LANGUAGE BARRIER AND ACCESS TO HEALTHCARE SERVICES: THE CASE OF AFAAN OROMO SPEAKING PATIENTS IN DIRE DAWA ADMINISTRATION HEALTHCARE SETTING: THE CASE STUDY OF DIL CHORA HOSPITAL

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Dedication

To my Sister Kunuza Aliyi (blessed memory).

You were everything for me. A mother, sister, friend and model in supporting other peoples!

Plagiarism Declarations

I, Ararsa Aliyi Ahmed, declare that this thesis is my original work and has not been presented for a degree in any other University, and that all sources of material used for this thesis have been duly acknowledged. I assume personal responsibility to the correctness of facts contained herein and to the presentation thereof.

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Approval Page

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The thesis entitled "Language Barrier and Access to Healthcare Services: The Case of Afaan Oromo Speaking Patients in Dire Dawa Administration Healthcare Setting by Student Ararsa Aliyi is approved for the Degree of Master of Laws in Human Right Law

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This work would not have been possible had you not kept me secure. Thanks God!

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Abbreviations and Acronyms

ACHPR-African Charter on Human and Peoples' Rights

AOSPs-Afaan Oromo Speaking Patients

ART-Antiretroviral Therapy

Art –Article

CEDAW-Convention on the Elimination of All Forms of Discrimination against Women

CERD-Convention on the Elimination of All Form Racial Discrimination

CHF-Congestive Heart Failure

Committee on ESCRs- Committee on Economic, Social and Cultural Rights

CRC-Convention on the Rights of the Child

CRMW-Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

CRPWD-Convention on the Rights of Persons with Disabilities

CSA-Central Statistical Agency

DCH-Dil Chora Hospital

DDA-Dire Dawa Administration

DDHB- Dire Dawa Health Bureau

FDRE - Federal Democratic Republic of Ethiopia

GTP I-Growth and Transformation Plan I

GTP II-Growth and Transformation Plan II

HEP-Health extension programme

HSDP-Health Sector Development Program

HSTP-Health Sector Transformation Plan

ICESCR-International Covenant on Economic, Social and Cultural Rights

IOM-Institute of Medicine

LAS-Language Assistance Service

LLPPs-limited language proficiency patients

MDGs-Millennium Development Goals

MoH-Minister of health

NASNs-Non-Arabic Speaking Nurses

NHCQS-National Health Care Quality Strategy

NHPTGE- National Health Policy of the Transitional Government of Ethiopia

NHRAP-National Human Rights Action Plan

OPD- Outpatient Department

RSMI- Remote simultaneous medical interpretation

TI- Telephone interpreting

TISPA-Translating and Interpreting Service Provider Agency

UDHR-Universal Declaration of Human Rights

VDPA-Vienna Declaration and Programm of Action

VMI- Video Medical Interpretation

WHO- world health organization

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Chapter One: Introduction

Communication with everything in life is paramount, especially in medicine. It's the most important tool that one has. When there is a language barrier, I feel handcuffed. I don't feel as though I can get all the information that I really need to have in order to provide the best patient care.[1]

1.1.Background

Language barrier affects quality of care in the healthcare system around the world significantly,[2] and has adverse effects on accessing the proper service, patient satisfaction, patient health outcomes[3]and healthcare provider satisfaction.[4]Since collections of accurate and comprehensive patient-specific data are the basis for proper diagnosis and prognosis, it requires effective communication between the healthcare services providers and the patients.[5] When there is the language barrier between the providers and the patients, for the patients, explaining a medical problem becomes an impossible task, because of the challenge of communicating effectively with the providers.[6] The absence of effective communication cause the provision of healthcare ends or proceeds only with errors, poor quality, and risks to patient safety.[7]

[1]B Lopez, Eight Critical Reasons to Address the Language Barrier in Healthcare, Canopy Innovation (2017), p.2

