is about to be conducted is likely to add new information to that body of knowledge."

(Seliger & Shohamy 1989: 69)

In this section I discuss the findings of my contextualisation process. The resources I managed to uncover can be grouped into one of three categories: (a) medical Zulu resources, (b) general Zulu second language courses and (c) other relevant resources. I will then outline the contribution to be made by my research.

2.5.1 Medical Zulu courses:

During my literature search, I consulted three medical Zulu handbooks:

- ***Zulu for Medics: The General Physical Examination And Taking a Case-History*** **by Susan Kramer and Trevor Mdaka (1981):** This book & tape course aimed at doctors, comprises some of the vocabulary, phrases and

questions doctors use frequently in the general examination and history-taking of a patient.

- ***Talking to your Patient in English/ Afrikaans/ Zulu/ Xhosa: The General Physical Examination And Taking a Case-History*** **by Susan Kramer (1986):** This booklet and tape were originally produced in 1981 as *Zulu for Medics* (see above). It was then extended to include Xhosa and Afrikaans and re-published by Groote Schuur Hospital.

- ***Handbook to Aid in the Treatment of Zulu Patients*** **by G.D. Campbell, and H.C. Lugg, (1958):** This resource is also a medical phrasebook, which covers a diverse spectrum of ailments and history-taking questions.

Of the three resources, I feel *Handbook to Aid in the Treatment of Zulu Patients* is the most complete and comprehensive source of medical vocabulary. The terminology is phrased as simply as possible, while still using correct Zulu grammar, and is well suited to beginners. The explanatory notes on the use of certain words and symptoms were also helpful. The book is set out exactly as one would expect to take a history from and examine a patient. The different systems involved in a systemic history are alphabetically listed on a ready-reference bookmark, which allows for easy location of history-taking questions relating to each system.

However, the biggest limitation of these three resources is that they are phrasebooks and there is very little grammatical explanation. Thus, while learners may be able to memorise the phrases listed in the book, they are not given the necessary linguistic tools to be able to generate their own unique sentences.

Another major drawback is that little attention was paid to the possible responses one might get from the patient. Thus, while the learner may be able to learn the phrases off by heart, he may struggle to understand the patient's response to his inquiries. The authors of *Handbook to Aid in the Treatment of Zulu Patients* explain that the majority of the questions have been worded such that the answers are either, "yes", "no", "I don't know", a number which can be indicated with the fingers or an anatomical sight that can be indicated with the hand. While it may be necessary to limit the patient's talking as much as possible in the initial stages of learning Zulu, I feel that some provision should be made to equip learners for

understanding the more frequent types of responses they can expect from a Zulu-speaking patient.

I also consulted ***Amaqiniso Ngempilo*** (Facts for Life) and the sections on medical Zulu terminology in the ***Hlabisa Hospital handbook*** and ***Learn More Zulu*** (all of which are listed in my Bibliography). These books are similar to the phrasebooks listed above as they simply list Zulu translations of English medical phrases but with no grammatical explanation or exercises.

2.5.2 General Zulu second language courses:

Having outlined a lack of grammatical explanation as one of the primary weaknesses of the medical Zulu resources I reviewed, I also consulted two general language courses:

- ***Asizwane* by Jeff Thomas (1992)**

Asizwane (Let us understand one another) is an introductory Zulu course designed by Jeff Thomas which, up until 2000, used to be run as part of a Winter School programme for the medical students at the University of Natal Medical School. *Asizwane* was not designed to cater specifically for the medical setting. However, there are two principles which I feel can be applied to the design of a medical ZSP course.

Firstly, the emphasis *Asizwane* places on the acquisition of oral skills, especially through the use of audio cassettes, parallels one of the primary concerns of a medical Zulu course, which aims to prepare learners for verbal interaction with patients.

Secondly, I strongly support the idea of teaching learners both "phrasebook" and "sentence building" skills. Thomas describes phrasebook skills as "common everyday pleasantries, gaining the assistance of Zulu-speakers in the learning of their language, in particular vocabulary, the exchange of personal information". Learners are taught phrases, which they can learn by heart to equip them with conversational basics as well as "help" phrases which enable them to express their failure to understand and to develop their Zulu further. Examples of such phrases include "Awuphinde kancane?" (Would you repeat slowly?) and

"Awuhumushe ngesiNgisi?" (Please translate into English?) Sentence building skills, on the other hand, teach learners how to manipulate the linguistic system of the language in order to formulate their own unique sentences. Simply put, in addition to memorising a cluster of useful phrases to jumpstart their learning process, learners are also taught how to construct their own sentences and are given the necessary grammatical tools to generate their own sentences using the grammar and vocabulary they have acquired. This method is recommended by Thomas and many other authors.

- **Introductory Zulu 1ZS course run by University of Natal Durban**

Having lectured this course for a number of years I have a good understanding of what language functions and grammatical structures learners are able to cope with as well as how best to arrange and link these elements in a logical fashion. This experience assisted me in the process of selecting and ordering of grammatical items for the syllabus of my introductory medical Zulu course.

2.5.3 Other relevant resources:

- **UCT Xhosa course for medical students**

Reviewing another university's second language course for medical students gave me an idea of what content and methodology another syllabus designer felt was important. I could see aspects of the Zulu 1ZS course (run by the Zulu Department at the University of Natal, Durban) mirrored in the Xhosa course but the Xhosa course obviously included more medical vocabulary. The University of Cape Town's medical Xhosa course in 2001 comprised two booklets. A lot of the material in the first booklet (even those sections related to the medical context e.g. hospital personnel, hospital reception office) did not seem particularly useful or relevant for conducting a consultation with a patient. However the second booklet seemed better suited to preparing medical students for conducting a consultation with a Zulu-speaking patient. Booklet two (entitled *Course Book: Xhosa for MBChB 1*) began with 4 lessons on greetings, asking after health, kinship terms and body parts. Lessons 5 to 16 all focussed on different aspects of taking a patient's history and the clinical examination. The content of the lessons included grammatical explanations, dialogues and written exercises including information-gap and translation exercises.

- ***Learning Language & Culture in the Medical Consultation*** **by Dr Chris Ellis (1999)**

Dr Ellis's book is neither a Zulu second language course for doctors nor a phrasebook of all the medical terms that doctors use in their everyday dealings with patients. Rather, it sets up a framework for learning. Drawing on principles from the communicative approach the book makes practical suggestions on *how* doctors can learn language in the medical setting rather than specifying *what* should be learnt. For example, to promote correct pronunciation, Dr Ellis suggests that learners invest in a hand held tape recorder to record questions and phrases on tape. He recommends asking a nurse/interpreter/helper to give the required phrase in correct idiomatic style and not in an artificial made-up way. By doing this you can build up your own collection of frequently needed phrases.

One of the most valuable contributions made by Dr Ellis's book, is the light it sheds on culture and the perspective of many Zulu speakers on matters relating to health and illness. This topic, which has been largely ignored in other resources, is addressed in detail in this book and is illustrated with entertaining anecdotes and real-life examples.

Reading this book will not equip doctors with the necessary skills or knowledge to communicate with Zulu-speaking patients. But it will educate readers on the role played by Zulu culture and traditions in the medical consultation and arm learners with some useful and practical language learning strategies. I strongly recommend that all doctors and medical students in South Africa read this book.

2.5.4 Contribution to be made by my research

In conclusion, I feel my research will contribute to existing medical Zulu resources in the following ways:

Firstly, the content of many existing second language Zulu courses is too general and does not cater for linguistic needs of doctors (medical students) working in the medical field. Conversely, those resources focussing solely on the medical situation were phrasebooks, which lacked grammatical explanation or instruction. As indicated by the literature search and preliminary investigations I did, there is a

definite need for a ZSP syllabus, which balances grammatical instruction (sentence building skills) with vocabulary (phrasebook skills).

Secondly, there is the aspect of recency. Most of the existing medical Zulu phrasebooks or courses were designed at least 10 years ago. The content, therefore, does not incorporate some of the pressing issues of our time e.g. HIV/AIDS, safe sex and the importance of using condoms, treatment of cancer and management of cancer patients, the use of anti-retroviral drugs (e.g. Nevaropine etc. Another aspect of outdated material is that it does not make use of modern technology such as web-based learning tools. In addition to the content being outdated, the materials are often lacking in terms of graphics and aesthetics. Learners generally respond better to updated, modern materials with illustrations than to handouts with no graphics, containing repetitive lists. Every effort should be made to engage the learners' interest through the use of visually stimulating and aesthetically pleasing handouts and resources.

Thirdly, the goal of a ZSP course for medical students like this one is to prepare doctors for spoken (as opposed to written) communication. Many of the resources I consulted did not cater for group activities such as role play and oral exercises. The ZSP syllabus I have designed incorporates as many opportunities for learners to speak and listen as possible.

Finally, I believe a medical Zulu course should include a section on Zulu culture and traditional beliefs regarding health and the treatment of disease for reasons previously discussed in section 2.4.2.3. Most of the resources I consulted did not attend to cultural issues in great detail. The syllabus I have designed contains a number of cultural issues pertaining to the medical field.

2.6 SUMMARY

In this chapter, I explained the communicative approach to second language learning that I have adopted and explored in the field of English for Specific Purposes (ESP) and its relevance to the syllabus I wanted to design. I discussed the two areas of course design that I was going to focus on, namely needs analysis and syllabus design.

In my discussion of needs analysis, I analysed Munby's needs analysis model (1978) and the approach to needs analysis as set forth by Hutchinson and Waters (1987). I explained that Munby's system gives careful consideration to the dynamics of the target situation but does not pay enough attention to the learning needs of the learner. I therefore, based my approach to needs analysis on Hutchinson and Water's framework, which recognises the need to investigate learning needs as well as target situation needs.

In addressing the aspect of syllabus design, I identified some of the main syllabus types used in second language learning e.g. grammatical, functional-notional, task-based, eclectic etc. I justified my choice of an eclectic syllabus and outlined the six sub-syllabuses which would be included in the ZSP syllabus I designed:

- Theme/topic
- Language functions
- Vocabulary
- Grammar
- Culture
- Language Activities

I explained that while materials design, methodology and evaluation are important considerations in specific purpose language teaching, I would only refer to these issues where they impacted on my decisions regarding the design of the ZSP syllabus.

After outlining the theoretical framework upon which my syllabus is built, I discussed the various Zulu second language courses and resources which doctors have used to learn Zulu in the past. I identified the strengths and weaknesses of these resources and justified why my research will contribute to the existing body of knowledge in this field.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The ultimate goal of this thesis as outlined in chapter one is to design the syllabus for an introductory medical Zulu course aimed at teaching non Zulu-speaking medical students how to communicate with their future Zulu-speaking patients. Before I could begin designing the syllabus, however, I needed to conduct a needs analysis to ensure that I had the data necessary to make informed choices about what to include in the syllabus. As explained in chapter two (section 2.4.1.3) the two primary concerns of the needs analysis I conducted are:

- Target situation analysis: The focus of the major portion of my research activities focussed on establishing the exact nature and demands of the target situation. This investigation of the various facets of an OPD consultation enabled me to identify which linguistic and cultural items should be included in the proposed ZSP syllabus.

- Learning situation analysis: Other research activities gave me valuable insight into the dynamics of the learning situation of the target learners which also influenced my decisions on what to include in the syllabus as well as how best to make this syllabus content accessible to learners.

In this chapter I explain the framework for my second language research design using Seliger and Shohamy's (1989) four parameters namely (a) approach, (b) objective, (c) degree of focus / control of context, (d) data and data collection (1989: 24). The first two parameters concern themselves with the general approach to the research problem and the purpose for which the investigation is conducted. The remaining two parameters deal with how the research plan is actually put into operation in terms of how data is to be gathered and analysed.

3.2 PARAMETER 1: RESEARCH APPROACH

There are different approaches to researching the complex subject of second language phenomena. Seliger and Shohamy (1989: 27) suggest that second language research can be approached from either a synthetic/holistic or an

analytic/constituent perspective. A "synthetic" approach views all the separate aspects as interdependent parts of a coherent whole. An "analytic" perspective isolates a single factor (or cluster of factors). The figure below represents the relationship between these two divergent views:

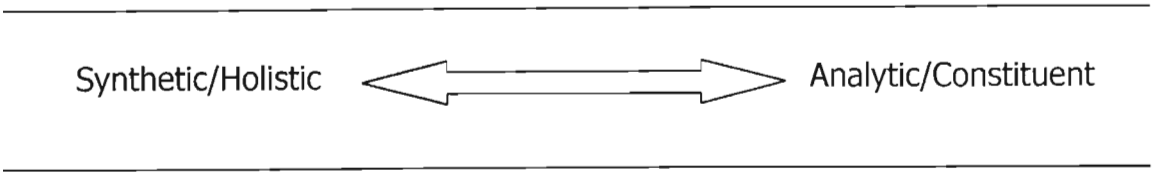


Figure 2.2 Parameter 1: Approaches to the study of second language phenomena (Seliger & Shohamy, 1989: 27)

Seliger and Shohamy suggest that

*"the **synthetic/holistic view** of a language phenomenon may be more valid in some instances because analysing a second language variable into its component parts may result in a distortion of the phenomenon."*

(Seliger and Shohamy, 1989: 28)

I felt this to be true of the situation that I intended to investigate. I did not want to limit the scope of my research by only looking at one aspect of the target situation. For example, I did not set out to investigate the communicative competence needed by a doctor to be able to conduct a consultation with a patient suffering from diabetes. I set out to capture as much information as possible about the wide spectrum of doctor-patient exchanges in the Out-Patients' Department (OPD) in order to generate a more complete picture of the communicative needs which should be catered for by the ZSP course I wanted to design. Therefore, I approached my research from a **synthetic** perspective.

3.3 PARAMETER 2: RESEARCH OBJECTIVES

Before commencing his research activities, the investigator should have a clear idea of the overall purpose of his research. Seliger and Shohamy explain that one can set out with either a heuristic or deductive objective in mind.

Research with a deductive objective sets out to test an existing assumption, expectation or hypothesis (which may have been generated by heuristic research). This kind of hypothesis-driven investigation makes predictions and tests hypotheses, the end product being theory.

The investigator conducting heuristic research might start out with a general idea of where his research may lead but there are often no complete theories or hypotheses to guide him. He gathers information about second language phenomena in order to describe it or discover possible patterns or relationships among the various factors. Heuristic research

"enables us to discover patterns, behaviours, explanations, and to form questions or actual hypotheses for further research"

(Seliger & Shohamy, 1989: 30)

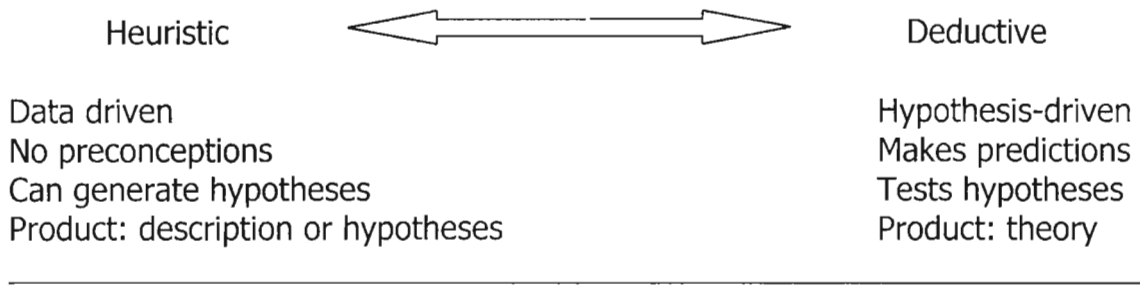


Figure 2.3 Parameter 2: Characteristics of heuristic and deductive research (Seliger & Shohamy, 1989: 31)

The objective of my research was to find out as much as possible about doctor-patient communication in the OPD and to record, categorise and analyse the content of these communicative exchanges. The purpose of my research was not to prove or disprove any existing theory or hypothesis but to formulate my own descriptions and conclusions. I would, therefore, categorise my research as having a **heuristic** objective.

3.4 PARAMETER 3: DEGREE OF FOCUS AND MANIPULATION OF CONTEXT

Research designs exert varying degrees of control on the research context. On one end of the spectrum, there are those designs that exercise very little restriction

on the data collected or behaviours observed and on the other, there are research plans with a high degree of manipulation. There are also a number of different positions in between these two extremes.

A research design with a synthetic approach and a heuristic objective like my own implies a fairly low degree of control and manipulation of the variable of the research situation. I set two basic restrictions on the data I collected:

- Firstly, I was only interested in investigating the communication between doctor and patient since the proposed ZSP course is aimed specifically to prepare medical students training to become doctors how to communicate with their future patients. In other words, this course is not designed to cater for the needs of nurses, homeopaths, dieticians, physiotherapists or other health professionals although the material covered will be helpful in all of these fields.

- Secondly, I elected to focus on the general consultation setting in the Out Patients' Department (OPD). I did not investigate the communicative exchanges that exist between doctor and patient in other medical settings e.g. AIDS counselling centre, paediatrics unit, physiotherapy practice etc.

In other words my research design placed very **few restrictions** on the scope of the data to be collected.

3.5 PARAMETER 4: DATA AND DATA COLLECTION

The four parameters of approach, purpose, degree of control of variables and data collection are all interrelated, with data collection being perhaps the most concrete manifestation of the decisions made regarding the other three parameters. When looking at the fourth parameter, there are two important questions that need to be addressed: firstly, "What constitutes data?" and secondly "How are data to be collected?"

In answer to the first question, "What is data?" I consider data to be all information relevant to the target situation and learning situation as defined in chapter two (section 2.4.1.4). My primary data constituted the information recorded during the doctor-patient consultations I observed in the OPD e.g. nature of presenting complaints, questions asked by the doctor to ascertain the patient's symptoms, instructions given to patients etc. When we use language as a means of

communication we usually pay more attention to the *content* of the words than the actual *form* of the language itself. My research required that I record not only the content of the communication but also the *manner* in which this information was conveyed, by noting things such as the level of politeness used, cultural references, appropriate metaphorical or euphemistic terminology for delicate subjects etc.

Secondly, how did I gather this information? Nunan defines needs analysis as *"techniques and procedures for collecting information to be used in syllabus design"* (1988:13). There are a number of different techniques used in second language research and ESP course design. A researcher's choice will depend on the resources and time available but, in view of the complexity of needs that have been outlined, the use of more than one method is desirable. In an attempt to gain a balanced and objective picture of both target situation needs and learning needs, I involved myself in a number of research activities. The information-gathering processes used in my needs analysis included:

- Interviews with doctors
- Observations of doctor-patient consultations
- Informal consultations with syllabus designers, lecturers and learners
- Attending workshops on Zulu culture and the medical context
- Collecting medical texts relevant to the field of study
- Course evaluation questionnaires, classroom observations & informal feedback from learners

3.5.1 Interviews with doctors

During the period of May 2000 – February 2002, I conducted informal interviews with six doctors (one of whom was a community service doctor) and one dietician (Appendix D). All of these doctors have experience consulting Zulu-speaking patients in the Out Patients' Department and most of them either are, or were, based at hospitals where the majority of patients can only speak Zulu.

I started interviewing doctors before I began my hospital observations and continued throughout the remainder of my research. This qualitative data collection technique consisted of an informal interview where I would initiate discussion by asking open-ended questions such as the following:

- How did you learn to communicate in Zulu?
- What do you find most challenging about communicating with Zulu-speaking patients?... (Vocabulary problems? Lack of cultural understanding?)
- What are the most common presenting complaints in the OPD?
- What topics do you find most difficult to discuss in Zulu?... (Sexual matters? Infertility? Cancer? Depression?)

The information rendered by these interviews gave me an indication of what to expect once I began observing consultation in the hospitals. The doctors I interviewed also explained which communication areas they perceived to be the most problematic in the OPD. I was also able to ascertain what techniques these doctors had found useful in learning to speak Zulu in the medical context.

3.5.2 Observations of doctor-patient consultations

My primary field research involved observing doctor-patient consultations in the Out-Patients' Department. In order to observe consultations, I had to get permission from the Medical Superintendent of each hospital. I also needed permission from each patient. At the start of the consultation, the doctor I was observing explained to the patient that I was conducting research, which required me to observe consultations and gave them the option to refuse my presence in the consultation room. Most doctors and patients were very co-operative in this regard. The aim of each observation was to catalogue:

- Greetings and form of address (based on gender and age)
- Chief symptoms and presenting complaints
- Questions asked by the doctor to take the patient's history
- Instructions or explanations given to the patient by the doctor
- Patient's responses
- Common euphemisms, metaphors or cultural aspects related to medicine
- The linguistic items (language functions, grammar and vocabulary) used by both doctor and patient

To do this, I either tape-recorded the conversation or jotted down notes recording the specifics of the consultation. Appendix B is a summary table of the

consultations I observed. Transcripts of 12 of these consultations may be found in Appendix C.

I would just like to comment briefly on the subjectivity of translation as evidenced by my research. I enlisted the services of a mother tongue Zulu speaker who is also a teacher to transcribe and translate the recordings of these 12 consultations. Upon examining the English translations rendered for the original Zulu dialogue, I noticed that some of the translations were not literal and that a certain amount of interpretation had been done by the translator based on his understanding of the dynamics of the consultation (see example below). This supports the claim made by a number of doctors that when nurses act as interpreters they experience a similar phenomenon because the nurses sometimes summarise or add their own interpretation to the words expressed by the patient.

	EXTRACT FROM CONSULTATION 7 (APPENDIX C)	**TRANSLATION RENDERED BY MOTHER TONGUE ZULU SPEAKER**	**LITERAL TRANSLATION**
Patient:	Mmm, manje kodwa le BP le iyehla kodwa kusenendawo ebuhlungu ngathi kukhona indawo edabukile dokotela. Iphela nje ngesifuba. Isifuba sona anginaso, angikhwehleli. Manje angazi noma nginezikelemu, ngizwa sekukhala lapha.	Yes but this BP drops and there is still pain as if there is a swelling doctor. It ends in the chest. I don't have chest problems (TB) and I'm not coughing. I don't whether its worms because of the sound (crying) I can hear in my stomach.	Yes, now but this BP is dropping but there is still a sore area, that is, there is still a place that is torn, doctor. It ends in the chest. I don't have chest problems, I'm not coughing. Now I don't know if I have worms, I can hear there is now crying here.

Another aspect which I needed to consider during my research was ensuring that I obtained a representative sample of OPD consultations. If I had, for example, only recorded consultations with TB patients, this would not have been reflective of the broad spectrum of consultation types encountered by doctors in the OPD. As Seliger and Shohamy explain:

"In order for research to be generalisable, that is, applicable outside the immediate research environment, it must be possible to assume that the population used in the research is representative of the general population to which the research would apply."

(Seliger & Shohamy 1989: 96)

In an attempt to obtain generalisable results, I observed as many consultations as I could in the allocated time frame. Furthermore, the consultations that I observed

were conducted by different doctors in different hospitals. I sat in on a total of 80 consultations at 5 different hospitals. Four of these hospitals are located in the rural areas of northern Zululand, namely Bethesda Hospital, Mosvold Hospital, Manguzi Hospital and Mseleni Hospital. The fifth hospital, McCords, is situated in Overport, Durban and is the only urban hospital at which I observed. (See Appendix A for a map displaying the location of these hospitals in KwaZulu Natal). 11 of the 80 consultations I observed took place in the Maternity or Paediatrics ward and the remaining 69 consultations occurred in the Out-Patients Department.

3.5.3 Informal consultations with other syllabus designers

I interviewed 2 second language Zulu course designers, Beverley Muller (senior lecturer in the Zulu Department at UND) and Patrick Frickel (freelance lecturer at McCords Hospital and skills trainer at Added Advantage Academy). My discussions with them focussed largely on the process of selecting course content and appropriate teaching methodology.

I also had informal meetings with Professor Michelle McLean and Veena Singaram, staff members at the Medical School, who were responsible for co-ordinating the various modules of the 2001 syllabus for first year medical students. They provided me with information relating to the resources available to learners at the Medical School (e.g. WebCT, which I discuss in chapter four) as well as guidelines on the Medical School's expectations of an introductory medical Zulu course.

3.5.4 Workshops on cross-cultural communication in the medical consultation

I attended 3 workshops presented by Dr Chris Ellis, author of *Learning Language and Culture in the Medical Consultation* (1999), on the theme of cross-cultural communication in the medical consultation. The first workshop, held at Mseleni Hospital on 26 August 2000, introduced participants to a Zulu perspective on health and well-being. On 13 October 2000 I attended a second workshop by Dr Ellis at Valley Trust in Botha's Hill, focussing on the taboo subjects of "Death and Sex". On 28 February 2001, at his third workshop at the University of Natal Medical School, Dr Ellis addressed a group of 6th year medical students on the topics of hermeneutics and culture bound syndromes.

3.5.5 Data collection: gathering texts

During my research I gathered as many texts as I could on cross-cultural communication in the medical consultation. Zulu texts were of particular relevance but I also collected medical documents in English (e.g. the Medical School's official history taking protocol in Appendix H) and Xhosa (like the two medical Xhosa course manuals from the University of Cape Town which I reviewed in chapter two, section 2.5.3).

3.5.6 Course evaluation questionnaires, classroom observations and feedback from learners

As explained in chapter one, I presented an introductory medical Zulu course to the first year students at the University of Natal Medical School from January-October 2001. The material covered in this course was based on my observations of consultations in the OPD, syllabus guidelines provided by the Medical School and course notes from the part-time course run by the Zulu Department at the University.

It is important for special purpose courses like this one to have built-in feedback structures, e.g. post-course evaluation questionnaires, to allow for course modification and enrichment as learner needs become more clearly defined or as learner needs change over time. As Hutchinson and Waters explain:

"Course design is a dynamic process. It does not move in a linear fashion from initial analyses to completed course. Needs and resources vary with time. The course design, therefore, needs to have built-in feedback channels to enable the course to respond to developments."

(Hutchinson & Waters, 1987: 74)

Therefore, after the completion of the course at the Medical School, I asked learners to fill out a course evaluation questionnaire (Appendix F) to get some feedback on the experimental syllabus I had designed (Appendix G). In addition to input from the questionnaires, I observed learners in the classroom situation to discover what learners responded to favourably and what they battled with. I noted

which sections aroused their interest, which exercises they got bored with quickly, which grammatical elements they battled to grasp etc.

3.6 ANALYSIS OF RESULTS OBTAINED

As explained in this chapter, I chose to approach my research from a synthetic-heuristic perspective and placed very few restrictions on the information gathered during my research activities. This implies that in order for the results obtained (reported in chapter four) to have any kind of significant impact they will need to be analysed and interpreted.

"Typical of all qualitative analyses is that at different stages of the analysis the researchers identify, delimit, and sort the relevant segments of the text according to an organising scheme. They look for commonalities, regularities or patterns across the various data texts..."

(Seliger & Shohamy, 1989: 205)

Seliger and Shohamy (1989:205) identify two main types of techniques in analysing qualitative data. They suggest that, in certain instances, categories emerge from the data themselves without a specific analysis being imposed on the data. At other times, researchers approach the data with predetermined categories (usually obtained from other sources) in mind and apply this system to the data.

The analysis procedure I employed most closely resembles the latter technique. I had already selected the six mini-syllabuses to be considered in my eclectic syllabus design as outlined in chapter two (section 2.4.2.3). I then grouped the information I had collected into these categories in order to determine which language items seemed most useful and occurred most frequently. The criteria I employed in selecting and arranging syllabus content is discussed more fully in chapter five.

CHAPTER 4
RESEARCH RESULTS

4.1 INTRODUCTION

As explained in chapter two (section 2.4.1.4), I identified two main areas of investigation relating to the design of a specific purpose language course:

- Target situation (doctor-patient consultations in the Out-Patients' Department)
- Learning situation (the environment where learners are taught the necessary skills and knowledge to be able to communicate in the target situation).

In this chapter I will report the findings of my research into the target situation and the learning environment, using Hutchinson and Water's approach to needs analysis (1987). In other words, I will discuss the dynamics of each area of investigation in light of Kipling's "honest serving-men": *What*, *Why*, *When*, *How*, *Where* and *Who* (as discussed in chapter two, section 2.4.1.4). While all aspects related to the target and learning situations are considered to be important, the primary focus of my research activities and the major part of chapter four is dedicated to answering the question, 'What do learners need to be able to express in the target situation?'

4.2 FINDINGS RELATED TO THE TARGET SITUATION

4.2.1 Why is the language needed by the learner?

Many doctors in KwaZulu Natal are unable to speak Zulu and have to rely on Zulu-speaking nurses to act as ad-hoc interpreters. As explained in chapter one, there a number of deficiencies associated with the practice of using nurses as interpreters and it is now generally accepted that doctors should assume some of the responsibility in learning how to communicate with patients in the patient's mother tongue.

4.2.2 With whom will the learner be communicating?

The envisaged ZSP course is aimed at preparing learners to converse with Zulu-speaking patients, ranging in age and gender. Of the 80 consultations I observed,

63 patients were female (including mothers with young children who spoke on behalf of their children) and the remaining 17 were male. Patients ranged in age from small children to very elderly.

All 69 of the patients I observed at the rural hospitals, namely Bethesda, Mseleni, Mosvold and Manguzi were Zulu speakers. Of the 11 patients I observed at McCords (the only urban hospital I attended), 5 were conducted in English and 6 in Zulu. Dr Todd-Ngubane, who works at McCords Hospitals, estimated that approximately 50% of her patients are African (mostly Zulu speakers), 45% are Indian and White (English speakers) and the remaining 5% comprised speakers of other minority languages (e.g. Portuguese) who were generally able to communicate in English. According to Dr Todd-Ngubane, a number of the patients whose mother tongue is Zulu are able to communicate in English.

4.2.3 Where will the language be used?

The physical setting is the hospital Out-Patients Department (henceforth referred to as OPD). As indicated above, it is advantageous for doctors at urban hospitals, like McCords, to be able to communicate in Zulu. However the most pressing linguistic need is for doctors based at rural hospitals such as those located in Northern Zululand (e.g. Bethesda, Mseleni, Mosvold and Manguzi).

Since Zulu is closely related to some of the other African languages, like Xhosa and Swati, the Zulu learnt by medical students will assist them in communicating in hospitals in the Cape, Gauteng and Swaziland.

4.2.4 How will the language be used?

One of the most distinguishing features of the communication between doctor and patient in the OPD is that it is almost entirely spoken. The channel of communication is face-to-face discussion therefore non-verbal cues such as facial expression and gesture also form part of communication. Doctors do not need to be able to communicate about their patients' illnesses on an academic or highly technical level since most patients would not understand specialised descriptions of their conditions on a conceptual level never mind a linguistic one. The level of language used in consultations is, therefore, conversational and accessible to a layperson.

4.2.5 When will the language be used?

Learners (medical students) will start using Zulu concurrently with their Zulu studies because they begin their hospital visits where they encounter Zulu-speaking patients from their fist year of study. Their ability to communicate in Zulu will become increasingly more important during their community service year and of course, after that, when they are practising medicine in hospitals that admit Zulu-speaking patients (as well as Xhosa- and Swati-speaking patients, for the reason explained in section 4.2.3 above).

4.2.6 What do learners need to be able to express?

4.2.6.1 Language functions observed in the OPD consultation

After observing 80 consultations in 5 different hospitals, I identified certain trends. Based on my observations, this is the pattern of a typical OPD consultation.

- Greeting and introducing
- Asking after health
- Taking a patient's history / inquiring into the specific nature of the problem e.g. regarding intensity, duration, other symptoms etc. (Questioning)
- Conducting a physical examination if necessary (Instructing)
- Explaining
- Reassuring (when necessary)
- Suggesting further action (Instructing)
- Saying goodbye / closing the conversation

Upon closer examination we see that these activities correlate to the language functions which doctors need to be able to express when communicating with patients in the OPD.

My observations of the general pattern of a consultation were confirmed by the History Taking protocol given to me by the University of Natal Medical School (Appendix H), which identified the three basic phases of a clinical examination as: (1) history taking, (2) examination: physical & mental, and (3) explanation. With the

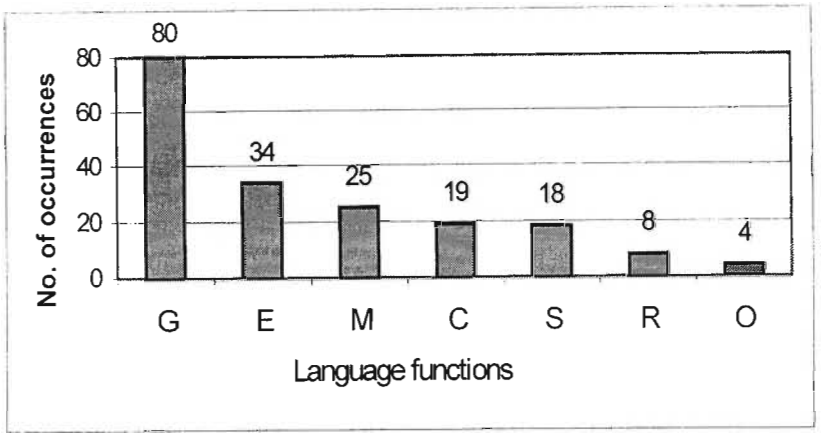
exception of greeting and saying goodbye, the language functions identified and listed above can be categorised according to these 3 phases.

Phase	Title	Purpose	Language functions
1	History taking	Information gathering	➢ Introducing ➢ Asking after health ➢ Questioning
2	Examination: physical & mental	Objective findings	➢ Instructing ➢ Reassuring
3	Explanation	Information giving, decision making	➢ Explaining ➢ Reassuring ➢ Suggesting further action

Of the 80 consultations I witnessed:

- 34 of them involved some kind of physical examination, ranging from an examination of a patient's mouth to a vaginal examination.
- In 25 consultations, doctors prescribed medication or explained some course of treatment that the patient had to follow.
- 19 consultations were check-ups where the doctor either explained the patient's test results or checked to see that their vital signs (e.g. blood pressure) were in order.
- 18 patients had to be referred to other departments (for X-rays, urine or blood tests, malaria tests etc) or sent to other hospitals for surgery.
- Doctors instructed 8 patients to return either to hear the results of tests performed or for the doctor to assess whether the prescribed treatment is working.
- There were also 4 instances where doctors had to explain to the patient that he needed to have an operation and when and what this would entail.

Figure 1 below is a graphic representation of the number of times I observed each of the outlined language functions during consultations.



KEY:

G =	Greeting/ introducing
E =	Physical examination
M =	Prescribe medication
C =	Check-up, explain test results
S =	Send to another dept e.g. for X-rays
R =	Instruct patient to return to hospital
O =	Explain patient's need for operation

Figure 1: No of times each language function occurred during the consultations I observed in 2000-2001 (Based on data in Appendix B

I would now like to illustrate the use of some of these language functions by quoting excerpts from some of the consultations observed (full transcripts of 12 of these consultations can be found in Appendix C).

A) Greeting & Introducing

Crawford's paper, which he presented at the *Communication for Health Professions in a Multilingual Society Conference* (1996), points out that *"the language problem is inextricably bound up with the problem of unequal power"* in the hospital setting. For many African patients, particularly those who live in rural areas, the world of Western medicine is unfamiliar territory, described by Dr Ellis as "terra incognita or more aptly *terror* incognita" (Appendix K). Doctors are generally the most "powerful" (or knowledgeable) role players in any medical consultation, and this is even more true when the patient comes from a rural and possibly uneducated background. When the doctor is unable to communicate in the patient's mother tongue, this compounds the problem of unequal power relations even further and often results in the patient feeling helpless, frustrated or inadequate at not being able to express himself in the language of the educated doctor.

All 80 consultations observed commenced with some kind of greeting which was sometimes followed by an introduction if the patient was new. Greeting a patient appropriately can help the doctor to gain their trust and put them at ease right from

the start of the consultation. It also shows the patient that the doctor is making an effort to meet the patient in his own world.

Here are some of the greetings observed in the OPD:

Appendix C: Consultation 2

Doctor:	(Addressing child) Xhawula, letha isandla, letha nalesi. Unjani?	Let's shake hands, bring that other hand. How are you?
Patient:	**(Mother replies) Yithi "Ngiyaphila"**	**Say "I am fine"**
Doctor:	Ubani igama lakho?	What is your name?

In this consultation the patient is a young child accompanied by his mother. The doctor talks directly to the child instead of speaking only to the mother in an attempt to calm the child who is obviously intimidated by the hospital environment. The doctor says to the child *Xhawula* which is an invitation to shake hands. The custom of shaking hands is very prominent in the Zulu culture. In Western culture, adults may shake hands when greeting but children are not usually expected or encouraged to do so. Here we see a doctor shaking hands with a toddler. In this situation it was a way for the doctor to establish friendly, non-threatening contact with the child who was visibly anxious in these unfamiliar surroundings. The doctor also inquires after the child's name, asking *Ubani igama lakho?*

Doctors often greet patients with the well-known phrase *Sawubona* or *Sanibona*, if more than one person enters the room. The monosyllabic phrase *Ya* (roughly translated as "yes") can also serve as an acceptable greeting:

Appendix C: Consultation 12

Doctor:	Sawubona sisi.	Hello, sister.

Appendix C: Consultation 2

Doctor:	Ya Thokozani.	Hello, Thokozani.

B) Asking after health

The consultation usually begins with some form of the question, "How are you?" Often when a doctor asks a patient how he is, the response is "I am fine" when quite obviously he is not fine otherwise he would not be seeking medical treatment

in a hospital! The example below shows how a doctor responds humorously to this answer.

Appendix C: Consultation 1

Doctor:	Unjani?	How are you?
Patient:	**Ngiyaphila.**	**I am fine.**
Doctor:	Ngiyajabula uma uphila, kusho ukuthi uzongivakashela nje!	I am happy that you are well, because that means you have just come to visit me!

There are a number of alternatives to the commonly used question, *Uphethwe yini?* (What is wrong with you?). Below are some examples:

Appendix C: Consultation 7

Doctor:	Uthini namhlanje?	What are you saying today?

Appendix C: Consultation 9

Doctor:	Yini inkinga? Kwenzenjani manje?	What's the problem? What's happening now?

C) Questioning: Taking a patient's history

During the history taking phase the doctor tries to gather as much information as possible about the patient's presenting complaint and related issues.

The University of Natal Medical School's history taking protocol (Appendix 3.1) identifies two main types of inquiry – open and closed. Examples of open-ended questions are *Ngitshele ngenkinga yakho* (Tell me about your problem) and *Emva kwalokho?* (What happened next?) Closed inquiries include *Kuqale nini?* (When did it start?) and *Kukhona omunye emndenini onesifo esifanayo?* (Does anyone else in your family have a similar problem?) Phrasing inquiries as open questions often extracts more information and should be considered the ideal starting point. Dr Ellis suggests using open-ended questions and listening to the patient's whole story before intervening with more specific questioning:

"Very few people are able to tell the doctor how they feel in a precise and well-sequenced manner. Most of us begin at random and introduce symptoms and events as they come to mind. There is a great deal to be said therefore for listening to the whole story and then recapitulating with specific questions.

Rephrasing questions or approaching the subject from a different angle can sometimes yield almost opposite responses. Perhaps one of the most common examples (and this is in all medical practices) is asking the patient whether they have ever had an operation and receiving the answer, no. Then, asking if they have ever been in hospital before and receiving the answer that they have only been in hospital to have their tonsils and appendix out."

(Ellis, 1999: 41)

Dr Ellis also points out that closed questions can sometimes pre-empt the wrong answer. When a patient volunteers specific information related to his symptom which has not been prompted by the phrasing of the question, this is usually the most accurate kind of information.

*"The **diagnostic power** of a question usually increases when affirmative answers are received from indirect questions rather than direct questions. If you ask the question, 'Does your urine burn?' and receive an answer of 'yes', it may be due to an automatic response... or from a mistranslation such as 'burn' for 'hot'. If you were to ask 'Any other problems?' or "Any problems with the waterworks?' and receive the answer "Yes, my urine burns', then it probably does."*

(Ellis, 1999: 42)

However, asking open-ended questions is not always the most suitable option as the doctor's level of understanding might not be sufficient to cope with the kinds of responses that open-ended questions elicit. In the initial stages of learning it may be best for the doctor to stick to more closed questions until he has developed his vocabulary and communicative competence to a level where he is able to understand the responses generated by his open inquiries.

During my observations I noted that once the presenting complaint had been established and the patient had given an account of his illness, the doctor usually followed up with close-ended questions to ascertain the specific details of the patients' past personal & family medical history. There are certain questions which occurred repeatedly and which can be easily learnt.

My observations, which were confirmed by the history taking protocol from the University of Natal Medical School (Appendix H), revealed that a general line of questioning usually included one or more of the following elements:

- Introduction & patient's background details (age, marital status, previous or present occupation, number of dependents etc.)
- Presenting complaint
- Past medical history
- Drug history
- Social/ family history
- Systemic or general symptom inquiry
- Further information from a third party (where necessary)

Below are extracts from 4 consultations where the doctor is taking the patient's history:

Appendix C: Consultation 7

Doctor:	Kuqale nini?	When did it start?
Patient:	**Kuqale kulo nyaka ophelile.**	**It started last year.**
Doctor:	Ulala kahle ebusuku?	Do you sleep well at night?
Patient:	**Ebusuku ngike ngiqwashe, ngingalali.**	**Sometimes I don't sleep well, I wake up.**
Doctor:	Ungalali, mmm, Udla kahle futhi?	You don't sleep, hmm? Do you eat well?
Patient:	**Ngiyadla nje lokho engikudlayo, angidli kahle...**	**I just eat although not well...**

Appendix C: Consultation 9

Doctor:	Kuqale nini?	When did it start?
Patient:	**Kuqale kulezi zinsuku nje.**	**It started recently (these days).**
Doctor:	Ulala kahle ebusuku?	Do you sleep well at night?
Patient:	**Ngilala kahle ebusuku.**	**Yes, I sleep well.**
Doctor:	Udla kahle futhi? Uyakhwehlela?	Do you also have a good appetite? Are you coughing?
Patient:	**Ngiyakhwehlela.**	**Yes, I do cough.**
Doctor:	Siyaphuma isikhwehlela?	Are you coughing up sputum?
Patient:	**Siyaphuma.**	**Yes.**
Doctor:	Uyazi iminyaka yakho?	Do you know your age?
Patient:	**Angiyazi.**	**No I don't.**

Appendix C: Consultation 8

Patient:	**Ngineminyaka engu-43.**	**I am 43 years old.**
Doctor:	Unazo izingane?	Do you have children?
Patient:	**Nginazo.**	**Yes I do.**
Doctor:	Zingaki?	How many?

Appendix C: Consultation 1

Doctor:	...Amanzi uyawomela nje kakhulu?	...Do you thirst for water?
Patient:	**Ya ngiyawomela impela amanzi.**	**Yes I feel thirsty for water a lot.**

Doctor:	Uyawomela, umzimba uyakhathala nje kancane uzwe ukhathele?	You are thirsty for it. Does your body also feel tired sometimes?
Patient:	**Ngiyakhathala kodwa umsebenzi engiwenzayo awukho owamandla kakhulu. Ngoba nokujuluka ngiyajuluka futhi uma ngilele ngoba futhi ebusuku ngiyajuluka.**	**I feel tired but the work I do is not tiring. I also sweat when I am sleeping at night.**
Doctor:	Awukhwehleli kodwa?	Are you not coughing?
Patient:	**Hayi angikhwehleli.**	**No I am not coughing.**

D) Instructing: Conducting a physical examination

I observed that phase 2 of the medical consultation, the physical examination, requires that the doctor be able to instruct the patient to perform certain actions e.g. remove his clothes and lie on the bed, turn onto his side, open his mouth, breathe deeply, look upwards etc.

Appendix C: Consultation 9

Doctor:	Khumula izingubo zonke lala embhedeni ngifuna ukuhlola umzimba. Uyezwa?	Take off all your clothes and lie on the bed. I want to examine you. Do you understand?

Appendix C: Consultation 12

Doctor:	Awuhlale la ...Hlala nje khona lapho.	Sit down here ... Just sit down there.

Appendix C: Consultation 10

Doctor:	Okay awuthi ke sibone kancane, ya mgone kanje, mncelise khona engezukhala...	Okay let me check, yes, hold him like this, breastfeed him so that he does not cry...

E) Reassuring

In some consultations the doctor needs to reassure an anxious patient that he will not hurt them while examining them or reassure them about their condition. The mention of an injection is often cause for alarm in a patient and it is one of those situations where it is helpful for the doctor to be able to reassure the patient that he will not hurt them and that they must remain calm etc.

In the extract below, the doctor asks the mother to hold her child & distract him by breast feeding him while he examines him. He uses friendly, reassuring language and shakes hands with the child to calm him:

Appendix C: Consultation 10

Doctor:	Okay awuthi ke sibone kancane, ya mgone kanje, mncelise khona engezukhala. Ya mnganami ya, xhawula. Okay kulungile...	Okay let me check, yes, hold him like this, breastfeed him so that he does not cry. Hello, my friend, shake hands. Okay, it's all right...