[2] R.Schwei et al. "Changes in Research on Language Barriers in Health Care Since 2003: Across-Sectional Review Study" Int J Nurs Stud,(2016),p.3; N Ponce et al. "Linguistic disparities in health care access and health status among older adults." J Gen Intern Med, Vol.21 No.7(2006), p.787;L Murray et al. "The experiences of African women giving birth in Brisbane, Australia."Health Care for Women International, Vol. 31 No.5 (2010), p.4; Fassaert T et al. "Ethnic differences and similarities in outpatients' treatment for depression in the Netherlands. Psychiatric Services, Vol. 61 No.7 (2010), p. 690-691; L Adam et al., "Are Language Barriers Associated With Serious Medical Events in Hospitalized Pediatric Patients?" PEDIATRICS, Vol.116 No.3 (2005), p.575-6; S Yeo, "Language Barriers and Access to Care" Annu Rev Nurs Res, Vol. 22 (2004), p.60

[3]N.Zezula et al. "Improving interpreting in clinical communication: models of feasible practice from the European project 'Migrant-friendly' Hospitals" Diversity in Health and Social Care, Vol.2 (2005), p.224; S Murphy, "Communicating with Limited English proficiency patients: question of health-care access "Journal of Medical Practice Management, Vol.20 (2004), p. 2327

[4]Schwei et al, cited above at note 2 p.1

[5]P.Schyve, "Language Differences as a Barrier to Quality and Safety in Health Care: The joint commission perspective" J Gen Intern Med 22, (2007) (supp12) p.360

[6]A. Decola, "Making language access to healthcare meaningful: The need for a federal healthcare interpreters' statute" Journal of Law and Health, Vol.58 No151 (2010), p.156

[7]Schyve, cited above at note 5

Often, this gap in communication leads to medical complications and untreated diseases.[8]The language barrier also limits the healthcare providers' ability to provide optimum care and also prevent a patient from understanding the warnings, which result in serious consequences, including death.[9]

Since Ethiopia is the most populous country in Africa[10] with 108,691,237 peoples[11]and it is the home of varieties of nations, nationalities and peoples with more than 83 different spoken languages,[12]the challenges due to language difference could be one of the concrete factors for poor health outcome. Pursuant to the last population census 341,834 peoples[13]live in Dire Dawa Administration (herein after DDA). Of these 163,920 peoples are Afaan Oromo speakers[14] while Amharic speakers are 90,459.[15]Though, the world health organization (herein after WHO) physician-to-population ratio is 1:8,000,[16]the current Ethiopia physician-to-population ratio is 3:100,000.[17] In this regard, the study area of this thesis, Dil Chora Hospitals (herein after DCH), serves a population of approximately 5 million from DDA, and neighboring Oromia and Somali regions.[18]Accordingly, pursuant to WHO ratio, this hospital is expected to have 625 physicians, while it has 47 physicians.[19] Of those physicians, only 3 speak Afaan Oromo as their first language.[20]As a natural consequence, this hospital has experienced an influx of Afaan Oromo speaking patients (herein after AOSPs), who are with limited or non Amharic proficiency. Undoubtedly, AOSPs has healthcare needs and requires quality care in equal footing with those who are proficient in the working language (Amharic), however, due to the language barrier

[8]Decola, cited above at note 6
[9]Id, P.170-170
[10] http://www.worldometers.info/population/countries-in-africa-by-population/last visited on may 11,2018
[11]Ethiopia Population, www.worldometers.info/world-population/Ethiopia-population/ last visited on December 11, 2018
[12] Ethiopian Treasures, (http://www.ethiopiatreasures.co.uk/pages/language.htm) last visited on May 13, 2018
[13] S. Zekaria, The 2007 Population and Housing Census of Ethiopia: Statistical Report for Dire Dawa City Administration (2008), p.7
[14] Id, p.25
[15] Ibid
[16] Y Berhan, Medical Doctors profile in Ethiopia: Production, Attrition & Retention, In Memory of 100 years of Ethiopian Modern Medicine & the New Ethiopian Millennium, (2006, Unpublished, Hawasa University Medical Faculty library) p.45
[17] Top ten countries with the lowest Doctor to Patient Ratio (https://www.ezega.com/news/NewsDetails?Page=news&NewsID=1486) last visited on may 15, 2018
[18]U.S. Government Inaugurates New Outpatient Department at Dil Chora Hosptial, httpt://et.usembassy.gov/pr_12202013/last visited on May 16, 2018
[19]Dire Dawa Health Bureau, health professional data (unpublished, Dire Dawa Health Bureau, Human Resources Office)
[20]Ibid

many patients face challenges to acquire equal and quality healthcare service. It is an orthodox in Ethiopia healthcare setting to use ad hoc interpreters to solve the language barriers or simply proceed despite the existence of the language barrier. Even though, there is no study in Ethiopia regarding the impact of the language barrier, one hospital in United States ended up paying a $71 million malpractice settlement for lawsuit against it,[21] due to a misinterpretation of a single word by ad hoc interpreter, a report of a prolonged hospitalization for perforated appendicitis that might have been avoided if professional interpreter had been called.[22]

Hence, this research seeks to examine whether the right to health of AOSPs in DDA healthcare setting is realized and to indicate the extent to which language is being a barrier in accessing healthcare services. It explores the international, regional and domestic instruments on the right to health as well as the domestic health policies and will analyses whether the right to access the healthcare setting requires, Ethiopia to put in place the language assistance services (herein after LAS) in the federal healthcare setting. It will also tough upon the experience of other countries on LAS in the healthcare setting.

1.2.Statement of the problem

Despite the existence of multilingual societies in the Ethiopian federal healthcare setting there is a monolingual healthcare service. As Ethiopia is a heteroglossic society with more than 83 living languages and many of them could not speak Amharic and many are limited Amharic proficient, it is the failure of the policy maker for not forecasting the possible ramification of the non-existence of the LAS in a healthcare setting since the rationale for court interpretation can be analogies to the medical interpretation too. As a result, other language speaking patients right to access healthcare services were affected due to the language barrier. This problem is magnified in the case of AOSPs in DDA healthcare setting ipso facto, pursuant to the last population census the number of people who speak Afaan Oromo as their mother tongue are 163,920

[21]X Wang, "The impact of using Ad hoc interpreters and professional interpreters on hospital costs and patients satisfaction rates of Limited English Proficient patients in the Emergency department" International Journal of Economics, Commerce and Management, United Kingdom , Vol.4 No.3 (2016), p.254

[22] G Flores et al."The importance of language and culture in pediatric care: case studies from the Latino community."J Pediatr, Vol.137 No.6 (2000),p. 847

people[23]whereas working language speakers are 90,459.[24]Thus, it is logical to assert that AOSPs in DDA healthcare setting are more affected by the language barrier.

Several countries in order to solve the language barrier in their healthcare setting, have instituted LAS to ensure effective communication between the healthcare providers and the patients. For instance, countries like Australia, Canada, South Africa, Saudi Arabia, USA and many other countries have put in place LAS. In spite of these countries encouraging trend, many countries did not institute the LAS in their healthcare setting, amongst which Ethiopia is one. In practice, in a very rare scenario in Ethiopia healthcare setting the healthcare providers try to use ad hoc interpreters. Hence, this cannot solve the problem of the language barrier; because such volunteer interpreters are not always available, and it consumes time to find such volunteer. Further, the volunteer interpreters are not familiar with medical terms and they do not interpret as their obligation. This thesis argues that, non-existence of LAS in DDA healthcare setting is amount to an implied denial of the right to access healthcare service of AOSPs.

1.3.Objectives of the Study

1.3.1. General Objective

The main objective of the study is to examine the implications of the language barrier in the DDA on the patient's right to access and utilize the healthcare.

1.3.2. Specific Objectives

- To identify the relevant international, regional and domestic laws that recognized the right to health, and domestic health policies.
- To assess whether the right to health of AOSPs is fully realized or not.
- To delineate the possible ramifications of the language barrier on the patient's right to access and utilize the healthcare.
- To look into cases of possible medical errors due to the language barrier in DCH.
- To explore the negative ramifications of medical interpretation by the ad hoc interpreters at DCH, if any.

[23] Zekaria, cited above at note 13, p.25
[24] Ibid

- To indicate the experiences from other countries regarding the use of the LAS in healthcare centers.
- To indicate the possible remedies for the violation of the right to health due to the language barriers.