F) Explaining

The doctor needs to be able to explain things like the patient's condition, his diagnosis, or what he is going to do to the patient while examining him. In the extract below, the doctor explains to the patient what diabetes is.

Appendix C: Consultation 1

Doctor:	Isifo sikashukela siyakwenza lokhu uzizwe umzimba uphansi, womele kakhulu amanzi. Okunye okwenzakaya ukuthi amasosha lana avikela umzimba wakho athanda ukuphazamiseka uma kuwukuthi unesifo sikashukela, Kulula ukuthi izifo njena okungamagciwane kukuhluphe ...	Diabetes causes the body to feel tired and rundown and to thirst for water. Another thing that happens is that the soldiers in your body are disturbed when you are diabetic. You then become vulnerable to disease and may get an infection ...

G) Suggesting further action

This is linked to the process of explaining, with an emphasis on suggesting what future action(s) the patient should take to improve his ailment/ treat his illness. Examples of specific language functions which I observed in this phase included prescribing medication, sending the patient for tests (e.g. X-rays, bloods, urine or stool samples), describing the dietary needs of a child to its mother or instructing a patient to return to the hospital on a certain date. It is at this point that the doctor may need to address any concerns or questions the patient had about his diagnosis and / or recommend a course of treatment.

In the extract below we see a doctor recommending exercise and a revised dietary plan as appropriate methods of treating his diabetes. He ends by giving the patient an opportunity to ask any questions.

Appendix C: Consultation 1

Doctor:	...Okunye ke futhi siye sithande unyakazise umzimba.-umzimba uthi ukwehla kancane. Kuyasiza nalokho	... The other thing that you must do is to exercise to lose some weight. That actually helps and you may not have to

	kwenza ukuthi ungaze udinge amaphilisi amaningi. Kungaze kube ngcono kuyasebenza kakhulu ukwedlula amaphilisi. Okay lezozinto-indlela odla ngayo nokunyakazisa umzimba. ...Kukhona okunye othanda ukukubuza	take as many pills, it will get better, it helps a lot more than tablets. Just those two things the way you eat and exercise ... Do you have any other questions?

In the next consultation the doctor prescribes some painkillers for the patient and explains exactly how to take them.

Appendix C: Consultation 3

Doctor:	... Amaphilisi azokusiza lawa ezinhlungu. Kunamaphilisi amanje engifuna uwafake egilasini, bazokusiza lapha ewindini la kuthathwa khona amaphilisi, uwafake egilasini uthele amanzi abe uhafu nje bese uyahahaza ngawo. Emva kwalokho ungawachithi uwagwinye.	... These painkillers will help you. I will give you some pills that you must put in half a glass of water and take them now. You can get them from the dispensary window. Just dissolve them in the water and drink it all, don't spill the water swallow it. I am sure this will help you with your throat and ease the pain.

H) Saying goodbye / closing the conversation

The most common way of saying goodbye to someone who is leaving *is Hamba kahle*. If there is more than one person, one would use the plural form *Hambani kahle*. This may also be expressed in the subjunctive, *Uhambe kahle* or *Manihambe kahle*. If the doctor is going to see the patient again he may end the conversation with *Ngizokubona* or *Sobonana (ngesonto elizayo)* (See you again [next week]).

4.2.6.2 Vocabulary/Lexis:

The learner's ability to communicate efficiently about a particular disease or presenting complaint is directly related to his knowledge of the vocabulary that is relevant to that ailment. Some lexical items are very specific to the type of consultation whilst others are common to more than one disease or complaint. Cataloguing the nature of patients' presenting complaints gives a good idea of the vocabulary needed to communicate in the OPD. This has obvious implications on the lexical content that is selected for a medical Zulu course. The graph below is a summary of patients' presenting complaints in the OPD consultations I observed:

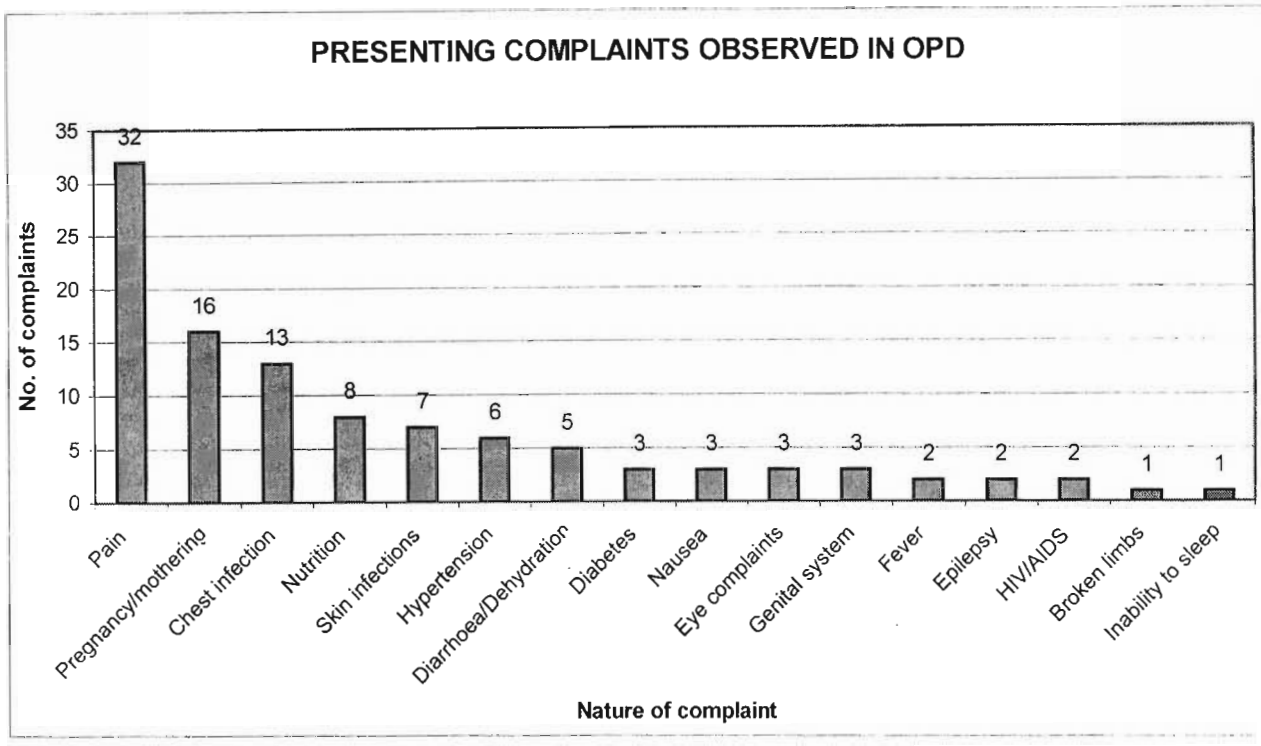


Figure 2: Complaints which patients presented with during consultations I observed (Based on data in Appendix B)

In the section that follows, I look at the presenting complaints identified in the graph and discuss the vocabulary items linked to each. I will illustrate using extracts from some of the consultations I observed and will also draw on the recommendations and input from the doctors I interviewed. Under each vocabulary theme you will see the sub-heading, "Key phrases", which lists some of the more common and important lexical items associated with each of these complaints

A) Pain

Key phrases:

- *Ubuhlungu* (Pain)
- *Kuphi ubuhlungu?* (Where is the pain?)
- *Ngikhombise ngesandla* (Show me with your hand)
- *Kubuhlungu kakhulu noma kancane?* (Is the pain severe or mild?)
- *Kuqale nini?* (When did it start?)

The most frequent presenting complaint I observed was pain. 32 patients out of 80 complained that they were experiencing pain in one or more of the following body parts: throat, lower back, chest, leg, knee, foot, ankle, testicle, flanks, stomach, ear, general all over body pain, headache, bottom and neck.

Dr Ellis identified pain as one of the top 2 complaints his patients present with (Appendix D) and according to the Medical School's history taking protocol (Appendix H), pain is the commonest presenting problem, accounting for about half of all consultations.

These are examples of some of the questions a doctor might ask to establish the nature of a patient's pain:

Appendix C: Consultation 2

Doctor:	... Kubuhlungu la? Kuqale nini ubuhlungu? ... Kubuhlungu kakhulu?	...Is it sore here? When did the pain start? ... Is it very sore?

Appendix C: Consultation 3

Doctor:	... Kubuhlungu uma ugwinya?	...Is it sore when you swallow?

B) Pregnancy / Birth / Mothering

Key phrases:

- *Ukukhulelwa* (Pregnancy)
- *Ukubeleta* or *ukuteta* (Giving birth)
- *Ukukhulisa ingane* (Mothering)
- *Ukuncelisa* (To breastfeed)
- *Ingane incelisa kahle?* (Is the baby breast-feeding well?)
- *Kungcono ukuncelisa umntwana ezinyangeni eziyisithupha.* (It is better to give your child breast milk for the first 6 months)
- *Unabantwana abangaki?* (How many children do you have?)

The second most common situation I observed doctors dealing with was matters relating to pregnancy, childbirth and the mothering of young children. When I spent a morning in the maternity and paediatrics ward at Bethesda Hospital, Dr

Ruthvin (Appendix D) outlined the following as some of the routine questions to ask mothers who have just given birth:

Day 1:

- *Unjani mama?* (How are you feeling?)
- *Ingane incelisa kahle?* (Is the baby breast-feeding well?)

Day 2:

- *Amakaka abemahle?* (Have you passed stools normally?)
- *Usuzile na?* (Have you experienced flatus?)

Day 3:

- *Ungadla ukudla (okuthambile) manje.* (You can start eating [soft] food again.)

The following extract is from a consultation where a pregnant female came to have her cholesterol checked. However, as the consultation progresses, it becomes apparent that she also wants to ask about her baby.

Appendix C: Consultation 4

Doctor:	Asibone ke la emafutheni ukuthi.... (interrupted) Ngenkathi uye emafutheni la bathi hayi umntwana uphila kahle ngaphakathi. Inhliziyo ishaya kahle, uyanyakaza futhi umntwana, uza ngekhanda? Uyezwa ma? Owesingaki umntwana wakho?	Lets see what your cholesterol is...(interrupted) When you were here for your test what did they say about how the child is doing inside. Is the heart beating well, is the child moving, is the child's head facing down? Are you listening? Is this your first born or second child?
Patient:	**Owesibili.**	**It's my second.**
	...	...
Patient:	**Ngicela ukubuza ukuthi umntwana muni?**	**May I ask the baby's gender?**
Doctor:	Akulula ukubona lana ngoba ababhalile...Kubonakala la usesemshinini. Uma bebheka la bayakwazi ukubona ukuthi umfana noma intombazane okay. Kube mhlambe ucele ngalesisikhathi usenziwa ...	It's not easy to see here because they did not write it down... Its easy to see on the machine whilst you are still there. They can tell there whether it's a male of female. They would have tried it there if you had asked then and there...

Mseleni Hospital was running a breastfeeding campaign at the time that I was doing my research there. Two of the slogans for this campaign were *Ukuncelisa yilungelo lakho* (Breast-feeding is your right) and *Ubisi lukamama lodwa ezinyangeni eziyisithupha* (Breast-feeding exclusively for 6 months). Doctors and the hospital dietician emphasised the need for education on good mothering

practices, such as correct breast-feeding techniques. Dietician Kerry Mould (Appendix D) explained that one of the biggest problems occurs when mothers see healthy babies pictured in adverts for powdered milk products and are led to believe that if they feed their babies the same products their children will also be healthy and well nourished. They substitute breast milk for these products but because they are so expensive they dilute them to make them last longer and as a result the children are malnourished.

My observations in Bethesda's Paediatric ward revealed that mothers (and grandmothers) complained frequently about weight loss or poor appetite in the child as well as coughing or general distress signified by crying. Doctors asked questions related to the duration of the symptoms, the health of others in the home as well as the child's diet. One of the aspects doctors needed to be able to advise on was correct diet for young children, particularly since 3 of the 6 in the paediatric ward were suffering from the nutrition-related disease, Kwashiorkhor.

C) Respiratory problems (e.g. flu, colds, TB, coughs)

Key phrases:

- *isifuba* (Chest) e.g. *Nginesifuba* (I have a chest infection)
- *i-TB* (TB)
- *umkhuhlane* (cold, cough, flu)
- *isifuba somoya* (asthma) e.g. *Unesifuba somoya?* (Do you have asthma?)
- *iphika* (breathlessness)
- *ukukhwehlela* (to cough) e.g. *Uyakhwehlela?* (Are you coughing?)
- *Siyaphuma isikhwehlela? / Uyazikhipha izikhwehlela?* (Are you coughing up sputum?)
- *Kubuhlungu esifubeni?* (Is it painful in your chest?)
- *Udla kahle yini?* (Are you eating properly?)
- *Ulala kahle ebusuku?* (Do you sleep well at night)
- *Uyabhema na?* (Do you smoke?)
- *Kukhona ophethwe yi-TB ekhaya?* (Does anyone else at home have TB?)
- *Kufanele ukuba uqede onke amaphilisi akho nakanjani!* (You must finish all your pills no matter what!)
- *Sizothatha isithombe sesifuba* (We will take a chest X-ray)

Respiratory infections accounted for 13 of the consultations I observed. In the extract below, the doctor establishes the nature of the patient's respiratory problem:

Appendix C: Consultation 9

Doctor:	Ulala kahle ebusuku?	Do you sleep well at night?
Patient:	**Ngilala kahle ebusuku.**	**Yes, I sleep well.**
Doctor:	Udla kahle futhi? Uyakhwehlela?	Do you have a good appetite? Are you coughing?
Patient:	**Ngiyakhwehlela.**	**Yes, I do cough.**
Doctor:	Siyaphuma isikhwehlela?	Are you coughing up sputum?
Patient:	**Siyaphuma.**	**Yes.**

Dr Nash, Dr Kenneth and Dr Cairns (Appendix D) all identified TB and chest infections as one of the most common problems in the OPD. They described coughing, night sweats and loss of appetite as common TB symptoms and usually prescribe a 6-month treatment for TB patients. It is vital that doctors are able to counsel patients on the importance of completing their course of treatment even if they start to feel better before their medication is finished.

D) Nutrition

Key phrases:

- *impilo* (health/ nutrition)
- *isisu (stomach)*
- *izikelemu* (worms)
- *Unazo izikelemu? / Unezikelemu?* (Do you have worms?)
  Bezinjani? (What were they like?)
  Ezimhlophe? (White ones = tapeworms) / *Ezimbomvu?* (Red ones = round worms) / *Ezincane?* (Small ones = thread worms)
- *ukudla* (food)
- *Uyakuthanda ukudla?* (Do you like your food/ Do you have an appetite?)
- *Ingane idla kahle yini?* (Is the child eating well?)
- *Uyazaca na?* (Are you losing weight?)
- *Ukhuluphele kabi kakhulu.* (You are badly overweight.)
- *Ungadli ushukela / isinkwa / amazambane…* (Don't eat sugar, bread, potatoes etc…)
- *Bilisa amanzi njalo ngaphambi kokuphuza.* (Always boil water before drinking).

As discussed above, incorrect nutrition was quite a big problem in the paediatrics ward. Dr Kenneth (Appendix D) identified malnutrition as one of the most recurrent problems in paediatric medicine. I observed 3 consultations where babies were diagnosed with Kwashiorkor (Appendix B). During these consultations, Dr Kenneth explained the dietary needs of the child to its mother. At Bethesda Hospital they hand out packets of soya seeds to mothers and encourage them to grow these at home. Dr Kenneth also explains to mothers how to slowly introducing weaning foods such as mashed potato, beans and pumpkin to growing children.

I witnessed two consultations with elderly patients complaining of general all over body pain and suffering from malnourishment, muscular wasting and possible neglect and one consultation where the patient reported a loss of appetite.

Two other patients complained of *izikelemu* (worms), a problem which Dr Nash (Appendix D) highlighted as one of the more frequent presenting complaints she has to deal with in OPD.

On the opposite end of the nutritional scale, there is the issue of obesity. One patient was grossly overweight and needed to be given instructions on how to lose weight. Dietician Kerry Mould (Appendix D) explained that obesity is a problem in the Zulu culture because those who can afford to eat well often eat too much. One of the reasons for this is that being overweight is seen as a sign of wealth and there is a general perception that fat people do not have HIV/AIDS.

E) Skin infections (sores, abscesses, rashes etc)

Key phrases:

- *isikhumba* (skin)
- *isilonda* (sore)
- *ithumba* (abscess)
- *umqubuko* (rash)
- *Uphethwe yisifo sesikhumba?* (Have you had skin trouble?)

Three of the patients I observed, were suffering from abscesses/ boils, three had some kind of a rash/ allergy and one had what seemed to be an enflamed lymph node. Dr Nash (Appendix D) listed skin infections as a frequent presenting

complaint amongst patients and Dr Cairns (Appendix D) said scabies was one of the more common ailments she treated in young patients.

In this extract a patient complains about a rash on his penis:

Appendix C: Consultation 1

Patient:	**... induku yami kusho ukuthi kade iqubukile.**	**... my penis had a rash.**

The following is an extract from a consultation where a doctor tries to explains to the child's mother that he needs to be injected so his abscess can be lanced:

Appendix C: Consultation 2

Doctor:	... Uphethwe yini mntanami eh? Kubuhlungu la? Kuqale nini ubuhlungu? Awuthi ngibone. Sekuvuthiwe. Kubuhlungu kakhulu?...	...What is wrong my child, hmm? Where is the pain? When did it start? Let me see. It's fully developed (about to burst – referring to abscess). Is it very sore?...
	...	...
Doctor:	Okay kulungile, ngizofuna ukuthi ungabe usamupha ukudla manje uyezwa. Sokunikeza umjovo omncane la. Alale khona engazobuzwa ubuhlungu bese siyalikhama ithumba.	Okay, from now on don't give him any food, do you understand. We shall give you a little injection here. That will make him sleep so that we can clean the abscess without him feeling pain.
Patient:	**...Sebeke bamzama lona ngeSpray angazi noma ungamuzama yini ngaso.**	**... They have tried him with a spray I don't know if you can also try it.**
Doctor:	Singasifaka sona iSpray kodwa into elukhuni kakhulu leyo, mncane lo uzokhala kakhulu kanti singakwazi ukumbamba uyabona.	We can use a spray but that is a difficult thing. He is young he will cry more with a spray but I think we can hold him and squeeze the boil.
Patient:	**Ngizombamba mina.**	**I will hold him.**
Doctor:	Ngeke kulunge ngoba kufanele simlalise manje kuzoba yinkinga ngoba kufanele simlalise. Okay likhulu kakhulu sizokwazi ukulikhama kahle yonke into iphume...	I don't think that will work. It will be a problem if we don't put him to sleep. The boil is very big. We have to clean it and make sure we have done it thoroughly...

F) Hypertension

Key phrases:

- *isifo somfutho wegazi* (hypertension)
- *i-high high* (hypertension)
- *Ungafaki kakhulu usawoti namafutha ekudleni.* (Don't put lots of salt or oil in your food.)
- *Asibone ukuthi umfutho unjani.* (Let us see what your blood pressure is like.)

- *Umfutho kubi impela* . (Your blood pressure is very bad)
- *Umfutho wakho wehlile / akukubi kakhulu.* (Your blood pressures has decreased / not bad at all)

I observed 6 hypertensive patients coming in to the OPD either to renew their script for medication or to complain that they were suffering from high blood pressure, or hypertension. A number of the doctors I spoke to listed high blood pressure as a common complaint in the OPD. Both Dr Nash and Dr Cairns (Appendix D) specified hypertension as accounting for a fair percentage of their patients. According to these doctors, one of the difficulties with hypertensive patients is getting them to renew their scripts timeously and to keep taking their medication regularly even when they start to feel better. The extract below illustrates how a doctor may caution a patient, with high blood pressure, regarding his diet:

Appendix C: Consultation 1

Doctor:	Ehe kuba yinkinga impela, ikakhulu kukhona nesifo lesi iBP... Uyazi angithi ngesifo iHigh-high ukuthi sithanda udle ngendlela enjani Ungafaki kakhulu usawoti, namafutha. Awuphuzi?	Yes, it becomes a problem especially with other diseases like BP... Do you know anything about high blood pressure. If you have it you must be strict with your diet. You mustn't have too much oil and salt? Do you drink?

Dr Ellis offers the following advice on how to explain hypertension to a patient:

"Hypertension may be explained using metaphors on blood, rivers, pipes and using analogies to beasts' blood vessels and tubes of bicycles tyres. Hypertension may also be described via attempts at almost direct translation, for instance: ***isifo somfutho wegazi*** *which means 'You are suffering from an abundance of blood" (Zulu), igazi lakho liphakamile means "Your blood is raised up" in Xhosa... The words now used for hypertension in African languages have been partially borrowed from English and it is now commonly referred to as* ***high high*** *or* ***high blood****."*

(Ellis, 1999: 56)

G) Diarrhoea and Dehydration

Key phrases:

Uhudo (diarrhoea)
Uhanjiswa isisu? (Do you have a runny tummy?)
Ukuphelelwa ngamanzi (Dehydration)
Uphelelwe ngamanzi emzimbeni (You have lost water from your body)
Kukhona ophethwe yi-kholera ekhaya? (Does anyone at home have cholera?)

Diarrhoea and dehydration accounted for five of the consultations I observed. These symptoms are particularly relevant to rural medicine where illnesses like cholera can flare up so easily. During some of these consultations, doctors instructed patients on correct water purification techniques as well as how to mix up a rehydration solution when someone has lost a lot of fluid.

H) Diabetes

Key phrases:

- *isifo sikashukela* (diabetes)
- *Kukhona onesifo sikashukela ekhaya?* (Does anyone at home have diabetes?)
- *Uya endlini encane njalo?* (Do you often need to urinate?)
- *Uyancipha emzimbeni?* (Have you lost weight?)
- *Womile njalo?* (Are you always thirsty?)
- *Ukhathele kakhulu?* (Are you very tired?)
- *Isifo sikashukela siyakwenza lokhu uzizwe umzimba uphansi, womele kakhulu amanzi.* (Diabetes causes your body to feel tired and rundown and makes you thirsty for water)

I saw 3 diabetic patients come in for a check-up. The extracts below are from 2 separate conversations between a doctor and a diabetic patient.

Appendix C: Consultation 1

Doctor:	Bathe uma behlola ushukela wakho bawuthola uphezulu izolo. Unayo vele inkinga kashukela ophezulu?	When you were examined they found that your sugar level was high. Do you have a problem with high sugar (diabetes)?
Patient:	**Kusho ukuthi nginayo ngoba ngihlala ngihlale ngiphethwe yikhanda.**	**It seems I must have because sometimes I have this headache.**
	...	...
Doctor:	... Amanzi uyawomela nje kakhulu?	... Do you thirst for water?
Patient:	**Ya ngiyawomela impela amanzi.**	**Yes I feel thirsty for water a lot.**
Doctor:	Uyawomela, umzimba uyakhathala nje kancane uzwe ukhathele?	You are thirsty for it. Does your body also feel tired sometimes?

Patient:	**Ngiyakhathala kodwa umsebenzi engiwenzayo awukho owamandla kakhulu. Ngoba nokujuluka ngiyajuluka futhi uma ngilele ngoba futhi ebusuku ngiyajuluka.**	**I feel tired but the work that I do is not tiring. I also sweat when I am sleeping at night.**
	...	...
Doctor:	Isifo sikashukela siyakwenza lokhu uzizwe umzimba uphansi, womele kakhulu amanzi. Okunye okwenzakaya ukuthi amasosha lana avikela umzimba wakho athanda ukuphazamiseka uma kuwukuthi unesifo sikashukela, Kulula ukuthi izifo njena okungamagciwane kukuhluphe ...	Diabetes causes the body to feel tired and rundown and to thirst for water. Another thing that happens is that the soldiers in your body are disturbed when you are diabetic. You then become vulnerable to disease and may get an infection ...
	...	...
Doctor:	... Okunye ke futhi siye sithande unyakazise umzimba.-umzimba uthi ukwehla kancane. Kuyasiza nalokho kwenza ukuthi ungaze udinge amaphilisi amaningi...	... The other thing that you must do is to exercise to lose some weight. That actually helps and you may not have to take as many pills ...

Appendix C: Consultation 3

Doctor:	... Amaphilisi akho kashukela ugcine nini ukuwathatha?	...When did you last take your diabetic pills?

Dr Cairns and dietician Kerry Mould both specified diabetes (Appendix D) as a frequent presenting complaint. Dr Cairns said it was particularly common amongst older patients.

l) Eye complaints

Key phrases:

- *Inhlokosela* (Growths in eye)
- *Izinkinga zamehlo* (Problems with eyes)
- *Ngiphethwe yihlo* (I have a problem with my eye)
- *Uyakwazi ukubona kahle?* (Are you able to see properly?)
- *Bheka phezulu/phansi.* (Look up/down)
- *Vula ihlo* (Open your eye)
- *Bheka phezulu / phansi / phambili* (Look up / down/ straight ahead)

Three of the patients I observed had problems with their eyes: one had cataracts, one had an infection and one had a growth in his eye. Below is an extract from a consultation where the doctor explains to the mother that the growth in her child's eye needs to be operated on and removed.

Appendix C: Consultation 6

Patient:	**Uphethwe yihlo. Kunento emile la ehlweni.**	**He is troubled by his eye. There is something developing in his eye.**
Doctor:	Ubone nini?	When did you see it?
Patient:	**Kusho ukuthi kunenyanga yonke, kusho ukuthi nje yingoba kuyingane engakhulumi.**	**I would say a month ago, it's just that he hasn't complained and does not talk much.**
	...	...
Doctor:	Vul'ihlo.	Open your eye.
Patient:	**Kula phansi.**	**It's on the base here.**
Doctor:	Okay.	Okay.
Patient:	**Kuye kukhule kube kukhulu, kuphume amahlule.**	**It has grown large, and blood clots have formed.**
Doctor:	Okay, kufuneka isuswe. Uyazi ukuthi ugcine nini ukudla?	Okay, we must take it out. Do you know when he last ate?

J) Genital system

Key phrases:

- *Ugcusula* or *Ukuluma ngaphambili* (Genital problems)
- *Ngaphambili* (polite term for woman's genitals)
- *Induku* or *umphambili* (penis)
- *isikhathi* or *i-menstruation* (period/ menstrual cycle)
- *ikondom* (condom)

Three patients presented with complaints relating to the genital system: one had very enlarged testicles, one had a rash on his penis and one complained of decreased libido (see extract below). The topic of sex and sexuality is discussed in more detail in more detail in section 4.1.6.4.

Appendix C: Consultation 1

Patient:	**Besengivilapha ukumema umama ngoba umzimba uphansi.**	**I was too lazy to invite my wife over because my body (libido) was low.**

K) Sexually transmitted diseases (STD's)

Key phrases:

- *izifo zocansi* (sexually transmitted diseases)
- *ingculazi* or *i-AIDS* (AIDS)

- *amagama amathathu*, *zu3* and the non-verbal indication of holding up 3 fingers are all social references to HIV, according to Dr Ellis.

Only 2 of the 80 patients I observed actually admitted to having a sexually transmitted disease. One was a woman who knew she had HIV but was coming to the hospital to be treated for a skin irritation and one was a young man coming back for his HIV/AIDS test results. The doctor explained that he was in fact HIV positive and gave him condoms and a sexual contact card. The infected person is supposed to give the sexual contact card to his partner(s) so that they become aware of the risk and also come in to be tested.

Despite the fact that patients with STD's seem to account for a relatively low percentage of the consultations I observed, this is not a true reflection of the number of patients suffering from HIV/AIDS and other STD's. Patients may present with symptoms like chest infections or skin irritations but many of these are HIV-related ailments. Every doctor I spoke to identified HIV/AIDS as the biggest, or one of the biggest, problems they have to deal with in the medical consultation – both from a medical and linguistic perspective.

Consulting patients with sexually transmitted diseases is a complex procedure. One of the difficulties is that patients are hesitant to mention to the doctor that they think they may be infected. Dr Cairns explains that a patient with a sexually transmitted disease will often complain of headaches, stomach ache and other symptoms and may only mention a symptom like "discharge" at the end of the list. Certain topics like sex, sexuality and sexually transmitted diseases are not broached directly, particularly in the Zulu culture.

Dr Todd-Ngubane at McCords said she was able to speak some Zulu but needed a Zulu-speaking nurse to interpret during more complex consultations. For example, when a possible sexual assault victim came in for a consultation, Dr Todd-Ngubane asked a nurse to act as an interpreter during the consultation and physical examination as she was not able to fully understand the girl's story. She then sent the girl to receive proper trauma counsel at House 35 (The Aids Clinic at McCords Hospital) where they would further explain the possible risk of HIV and its implications.

Dr Cairns explains that normally trained counselors do pre- and post-test counselling because it takes a lot of time to counsel properly. However some doctors feel that they should also be able to give basic HIV/AIDS counselling to their patients. Pre-test counselling is extremely important: no patient should come for their results without already knowing what HIV is and what the implications of a positive result is.

Dr Cairns says she would probably explain HIV by talking about the soldiers in your blood, which fight disease. HIV is a germ that kills these soldiers so that you can get other diseases like TB more easily. It is important to explain to the patient that he may be asymptomatic and infectious for many years. Doctors should instruct infected patients to tell their health care worker about their results and advise them not to shop around from one doctor to another. The patient should also be advised to get medical help early and to use condoms even with an HIV+ partner. Dr Cairns says that when counseling an HIV+ patient she tries to give some form of hope and reassurance even if they have not voiced their fears (few will because of the cultural belief that STD's are taboo). HIV is a terrible disease and people are afraid of dying and suffering. Doctors should be able to reassure patients that even if they are HIV+, they could live for many years and still have a fruitful and productive life.

L) Nausea

Key phrases:

- *Ukubuyisa* (Nausea) – more acceptable word than *ukuhlanza*
- *Ukhwelwa yingongo?* (Have you been bilious?)
- *Kuqale nini?* (When did it start?)

Three patients complained of nausea or vomiting.

M) Fever

Key phrases:

- *Ukushisa* (fever)
- *Umalal'eveva* (Malaria) (*uma* – when, *lala* – sleep, *eveva* – shiver i.e. roughly translated as the disease that makes you shiver when you sleep?)

Two patients presented with a fever. A fever combined with the presence of a headache is often an indication of **malaria**. Malaria is largely a "seasonal" disease. Dr Nash (Appendix D) indicated that it is often a serious problem during the summer months in northern Zululand. My research took place in August so malaria was not prevalent then. Only one woman presented with severe nausea, diarrhoea, fever and headaches and was sent for a malaria test.

N) Epilepsy

Key phrases:

- *isifo sokuwa* (Epilepsy)

Two epileptic patients came in for a check-up and to get more medicine.

Dr Nash (Appendix D) said she saw quite a few epileptic patients in the OPD at Mseleni Hospital.

O) Broken Limbs

Key Phrases:

- *Ukuphuka* (Broken limbs)
- *Sizokufaka ukhonkholo* (We will put on a plaster cast)
- *Sizokukhumula ukhonkholo (ngo-6 Disemba)* (We will remove the plaster cast [on the 6th of December])
- *Ungahambi ngawo. Uyezwa?* (Don't walk on it. Do you understand?)

One patient who had just had his arm set in a plaster cast returned to the OPD for his X-rays. The doctor explained that he needed to keep his cast on for 4-6 weeks and instructed him to return to the hospital on a given date.

P) Inability to sleep

Key Phrases:

- *Ukuqwasha* (Inability to sleep)
- *Awukwazi ukulala?* (Can't you sleep?)

One patient expressed an inability to sleep well at night.

Q) Inappropriate vs. polite terminology:

Whilst conducting my research I compiled a list of words which doctors and other mother tongue Zulu speakers identified as inappropriate terminology / words to be avoided. I have also listed the preferred terminology:

English meaning	Inappropriate terminology	Preferred terminology
Woman	*Umfazi* (Only a woman's husband may refer to her as such)	*unkosikazi* or any of the familial terms such as *umama* or *usisi*
To vomit/ nausea	*Ukuhlanza* – less polite term but still used	Ukubuyisa
To be pregnant/ pregnancy	*Ukumitha* (animals)	Ukukhulelwa *(people)*
To give birth	*Ukuzala* (animals)	Ukubeletha
To defecate	Ukubhosha	Ukukaka
Faeces	Amasimba / Amaboshi	Amakaka
Anus	Ingquza	*Ngemuva* (lit. behind)
Menstrual cycle / period	-	*Isikhathi / I-menstruation / Ukuya enyangeni*
Vagina / female private parts	*Imomozi / Igolo* (this term is exceptionally rude and is sometimes used as a term to curse/ insult someone) *Ingquthu* (vagina/vulva)	*Ngaphambili / Isitho sangasese sowesifazane / Inkomo* (lit. cow)
Penis	*Umthondo* (should be avoided as it is used a curse word)	*Induku / Umphambili*

Condom	-	There are a few commonly used alternatives for this "modern" reality: • *Ikondom* (condom) • *Ijazi* (lit. jacket) • *Ijazi lomkhwenyana* (lit. the bridegroom's jacket) • *Amajazi amadoda* (lit. men's jackets - plural)

R) Days/ times/ numbers (as in the following examples):

Another aspect of vocabulary which doctors need to be able to express is that of days, times, numbers etc. For example, a doctor may need to give explicit instructions on how often a patient should take his medications: "Gwinya amaphilisi amabili kathathu ngelanga" (Swallow 2 pills three times a day). The aspect of time also comes in when a doctor is trying to ascertain the duration of a symptom as in the extract below:

Appendix C: Consultation 2

Doctor:	... Kuqale nini ubuhlungu? ...Ukugcine nini ukudla umntwana mama?	... When did the pain start? ... When did the child last eat, mom?

Doctors also need to be able to understand the multitude of answers they may get to this question, ranging from last night to last week to last year.

Appendix C: Consultation 7

Patient:	Kuqale kulonyaka ophelile.	It started last year.

During one of our interviews, Dr Ellis identified the concept of Time as one of the greatest differences between the new Western world and the old African world. One of the results of this difference may be an ability of the patient to give an exact answer regarding the duration of the illness. One way to overcome this is to ask the patient to link their symptom to the season of the year or a well-known event in the community e.g. a flood or drought.

Counting in Zulu is one of the most complicated grammatical challenges for a second language speaker as it involves the use of different basic prefixes and relative concords for each noun class. Fortunately, however, there is an

increasing trend for Zulu speakers to use English numbers, as in these 2 examples:

Appendix C: Consultation 8

Patient:	**... una-5yrs.**	**[He is] 5 years old.**

Appendix C: Consultation 8

Patient:	**Ngineminyaka engu-43.**	**I am 43 years old.**

S) Code-switching & borrowed words:

Code-switching, (changing between two or more languages in the same utterance) and importing Afrikaans or English words was a phenomenon I observed on a number of different occasions whilst observing in the OPD. The extract below illustrates how a patient switches between Zulu and English:

Appendix C: Consultation 8

Doctor:	Unazo izingane?	Do you have children?
Patient:	**Nginazo.**	**Yes I do.**
Doctor:	Zingaki?	How many?
Patient:	**I have got 5. ***	**I have five.**

Sometimes patients might use complete sentences as in the example above but usually a single word or phrase will be imported as in the examples below:

- *iSpray* (spray) — Appendix C: Consultation 2:

Patient:	**... Sebeke bamzama lona ngeSpray angazi noma ungamuzama yini ngaso.**	**...They have tried him with a spray I don't know if you can also try it.**

Familiarising learners with the phenomenon of code-switching is particularly relevant when it comes to dealing with brand names e.g. "iPanado" or "iDisprini". The general trend is for singular nouns to take the class 5 prefiix "i" e.g. "iSpray" (spray) with their plural form following the pattern of noun class 3 which takes the "ama" prefix e.g. "amaphilisi" (pills).

- *ubhizi* (busy) — Appendix C: Consultation 5:

Patient:	**Nami ngibonile ukuthi ubhizi.**	**I also saw that you were busy.**

- *sheka* (to check) Appendix C: Consultation 8:

Patient:	**Eyi ngizozisheka ngoba angiqondi ukuthi kwenzekani.**	**I have just come for a check up because I don't understand what is happening.**

- *i-menstruation* (menstruation) Appendix C: Consultation 8:

Patient:	**I-menstruation yami ayizange kube khona shintsho.**	**My menstrual cycle has not changed.**

- *imbijana* (from Afrikaans *'n bietjie* = a little) Appendix C: Consultation 3:

Doctor:	Wo [amaphilisi] asekhona ekhaya?	Do you still have them [the pills] at home?
Patient:	**Akhona imbijana.**	**Yes but only a few.**

Difficult communication areas not observed but outlined by doctors during interviews:

My findings regarding the target situation were based not only on my observations in the OPD, but also on input received from doctors during informal interviews. A number of the problems identified by doctors in our interviews confirmed my observations. Some of their comments, however, highlighted communication concerns which were not apparent during the consultations I witnessed. Below I have listed two presenting complaints which I did not observe in the consultation room but which Dr Ellis identified as tricky but significant communication areas in the OPD.

T) Depression:

Key Phrases:

- *umoya uphansi* (the spirit is low/ depression)
- *inhliziyo ibuhlungu* (the heart is sore/ depression)
- *ukuphatheka kabi* (to be doing badly/depression)
- *wonke umzimba ukhathele* (the *whole* body is tired)

"Depression does not have a single Zulu equivalent. Zulu terms for depression include ***umoya uphansi:*** *the spirit is down,* ***inhliziyo ibuhlungu:*** *the heart is sore, and* ***ukuphatheka kabi****: not feeling well. The symptoms of depression are often 'carried' by words such as fatigue, loss of energy or the very expressive 'the whole body':* ***wonke umzimba****."*

(Ellis, 1999: 57)

Some suggestions for taking the history from a patient with depression are:

"Questions about loss of interest, ask whether they enjoy listening to the radio or watching soccer. Loss of libido is also a sensitive and early symptom. Loss of weight in people who do not have scales, ask about fitting of clothes. Early morning awakening or delay in getting to sleep, inquire from other household members."

(Ellis, 1999: 43)

Dr Nash (Appendix D) also outlined loss of libido as a significant presenting complaint in her consultation room.

U) Cancer:

Key Phrases:

- *isifo somhlaza* (cancer)
- *umdlavuza* (cancer)

The term *isifo somhlaza* is currently one of the most popular terms for cancer.

"One of the most difficult diseases or illness concepts to explain is cancer. Again the African languages do not usually have a specific word for cancer. Because of the implications of the diagnosis and the management decisions that have to be made following the diagnosis it is important to give it an understandable identity in the patient's culture. Cancer has almost always been treated by traditional healers before the patient presents at the western doctor's rooms. The patients are often given conflicting advice and are subjected to various, often contradictory, family and social pressures. It is therefore important, as with depression, hypertension and other medical diseases, to start with a commonly agreed vocabulary as a

baseline from which one may explain and start management. In Zulu old words such as ***umhlaza*** *or* ***isigaxa*** *which means a lump have been borrowed and used as synonyms for cancer. Similarly* ***umdlavuza*** *is used to mean cancer or the sore that never heals... It is perhaps better to encourage the trend of using the western words or labels for western disease concepts and explaining the diseases from the starting point of the western names of cancer, hypertension, depression or whatever..."*

(Ellis, 1999: 58)

4.2.6.3 Grammatical Structures:

In addition to noting those lexical items that are used frequently in the OPD, I also identified some of the grammatical structures, which featured regularly. Below I have listed some of the grammatical structures which occurred frequently during the consultations I observed:

A) The Zulu noun class system:

Most consultations are conducted in the first person e.g. *Uphethwe yini?* (What is bothering *you*?) and the answer, Ngiphethwe yisisu (*I* have stomach problems). However the doctor also needs to be able to ask questions in the third person, in cases where the patient may be too young or too sick to answer.

- the personal pronouns;

mina (I), *wena* (you – singular), *thina* (we) & *nina* (you – plural)

- focus on subject concords for the "people noun classes":

e.g. *umntwana uyagula* (the child is sick) - noun class 1 singular
e.g. *abantwana bayagula* (the children are sick) - noun class 1 plural
e.g. *ingane iyagula* (the child is sick) - noun class 5 singular

- relevant medical terminology from various noun classes:

e.g. *umuthi* (medicine/tree) - noun class 2 singular
e.g. *amaphilisi* (pills) - noun class 3 plural

B) *-na-* (to have)

The Zulu *-na-* (meaning "to have") is commonly used in the medical context when referring to ailments or diseases which the patient is suffering from. It is also used to ask after and express age.

Appendix C: Consultation 3

Patient:	Eyi nginezilonda esifubeni.	Eh, I have sores in the chest.

Appendix C: Consultation 8

Patient:	Ngineminyaka engu-43.	I am 43 years old. [I *have* 43 years]

C) *Nga-* (by means of/about)

Appendix C: Consultation 1

Doctor:	...Uyazi angithi ngesifo iHigh-high?...	...Do you know anything about high blood pressure?...

D) Agentive prefixes *ng-* and *y-*

The identificative prefixes *ng-* and *y-* are used in such questions *as Ungubani igama lakho?* (What is your name") and *Uphethwe yisifo sikashuekela?* Do you have diabetes?)

E) Locatives

Locatives used during consultations can refer to body parts e.g. when indicating the site of pain), the areas where patients live and work as well as the clinics and hospitals patients have visited previously.

Appendix C: Consultation 6

Patient:	**... Kunento emile la ehlweni.**	**... There is something developing in his eye.**

Appendix C: Consultation 1

Doctor:	Kade useclinic eMbazwana?	Have you been to Mbazwana clinic?

Appendix C: Consultation 5

Doctor:	...Ufuna sikubhukhele eNgwelezane?	... Do you want us to book you in at Ngwelezane?

F) Question words

Taking a patient's history requires that a doctor is able to inquire about the specific details of the patient's ailment by asking the following kinds of questions:

- *-phi* (where) Appendix C: Consultation 10

Doctor:	Likuphi ithumba sisi?	Where is the abscess, sister?

- *-ni* (what) Appendix C: Consultation 11

Doctor:	Yini indaba baba.	What is the matter?

- *-ngani* (by means of what) Appendix C: Consultation 10

Doctor:	Nifike ngani namhlanje?	How did you come here today?

- *nini* (when) Appendix C: Consultation 3

Doctor:	Kuqale nini?	When did it start?

- *-ngaki* (how many) Appendix C: Consultation 2

Patient:	Amahora amangaki?	For how many hours?

- *-ngani* + negative (why not) Appendix C: Consultation 5

Doctor:	...Waya ngale ukuyothatha igazi?	...Did you go for the blood test?
Patient:	No, angilithathanga.	No I did not.
Doctor:	Awulithathanga ngani?	Why didn't you have the test?

G) Object concords

An object concord can be used to replace an object in a sentence or may be used in conjunction with the object to add emphasis. It is also necessary to use an

object concord when asking a question or expressing a negative statement, where there is an object in the sentence.

Appendix C: Consultation 2

Doctor:	... kufanele si**ml**alise manje ...	... we have to let **him** sleep now ...

Appendix C: Consultation 11

Doctor:	Aka**ku**bhalelanga incwadi usister?	Didn't the sister write **you** a letter?

H) Statives

Statives, expressing states of being such as thirst, *Ngomile ngaso sonke isikhathi* (I am thirsty all the time), hunger, *Ngilambile* (I am hungry) or fatigue, *Ngikhathele* (I am tired), are used in the medical consultation.

Appendix C: Consultation 1

Patient:	**... ngiyajuluka futhi uma ngilele ngoba futhi ebusuku ngiyajuluka.**	**... I also sweat when I am sleeping at night.**

I) Passive mood

The passive is used quite frequently in such expressions as *Uphethwe yini?* (You are suffering from what?), *Uhlushwa yini?* (You are troubled by what?), *Ngikhishwa yisisu* (I am being "emptied" by my stomach).

Appendix C: Consultation 6

Doctor:	Uphethwe yini?	What is wrong?
Patient:	**Uphethwe yihlo...**	**He is troubled by his eye...**
	...	...
Doctor:	Okay, kufuneka isuswe...	Okay, we must take it out (it must be taken out)...

J) Present Tense (positive and negative)

Doctors need to be able to express themselves in (and understand) the present, past & future tenses, in both the positive and negative. Here are some examples:

- Present negative

Appendix C: Consultation 1

Patient:	Hayi angikhwehleli.	No I am not coughing.

K) Future Tense (positive and negative)

➢ Future

Appendix C: Consultation 2

Patient:	Ngizombamba mina.	I will hold him.