1.4. Research Questions

This thesis is endeavoring to answer many questions that pose herein below. The central question is whether the language barrier challenges AOSPs to exercises their right to access and utilized the healthcare in DDA healthcare setting? Within this broad question, the study, inter alia, addresses the following specific questions:

- Do the relevant international, regional and domestic laws that recognized the right to health embrace the language access as an element of the right to health?
- Has the language been a barrier to AOSPs while they sought healthcare services from DCH?
- Does the existence of the language barrier affect the quality of healthcare and thereby result in adverse health outcome?
- Is there any potential correlation between the communication predicament and medical errors in DCH?
- What are the experiences and perception of the healthcare providers, the patients and patient's family regarding the language barrier and the ramifications thereof?
- What are the potential negative ramifications of using ad hoc interpreters?
- What are the experiences of other countries regarding the LAS look like?
- What are the remedies for the victim of violation of the right to access healthcare services?

1.5.Research Methodology

In this study, the methodology used is significantly qualitative procedures. As such, the research has relied on both primary and secondary sources. The primary sources include interviews, observations and focus group discussions. The researcher has collected data from patients, healthcare providers, officials in the MoH, DDHB and DCH. National legal instruments and health policies were also consulted. As secondary sources; international and regional instruments has been consulted. Review of literatures is one of the methodological approaches for this thesis. Hence, the researcher has consulted scientific journals and various documents on the language

barrier and LAS in the healthcare setting. My inclusion criterion is the publication date of the journals, which published from 2000 to 2017 and articles published before 2000 will be included only where it is necessary. The experiences of some countries were also examined through extensive reviews of journal articles, legislations and policies on the LAS in the healthcare setting, so that such experiences may consider in the Ethiopian health policies frameworks.

1.5.1. Sampling Techniques

The use of appropriate sampling technique is important in any research.[25]In view of this; the researcher has employed non-probability sampling techniques. By taking into account the purpose of the study, the nature of the study population, available resources and the ethical consideration, the researcher has employed convenience sampling, purposive sampling and snowball sampling techniques. The researcher chooses purposive sampling based on the appropriateness of the respondents for the study because all respondents have no the same expertise and experience on the issues intended to be researched. In, this sampling technique the criteria of the elements that have been included in the study were pre-defined.[26]In applying this sample, everyone who was available would have not been included rather among those available who had met the defined criteria were included.[27]This sampling technique is an ease to access the respondents whereas it is criticized for a subject to biases.[28]Due to the fact that impossible to identify the patients who were AOSPs from the rest of patients, the researcher has applied snowball or chain sampling. In this sampling, one element of the population was approached at a time and then was asked to refer the researcher to the other respondent who could meet the same criteria. Then the second respondent approached is asked to refer the researcher to another one and in this way a chain was continued.[29]This technique is useful in approaching the type of population which were not readily available in the small number whereas criticized for a subject

[25]M Alvi, "A Manual for Selecting Sampling Techniques in Research" (2016), p.40

[26]K Jawale, "Methods of Sampling Design in the Legal Research: Advantages and Disadvantages "international interdisciplinary Research Journal Vol. 2 No.6 (2012), p.187

[27] Alvi, cited above at note 25, p.30

[28] Jawale, cited above at note 26, p.188

[29] Alvi, cited above at note 25, p.33

to biases.[30] Finally, the researcher chooses the convenience sampling because the target population were defined in terms of broad category,[31] which are AOSPs and healthcare providers in DDA. Hence, any member of the target population who were available in DCH at the moment has been approached. Even though, this sampling technique is criticized for a subject to biases and not representative, the researcher prefer because it is inexpensive and less time consuming.[32]

1.5.2. Data Collection Procedures

Since one of the most important rationales for the researcher to collect data directly from respondents is to get accurate information, the researcher has collected data from respective respondents using three basic data collection types. These are; personal interviews, observation and focus group discussion. Thus, a total of 62 respondents were communicated via personal interview and three focus group discussions were conducted with 15 patients.