L) Recent and Remote Past Tense (positive and negative)

➢ Recent Past

Appendix C: Consultation 1

Doctor:	Kodwa udlile namhlanje ekuseni?	Did you eat this morning?

➢ Past negative

Appendix C: Consultation 5

Patient:	No, angilithathanga.	No I did not take it (the blood test)

M) Recent and Remote Past Compound Tenses

The compound past tenses are used to express an action, state of being, or activity that lasted for a continuous time in the past.

Appendix C: Consultation 1

Doctor:	Kwakungu-1997 lapho? ...	Was that in 1997? ...

N) Subjunctive mood

The subjunctive mood in Zulu is used to express suggestions, requests and polite commands. It is used with expressions such as *Kufanele ukuba...* (It is fitting/ necessary that...) and *Kudingeka ukuba...* (It is necessary that...) as well as polite commands using the expression *Ngicela ukuba...* (I request that/Please may you...)

Appendix C: Consultation 2

Doctor:	Okay, asizame ukuthi kancane ma... Kufanele angadli amahora awu-4 ngaphambi kokuba sikwazi ukumenza.	Okay, mom, lets try... He must not eat for 4hours before we can perform the operation.

Appendix C: Consultation 1

Doctor:	...Ungafaki kakhulu usawoti, namafutha.	...You mustn't have too much salt or oil.

In the extract below, the doctor is addressing an elderly man. The use of the polite subjunctive form *Sicela usidonsele* indicates the level of respect with which the doctor treats the elderly patient.

Appendix C: Consultation 3

Doctor:	Sicela usidonsele umnyango baba. Ninjani namhlanje?	Kindly close the door as you come in, baba. How are you today?

O) Imperatives

The use of the imperative is also fairly common when giving instructions to patients, especially during the physical examination phase of the consultation.

Appendix C: Consultation 8

Doctor:	Khumula izingubo. Lala embhedeni la...	Take off your clothes. Lie on the bed...

Appendix C: Consultation 7

Doctor:	Gibela lapha embhedeni.	Climb onto the bed.

P) Dependent Tense

The dependent tense is used after certain constructions e.g. *Uma* (when/if), *noma* (whether), *bese* (and then).

Appendix C: Consultation 1

Doctor:	Bathe uma behlola ushukela wakho bawuthola uphezulu izolo.	When you were examined they found that your sugar level was high.

Q) -nga- (can)

Appendix C: Consultation 2

Doctor:	Singasifaka sona iSpray kodwa into elukhuni kakhulu leyo...	We can use a spray but that is a very difficult thing...

R) Adjectives

Appendix C: Consultation 2

Doctor:	...Sokunikeza umjovo om**ncane** la...	... We shall give you a **little** injection here...

Appendix C: Consultation 1

Doctor:	Ya kona noma kunjalo uthanda ukuba phezulunyana kodwa hayi akuku**bi** kakhulu.	Even though it's like this, a bit high, it's not too **bad**.

Appendix C: Consultation 1

Doctor:	Aku**lula** ukubona lana ngoba ababhalile.	It's not **easy** to see here because they did not write it down..

S) Relatives

Appendix C: Consultation 4

Doctor:	...Owesingaki umntwana wakho?	... Is this your first or second child?
Patient:	**Owesibili.**	**It's my second.**

T) Possessives

Appendix C: Consultation 9

Doctor:	Uyazi iminyaka yakho?	Do you know your age?

U) Demonstratives and locative demonstratives

The use of locative demonstratives e.g. *Nali* (Here is), as in the example below, are also fairly frequently used when the patient is indicating the site of his pain or ailment.

Appendix C: Consultation 10

Doctor:	Likuphi ithumba sisi?	Where is the abscess, sister?
Patient:	**Nali ngapha.**	**It's here this side.**

V) Inclusive and exclusive pronouns

Appendix C: Consultation 9

Patient:	**Kubuhlungu wonke umzimba, manje ngiyagodola kuqaqamba amathambo.**	**My whole body is sore, I feel cold (shivering) and my bones are very sore.**

	...	...
Doctor:	Khumula izingubo zonke lala embhedeni ngifuna ukuhlola umzimba uyezwa?	Take off all your clothes and lie on the bed. I want to examine you. Do you understand?

Appendix C: Consultation 2

Patient:	**Hlambe selidlulile elilodwa.**	**I think perhaps one hour has passed.**

W) Se- implication (meaning now)

Appendix C: Consultation 2

Doctor:	...Sekuvuthiwe. Kubuhlungu kakhulu? Ukugcine nini ukudla umntwana mama?	... It's fully developed now (about to burst , referring to abscess). Is it very sore? When did the child last eat, mom?
Patient:	**Usenesikhashana akugcinile ukudla.**	**It's a while now.**
Doctor:	Nini mhlawumbe? Seliphelile ihora?	Can you estimate the time? An hour ago now?

4.2.6.4 Cultural elements:

Equipping learners with an understanding of Zulu culture is an important aspect of their preparation for interacting with Zulu-speaking patients. The learner needs to know what is considered rude or impolite in the target culture. He should know how to address people respectfully and appropriately, how to interact with older and younger people, how to ask questions and give instructions politely. He should also be aware of the types of behaviour he may expect from his patients. For example, a patient may mutter almost inaudibly, as a sign of respect for the superior position held by the doctor in the consultation situation.

A) Terms of address

In Zulu culture, most terms of address are "familial" and based on gender and age. For example, addressing an older woman as "mama" (mom) or even "gogo" (granny) and an older man as "baba" is preferable to the use of "nkosikazi" (mrs) or "ndoda" (mr) as it establishes a more personal link between doctor and patient. A man or woman of similar age to the doctor could be addressed as "mfowethu" (brother) or "sisi" (sister) respectively. Even if the doctor is not a Zulu speaker, it is still acceptable for him to use this kind of familial terminology.

Here is an example of a greeting observed in the OPD:

Appendix C: Consultation 2

Doctor:	(Addressing child) Xhawula, letha isandla, letha nalesi. Unjani?	Let's shake hands, bring that other hand. How are you?
Patient:	**(Mother replies) Yithi "Ngiyaphila"**	**Say "I am fine"**
Doctor:	Ubani igama lakho? ... Uphethwe yini mntanami eh? ... Ukugcine nini ukudla umntwana, mama?	What is your name? ... What is wrong my child, hmm? ...When did the child last eat, mom?

In this consultation the patient is a young child accompanied by his mother. The doctor calls the child "mntanami" (short form of "umntwana wami" = my child). This informal reference is completely acceptable even though the doctor does not know the child. The doctor addresses the mother as "mama" (mother), which is the generally accepted term for a middle-aged woman or a woman of child-bearing age who is most likely as old as, or older than, the doctor.

B) An introduction to the cross-cultural medical consultation

Most of the doctors I consulted reported significant differences between Western and African ways of thinking with regard to matters concerning health and the treatment of illness. In this section I discuss some of these differences, drawing on information provided by Dr Chris Ellis and Dr Thenji Magwaza, lecturer in gender studies at the University of Natal, as well as the topics dealt with during Dr Ellis' workshops on the theme of the cross-cultural medical consultation. I have identifed five areas, namely (a) culture bound syndromes (*using ukufa kwabantu* and *idliso* as examples), (b) the role of traditional healers in Zulu culture, (c) the use of euphemism and metaphor with specific reference to the topics of death and sex, (d) a comment about the "entry ticket complaint", and (e) polite vs. inappropriate terminology compiled during my research.

Based on my discussions with doctors and my observations of the syllabus guidelines at the Medical School, it appears that South African doctors are still being trained in the Western biomedical model of taking a patient's history, which includes the asking of a routine set of questions. Dr Ellis encourages doctors to step outside of their own paradigm, to look beyond their preconceived ideas of health and illness and ask the patient to explain his own perception of why he is sick. By doing this, Dr Ellis suggests that doctors will be one step closer to understanding the patient's illness.

"Now I want to introduce you to a whole new world by including just one more question in your consultation (and if you do this routinely I apologise for this inference of ommission). The question is "what do you think has caused your illness?" (Ucabanga ukuthi yini imbangela yalokhu?) By doing this you may gain insight into the other agencies from whom the patient has already sought help as well as the personal beliefs of the patient. They may have sought help from other doctors and received medical diagnoses or from alternative or complimentary medicine or from their traditional healers."

(Ellis, 2001: Appendix J)

According to Professor Ngubane, Head of the Zulu Department at UND, in Zulu culture, things like *ukufa kwabantu* or *izifo zabantu* (diseases affecting black people), *ukuthwasa* (the calling from the ancestral spirits to become a diviner or to perform ritual ceremonies) and *idliso* (a kind of sorcery where "muthi" or some kind of herbal substance is put into somebody's food) are as much a part of everyday reality as a common cold or broken bones. For example, if a patient believes he has been poisoned by his jealous wife, this information may be helpful to the doctor in his diagnosis of the patient's reported stomach pains. If Western trained doctors are able to recognise these kinds of cultural realities and understand the traditional African approach to taboo subjects like death and sex, they will gain a deeper insight into their patients' culturally-embedded explanatory theory of their illness and this will hopefully enable them to treat the patient in a more holistic way.

C) Culture bound syndromes

"A culture bound syndrome is a disorder (usually psychiatric) which is influenced by and restricted to a specific cultural setting. But this is really a misnomer because all disorders are bound to a culture. Culture specific or based or culture-specific disease phenomenon are more accurate terms."

(Ellis, 1999: 61)

In this section I have listed two of the culture bound syndromes doctors may come across when treating Zulu patients, namely *ukufa kwabantu* and *idliso*. The information gathered here came out of my interviews with Dr Ellis, informal discussions with other mother tongue Zulu speakers (doctors and lay people) and material from Dr Ellis's book and his journal articles (Appendix J and K)

➢ *Ukufa kwabantu*

The terms *ukufa kwabantu* and *izifo zabantu* literally mean African diseases, or diseases or afflictions that only affect African as opposed to western people.

"Usually [ukufa kwabantu] is given as an explanation by relatives of a patient to a western trained doctor that they feel the patient is suffering in a different dimension than the biomedical or technical framework of western medicine. It is an attempt to explain the spirit world and cultural traditions and fears as a cause of the patient's illness. Ukufa kwabantu has been defined as 'those culture-bound syndromes which the Zulu people themselves believe are unique or peculiar to their people in the sense that their aetiology, diagnosis and treatment are all inextricably bound up with traditional African world views of sickness and health.' "

(Ellis, 1999: 61)

➢ *Idliso*

The dictionary term for *idliso* is poisoning. In practice it refers to the kind of sorcery where a substance is put into somebody's food in order to bewitch them in some way. Dr Cairns (Appendix D) described an incident involving a patient at Inkandla Hospital who had been diagnosed with renal failure. The man was the husband of one of the nursing sisters and was therefore a fairly well educated man. The doctor explained the man's condition as having "poison in the blood" and he later died. His condition was misinterpreted by his family as *idliso* due to the notion of "poison" being used. Threats between family members started up as each one suspected the other of being responsible for poisoning the man. Some were too afraid to attend the funeral in case they fell under suspicion and someone took revenge on them.

One of the points which Dr Ellis raised with me during our discussion on African sexuality was that African women often feel sexually neglected. One of the reasons for this may be due to the fact that it is still an accepted Zulu practice for a man to have more than one wife. According to Dr Ellis, this sometimes results in the wife going to a sangoma to get "muthi" (medicine), or a herbal remedy otherwise known as *idliso*, to put in her husband's food to make him feel unattracted towards his girlfriend(s) or other wife/ wives.

D) Traditional healers

Izangoma and *izinyanga*, commonly known today as a traditional healers, play a very important role in Zulu culture. A large number of Zulu patients are uncomfortable with Western medicine. For certain ailments they seek help from an *isangoma* or an *inyanga* before they consider consulting a Western doctor.

"Broadly speaking, the traditional doctor is consulted for supernatural causes and explanation, whereas the Western doctor is consulted for symptom relief, examination and an injection"

(Ellis, 1999: 101)

Upon discussing the topic of traditional healers with some well-educated, urban mother tongue Zulu speakers living a "Western" lifestyle it became clear that it is not only rural, uneducated Zulu speakers who choose to consult an *isangoma* or an *inyanga*. It was explained to me that when many Zulu people are affected by certain ailments they will first seek help from a traditional healer before considering the hospital as an option.

In a recent journal article entitled "The Culturally Sensitive Medical Consultation" (Appendix J), Dr Ellis suggests the following questions as an aid or shortcut to understanding an African patient's beliefs regarding his illness:

- *Uke wasibona isangoma mayelana nalesi sifo?* (Have you seen an isangoma about this?)
- *Wathini mayelana naso?* (What did he say about it?)
- *Ucabanga ukuthi yini imbangela yalokhu?* (What do you think caused this illness?"

E) Use of euphemism and metaphor

The following example recorded in Dr Ellis's book, "Learning Language & Culture in the Medical Consultation" (1999), illustrates how an African male might typically present his concern about his impotence using metaphor:

"A black male comes to consult me. We are much of an age. He is greying, well dressed, polite. We sit for a moment in silence. He speaks – 'My heart is very weak.'

Now I know we are not into cardiology. For two to three minutes we talk about how difficult it must be for a man of his age to have a weak heart. I give the conversation a subtle turn and we talk about how difficult it must be for the woman in his life. Finally he tells me that he can't raise an erection.

I am suddenly aware of the profoundness of his upbringing where a child is taught to address an elder, how men talk to women and men to men. I am also aware how quickly we will lose these beautiful metaphors. We will push him into the white way.

Dr Bernard Levinson, Johannesburg: 1995"

(Ellis, 1999: 44)

During my interview with Dr Ellis, he explained that the world surrounding illness and medical practice is full of idioms, euphemisms and circumlocutions – in all languages. As in other cultures, Zulu mother tongue speakers prefer polite words, phrases, statements and expressions, especially when discussing delicate matters such as sex, sexuality and death. One of the ways to make sure that you are using appropriate language to discuss sensitive matters is to ask a nurse-interpreter to correct you if she hears you unintentionally using words that may be considered rude.

- **Death**

As with most languages, Zulu has a number of euphemisms surrounding the subject of death. Instead of saying *Angeke asinde* (He will never recover), it is preferable to use one of the following euphemisms:

- *Kwebulwa kwembeswa* (The person is not going to recover)
- *Uphethwe yisifo esiyingozi* (He is suffering from a dangerous disease) or
- *Izinhlanga zimuka umoya* (It is to no avail. Literally, the mealie stalks are being carried away by the wind).

During one of our interviews, Dr Ellis (Appendix D) suggested that it is sometimes a good idea to ask the patient what he knows or understands about the situation. This may be done by asking questions like, "How sick are you?" or, "How sick is your child?", "Do you want to ask me anything about your illness?" or "Do you want to ask me anything about the child?" This allows the patient to reveal his own perception of his illness and how he views death.

- **Sex/Sexuality:**

Below I have included an extract from one of the consultations I recorded where a patient uses a metaphor for "penis". *Induku* is an example of a polysemous word i.e. it has more than one meaning. *Induku* can refer to a stick, passive resistance or, in this case, a polite word for a penis.

Appendix C: Consultation 1

Patient:	**Ngoba inkinga ebengiyilethile enye izolo, induku yami kusho ukuthi kade iqubukile.**	**My second problem yesterday was that my penis had a rash.**

The following are examples of euphemisms/metaphors relating to sex:

- *Ukulalana/Ukuya ocansini nomuntu wesifazane/ wesilisa* (*To have sex.* Literally, to go to the sleeping mat with a woman/man)
- *Ukulangazela ucansi* (To long for (sexually). Literally, to long for the sleeping mat) Note: this expression can only be used by a man because it is not considered appropriate for women to express sexual desire in this way.
- *Ayivuki induku* (I cannot have an erection. Literally, the stick will not arise)
- *Ayithi shu* (I cannot have an erection. Literally, it won't do anything)

F) A note about the "Entry Ticket Complaint"

Dr Ellis and Dr Cairns (Appendix D) both described a phenomenon which Dr Ellis refers to as the "entry ticket complaint" (Ellis, 1999: 30). He explains that often a patient will complain of a general symptom like stomach-ache or backache when, in fact, he fears that something else is the real cause of his illness. For example a female patient may present with stomach ache but what they are really concerned about is whether they are pregnant/ infertile/ carrying HIV/AIDS. Men will

sometimes present with an "entry ticket symptom" when their real concern is that they may be impotent or carrying a sexually transmitted disease.

During my interview with her, Dr Cairns described the scenario where women come into the OPD complaining of stomach pain or irregular periods when, in fact they are afraid they may be infertile or suspect they are pregnant. Dr Cairns explains that the patient will not broach the subject directly but hopes that the doctor will diagnose her problem. She suggests that a useful question to ask is, "Do you want to have children?" as this helps to gets to the root of the problem, which may be infertility. Sensitive issues such as infertility and pregnancy are not frequently addressed directly but rather suggested or implied in the naming of other symptoms.

"One of the most common mistakes is to take the presenting symptom at face value, or literally, and not as a metaphor. Common symptoms presented this in this way are 'kidneys' (izinso), 'waist' pains or backache in males. The kidney may be an important organ of potency and masculinity and the complaint of kidneys or backache may refer to impotence, weakness or an STD. In women complaints of stomach ache or bladder pain may represent a request to check whether they are pregnant or conversely to treat them for infertility. Stomach ache may also represent pollution or fear of AIDS or STD."

(Ellis, 1999: 42)

4.3 FINDINGS RELATED TO THE LEARNING SITUATION

In addition to the research I conducted in hospitals, I gained valuable insight from my experience designing and lecturing an introductory medical Zulu course to first year medical students at the University of Natal Medical School in 2001. One of the chief advantages of lecturing this course was that it helped me to establish what one could realistically expect learners to cover in a period of 52 hours, the time allocated to the Zulu course.

Furthermore it provided me with the opportunity of getting feedback from learners on the syllabus I had designed. As explained in chapter two, course evaluation should be an integral part of the process of syllabus design. It is not enough to select the syllabus content on a once-off basis and to assume that it will never have to be modified. Once a syllabus has been designed and introduced to

learners, we must ask whether the course was successful, re-evaluate the syllabus based on feedback structures such as course evaluation questionnaires and be committed to making the necessary changes to improve the course. In an attempt to assess my medical school syllabus design, I asked learners to complete a course evaluation questionnaire (Appendix F).

In the section that follows I report back my findings relating to the learning situation, based on and my classroom observations, informal feedback from learners and the results of the course evaluation questionnaire.

4.3.1 Who are the learners?

4.3.1.1 Justification for selection of medical students as ideal target learners

Before I give a detailed description of my target learners, I would like to first explain why I have selected medical students instead of qualified doctors as ideal target learners. During the past three years I have lectured both full-time medical students and doctors who are trying to learn Zulu part-time and it is my opinion that the best time for doctors to learn to speak Zulu is while they are still studying at university. These are my reasons for selecting medical students as the ideal target learners for this course:

Firstly, medical students are still in the "studying mode": their schedule and mental attitude are well suited to learning a second language. Patrick Frickel, a fellow syllabus designer who used to lecture medical Zulu to doctors at McCords Hospital, identified a high level of absenteeism and infrequency of lectures as two of the biggest obstacles he faced whilst teaching doctors. Once doctors are working full-time, it is virtually impossible to find a regular time to suit everybody in the class and it is not feasible to run a course for one or two people. Irregularity in attendance is a significant hindrance to efficient learning.

Secondly, the facilities offered by a tertiary learning institution like the University of Natal Medical School, in terms of teaching venues, equipment (e.g. overhead projectors and computers) and technology (e.g. web-based learning tools) assist in the achievement of learning goals.

Thirdly, with the institution of the new PBL (problem-based learning) curriculum at the UN Medical School, learners are being sent out into the hospitals right from their first year of study. Learners are thus given opportunities to practice their medical Zulu in real situations from year one. It is important (and possible) for learners to start speaking Zulu right from the beginning of their studies so that they can develop their confidence and competency and so that they do not get into the habit of relying on nurse-interpreters to communicate with patients.

4.3.1.2 Description of target learners

- **Intellectual capacity:**

The first consideration I would like to mention is the intellectual capacity of the medical students constituting my target learners. Students who have been accepted to study medicine represent the top academic achievers in the country. They are top students selected from hundreds of applicants and are therefore, extremely clever. This means that their rate of learning is quite accelerated and it is possible to cover a lot of ground in a short space of time.

- **Age / sex / nationality:**

The first year medical students which I lectured in 2001 comprised a variety of cultures and race groups, including Indian, White and African. The initial number of students attending the course was 92, of which 63 were male and 29 were female. The number of regular attendees dropped to approximately 60 students by the end of the course, due to clashes with other courses or pressurised schedules. Of the 49 students who completed the course evaluation questionnaire, there were 32 English speakers, 6 Sotho speakers, 6 Venda speakers, 2 Tswana speakers, 1 Pedi speaker and 1 Swahili speaker.

- **Previous knowledge of Zulu:**

According to the questionnaire, at the beginning of the course only 2 students rated their Zulu proficiency as "excellent", 4 said their spoken Zulu was "good" and 6 rated their ability to speak Zulu as "average". Over 75% of students rated their ability to speak Zulu as "poor" or said they were completely "unable to" speak Zulu. (See figure 3 below.)

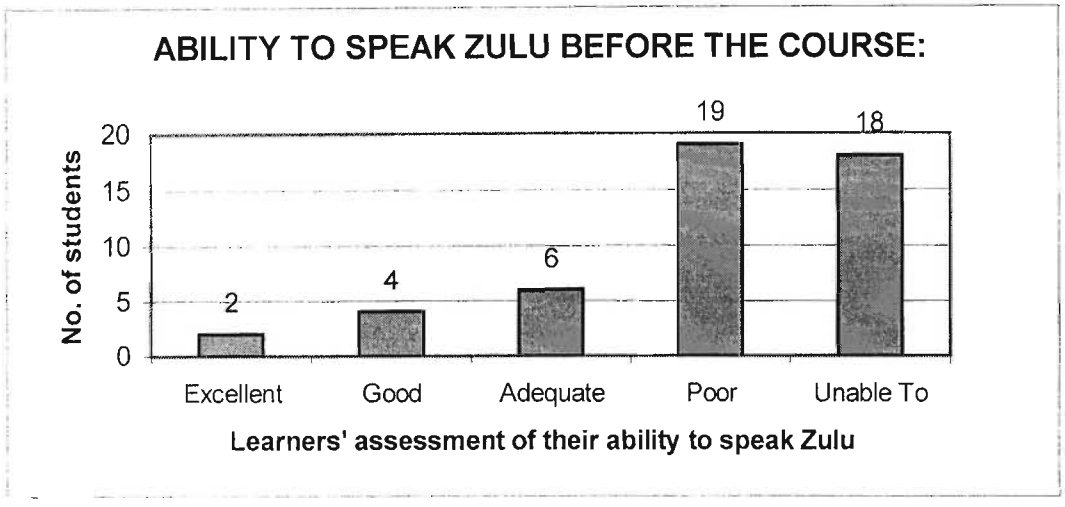


Figure 3: Learners' assessment of their ability to speak Zulu before the commencement of the Introductory Medical Zulu course in 2001 (Based on course evaluation findings in Appendix G)

After completing the course, 47 students recorded varying degrees of improvement and only 2 students said their ability to speak had not improved at all, as depicted in figure 4 below. Please refer to the course evaluation questionnaire and results (Appendix F and G) for a more detailed review.

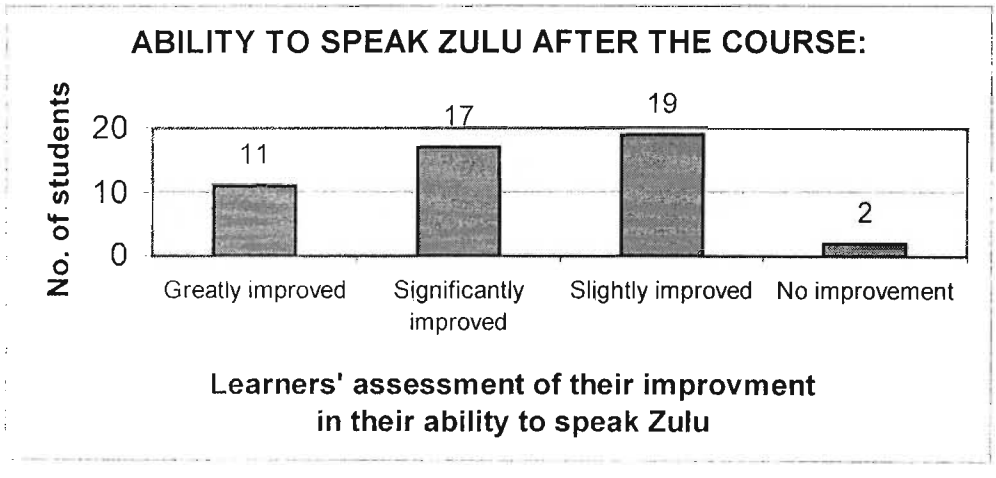


Figure 4: Learners' assessment of the improvement in their ability to speak Zulu after completing the Introductory Medical Zulu course in 2001 (Based on course evaluation findings in Appendix G)

➢ **Size of class:**

One of the constraints of the classroom situation was that of the size of the class. Approximately 80 students attended the introductory Zulu lectures in 2001. Because the class was so big, this limited the individual attention I was able to give learners and necessitated the inclusion of language activities that did not rely solely on interaction with the teacher.

4.3.2 Why are learners taking the course?

Most learners doing the Medical School Zulu course opted to because they felt their ability to speak Zulu would benefit them in their careers. They attended the course as a result of their own motivation and recognition of the importance of being able to communicate in Zulu in the hospital setting. According to the course evaluation questionnaire, nearly 80% of students recognised that attending a medical Zulu course was highly important, as indicated in figure 5 below.

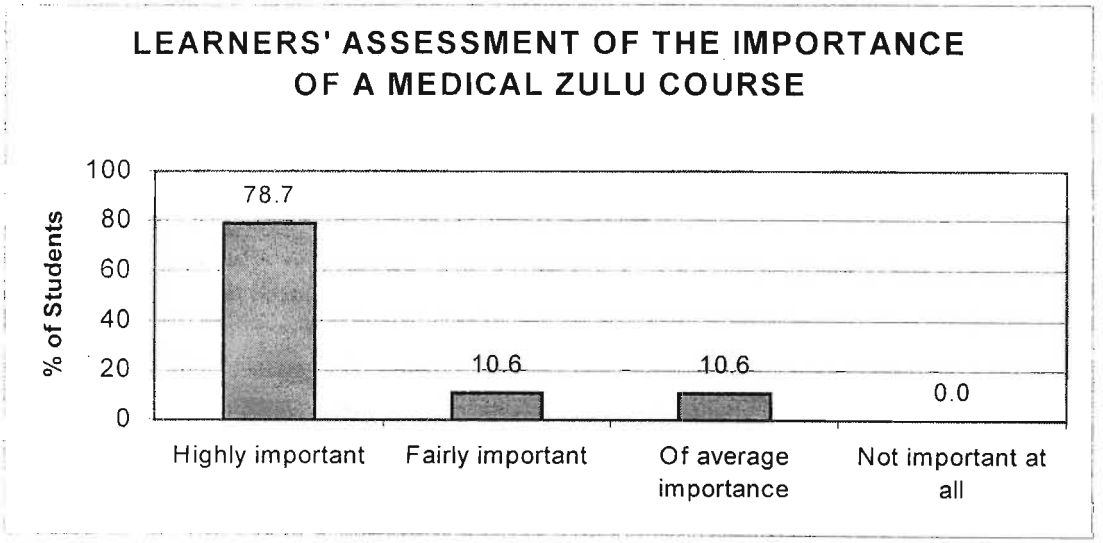


Figure 5: Students' perception of the importance of learning Zulu for their future careers (Based on course evaluation findings in Appendix G)

The graph in figure 6 illustrates that learners are aware that they will be required to speak Zulu in the workplace. Nearly all learners felt they would need to speak some Zulu in their career and only 2.1% of the felt they would never use Zulu once they were practicing medicine.

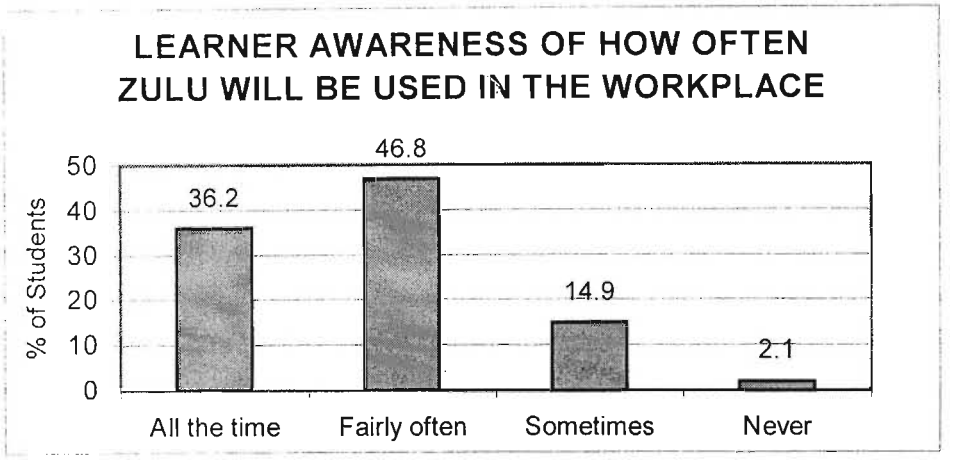


Figure 6: Students perception of how often they will need to speak Zulu in the workplace (Based on course evaluation findings in Appendix G)

University courses are usually either compulsory/examinable courses or optional/ non-examinable. The Zulu course I ran at the Medical School was voluntary and learners were encouraged to attend the course as an enrichment subject. Approximately 80% of learners who completed the course evaluation questionnaire (Appendix F) said they would not want Zulu to be an examinable subject, explaining that they enjoyed Zulu more because they were not forced to attend classes and because there was no pressure to excel in tests and exams.

While I personally believe that examinable subjects usually receive more attention from students, the optional status of the Zulu course did ensure that only the truly dedicated and motivated students attended the course. Over the months of tuition the number of students regularly attending lectures dwindled from approximately 90 to 60. Learners also commented that they would rather have a smaller group of dedicated students than a larger, more disruptive class of students who have no interest in learning Zulu but who have been forced to attend.

4.3.3 How do learners learn?

4.3.3.1 An overview of a typical 2-hour lecture

A typical 2-hour lecture would usually commence with an informal oral review session of the previous lecture's material. Learners were then given a handout (see sample handout in Appendix L) containing a dialogue (usually between a doctor and a patient) introducing the language functions, grammar and vocabulary items to be taught during the lecture. After explaining any new lexical items or grammatical structures, students paired up for role-play exercises, using the conversation provided in the handouts as a guide. Vocabulary and grammar were then reinforced with written and oral exercises.

4.3.3.2 Reading and writing activities

While doctors are not required to read or write Zulu in the OPD and the primary aim of the course is to help doctors to communicate verbally with their patients, reading and writing skills should not be neglected in a course such as this one. One of the practical benefits of teaching learners to read and write is that it allows the teacher to set self-study/homework exercises for learners to complete outside of classroom hours. The ability to read and write Zulu should enable learners to progress further in their language learning career as they will be able to read other Zulu literature such as magazines, newspapers and other medical Zulu phrasebooks etc.

4.3.3.3 Emphasis on oral activities

There are a number of reasons why dialogues play an important role in a specific purpose language course such as the one I lectured at the Medical School. Below is a discussion of some of these reasons.

Firstly, the main objective of the syllabus is to help learners become orally proficient within the stipulated context of the Out Patients' Department. Therefore it makes sense that a large portion of classroom time is allocated to activities that involve the skills necessary to speak and understand Zulu. It is for this reason that dialogues feature frequently in the course handouts.

Secondly, the large number of students in the class necessitates pair work because it is not possible for the lecturer to conduct conversations with each individual student.

Thirdly, dialogues are a useful and effective way of introducing grammar and vocabulary sections in context. Grammatical and lexical items introduced in this way are often understood better than if they were presented only in list form or in a table. "Living" language, or language in use, is always the best teacher.

- **Types of dialogues and role-play exercises:**

Pottow (1996) suggests various classroom techniques to promote oral competency, including different types of dialogues and role-play exercises:

Memorised dialogues do not cater for creative expression but serve to provide learners with a basic core of expression that they can use in the initial stages of learning until they have built up a more substantial linguistic repertoire. With **response dialogues**, the words of Speaker A will have been pre-determined and the learner will be expected to respond appropriately as Speaker B. While these interactions allow for slightly more creative input than memorised dialogues, they are still a little artificial. **Cued dialogues** allow for even more creative freedom. With these exercises, learners are required to formulate sentences based on cues. Examples of cues include, "Greet A", "Ask B what is wrong with him?" or "Instruct B to take three pills twice a day".

Role-play is not simply the acting out of memorised dialogues but improvisation. The teacher might "pre-teach" certain useful expressions and vocabulary items before giving learners the details of their interaction. For example, they may be told to act out a scenario between a doctor and the mother of a child suffering from malnutrition. Further guidance may be given to learners about the information they should elicit from the mother but little control should be exercised over the execution of the role-play and creativity and boldness should be recognised and rewarded by the teacher.

4.3.3.4 Homework assignments and learner evaluation activities

Homework assignments were frequently set as a means of continuous assessment of learners' improvement and to extend learning time.

Written tests were used as an incentive for learners to keep up to date with grammar and vocabulary. The focus was on oral assessment where students were required to present a doctor-patient dialogue in pairs on a given topic. For example, upon completion of the diabetes module, learners were asked to re-enact a consultation between a doctor and a diabetic patient.

The importance of evaluation activities cannot be underestimated. As mentioned in section 4.3.1.2, the first Zulu lecture I gave in 2001 was attended by 92 students. The number of regular attendees dropped to approximately 60 students by the end of the course. However, even though a number of students were unable to regularly attend the lectures due to clashes with other courses or pressurised schedules, most of these students made sure that they did not miss evaluation activities such as the written tests and oral assessments.

4.3.4 What resources are available?

Resources included handouts, a chalkboard, an overhead projector and a screen for displaying notes and exercises not contained in the handouts.

4.3.4.1 Handouts

As explained in chapter two (section 2.4.3), materials design or adaptation is often an integral part of implementing a specific purpose language course because there are often few or no suitable resources available. I designed all of the handouts given to learners, based on the field-work I had done in hospitals and previous teaching experience. As part of the course evaluation I asked learners to assess the handouts in terms of presentation and interest. Over 93% rated them as good or excellent.

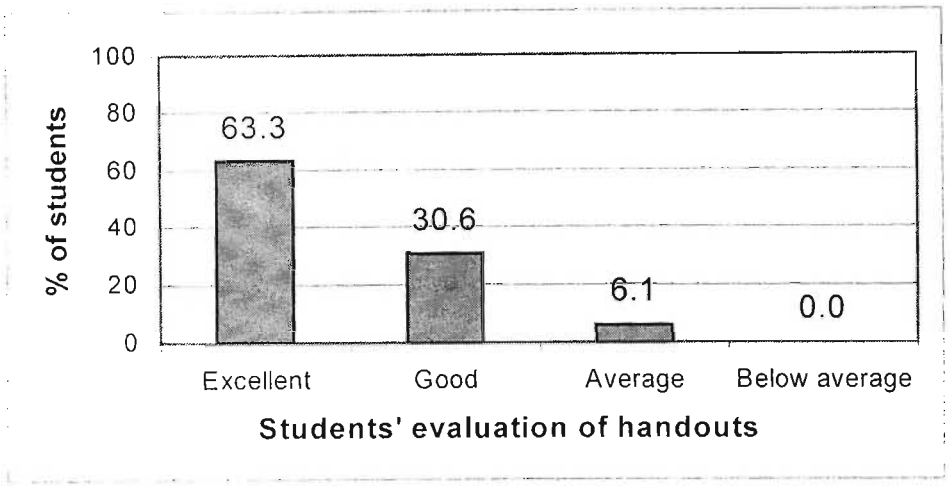


Figure 7: Learners' evaluation of handouts in terms of presentation, interest and layout (Based on course evaluation findings in Appendix G)

4.3.4.2 WebCT

One of the most useful and modern resources available at the Medical School was WebCT, a web-based learning tool operated by the university to enable lecturers to post additional material on a website for learners to access in between classes thereby extending learning time and encouraging self-study. Lecturers can post revision worksheets and model answers on the site to help prepare learners for tests and exams. There is also a "comments" section on WebCT, which allows learners to ask questions and make comments about the work they are studying. This feedback helps to inform the lecturer which areas the learners are struggling with most and if there is a need for further revision of certain sections. One of the added advantages of the WebCT system is that learners can access it on campus or from their personal computers at home as long as they are registered students at the university, which makes it a very convenient way to disseminate information.

According to the course evaluation questionnaire only 14% of students didn't access the Zulu worksheets on WebCT. The majority of the class, however, made use of the facility to varying degrees. Of those learners who did access WebCT, every single one indicated that it was beneficial to their studies:

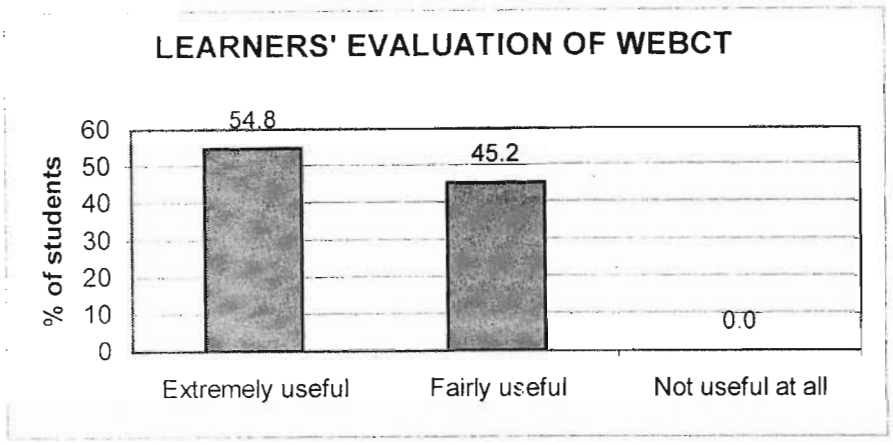


Figure 9: Learners' assessment of the usefulness of WebCT (Based on course evaluation findings in Appendix G)

4.3.4.3 Certificates upon completion of course

A resource that also acted as a learning incentive, was the official certificate offered to all students who achieved 50% and above for their final Zulu course mark. Since the course was optional and would not be reflected on their official record, students felt that such a certificate would enhance their medical qualification and were thus motivated to put extra effort into their Zulu studies in order to obtain the certificate.

4.3.4.4 Recommended resource for future use: audio tapes

A resource not yet available at the Medical School but which I would recommend is either a tape library or an audio-visual CD-rom system. This would enhance learner's listening skills and pronunciation. I feel this is particularly important for those learners who are not regularly exposed to Zulu and whose only opportunity to speak and hear the language is during Zulu lectures.

4.3.5 Where does ZSP course take place?

The lectures at the University of Natal Medical School were conducted in a conventional lecture hall able to accommodate approximately 200 people. The venue for our lectures was too big for the 50-80 learners who attended the Zulu classes. Ideally a venue for an interactive course such as the one I was running should be just large enough to accommodate approximately 80 people so that

learners feel connected to one another and to the teacher. The visual and conceptual impact of a smaller venue encourages learners to participate more freely in activities such as role-play exercises.

There was no language laboratory facility at the Medical School but learners could make use of this facility on the main campus. I would like to suggest that syllabus designers at the Medical School include a language laboratory session on main campus as part of the course requirement, to develop both aural and oral skills. A one-hour slot every 2 weeks would definitely help to improve their listening and speaking skills and it is still a realistic goal with regard to time constraints.

4.3.6 When does ZSP course take place?

The ZSP course took place in the first year of the study. Between the months of February - October 2001, I had a total of 52 contact hours with the first year medical students. One can achieve a substantial amount in this time but this depends to a large degree on the frequency and regularity of contact between lecturer and student and not allowing weeks to lapse in between points of contact.

In the first module I lectured in 2001 I saw students once or twice a week with each session being 2 hours in duration. During this module I managed to cover a significant amount of work. In the modules that followed, my contact sessions with students were more spaced apart which was extremely detrimental to students' progress as they forgot a lot in the long intervals between lectures. In 2002, the Zulu lectures at the Medical School were even more spaced apart and even though the teacher was allocated the same number of hours as I was given in 2001 (i.e. 52 hours), she was unable to cover the same amount of work as I did. This is evidence of the fact that learners need frequent contact sessions, especially in the initial stages of learning.

4.4 SUMMARY

In this chapter I reported the findings of my investigation into target situation needs and I commented on the dynamics of the learning situation of my target learners.

My target situation analysis enabled me to observe and catalogue the typical situations, language functions, vocabulary, grammar and cultural items which learners can expect to encounter in the OPD.

Whilst lecturing an introductory medical Zulu course at the Medical School in 2001, I gained valuable insight into the dynamics of the learning situation. I was able to assess various aspects relating to the practicalities of the learning process e.g. how best to make syllabus content available to learners, what was realistically achievable given the time constraints, how to motivate learners to study Zulu, how to manipulate the available resources to make learning activities more enjoyable, how to extend learning time etc.

Both of these areas of investigation have provided me with important information upon which I based my decisions regarding the design of an introductory Zulu syllabus aimed at preparing medical students for their future interactions with patients in the OPD. The syllabus I have designed will be discussed in the next chapter.

CHAPTER 5: APPLICATION OF RESULTS & RATIONALE FOR SELECTION OF SYLLABUS CONTENT

5.1 ANALYSING AND INTERPRETING THE RESULTS

"Given that the purpose of an ESP course is to enable learners to function adequately in a target situation... then the ESP course design process should proceed by first identifying the target situation and then carrying out a rigorous analysis of the linguistic features of that situation. The identified features will form the syllabus of the ESP course."

(Hutchinson & Waters, 1987: 12)

Having completed my investigation into the target situation and the learning environment, I then had to attend to the task of analysing and interpreting the results in order to design the syllabus for an introductory medical Zulu course. In chapter five I explain my ZSP syllabus design and justify my choices regarding the selection and arrangement of syllabus content, based on the findings of my research (as reported in chapter four), readings (as discussed in chapter two), and teaching experience (as outlined in chapter four).

5.2 DEFINING FEATURES OF THE INTRODUCTORY MEDICAL ZULU SYLLABUS I HAVE DESIGNED

Before I discuss the selection and organisation of items in the syllabus, I would like to summarise the most important features of the syllabus I have designed:

- It is designed for a specific purpose
- It has been designed with a specific group of target learners in mind
- The syllabus aims to promote oral competency
- There are six mini-syllabuses comprising the eclectic syllabus
- It allows for 60 contact hours between lecturer and learners

5.2.1 It is designed for a specific purpose

The overall objective of the syllabus I have designed is to teach learners whose mother tongue is not Zulu to communicate with Zulu-speaking patients within the designated setting of a hospital Out-Patients Department.

5.2.2 It has been designed with a specific group of target learners in mind

Another defining feature of this syllabus is that it is aimed at a specific group of target learners. I have selected medical students as the ideal group of target learners, for reasons discussed in chapter four (section 4.3.1.1).

5.2.3 The syllabus aims to promote oral competency

Since the primary language activity in the target situation is spoken communication, one of the main aims of the syllabus is to facilitate language activities that develop listening and speaking skills. Reading and writing activities also form part of the syllabus but these are more a means to an end as they are designed to assist the learner in acquiring oral and aural skills. The strong emphasis on the spoken nature of the Zulu language affected my choices regarding which language functions, vocabulary items, grammatical constructions and exercises to include in the syllabus.

5.2.4 There are six sub-syllabuses comprising the eclectic syllabus

For reason discussed in chapter two (section 2.4.2.3), I chose an eclectic syllabus design. The organisation of the ZSP syllabus is based on more than one criteria and a single lesson may include a number of linguistic elements such as language functions, vocabulary themes, notions or grammatical structures. As Littlewood explains:

"It is not necessary to opt for only one form of organisation for a course as there are several ways in which different organisational principles can be combined. For example, different forms of organisation can be 'nested' inside each other."

(Littlewood, 1981:79)

The six sub-syllabuses "nested" inside my eclectic syllabus, to be discussed in further detail in this chapter, are:

- Themes/ Topics
- Language functions
- Vocabulary/ Lexis
- Grammatical structures
- Cultural elements
- Language activities

5.2.5 60 Contact hours between lecturer and learners

Until 2001, the only medical Zulu tuition available to learners through the Medical School was a 1-week course during Winter School. Therefore, the allocation of 52 hours to Zulu classes in the 2001 syllabus is a substantial improvement.