1.5.2.1. Personal interviews

There are two types of personal interview. These are: structured and unstructured interview.[33]In the case of the structured interview, the exact information needed is known in advance, which contains a set of questions arranged in a logical order.[34] As for an unstructured interview, the questions are not prepared in the specific sequence or in predetermined words before conducting the interview.[35]The researcher of this study has used both types of interviews. As part of procedure for conducting a personal interview, the researcher has asked broad questions initially, asked questions as prepared; clarified issues and avoided leading questions and has taken note of the responses thereof.[36]

As interview is firsthand information and very useful to understand the perception and experience of respondents, the researcher has conducted an interview with 28 patients aged from 18 to 65 years from DCH in the same hospital compound. Accordingly, 14 female patients and

[30] Ibid
[31] Id, p.29
[32] Id, p.30
[33] Murtala Murgan, "A Critical Analysis of the Techniques for Data Gathering in Legal Research"Journal of Social Sciences and Humanities, Vol.1 No.3 (2015), p.269
[34] Ibid
[35] Ibid
[36] Ibid

14 male patients were approached based on the snowball sampling techniques. 3 female physicians, 3 male physicians, 2 male psychiatrists (no female psychiatrist), 3 male public health officers (only 1 female public health officer interviewed), 2 female nurses, 2 male nurses, 2 male pharmacists, (only 1 female pharmacist interviewed), 7 higher officials from the MoH, head of and human resources director of DDHB, Chief executive officer of, medical director of, and human resources directorate director of DCH, 2 female ad hoc interpreters of DCH and deputy head of DDA public service and human resource development bureau were interviewed based on the purposive sampling technique.

1.5.2.2. Observation

By keeping in mind the nature of observation, the researcher has attained the examination and consultation sessions at DCH after securing permission from DCH, physicians and patients. Further, the researcher has observed the AOSP's treatment situation while they communicated with physicians and nurses in three patients' bedroom for two hours in three days, and when the patients communicated with public health officer at central triage for one day and when pharmacists told AOSPs how to take the prescribed drugs for two days based on the convenience sampling technique.

1.5.2.3. Focus group discussion

Due to the fact that, the focus group discussion allows the patients to express their point of view in one, the researcher has entertained various perspectives of the patients in the hospital compound. Accordingly, the researcher via convenience sampling technique has created 3 groups, each of which comprised 5 patients who have started treatment.

1.6.Respondents' eligibility

AOSPs that have limited Amharic proficiency and aged from 18 to 65 year were included. The patient respondents who were incapacitated by medical illness thereby unable to understand the interview questions were excluded. Officials from the MoH, DDHB, DCH and DDA public service and human resource development bureau with at least six months and above experience on their respective position or profession were contacted.

1.7.Ethical Consideration

Since the health-related issues are very sensitive, the need to follow the principles of confidentiality and respect for human dignity is must from moral consideration during data collection from the patients. The ethical clearance has been secured from the DDHB and DCH. As a compliance with the obligation arise from the research ethics, the researcher has introduced the purpose of the study to the respondents. The informed consent of the respondents was secured. The researcher briefed the respondents that their privacy and information confidentiality is protected. Besides that, the anonymity of the respondents maintained during and after the data collection for those who asked non-disclosure of their identity.

1.8.Pilot test

A pilot test was conducted through convenience sampling on five AOSPs via personal interview, which enabled the researcher to ensure the effectiveness of the data collection procedures and to correct the interviews questions.

1.9.Data Analysis

After collection of data, initially data were cleaned and then has been transcribed. Different data analysis systems were employed. Mainly, percentage, numeric and table were used to know the proportion of the patients and healthcare providers who has answered in a certain way. The researcher has used inference as a central process of identification aspects of various finding to reach on palatable conclusion.

1.10. Literature Survey

When there is language barrier, I can't get a patient history or a true picture, it's completely distorted. In the case of assessment and seeing how the patients are improving I find it a guessing game.[37]

The issue of the language barrier in healthcare settings has received significant attention in many countries.[38] To this end, there are vast empirical literatures[39] that demonstrate the impact of the

[37] J McCarthy et al. "Conversions through barriers of language and interpretation" British Journal of Nursing, Vol. 22 No 6 (2013) p. 337

language barrier to acquire the quality healthcare in the heterogeneous communities. To begin with the correlation between the language barrier and the quality of healthcare, Flores by conducting a systematic review of 43 literatures, found that the quality of healthcare is compromised when limited language proficiency patients (herein after LLPP) need but do not get medical interpreters.[40] He also identified that LLPP's quality of care is inferior, and more interpretation errors occur with ad hoc interpreters and in contrast the optimal communication, patient satisfaction, and better health outcomes and the fewest interpretation errors occur when LLPP have access to professional interpreters or bilingual providers.[41] Almutairi found that high quality, patient centered care depends on good communication between healthcare providers and the patients.[42] Gregg and Saha found that healthcare provider-patient communication barrier leads to poor clinical decision making, increased chances of medical errors and longer hospital stays.[43] Gerrish et al[44], and Briscoe and Lavender[45] underscored that language barrier results in patients' lack of understanding of their health problems. Wilson et al., found the language barrier resulted in patients' confusion about their medications.[46] Youdelman and Perkins has identified that LLPPs are less likely to use primary and preventive care services and more likely to use emergency rooms.[47] They also come up with the finding that LLPPs use more time than other patients[48] and are less likely to keep scheduled appointments.[49]