I have decided to round the number of hours for my syllabus design up to 60 to allow more time for revision, consolidation and evaluation activities. Therefore, in order for learners to complete the content in the syllabus I have designed (Section 5.3), there needs to be a minimum of 60 contact hours between lecturer and learners. This estimate, based on what was realistically achievable during the Zulu lectures in 2001, includes time for evaluation activities (e.g. oral and written tests) but excludes personal study time and self-study/homework activities. Based on my experience at the Medical School, I found that it took approximately 9 hours for evaluation activities, which included oral assessments and written tests. Thus, with the 60-hour syllabus I have designed, this allows for approximately 51 hours of actual teaching time.

5.3 OUTLINE OF THE ZSP SYLLABUS I HAVE DESIGNED:

5.3.1 HOW TO INTERPRET THE SUMMARY TABLE IN SECTION 5.3.2

The syllabus I have designed has been organised into nine units or modules, with the designated theme or topic as the primary unit of organisation. The language functions, vocabulary, grammar and cultural content were chosen to complement the theme selected for each unit. The choice of language activities / teaching methodology to be employed in the classroom is up to the discretion of the

teacher. As explained in chapter two, methodological issues are not the focus of my thesis. However I have made some suggestions as to which kinds of classroom activities are suited to the syllabus I have designed in section 5.6.7. I have also included some sample handouts to illustrate the kinds of materials suited to this syllabus design (Appendix L-Q).

I have not prescribed the specific number of hours to be allocated to each unit (module) of the syllabus that I have designed in section 5.3 below. The lecturer should be flexible enough to spend extra time on a certain unit if learners are struggling, or move more quickly through sections that learners grasp easily. As a rough guide, I would suggest that each unit should take approximately 4 – 6 hours to complete, excluding evaluation activities. Written tests and oral assessments should be done after every two or three units. Homework assignments and revision exercises should also be set frequently to extend learning time and to provide the teacher with a means of monitoring learners' progress.

I will be referring to the syllabus summary in section 5.3.2 in my discussion of content selection, the organisation and arrangement of content, and the six sub-syllabuses comprising my eclectic syllabus

5.3.2 SUMMARY TABLE OF SYLLABUS DESIGNED FOR INTRODUCTORY MEDICAL ZULU COURSE

UNIT	THEME/ TOPIC	LANGUAGE FUNCTIONS	VOCABULARY	GRAMMATICAL STRUCTURES	CULTURAL INPUT
1	***Sawubona***	✓ Greeting ✓ Asking after health ✓ Asking and giving names/ surnames ✓ Asking where someone is gong & responding appropriately ✓ Expressing sympathy ✓ Offering encouragement ✓ Saying goodbye/ closing the conversation	✓ Medical nouns (introduction to class 1–8) ✓ Terms of address ✓ Basic medical vocabulary ✓ Verbs expressing pain/ discomfort ✓ Verbs describing symptoms ✓ Verbs describing medical procedures ✓ Locatives relevant to medical field ✓ Introduce Power texts 1 survival phrases e.g. "Awuphinde" (Please repeat)	✓ Personal pronouns ✓ Complete overview of noun classes 1- 8 ✓ Noun class system & subject concords for classes 1 and 1a ✓ Question words: "phi" (where) and "ni" (what) ✓ Associative non-verbal predicate "na" (to have) ✓ Verbs and statives in present tense	✓ Zulu greetings & use of familial terms of address ✓ Ukuhlonipha (respect) tradition
2	***Uphethwe yini?*** Consultation between doctor, mother & child	✓ Asking what is wrong with someone (Taking a patient's history) ✓ Instructing patient to take medicine ✓ Thanking	✓ "Uphethwe yini?" (What is wrong with you?) ✓ Appropriate answers to questions concerning health ✓ Medical vocabulary relating to symptoms of colds, flu's and coughs etc ✓ Power texts 2	✓ Noun classes 2-8 ✓ Question word "ubani" (who) ✓ Statives ✓ Passive tense & agentive prefixes "ng" and "y" (e.g. Ngiphethwe yihlo) ✓ Third person questions (especially mother answering on behalf of child) ✓ Future tense	✓ Non-verbal displays of respect for doctor e.g. silence, averting eyes, saying "yes" just to please doctor ✓ Polite phraseology of questions relating to health
3	***Ngicela ukukuhlola*** Conducting a physical examination	✓ Questioning ✓ Instructing ✓ Reassuring	✓ Medical vocabulary related to physical examination ✓ Pain: types of pain and locating pain ✓ Body parts ✓ Vocabulary related to time ✓ Power texts 3	✓ Commands/ Imperative (positive) ✓ Question words "phi" (where) and "nini" (when) ✓ Introduce locatives using body parts ✓ Recent Past Tense	✓ Zulu perspective on time
4	***Impilo*** Advising a patient about good nutrition & healthy lifestyle habits	✓ Taking a patient's history ✓ Instructing ✓ Suggesting further action (e.g. better eating habits)	✓ Vocabulary related to nutrition ✓ Vocabulary related to other lifestyle habits e.g. smoking and drinking ✓ Power texts 4	✓ Associative non-verbal predicate "na" (to have) ✓ Introduce object concords ✓ Question word "ngaki" (how many) e.g. "Uneminyaka emingaki?" (How old are you?) ✓ Imperative: positive and negative	✓ Zulu beliefs related to nutrition

5	***Ikholera*** Paediatric Consultation with patient suffering from cholera	✓ Taking a child's history from the patient's mother ✓ Questioning ✓ Instructing ✓ Explaining	✓ Diarrhoea ✓ Dehydration ✓ Nausea ✓ Diet ✓ Power texts 5	✓ Revise object concords ✓ Questions with object concords ✓ Commands ✓ Remote past tense	✓ The role of traditional healers: sangoma's and inyanga's
6	***Isifo sikashukela*** Diabetes Consultation	✓ Taking a diabetic patient's history ✓ Explaining	✓ Medical vocabulary related to diabetes ✓ Related vocabulary e.g. hypertension ✓ Signboards in hospital e.g. X-ray dept. ✓ Power texts 6	✓ Introduce polite commands & the subjunctive tense ✓ Locatives ✓ Object concords ✓ Present tense negative ✓ Relatives as in "Kukhona onesifo sikashukela ekhaya" (Is there someone with diabetes at home?)	✓ "Idliso" (bewitchment by poisoning)
7	***Isifuba*** Consultation with patient suffering from respiratory problems	✓ Taking the history of a patient with a respiratory problem ✓ Conducting a physical examination ✓ Instructing ✓ Prescribing medication	✓ Vocabulary related to chest, lungs & breathing ✓ Colds, flu's, coughs, i-TB, asthma and related medical vocabulary ✓ Power texts 7	✓ Further locatives in reference to body parts e.g. "esifubeni" (in my chest) ✓ "Kufanele ukuba" + subjunctive (urging patient to complete course of treatment)	✓ "Ukuthwasa" (the calling to become a diviner)
8	***Ukukhulelwa*** Consultation with a pregnant woman/ Conducting a physical examination	✓ Taking a pregnant woman's history ✓ Instructing ✓ Reassuring	✓ Vocabulary relating to pregnancy & sexual history ✓ Past and family history ✓ Time: "Sekunesikhathi esingakanani?" (For how long?) ✓ Power texts 8	✓ Revision of present tense (negative) ✓ Future tense (negative) ✓ Remote past tense revision & possessives	✓ "Isisu" (stomach) and the entry ticket complaint
9	***Izifo Zocansi*** Sexually transmitted diseases	✓ Taking the history of a patient with AIDS ✓ Explaining ✓ Instructing ✓ Suggesting ✓ Reassuring	✓ Polite terms for sexual organs ✓ Sexually transmitted diseases ✓ Ingculazi / i-AIDS ✓ Related symptoms e.g. kin infections, chest infections etc ✓ Power texts 9	✓ Revision of present and future tense (negative) ✓ Recent and remote past tense (positive and negative)	✓ Myths surrounding sexually transmitted diseases ✓ Euphemisms and metaphors for sexual organs

5.4 CRITERIA FOR SELECTING SYLLABUS CONTENT

Having conducted a needs analysis into the target situation and obtained research findings, choices needed to be made about which linguistic items should be included based on the purpose, length and level of the projected course. Nunan reminds us that the process of content selection is particularly important with an introductory (short) course, such as the one I am proposing:

"The need to make value judgements and choices in deciding what to include (or omit from) specifications of content and which elements are to be the basic building blocks of the syllabus, present syllabus designers with constant problems. The issue of content selection becomes particularly pressing if the syllabus is intended to underpin short courses."

(Nunan,1988: 10)

In this section I will highlight the selection criteria employed in order to determine which language items to include in the syllabus:

- Situational need
- Frequency of occurrence
- Linguistic knowledge already possessed
- Time constraints
- Emphasis on oral competency
- Size of class
- Facilities available
- Learner motivation and enjoyment

5.4.1 Situational need

"Decisions about which items to include in the syllabus can no longer be made on linguistic grounds alone, and designers need to include items which they imagine will help learners to carry out the communicative purposes for which they need the language... This is particularly so when developing syllabuses for courses with a specific focus."

(Nunan, 1988: 36)

The above quote reflects the view that syllabus designers should start by asking themselves the question, "What do learners need to be able to communicate in the target situation?" Given that the Zulu course I have designed is a specific purpose language course and the target situation for which learners are preparing themselves is fairly well defined, the aspect of situational need was one of the most important factors in determining syllabus content.

The vast majority of themes/topics, language functions, structures, vocabulary items and cultural aspects selected for this course were chosen because my research proved that they were the linguistic items which learners would find most useful in the target situation. For example, in 34 of the 80 consultations I observed (see figure 1 in chapter four, section 4.2.6.1) the doctor conducted some form of physical examination. For this reason I selected the theme of *Ngicela ukukuhlola* (I would like to examine you) for Unit 3. Conducting a physical examination requires that the doctor is able to instruct the patient, ask after location (e.g. the site of pain), explain and reassure. The extracts below illustrate some of the language functions, structures and vocabulary involved in the theme of the physical examination.

Appendix C: Consultation 8

Doctor:	Khumula izingubo lala embhedeni la. Ugcine nini esikhathini?	Take off your clothes and lie on the bed. When was your last period?

Appendix C: Consultation 9

Doctor:	Khumula izingubo zonke lala embhedeni ngifuna ukuhlola umzimba uyezwa?	Take off all your clothes and lie on the bed. I want to examine you. Do you understand?

Appendix C: Consultation 12

Doctor:	Awuhlale la ngithi ukuhlola inhliziyo ngizwe ukuthi ishaya kanjani namhlanje. Hlala nje khona lapho.	Sit down here so that I can examine your heart and check how it is beating today. Just sit down there.

However, identifying the linguistic items used in doctor-patient consultations in the OPD was not the end point of the syllabus design process. Due to time constraints it is not possible for this course to cover every linguistic element that learners may encounter in the target situation. It was therefore necessary to consider other factors (e.g. frequency of occurrence and time constraints, which are discussed below) in order to decide what to include and what to omit from the syllabus.

5.4.2 Frequency of occurrence

One of the other factors influencing my selection process is that of frequency. Those language items that occurred often usually took precedence over linguistic elements occurring less frequently. Examples of how frequency influenced the selection of content are as follows:

- In Unit 3 I have included a vocabulary section on *ubuhlungu* (pain) because pain was identified as the most frequent complaint which patients present with. It is thus important that doctors are able to discuss relevant issues e.g. the nature, duration and site of the pain etc.

- The primary language functions in unit one were greeting, asking after health, asking after names and surnames. As explained in chapter four, every consultation began with some form of greeting and enquiry into the health of the person.

- I selected the following themes for Units 4, 7 and 8: *Impilo* (Health), Isifuba (Chest) and *Ukukhulelwa* (Pregnancy) primarily because they accounted for three of the four most common consultation types in the OPD.

5.4.3 Linguistic knowledge already possessed

Some of the learners in the 2001 class did have some background Zulu knowledge. However, the syllabus I designed presumes no previous knowledge of Zulu, as I did not want to disadvantage learners who had no Zulu learning experience. For this reason, certain seemingly elementary sections, which may be unnecessary for learners with some experience in Zulu, were included in the syllabus. However, as these constitute some of the fundamental building blocks of the Zulu language, it was necessary to make sure all learners had a good understanding of these items before moving on to more complicated, lesser known aspects of the language. For example:

- The personal pronouns and their subject concords e.g. *Wena* (you, sing), *Mina* (me), *Nina* (you, plural), *Thina* (we)
- Greetings e.g. *Sanibona bafowethu* (Hello, my brothers)

- Asking after health e.g. *Wena usaphila* na? (How are you?)
- Asking after names and surnames e.g. *Ungubani igama lakho?* (What is your name?)

5.4.4 Time constraints

The issue of time constraints was probably the most significant and limiting factor affecting the selection of syllabus content. As explained in section 5.2.5 I have designed a 60-hour syllabus because anything more extensive than this would not be feasible given the time allocation for learning Zulu at the Medical School. Therefore the content selected for the syllabus had to be realistically achievable in 60 hours. There are a number of techniques which teachers can employ to extend learning time and I will mention a few of these in my discussion of the syllabus. However, since this a matter for methodology, I will not be discussing this aspect in great detail in my thesis.

Ideally, target learners should receive Zulu tuition at least once a week (for a minimum of two hours) for a full year. Professor Loening, Director of Medical Education Development at the University of Natal Durban, also highlights the importance of a substantial language course for medical students.

"It is patently obvious that much more than a 6-month course in an African language is essential."

(Prof. Loening, SAMJ Volume 87: 1997)

5.4.5 Emphasis on oral competency

The overall aim of this syllabus was to promote oral competency. In order to achieve this, I needed to allow for a substantial amount of time in the syllabus for oral exercises whereby learners could practice the functions, structures and vocabulary acquired during classes. Oral activities are very time consuming therefore this restricted the content covered in the syllabus.

5.4.6 Size of class

As explained in chapter four (section 4.3.1.2), one of the constraints of the classroom situation was that of the size of the class. Each lecture was attended

by between 90 and 60 students. Because the class was so big, this limited the individual attention I was able to give learners. With a class of this size it is not possible to cover as much material as one could achieve with a smaller class.

5.4.7 Facilities available

In addition to the usual facilities available in a second language classroom (such as a chalkboard / whiteboard, overhead projector etc.), there was one facility available at the Medical School which enabled me to extend learning time and include more "D.I.Y." (Do It Yourself) content in the syllabus. As explained in chapter four, WebCT is a web-based learning programme at the Medical School which enables learners to access material such as revision worksheets and model answers outside of class time. This facility enabled me to set homework tasks, which learners were required to complete in their private study time. I was also able to post revision exercises and model answers to assist learners in preparing for their assessments.

5.4.8 Learner motivation and enjoyment

Learner motivation is a key factor in this syllabus because the Zulu classes are optional and non-examinable. It is, therefore, important to choose content and material that is stimulating and appeals to the interests of the learner. When learners are interested in the subject matter and are enjoying the learning experience, they are motivated to continue learning and eager to expand their existing knowledge. According to the course evaluation questionnaire administered to students at the Medical School (Appendix G), one of the key aspects, identified by learners, in learning a language is a high level of motivation.

I found that learners are more motivated about learning through the use of relevant, realistic medical discourse and interesting or entertaining dialogues rather than endless lists of grammatical structures that seem to have little relevance to the end goal of speaking Zulu to their patients. This was one of the reasons why I decided not to design a syllabus with a strong grammatical emphasis. Instead I structured my syllabus around a number of varied sub-syllabuses: lexical, cultural, functional, grammatical etc. Below is an extract from a handout (Appendix N) which I recommended for use in unit 3, where the theme is that of the physical examination.

READING: THE PHYSICAL EXAMINATION

USibongile uyisiguli. Uya esibhedlela. Udokotela uhlola uSibongile. Udokotela welapha uSibongile.
Udokotela uthi, *"Khamisa, Sibongile!"*
USibongile uthi, *"AAAH."*
Udokotela uthi, *"Khipha ulimi Sibongile!"*
USibongile ukhipha ulimi.
Udokotela uthi, *"Donsa umoya. Khipha umoya."*
Udokotela ulalela inhliziyo kaSibongile.
Udokotela uthi, *"Lala embhedeni, Sibongile. Ngifuna ukukuhlola."*
USibongile ulala embhedeni kodwa wesaba udokotela. Uyaqhaqhazela.
Udokotela uthi, *"Musa ukukhathazeka. Ngeke ngikulimaze."*
USibongile uthi, *"Ngesaba ukujovwa!"*
Udokotela uthi, *"Kulungile, Sibongile. Ngizokuhlola nje. Buphi ubuhlungu?"*
USibongile uthi, *"Isisu sami sibuhlungu."*

AMAGAMA AMASHA

- Phefumula - breathe in & out
- Donsa umoya - breathe in
- Khipha umoya - breathe out
- Khipha ulimi - Stick out tongue
- Lalela - listen
- Qhaqhazela - tremble
- Khathazeka - worry
- Limaza - hurt/cause injury to

This reading introduces learners to the theme of the physical examination and the language function of giving instructions. New lexical items are listed with their meanings in the vocabulary extension box marked *Amagama Amasha* (new words). The grammar needed to express these functions can be explained using the dialogue as an illustration. This proved to be an effective way of introducing learners to the relevant linguistic features because it is based on a realistic situation which they might actually encounter and can be adapted into a fun role-play exercise.

This particular role-play exercise proved to be a source of amusement for the class I lectured because some learners really became immersed in the character they were role-playing and enjoyed sticking out their tongues and lying on the desks when instructed to do so. It was a good ice-breaker and encouraged learners to become more relaxed and confident about speaking in class.

Note on aesthetic value of handouts

At this point I would also like to comment on the importance of selecting (if available) or designing appropriate, aesthetically pleasing materials. Graphics and an appealing layout contribute enormously to the level of interest of a textbook or

set of notes. As mentioned in chapter four (section 4.3.4.1) the learners attending the medical Zulu classes I was lecturing responded very positively to the materials I designed. I believe learners liked the handouts because they were clearly set out, made use of a modern font (Comic Sans MS) and included pictures. Below I have included a table of some of the "symbols" indicating particular types of exercises. For examples of the handouts I designed to illustrate my syllabus design, please consult Appendices L-Q.

Picture symbol	What the picture signifies
	A written exercise
	An oral exercise
 *HOMEWORK ASSIGNMENT 6*	Homework Exercise
	An explanation of some aspect of Zulu culture

5.5 ORDERING SYLLABUS CONTENT

5.5.1 Unit of organisation

Once the language items had been selected according to the criteria listed above, the next task was that of ordering the content into units. Deciding what to include in each unit or lesson depends on the type of syllabus that has been chosen. If a syllabus designer has selected a functional syllabus, for example, the unit of organisation will be the language function. With an eclectic syllabus such as the one I have opted for, the syllabus can be arranged according to language functions, notions, situations, topics or structures.

I chose the sub-syllabus of theme/topic as the primary unit of organisation in my syllabus. Each unit revolves around a different theme, related to the medical setting. Once I had chosen a theme, I identified the language functions, grammatical structures, vocabulary and points of cultural interest necessary for the learner to be able to communicate in that situation.

For example in Unit 8, I selected a pregnancy theme - *Ukukhulelwa*. I designed a conversation (Appendix P) based on some of the consultations I had observed in the OPD where a doctor asked his patient a few routine questions about her pregnancy and then conducted a vaginal examination. I did not include all the possible questions a doctor might ask a pregnant woman as this would have resulted in a rather tedious dialogue overloaded with information.

Some of the language functions included in this theme were:

- Asking after patient's symptoms e.g. *Amabele abuhlungu?* (Are your breasts painful?)
- Asking after quantity e.g. *Unabantwana abangaki?* (How many children do you have?)
- Asking after location e.g. *Wabeletha ekhaya noma esibhedlela?* (Did you deliver at home or at the hospital?)
- Suggesting/advising e.g. *Kungcono ukuncelisa izinyanga eziyisithupha.* (It is better to breastfeed only for the first six months)
- Instructing e.g. *Khumula izingubo ulale embhedeni.* (Take off your clothes and lie on the bed)

- Explaining e.g. *Ngizofaka iminwe ngaphambili.* (I will insert my fingers into your vagina.)
- Reassuring e.g. *Ungakhathazeki, mama. Ngeke ngikulimaze.* (Don't worry, mother. I would never hurt you.)

The vocabulary selected is chosen to complement the theme and to enable learners to be able to express the necessary language functions. Below is an example of the vocabulary extension box included in the handout for this unit (see Appendix P).

AMAGAMA AMASHA

- -khulelwe - pregnant
- -vuvukele - swollen
- -buhlungu - sore
- -vuza - ooze
- Unabantwana abangaki? How many children do you have?
- Nibangaki ekhaya? You are how many in your home?
- Nginomntwana oyedwa (only 1 child)
  Nginabantwana ababili (2), abathathu (3), abane (4), abahlanu (5)
- -beletha - give birth
- phansi kweshidi -under the sheet.
- -zwa - feel
- -faka - put
- Gqoka - Get dressed
- Iminwe - fingers
- Insimbana - small instrument
- Ngaphambili - vagina /down below (lit)
- -kathazeka - worry
- Sekuyaphela - it will soon be over

Some of the grammatical structures needed to express the language functions identified for this theme are beyond the learners' linguistic competence at this stage e.g. the use of the relative with the exclusive pronoun in the expression, *Nginomntwana <u>oyedwa</u>* (I only have one child)

Examples of grammar sections which could be explained in this Unit are:

- Remote Past tense e.g. *<u>Wa</u>beletha ekhaya noma esibhedlela?* (Did you deliver at home or at the hospital?)

- Object concords e.g. *Uyabanika abantwana ibele?* (Do you give the children the breast / Do you breastfeed?)

The cultural input I chose to include in this syllabus relates to the "entry ticket complaint" as referred to by Dr Ellis (Ellis, 1999: 30). He explains that often a patient will complain of a general symptom like stomach-ache or backache when, in fact, he or she fears that something else is the real cause of his illness. For example a female patient may present with stomach-ache (*isisu*) but what they are really concerned about is whether they are pregnant/ infertile/ infected with HIV/AIDS.

5.5.2 Grammatical complexity

Grammatical complexity was one of the considerations, which influenced the design of the ZSP syllabus. With Zulu in particular, it is useful to start with certain grammatical items because others seem to naturally follow on from there. For example, I recommend teaching the Zulu noun class system early on because it represents the most basic building blocks of the Zulu language and a large number of other grammar sections rely on the learner's understanding of the noun classes. As this course is targeting first-time learners of Zulu, simple linguistic items were prioritised above more complex structures, wherever possible, and attempts were made to avoid complicated phraseology whilst still using "everyday" Zulu constructions that are acceptable to mother tongue speakers.

While I did attempt to start with simpler, less dense structures in unit one and gradually introduce more complicated, longer sentences once learners had acquired the basics, arrangement of items in the syllabus was not simply a case of ordering them from the least to the most complex. It is not always possible (or recommended) to completely avoid complex structures or phrases in the early stages of learning if it results in unnatural or contrived language.

For example, let us consider what happens when a particular situation or language function requires the use of a difficult grammatical structure for correct expression early on in the learning process. Some teachers may avoid teaching that situation or language function altogether while others might insist on giving an in depth explanation of the grammatical structures used before introducing learners to the material. I do not recommend avoiding complicated structures altogether nor do I

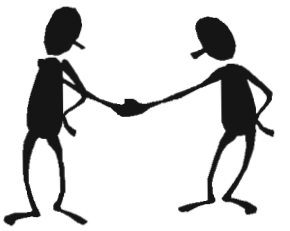
think it is advisable to substitute them for simpler alternatives if it results in less appropriate language. My suggestion is to gradually introduce small chunks of advanced language and to encourage learners to memorise difficult language items as "power phrases". An in-depth explanation of that particular grammatical section can be postponed until a later stage when learners have acquired greater communicative competency and have already mastered the use of the structure in context.

The extract below, taken from unit 1 (Appendix L), is an example of a situation where I chose not to avoid or substitute complicated phraseology even though it was beyond learners' grammatical understanding at the time. Prior to encountering this dialogue, learners had only been exposed to very simple sentence structures, for example:

- *Ngisaphila* (subject concord + infix + verb)
- *Ngiya khona* (subject concord + verb + locative)
- *Ngifunda isiNgisi* (subject concord + verb + object)

DIALOGUE: WHAT IS YOUR NAME?

UThandi:	Ungubani igama lakho?
UMuzi:	Igama lami nguMuzi / NginguMuzi.
	Wena ungubani?
UThandi:	Igama lami nguThandi / NginguThandi.
UMuzi:	Ngiyajabula ukukwazi.
UThandi:	Nami ngiyajabula ukukwazi



Suddenly they were faced with more complicated structures like identificative prefixes and possessives in the question *Ungubani igama lakho?* (What is your name?) and infinitives, vowel verbs and object concords in the response *Ngiyajabula ukukwazi* (I am happy to meet you). However, the language functions covered by this piece of language were vital in assisting learners to make acquaintance with strangers and I instructed them to memorise the dialogue (the concept of power phrases). Explanation of the underlying grammatical structures would be explained at a later stage. For example in unit 2 (Appendix 5.2), the subject of agentive prefixes is expanded on and applied to the passive construction *Uphethwe yini?* (What are you suffering from?)

5.5.3 Cyclical / Spiral syllabus

A number of linguists recommend structuring a communicative syllabus in a cyclical or spiral manner.

"A spiral approach should be used in the presentation and practise of any linguistic or cultural items. In a spiral approach we return to a topic, a functional category, or a structural category one or two months or even a semester after its initial presentation. After reviewing what the students had already learned about it, we proceed to go into the category or topic in greater depth – presenting one or more additional facets of it."

(Finocchiaro & Brumfit, 1983:58-59)

E.g. Staggering the teaching of question words

In Unit 1 of my syllabus I introduce the question words *-ni* (what) and *-phi* (where). These two question words are probably the easiest to master and provide a good basis for other question words which follow the same pattern. I chose to give learners time to familiarise themselves with these two questions before adding other question words such as *ubani* (who), in unit 2, and *nini* (when), in unit 3, to their repertoire. After learning the section on object concords (unit 4) the area of question words will be revisited and learners will be taught how to phrase questions with objects in the sentence.

5.5.4 Dependence on previously taught structures

The learning process can be assisted by planning the order in which certain constructions are taught as it is sometimes easier to teach certain more complicated phraseology by relating it to previously taught structures which learners have already mastered. A cyclical syllabus enables the teacher to stagger the teaching of a section by starting with a few facts and some simple examples and waiting before moving on to longer, denser expressions. Learners are thus given enough time to master the basics before being prematurely rushed into the use of more complicated structures.

Below is an illustration of how I put this principle into practice in the syllabus I designed:

E.g. Possessive concords and remote past tense concords

To express possessive constructions, one uses the same concords that are employed in the remote past tense. In the summary of my syllabus (section 5.3) I suggested learning the remote past tense in Unit 5, *Ikholera*. This would then be reinforced and revised in Unit 8, *Ukukhulelwa*, before the possessive was taught by building on learners' knowledge of the remote past tense concords.

5.5.5 Priority of needs

Certain language functions, grammatical structures and vocabulary items are taught before others because learners will most likely encounter them first. For example, greeting a patient and being able to ascertain his presenting complaint by asking *Uphethwe yini?* (What are you suffering from) are considered to be more pressing needs than being able to explain the patient's need for a surgical procedure. For this reason they have been included in units 1 and 2 rather than later on in the syllabus. Below is an example of a section in Unit 2 *Uphethwe yini?* (extract from Appendix M).

UPHETHWE YINI? UHLUSHWA YINI?

Izibonelo:

1)	Uphethwe yini? (ikhanda)	Ngiphethwe yikhanda.
2)	Uhlushwa yini? (amehlo)	Ngihlushwa ngamehlo.

Phendula imibuzo

1. Wena uphethwe yini? (umlenze)
2. Wena uhlushwa yini? (amadolo)
3. Abafana baphethwe yini? (isisu)
4. Umama uphethwe yini? (amehlo)
5. Umntwana uhlushwa yini? (amazinyo)
6. Isalukazi siphethwe yini? (iqolo)
7. Nina niphethwe yini? (isifo sikashukela)
8. Ihhashi liphethwe yini? (imilenze)
9. Uthisha uhlushwa yini? (ikhanda)
10. Iziguli ziphethwe yini? (ikholera)

AMAGAMA AMASHA

Uphethwe yini? (What are you suffering from?) / Uhlushwa yini? (What are you bothered by?)

Ngiphethwe... (I am suffering from)

...ngumlenze (sore leg)
...wunyawo (sore foot)
...ngamehlo (sore eyes)
...yizinyo (toothache)
...yisisu (stomach ache)
...yikhanda (headache)
...yinhliziyo (heart trouble)
...yisifo sikashukela (from diabetes)
...yiT.B. (from TB)
...yikholera (from cholera)

5.5.6 Cohesion with other modules in the Medical School syllabus

While I was not able to plan my entire Zulu syllabus around the modules covered by the Medical School, I did make an attempt to align my syllabus content with the modules being covered in other classes where possible. For example, when learners were studying a module on Diabetes Mellitus, I introduced my unit on *Isifo sikashukela*. Of course, it is not always possible for the two syllabi to coincide but I found that when they did, learners were especially focussed and motivated about what they were learning in my Zulu classes.

5.6 DISCUSSION OF THE SIX SUB-SYLLABUSES INCLUDED IN THE SYLLABUS I HAVE DESIGNED

As you will have noticed from the summary table in section 5.3.2, I have divided the syllabus into 9 units, each focussing on a different theme/topic. In this section I will discuss my choices relating to the six sub-syllabuses comprising my eclectic syllabus, namely

- themes / topics
- language functions
- grammar
- vocabulary
- culture
- language activities

5.6.1 Themes/Topics

Unit 1: *Sawubona* (Hello)

I chose the general theme of meeting, greeting and asking after health for the first unit because the basic language functions expressing this theme are used in most communicative encounters and will empower learners with the necessary skills for initiating conversations with other mother tongue Zulu speakers (who may not necessarily be patients). All 80 consultations I observed commenced with some kind of greeting and asking after health.

Appendix C: Consultation 2

Doctor:	Ya Thokozani.	Hello, Thokozani.
Patient:	**(Mother speaks on behalf of her child) Yebo.**	**Hello.**
Doctor:	(Addressing child) Xhawula letha isandla, letha nalesi. Unjani?	Let's shake hands, bring that other hand. How are you?

Unit 2: *Uphethwe yini?* (What are you suffering from?)

Being able to ask a patient to explain what is wrong with him or why he has come to see the doctor is the first step in discovering what the patient's presenting complaint is. In other words this unit assists the learner with how to start taking a patient's history.

Appendix C: Consultation 1

Doctor:	Unjani?	How are you?
Patient:	**Ngiyaphila.**	**I am fine.**
Doctor:	Ngiyajabula uma uphila, kusho ukuthi uzongivakashela nje. Kade ekliniki eMbazwana?	I am happy that you are well, because that means you have just come to visit me. Have you been to Mbazwana clinic?

Unit 3: *Ngicela ukukuhlola* (I would like to examine you)

34 of the 80 patients I observed required a physical examination of some sort thus examining a patient is a fairly routine aspect of many OPD consultations. The learner should also be able to give clear instructions to the patient, such as telling him to undress and lie on the bed or to breathe in or out etc. Being examined by a doctor can make some patients feel anxious or uncomfortable so it is important that the doctor is able to reassure them and explain what he is doing.

Appendix C: Consultation 1

Doctor:	Khumula izingubo lala embhedeni la.	Take off your clothes and lie on the bed.

Unit 4: *Impilo* (Health)

I chose this theme on general health and well-being, because it is not limited to a specific disease and it equips the learner with the basic skills necessary to advise patients on general good nutrition and healthy lifestyle habits.

The language functions, structures and vocabulary taught in this theme (e.g. instructing patients not to smoke or explaining the importance of good nutrition) can be generalised and applied to a number of different illnesses. This unit can also be structured to coincide with the first year module on "Nutrition", run by the Medical School.

Appendix C: Consultation 1

Doctor:	Awubhemi futhi? Ngoba izinto ezihluphayo lezo. Okunye ke futhi siye sithande unyakazise umzimba.-umzimba uthi ukwehla kancane. Kuyasiza nalokho kwenza ukuthi ungaze udinge amaphilisi amaningi. Kungaze kube ngcono kuyasebenza kakhulu ukwedlula amaphilisi. Okay lezo zinto-indlela odla ngayo nokunyakazisa umzimba. Kodwa ke sizoqala lapha kancane kancane kuthi ke ngoLwesibili oluzayo uphindele ekliniki eMbazwane. Bayochofoza futhi bahlole ukuthi ushukela unjani emva kokuthi sikuqalise lamaphilisi. Okay kulungile ke. Kukhona okunye othanda ukukubuza	You also don't smoke? I saying these because can contribute to the problem. The other thing that you must do is to exercise to lose some weight. That actually helps and you may not have to take as many pills, it will get better, it helps a lot more than tablets. Just those two things the way you eat and exercise. But we will start bit by bit here and then next Tuesday please go back to the clinic at Mbazwana. They will test you again to see what your sugar level is like and after that you will start the diabetes tablets. Okay then its fine. Do you have any other questions?

Unit 5: *Ikholera* (Cholera)

I selected this theme because cholera was a particularly topical disease with the outbreak that occurred in Kwa-Zulu Natal earlier this year. Choosing an interesting and relevant theme that learners can relate to increases their motivation levels. Furthermore, some of the symptoms associated with cholera, such as diarrhoea and dehydration, are not restricted to this disease. Being able to instruct a patient on issues like the importance of clean drinking water, good sanitation and how to make a rehydration solution for a dehydrated patient can also be applied to other situations e.g. patients with gastric infections or mothers with malnourished babies.

Unit 6: *Isifo sikashukela* (Diabetes)

While I only observed 3 diabetes consultations during my research, Dr Cairns, dietician Kerry Mould and the Medical School syllabus designers all felt it was an important topic to cover. I lectured on this theme when I was teaching the first year medical students in 2001 and it was an effective theme for illustrating how to take a patient's history. It was particularly successful as it ran concurrently with

the Medical School module on diabetes. The theme of diabetes can also be linked to hypertension.

Appendix C: Consultation 1

Doctor:	Isifo sikashukela siyakwenza lokhu uzizwe umzimba uphansi, womele kakhulu amanzi. Okunye okwenzakaya ukuthi amasosha lana avikela umzimba wakho athanda ukuphazamiseka uma kuwukuthi unesifo sikashukela, Kulula ukuthi izifo njena okungamagciwane kukuhluphe njengoba usho ukuthi induku yakho ibithanda ukuqubuka kancane.... So ngenxa yalokho kukhona vele izimpawu ezikhomba ukuthi unesifo sikashukela. Nalana uma uhlolwa kutholakala ukuthi uphezulu. Ngibona kukuhle ukuthi silona... (interrupted)	Diabetes causes the body to feel tired and rundown and to thirst for water. Another thing that happens is that the soldiers in your body are disturbed when you are diabetic. You then become vulnerable to disease and may get an infection as might be the case with your penis. ...Because of that signs of diabetes might show up. When you go for a check up they will find the level high. I suggest that we...(interrupted).

Unit 7: *Isifuba* (Chest)

Coughs, colds, flu's and respiratory infections like T.B are commonplace in the OPD and being able to take the history a patient with a chest complaint and instructing the patient on a recommended course of treatment is an important part of the general consultation.

Appendix C: Consultation 3

Patient:	**Eyi nginezilonda esifubeni.**	**Eh, I have sores in the chest.**
Doctor:	Uzwe kanjani ukuthi unezilonda?	How did you find out that you have sores.
Patient:	**Ngiyezwa kuyathunukala.**	**I can feel the pain.**

Unit 8: *Ukukhulelwa* (Pregnancy)

This theme was chosen because pregnancy and mothering accounted for a fairly large percentage of the consultations I observed. It may include a wide range of topics from a routine check-up on a pregnant mom to performing a vaginal examination to good breast feeding techniques and explaining the importance of weaning foods to a new mom. The ability to talk about or explain these topics (especially the instructions and explanations associated with performing an internal examination of a pregnant woman, which is a rather sensitive activity) is an important part of OPD medicine.

Appendix C: Consultation 4

Patient:	**Ngicela ukubuza ukuthi umntwana muni?**	**May I ask the baby's gender?**
Doctor:	Akulula ukubona lana ngoba ababhalile. Uyabona ukuba usho ngesikhathi usahlolwa emafutheni, ufike wacela uma bekwazi ukubheka bakubhekele kodwa baye bangabhali laphansi. Kubonakala la usesemshinini. Uma bebheka la bayakwazi ukubona ukuthi umfana noma intombazane okay. Kube mhlambe ucele ngalesisikhathi usenziwa kodwa angikholwa ukuthi bebengakwazi ukukutshela kodwa bebengazama. Ngoba bona babheka ukuthi nje umntwana akananking a, isisindo sakhe singakanani, mangaki amasonto manje.	It's not easy here because they did not write it down. You see if you had asked them to look when you went for your cholesterol test, they would have given you answers if they knew but they normally don't write it down. Its easy to see on the machine whilst you are still there. When they look, they can tell it's a boy or girl. They would have tried it there if you had asked then and there but I cannot tell you because they didn't even try to establish the sex. They would have tried because their job is to see that the baby is healthy, to look at the weight and development of the child, how many weeks old the child is now.
Patient:	**Ngiyabonga.**	**Thank you.**

Unit 9: *Izifo Zocansi* (Sexually transmitted diseases)

The one topic which doctors unanimously agreed upon as a difficult communication area was that of sexually transmitted diseases, especially HIV/AIDS. The correct use of polite terms and euphemisms concerning sexual matters is an important aspect of a doctor's education when dealing with these issues. Since this is an introductory course, it cannot provide doctors with extensive counseling skills. What it will do, however, is give doctors a base vocabulary to be able to discuss sexually related matters to a limited degree before referring them to an AIDS counselor for more in-depth counseling.

5.6.2 Language Functions

From the list of language functions observed in the OPD, as outlined in chapter four (section 4.2.6.1), I have selected those which complement the themes I have chosen for each unit. Most of the examples listed below are based on my research findings.

For example, these are some of the language functions which should be taught in **Unit 1: *Sawubona:***

- *Greeting*
  e.g. Sawubona, mama *(Hello, mother)*

- *Asking after health*
  e.g. Uphethwe yini? *(What are you suffering from?)*
  e.g. Unani? *(What is wrong with you?)*

- *Asking after someone's name and surname*
  e.g. Ungubani igama lakho? *(What is your name?)*
  e.g. Ungowakwabani? *(What family are you from?)*

- *Requesting*
  e.g. Ngicela uphinde *(Please repeat)*

- *Expressing sympathy*
  e.g. Hawu, kwakubi lokho. Ngiyakuzwela. *(Gosh, that's bad. I sympathise with you.)*

- *Saying goodbye/ Closing the conversation*
  e.g. Hamba kahle. Sobonana ngesonto elizayo. *(Goodbye. See you next week.)*

The following are examples of some of the language functions I chose to include in ***Unit 3:*** **Ngicela ukukuhlola**

- *Asking after location*
  e.g. Buphi ubuhlungu? *(Where is the pain?)*

- *Describing (pain, symptoms, colour, duration, intensity)*
  e.g. Ubuhlungu obunjani? *(What kind of pain is it?)*
  e.g. Isikhwehlela sibomvu noma siphuzi? *(Is your sputum red or yellow?)*
  e.g. Kuqale nini? *(When did it start?)*
  e.g. Kubuhlungu kakhulu noma kancane? *(Is the pain severe or mild?)*

- *Expressing ability / inability to do something*
  e.g. Uyakwazi ukugwinya kahle? *(Are you able to swallow properly?)*

- *Instructing or commanding (using the imperative)*
  e.g. Khumula izingubo zakho *(Take off your clothes)*
- *Requesting*

e.g. Ngicela ukhumule, baba *(Please will you get undressed, father)*

The language functions listed below are appropriate for the theme of pregnancy in ***Unit 8:*** **Ukukhulelwa**

- *Asking after age*
  e.g. Uneminyaka emingaki? *(How old are you?)*

- *Asking after quantity*
  e.g. Unabantwana abangaki? *(How many children do you have?)*
  e.g. Nibangaki ekhaya *(How many are you at home?)*

- *Reassuring*
  e.g. Ungakathazeki, sisi. Ngeke ngikulimaze. *(Don't be anxious, sister. I would never hurt you.)*

5.6.3 Vocabulary

The majority of these lexical items, noted during my research, were selected to complement the themes or topics chosen for each unit. Below I will give examples of nouns, verbs, statives, adjectives and adverbs that are relevant to the medical situation, most of which were recorded during my research, and therefore suitable content for the syllabus I have designed.

A) Explanation of how vocabulary items are to be taught in the syllabus I have designed, using Unit 3: *Ngicela ukukuhlola* (I would like to examine you) as an example

In this section I will illustrate how the nouns, verbs, statives, adjectives, adverbs and phrases which are suggested vocabulary items for each unit are relevant to the theme/topic of the unit, using Unit 3 as an example. These lexical items have all been selected because they complement the theme of Unit 3 and because they are necessary to be able to express the relevant language functions.

Nouns:

- *ubuhlungu* (pain).
- *isifuba* (chest)
- *umlenze* (leg)
- *ikhanda* (head)
- *izingubo* (clothes)
- *umbhede* (bed)

Verbs:

- *-phila* (live / be well)
- *-gula (*sick)
- *-dla* (eat)
- *-phuza* (drink)
- *-khwehlela* (cough)
- *-hlola* (examine)
- *-hlinza* (operate)
- *-jova* (inject)
- *-khala* (cry/complain)
- *-gwinya* (swallow)
- *-lala* (sleep)
- *-khathazeka* (worry)

Statives:

- *-khathele* (tired)
- *-lambile* (hungry)
- *-omile* (thirsty)

Adjectives:

- *-buhlungu* (painful)
- *-bomvu* (red)
- *-phuzi* (yellow)
- *-mhlophe* (white)
- *-khulu* (big)

- *-ncane* (small)
- *-ningi* (many)
- *-bili* (two)
- *-thathu* (three)
- *-ne* (four)
- *-hlanu* (five)

Adverbs:

- *kakhulu* (a lot)
- *kancane* (a little)
- *kahle* (well)
- *kanzima* (with difficulty)
- *kanye* (once)
- *kabili* (twice)
- *kathathu* (three times)
- *kanjani* (how)
- *ngokushesha* (fast)

Phrases relating to pain:

There is a vocabulary section on pain in unit 3. I would therefore introduce some power phrases relating to the nature, location and duration of pain. For example:

- *Buphi ubuhlungu?* (Where is the pain?)
- *Ngikhombise ngesandla* (Show me with your hand)
- *Kubuhlungu kakhulu noma kancane?* (Is the pain severe or mild?)
- *Kuqale nini?* (When did it start?)

Phrases relating to Time / Duration:

I also chose to include some history-taking questions relating to the aspect of time / duration:

- *Kuqale nini?* (When did it start?)
- *Namhlanje* (Today)
- *Kusasa.* (Tomorrow)

- *Izolo* (Yesterday)
- *Kuthangi.* (The day before yesterday)
- *Izinsuku ezingaki?* (How many days?)
- *Isonto / ngesonto elidlule / ngesonto elizayo* (A week / last week / next week)
- *Inyanga / ngenyanga edlule / ngenyanga ezayo* (A month/ last month / next month)
- *Unyaka / ngonyaka odlule / ngonyaka ozayo* (A year / last year / next year)
- *Ekuseni* (In the morning)
- *Ntambama* (In the afternoon)
- *Ebusuku* (At night)

B) Summary table used to introduce the Zulu noun class system:

I chose to illustrate the noun class system using nouns which learners can expect to encounter in the target situation, rather than the typical, traditional examples taught in other second language Zulu courses. For example instead of explaining noun class two using the common examples of *umuzi* (homestead) and *umfula* (river), it was more relevant to use *umuthi* (medicine), *umjovo* (injection), *umphimbo* (throat) and *umkhuhlane* (cold/flu). The noun class table below is an extract from Unit 1 (Appendix 5.1).

NOUN CLASS	NOUNS	SC	NOUN PREFIX
1 sing	umngane, umuntu, umfowethu	u-	um / umu-
plural	abangane, abantu, abafowethu	ba-	aba-
1a sing	ubaba, uRaymond, unesi, uthisha	u-	u-
plural	obaba, oRaymond, onesi, othisha	ba-	o-
2 sing	umuthi, umjovo, umphimbo, umkhuhlane	u-	um / umu-
plural	imithi, imijovo, imiphimbo, imikhuhlane	i-	imi-
2a sing	ushizi, ugwayi, ubhanana, utmatisi	u-	u-
plural	oshizi, ogwayi, obhanana, otamatisi	ba-	o-
3 sing	iphilisi, ikhanda, iqolo, ihlo	li-	i(li)-
plural	amaphilisi, amakhanda, amaqolo, amehlo	a-	ama-
4 sing	isiguli, isisu, isifuba, isifo, isinye	si-	isi-
plural	iziguli, izisu, izifuba, izifo, izinye	zi-	izi-
5 sing	inyongo, inhliziyo, indlebe, imali	i-	in / im-
plural	izinyongo, izinhliziyo, izindlebe, izimali	zi-	izin / izim-

6	sing plural	ulimi, unyawo, ulwandle, ubisi (no plural) izilimi, izinyawo, izilwandle	lu- zi-	u(lu)- izi / izin / izim-
7	sing	ubuso, ubuhlungu, utshani, utshwala	bu-	u(bu)-
8	sing	ukudla	ku-	uku-

C) Attitude towards "Borrowed" words:

There are a number of Zulu words that are used in the medical context which have been derived from English or Afrikaans. In chapter four, section 4.2.6.2, I gave some examples of borrowed words, which were used in the consultations I observed e.g. *iSpray* (spray), *-sheka* (to check), *imbijana* (a bit) etc. Some teachers think that these words should be avoided where possible because they are not "pure" Zulu. I do not hold to this view. If the borrowed word is accepted and used in the medical context then I have encouraged its use amongst my target learners.

The use of borrowed words is also advantageous because it helps learners to learn the vocabulary more quickly. For example, the Zulu word *amasosha* (soldiers) (e.g. when explaining to a patient about the "soldiers" in one's blood that fight disease – refer to Consultation 1, Appendix C) is easier to for the learner to remember than *amabutho*. The explanation behind the use of some borrowed words e.g. *izikelemu* (worms), which is originally derived from the Afrikaans word, *skelm* (rogue), is particularly interesting and amusing for learners. The inclusion of this kind of lexis and the explanation of the use of such words results in a more interesting syllabus.

D) Familiarity of learners to Zulu lexis:

A number of Zulu words have become part of the English spoken in KwaZulu Natal. I included some Zulu words that would be familiar to the average non-Zulu speaking South African to show learners that they already know some Zulu and encourage them in their learning of the language. For example:

- *umuthi* (medicine) Note: the word "muti" has been assimilated into general South African English and is even listed as a recognised word in the South African Pocket Oxford Dictionary.

- *abafana* (boys) Learners are often amused to learn that our national soccer team, *Bafana Bafana* means "Boys Boys".
- *amasi* (maas)
- *-jova* (to inject)
- *-shaya* (to hit)
- *indaba* (story)
- *ikhehla* (old man)
- *ubuntu* (humanity)

E) Special note on Pronunciation, especially the click system

Teaching a section on the Zulu click system has great fun potential because most learners enjoy attempting the click sounds and engage in this activity with enthusiasm. In Zulu, there are three varieties of clicks. The dental, or "c", click is perhaps the easiest to pronounce but the palatal "q" and lateral "x" click are a little more difficult for a non mother-tongue Zulu speaker to master. Attention should be given to assisting learners to correctly pronounce these clicks as failure to do so could result in misunderstanding on the part of the patient. Below I have listed some of the more common "click" words, which occur in the medical context.

The "c" click:

- *umchamo* (urine)
- *-chama* (urinate) e.g. *Uyachama njalo na?* (Do you pass urine often?)
- *-cela* (request) e.g. *Ngicela uphinde* (Please repeat)
- *-ngcono* (better) e.g. *Kungcono manje?* (Is it better now?)
- *-cinana* (to be tight or closed) e.g. *Isifuba sami sicinene* (My chest is tight/ congested).
- *-ncelisa* (to breastfeed) e.g. *Uyabancelisa abantwana bakho*? (Do you breastfeed your children?)

The "x" click:

- *isigaxa* (a lump)
- *owesokunxele* (the left)

The "q" click:

- *-qala* (to start) e.g. *Kuqale nini?* (When did it start?)
- *-quleka* (to faint) e.g. *Uyaquleka?* (Do you ever faint?)
- *-qaqamba* (throbbing or aching) e.g. *Umlenze wami uyaqaqamba* (My leg is throbbing/aching.)
- *umqubuko* (rash) e.g. *Nginomqubuko esiswini* (I have a rash on my stomach)
- *iqolo* (back) e.g. *Ngiphethwe yiqolo* (My back is sore)
- *iqakala** (ankle) e.g. *Amaqakala avuvukele na?* (Are your ankles swollen?)
  * Not to be confused with *ikhala* (nose)

How to incorporate click words into the syllabus:

The verb *–chama* (urinate), for example is a lexical item which could be included in Unit 6, *Isifo Sikashukela* (Diabetes) when asking a patient, *Uyachama njalo?* (Do you urinate frequently?). This could then be linked to other click words with a similar sound and enforced through oral drill activities. When I introduced click words to the 2001 medical students, I gave them a written example of each variety of click, starting with words using the dental click as it is the easiest to pronounce. I then got learners to repeat the words after me, slowly at first and then building up speed. After they had built up their confidence practicing words incorporating dental clicks, I then moved onto lateral and palatal click words. Most second language learners battle to pronounce click words initially. However through practice and perseverance it is possible to master these sounds. As the Zulu proverb says:

Inja iqeda amanzi ngolimi (Persistence brings success. Literally, the dog finishes the water by lapping with its tongue).

F) "Power texts" / "Phrasebook skills"

Another aspect of vocabulary which I feel learners should be introduced to early on is that of "power texts" or "phrasebook skills". A number of linguists and second language teachers suggest that it is helpful to begin one's language learning career by memorising phrases that help the learner to learn as well as the phrases one will use frequently. Dr Ellis suggests that learners should learn "power texts", which he defines as follows:

"Learn power texts – these are the few questions and phrases that you need or use often... Power texts may be such phrases as 'Hello', 'What is the matter?' 'Please get up on the bed and take your shirt off', 'Take the pills three times a day until they are all finished', and 'When did the pain start?' "

(Ellis, 1999: 5)

In the introduction to his Zulu second language course, *Asizwane*, Jeff Thomas speaks about the importance of learning "phrasebook skills" (Thomas, 1992) which enable the learner to express his inability to understand or to request assistance in Zulu without having to revert to English the moment he experiences difficulty in understanding or speaking Zulu. This encourages the learner to persevere with Zulu. An example of a survival-type "phrasebook" sentence would be *Angizwa kahle. Ngicela uphinde.* (I don't understand properly. Please repeat.)

As explained in section 5.5.2, the structures employed in certain phrases is beyond the level of understanding which the learner has of the Zulu grammatical system. Instead of avoiding the teaching of these phrases I would suggest teaching them as "power texts" and encouraging learners to memorise them.

Below I have listed examples of other "power texts" which could be introduced in the syllabus I have designed. Some of these phrases could be introduced in the dialogues and exercises covered in class and some could be made available to learners in vocabulary extension boxes or on the WebCT.

Power texts suggested for inclusion in Unit 1: *Sawubona* (Hello) (see Appendix L):

POWER TEXTS 1: *"SURVIVAL PHRASES"*

- Ngisafunda isiZulu. *(I am still learning Zulu.)*
- Angizwa kahle. Ngicela uphinde. *(I don't understand properly. Please say it again.)*
- Awuphinde kancane kancane. *(Please repeat slowly.)*
- Awuphinde ngesiNgisi. *(Please repeat in English.)*
- Ngicela uhumushe ngesiNgisi. *(Please translate into English.)*
- Ungakhulumi ngokushesha! *(Please don't speak quickly!)*

Recommended "power texts" for inclusion in Unit 2: *Uphethwe Yini?* (What are you suffering from?)

- *Uphethwe yini?* (What are you suffering from?)
- *Unani?* (What is wrong?)
- *Uzizwa unjani namhlanje? / Unjani namhlanje?* (How are you feeling today?)
- *Uzizwa ungcono namhlanje?* (Are you feeling better today?)
- *Kuqale nini?* (When did it start?)
- *Buphi ubuhlungu?* (Where is it sore?)
- *Ngikhombise ngesandla.* (Indicate with your hand.)
- *Uyazaca na?* (Have you lost weight?)
- *Uyagodola?* (Have you been shivering?)
- *Ujuluka kakhulu?* (Do you sweat a lot?)
- *Womile?* (Have you been thirsty?)
- *Uhlala nobani ekhaya?* (Who do you live with at home?)
- *Uyabhema?* (Do you smoke?)
- *Uphuza utshwala (besiZulu / besilungu)?* (Do you drink beer (Zulu or White man's beer)?)

Recommended "power texts" for inclusion in Unit 5: *Ikholera* (Cholera) where the cultural syllabus discusses the role of traditional healers

- *Uyayiphuza imithi na?* (Do you take medicines?)
- *Uyaya yini ezinyangeni (zabantu)?* (Do you see the witchdoctor?)
- *Uyayithatha yini imithi ezinyangeni?* (Do you take anything from the witchdoctor?)
- *Kukhona imithi noma umjovo okuphatha kabi?* (Is there any medication/ injection which you are allergic to?)

Recommended "power texts" for inclusion in Unit 3: *Ngicela ukukuhlola* (Please may I examine you)

- *Khamisa.* (Open your mouth.)
- *Khipha ulimi.* (Stick out your tongue.)
- *Phefumula.* (Breathe.)
- *Donsa umoya.*(Breathe in.)
- *Khipha umoya.* (Breathe out.)

- *Bheka phezulu/ phansi.* (Look up/ down.)
- *Buka mina.* (Look at me.)
- *Ngicela ukhumule izingubo.* (Please take off your clothes.)
- *Gibela embhedeni.* (Climb up on the bed.)
- *Lala phansi.* (Lie down.)
- *Lala ngomhlane/ ngesisu/ ngohlangothi.* (Lie on your back/ stomach/ side.)
- *Hlala uqonde.* (Sit up.)
- *Thambisa umzimba.* (Relax.)
- *Ngeke ngikulimaze.* (I won't hurt you.)
- *Ungesabi.* (Don't be frightened.)
- *Ungakhathazeki / Musa ukukhathazeka.* (Don't worry.)
- *Kubuhlungu kuphi? / Buphi ubuhlungu?* (Where is the pain?)
- *Ngikhombise ngesandla.* (Indicate with your hand.)
- *Ubuhlungu obunjani?* (What kind of pain is it?)
- *Kuyahlaba? Kuyaluma?* (Stabbing? Colicky?)
- *Ubuhlungu obukhulu? Noma ubuhlungu obuncane?* (A bad pain? Mild pain?)

5.6.4 Grammatical Structures

As explained in chapter two (section 2.4.2.3), learners need to possess sentence building skills as well as phrasebook skills in order to be able to manipulate language structures and generate their own sentences. Since learners are subjected to major time constraints, it is not possible for them to learn every possible phrase necessary for communication in the target situation. Therefore, increasing the generative capacity of learners by teaching them how to create their own sentences is a time-saving technique.

One of the most important grammatical sections included for the purpose of promoting the generative capacity of learners is the Zulu noun class system, which I introduced in Unit 1. While not all the nouns are immediately applicable to the exercises and content covered in unit 1, knowledge of how the noun classes and their corresponding subject concords operate is essential in understanding the Zulu grammar system and in creating one's own sentences.

In deciding to teach learners the Zulu noun class system it was necessary to decide which approach to use. Many Zulu grammarians, including Doke and Cope prefer to deal with only 8 noun classes where the singular and plural of each noun belong to the same "class". For a more scientific approach it is better to use the numbering system associated with the German linguist Carl Meinhof and other scholars of comparative African linguistics, which considers singular and plural as two separate classes. Using Meinhof's approach Zulu nouns can be grouped into 15 different noun classes. Given the time constraints, I chose to use Doke's system of eight noun classes as I believe that this is simpler and easier to understand. Furthermore, the target learners do not need to be specialists in Zulu linguistics and the description of a more complex noun class system is unnecessary for the purpose for which this syllabus is designed.

The principle reason for including the particular grammatical items specified in the summary table in section 5.3 is to enable learners to communicate about the themes / topics selected for the syllabus and to give them the necessary tools to express the related language functions. For example, in unit 2, the theme was *Uphethwe yini?* (What are you suffering from?). In order to be able to express the language function of "Asking after health", learners needed to be able to use the passive form and agentive prefixes. Another example can be found in Unit 3

where the syllabus sets out to teach learners how to refer to the site of pain. In order to be able to explain the location of pain using body parts, it is necessary to understand the grammatical rules which govern the transformation of a noun into a locative. I therefore included a section on locatives in the grammatical syllabus for this unit.

In Zulu, as with other languages, there is sometimes a number of different ways to express the same thing. For example, there is more than one way to express the negative. The most frequently used form requires the use of object concords (if there is an object in the sentence), which is time-consuming to teach. The emphatic form of the negative does not require the use of these concords.

E.g.	**Present Negative using object concords**	**Emphatic form of Present Negative without object concords**
1	*Angibuphuzi utshwala* (I don't drink beer)	*Angiphuzi tshwala*
2	*Angiwubhemi ugwayi* (I don't smoke tobacco)	*Angibhemi gwayi*

For the purpose of my syllabus I opted for the form which uses object concords because it is the most frequently used form of the negative and the one which learners are most likely to encounter in the target situation. Furthermore, learning object concords is important for other aspects of expression (e.g. when asking questions) and is thus a grammar section that I would teach learners anyway. Below is a plan of how I staggered the various grammar sections necessary to teach learners how to express the negative, which also illustrates my use of a cyclical approach to syllabus design.

Unit 1: Introduce noun classes (learn subject concords)
Unit 2: More work on noun classes (practise use of subject concords)
Unit 4: Introduce object concords (once learners have mastered subject concords)
Unit 5: Revision and extension of object concords
Unit 6: Introduction of present tense negative, using object concords

The aspect of time constraints limited the amount of grammar that could be included in the syllabus. In chapter four, section 4.2.6.3 I list the most common grammatical structures I observed in consultations. However, bearing in mind time

constraints, I had to make decisions about which of these structures should be included and which should be omitted from the syllabus based on factors like priority of needs and frequency of occurrence. In the light of time constraints, I did not allow for instruction on grammatical sections such as the compound tenses, dependent tense or the use of relative concords with adjectives etc.

5.6.5 Cultural Input

The importance of culture in the medical consultation cannot be over-emphasised. As Dr Ellis explains:

"It is well known that by learning a language one is beginning to bond with a culture because language and culture lead into one another. It is hoped that this [book] will facilitate a better understanding of the patient's agenda and thereby a better outcome to the consultation."

(Ellis, 1999: 1)

The specific cultural elements I have included in the syllabus have been chosen for a number of reasons.

Firstly, because they were identified during consultations or by doctors as some of the most common cultural differences. For example, the notion of the "entry ticket complaint" was first brought to my attention by Dr Ellis when he explained that some patients use a presenting complaint such as *isisu* (stomach) to cloak their real concerns about their health, which may range from fear of being infected by AIDS or a desire to know whether they are pregnant. This was confirmed by Dr Cairns who had observed the same phenomenon.

Another example of basing my selection of cultural content on situational need can be found in Unit 9: *Izifo Zocansi* (Sexually transmitted diseases). Since the theme of this unit was sexually transmitted diseases I chose to include a cultural note on the use of euphemisms and metaphors relating to sex and sexual organs. In one of the consultations I observed (Appendix C: Consultation 1), the patient used the word *induku* (stick) in reference to his penis. This is a frequently used polite word for penis.

Secondly, the cultural items were chosen because they relate in some way to the theme of the unit. Using the same example of *isisu* (stomach), I included the notion of the "entry ticket complaint" and *isisu* in Unit 8: *Ukukhulelwa* (Pregnancy) because, according to Ellis, *"A female patient may complain of* ***isisu*** *when the real reason for the encounter is infertility."* (1999: 30)

Another example of how a cultural item was selected for its relevance to the theme can be found in Unit 4: *Impilo* (Health). In this Unit I suggest that learners are made aware of some of the more popular beliefs held by a number of Zulu speakers regarding health. Kerry Mould, the dietician at Bethesda Hospital in 2000, explained that many of her patients view obesity as a sign of wealth & good health. The general perception is that fat people don't have AIDS.

The third factor influencing my choice of cultural items for the syllabus was their interest value for learners. The subject of traditional healers, labeled by some as "witchdoctors", is shrouded in mystery and is a source of fascination for may learners. Inclusion of items that peak the learners interest is essential in sustaining learners' level of motivation.

5.6.6 Language Activities

There is much to be said on the subject of language activities and teaching methodology. However, I will limit myself to a few comments on the subject which should contribute to a better understanding of my syllabus design. I will use illustrations from the sample handouts I have designed (Appendix L-Q).

- **Develop conversational skills from the start**

I chose to insert a dialogue at the very beginning of the handout for Unit 1 (Appendix L), which I have copied below. Rather than begin with a grammatical introduction to the Zulu noun class system, which could be a legitimate starting point for such a course, I elected to equip learners first with some basic conversational skills.

DIALOGUE: GREETINGS & ASKING AFTER HEALTH

USindi:	Sawubona Themba
UThemba:	Yebo, sawubona Sindi
USindi:	Usaphila na?
UThemba:	Yebo ngisaphila. Wena unjani?
USindi:	Nami ngisaphila. Uyaphi manje?
UThemba:	Ngiya eThusini.
USindi:	Ufunda khona?
UThemba:	Yebo, ngifunda khona. Ngifunda isiZulu.
USindi:	Nami ngifunda khona. Ngifunda isiNgisi.
UThemba:	Hamba kahle.
USindi:	Yebo, sala kahle.

- **Do not exceed the learning capacity of the learners**

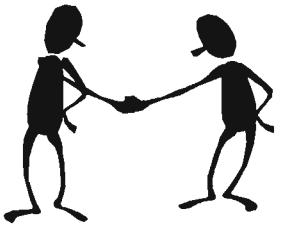
It is advisable to proceed too slowly (rather than too fast) in the initial stages of learning. This gives learners who know absolutely nothing about Zulu a chance to catch up with those who may already have some knowledge of the language. Thus in unit 1 I suggest that the rate of learning should be slower and the density of content less than in later units.

It is also particularly important to include interesting, enjoyable activities that learners feel they can cope with during the first few classes to encourage learners about the learning process that lies ahead. Speaking in a language that is not one's mother tongue requires courage. It is crucial that the teacher encourages and develops the abilities of learners without making them feel daunted or threatened.

- **Move from close-ended activities to more creative, open-ended activities**

Another strategy recommended in developing learners ability to communicate is to start with more structured, close-ended activities and move on to more creative, open-ended questions. For example, in unit 1 (Appendix L) the first oral interaction which learners were required to participate in, was to act out the simple dialogue that was printed in the notes, as shown in the extract below:

DIALOGUE: WHAT IS YOUR NAME?



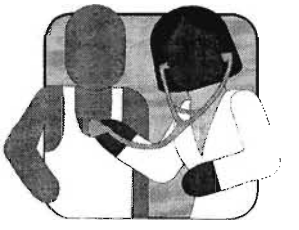
UThandi: Ungubani igama lakho?
UMuzi: Igama lami nguMuzi / NginguMuzi.
Wena ungubani?
UThandi: Igama lami nguThandi / NginguThandi.
UMuzi: Ngiyajabula ukukwazi.
UThandi: Nami ngiyajabula ukukwazi

Ngubani isibongo sakho?
Ungowakwabani?
Isibongo sakho ngubani?
Isibongo sami nguMkhize.

Oral exercise : Practice the above dialogue in pairs.

Later on in the same unit, learners were taught how to ask questions using *-ni* (what) and *-phi* (where). Learners were given an opportunity to practise this first with written exercises and had already done some structured oral work to build up their confidence. The next oral activity was a little more open-ended and required learners to formulate their own short questions and answers, based on the vocabulary covered in previous examples. See below:

NI - WHAT?



Ubonani? You see what? (What do you see?)
Ngibona udokotela (I see the doctor).

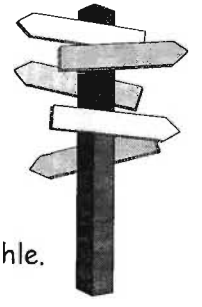
Uthengani? You buy what? (What do you buy?)
Ngithenga iPanado (I buy Panado).

AMAGAMA AMASHA

Umuthi (medicine)	amaphilisi (pills)
ingubo (dress)	utshwala (beer)
amanzi (water)	unesi (nurse)

Phendula imibuzo (Answer the questions).

1. Ufunani namhlanje?
2. Udingani?
3. Uthengani?
4. Uphuzani?
5. Nifunani?



PHI - WHERE?

UThandi: Uyaphi?
UMuzi: Ngiya esibhedlela eKing Edward ngoba (because) ngiyagula.
UThandi: Hhawu nami ngiyagula. Ngiya kudokotela edolobheni. Hamba kahle.
UMuzi: Kulungile, hamba kahle.

Phendula imibuzo:

1. Uyaphi namhlanje?
2. Ufundaphi?
3. Nithengaphi?
4. Usebenzaphi?
5. Nihlalaphi?

AMAGAMA AMASHA	
esibhedlela (hospital)	kudokotela (doctor)
eThusini (UND)	ekhemisi (chemist)
eThekwini (Durban)	eGoli (Jo'burg)
edolobheni (town)	emsebenzini (work)
kwaGame (at Game)	esikoleni (at school)

Umsebenzi 3: Practice asking & answering questions using "ni" and "phi" with fellow students

In Unit 2, learners revise the language functions introduced in unit two in a slightly more open-ended and creative manner. This time they are given prompts, in English but they are required to formulate the sentences on their own:

REVISION:

Pair up with another student.
You are waiting for your transport to arrive and begin to chat. One student is A and the other is B.

A	B
Greet B	-
-	Greet A
Respond saying you are well. Ask after B's health.	-
-	Respond, saying you are sick.
Respond sympathetically.	-
-	Ask for A's name.
Respond and ask for B's name.	-
-	Respond and ask where A is going.
Respond and ask where B is going.	-
-	Respond. *Nali ibhasi lami.* (Here is my bus)
Kuhle / Kulungile. (Good / OK) Say you hope B gets better soon.	-
-	Thank A and say goodbye.
Say goodbye.	-

- **Techniques and activities that extend learning**

As mentioned previously, there are number of teaching techniques and activities which help the teacher to extend learning time. I made use of some of these tactics:

- Firstly I set exercises on WebCT for learners to do during personal study time. This gives learners the opportunity to revise and expand sections introduced in class and allows for the inclusion of "DIY" (Do it Yourself) content, which are language items, which learners can pursue on their own.

- Secondly I made use of vocabulary extension boxes entitled *Amagama Amasha (*new words) which contained new or additional Zulu words and their meanings. Giving translations for new vocabulary is very time-consuming. Therefore to avoid wasting time translating new words covered in a passage or exercise, I would supply meanings for new words in the vocabulary extension boxes.

- Suggested Self-Study worksheets/modules: Topics such as HIV/AIDS, depression and cancer were identified by my research as important communication areas. Unfortunately due to time constraints it is not possible to give these themes the attention they deserve in the syllabus I have designed. I would recommend that teachers design self-study assignments or introduce modules on these topics in subsequent opportunities for Zulu study.

- The use of audio tapes would be a very effective way of extending learning time and developing learners' pronunciation and listening skills. Tapes are a fairly inexpensive resource and are an easy way of promoting good aural and oral skills. The creation of a tape library or some kind of system where learners can borrow or purchase tapes with relevant dialogues and oral activities is highly recommended for the target learners.

5.7 SUMMARY & CONCLUSIONS

In this chapter I have outlined the linguistic and cultural items to be included in an introductory medical Zulu syllabus aimed at teaching medical students how to communicate with their future patients in the Out-Patients' Department. My choices regarding syllabus content were justified and linked to the research findings outlined in chapter four and the readings on second language theory in chapter two. Factors affecting the arrangement and ordering of items in each unit were also discussed and justified.

Although materials design falls under methodology rather than syllabus design, I have included some sample handouts in Appendix L-Q, many of which I used when lecturing Zulu at the Medical School in 2001, as examples of the kinds of materials suited to this kind of syllabus.

In chapter two (section 2.4.5), I highlighted the validity of course evaluation in the creation of specific purpose language syllabuses. I hold the view that language syllabuses are not static because language is not static. A good learning-centred syllabus should be subjected to constant evaluation as learner needs become more clearly defined and as target situation and learning situation needs change. In light of this, the syllabus I have designed should be seen not as the final word on medical Zulu for doctors, but rather as a starting point for further study, investigation and analysis. This syllabus would, ideally, be modified over time, according to changing learning and target situation needs.

CHAPTER 6: SUMMARY & CONCLUDING REMARKS

In this chapter I summarise the main findings of my thesis and discuss the contribution made by this research to the existing body of knowledge on Zulu second language syllabi aimed at preparing learners for communication in the medical field.

In chapter one I discussed the language barrier that exists between many doctors and patients because they are unable to communicate in one another's language. I referred to an article by Crawford where he outlines the view expressed by a Xhosa patient in a hospital situated in the Cape: *"Asikwazi sonke uku-undastanda isiLungu"* (We can't all understand the White's language) (Crawford, 1999: 28). One of the methods employed in a number of hospitals in an attempt to overcome this language gap is the use of ad-hoc nurse-interpreters. I discussed some of the deficiencies of this method and explained that it is now generally accepted by those involved in the medical field in South Africa that doctors should be able to communicate with their patients in their patient's mother tongue.

I also explained in chapter one that it has been suggested that a substantial language course (of at least 6 months) should be provided for medical students to teach them to communicate in the target situation. When I was approached by the University of Natal Medical School to lecture an introductory medical Zulu course in 2001, I decided to investigate this area in more detail for my Masters thesis. I set out with the following objectives in mind:

- To investigate what kinds of things doctors need to be able to say and understand in the medical consultation (needs analysis)

- To design a syllabus for an introductory medical Zulu course aimed at teaching non Zulu-speaking medical students training to become doctors how to communicate with their future patients in Zulu (syllabus design)

In chapter two, I discussed the theoretical background to my choice of approach. I outlined the three basic principles upon which my approach to language learning is based. Firstly, I identified the end goal of the learning process as communicative

competency rather than grammatical mastery. Secondly I discussed the validity of the "Design Down" principle, as outlined by Outcomes Based teaching theory, which suggests that syllabus designers should start their syllabus where they want learners to end up. Thirdly, I explained my reasons for adopting a learning-centred approach, as described by ESP theorists, Hutchinson and Waters. This approach prioritises learners' needs by placing the learner in the centre of the syllabus design process and recognises the importance of ongoing needs analysis and course evaluation.

In chapter two I also commented on the two key elements of designing the syllabus for a specific purpose course: needs analysis and syllabus design. There are other aspects associated with the implementation of a specific purpose language course, such as teaching methodology, materials design and evaluation. However since my objective was to investigate the needs of the target learners and to design a syllabus to meet those needs, I explained that these areas would not be addressed in detail in my thesis. In my discussion of needs analysis I outlined two equally important areas of investigation – target situation analysis and learning situation analysis. In my commentary on syllabus design I examined some of the main types of syllabuses (e.g. grammatical, functional-notional, task-based, eclectic etc.) and justified my choice of an eclectic / multidimensional syllabus as the syllabus type most suited to the syllabus I have designed. I also outlined the six sub-syllabuses which formed my eclectic syllabus: themes/topics, language functions, lexis, grammar, cultural items and language activities.

The final section of chapter two looked at some of the options that have been available to learners in the past to teach them how to speak Zulu. I discussed the inadequacies, as well as the positive contributions to be made by some of these methods and explained why I felt my research would make a significant contribution to the work that has already been done in this field.

Chapter three is a description of the research methodology I employed to investigate target situation and learning needs. I explained my synthetic approach to collecting data and the heuristic objectives of my investigations. I then identified the kinds of data I wanted to collect and listed the ways in which I would collect data. The information-gathering processes I selected, as discussed in chapter three, were: interviews with doctors; observations of doctor-patient consultations at Bethesda, Mosvold, Manguzi, Mseleni and McCords Hospital (see map in

Appendix A); informal consultations with syllabus designers, lecturers and learners; attending workshops on Zulu culture and the medical context; collecting medical texts relevant to the field of study; and finally, course evaluation questionnaires, classroom observations & informal feedback from learners

In chapter four I discussed the results yielded by my research activities in terms of target situation needs and learning needs. In my discussion of what learners need to be able to express in the target situation, I outline the themes/topics and related vocabulary, grammatical structures and cultural items that my research identified as key communication areas. For example, pain was identified as the most common presenting complaint. I also observed a number of consultations relating to chest infections/respiratory disorders and pregnancy/mothering issues. I commented on the results of my learning need analysis, which provided me with insight into the dynamics of the learning situation and indicated what was realistically achievable given the time constraints of the learning situation. My research also confirmed my choice of medical students as ideal target learners.

In chapter five, I outline the syllabus I have designed, based on the language learning theory I adopted from the readings discussed in chapter two and the results of my research reported in chapter four. I discuss the factors influencing the selection and organisation of syllabus content, using examples from my research results in chapter four and illustrations from some of the sample handouts I designed (Appendix L - Q). I also emphasised how time limitations affected the syllabus I designed. It would be highly desirable if more than 60 hours of the Medical School syllabus could be allocated to learning Zulu. However, until such time as more hours are made available for this purpose, the 60-hour syllabus I have designed should equip learners with the communicative skills, linguistic knowledge and cultural understanding necessary to conduct a basic consultation with a Zulu mother tongue speaker in the Out-Patients Department.

There are a number of areas that have not been attended to, in this thesis, which remain potential research areas for other investigators. For example, in light of the HIV/AIDS crisis in Kwa-Zulu Natal, the aspect of AIDS counselling could definitely be researched further. An extension of the number of hours available for medical students to learn Zulu would allow for more units to be included in the syllabus. These units could then give attention to more in-depth AIDS counselling or

explaining to patients about the use of anti-retroviral drugs, should these drugs become available to pregnant mothers.

It was most fulfilling to have been involved in such an interesting and enjoyable research project. I am satisfied that the research done for this thesis has made a valuable contribution to the field of Zulu second language teaching aimed at preparing medical students for their oral interactions with their future Zulu-speaking patients. The introductory medical Zulu course that I lectured in 2001, which was based on my research findings, was well received by learners and was lectured again in 2002. It seems likely that this ZSP course will become a permanent fixture in the Medical School syllabus.

One can only hope that a continued commitment (on the part of learners, syllabus designers, administrators and teachers) to teaching medical students to speak Zulu, will result in fewer patients feeling alienated and misunderstood in the medical consultation setting. Perhaps, in the future, instead of hearing Zulu-speaking patients say *"Asikwazi sonke uku-undastanda isiLungu"* (We can't all understand the White's language), we will hear them express the following sentiment, *"Angibanga nenkinga, sezwana kahle nodokotela"* (I didn't have a problem, the doctor and I understood each other well.)

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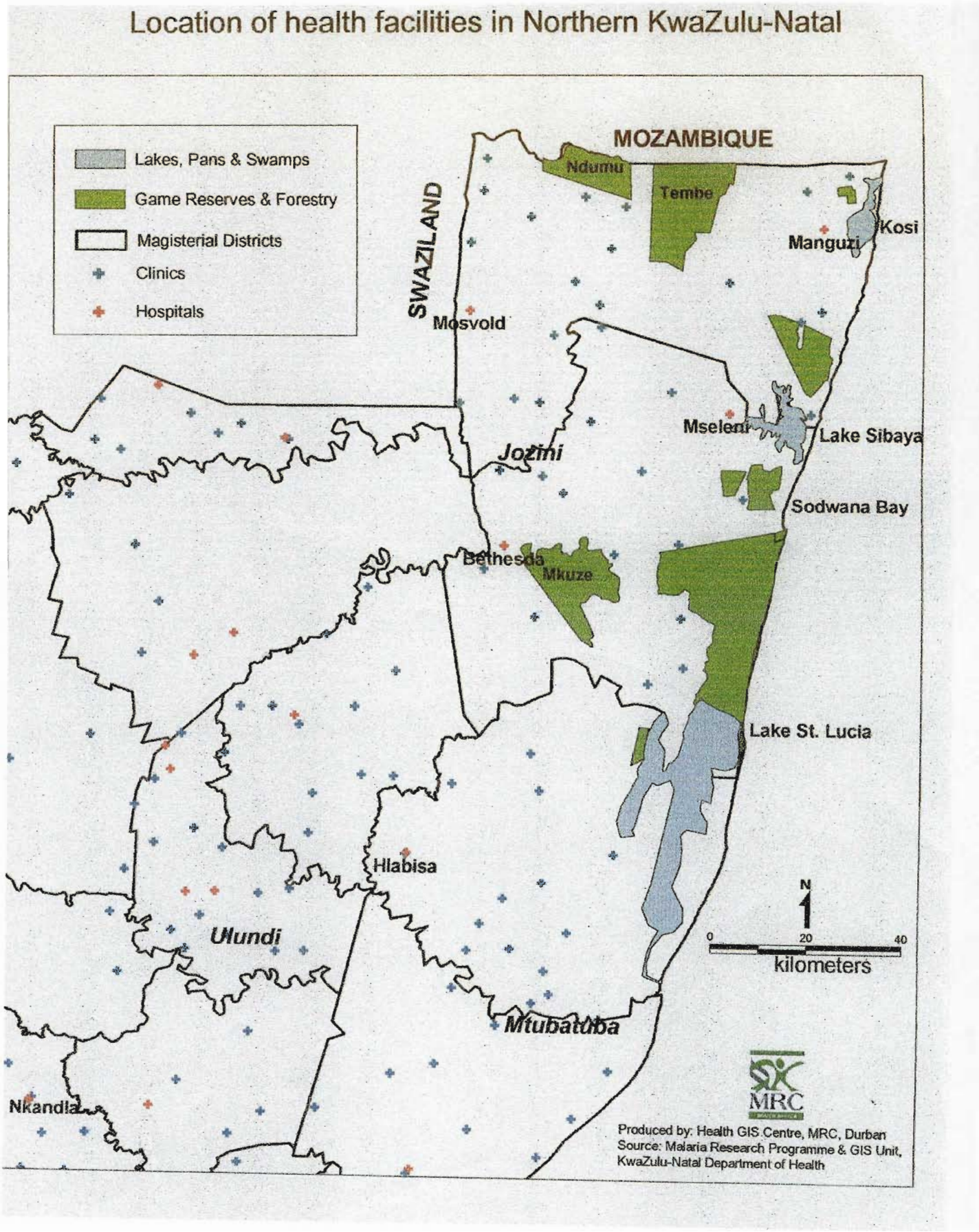
Location of health facilities in Northern KwaZulu-Natal
Lakes, Pans & Swamps
Game Reserves & Forestry
Magisterial Districts
Clinics
Hospitals
MOZAMBIQUE
SWAZILAND
Ndumu
Tembe
Kosi
Manguzi
Mosvold
Mseleni
Lake Sibaya
Jozini
Sodwana Bay
Bethesda
Mkuze
Lake St. Lucia
Hlabisa
Ulundi
Mtubatuba
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Produced by: Health GIS Centre, MRC, Durban
Source: Malaria Research Programme & GIS Unit,
KwaZulu-Natal Department of Health

APPENDIX B: SUMMARY OF CONSULTATIONS OBSERVED

OUTPATIENTS' DEPARTMENT, MSELENI HOSPITAL: 3 AUGUST 2000

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
1	Middle-aged woman Zulu speaking	Palpitations & Hypertension Check up re: medication	Reassure patient that heart is beating normally. Instruct patient to go for X-ray.
2	Teenaged mother with 11 month old baby Zulu speaking	Child has multiple lymph nodes	Need to drain poison from lymph nodes.
3	Elderly man Zulu speaking	Problems with eyes	Cataracts need to be removed – patient has to go to another hospital with eye specialist.
4	Adult woman Zulu speaking	Headaches, Palpitations Check up on hypertension medication	Explain that heartbeat and pulse are fine. Prescribe headache pills and instruct to continue with hypertension pills.
5	Young woman Zulu speaking	Check up on pregnancy.	Instruct to lie down so patient can be examined. Explain that everything is fine.
6	Adult man Zulu speaking	Overweight, sugar diabetes	Explain importance of diet and exercise. Prescribe medication. Ask patient to return next week for check up.
7	Adult mother with 3 year old boy Zulu speaking	Abscess at base of child's neck.	Explain need for operation & that child will be given anaesthetic.
8	Adult mother with 1 year old Down Syndrome baby Zulu speaking	Check up on child's medication	Change dosage of child's medication.
9	Adult man Zulu speaking	Sore throat Check up on hypertension & sugar diabetes.	Instruct to open mouth. Explain tonsils are fine. Prescribe medication. Renew script for hypertension & diabetes.
10	Adult woman Zulu speaking	Check up on pregnancy – when baby is due.	Explain results of ultrasound & when baby is due.
11	Adult woman Zulu speaking	Lower back pain	Conduct physical examination. Instruct patient to go for X-ray.
12	Adult man Zulu speaking	Painful left chest & left leg.	Conduct physical examination. Instruct patient to go for X-ray.

MATERNITY/PAEDIATRICS WARD: BETHESDA HOSPITAL: 4 AUGUST 2000

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
13	Mother & baby Zulu speaking	Gave birth to baby.	Ask after health of mom & baby & breast-feeding.
14	Mother & baby Zulu speaking	Gave birth to baby.	Ask after health of mom & baby & breast-feeding. Explain that she is ready to be discharged.
15	Mother & baby	Gave birth to baby.	Examine C-section scar. Ask

	Zulu speaking		after mom's appetite and if she has passed stools.
16	Mother & baby Zulu speaking	Gave birth to baby. Headache.	Ask after health of mom & baby & breast-feeding. Prescribe pill for headache.
17	Mother & child Zulu speaking	Baby not feeding properly.	Explain to mother to increase feeds - express 50ml breast milk to feed child every 3 hours
18	Mother & child Zulu speaking	Baby has chronic chest infection & inflamed lymph nodes. Not TB but could be retroviral but mother refused HIV test.	Ask mother what she knows about HIV. Ask if baby has been nebulized every 4 hours.
19	Granny & child Zulu speaking	Baby unwell, crying.	Take pulse & measure heartbeat.
20	Mom & child Zulu speaking	Baby unwell, sweating, loss of appetite	Ask about home and if anyone has TB. Ask when child sweats.
21	Mom & child Zulu speaking	Baby has kwashiorkhor.	Explain dietary needs of child. Give mother soya seeds to grow at home. Slowly introduce weaning foods (one at a time) e.g. mashed potato, beans, pumpkin.
22	Mom & child Zulu speaking	Baby has kwashiorkhor.	See above.
23	Granny & child Zulu speaking	Baby has kwashiorkhor.	See above.

OUTPATIENTS DEPT, MOSVELD HOSPITAL: WED 1 AUGUST 2000

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
24	Elderly man Zulu speaking	Enlarged testicles	Instruct patient to undress and lie on bed for physical examination.
25	Elderly woman Zulu speaking	Unable to sleep at night, loss of appetite, pain in flanks	Instruct patient to undress and lie on bed for physical examination.
26	Adult woman Zulu speaking	Pain in stomach, 1 full day of menstruation (not at usual time of period)	Instruct patient to undress and lie on bed for physical examination. Performed pap smear, prescribed pills & instructed patient when to return
27	Elderly woman Zulu speaking	Check up on sugar diabetes	Ask after health, take pulse and heartbeat, check blood sugar levels
28	Mother with baby Zulu speaking	Little girl has ear infection	Ask mother whether she wants injection or pills for child, mother chose pills, prescribe pills
29	Mother with baby Zulu speaking	Check up	Doctor explained X-ray results
30	Granny with child Zulu speaking	Boy unable to stand properly, vomiting, lolling head, dehydrated	Prescribe sugar-salt-water solution for dehydration and pills
31	18-year old girl Zulu speaking	Discomfort in stomach - growth on cervix	Did pap smear, Explain to girl that she has growth and needs an operation

32	Mother with 5-year old boy Zulu speaking	Scar tissue in left eye, eye infected and inflamed	Prescribe medication
33	Adult woman Zulu speaking	Pregnant, routine check-up	Instruct to lie down and examine
34	Elderly woman Zulu speaking	General body pains, palpitations	Ask her to undress, Breathe in and out, open mouth, examine eyes, send for X-ray. Has arthritis in hips - prescribe pills
35	Adult man Zulu speaking	Check up on blood pressure	Prescribe more pills, instruct patient to return in 4 weeks
36	1 year old girl accompanied by mom Zulu speaking	Sore throat	Ask when it started, examine throat, ask patient's mom if she wants medicine or injection (They vary rarely perform tonsillectomies in Zululand)
37	Mother with 11 year old boy Zulu speaking	Child has been coughing for about 1 month but otherwise healthy and well nourished	Ask about colour of mucous, send child for injection - & put him on nebulizer to see if it improves his chest
38	Adult woman Zulu speaking	Skin allergy on back of thighs and bottom	Prescribe medication
39	Adult woman Zulu speaking	Coughing	Send her for chest X-ray
40	Mother with 3 year old boy Zulu speaking	Bad chest cold	Examine child and prescribe medication
41	Adult woman Zulu speaking	Woman completed TB treatment & returning for check-up	Send for X-ray (to check if treatment was successful)
42	Adult woman Zulu speaking	returning for results of pregnancy test	Tell patient she is pregnant.
43	Mother with baby Zulu speaking	Child has fever	Ask if he has diarrhoea or if he is vomiting. Instruct on how to rehydrate & nourish child.
44	Adult woman Zulu speaking	Headache since yesterday	Ask if she has fever as headaches often accompany malaria - no fever. Prescribe headache pill.
45	10 year old boy Zulu speaking	Needs epilepsy medication	Prescribe medication
46	Adult woman Zulu speaking	Chronic cough	Send for X-ray to check for TB
47	Teenage girl Zulu speaking	Burning stomach pains all over	Instruct patient to lie on bed & conduct physical examination
48	Teenage girl Zulu speaking	Bad cough	Send for X-ray. Diagnosis after X-ray: she has TB. Explain that TB treatment must be taken for the full 6 months.
49	Young man Zulu speaking	Has sexually transmitted disease	Give him condoms and sexual contact card(s) which he is supposed to give to his sexual partner(s) so that they will be aware of the risk and hopefully also come in for treatment.

OUTPATIENTS' DEPARTMENT, MANGUZI HOSPITAL: 7 SEPTEMBER 2000

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
50	25 year old woman Zulu speaking	Pregnant and at term. Complaining of pains that feel like contractions.	Ask after personal details, whether it burns when she urinates, if she has any vaginal discharge. Conduct an internal examination.
51	Mother with 8 year old boy Zulu speaking	Child had abscess drained – returning for check up.	Remove bandage & examine abscess. Instruct to keep taking pills & change dressing everyday.
52	Adult woman Zulu speaking	Woman has HIV and a skin irritation on her bottom and thighs – like eczema.	Prescribe cream and instruct how often to apply.
53	Adult woman Zulu speaking	Complaining of pain on bottom.	Examine patient and prescribe oral medication for abscess on bottom. Instruct to bath every day.
54	Adult man Zulu speaking	Just had arm set in plaster cast and returning for x-ray.	Explain that cast must stay on for 4-6 weeks and instruct to return to hospital on 13 October.
55	Elderly woman Zulu speaking	Been going for physiotherapy treatments & returning for check-up.	Send to X-ray.
56	Adult woman Zulu speaking	High blood pressure and headaches.	Check blood pressure, heartbeat and examine eyes for signs of malignant hypertension. Prescribe more hypertensive medication.

OUTPATIENTS' DEPARTMENT, MOSVOLD HOSPITAL: 7 SEPTEMBER 2000

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
57	Young teenage boy Zulu speaking	Coughing on and off for a few years. Had TB as a child.	Listen to breathing & ask if coughing up blood or sputum. Explain that lungs are damaged from exposure to TB & will probably have a cough for the rest of his life.
58	Adult woman Zulu speaking	Pregnant. Headache since yesterday.	Recommend woman attends antenatal clinic every month and send for malaria test.
59	Adult woman Zulu speaking	Sore neck, stomach & knee.	Ask if woman carries water on head, conduct physical examination and prescribe painkillers.
60	Adult woman Zulu speaking	Diarrhoea containing blood and fever.	Conduct physical examination. Explain how to sterilise river water with Jik.
61	Elderly man Zulu speaking	Headache and fever.	Treated for malaria & finished pills but not better. Conduct physical examination and admit to hospital.
62	Adult woman	Painful foot and ankle.	Examine foot & prescribe anti-

	Zulu speaking		inflammatory.
63	Elderly woman Zulu speaking	Severe nausea, diarrhoea & headaches.	Conduct physical examination & send for malaria test.
64	Mother and baby Zulu speaking	Baby has fever and a cough.	Listen to baby's breathing and heartbeat.
65	Mother and baby Zulu speaking	Baby finished TB medication but still has snotty nose, underweight & coughing	Weigh baby and conduct physical examination. Prescribe medication for worms.