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[38] Al Khathami et al. "The effect of nurse-patient language barrier on patients' satisfaction," Saudi Med J Vol.31 No.12 (2010) p.1356

[39] K. Gerrish et al. "Bridging the language barrier: the use of interpreters in primary care nursing" Health and Social Care in the Community, Vol.12 No 5(2004), p.410

[40] G Flores, "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review" Medical Care Research and Review,Vol.62 No. 3 (2005) p.259-266

[41] Ibid

[42] K Almutairi, "Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia" Saudi Med J, Vol.36 No.4 (2015), p.429;

[43] J Gregg and S Saha, "Communicative competence: A framework for understanding language barriers in health care" Journal of General Internal Medicine,Vol.22 (suppl 2)(2007), p.368

[44] K Gerrish et al. "Bridging the language barrier: the use of interpreters in primary care nursing." Health and Social Care Community, Vol. 12 No.5 (2004), p.408

[45] L Briscoe and T Lavender, "Exploring maternity care for asylum seekers and refugees" British Journal of Midwifery, Vol.17 No.1 (2009), p.21-22

[46] E Wilson et al., "Effects of Limited English Proficiency and Physician Language on Health Care Comprehension" Journal of General Internal Medicine, Vol.20 (2005), p.802

[47] M Youdelman and J Perkins, "Providing Language Interpretation Services in Health Care Settings: Examples from the Field. National Health Law Program" The Commonwealth Fund, (2002) p.1

[48] Id, p.2

[49] Ibid

Schlemmer and Mash found that the LLPPs were discharged without knowing their diagnoses, without knowing how to take their medication, and without knowing what to do with the letter they received on discharge.[50]They also found the concrete correlation between the language barrier and unnecessary medical resource costs because doctors and patients do not understand each other, many tests that already been done are repeated unnecessarily.[51]In this study, one of the nurses shared her experience of a patient who responded incorrectly to his name and died after a drain was put into his normal chest, and many people already died due to communication problem.[52]

Al-Khatbami et al., come up with the finding that of 116 Arabic speaking patients two thirds reported difficulties in understanding nursing instructions, and felt non-Arabic speaking nurses (hereinafter NASNs) could not understand their concerns on many occasions.[53] Patients noticed 50 % NASNs avoid conversion and 70 % end conversion due to language barriers.[54] They found that patients had less trust, less comfort and some doubts towards nursing care delivered in the presence of language barrier.[55] Flores et al., found, family's of LLPP often prefer not to bring their child to healthcare centers.[56]Alpert et al., identified LLPPs have a higher risk of leaving the hospital against medical advice.[57]Kirkman-liff and Mondrago reached on the conclusion that, LLPPs are less likely to have a regular healthcare provider.[58] Manson found, LLPPs are more likely to miss follow-up appointments and non-adherent with medications.[59] Bowen had confirmed the assertion of Gregg and Saha that the language barrier resulted in misdiagnosis.[60]In this regard, Bowen mention one case; in which a man who was not fluent in English had his leg