OUTPATIENTS' DEPARTMENT, BETHESDA HOSPITAL: 26 JUNE 2001

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
66	Elderly woman Zulu speaking	Covered in bruises, tests show no platelets in blood.	Write letter for patient and refer to Durban for liver biopsy.
67	Mother and young boy Zulu speaking	Child has growth in eye.	Explain that growth needs to be operated on.
68	Elderly woman Zulu speaking	Returning for blood test results - wants to see specific doctor.	Refer to doctor she wants to see.
69	Elderly man Zulu speaking	Severe muscular wasting and general body pain.	Doctor questions patient about age, habits and living conditions. Dr conducts physical examination and admits patient for blood tests, X-rays and further investigation.

OUTPATIENTS' DEPARTMENT, McCORDS HOSPITAL: 23 JULY 2001

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
70	Adult woman *** English speaking**	Headaches since motor vehicle accident (MVA).	Ask about specifics of headaches and take urine and blood samples to check for other diseases.
71	Adult man Zulu speaking	Returning to hear test results.	Explain results.
72	Adult woman Zulu speaking	Pregnant, request ultrasound.	Ask questions about pregnancy & tell woman when to return for ultrasound.
73	Adult woman *** English speaking**	Cough, vomiting, abdominal pain & headaches for 4 days. Pregnant.	Ask about nature of pain & duration of symptoms. Ask if woman is attending antenatal clinic. Conduct physical examination.
74	Adult man Zulu speaking	Hypertensive -medication finished & patient suspects BP is high.	Take patient's BP and conduct physical examination. Prescribe more medication for hypertension.
75	Elderly man ** English speaking*	Pain in left knee and discomfort in calf and thigh.	Conduct physical examination and routine history: 1. Identify main symptom. 2. History of main symptom (how long etc) 3. What aggravates or relieves symptom? 4. History of other systems in

			body. 5. Allergies etc. Send patient for bloods and X-rays.

OUTPATIENTS' DEPARTMENT, McCORDS HOSPITAL: 25 JULY 2001

	Patient's details	Patient's symptoms/ Comments	Doctor's explanations/ instructions
76	Adult woman Zulu speaking	Main complaint = stomach. Bad diarrhoea for 3 months.	Conduct physical examination and ask routine questions. Ask for stool sample & blood sample.
77	Adult woman Zulu speaking	Pain in knee.	Conduct physical examination and ask routine questions. Send patient for bloods & instruct to return.
78	Adult man * *English speaking*	Patient is chronic epileptic & needs new script for medication.	Explain that patient must keep up with medication and not forget to take pills.
79	Adult man Zulu speaking	Patient has TB symptoms.	Give patient 3 small bottles and instruct to take sputum samples on 3 consecutive mornings and return bottles for TB test.
80	Adult woman * *English speaking*	Boil under arm, poison spreading to face – upper lip & eye swollen. Worsened after patient put plaster on.	Ask about patient's allergies. Prescribe medication to fight infection.

APPENDIX C: TRANSCRIPTS OF 12 CONSULTATIONS

(Translations by Francis Zungu)

Hospitals: **Mosvold & Mseleni, Northern Zululand**
Doctors: **Dr J Hesse and Dr S Zwane**
Date: **1 and 3 August 2000**

CONSULTATION 1:

	ZULU	ENGLISH TRANSLATION
Doctor:	Unjani?	How are you?
Patient:	**Ngiyaphila.**	**I am fine.**
Doctor:	Ngiyajabula uma uphila, kusho ukuthi uzongivakashela nje. Kade useclinic eMbazwana?	I am happy that you are well, because that means you have just come to visit me. Have you been to Mbazwana clinic?
Patient:	**Yebo.**	**Yes.**
Doctor:	Ubuye nini?	When did go there?
Patient:	**Bengiye izolo.**	**I went there yesterday.**
Doctor:	Bathe uma behlola ushukela wakho bawuthola uphezulu izolo. Unayo vele inkinga kashukela ophezulu?	When you were examined they found that your sugar level was high. Do you have a problem with high sugar (diabetes)?
Patient:	**Kusho ukuthi nginayo ngoba ngihlala ngihlale ngiphethwe yikhanda.**	**It seems I must have because sometimes I have this headache.**
Doctor:	Kodwa abakaze basho esibhedlela noma eclinic ukuthi ushukela wakho uphezulu?	Have the hospital or clinic told you about that problem?
Patient:	**Udokotela wake washo, kukhona udokotela engake ngaya kuye eMtuba. Wangitshela ukuthi cha wona ushukela wami uphezulu kwakungu97.**	**A doctor told me, I once went to a doctor at Mtuba. He told me that my sugar level was high. It was in 1997.**
Doctor:	Kwakungu-1997 lapho? Ngisho ngoba uhlolile owalapha ekhaya namhlanje wathola ukuthi uphansi, awukho kahle kahle, uthanda ukuba phezulunyana kodwa akuthusi njengayizolo. Izolo bewu-17 namhlanje uwu-9.	Was that in 1997? I am saying that because our doctor here found it low, its not good, a bit high compared to the normal level but not scary like it was yesterday. Yesterday it was 17 and today it is 9.
Patient:	**Ya izolo ngiyacabanga ukuthi bengisanda kuphuza ne-drink.**	**Yes, yesterday the reason is that I had just had a drink.**
Doctor:	Okay.	Okay.
Patient:	**So ke namhlanje ngehlisile ukuphuza.**	**But today I have reduced the drinking.**
Doctor:	Kodwa udlile namhlanje ekuseni	Did you eat this morning?
Patient:	**Ya ngidlile namhlanje.**	**Yes I did eat this morning.**
Doctor:	Ya kona noma kunjalo uthanda ukuba phezulunyana kodwa hayi akukubi kakhulu. Hlambe kuzofanele silokhu siwuhlola , siwuhlole njalo uyabona, sibone ukuthi kuhamba kanjani. Kodwa wona awumubi kakhulu kodwa izolo ubumubi kakhulu, ubuphezulu impela. Hlambe into esizoyenza sizokuqalisa iphilisi lawo, njengoba usho bake bakutshela ngaphambili udokotela	Even though it's like this, a bit high, it's not too bad. Maybe it has to be checked regularly so that we can monitor its progress. But as I have said it's not as bad as it was yesterday. We have to start giving you pills, especially as you have said that the other doctor also said it was high. We have to give you pills to reduce it.

	omunye. Owayizolo bawuthole uphezulu nanamuhla uthe ukuba phezulunyana. Hlambe kuzodingeka sikuqalise amaphilisi okuwehlisa.	
Patient:	**Ngoba inkinga ebengiyilethile enye izolo, induku yami kusho ukuthi kade iqubukile. Ngilokhu ngizinwaya kusukela ngoMsombuluko. Mangithi ngiyageza ngoLwesibili ngiyayibona nje iqubukile, kodwa emva kwalokho yase isiyehla futhi.**	**My second problem yesterday was that my penis had a rash. It was very itchy on Monday. I noticed the rash when I was taking a bath on Tuesday but it has diminished.**
Doctor:	Ya kungenzeka – ngisazobuza futhi. Amanzi uyawomela nje kakhulu?	Yes it's possible, I have to confirm with other doctors. Do you thirst for water?
Patient:	**Ya ngiyawomela impela amanzi.**	**Yes I feel thirsty for water a lot.**
Doctor:	Uyawomela, umzimba uyakhathala nje kancane uzwe ukhathele?	You are thirsty for it. Does your body also feel tired sometimes?
Patient:	**Ngiyakhathala kodwa umsebenzi engiwenzayo awukho owamandla kakhulu. Ngoba nokujuluka ngiyajuluka futhi uma ngilele ngoba futhi ebusuku ngiyajuluka.**	**I feel tired but the work that I do is not tiring. I also sweat when I am sleeping at night.**
Doctor:	Awukhwehleli kodwa?	Are you not coughing?
Patient:	**Hayi angikhwehleli.**	**No I am not coughing.**
Doctor:	Isifo sikashukela siyakwenza lokhu uzizwe umzimba uphansi, womele kakhulu amanzi. Okunye okwenzakaya ukuthi amasosha lana avikela umzimba wakho athanda ukuphazamiseka uma kuwukuthi unesifo sikashukela, Kulula ukuthi izifo njena okungamagciwane kukuhluphe njengoba usho ukuthi induku yakho ibithanda ukuqubuka kancane. Kuyenza kakhulu lokho ngoba manje uma amasosha akho ephazamiseka, ephansi kancane kulula ukuthi amagciwane ande kakhulu ngoba manje awekho amasosha azowabulala. Kufana noma nje ukhathazekile kabi isikhathi eside, kuyenzeka futhi ukuba amasosha akho ashone phansi bese kuba lula ukuthi amagciwane azandise. So ngenxa yalokho kukhona vele izimpawu ezikhomba ukuthi unesifo sikashukela. Nalana uma uhlolwa kutholakala ukuthi uphezulu. Ngibona kukuhle ukuthi silona... (interrupted)	Diabetes causes the body to feel tired and rundown and to thirst for water. Another thing that happens is that the soldiers in your body are disturbed when you are diabetic. You then become vulnerable to disease and may get an infection as might be the case with your penis. When the soldiers of your body decrease, this allows germs to multiply easily because there are no soldiers to kill the germs. This also happens when you are anxious for a long period. Because of that signs of diabetes might show up. When you go for a check up they will find the level high. I suggest that we...(interrupted).
Patient:	**Besengivilapha ukumema umama ngoba umzimba uphansi.**	**I was too lazy to invite my wife over because my body (libido) was low.**
Doctor:	Ehe kuba yinkinga impela, ikakhulu kukhona nesifo lesi iBP. Ziyahlupha zombili lezi zifo. Kunokwenzeka nje kwabanye abantu uthole ukuthi ziyahambisana zikhona zombili. Uyazi angithi ngesifo iHigh-high ukuthi sithanda udle ngendlela enjani. Ungafaki kakhulu usawoti, namafutha. Awuphuzi?	Yes, it becomes a problem especially with other diseases like BP. Both are problematic. Some people have both. Do you know anything about high blood pressure? If you have it you must be strict with your diet. You mustn't have too much oil and salt? Do you drink?
Patient:	**Cha.**	**No.**
Doctor:	Awubhemi futhi? Ngoba izinto ezihluphayo lezo. Okunye ke futhi siye sithande	You also don't smoke? I saying these because can contribute to the problem.

	unyakazise umzimba - umzimba uthi ukwehla kancane. Kuyasiza nalokho kwenza ukuthi ungaze udinge amaphilisi amaningi. Kungaze kube ngcono kuyasebenza kakhulu ukwedlula amaphilisi. Okay lezo zinto-indlela odla ngayo nokunyakazisa umzimba. Kodwa ke sizoqala lapha kancane kancane kuthi ke ngoLwesibili oluzayo uphindele ekliniki eMbazwane. Bayochofoza futhi bahlole ukuthi ushukela unjani emva kokuthi sikuqalise lamaphilisi. Okay kulungile ke. Kukhona okunye othanda ukukubuza	The other thing that you must do is to exercise to lose some weight. That actually helps and you may not have to take as many pills, it will get better, it helps a lot more than tablets. Just those two things the way you eat and exercise. But we will start bit by bit here and then next Tuesday please go back to the clinic at Mbazwana. They will test you again to see what your sugar level is like and after that you will start the diabetes tablets. Okay then its fine. Do you have any other questions?
Patient:	**Ayi cha.**	**No.**
Doctor:	Ugculisekile.	You are satisfied.
Patient:	**Ehe.**	**Yes.**
Doctor:	Oho kulungile.	Fine, then.

CONSULTATION 2:

Doctor:	Ya Thokozani.	Hello, Thokozani.
Patient:	**(Mother speaks on behalf of her child) Yebo.**	**Hello.**
Doctor:	(Addressing child) Xhawula letha isandla, letha nalesi. Unjani?	Let's shake hands, bring that other hand. How are you?
Patient:	**(Mother replies) "Ithi ngiyaphila"**	**Say "I am fine"**
Doctor:	Ubani igama lakho? Yilomunye ukwenzani lomunye? Uphethwe yini mntanami eh? Kubuhlungu la? Kuqale nini ubuhlungu? Awuthi ngibone. Sekuvuthiwe. Kubuhlungu kakhulu? Ukugcine nini ukudla umntwana mama?	What is your name? What is the other one doing to you? What is wrong my child, hmm? Is it sore here? When did the pain start? Let me see. It's fully developed (about to burst – referring to abscess). Is it very sore? When did the child last eat, mom?
Patient:	**Usenesikhashana akugcinile ukudla.**	**It's a while now.**
Doctor:	Nini mhlawumbe? Seliphelile ihora?	Can you estimate the time? An hour ago now?
Patient:	**Uyazi anginakanga**.	**You know I didn't notice.**
Doctor:	Okay, uke wamupha ukudla kuyilokhu ufikile?	Okay, have you given him food since you came here?
Patient:	**Yebo uke wadla.**	**Yes he has eaten.**
Doctor:	Okay kulungile, ngizofuna ukuthi ungabe usamupha ukudla manje uyezwa. Sokunikeza umjovo omncane la. Alale khona engazobuzwa ubuhlungu bese siyalikhama ithumba.	Okay, from now on don't give him any food, do you understand. We shall give you a little injection here. That will make him sleep so that we can clean the abscess without him feeling pain.
Patient:	**Ukuthi njengoba uke wabona uyakhala ufuna ijuice manje angazi? Sebeke bamzama lona ngeSpray angazi noma ungamuzama yini ngaso.**	**As you can see, he is crying, he wants a juice now I don't know? They have tried him with a spray I don't know if you can also try it.**
Doctor:	Singasifaka sona iSpray kodwa into elukhuni kakhulu leyo, mncane lo uzokhala kakhulu kanti singakwazi ukumbamba uyabona.	We can use a spray but that is a very difficult thing. He is young he will cry more with a spray but I think we can hold him and squeeze the boil.
Patient:	**Ngizombamba mina.**	**I will hold him.**
Doctor:	Ngeke kulunge ngoba kufanele simlalise manje kuzoba yinkinga ngoba kufanele	I don't think that will work because we have to let him sleep now. The boil is very big.

	simlalisa. Okay likhulu kakhulu sizokwazi ukulikhama kahle yonke into iphume. Okay awuzame nje. Mnganami ufuna ukuphuza hee? Ufuna ukudla? Yima kancane.	We have to clean it make sure we have done it thoroughly. Let's just try. My friend, do you want anything to drink? Or some food? Just wait a bit.
Patient:	**Iyayithanda le ngane ijuice (/ijusi).**	**This baby likes juice.**
Doctor:	Okay, asizame ukuthi kancane ma, ake simzame nje kancane. Isikhashana sizobe sesiyamenza. Angadli niks okwamanje ngoba asazi ukuthi ugcine nini ukudla. Kufanele angadli amahora awu-4 ngaphambi kokuba sikwazi ukumenza. Uyabo?	Okay, mom, lets try him (injection), in a few minutes we will start the boil. Please, mom, make sure that he does not eat anything now as we don't know when he last ate. He must not eat for 4hours before we can perform the operation.
Patient:	**Hlambe selidlulile elilodwa.**	**I think perhaps one hour has passed.**
Doctor:	Mbambe nje lona omncane bese siyamenza. Okay.	Hold him and we start. Okay.
Patient:	**Amahora amangaki?**	**For how many hours?**
Doctor:	Hlambe sithi amabili azayo angadli. Cha iyakhala shame- ngoba kuzoba nenkinga uma simalisa kanti usaqeda kudla, angifuni ukuthi kube khona inkinga.	Okay because he is crying so much for food let's say 2 hours, it becomes a problem if we give sleeping injection if he has just eaten, I don't want that problem to happen.
Patient:	**Uyazi kungcono ukuba kuthiwa kukhona iSpray uyazi nje ngendlela akhala ngayo kwimanje nje.**	**I still prefer spray I think it would be better if we use it, I am just concerned about the way he is crying.**
Doctor:	Ngeke sikwazi ukusebenzisa iSpray kuzoba yinkinga uzogcina esezwa ubuhlungu futhi lingakhameki kahle. Okay.	We can't use spray, it will cause problems and he will end up feeling more pain and the boil will not be clean properly. Okay?
Patient:	**Ngiyabonga.**	**Thank you.**

CONSULTATION 3:

Doctor:	Sicela usidonsele umnyango baba. Ninjani namhlanje?	Kindly close the door as you come in, baba. How are you today?
Patient:	**Eyi nginezilonda esifubeni.**	**Eh, I have sores in the chest.**
Doctor:	Uzwe kanjani ukuthi unezilonda?	How did you find out that you have sores.
Patient:	**Ngiyezwa kuyathunukala.**	**I can feel the pain.**
Doctor:	Oho nakhoke, uma ugwinya kubuhlungu.	That's it, do you feel it when you swallow.
Patient:	**Yebo.**	**Yes.**
Doctor:	Kubuhlungu uma ugwinya?	It's painful when you swallow?
Patient:	**Yebo.**	**Yes.**
Doctor:	Kuqale nini?	When did it start?
Patient:	**Kusukela nje ngoLwesine ngezwa ngiphethwe yikhanda kwase kwabuhlungu nasesifubeni. Kusho ukuthi ke ngoMgqibelo ngase ngiza la.**	**As from Thursday I had this headache and then the pain in the chest. Then on Saturday I decided to come here.**
Doctor:	Okay. Bakunikeza amaphilisi?	Okay, did they give you any pills?
Patient:	**Yebo.**	**Yes.**
Doctor:	Kwabanjani emva kokuba usuthole amaphilisi?	How was it after getting those pills?
Patient:	**Ayi ikhanda laba ngcono.**	**The headache got better.**
Doctor:	Laba ngcono?	Did it?
Patient:	**Kodwa akukakabi ngcono la, inkinga sekusele la. Ngangithi uma ngikhwehlela kube buhlungu ovalweni ayi cha sekungcono manje kusele la**	**But it's not yet better here, the problem is still there. It used to be painful in the chest when I coughed but now it's only in the throat.**

	emphinjeni.	
Doctor:	Oya, bathi ubuye namhlanje uma kungabi ngcono?	Oh, did they say you should come back here if doesn't get better?
Patient:	**Ehe.**	**Yes.**
Doctor:	Awuhlale la ngihlole emphinjeni kwenzakalani baba. Amaphilisi azokusiza lawa ezinhlungu. Kunamaphilisi amanje engifuna uwafake egilasini, bazokusiza lapha ewindini lakuthathwa khona amaphilisi, uwafake egilasini uthele amanzi abe uhafu nje bese uyakaza ngawo. Emva kwalokho ungawachithi uwagwinye. Okay kodwa azokusiza kakhulu lapha emphinjeni apholise izinhlungu ebese zikhona. Okay so ngizokunikeza wona namhlanje namanye owawuwathole ngoMgqibelo siwahlanganise womabili sibone ukuthi kuhamba kanjani. Kodwa khona namuhla kubohlile kakhulu izindawo zombili kusho ukuthi kuya ngokuya kuba ngcono. Uma usezwa ubuhlungu kusho ukuthi akukapheli kahle, uyezwa baba? Amaphilisi akho kashukela ugcine nini ukuwathatha?	Sit here so that I can examine your throat to see what is wrong. These painkillers will help you. I will give you some pills that you must put in half a glass of water and take them now. You can get them from the dispensary window. Just dissolve them in the water and Drink it all, don't spill the water swallow it. I am sure this will help you with your throat and ease the pain. So I will give you both these ones and the ones you got last time on Saturday. Use them both to see what will happen. But today the swelling on your throat has decreased, as you still feel some pain it shows that it is still there. When did you last take your diabetic pills?
Patient:	**Ngenyanga lena edlule.**	**Last month.**
Doctor:	Ugcine nini ukuwaphuza?	When did you last drink them?
Patient:	**Namhlanje ekuseni.**	**This morning.**
Doctor:	Wo asekhona ekhaya?	Do you still have them at home?
Patient:	**Akhona imbijana.**	**Yes but only a few.**
Doctor:	Uzowalanda nini amanye?	When are you going to collect them?
Patient:	**Ngiwafuna namhlanje amanye.**	**I would love to have some more today.**
Doctor:	Hawu!	Gee!
Patient:	**Ikuthi mancane asesele semancane kakhulu.**	**It's because there are few left.**
Doctor:	Uwathatha kuphi vele amaphilisi?	Where do you normally collect them?
Patient:	**Ngiwathatha khona lapha ekhaya.**	**I collect them here.**
Doctor:	Okay.	Okay.

CONSULTATION 4:

Doctor:	...Okay, kuhamba kahle konke ubuze emafutheni nje kuphela akukho okukuhluphayo wena?	...Okay, is everything fine so far, you were just coming to check your cholesterol? There is nothing else troubling you?
Patient:	**Ayi cha.**	**No.**
Doctor:	Asibone ke la emafutheni ukuthi.... (interrupted) Ngenkathi uye emafutheni la bathi hayi umntwana uphila kahle ngaphakathi. Inhliziyo ishaya kahle, uyanyakaza futhi umntwana, uza ngekhanda, uyezwa ma? Owesingaki umntwana wakho?	Lets see what your cholesterol is...(interrupted) When you were here for your test what did they say about how the child is doing inside. Is the heart beating well, is the child moving, is the child's head facing in a downwards direction, are you listening? Is this your first born or second child?
Patient:	**Owesibili.**	**It's my second.**
Doctor:	Bathi ke kungenzekake la, kodwa bayahlawumbisela ngeke kube yiqiniso ngoba isikhathi sesihambe kakhulu.	Here they say, it's possible although they are guessing because of the time elapsed, they say its about 34 or 35 weeks, meaning it's

	Uyezwa ma? Kodwa manje bathi lana amasonto asewu34 noma 35 okusho ukuthi izinyanga sezingaki, lena sekuyinyanga yesikhombisa. Sekusele kancane ke njena ukuthi umthole umntwana, okay. Kodwa lana bahlawumbisela ukuthi uyomthola ngoSeptember. Kusho ukuthi njengoba kungu-August- ngenyanga ezayo. Okay. Akukho ofuna ukukubuza wena?	only a month until you give birth. The possible birth month is September. As it is August now that means only one month to go. Is there anything that you want to ask?
Patient:	**Ngicela ukubuza ukuthi umntwana muni?**	**May I ask the baby's gender?**
Doctor:	Akulula ukubona lana ngoba ababhalile. Uyabona ukuba usho ngesikhathi usahlolwa emafutheni, ufike wacela uma bekwazi ukubheka bakubhekele kodwa baye bangabhali laphansi. Kubonakala la usesemshinini. Uma bebheka la bayakwazi ukubona ukuthi umfana noma intombazane okay. Kube mhlambe ucele ngalesisikhathi usenziwa kodwa angikholwa ukuthi bebengakwazi ukukutshela kodwa bebengazama. Ngoba bona babheka ukuthi nje umntwana akanankinga, isisindo sakhe singakanani, mangaki amasonto manje.	It's not easy here because they did not write it down. You see if you had asked them to look when you went for your cholesterol test, they would have given you answers if they knew but they normally don't write it down. Its easy to see on the machine whilst you are still there. When they look, they can tell it's a boy or girl. They would have tried it there if you had asked then and there but I cannot tell you because they didn't even try to establish the sex. They would have tried because their job is to see that the baby is healthy, to look at the weight and development of the child, how many weeks old the child is now.
Patient:	**Ngiyabonga.**	**Thank you.**

CONSULTATION 5:

Doctor:	Kunjani?	How are you?
Patient:	**Eyi sikhona.**	**No, we are fine.**
Doctor:	Uxole lento yayizolo kuvele kwayinyakanyaka.	My apologies for what happened yesterday, I was very busy and things were out of control.
Patient:	**Nami ngibonile ukuthi ubhizi.**	**I also saw that you were busy.**
Doctor:	Kuvele kwayinyakanyaka. Ufuna sikubhukhele eNgwelezane? Alright awuthi ngibafonele, konje yini enye ebengithi ngifuna ukuyibuza? Waya ngale ukuyothatha igazi?	I was so busy. Do you want us to book you in at Ngwelezane? All right, let me phone them. What else did I want to ask you? Did you go for the blood test?
Patient:	**No, angilithathanga.**	**No I did not.**
Doctor:	Awulithathanga ngani?	Why didn't you have the test?
Patient:	**Kodwa khona imiphumela yakhona bangitshelile ukuthi bathini laphayana.**	**But what are they saying there about my results.**
Doctor:	Okay sisazoxoxa kahle awuthi ngiyofonela eNgwelezane, ngizokubhekela Msomi.	Okay, we will talk further, let me go and phone Ngwelezane to check them for you.

CONSULTATION 6:

Doctor:	Kugula bani? Ninjani?	Who is sick? How are you?
Patient:	**Siyaphila, kugula umfana.**	**We are fine, it's the boy who is sick.**
Doctor:	Uphethwe yini?	What is wrong?
Patient:	**Uphethwe yihlo. Kunento emile la ehlweni.**	**He is troubled by his eye. There is something developing in his eye.**

Doctor:	Ubone nini?	When did you see it?
Patient:	**Kusho ukuthi kunenyanga yonke, kusho ukuthi nje yingoba kuyingane engakhulumi.**	**I would say a month ago, it's just that he hasn't complained and does not talk much.**
Doctor:	Yini eyenze ukuthi kube nimlethe namhlanje?	What made you bring him today?
Patient:	**Siye eclinic ngoLwesine bathi asize izolo, izolo kwathi sashiywa amabhasi.**	**We went to the clinic on Wednesday and they said we should come here yesterday, but we missed the bus.**
Doctor:	Vul'ihlo.	Open your eye.
Patient:	**Kula phansi.**	**It's on the base here.**
Doctor:	Okay.	Okay.
Patient:	**Kuye kukhule kube kukhulu, kuphume amahlule.**	**It has grown large, and blood clots have formed.**
Doctor:	Okay, kufuneka isuswe. Uyazi ukuthi ugcine nini ukudla?	Okay, we must take it out. Do you know when he last ate?
Patient:	**Ukudla! Kusho ukuthi ngimyekise namhlanje.**	**Food! I didn't give him today.**
Doctor:	Akazange adle? Ngoba udokotela wamehlo uyahlinza namhlanje, kungenzeka amhlinze namhlanje, ayisuse lento. Kufuneka sihambe siye kombuza. Asihambe.	He hasn't eaten at all? Because the optician operates today. It's possible to operate on him today and remove this thing. We should go and ask the doctor. Let's go.

CONSULTATION 7:

Doctor:	Sawubona.	Hello.
Patient:	**Yebo dokotela.**	**Yes doctor.**
Doctor:	Uthini namhlanje?	What are you saying today?
Patient:	**Ngiyagula dokotela. Kubuhlungu dokotela. Kwathiwa angobuya ngomhlaka-2.**	**I am sick doctor. It's painful, doctor. They said I should come on the second.**
Doctor:	Konje wena uphethwe yiBP.	Are you a BP patient?
Patient:	**Mmm, manje kodwa le BP le iyehla kodwa kusenendawo ebuhlungu ngathi kukhona indawo edabukile dokotela. Iphela nje ngesifuba. Isifuba sona anginaso, angikhwehleli. Manje angazi noma nginezikelemu, ngizwa sekukhala lapha.**	**Yes but this BP drops and there is still pain as if there is a swelling doctor. It ends in the chest. I don't have chest problems (TB) and I'm not coughing. I don't whether its worms because of the sound (crying) I can hear in my stomach.**
Doctor:	Kuqale nini?	When did it start?
Patient:	**Kuqale kulonyaka ophelile.**	**It started last year.**
Doctor:	Ulala kahle ebusuku?	Do you sleep well at night?
Patient:	**Ebusuku ngike ngiqwashe, ngingalali.**	**Sometimes I don't sleep well, I wake up.**
Doctor:	Ungalali, mmm, Udla kahle futhi?	You don't sleep, hmm? Do you eat well?
Patient:	**Ngiyadla nje lokho engikudlayo, angidli kahle, ngiyadla nje lokho okuncane. Angithandi ukuthi ngidle kakhulu.**	**I just eat although not well, I eat a bit. I don't feel like eating a lot.**
Doctor:	Gibela lapha embhedeni.	Climb onto the bed.

CONSULTATION 8:

Patient:	**Ukukhwehlela kwangiqala ngoJuly 6. Isibeletho sami asizi kahle. Imenstruation yami ayizange kube**	**The coughing started on July 6th. My womb is not well. My menstrual cycle has not changed.**

	khona shintsho.	
Doctor:	Uneminyaka emingaki?	How old are you?
Patient:	**Ngineminyaka engu-43.**	**I am 43 years old.**
Doctor:	Unazo izingane?	Do you have children?
Patient:	**Nginazo.**	**Yes I do.**
Doctor:	Zingaki?	How many?
Patient:	**I have got 5.**	**I have five.**
Doctor:	Omncane uneminyaka emingaki yena?	How old is the youngest?
Patient:	**The smallest one una-5yrs.**	**The youngest is 5 years old.**
Doctor:	Uyahlela?	Are you using contraception?
Patient:	**No.**	**No.**
Doctor:	Ufuna ingane futhi?	Do you want another child?
Patient:	**Eyi ngizozisheka ngoba angiqondi ukuthi kwenzekani.**	**I have just come for a check up because I don't understand what is happening.**
Doctor:	Utheni uneminyaka emingaki 42?	Did you say you are 42?
Patient:	**43.**	**43.**
Doctor:	Khumula izingubo lala embhedeni la. Ugcine nini esikhathini?	Take off your clothes and lie on the bed. When was your last period?
Patient:	**15 July, 15days ago.**	**15th July, 15 days ago.**

CONSULTATION 9:

Doctor:	Sawubona.	Hello.
Patient:	**Yebo.**	**Yes.**
Doctor:	Yini inkinga? Kwenzenjani manje?	What is the problem? What is happening now?
Patient:	**Kubuhlungu wonke umzimba, manje ngiyagodola kuqaqamba amathambo.**	**My whole body is sore, I feel cold (shivering) and my bones are very sore.**
Doctor:	Kuqale nini?	When did it start?
Patient:	**Kuqale kulezizinsuku nje.**	**It started recently (these days).**
Doctor:	Ulala kahle ebusuku?	Do you sleep well at night?
Patient:	**Ngilala kahle ebusuku.**	**Yes, I sleep well.**
Doctor:	Udla kahle futhi? Uyakhwehlela?	Do you have a good appetite? Are you coughing?
Patient:	**Ngiyakhwehlela.**	**Yes, I do cough.**
Doctor:	Siyaphuma isikhwehlela?	Are you coughing up sputum?
Patient:	**Siyaphuma.**	**Yes.**
Doctor:	Uyazi iminyaka yakho?	Do you know your age?
Patient:	**Angiyazi.**	**No I don't.**
Doctor:	Khumula izingubo zonke lala embhedeni ngifuna ukuhlola umzimba uyezwa?	Take off all your clothes and lie on the bed. I want to examine you. Do you understand?

CONSULTATION 10:

Doctor:	Sawubona ma. Unjani namhlanje?	Hello mom, How are you today?
Patient:	**Ngisaphila.**	**I am fine.**
Doctor:	Ha niyaphila, nizongivakashela nje? Okay-Uphethwe yini umntwana?	Oh you are well, so you have just come for a visit? Okay, Whats wrong with the child?
Patient:	**Uphethwe yithumba.**	**He has an abscess (or boil).**
Doctor:	Likuphi ithumba sisi?	Where is the abscess, sister?
Patient:	**Nali ngapha.**	**It's here this side.**
Doctor:	Ah, liqale nini ukuba khona?	Ah, when did it start to develop?
Patient:	**Selinamasonto amabili.**	**Two weeks ago.**
Doctor:	Hawu ubuhleli ekhaya amasonto amabili?	You have waited at home for two weeks?
Patient:	**Imali beyingekho.**	**I didn't have money.**

Doctor:	Imali lutho? Okay wazi kanjani ukuthi ithumba?	No money? How do you know it's an abscess?
Patient:	**Ngibona kuqinile phakathi.**	**I can see it's hard on the inside.**
Doctor:	Okay awuthi ke sibone kancane, ya mgone kanje, mncelise khona engezukhala. Ya mnganami ya, xhawula. Okay kulungile. Sisi lokhu okuvuvukele lapha komntwana indlala noma izimbilaphu. Angithi uyabona uma ulimele onyaweni, angithi uke ubone kuvuvukele la kubebuhlungu la. Nakuye ke mhlambe unenkinga la esifubeni yingakho evuvukele laphayana. Okay, akuwona amathumba kuqinile kuningi futhi. Kungenzeka futhi ukuba kubangwa isifo sofuba iTB. Kungenzeka kuyena ukuthi ingene lapha ezindlaleni asazi ke sisazohlola-ke kodwa akuwona amathumba. Nihlala kuphi eMabibi?	Okay let me check, yes, hold him like this, breastfeed him so that he does not cry. Hello, my friend, shake hands. Okay, it's all right. Sister, the swelling is just the glands or swelling of the glands. You must have noticed that when you injure your foot the glands in your groin swell. I presume with him that it's because he has a problem in the chest that he has become swollen here. These are not boils, they are very hard. This can be caused by TB. TB can get into the glands but I will examine him first and confirm but these are definitely not boils. Where about do you live in Mabibi?
Patient:	**Yebo**	**Yes.**
Doctor:	Nifike ngani namhlanje?	How did you come here today?
Patient:	**Sifike ngemoto.**	**We arrived by car.**
Doctor:	Oh, niqashe imoto?	Oh, you hired a car?
Patient:	**Yebo.**	**Yes.**
Doctor:	Iphi imoto isanilindile?	Where is the car, is it still waiting for you?
Patient:	**Seyihambile.**	**It has gone now.**
Doctor:	Ha manje nibuyela ngani emuva?	Then how are you going to go back?
Patient:	**Angazi.**	**I don't know.**

CONSULTATION 11:

Doctor:	Yebo baba, unjani namhlanje?	Yes how are you today, father?
Patient:	**Ayi kuhlwile angiboni. Kunzima kakhulu namhlanje.**	**No, its dark, I can't see. Today it's very difficult.**
Doctor:	Yini indaba baba.	What is the matter?
Patient:	**Amehlo nje awaboni.**	**My eyes simply can't see.**
Doctor:	Yilokho nje okukulethe lapha esibhedlela namhlanje?	Is that what brought you to hospital today?
Patient:	**Yebo.**	**Yes.**
Doctor:	Ububoniwe la usister wamehlo?	Did the optician sister see you?
Patient:	**Yebo.**	**Yes.**
Doctor:	Wase uthi uze ngapha namhlanje.	Then she referred you this side today?
Patient:	**Yebo.**	**Yes.**
Doctor:	Okay, awuthi ke sibone ukuthi usister wamehlo ubeboneni, yini kungathi amehlo anenkungu?	Okay, let me see what the optician has seen. Is it like your eyes have a film over them?
Patient:	**Yebo anenkungu.**	**Yes.**
Doctor:	Anenkungu ndawozombili?	Do they both have the same film?
Patient:	**Yebo.**	**Yes.**
Doctor:	Sekunesikhathi esingakanani engafuni ukubona kahle amehlo?	For how long have your eyes not been seeing properly?
Patient:	**Sekuyinyanga nohhafu.**	**A month and the half.**
Doctor:	Wawufike nini konje kusister lo wamehlo?	When did you come to the optician sister.
Patient:	**Ngafika ngoLwesine. Wasengithumela ukuthi angize ngapha.**	**I was here on Thursday. Then she referred me here.**
Doctor:	Okay, uthe ufike la namhlanje?	Okay, did she say you should come today?

Patient:	**Yebo.**	**Yes.**
Doctor:	Wathi uze kuye noma ubonwe udokotela?	Did she ask you to return to her or to the doctor?
Patient:	**Uthe nje oya eMpangeni.**	**She just said, "You should go to Empangeni".**
Doctor:	Ngibone sebekuletha ngapha kimi.	I saw them bringing you to me.
Patient:	**Angazi phela lapha mina , mina ngivele ngifake nje.**	**I don't know this place, that's why I have put my card here.**
Doctor:	Akakubhalelanga incwadi usister?	Didn't she write you a letter?
Patient:	**Uthe incwadi izotholakala ngizoyithola ngapha.**	**She said I would get a letter here.**
Doctor:	Ngisho ngoba isikhathi esiningi uye abhale incwadi bese kuba uye okuxhumanisa nodokotela osebenza naye eMpangeni.	I am saying this because normally she writes a letter to refer you to a doctor at Empangeni, whom she will contact.
Patient:	**Kusho ukuthi ikuye ngoba uyibhalile khona izolo.**	**It must mean it is with her because she wrote it yesterday.**
Doctor:	Uyibhale khona izolo incwadi?	Did she write it yesterday?
Patient:	**Uyibhale ikuye uma ngicabanga.**	**I think it's with her because she did write it.**
Doctor:	Okay, kufanele ngikutholele mina ukuthi ikuphi incwadi, hlambe ufike wayishiya ngale ekuqaleni, uma kungukuthi ikhona kubese kubalula ukuthi sikubhalise ukuthi uya eMpangeni namhlanje. Kulungile, baba, ngizokubhekela incwadi, ngikutholele ukuthi ikuphi uyezwa, baba. Okay kulungile.	Okay, I will find out for you where the letter is, maybe she left it at registration. If it is there it will be easy for us to register you as a person going to Empangeni. Okay, father, I will look for the letter. Do you understand, father? Okay, it's fine.

CONSULTATION 12:

Doctor:	Sawubona sisi.	Hello, sister.
Patient:	**Yebo.**	**Yes.**
Doctor:	Unjani namhlanje?	How are you today?
Patient:	**Kuyafana nje.**	**It's still the same.**
Doctor:	Kuyafana nje? Yini inkinga? Uma uthi kim kuyafana nje angazi ukuthi yini inkinga.	Is it the same? What is the problem? When you tell me "it's the same", I don't know what the problem is.
Patient:	**Amaphilisi lawa enanginikeza wona ukuthi angiwasebenzise...**	**The tablets you gave me to use...**
Doctor:	Konje wawuphethwe yini?	By the way what was wrong with you?
Patient:	**Ikhanda.**	**Headache.**
Doctor:	Enze njani amaphilisi?	What did the pills do?
Patient:	**Awanabungcono nginle ngiwaphuze ikhanda libebuhlungu.**	**They do not make me any better, immediately I take them the headache starts.**
Doctor:	Awuthi-ke sibone ukuthi umfutho unjani. Namhlanje ikhanda usalizwa?	Let me see how is your blood pressure, do you still have a headache today?
Patient:	**Yebo.**	**Yes.**
Doctor:	Konje ngangithe ubuye nini mina?	Remind me, when did I say should come back?
Patient:	**Wawuthe angobuya nje, kodwa mina ngase ngiba nohambo lomsebenzi.**	**You just said I must come back but I had a work commitment to fulfil.**
Doctor:	Cha ngangikubonile mina ngathi ubuye kulamasonto alandelayo uthathe isonto leliya elilodwa nje. Kodwa ke namuhla	I realised that during the examination that's why I said you should come back in a week's time. But your blood pressure has decreased,

	umfutho wakho wehlile, awufani njengaleliya langa ngenkathi ufukile la. Uyabona ekuqaleni wawubhalwe ngepeni elibomvu-160/100 uyawubona owanamuhlanje uzobhalwa ngepeni eliluhlaza. Okusho ukuthi awumubi 120/90.	it's not like the last time you were here. Last time it was written in red pen - 160/100. Look at today's one, its in blue. Which shows that it's not bad. It's 120/90.
Patient:	**Manje iyashaya inhliziyo ikhanda libuhlungu.**	**Now my heart is beating and I have a headache.**
Doctor:	Kodwa wona umfutho akukubi kakhulu. Ishaya nin' inhliziyo kakhulu, uma ngabe wenzenjani?	But your blood pressure is not bad. When does your heartbeat accelerate? When you are doing what?
Patient:	**Noma ngingenze lutho nje. Ikhanda ke lona njalo ekuseni libuhlungu.**	**Even when I am doing nothing. The headache is always in the morning.**
Doctor:	Kodwa cha umfutho wakho uyangigulisa awumubi kakhulu nje awufani njengaloluyasuku. Kusho ukuthi amaphilisi esikunikeze wona akusizile ukwehlisa wona noma ke ikhanda ke lona lingakabi ngcono nanokuthi ke ukhala ngenhliziyo ethanda ukushaya kakhulu. Uke wawaphuza amaphilisi ekhanda kodwa?	But I am still satisfied with the level of your BP, it's not as bad as it was last time. That means the pills we gave you managed to keep it low although the headache is still there and the heartbeat is still high. Have you taken your pills today?
Patient:	**Cha angikaze ngiwaphuze. Aphela lawa enanginika wona.**	**No, I have not taken them. The ones you gave me finished.**
Doctor:	Ngesikhathi usawaphuza laliba ngconywana, laliba njani ikhanda?	When you were still taking them, how was the headache?
Patient:	**Laliba ngcono ikhanda.**	**It was better.**
Doctor:	Okay, Uyizwa nini inhliziyo eshaya kakhulu, uma uqeda ukuthatha amaphilisi noma?	Okay, when does your heartbeat accelerate, is it when you have just taken pills?
Patient:	**Noma ngiwaphuzile noma ngingawaphuzanga noma ngingakawaphuzi bese ngiyawathatha ngiyawaphuza bese kwenzenjalo.**	**Whether I take them or not, it doesn't make a difference, the same thing happens.**
Doctor:	Awuhlale la ngithi ukuhlola inhliziyo ngizwe ukuthi ishaya kanjani namhlanje. Hlala nje khona lapho.	Sit down here so that I can examine your heart and check how it is beat ing today. Just sit down there.

APPENDIX D

SUMMARY NOTES BASED ON INTERVIEWS WITH DOCTORS:

Name of doctor and date of interview	Hospital	Comments
Dr Geoff Solarsh 7 June 2000	University of Natal Medical School, Durban/ Hlabisa Hospital	COMMON PROBLEMS IN PAEDIATRICS Two issues relating to rural medicine which Dr Solarsh raised during our interview were: 1. Immunisation (He has run a number of immunisation campaigns, especially for measles, where thousands of people arrive for treatment). 2. "Unofficial" Jeyes fluid enemers (often administered by traditional healers or family members)
Dr Chris Kelly 17 June 2000	Prince Msheni Hospital	ROUTINE QUESTIONS WHICH ARE COMMONLY USED & EASILY LEARNT: What is the problem? Why did you come here? How long have you been suffering? Where is the problem? etc BIGGEST PROBLEM IN PAEDIATRICS: HIV/AIDS Doctors see between 6000 – 7000 children in OPD per month, and admit about 200 of these for HIV-related illnesses. Dr Kelly feels that doctors should be able to counsel patients regarding their HIV status and should not expect this to be handled only by AIDS counsellors. VIEWS ON NURSE-INTERPRETER SYSTEM: Frustrating when nurses misinterpret/ summarise patient dialogue.
Dr Jenny Nash 3 August 2000	Mseleni Hospital, Northern Zululand	COMMON PROBLEMS IN OPD: 1. HIV/AIDS 2. TB/ Chest infections 3. Hypertension 4. Worms 5. Malaria 6. Decreased libido 7. Urinary infections 8. Skin infections/Sores/Ulcers 9. Epilepsy

Dietician Kerry Mould 3 August 2000	Bethesda Hospital Northern Zululand	COMMON DIETARY PROBLEMS 1. Malnutrition (mostly due to poverty & HIV/AIDS) 2. Obesity (amongst wealthier citizens – obesity is seen as a sign of wealth & good health, the perception is that fat people don't have AIDS). 3. Diabetes 4. Incorrect breast-feeding techniques: mothers substitute mother's milk for other diluted products because adverts for such products always show healthy babies. Need for instruction on breast-feeding. When I was in Ubombo in August, they had a campaign for which the slogan was "Ukuncelisa yilungelo lakho" (Breast-feeding is your right). Other posters read "Ubisi lukamama lodwa ezinyangeni eziyisithupha" (Breast-feeding exclusively for 6 months).
Dr Lynelle Ruthvin 4 August 2000	Bethesda Hospital Northern Zululand	COMMON QUESTIONS IN MATERNITY Day 1: • How are you feeling? (Unjani mama?) • Is the baby breast-feeding? (Ingane incelisa kahle?) Day 2: • Have you passed stools normally? (Amakaka abemahle?) • Have you experienced flatus? (Usuzile na?) Day 3: • You can start eating (soft) food again. (Ungadla ukudla (okuthambile) manje).
Dr Lyn Kenneth 4 August 2000	Bethesda Hospital Northern Zululand	COMMON PROBLEMS IN PAEDIATRICS 1. Malnutrition (Kwashiorkhor, Marasmus) 2. HIV/AIDS (Pre-test & post-test counselling) 3. TB (sweating at night, loss of appetite, 6 month treatment - need counselling to encourage mothers to continue with pills) 4. Gastro 5. Chest infections/Pneumonia
Dr Chris Ellis 28 February 2001 & 20 March 2002	Hayfields Medicross Medical Center Pietermaritzburg	Dr Ellis outlined the two most frequent complaints that his patients present with as: 1. Pain 2. Tiredness Other concerns: 1. Cultural misunderstandings (Western biomedical model of medicine vs. African perspective on health & healing) 2. HIV/ AIDS!!!

Dr Tappie Cairns 4 February 2002	Nkandla Hospital, Zululand	CHILDREN: 1. colds and flu 2. scabies 3. worms 4. HIV CHILD-BEARING AGE: 1. TB 2. HIV/AIDS 3. Other STD's 4. Pregnancy OLDER PEOPLE: 1. Hypertension 2. Diabetes 3. Arthritis OTHER: 1. Application for diability grants (lots of these!) 2. Frustration of nurses misinterpreting/ summarising patient dialogue.

OTHER DOCTORS WHOSE CONSULTATIONS I OBSERVED IN THE OPD:

- Dr J. Hesse (Mosvold Hospital)
- Dr S. Zwane (Mseleni Hospital)
- Dr Todd-Ngubane (McCords Hospital)
- Dr D. Hacking (McCords Hospital)

APPENDIX E

Notes on Weight Loss: prepared by Kerry Mould (Dietician at Bethesda & Mseleni Hospitals) August 2000

UKWEHLISWA KWESISINDO

Kayikho imilingo yokudla ukwehlisa isisindo. Indlela yokuphila eguqukayo okufanele ime njalo. Lendlela yokuphila eguquguqukayo ifaka ukudla ngendlela enempilo, okufanele wonke umuntu omsemdemini ayilandele (hhayi nje labo abafuna ukwehlisa isisindo). Okulandelayo uhlaka olokuthi ungazenza kanjani izinguquko zokulandela ukudla okunemphilo.

1. **Ukwehlisa amafutha** – ukudla okunamafutha amaningi kuyi mbangela yokukhuluphala
   - Ungaqcobisa kakhulu amafutha (margarine) esinkweni – sigcobe koluzacile ucezu. Uma esebenzisa iphinath butter ungayisebenzisi imargarine
   - Susa amafutha enyameni ngaphambi kolayipheka
   - Khipha esikhumba senkukhu ngaphambi kokuyipheka
   - Sebenzisa amafutha amancane uma upheka
   - Balekela ukusebenza ukudla okuthosiwe ngamafutha – amachips, amagwinya (shishiliza)

2. **Phuza 6 – 8 amaglasi amanzi**
   - Amanzi akwenza uhlale ugcwele futhi akuvimba ukuba ungaphuzi kakhulu iCoke, itye kanye ikhofi

3. **Idla izithelo eziningi kanye nemifino**
   - Lokhu kunikeza amavitamin amaningi nokusasa woti okusiza kakhulu ukusigcina siphile kahle
   - Idla kane kuya kusihlanu izithelo ezahluken nemifino umakwenzeka ngosuku
   - Pheka imifino ngamanzana amancane ungawa faki amafutha

4. **Idla ukudla okunomsoco zonke izinsuku**
   - Umsoco usekudleni okufana nesinkwa esinsundu (hhayi esimhlope) izithelo (ikakhulukazi umango kanye nobhanana), imifino ubhontshisi kanye usoya
   - Lokhu kukusiza ukukugcina ugcwele isikhathi eside nokukuvikela ekudleni okukhulaphalisayo
   - Kuyasiza ukusivikela kumdlavuza (cancer)
   - Kukusiza ukugcineka uphile kahle

5. **Idla kancane inyama ebomvu bese udla kakhulu eyenkukhu, ufishi nobhontshisi**
   - Inyama ebomvu eyenkomo nesiklabhu enamafutha amaningi acashile
   - Zama ukudla izigaxa ezimbili kuya kwezinthathu ngeviki
   - Isigaxa sisho inyama elingana nemphama yakho

6. **Nciphisisa ukudla okusemphaketheni**
   - Ukudla okusemphaketheni ukudla okufana nama chips, uswidi, ushokoledi, ushukela omningi etiyeni nasekhofini, iCoke nezinye ezinhlobo zokuphunzwayo okunoshukela omningi
   - Lokhu kusinikezi izinto ezinhle (amavithamin, okusasawoti okusisiza ukulwa nezifo)

7. **Okungenani sidle kathathu ngosuku**
   - Ungeqi izikhathi zokudla – lokhu kungekusize ekwehliseni isisindo

8. **Ukujima**
   - Ukudla okufanele kuzokusiza, kodwa uzobona umehluko omkhulu ngokujima. Isibonela, uma uhamba, zama ukusheshisa wandise usuku nosuku.

WEIGHT LOSS

There are no miracle diets for weight loss. It is a lifestyle change that must be made forever. This lifestyle change includes healthy eating habits, which everyone in the family should follow (not just those who need to lose weight). The following is a guideline on how to make the changes to follow a healthy diet.

1. **Reduce FAT intake.** Eating a lot of fat is the main cause for people being overweight.
   - Avoid using a lot of margarine on bread – spread on bread thinly. If you eat peanut butter don't use the margarine as well.
   - Trim all meat of the fat before cooking
   - Remove the skin of the chicken before cooking
   - Use very little fat or oil when cooking food
   - Avoid eating foods that have been baked or fried in oil – chips, amagwinya (shiselisa)

2. **Drink 6 – 8 glasses of water.**
   - Water helps to make you full and also stops you drinking too much coke, tea and coffee.

3. **Eat many fruit and vegetables**.
   - These provide you with many vitamins and minerals that help to make you very healthy
   - Eat about 4-5 different fruit and vegetables per day if possible
   - Cook the vegetables in a little water and don't add oil

4. **Eat food with fibre every day.**
   - Fibre is in foods like brown bread (not white bread), fruit (especially mangoes and bananas) vegetables, beans, oats and Soya.
   - This helps to keep you fuller for longer and prevents snacking on fatty foods
   - It helps in prevention of cancer
   - It helps to keep you regular

5. **Eat less red meat and more chicken and fish**
   - Red meat is beef and mutton which has a lot of hidden fat
   - Try to eat only 2-3 portions of red meat per week
   - A portion is about the size of your palm

6. **Limit empty calories**
- Empty calories are foods such as packets of chips, sweets, chocolates, a lot of sugar in tea and coffee, coke and other fizzy drinks
- These don't give much of the good things (vitamins and minerals that help to fight disease, that we get from our food

7. **Eat at least 3 balanced meals per day**

   - Don't skip meals – this does **not** help you lose weight
   - Avoid snacking between meals or snack on fruit

9. **Exercise**
   - The right diet will definitely help, but you will see a much bigger improvement with exercise. For example, when you walk, try and do this faster and a little bit further each day.

APPENDIX F

UNIVERSITY OF NATAL

NELSON R. MANDELA SCHOOL OF MEDICINE

INTRODUCTION TO MEDICAL ZULU: 2001 COURSE EVALUATION

To assist the Faculty of Medicine with the evaluation assessment of the introductory Medical Zulu course you have been involved in, you are requested to complete the following questionnaire. PLEASE TICK (✓) THE APPROPRIATE BOX when answering questions.

GENDER: Male ❑ Female ❑

A. LANGUAGE SKILLS ACQUIRED

1. **Home language:** _____

2. **Zulu proficiency: How would you rate your skills/ability with respect to the following <u>BEFORE</u> completing the Zulu component of Module 1? Please ✓ in the appropriate block.**

Speak Zulu:	excellent ❑	good ❑	adequate ❑	poor ❑	unable to ❑
Read Zulu:	excellent ❑	good ❑	adequate ❑	poor ❑	unable to ❑
Write Zulu:	excellent ❑	good ❑	adequate ❑	poor ❑	unable to ❑

3. **Zulu proficiency: <u>AFTER</u> completing the Zulu component of Module 1, how has your competence in Zulu improved in the following areas? Please ✓ in the appropriate block.**

Speak Zulu:	greatly improved ❑	significantly improved ❑	slightly improved ❑	no improvement ❑
Read Zulu:	greatly improved ❑	significantly improved ❑	slightly improved ❑	no improvement ❑
Write Zulu:	greatly improved ❑	significantly improved ❑	slightly improved ❑	no improvement ❑
Pronounce Zulu:	greatly improved ❑	significantly improved ❑	slightly improved ❑	no improvement ❑

If you answered above that your ability to speak/read/write Zulu <u>HAS IMPROVED</u> since you completed the Zulu component of Module 1, to what do you attribute this improvement? Please ✓ ALL relevant answers.

Teacher's competence ❑
Learner's motivation ❑
Other ❑ Please specify

_____
_____
_____

If you answered above that your ability to speak/read/write Zulu has NOT improved since you completed the Zulu component of Module 1, to what do you attribute this lack of improvement? Please ✓ ALL relevant answers.

Teacher's incompetence ❑
Learner's lack of motivation ❑
Other ❑ Please specify

_____
_____
_____

B. TEACHING METHODS / MATERIAL COVERED

1. **How would you evaluate the lecturer in terms of competency and teaching methods. Please ✓ in the appropriate block.**

Excellent ❑ Good ❑ Average ❑ Below average ❑

2. **How often did you make use of the revision worksheets on WebCT? Please ✓ in the appropriate block.**

All the time ❑ Often ❑ Sometimes ❑ Never ❑

If you made use of WebCT, how helpful did you find the worksheets posted on WebCT? Please ✓ in the appropriate block.

Extremely useful ❑ Fairly useful ❑ Not useful at all ❑

3. **How enjoyable were the Zulu lectures? Please ✓ in the appropriate block.**

Very enjoyable ❑ Enjoyable ❑ Average ❑ Boring ❑

4. **How relevant to your future career did you find the material covered in the handouts? Please ✓ in the appropriate block.**

Very relevant ❑ Mostly relevant ❑ Slightly relevant ❑ Irrelevant ❑

5. **How would you assess the Zulu handouts in terms of presentation, interest and layout? Please ✓ in the appropriate block.**

Excellent ❑ Good ❑ Average ❑ Below average ❑

6. **How often have you used your medical Zulu in real situations since the beginning of the course? Please ✓ in the appropriate block.**

Frequently ❑ Fairly regularly ❑ A few times ❑ Not at all ❑

7. **What vocabulary, exercises or activities did you find MOST useful and practical? Please explain.**

_____
_____
_____
_____

8. **What vocabulary, exercises or activities did you find LEAST useful or impractical? Please explain.**

_____
_____
_____
_____

9. **Which of the following aspects do you think would result in an improved Medical Zulu course? Please ✓ in the appropriate blocks.**

More oral work ❑ More regular lectures ❑
More revision exercises ❑ Audio tapes with conversations and exercises ❑
Smaller classes / tutorial groups ❑ More material on Zulu culture and traditions ❑
Other. ❑ Please specify

_____
_____
_____
_____

10. **What aspects of the course did you find most enjoyable? Please explain.**

_____
_____
_____
_____

11. **What vocabulary/ expressions do you think SHOULD be included that were NOT part of the course?**

_____
_____
_____
_____

12. **Would you like to continue learning Zulu in a similar way?** YES ❑
NO ❑
Please explain

_____
_____
_____

13. **Is first year the best stage of your studies for a Medical Zulu course?** YES ❑
NO ❑
If your answer is NO, when do you think a medical Zulu course should be implemented? And why?

_____
_____
_____

C. STUDENT'S PERCEIVED NEED FOR A ZULU COURSE

1. **How useful and important do you think an introductory Medical Zulu course is to your degree?**
Highly important ❑ Fairly important ❑ Of average importance ❑ Not important at all ❑

2. **How often do you think you will need to communicate in Zulu in your career once you have graduated?**
All the time ❑ Fairly often ❑ Sometimes ❑ Never ❑

3. **How motivated were you to succeed in your Zulu studies?**
Highly motivated ❑ Fairly motivated ❑ Unmotivated ❑

4. **What would have motivated you to put MORE effort into your Zulu studies? Please explain.**

5. **Would you prefer it if Zulu was an examinable subject?** YES ❑ NO ❑
Please explain

D. MISCELLANEOUS

Do you have any other suggestions or comments regarding the Medical Zulu course which have not been covered in previous questions?

Thank you for participating in this questionnaire. Your co-operation has been greatly appreciated!

Kind regards,

Jacqui Cockerill
Course Co-ordinator & Syllabus Designer for the "Introduction to Medical Zulu" course

COURSE EVALUATION QUESTIONNAIRE FINDINGS

A. LANGUAGE SKILLS ACQUIRED

1 *Home Language:*

	English	Sotho	Venda	Tswana	Pedi	Swahili	TOTAL
No. of students:	32	6	6	2	1	1	49
Percentage %	65.3	12.2	12.2	4.1	2.0	2.0	100.0

2 *How would you rate your Zulu proficiency BEFORE completing the Zulu component of Module 1?*

	Excellent	Good	Adequate	Poor	Unable To	TOTAL
Speak Zulu	2	4	6	19	18	49
%	4.1	8.2	12.2	38.8	36.7	100.0
Read Zulu	2	2	11	13	21	49
%	4.1	4.1	22.4	26.5	42.9	100.0
Write Zulu	2	1	7	16	23	49
%	4.1	2.0	14.3	32.7	46.9	100.0

3 *How would you rate your Zulu proficiency AFTER completing the Zulu component of Module 1?*

	Greatly improved	Significantly improved	Slightly improved	No improvement	TOTAL
Speak Zulu	11	17	19	2	49
%	22.4	34.7	38.8	4.1	100.0
Read Zulu	12	21	14	2	49
%	24.5	42.9	28.6	4.1	100.0
Write Zulu	12	17	18	2	49
%	24.5	34.7	36.7	4.1	100.0
Pronounce Zulu	9	21	16	3	49
%	18.4	42.9	32.7	6.1	100.0

To what do you attribute your improvement:?

	Lecturer's competence	Learner's motivation	Both	Other	TOTAL
No of students	6	3	36	2	47
%	12.2	6.1	73.5	4.1	95.9

To what do you attribute your lack of improvement?

	Lecturer's incompetence	Learner's lack of motivation	Both	Other	TOTAL
No of students	1			1	2
%	2.0			2.0	4.1

B. TEACHING METHODS/ MATERIAL COVERED

1 *How would you evaluate your lecturer's competency and teaching methods?*

	Excellent	Good	Average	Below average	TOTAL
No. of students	28	18	2	1	49
%	57.1	36.7	4.1	2.0	100.0

2 *How often did you make use of the revisions worksheets on WebCT ?*

	All the time	Often	Sometimes	Never	TOTAL
No of students	8	13	20	7	49
%	16.3	26.5	40.8	14.3	100.0

How helpful was WebCT?

	Extremely useful	Fairly useful	Not useful at all	TOTAL
No of students	23	19	0	42
%	54.8	45.2	0.0	85.7

3 *How enjoyable did you find the Zulu lectures?*

	Very enjoyable	Enjoyable	Average	Boring	TOTAL
No of students	13	25	6	5	49
%	26.5	51.0	12.2	10.2	100.0

4 *How relevant to your future career did you find the material covered in the handouts?*

	Very relevant	Mostly relevant	Slightly relevant	Irrelevant	TOTAL
No of students	30	12	7	0	49
%	61.2	24.5	14.3	0.0	100.0

5 *How would you assess the handouts in terms of presentation, interest and layout?*

	Excellent	Good	Average	Below average	TOTAL
No of students	31	15	3	0	49
%	63.3	30.6	6.1	0.0	100.0

6 *How often have you used your medical Zulu in real situations since the beginning of the course?*

	Frequently	Fairly regularly	A few times	Not at all	TOTAL
No of students	7	6	26	10	49
%	14.3	12.2	53.1	20.4	100.0

7 *What did you find most useful and practical about the course?*

	Oral work	History taking	Oral tests	Revision exercise:	Diabetes module	TOTAL
No of students	20	10	3	3	3	49
%	40.8	20.4	6.1	6.1	6.1	100.0

8 *What did you find least useful and practical about the course?*

	Too much grammar	Vocab not related to medicine	TOTAL
No of students	6	1	49
%	12.2	2.0	100.0

9 *What would improve this course?*

	More (>) oral work	> regular lectures	> exercises	Audio tapes	Smaller class	Cultural info	TOTAL
No of students	35	31	21	21	20	12	49
%	71.4	63.3	42.9	42.9	40.8	24.5	100.0

10 *What aspects of the course did you find most enjoyable?*

	Oral work	Oral tests	Student-lecturer interaction	Other	Assignmen	TOTAL
No of students	20	5	5	5	3	49
%	40.8	10.2	10.2	10.2	6.1	100.0

11 *What vocabulary/expressions should be included that were not part of the course?*

	Past tense	Parts of the body	Nutrition vocab	Paediatrics	Idioms/Slang	Physiologic	TOTAL
No of students	3	2	1	1	1	1	49
%	6.1	4.1	2.0	2.0	2.0	2.0	100.0

12 *Do you wish to continue learning Zulu in this way?*

	Yes	No	TOTAL
No of students	37	8	45
%	82.2	17.8	91.8

13 *Is first year the best stage of your studies for a Medical Zulu course?*

	Yes	No	TOTAL
No of students	37	10	47
%	78.7	21.3	95.9

C. STUDENTS PERCEIVED NEED FOR A ZULU COURSE

1 *How useful & important is a medical Zulu course?*

	Highly important	Fairly important	Of average imp.	Not important at all	TOTAL
No of students	37	5	5	0	47
%	78.7	10.6	10.6	0.0	95.9

2 *How often do you think you will need to speak Zulu in your career after graduating?*

	All the time	Fairly often	Sometimes	Never	TOTAL
No of students	17	22	7	1	47
%	36.2	46.8	14.9	2.1	95.9

3 *How motivated were you to succeed in your Zulu studies?*

	Highly motivated	Fairly motivated	Unmotivated	TOTAL
No of students	21	23	2	46
%	45.7	50.0	4.3	93.9

4 *What would have motivated you to put more effort into your Zulu studies?*

	> Practice in hospitals/field trips	> regular lectures	> test/exams	> oral work	Other	TOTAL
No of students	8	7	2	2	6	49
%	16.3	14.3	4.1	4.1	12.2	100.0

5 *Would you prefer Zulu to be an examinable subject?*

	Yes	No	TOTAL
No of students	10	37	47
%	21.3	78.7	95.9

APPENDIX H

HISTORY TAKING PROTOCOL

*** Source: University of Natal Medical School (January 2002)**

THE PHASES OF A CLINICAL EXAMINATION:

A clinical examination has three phases.

	Title	**Purpose**
Phase 1	History-taking	Information gathering
Phase 2	Examination; physical and mental	Objective findings
Phase 3	Explanation	Information giving, decision making

IMPORTANCE OF GOOD INTERVIEW TECHNIQUE

It is the history, which provides the basis for priorities in the clinical examination and subsequent investigation, and management. The style of obtaining a history leads to the therapeutic alliance between doctor and patient which is essential for establishing trust and satisfaction.

Clinicians are judged to be 'good doctors' irrespective of their other attributes if they display the following:

1. Courtesy
2. Patience
3. Interest
4. Encouragement of patients and relatives to ask questions
5. Spend time explaining the situation in a way which is understood

ROLE OF THE STUDENT

If students are asked by a patient to give a medical opinion, they should remind the patient of their status and either suggest that the inquiry is redirected to the doctor or offer to raise that concern with the doctor.

PREPARATION

THE SETTING

Privacy is a key requirement for all clinical examinations.

It is useful to take detailed notes while the patient is being seen. This enables the record to be more complete and accurate.

APPEARANCE AND DEMEANOUR

Patients and relatives appreciate doctors, and other hospital staff, who wear a badge which provides their name and clinical status. Many would like to meet doctors who dress smartly and to be addressed by their title and surname.

HISTORY

INTRODUCTION

Clinicians should introduce themselves by name and explain their position.

If appropriate, the patient's identity should be confirmed along with that of any accompanying person. The patient may wish to be accompanied during the interview. This can help allay anxiety, and may be necessary in some situations, such as memory impairment and language difficulties. At other times it may be counterproductive. The most advantageous time to involve a third party is during the discussion after the clinical examination.

INTERVIEW TECHNIQUE:

WHAT TO ASK ABOUT

History-taking involves inquiries into a series of topics. It is helpful to think in terms of nests or clusters of questions which are multilayered. Hence a negative response to a stem inquiry moves the clinician on to the next topic, whereas a positive response leads to further questioning.

HOW TO ASK

There are two main types of inquiry – open and closed.

1. Open inquiries are generally 'how, 'what', 'why' questions: 'tell me about inquiries. Such questions give patients the opportunity to say what they want to say, and to tell the doctor the history as they perceive it.

2. Closed inquiries are generally 'who, 'when', 'where' questions: 'is it or is it not' inquiries. They are mainly used to expand the patient's story and to clarify specific points.

History-taking normally begins with open questions to establish the nature of the presenting problem or problems. Only then is it appropriate to introduce more closed inquiries as the doctor focuses on the problem to establish facts and details.

ELEMENTS IN A CLINICAL HISTORY

1. Presenting complaint
2. Past medical history
3. Drug history
4. Social history
5. Systemic or general symptom inquiry
6. Further information from a third party

EXAMPLES OF INQUIRY TECHNIQUES

Open inquiry

1. Tell me about your pain
2. What effects has this illness had on your life?
3. What happened next?
4. How did you react to that tragedy?

Closed inquiries

1. When did your headache begin?
2. Have you had chest pain?
3. Has anyone in your family had a similar problem?

4. Do you smoke? If so, how many cigarettes per day?

Remember – phrasing inquiries as open questions extracts more information.

Presenting complaint (PC)

After the initial introduction, many clinicians obtain basic details of the patient's background such as:

1. Age
2. Date of birth
3. Marital status
4. Previous or present occupation
5. Number of dependants

Thereafter it is important to establish the patient's presenting complaint or complaints.

Use the patient's language and not technically correct terms like occipital headache, retrosternal pain and dyspnoea.

Patients should be encouraged to give their history right up to the time of the interview with a minimum of interruption. The clinician's aims at outset are threefold:

1. Keep the history flowing, e.g. 'so what happened then?'
2. Identify those aspects of the history which are incomplete and require further closed questions
3. Observe the patient, picking up clues about the patient's emotional state, intelligence and understanding that may also influence subsequent inquiries, the physical (or mental) examination and the explanation.

PAIN

Pain is the commonest presenting problem, accounting for about half of all consultations.

Associated symptoms

Part of the body's response to pain or stress is autonomic arousal. As a result, the patient may experience symptoms, such as faintness, sweating, nausea, vomiting, diarrhoea and increased frequency of micturition.

The effects of pain on sleep and appetite should be noted. the persistent disturbance of sleep by pain suggests a physical as opposed to a psychological cause.

Effects on lifestyle.

Characteristics of the pain

1. Main site: well localised or more diffuse
2. Radiation
3. Character: sharp/dull, burning/tingling, boring/stabbing, crushing, preferably using the patient's own description rather than offering suggestions.
4. Severity: Difficult to assess as so subjective. Sometimes helpful to compare with other common pains, e.g. toothache.
5. Onset. Speed of onset.
6. Duration:
7. Course: Episodic or continuous. If episodic, duration and frequency of attacks; if continuous any changes in the severity.

8. Pattern: Variation by day or night, during the week or month (e.g. relating to menstrual cycle)
9. Aggravating factors: Circumstances in which pain is provoked or excerbated (e.g. food). Specific activities or postures, and any avoidance measures that have been taken to prevent its onset.
10. Relieving factors: Effects of specific activities or postures. Includes effects of medication.

The social effects of chronic pain

Employment:

Ability to maintain work
If so, any changes to duties
If not, duration of work
Reasons for not working

Relationships:

Effects on key relationships
Changes in physical and emotional aspects of marriage
Changes in role, decision-making, etc. within the family
Changes in contact with family or friends

Leisure:

Effects on social activities, holidays, hobbies and interests
Changes in habits such as smoking and drinking

PAST MEDICAL HISTORY (PMH)

What matters are illnesses that are clinically significant or potentially relevant to the presenting complaint.

DRUG HISTORY (DH)

These include over-the-counter remedies and alternative medicine treatments, particularly:

1. Herbal remedies
2. Laxatives
3. Analgesics
4. Vitamin/mineral supplements

The name of each drug, the dose, dosage regime and duration of treatment should be noted, along with significant side-effects.

COMPLIANCE

About 50% of patients are non-compliant.

Drug allergies/reactions

Family history

SOCIAL HISTORY

HABITS

Because of the extent that smoking cigarettes, drinking alcohol and abusing drugs contribute to disease, inquiries into these habits is necessary. It may be important to seek collateral information from a relative or the general practitioner.

Tobacco

It is important to determine whether the patient is a smoker, and ex-smoker or a lifelong non-smoker. If the patient smokes, the following information is required.

1. Form (cigarettes, cigars or pipe)
2. Quantity (number of cigarettes/cigars or amount of pipe tobacco per day)
3. Duration

Alcohol

It is necessary to ask whether the patient is teetotal or drinks alcohol, with the approximate weekly quantity in units.

This is usually obtained by asking the patient to go through a typical week's drinking day by day and then calculating the total alcohol consumed.

SYSTEMIC INQUIRY

THE GENERAL SYMPTOM INQUIRY: 'CARDINAL' SYMPTOMS

General health

1. General well-being
2. Sleep
3. Appetite
4. Weight change
5. Energy

Cardiovascular system

1. Ankle swelling
2. Palpitations
3. Breathlessness when lying flat (orthopnoea)
4. Attacks of nocturnal breathlessness (paroxysmal nocturnal dyspnoea)
5. Chest pain and exertion
6. Pain in legs on exertion

Respiratory system

1. Shortness of breath: exercise tolerance
2. Wheezing
3. Cough
4. Sputum production (colour, amount)
5. Chest pain related to respiration or coughing
6. Blood in sputum (haemoptysis)

Alimentary

1. Condition of mouth
2. Difficulty with swallowing (dysphagia)
3. Nausea and vomiting
4. Indigestion
5. Heartburn
6. Abdominal pain
7. Weight loss
8. Change in bowel habit
9. Colour of motion (e.g. pale, dark, black, fresh blood)

Urogenital

1. Pain on passing urine (dysuria)
2. Frequency of passing urine by day or night (nocturia)
3. Abnormal colour of urine (e.g. blood)
4. Number of sexual partners

Males

Is appropriate age, prostatic symptoms such as:

1. Difficulty in starting to pass urine
2. Poor stream
3. Terminal dribbling

Females

If premenopausal:

1. Age of onset of periods (menarche)
2. Regularity of periods (e.g. 28-day cycle)
3. Length of period
4. Blood loss (e.g. clots, flooding)
5. Date of last period
6. Contraception if relevant
7. Presence of vaginal discharge

If post-menopausal:

1. Bleeding
2. Stress incontinence

Central nervous system

1. Headaches
2. Fits
3. Faints and blackouts
4. Tingling (paraesthesiae)
5. Numbness
6. Muscle weakness
7. Hearing symptoms (e.g. deafness, tinnitus)
8. Disturbance of vision, including dyplopia

Locomotor

1. Joint pain or stiffness

2. Muscle pain or weakness

Endocrine

1. Heat intolerance
2. Cold intolerance
3. Change in sweating
4. Swelling in neck
5. Excessive thirst

COMPLETING THE HISTORY-TAKING

PATIENTS WHO PRESENT DIFFICULTY IN HISTORY-TAKING

Patient too unwell (sever pain, severe breathlessness).

Principles:

1. Treat the patient
2. Obtain history from third party
3. Review in detail when the patient is fir enough

Mental incapacity (coma, confusion)

Seek history from a third party

Third Party Information

Consultations that involves third person presenl special problems in terms of maintaining patient confidentiality. This is why, whenever possible, the clinician should establish the patient's agreement with this arrangement.

This may prove crucial in arriving at the correct diagnosis, for instance if the patient is withholding information about an alcohol problem.

Sometimes it is not practical for the interview to take place in the patient's presence, but this is generally preferable.

THE PHYSICAL EXAMINATION

The time-honoured sequence of physical examination is:

1. Inspection
2. Palpation
3. Percussion
4. Auscultation

ENVIRONMENT AND EQUIPMENT

The physical examination should be performed in privacy.

It is useful if the couch has an adjustable back-rest.

The part of the body being examined needs to be properly exposed and illuminated. The rest of the patient should be covered with a blanket or sheet.

If a rectal or vaginal examination is to be performed then the presence of a nurse or relative is essential. In fact that should e standard procedure for all aspects of the examination.

The equipment that is required will depend upon the nature of the examination.

THE MENTAL STATE EXAMINATION

The following form part of the general assessment of every patient:

1. Appearance
2. Demeanour
3. Speech
4. Mood

APPEARANCE AND DEMEANOUR

1. Evidence of self-neglect or emaciation
2. Lack of cooperation and difficulty in establishing rapport

ORIENTATION

Orientation is considered in terms of:

1. Time
2. Date
3. Place
4. Person

GENERAL OBSERVATIONS

COMMON ABNORMALITIES

Many conditions can be identified at first glance. Some are very obvious, such as gross obesity.

POSTURE AND GAIT

Useful information can be obtained by observing a normal gait, which ranges from the brisk and erect to the slouched and shuffling.

HAEMOGLOBIN

Pallor may be due to anaemia or to vasoconstriction, which may occur when subjects faint or are frightened.

Examination of the mucous membranes may help to distinguish the pallor of anaemia from that of other causes.

CYANOSIS

JAUNDICE

In jaundice, the sclera, mucous membranes and skin are lemon-yellow in colour. Jaundice that may be obvious in daylight may be undetected in artificial light.

In haemolytic jaundice there is an increase in circulating unconjugated bilirubin, which is not excreted in the urine. The stools are dark and the urine looks normal but contains an excess of urobilinogen.

In hepatocellular and obstructive jaundice, conjugated bilirubin is water soluble and readily passes through the renal glomeruli. The urine is brown like beer and the stools tend to be pale in colour like putty, because of the reduction in the amount of bile in the faeces.

Scratch marks may be prominent in obstructive jaundice.

MEASUREMENT OF HEIGHT, WEIGHT AND TEMPERATURE

In adults, nutritional status is best assessed in terms of body mass index (BMI), which is derived from the formula Wt/Ht^2, measured in kg/m^2.

	BMI
Underweight	<18
Normal	18-25
Overweight	26-29
Obese	30-39
Morbid obesity	$\geq$ 40

1. Determine the weight of outpatients in indoor clothing without shoes, and of inpatients with pyjamas and dressing gown.

2. Determine waist-hip ratio in the erect patient by measuring the girth at the level equidistant between costal margin and iliac crest and at the level of the greater trochanters.

3. Look for any evidence of malnutrition or abnormal fat distribution.

TEMPERATURE

The normal oral temperature is 37^0C. Cardian variations of 0.5^0C occur, the lowest temperature being in the early morning. Rectal temperature is usually about 0.5^0C higher than that in the mouth, which in turn is 0.5^0C higher than in the axilla. Body temperature is best recorded either beneath the tongue, which is convenient, or in the rectum, which is reliable. Digital thermometers are becoming increasingly available.

Take the temperature either by using a digital thermometer inserted into the external auditory meatus, or with a mercury thermometer beneath the tongue or in the rectum. Use a low-reading thermometer if there is a possibility of hypothermia.

STATE OF HYDRATION

Examination sequence

1. Assess the state of hydration by:
   a. Testing skin elasticity
   b. Testing intraocular pressure
   c. Recording the blood pressure and looking for a postural drop in blood pressure.

2. Check for dependent oedema by firm pressure at the ankle behind the medial malleolus and, when present, the medial thigh and in the sacral area.

Clinical manifestations of oedema

When oedema is due to generalised fluid retention, its distribution is determined by gravity. It is usually observed in the legs, back of the thighs and the lumbosacral area in the semirecumbent patient.

The cardinal sign of subcutaneous oedema is the pitting of the skin, made by applying firm pressure with the examiner's finger or thumb for a few seconds. The pitting may persist for several

minutes until it is obliterated by the slow redistribution of the displaced fluid. However, pitting on pressure may not be demonstrated until body weight has increased by as much as 10-15%.

THE HANDS

COMMON ABNORMALITIES

Movements

Tremors are studied with the hands at rest and then outstretched.

Nails

Systemic vasculitis producing splinter haemorrhages may also cause haemorrhages in the skin and retina and, occasionally, tender nodules in the fingertips (Osler's nodes). Although one or two are commonly seen under the nails of manual workers, multiple splincter haemorrhages raise the possibility of infective endocarditis.

In koilonychia the nails become brittle and flat, and ultimately spoon-shaped. It is a sign of iron deficiency.

Whitening of the nails (leuconychia) is a sign of hypoalbuminaemia, as in cirrhosis of the liver.

Clubbing

MOUTH

1. Remove any dentures before examining the mouth
2. Use a pocket torch or other light source with a wooden tongue depressor or similar instrument
3. Note the symmetry, size and shape of the tongue and look for fasciculation
4. Carefully inspect the lips, teeth, gums, cheeks, floor of the mouth; use the spatula to separate the cheeks and tongue from the teeth and gums
5. Inspect the soft palate, tonsils and oropharynx; if a clear view cannot be obtained by asking the patient to say 'Ah', depress the tongue with the spatula

LIPS

Angular stomatitis, consisting of painful inflamed cracks at the corners of the mouth, is often caused by ill-fitting dentures allowing saliva to dribble out the mouth followed by infection with Candida albicans. Angular stomatitis may also be due to deficiency of iron or riboflavine.

THE TEETH

THE GUMS

Gingivitis. At first bleeding is apt to occur, and a narrow line of inflammation can be seen at the free border of the gum, and the interdental papillae are swollen. If the condition progresses, food debris, bacteria and pus tend to accumulate between the teeth and the gum margin (pyorrhoea alveolaris). Halitosis may be apparent and the teeth may become loose.

THE TONGUE

Central cyanosis can best be assessed clinically by inspection of the tongue.

A clean tongue, often red with prominent papillae, can result from antibiotic treatment. Iron or vitamin B_{12} deficiency causes a smooth clean-looking tongue from diffuse atrophy of the papillae.

Ulcers of the tongue may be caused by sharp, damaged teeth, but malignancy should always be considered.

THE PALATE

1. Hard palate
2. Uvula

THE TONSILS

In streptococcal tonsillitis the tonsils are swollon and inflamed, often with pus exuding from the tonsillar crypts.

THE PHARYNX AND BUCCAL MUCOSA

Koplik's spots

The measles small white spots on an erythematous background are distributed over the mucosa of the cheeks opposite the molar teeth and sometimes through-out the mouth. These Koplik's spots are diagnostic value as they appear before the rash.

COMMON DISORDERS OF THE MOUTH

Thrush

Fungal plaques may be seen as individual or coalescent white deposits adhering to the mucous membrane of any part of the mouth. There is very little evidence of inflammation.

SWELLINGS

It is important to ask if any change in size or other characteristics have been noted sine it was first detected and whether there are any associated features such as pain, tenderness or colour changes

EXAMINATION SEQUENCE

1. Inspect any mass carefully, noting change in the colour or texture of the overlying skin
2. Gently palpate to elicit any tenderness or change in skin temperature
3. Without causing undue tenderness (by palpation), define the site and shape of the mass. Measure its size and record the findings diagrammatically
4. Keep the hand on the mass for a few moments to determine if it is pulsatile
5. Assess the consistency, surface texture and margins of the mass
6. Assess skin fixation
7. Determine fixation to deeper structures
8. Look for fluctuation
9. Confirm the presence of fluctuation in two planes
10. Auscultate for vascular bruits and other sounds
11. Elicit transillumination

Consistency

The consistency of a swelling may vary from soft and fluctuant through increasing degrees of firmness until this may merit the term 'stony hard'.

Surface texture

The surface of a swelling may vary from the uniformly smooth to the grossly irregular.

Margin

The edge or margin may be:

1. Well delineated or ill defined
2. Regular or irregular
3. Sharp or rounded

THE LYMPH GLANDS

HISTORY

A patient's attention may be drawn to lymphatic enlargement by the presence of pain.

ANATOMY

In healthy subjects palpable glands can usually be detected, especially in the axilla and the groin. They are seldom greater than 0.5cm in diameter. They are usually described as soft, rubbery or shotty.

EXAMINATION SEQUENCE

General principles

1. Site
2. Size
3. Consistency
4. Tenderness
5. Determine if the gland is fixed to surrounding structures
6. Examine the cervical and axillary glands with the patient sitting
7. Lie the patient down to examine for the abdomen, inguinal and popliteal glands

Cervical glands

1. From behind, examine the submental submandibular, preauricular, tonsillar, supraclavicular and deep cervical glands in the anterior triangle of the neck. Palpate deeply for the scalene nodes

2. From the front of the patient, examine the posterior triangles, up the back of the neck and the posterior auricular and occipital nodes

Axillary glands

Sit in front of the patient, supporting the arm on the side under examination. Palpate the right axilla with the left hand and vice versa. Insert the fingertips into the vault of the axilla and then draw them downwards while palpating the medial, anterior and posterior axillary wall in turn.

Epitrochlear glands

While supporting the patient's right wrist with the left hand, grasp the partially flexed elbow with the right hand and use the thumb to feel for the epitrochlear gland. Examine the left epitrochlear with the left thumb.

Inguinal gland

Palpate in turn over the horizontal chain, which lies just below the inguinal ligament, and then over the vertical chain along the saphenous veins

Popliteal glands

Use both hands to examine the popliteal fossa with the knee flexed to less than 45^0. It is rarely of significance.

HISTORY TAKING IN PAEDIATRIC PRACTICE: SPECIAL QUESTIONING RELATED TO THE SYSTEMS

The question may vary according to the age of the child:

Cardiovascular	Have you noticed a change in colour of baby's hands or feet or tongue? Is baby having difficulty in breathing? Have you noticed any swelling of the face, hands or feet?
Respiratory	Is baby coughing? If baby is coughing is it worse at any time of the day or night? Have you noticed any wheezing or noisy breathing? Is baby breathing faster than usual? Is the sputum yellow? Is there any blood?
Central Nervous System	Has your child complained of headache? (applicable only to older child) Has baby had any fits? How well can baby see? How well can baby hear?
Gastrointestinal System	Is baby growing well? Is baby gaining weight as expected, Is baby growing taller? How well is baby eating? Is baby vomiting? Is baby having loose stools? If so how often, what is the colour, is there blood in the stool? Have you noticed any worms in the stools?
Skin	Has baby any skin problems? If so, do the sores itch? Where are the sores? Is there a nappy rash?
Urinary Tract	Is baby passing urine? Does the urine small normal? Is there pain on passing urine? How often does baby pass urine? Is there any blood in the urine? If a boy, is the stream normal?
Endocrine	Weight + height see earlier How often is baby passing urine and is the amount larger than expected? Does baby drink more water than expected? How often does baby drink?
Musculoskeletal	Is baby's walk normal? Is there any pain on walking? Is there a limp? Have you noticed any swelling of the joints or any lumps near the joints or on the skin?

APPENDIX I: EXTRACT FROM A HISTORY QUESTIONNAIRE SUPPLIED BY THE UNIVERSITY OF NATAL MEDICAL SCHOOL

Gastrointestinal System

1. Do you veel like vomiting?
   Uzwa kuthi hlanza?

2. Retching?
   Kuthi hlanza kungaphumi lutho Uyasonvuluka?

3. Are you vomiting?
   Uyahlanza?

4. Haematomesis?
   Uhlanza igazi?

5. Dysphaga?
   Ugwinya kalile?

6. Does eating cause you any discomfort?
   Uwuphatheki kabi emva kokudla?

7. Do you have heartburn?
   Unesihingulela?

8. Do you have abdominal pain?
   Isisu sibuhlungu?

9. Do you have swelling in your abdomen?
   Isisu siyavuvukala?

10. Do you have yellow eyes?
    Unamehlo aphuzi?

11. Do you have blood in your faeces?
    Amakaka anegazi?

12. Melaena?
    Amakaka amnyama?

13. Diarryhoea?
    Ukhishwa isisu?

14. Are you constipated?
    Uqumbile?

15. Have you had peptic ulcers?
    Unesilonda esiswini ngaphakathi?

16. Have you had any operations on your abdomen?
    Wake wahilzwa umgudu wokudla?

17. Do you drink alcohol?
    Uyaphuza?

Other?

Pulmonary System

18. Dysponoea?
Uzwa uphelelwa umoya?

19. Have you got a cough?
Uyakhwehlela?

20. Do you produce sputum?
Ziyaphuma izikhohlela?

21. Haemoptysis
Ukhwehlela igazi?

22. Do you wheeze? Do you have asthma?
Siyakhala isifuba? Uyacinana esifubeni?

23. Have you had tuberculosis?
Wake waba nesifo sofuba?

24. Are you in contact with anyone who has tuberculosis?
Kukhona onesifo sofuba osondelene naye?

25. Do you smoke cigarettes? If yes, how many per day?
Uyawubhema ugwayi? Uma ubhema, ubhema omungaki ngosuku?

Other?

Cardiovascular System

26. Do you get tired easily?
Ukhuthala kalula?

27. Orthopnoea?
Uphelelwa umoya uma ulele?

28. Paroxymal Nodum?
Uyavuka ebusuku yiphika uze ufune umoya?

29. Do you have chest pain or discomfort?
Uzwa izinhlungu noma ukungaphatheki kahle esifubeni?

30. Palpitation?
Uzwa inhliziyo ishaya ngamandla?

31. Syncope:
Wake waquleka?

32. Have your feet become swollen?
Izinyawo ziyavuvukala?

33. Claudication?
Zibabuhlungu izinyawo mawuhamba?

34. Are you on any drugs for your heart?

Kukhona imithi yesifo senhliziyo oyiphuzayo?

35. Do you have high blood pressure?
Unaso isifo se high-high?

36. Have you had heart disease?
Wake waba naso isifo senhliziyo?

37. Do you have rheumatic fever?
Unaso isifo senhliziyo?

38. Does anyone in your family have heart disease?
Kukhona onesifo senhliziyo ekhaya?

Other?

Genito-urinary System

39. How many times do you pass urine during the day?
Uchama kangaki ngosuku?

40. Do you have urinary urgency?
Kuthi chama ngokushesha?

41. Does it pain when you pass urine?
Kubuhlungu uma uchama?

42. Nocturia?
Uchama kangaki ebusuku?

43. Haematuria?
Umchamo unegazi?

44. Do you have urinary incontinence?
Uvakwazi ukubamba umchamo?

45. Do you have urethral discharge?
Kukhona okuphuma ngaphambili?

46. Do you have any lesions on your genitalia?
Unezilonda ngaphambili?

47. Do you have pain in your testicles?
Amasende buhlungu?

48. Do you have flank pain?
Abuhlungu amacala omzimba?

49. Hemosperma : Do you have blood in your sperms?
Isododa siphuma negazi?

Other?

NO YES

Birth Control

Birth Control

50. Do you use any birth control methods?
Uyahlela?

Female Genitalia

51. Do you have pelvic pain?
Uyaphathwa isinye?

52. Do you have a vaginal discharge?
Kukhona okuphuma ngaphambili?

53. Abnormal vaginal bleeding?

A. At what age did you first have periods?
Wathomba uneminyaka emngaki?

B. At what age did your periods stop?
Wayeka uneminyaka emingaki ukuya esikhathini?

C. How often do you get your periods?
Uya kangaki esikhathini?

D. How many days is your period?
Uya izinsuku czingaki esikhathini?

E. How much is your period?
Singakanani isikhathi sakho?

F. Date of your last menstrual period?
Ugcine nini ukuya esikhathini?

G. Do you bleed after intercourse?
Uyopha emva kokuya ocansini?

H. Have your periods stopped but you are now bleeding?
Sike sanqamuka isikhathi sakho sabuye sabuya?

Other?

Breast

54. Do you have a breast lump?
Unaso isigaxa ebeleni?

55. Do you have pain in the breast?
Abuhlungu amabele?

56. Do you have a discharge from the nipple?
Kukhona okuphuma engonweni yebele?

Other?

Skin

57. Does your skin itch?
Sivaluma isikhumba?

58. Do you have a skin rash?
Uqubukile?

Other?

Neurological System

59. Do you get headaches?
Uphathwa ikhanda?

60. Do you get epileptic seizures?
Uyadlithiza?

61. Do you have weakness in any of your limbs?
Uzwa ungenamandla?

62. Have you had a head injury?
Wake walimala ekhanda?

78. Have you had a stroke?
Wake waba nesifo sohlangothi?

Other?

Hematopoictic System

79. Do you get excessive bleeding/bruising?
Wopha kakhulu?

80. Have you had anemia?
Uphelewa igazi?

Other?