[50] A Schlemmer and B Mash, "The effects of a language barrier in a South Africa district hospital" SAMJ, Vol.96 No.10 (2006), P.1086
[51] Ibid
[52] Ibid
[53] Al-Khathami et al, cited above at note 38, p.1355
[54] Ibid
[55] Id, p.1357
[56] G Flores et al., "Access barriers to health care for Latino children" Arch Pediatr Adolesc Med, Vol.152 (1998), p.1122
[57] M Alpert et al., "The language barrier in evaluating Spanish-American patients" Arch Gen Psychiatry, Vol.29 No.5 (1973), p.56-57
[58] B Kirkman-Liff and D Mondrago'n, "Language of interview: relevance for research of southwest Hispanics" American Journal of Public Health, Vol. 81 No. 11(1991), p.1401, 1403
[59] A Manson, Language concordance as a determinant of patient compliance and emergency room use in patients with Asthma Med Care, Vol.26 No.12 (1988), p.1126-27
[60]S Bowen , The Impact of Language Barriers on Patient Safety and Quality of Care (2015), p.20

amputated as the result of medical misdiagnosis resulting from the language barriers.[61] Bowen has also cited the cases by which the language barriers were identified as a contributing factor in the death of a pregnant Vietnamese woman.[62] One interpreter, mistranslating for a nurse, told the mother of a seven-year-old girl with otitis media to put (oral) amoxicillin in the ears.[63]

Flores et al. found that, when the child of the patient was used as an interpreter, 84% of 58 errors the child committed had potential clinical consequences, and when an untrained nurse interpreted, 90% of 10 errors had potential clinical consequences.[64] They[65]have identified ample medical interpretation errors by ad hoc interpreters that have potential clinical consequence, included omitting questions about drug allergies and about the past medical history.[66] For instance, they mentioned cases by which ad hoc interpreters told a mother to give an antibiotic for 2 instead of 10 days[67] and told another mother to give soy formula, instead of a physician's instructions to breastfeed only.[68]

Adam et al. underscored that a communication barrier between patient and provider could contributed to medical events such as a failure to monitor patient and diagnostic procedures performed on the wrong patient.[69]Consequently, they have identified that there were no an increased risk for serious medical events in patients who used an interpreter compared with patients who needed but did not get an interpreter.[70] Jacob et al. reached on the conclusion, that the healthcare providers are less satisfied with their interactions with patients when they face a language barrier.[71] Hein found that using family members as interpreters can result in

[61] Ibid
[62] Ibid
[63] G Flores, "Language Barriers to Health Care in the United States" The New England Journal of Medicine, Vol.355 No.3 (2006), p.229
[64] G Flores et al, "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters" PEDIATRICS Vol.111 No.1 (2003), p.9
[65] Ibid
[66] Ibid
[67] Ibid
[68] Ibid
[69] L Adam et al., "Are Language Barriers Associated With Serious Medical Events in Hospitalized Pediatric Patients?" PEDIATRICS,Vol.116 No.3 (2005), p.578
[70] Id, p.577
[71] E Jacob et al., "The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda" The Milbank Quarterly,Vol. 84 No.1 (2006),p.117

confidentiality issues.[72] Gerrish et al. asserted that without the healthcare provider collaboration with LAS seekers in generating a greater demand for interpreting services, the health disadvantage and indirect discrimination currently experienced by patients with the language barrier will continue.[73] Ali and Johnson underscored that communicating with patients in their language result in increasing their expectations of what a provider can do for them.[74]Gregg and Saha have proposed the increment of the linguistic diversity of the healthcare providers to give patients greater choice in selecting providers whom they can understand and who can understand them.[75] Youdelman and Perkins asserted that in a hospital emergency room, clear and fast communications can mean the difference between life and death.[76]

Diamond and Jacobs,[77] Flores et al.,[78] Hoye and Severinsson,[79] McCarthy et al.,[80] Ali,[81] Al-Khathami et al.,[82] Baker,[83] Partida,[84] Adam,[85] Yeo,[86] Karlinereet al.,[87] Poisson,[88] Melanie et

[72] P Hein, "Best Methods for Increasing Medical Translators for Limited English Proficient Patients: The Carrot or the Stick?" Journal of Law and Health, Vol. 18 No.71 (2003), p.74

[73] Gerrish et al, cited above at note 44, p.413

[74] PA Ali and S Johnson, "Speaking my patient's language: Bilingual nurses' perspective about provision of language concordant care to patients with limited English proficiency" Journal of Advanced Nursing, Vol. 73 No.2 (2017), p.18

[75] Gregg and Saha, cited above at note 43, p.370

[76] Youdelman and Perkins, cited above at note 47, p. 13

[77] L Diamond and E Jacobs, "Let not contribute to disparities: The best method for teaching clinicians how to overcome language barriers to health care" Journal of General Internal Medicine, Vol.25 (2009), 189