NO YES

Musculoskeletal System

81. Do you have joint stiffness?
Ayaqina amalunga omzimba?

82. Do you have joint pain?
Abuhlungu amalunga omzimba?

83. Are you joints swollen?
Ayavuvukala amalunga omzimba?

84. Are you allergic to any drug?
Ikhona imithi ongezwani nayo?

Hospitalisations and Medications Date Location Reason

85. Hospitalisations/known disease

Wake walasiswa esibhedlela ugula?
Isiphi isifo onaso?

86. Current/past medications?
Unayo imithi obuyidla/oyidalyo?

THE PATIENT PROFILE

87. Are you employed?
Uyasebenza?

88. List your normal daily activities
Imisebenzi oyenza ngosuku.

Morning
Ekuseni

Afternoon
Ntambama

Evening
Ebusuku

89. What are your hobbies/interests?
Iziphi izinto ozithandayo?

90. Summary of Diet:

Breakfast
Ukudla kwasekuseni

Lunch
Ukudla kwasemini

Dinner
Ukudla kwantambama

Snacks
Ukudla okulula

Other
Okunye

91. What is your highest level of education?
Ugcine kweliphi ibanga esikoleni?

92. Do you have any financial difficulties?
Unazo izinkinga zezimali?

APPENDIX J

THE CULTURALLY SENSITIVE MEDICAL CONSULTATION

by Dr Chris Ellis (2001)

(In Press)

There is a concept that is occasionally written about in the medical literature called the cross-cultural or transcultural consultation. It is usually intuitively interpreted by the reader as a consultation between a doctor and a patient who have different nationalities or language groups. The model is used as an example of the difficulties and pitfalls that occur when consultations are conducted at the extremes of communication and interpretation between cultures and when the difficulties are often obvious.

I believe that cross-cultural is a misnomer and that all consultations are cross-cultural in one way or another. We all, both doctors and patients, bring our own unique belief systems to each consultation. The doctor brings his belief in the biomedical model in which he has been encoded and socialised at medical school as well as his own unique interpretations and experiences of the conditions he has seen in the past. These are mixed in with his own personal life views. The patients also bring their health beliefs, which have been learnt mainly from their mothers (in most cultures), other family members and the health beliefs of their immediate community and their wider nation or tribe. (I am talking here about health beliefs and not the health belief model, which is a concept described in a nutshell as an assumption that if you don't believe in the treatment then you are not going to take it). Each consultation is therefore a unique meeting of different cultures and in fact misinterpretations may occur more easily in "same-culture" consultations because of the assumptions that the patient's health beliefs are the same as one's own.

Now I want to introduce you to a whole new world by including just one more question in your consultation (and if you do this routinely I apologise for this inference of ommission). The question is "what do you think has caused your illness?" (ucabanga ukuthi yini imbangela yalokhu?). By doing this you may gain insight into the other agencies from whom the patient has already sought help as well as the personal beliefs of the patient. They may have sought help from other doctors and received medical diagnoses or from alternative or complimentary medicine or from their traditional healers.

Interestingly we are all capable of holding completely contradictory explanatory models of our misfortunes at one and the same time. We often just don't "connect" all the information we are now fed and we also accept naturally and without thinking the diagnoses of those we consult, who have "position" authority, whether medical or otherwise, as the truth. I would call this "health belief by proxy" (i.e it is given to us from an outsider, whether a doctor, traditional healer or newspaper, rather than coming from our own experience and intuition).

Another more specific question in this area could be "have you seen the sangoma about this?". (usuke wasibona isangoma mayelana nalesisifo?"). In this context the Western question might be "have you seen the homeopath\chiropractor\instructor at your health and racquet club about this?". The follow up question is "what did she say about it?" (Wathini mayelana naso?). In Zulu culture the answers may be that their illness has been caused by indiki (spirit possession by chance), ufufuyane (spirit possession by malice and betwitchment), ubuthakhati or ilumbo (bewitchment), or idliso (poison put in food or drink or spread over a path over which the patient steps (imikhondo). In a Western same-cultural consultation the answer may be that my homeopath tells me I have a hormone imbalance, my chiropractor tells me it is stress and my gym instructor tells me that I lack vitamins. And this is a very important point and that is that all cultures have their superstitions and unfounded beliefs and that, in many contexts, none are any better than any other.

The reason for asking these questions is that when you understand the beliefs and previous health seeking experiences of your patient it enables you to run your own beliefs and treatment alongside them. It also allows you to indicate to the patient that you accept their beliefs, at their face value for the time being, but that you may have something to add that will help them. By a process of connection and co-operation rather than confrontation your medical beliefs (which most doctors believe are the ultimate truth) may, overtime, counteract harmful habits and misconceptions and help in compliance.

APPENDIX K

SEVENTEENTH CENTURY MAN IN THE 21ST CENTURY

by Dr Chris Ellis (2001)

SAMJ "From General Practice", Volume 91, No. 7, pp. 568-569, July 2001.

I have a white patient who lives on a farm in the hills above the village of Donnybrook, sheltered in the valleys of the Southern Drakensberg mountians. The hills are, as Alan Paton wrote in Cry, the Beloved Country, "grass covered and rolling and they are lovely beyond any singing of it". He is a farmer and runs a business weaving rugs on the farm. The Zulu weavers live in the valleys around the farm and they arise early, at the time of *Kwampondozankomo,* which means the time when the horns of the cattle are just visible above the early morning mists in the fields (*uphondo* is a horn, *inkomo* is a cow and incidently a polite word for vagina, wherein another story).

The Zulu weavers walk over the hills in an easy rhythm, which is referred to as 'the pace of an ox". It is the pace of their lives and I believe the dimension of time that they live in is called, by the anthropologists, mythic time. In the quietness of the African day they weave the most magical natural patterns, colours and designs in the seclusion of the weaving huts.

When the rugs are ready my patient collects them up and drives the long journey to Johannesburg, where they are displayed at trade fairs and convention centres. They sell out very quickly, especially to buyers from Europe and America. He then returns home 'to the valley of the *umzimkulu*, one of the fairest valleys in Africa".

What is interesting, at this point, is that he does not go near the weaving area for about two days after his arrival back from Johannesburg. He says he is walking too fast, his respirations are too rapid and he is talking too quickly. He has come from another world and his presence would upset the patterns of the weavers. It is better as Ecclesiastes wrote that he approaches them "with an handful of quietness than both hands full of travail and vexation of spirit".

I want you to imagine, if you will, my patient bringing one of his Zulu weavers, who has become sick, down to see me at my busy clinic in the City of Pietermaritzburg. The doors swish open automatically and the fluorescent lights shine from every ceiling. Computers click on the reception counter, telephones ring, eyes look down at appointment lists. Everyone in the building has watches strapped to their wrists and clocks tick on every consulting room wall. Everyone is working against time, not with time. Western chronological time: measured, apportioned, unvalued.

I ask the elderly weaver when his sickness started and he replies that he started to feel ill at *inyanga ukholo*, the moon of the nesting yellow-billed kite (*uKholo* is a yellow-billed kite). It could have been at any other of the thirteen Zulu moons such

as *Umbaso*, when the fires are being lit in the hearths at the beginning of winter or *uZibandhlela*, the paths are lost moon, which is January when the green grass grows over the paths and they are difficult to find.

How, I ask myself, can I negotiate this man from his world of meaning and natural rhythms into this often meaningless world of technology. Into a world of Who Wants to be a Millionaire, of the Hang Seng index and the tunnel of an MRI scanner.

Our weaver from the hills is really a 17th century man entering the 21st century. Michel Foucault, the French intellectual, in his book The Order of Things describes the shifts that took place as man entered the 18th and 19th centuries. The source of knowledge for man was moved away from nature and religion towards a more rational and logical scientific way of knowing and being.

Not only is our patient in a different time dimension he is also in a different space. And it is not a safe space. It is terra incognita or more aptly terror incognita. As he steps into the clinic he is a stranger in a strange land with no map to follow. How can we give this patient a map to guide him along the coloured lines to the X-ray department?

If we could find a map it would have to explain how we are to cross some great canyons that offer widely differing views of the world and culture.

Firstly his world has a wholeness which does not divide his mind from his body. His dreams, his feelings, his telepathy and his visions are part of his tangible body. His cognitive functions blend with his physiological systems. He expresses himself in stories, in metaphors and in symbols which are mostly embodied and expressed in a physical form. He is in constant communion with his family of spirits, who are recently departed (*amadlozi)*. He worries with his heart (*inhliziyo)* and not his head. His explanatory models for his illness may be by pollution *(umnyama)*, spirit possession *(indiki)*, bewitchment *(ubuthakathi)* or callings *(twasa)*. He brings with him many virtues that 21st century man is losing touch with. He has wisdom and gratitude and a knowledge of the laws of the universe that brings with them a sense of proportion. He does not carry the angst of entitlement or the great burdens of self-analysis and guilt.

These differences are, of course, great over-simplifications and one must not over romanticise him like Jean-Jaques Rousseau's Noble Savage. Yet he is in all of us. We all grew up in the 17th century as children and we all return there when we are alone or sick or for that matter on holiday.

As we moved out of the earlier centuries of the last millennium we had to invent a whole new vocabulary to label the aggregations of experiences which the 19th and 20th centuries have created. How does one explain immune system, foreplay, hypertension and anorexia in the Bushman language? You have to have the concept or the collective experience before you can communicate it, discuss it and label it.

To illustrate this another patient of mine is a Zulu who is a senior manager in industry. He has degrees from the Universities of Natal, Oxford and Liverpool. He is a 21st century man. Recently he took a week off work for stress. I asked him if there was a Zulu word for stress. He replied that he did not know of one. In fact, he had just telephoned his parents, who live in Highflats, a rural village also not far from our Umzimkhulu valley. He said that they were uneducated and that he had told them that he was taking some time off for stress (he used the English word stress while speaking in Zulu). They did not really understand what he meant when he explained it. He then used the phrase "pressure at work" which they also did not understand so he settled it by saying he was tired (*ukukhathala)*. Ah, yes, they understood now. A man gets tired after a day in the fields. A man must rest in the shade after physical work well done.

APPENDIX L

SAMPLE HANDOUT 1 FOR PROPOSED ZSP COURSE

Unit 1: Sawubona

1. DIALOGUE: GREETINGS & ASKING AFTER HEALTH

USindi: Sawubona Themba
UThemba: Yebo, sawubona Sindi
USindi: Usaphila na?
UThemba: Yebo ngisaphila. Wena unjani?
USindi: Nami ngisaphila. Uyaphi manje?
UThemba: Ngiya eThusini.
USindi: Ufunda khona?
UThemba: Yebo, ngifunda khona. Ngifunda isiZulu.
USindi: Nami ngifunda khona. Ngifunda isiNgisi.
UThemba: Hamba kahle.
USindi: Yebo, sala kahle.

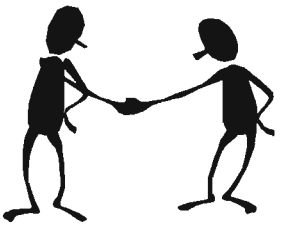
GREETINGS TO ONE OR MORE PEOPLE

Sawubona	Sanibona
Usaphila (na)?	Nisaphila (na)?
(K)Unjani?	Ninjani?
Ngiyaphila	Sisaphila
Ngi(se)khona	Si(se)khona

SUBJECT CONCORDS:

Ngi - I	Si - we
U - you (s)	Ni - you (pl)

2. DIALOGUE: WHAT IS YOUR NAME?



UThandi: Ungubani igama lakho?
UMuzi: Igama lami nguMuzi / NginguMuzi.
Wena ungubani?
UThandi: Igama lami nguThandi / NginguThandi.
UMuzi: Ngiyajabula ukukwazi.
UThandi: Nami ngiyajabula ukukwazi

Ngubani isibongo sakho?
Ungowakwabani?
Isibongo sakho ngubani?

Isibongo sami nguMkhize.

♣ *Oral exercise : Practice the above dialogue in pairs.*

Mother tongue Zulu speakers often use the plural subject concords "ni" and "si" even when the conversation is only between 2 people. For example, Speaker 1 may ask "Ninjani?" (How are you all?) and Speaker 2 may respond "Sikhona" (We are all fine). In Zulu culture it is tradition to ask after the health of the person and his wider family, whether they are present or not.

3. QUESTION WORDS "NI" AND "PHI"

NI - WHAT?

Ubonani? You see what? (What do you see?)
Ngibona udokotela (I see the doctor).

Uthengani? You buy what? (What do you buy?)
Ngithenga iPanado (I buy Panado).

Phendula imibuzo (Answer the questions):

AMAGAMA AMASHA	
Umuthi (medicine)	amaphilisi (pills)
ingubo (dress)	utshwala (beer)
amanzi (water)	unesi (nurse)

1. Ufunani namhlanje?
2. Udingani?
3. Uthengani?
4. Uphuzani?
5. Nifunani?

PHI - WHERE?

UThandi: Uyaphi?
UMuzi: Ngiya esibhedlela eKing Edward ngoba (because) ngiyagula.
UThandi: Hhawu nami ngiyagula. Ngiya kudokotela edolobheni. Hamba kahle.
UMuzi: Kulungile, hamba kahle.

Phendula imibuzo:

AMAGAMA AMASHA	
esibhedlela (hospital)	kudokotela (doctor)
eThusini (UND)	ekhemisi (chemist)
eThekwini (Durban)	eGoli (Jo'burg)
edolobheni (town)	emsebenzini (work)
kwaGame (at Game)	esikoleni (at school)

1. Uyaphi namhlanje?
2. Ufundaphi?
3. Nithengaphi?
4. Usebenzaphi?
5. Nihlalaphi?

Oral Exercise:

1. Practice greetings, asking after health and asking each other's names.
2. Practice asking each other questions using "ni" and "phi".

4. SUMMARY OF NOUN CLASSES & SUBJECT CONCORDS

NOUN CLASS	NOUNS	SC	NOUN PREFIX
PERSONAL PRONOUNS	Mina Wena Thina Nina	ngi u si ni	- - -
1 sing plural	umngane, umuntu, umfowethu abangane, abantu, abafowethu	u- ba-	um / umu- aba-
1a sing plural	ubaba, uRaymond, unesi, uthisha obaba, oRaymond, onesi, othisha	u- ba-	u- o-
2 sing plural	umuthi, umjovo, umphimbo, umkhuhlane imithi, imijovo, imiphimbo, imikhuhlane	u- i-	um / umu- imi-
2a sing plural	ushizi, ugwayi, ubhanana, utmatisi oshizi, ogwayi, obhanana, otamatisi	u- ba-	u- o-
3 sing plural	iphilisi, ikhanda, iqolo, ihlo amaphilisi, amakhanda, amaqolo, amehlo	li- a-	i(li)- ama-
4 sing plural	isiguli, isisu, isifuba, isifo, isinye iziguli, izisu, izifuba, izifo, izinye	si- zi-	isi- izi-
5 sing plural	inyongo, inhliziyo, indlebe, imali izinyongo, izinhliziyo, izindlebe, izimali	i- zi-	in / im- izin / izim-
6 sing plural	ulimi, unyawo, ulwandle, ubisi (no plural) izilimi, izinyawo, izilwandle	lu- zi-	u(lu)- izi / izin / izim-
7 sing	ubuso, ubuhlungu, utshani, utshwala	bu-	u(bu)-
8 sing	ukudla	ku-	uku-

An introduction to subject concords: Fill in the blanks

1. Umfana _____gula kakhulu.
2. Umntwana _____bona umama.
3. Abantu _____thanda udokotela.
4. Abafowethu _____saphila.
5. Unesi _____siza udkotela.
6. Ubaba _____sebenza esibhedlela.
7. Omama _____ya ekliniki.
8. Odokotela _____sebenza kakhulu.

AMAGAMA AMASHA

kakhulu (a lot)	-thanda (like)
-siza (help)	-sebenza (work)
-luma (bite)	-buhlungu (sore)
-phelile(finished)	-dulile (expensive)
-bulala (kill)	-vuvukele (swollen)

9. Umuthi _____dulile.
10. Umphimbo _____buhlungu.
11. Imithi _____phelile.
12. Ikhanda _____buhlungu.
13. Amaphilisi _____phelile.
14. Isiguli _____gula kakhulu.
15. Isisu _____yangiluma.
16. Izifo _____bulala abantu.
17. Inhliziyo _____buhlungu.
18. Imali _____phelile.
19. Izindlebe _____buhlungu.
20. Unyawo _____vuvukele.
21. Izinyawo _____buhlungu.
22. Ubuhlungu _____khulu.
23. Ukudla _____phelile.
24. Ingculazi _____yabulala.
25. Amehlo _____buhlungu.

AMAGAMA AMASHA

-dinga (need)
-khala (cry/complain)
-hlola (examine)
-phuza (drink)
-siza (help)
-jova (inject)
-hlinza (operate),
-khuluma (talk)

5. NOUN CLASS 1A (PEOPLE)

	Sing	Plural
Noun	ubaba	obaba
Noun prefix	u	o
Subject Concord	u	ba

Izibonelo:

1. Unesi usebenza esibhedlela - Onesi basebenza esibhedlela
2. UFred uyadlala (Fred plays) - OFred bayadlala

* NB! The '**ya**' is used in the present tense when nothing follows the verb!

ubaba (father)
umama (mother)
umalume (uncle)
u-anti (aunt)
udadewethu (my sister)

unesi (nurse)
uthisha (teacher)
udokotela (doctor)
ubabamkhulu (grandfather)
udadewenu (your sister)

usibari (brother in law)
umakoti (sister in law)
uThemba
ugogo (granny)
udadewabo (his/her sister)

Fill in the correct subject concords.

1. UTammy _____ dinga umuthi.
2. Omama _____hlala eThekwini.
3. Baba, _____phethwe yini namhlanje?
4. Udadewethu _____ funa ukudla.
5. Wena _____sebenza edolobheni
6. Ubaba _____sebenza.
7. Unesi _____siza isiguli.
8. Ubabamkhulu _____gula.
9. Mina _____funda isiZulu.
10. Odokotela _____sebenza.

Change the following into the plural:

1. Unesi uyangisiza.
2. Udokotela uhlola isiguli.
3. Mina ngithanda ukubhema.
4. Ubabamkhulu ubhema ugwayi.
5. UThandi uyagula impela.

Create 5 of your own sentences using nouns from class 1a:

1. _____
2. _____
3. _____
4. _____
5. _____

HOMEWORK ASSIGNMENT 1

Umsebenzi 1: Fill in the correct subject concords:

1. Mina _____ya eThusini.
2. UVusi _____funa iPanado.
3. Ogogo _____xoxa.
4. Abafundi _____hlala epulazini.
5. Wena _____thanda ukuphuza utshwala.
6. Thina _____khuluma nodokotela.
7. Umama _____khuluma isiZulu.
8. Nina _____hamba ngezinyawo.
9. OThemba _____gula.
10. Udadewethu _____dinga usizo.

Umsebenzi 2: Phendula imibuzo

1. (U)Ngubani igama lakho?
2. (U)Ngubani isibongo sakho?
3. Wena uhlalaphi?
4. Ufundaphi?
5. Ufundani?
6. Umama udingani?
7. Odokotela basebenzaphi?

8. Wena unjani namhlanje?
9. Abantwana baphuzani?
10. Ubaba usebenzaphi?

♣ *Umsebenzi 3: Practice asking & answering questions using "ni" and "phi" with fellow students*

==========

Zulu speakers often address others with familial terminology even when the person they are addressing is not a family member. For example, a doctor greeting an elderly male patient may say, "Sawubona, baba" (Hello, father). It is both acceptable and appropriate for you to address your patients using this kind of familial terminology even if you are not a black mother tongue Zulu speaker as it is a sign of respect and helps to put the patient at ease!

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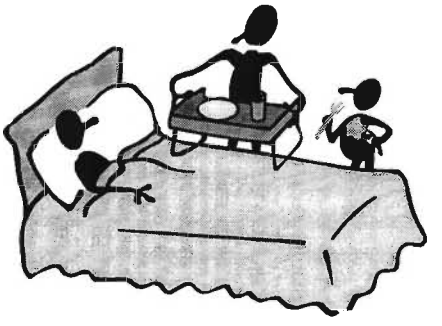
6. DIALOGUE: ASKING AFTER HEALTH

UMaNene:	Sawubona, MaKhumalo. Ninjani namhlanje?
UMaKhumalo:	Yebo, sawubona, MaNene. Sisaphila. Ninjani nina?
UMaNene:	Hawu, umntwana wami uSipho uyagula.
UMaKhumalo:	Uphethwe yini?
UMaNene:	Uphethwe yikholera.
UMaKhumalo:	Hawu kubi lo.
	Uphi umntwana wakho manje?
UMaNene:	Usesibhedlela eKing Edward nogogo.
UMaKhumalo:	Sengathi angaba ngcono.
UMaNene:	Ngiyabonga. Hamba kahle, MaKhumalo.
UMaKhumalo:	Yebo sala kahle.



Note on the Possessive:

-mi (my)	umntwana wami
-kho (your sing.)	umntwana wakho
-khe (his/her)	umntwana wakhe

Appropriate responses to wellness/ illness:

Kuhle - That's good
Ngiyajabula ukuzwa lokho - I'm happy to hear that
Kubi - That's terrible
Ngiyakuzwela - I sympathise with you
Sengathi angaba ngcono - I hope s/he recovers

7. DIALOGUE: EXPRESSING SYMPATHY

UMbali: Sawubona, gogo. Usaphila na?
Ugogo: Cha, ngiyagula, Mbali.
UMbali: Hhawu, Gogo. Kwakubi lokho / Kubi impela / Ngiyakuzwela.
Ngithemba ukuthi uzosinda ngokushesha.
Ngithemba ukuthi uzoba ngcono.

Revision of Class 1a: Fill in the correct subject concords & translate into English:

1. UBryan _____phuza umuthi.
2. Udokotela _____hlola isiguli.
3. Odadewethu _____dinga umuthi.
4. Unesi _____siza udokotela.
5. Thina _____thanda ukufunda isiZulu.

8. NOUN CLASS 1 (PEOPLE)

	Sing	Plural
Noun	umntwana	abantwana
Noun prefix	um / umu	aba
Subject Concord	u	ba

1. Umfundi ufunda eThusini (The student studies at UND)
   Abafundi bafunda eThusini (The students study at UND)

2. Umntwana uyakhala (The child is crying)
   Abantwana bayakhala (The children are crying)

umfundi (student) umuntu (person) umlimi (farmer)
umzali (parent) umzala (cousin) umngane (friend)
umfowethu (my brother) umfowenu (your brother) umfowabo (his/her brother)
umfundisi (teacher) umthakathi (witch) umlungu (white man) *abelungu

Fill in the correct subject concords:

1. Umfundi _____ thenga amabhuku.
2. Abazali _____hlala eThekwini.
3. Umuntu _____ dinga umuthi.
4. Umntwana _____khwehlela.
5. Abafundi _____funda isiZulu.
6. Umlimi _____ hlala epulazini.
7. Abantu _____ funa imali.
8. Umfowethu _____ khala.
9. Wena _____gwinya amaphilisi.
10. Mina _____dinga iPanado.

AMAGAMA AMASHA

-gwinya (swallow) -geza izandla (wash hands)
-dinga (need) -phefemula (breathe)
-khwehlela (cough) -khamisa (open mouth)
umjovo (injection) -jova (inject)

Change the following sentences into the plural

1. Unesi usiza isiguli.
2. Udokotela ugeza izandla.
3. Umuntu uyakhwehlela.
4. Wena uyagula.
5. Umuthi uphelile.
6. Iphilisi liphelile.
7. Umfowethu uthanda ukudlala.
8. Ubabamkhulu uphethwe yiqolo.
9. Udokotela ujova isiguli.
10. Indlebe ibuhlungu.
11. Ubaba usebenza edolobheni.
12. Mina ngifuna umjovo.
13. Unyawo lubuhlungu.
14. Umfundi ufunda isiZulu.
15. Isiguli siya esibhedlela.

Ubabamkhulu uphethwe yiqolo!
Grandfather's back is hurting

9. "NA" - TO HAVE

Vowel joining rules:

- na + i = ne — eg) Ngi + na + izingane = Nginezingane (I have children)
- na + u = no — eg) Ngi + na + umuthi = Nginomuthi (I have medicine)
- na + o = no — eg) Ngi + na + obhanana = Nginobhanana (I have bananas)
- na + a = na — eg) Ngi + na + amaphilisi = Nginamaphilisi (I have pills)

Umsebenzi 1: Complete the following sentences using the "na" construction

Isibonelo: ***uFred u + na + umkhuhlane*** ***uFred unomkhuhlane***

1. Ngina(ikholera)
2. Sina(amaphilisi)
3. Wena una(inja)
4. Umama una(izingane ezimbili)
5. Obaba bana(umsebenzi)
6. Umlimi una(amahhashi)
7. Unesi una(umjovo)
8. OMary bana(izinkomo)
9. Ngina(isifo sohudo)
10. Abantwana bana(umkhuhlane)

Umsebenzi 2: Answer the questions as in the example

Isibonelo: **Unani uThemba? (ikhanda)** **UThemba unekhanda.**

1. Unani umama? (umkhuhlane)
2. Banani obaba? (isifo sikashukela)
3. Inani ingane? (ikholera)
4. Sinani isiguli? (umuthi)
5. Banani othisha? (amaphilisi)
6. Wena unani? (isifuba)
7. Zinani izingane? (i-AIDS)
8. Unani udadewethu? (abantwana abathathu)
9. Wena unani? (umkhuhlane)
10. Ninani? (i-TB)

Umsebenzi 3: Write 5 sentences naming 5 different people who you talk to. Use the expression "khuluma na..." as in the example below.

Isibonelo: **Ngikhuluma na + umama - Ngikhuluma nomama.**

_____

_____

_____

_____

_____

Umsebenzi 4: Write 5 sentences naming 5 diseases / pains that you have. You could use: isisu, ikhanda, umkhuhlane, ikholera, isifo sikashukela, ingculazi, izikelemu etc...

Isibonelo: **Nginekhanda (I have a headache).**

_____

_____

_____

_____

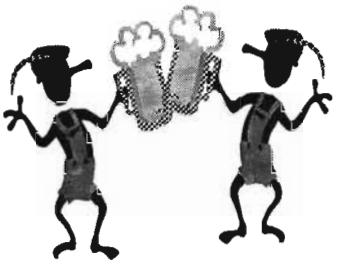
_____

Umsebenzi 5: Humusha ngesiZulu (Translate into Zulu)

1. The child has a cold.
2. You have diabetes.
3. Lindiwe has cholera.
4. Father, do you have pills?
5. Mother, do you have children?

10. STATIVES

dulile (expensive)	shibile (cheap)	khuluphele (fat)
khathele (tired)	valiwe (closed)	vuliwe (open)
omile (thirsty)	lambile (hungry)	limele (hurt)
thukhuthele (angry)	phelile (finished)	lele (sleeping)
esuthi (full) - person	gcwele (full) - thing	dakiwe (drunk)



Izibonelo:

1. Obaba ba*dakiwe* (Father & others are drunk)
2. Ngi*kathele* ngaso sonke isikhathi (I am tired all the time).
3. Mina ngi + omile = ng*omile* kakhulu (I am very thirsty).

Humusha ngesiZulu

1. My leg (umlenze) is hurt.
2. Are you thirsty often?
3. Granny is tired all the time.
4. The pills are finished.
5. The child is thirsty.
6. I am thirsty all the time.
7. The medicine is expensive.
8. The pills are expensive.
9. The child is hungry.
10. You are very overweight.

Statives do not get "ya" even when there is nothing following the stative.

Verb:	ugogo u**ya**pheka
Stative:	ugogo ulele.

11. POWER TEXTS 1: *"SURVIVAL PHRASES"*

- Ngisafunda isiZulu. *(I am still learning Zulu.)*
- Angizwa kahle. Ngicela uphinde. *(I don't understand properly. Please say it again.)*
- Awuphinde kancane kancane. *(Please repeat slowly.)*
- Awuphinde ngesNgisi. *(Please repeat in English.)*
- Ngicela uhumushe ngesiNgisi. *(Please translate into English.)*
- Ungakhulumi ngokushesha! *(Please don't speak quickly!)*

HOMEWORK ASSIGNMENT 2

Umsebenzi 1: Fill in the missing spaces

1. Mina _____ya eThusini.
2. Ubaba _____sebenza edolobheni.
3. Wena _____thanda ukuphuza utshwala .
4. Umntwana _____khwehlela.
5. Indlebe _____buhlungu
6. Udokotela _____hlola isiguli.
7. Wena _____phethwe yisifo sohudo.
8. Isifo sikashukela _____yahlupha.
9. Thina _____khuluma nodokotela.
10. Umama _____khuluma isiZulu.
11. Ubisi _____phelile.
12. Umkhuhlane _____hlupha.
13. Amehlo _____baba.
14. Iziguli _____ya esibhedlela.
15. Abafana _____thanda iCoke.
16. Nina _____phuza itiye.
17. Izindlebe _____yangihlupha.
18. Iqolo _____buhlungu.
19. Utshwala _____dulile.
20. Mina _____phethwe yidolo.

Umsebenzi 2: Give an appropriate response:

1. Wena unjani namhlanje?
2. Basaphila abazali bakho?
3. Basaphila abantwana bakho?
4. Uhlalaphi wena?
5. Hamba kahle.
6. Uthengaphi amaphilisi?
7. Umama uyaphi?
8. Ngubani igama lakho?
9. Ngubani isibongo sakho?
10. Mina ngigula kakhulu.

AMAGAMA AMASHA

-phuza (drink)
-khuluma (talk)
-hlupha (be troublesome)
-baba (be irritating)
-phethwe (suffer from)

Umsebenzi 3: Humusha ngesiNgisi

uThandi: Sawubona, gogo. Unjani namhlanje?
uGogo: Ngiyagula, Thandi. Ngiyagula impela.
uThandi: Hawu, gogo. Kubi. Ngiyakuzwela. Uyaphi manje?
uGogo : Ngiya esibhedlela. Ngidinga umuthi.
uThandi: Masihambisane gogo.
uGogo : Kulungile Thandi.

SUMMARY OF WORK COVERED IN UNIT 1:

Language functions:

- To greet
- To ask after health and answer appropriately
- To express sympathy
- To offer encouragement
- To ask and give names/surnames
- To ask where someone is going and respond appropriately
- To say goodbye

Vocabulary:

- "Medical" verbs (e.g. verbs expressing pain or discomfort or verbs explaining medical procedure etc.)
- Locatives (place names) relevant to the medical field
- Nouns covered in introduction to noun class system (e.g. people, body parts, diseases etc).

Grammar:

- Noun class system
- Subject concords and some absolute pronouns (personal pronouns)
- Question words: *-ni?* and *-phi?*
- *-Na-* (to have)
- Statives

Culture:

- The use of plural subject concords *ni-* and *si-* even when addressing one person
- The use of familial forms of address for non-family members

APPENDIX M

EXTRACT FROM SAMPLE HANDOUT 2 FOR PROPOSED ZSP COURSE

Unit 2: Uphethwe yini?

1. ♣ ORAL REVISION:

Pair up with another student.
You are waiting for your transport to arrive and begin to chat. One student is A and the other is B.

A	B
Greet B	-
-	Greet A
Respond saying you are well. Ask after B's health.	-
-	Respond, saying you are sick.
Respons sympathetically.	-
-	Ask for A's name.
Respond and ask for B's name.	-
-	Respond and ask where A is going.
Respond and ask where B is going.	-
-	Respond. *Nali ibhasi lami.* (Here is my bus)
Kuhle / Kulungile. (Good / OK) Say you hope B gets better soon.	-
-	Thank A and say goodbye.
Say goodbye.	-

2. IDENTIFICATION: *YINI LE? YIZINI LEZI?*

Identificative prefixes: "Ng" for nouns beginning with u,a or o
"Y" for nouns beginning with i

Izibonelo:	1)	Yini le? (ithemometha)	Yithemometha
	2)	Yizini le? (amaphilisi)	Ngamaphilisi

Phendula imibuzo

1. Yini le? (umuthi womkhuhlane)
2. Yini le? (iqolo)
3. Yizini lezi? (izinyoka)
4. Yini le? (incwadi)
5. Yizini lezi? (obhanana)
6. Yini le? (umuzi)
7. Yini le? (isihlalo)
8. Yini le? (amasi)
9. Yizini lezi? (amahhashi)
10. Yizini lezi? (amaSmarties)

3. UPHETHWE YINI? UHLUSHWA YINI?

Izibonelo:
1) Uphethwe yini? (ikhanda) Ngiphethwe yikhanda.
2) Uhlushwa yini? (amehlo) Ngihlushwa ngamehlo.

Phendula imibuzo

11. Wena uphethwe yini? (umlenze)
12. Wena uhlushwa yini? (amadolo)
13. Abafana baphethwe yini? (isisu)
14. Umama uphethwe yini? (amehlo)
15. Umntwana uhlushwa yini? (amazinyo)
16. Isalukazi siphethwe yini? (iqolo)
17. Nina niphethwe yini? (isifo sikashukela)
18. Ihhashi liphethwe yini? (imilenze)
19. Uthisha uhlushwa yini? (ikhanda)
20. Iziguli ziphethwe yini? (ikholera)

AMAGAMA AMASHA

Uphethwe yini? (What are you suffering from?) / Uhlushwa yini? (What are you bothered by?)

Ngiphethwe... (I am suffering from)

...ngumlenze (sore leg)
...ngunyawo (sore foot)
...ngamehlo (sore eyes)
...yizinyo (toothache)
...yisisu (stomach ache)
...yikhanda (headache)
...yinhliziyo (heart trouble)
...yisifo sikashukela (from diabetes)
...yiT.B. (from TB)
...yikholera (from cholera)

4. *ANGIKWAZI UKU...* (I CANNOT...)

Umsebenzi 1: Answer in the negative as in the example below
Isibonelo: Uyakwazi ukumsiza? (- Cha, angikwazi ukumsiza.

1. Wena uyakwazi ukudla? Cha...
2. Wena uyakwazi ukulala ebusuku (sleep at night)? Cha...
3. Niyakwazi ukugwinya? Cha...
4. Uyakwazi ukuya eThekwini namuhla?
5. Wena uyakwazi ukudla amazambane? Cha...
6. Uyakwazi ukulula (stretch) umlenze? Cha...
7. Uyakwazi ukuhamba (walk)? Cha...
8. Niyakwazi ukuya esikoleni? Cha...
9. Wena uyakwazi ukuzwa (feel) lokhu (this)? Cha...
10. Niyakwazi ukugwinya amaphilisi? Cha...

-Zwa (verb)

Hear, listen, feel, taste, smell, sense

Umsebenzi 6: Answer appropriately

1. Wena uyakwazi ukudla? Cha...
2. Wena uyakwazi ukulala ebusuku? Cha...
3. Niyakwazi ukugwinya? Cha...
4. Niyakwazi ukugwinya amaphilisi? Cha...
5. Wena uyakwazi ukuzwa lokhu? Cha...

APPENDIX N

EXTRACT FROM SAMPLE HANDOUT 3 FOR PROPOSED ZSP COURSE

Unit 3: Ngicela ukukuhlola

1. READING:

USibongile uyisiguli. Uya esibhedlela. Udokotela uhlola uSibongile. Udokotela welapha uSibongile.
Udokotela uthi, *"Khamisa, Sibongile!"*
USibongile uthi, *"AAAH."*
Udokotela uthi, *"Khipha ulimi Sibongile!"*
USibongile ukhipha ulimi.
Udokotela uthi, *"Donsa umoya. Khipha umoya."*
Udokotela ulalela inhliziyo kaSibongile.
Udokotela uthi, *"Lala embedeni, Sibongile. Ngifuna ukukuhlola."*
USibongile ulala embedeni kodwa wesaba udokotela. Uyaqhaqhazela.
Udokotela uthi, *"Musa ukukhathazeka. Ngeke ngikulimaze."*
USibongile uthi, *"Ngesaba ukujova!"*
Udokotela uthi, *"Kulungile, Sibongile. Ngizokuhlola nje. Kubuhlungu kuphi."*
Usibongile uthi, *"Isisu sami sibuhlungu."*

AMAGAMA AMASHA

- Phefumula - breathe in & out
- Donsa umoya - breathe in
- Khipha umoya - breathe out
- Khipha ulimi - Stick out tongue
- Lalela - listen
- Qhaqhazela - tremble
- Khathazeka - worry
- Limaza – hurt/cause injury to

APPENDIX 0

EXTRACT FROM SAMPLE HANDOUT 6 FOR PROPOSED ZSP COURSE

Unit 6: Isifo sikashukela

1. DIALOGUE

Udokotela:	Sawubona, baba. Unjani namhlanje?
Isiguli:	Sawubona dokotela. Angiphilile neze namhlanje.
Udokotela:	Uphethwe yini, baba?
Isiguli:	Ngikhathele njalo.
Udokotela:	Uyakwazi ukwenza umsebenzi wakho?
Isiguli:	Cha, dokotela. Angikwazi ukusebenza. Ngiphelelwa ngamandla.
Udokotela:	Usebenzaphi baba?
Isiguli:	Ngisebenza eGoli. Ngingumakhi.
Udokotela:	Kuqale nini ukudinwa, baba?
Isiguli:	Kuqale ngesonto eledlule, dokotela.
Udokotela:	Uyayiphuza imithi na?
Isiguli:	Angiwuphuzi umuthi dokotela. Angithathi lutho. Kodwa ngomile kakhulu.
Udokotela:	Uyawaphuza amanzi amaningi?
Isiguli:	Yebo, dokotela Ngiphuza amanzi amaningi.
Udokotela:	Futhi uya endlini encane njalo na?
Isiguli:	Yebo dokotela. Ngiyachama njalo.
Udokotela:	Baba, unaso isifo sikshukela na?
Isiguli:	Angazi dokotela.
Udokotela:	Kukhona onesifo sikashukela ekhaya?
Isiguli:	Yebo, umama wami unesifo sikashukela.
Udokotela:	Kulungile, baba. Ngicabanga ukuthi wena unesifo sikashukela.

AMAGAMA AMASHA:

- Phelelwa ngamandla - feel weak
- Kuqale nini? - When did it start?
- Ukudinwa - fatigue/tiredness
- Ngesonto eledlule - Last week
- Uyayiphuza imithi na? Are you on any medication?
- - Ningi - a lot
- Endlini encane - toilet
- Chama - urinate

1. PRESENT SUBJUNCTIVE & POLITE COMMANDS OR SUGGESTIONS

We have learnt how to give commands and instructions but sometimes it is necessary to employ a more polite form of command. In order to do this we need to use a tense called the Subjunctive.

Izibonelo:

1. Ngena (Enter) - Mawungene (please come in)
2. Hlalani phansi (Sit down) - Manihlale phansi (Please have a seat)
2. Siyafunda (We are studying) - Asifunde (Let us study)

Umsebenzi 1: Change the following into polite commands using "Mawu" or "Mani"

1. Funda ibhuku lakho!
2. Buya kusasa!
3. Phuza umuthi kabili ngelanga!
4. Phuzani umuthi!
5. Sebenzisa ikondom!
6. Thenga umuthi
7. Khumula izingubo! (Take off clothes)
8. Lala ngomhlane! (Lie on your back).
9. Ngenani bantwana!
10. Lala ngesisu! (Lie on your stomach)

We also use the subjunctive after certain constructions like "Ngicela ukuba..." (I request that...) and "Kufanele ukuba..." (It is necessary that...)

Izibonelo:

1. Phinda - Ngicela (ukuba) uphinde (I request that you repeat)
2. Khumula izingubo zakho - Ngicela ukhumule izingubo zakho (Please take off your clothes)
3. Phuza umuthi kathathu ngelanga - Kufanele ukuba uphuze umuthi kathathu ngelanga (It is necessary that/ You must drink the medicine 3 times a day).

Umsebenzi 2: Humusha ngesiZulu (using "Ngicela ukuba" and "Kufanele ukuba")

1. Please lie on your back
2. Students, please go to the hospital
3. Please drink the medicine twice a day
4. You must eat vegetables
5. You must drink water
6. Please buy bananas
7. You must use a condom
8. You must lose weight (ncipha)
9. Mother and others, please bake a cake
10. Please come back (buya) tomorrow

To change Polite Commands into the Negative we use "nga" and change the final letter of the verb to an "i"

Izibonelo:

1. Mawungene - Mawungangeni (Please do not enter)
2. Manipheke - Maningapheki (Please do not cook)
3. Ngicela ukuba ubheme - Ngicela ukuba ungabhemi (Please do not study)
4. Kufanele ukuba usebenze - Kufanele ukuba ungasebenzi (You must not work)

Umsebenzi 3: Change the following into the Negative

1. Mawufunde
2. Maniphuze utshwala
3. Mawubheme ugwayi
4. Masifunde
5. Masihambisane
6. Mawudle ikhekhe
7. Mawuphuze umuthi
8. Manibange umsindo
9. Mawubuye kusasa
10. Mawukhathazeke

Umsebenzi 4: Humusha ngesiZulu

1. You must return on Monday
2. Please will you undress
3. Please don't smoke
4. Let's go together
5. Lets not eat vegetables
6. Please don't drink beer
7. You must not eat salt (usawoti)
8. Please go to the hospital
9. Please help
10. Please don't cry

APPENDIX P

EXTRACT FROM SAMPLE HANDOUT 8 FOR PROPOSED ZSP COURSE

Unit 8: Ukukhulelwa

1. UKHULELWE?

Udokotela: Ukhulelewe?
Umama: Yebo, dokotela.
Udokotela: Izinyawo ziyavuvukela uma ukhulelwe?
Umama: Cha, azivuvukele.
Udokotela: Amabele abuhlungu?
Umama: Cha.
Udokotela : Amabele ayavuza?
Umama: Cha.
Udokotela: Unabantwana abangaki ekhaya?
Umama: Nginabantwana ababili.
Udokotela: Wabeleta ekhaya noma esibhedlela?
Umama: Esibhedlela. Kulesi sibhedlela.
Udokotela: Uyabanika abantwana ibele?
Umama: Yebo, dokotela.
Udokotela: Kuhle, mama. Kungcono ukuncelisa izinyanga eziyisithupha. Kulungile, ma. Ngifuna ukukuhlola manje. Khumula izingubo ulale embhedeni.
Umama: *(Uyakhumula. Ulala embhedeni.)*
Udokotela: Ngitshele uma uzwa ubuhlungu... Isisu sibuhlungu? Lokhu kubuhlungu?
Umama: Cha, dokotela. Angizwa ubuhlungu.
Udokotela: Vula imilenze, uphefumule kahle. Ngizofaka iminwe ngaphambili. Kubuhlungu lokhu?
Umama: Kubuhlungu kancane.
Udokotela: Manje ngizofaka le nsimbana ngaphambili. Ungakhathazeki, mama. Ngeke ngikulimaze... Sekuyaphela. Kulungile, sekuphelile. Gqoka manje.

AMAGAMA AMASHA

- Khulelwe - pregnant
- Vuvukele - swollen
- Buhlungu - sore
- Vuza - ooze
- Unabantwana abangaki? How many children do you have?
- Nibangaki ekhaya? You are how many in your home?
- Nginomntwana oyedwa (only 1 child) Nginabantwana ababili (2), abathathu (3), abane (4), abahlanu (5)
- Beleta - give birth
- phansi kweshidi -under the sheet.
- Zwa - feel
- Faka - put
- Gqoka - Get dressed
- Iminwe - fingers
- Insimbana - small instrument
- Ngaphambili - vagina /down below (lit)
- Kathazeka - worry
- Sekuyaphela - it will soon be over

2. UKUBELETHA

Khanula manje.	*Bear down now.*
Take a deep breath.	*Donsa umoya omningi.*
Yeka ukukhanula.	*Stop pushing.*
Halala! Umfana/ Intombi!	*Well done, it's a boy/girl!*
Amawele!	*Twins!*
Amawele amathathu!	*Triplets!*
Sizophelisa ubuhlungu ngomjovo.	*We will stop the pain with an injection.*

APPENDIX Q

EXTRACT FROM SAMPLE HANDOUT 9 FOR PROPOSED ZSP COURSE

Unit 9: Izifo zocansi

1. READ THE POSTER ON AIDS

i-AIDS/Ingculazi:

Zivikile wena nabanye engculazini:

- Yithi cha ngokuya ocansini
- Yethembeka
- Sebenzisa ikhondomu

Xhasa umkhankaso wokulwa neNgculazi:

- Yelekelela ekufundiseni ngengculazi
- Ungacwasi abanengculazi
- Shesha welashelwe ezinye izifo zocansi
- Xwaya izidakamizwa
- Xhasa izinhlelo zentuthuko emphakathini

Khumbula ukuba nengculazi akulona ihlazo,
ingculazi iyisifo njengezinye izifo
(Remember AIDS is not a disgrace, it's a disease like any other.)