[78] Flores G et al.,cited above at note 64, p.12

[79] S Hoye and E Severinsson, "Intensive care nurses encounters with multicultural families in Norway: an exploratory study." Intensive Crit Care Nurs, Vol.24 No.6 (2008), p.338-48

[80]McCarthy, cited above at note 37, p.335

[81] Ali and Johnson, cited above at note 74, p.20

[82] Al-Khathami et al, cited above at note 38, p.1357

[83] D Baker et al. "Interpreter use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients." Official Journal of the Medical Care Section, American Public Health Association, Vol.36 No.10 (1998), p.1469

[84] Y Partida, "Addressing Language Barriers: Building Response Capacity for a Changing Nation" Journal of General Internal Medicine, Vol.22 (Suppl 2) (2007), p.349

[85] Adam et al, cited above at note 69, p.579

[86] S Yeo, "Language Barriers and Access to Care" Annu Rev Nurs Res, Vol. 22 (2004),p.67

[87] L Karliner et al, "The Langauge Divide: The Importance of Training in the Use of Interpreters for Outpatient Practice" Journal of General Internal Medicine ,Vol.19 (2004), p.175

[88] T Poisson, "Finding Solutions to Language Barriers between Nurses and Their Clients" Honors Projects Overview, Vol.33 (2009), p.3,4

al.,[89] Ferguson and Candib,[90] Zezula et al.,[91] Carrasquillo et al.,[92] Divi et al.,[93] Steinberg et al.,[94]Perkins,[95]Badruddin and Arif,[96]Metzger et al.,[97]Gerrish et al.,[98]Gregg and Saha,[99]Wilson et al.,[100]Wang,[101]Ouimet et al.,[102]and Baruch,[103]Cox and Gutierrez,[104]they all recommended the provision of professional medical interpreters as an important means of reducing medical errors, improving the quality of healthcare and consequently, bridge the gap in communication and thereby avoid the legal suit against healthcare providers and healthcare institution for malpractice caused by the language barrier.

Schlemmer and Mash underscored that the cost of employing professional interpreters will be compensated by improved quality of healthcare and utilization of resources.[105] Poisson has recommended instead of providing costly diagnostic test to patients, money be better spent paying for interpreter services that may decrease the need for costly tests.[106]

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[89] A Melanie et al, "Improving Access to Language Services in Health Care: A Look at National and State Efforts" Mathematica Policy Research, (2009), p.2

[90] W Ferguson and L Candib, "Culture, Language, and the doctor-patient relationship " Family Medicine and Community Health, Vol.34 No.5 (2002), p.359

[91]Zezula et al, cited above at note 3, p.223-224

[92] O Carrasquillo et al, "Impact of language Barriers on Patient Satisfaction in an Emergency Department" Journal of General Internal Medicine ,Vol.14 (1999), p.86

[93] C Divi et al, "Language proficiency and adverse events in US hospitals: a pilot study " International Journal for Quality Health Care, Vol.19 No.2 (2007), p.66

[94] E Steinberg et al, "The Battle of Managing Language Barriers in Health Care" Clin Pediatr (Phila), Vol.55 No.14 (2016), p.7

[95] J Perkins, "Overcoming Language Barriers to Health Care" Popular Government Vol.65 No.1(1999), p.39

[96] S Badruddin and S Arif, "Beyond the Language Barrier 'Speak' , See' , 'Help Me" Journal of Nursing and Care, Vol.6 Issue 4 (2017), p.4

[97] Ngo-Metzger et al, "Providing High-Quality Care for Limited English Proficient Patients: The Importance of Language Concordance and Interpreter Use" Journal of General Internal Medicine, Vol.22 Suppl 2 (2007), p. 328

[98]Gerrish et al, cited above at note 44, p.413

[99]Gregg and Saha, cited above at note 43, p.370

[100] Wilson et al, cited above at note 46, p.805

[101] Wang, cited above at note 21, p.255

[102] A Ouimet, et al, Language Adaption in Health Care and Health Services: Issues and Strategies, (2013), p.15

[103] E Baruch, Health Equity and Language Access: How Language Access Issues Affect Patients, Policymakers and Health Care Providers, The Colorado Trust, (2013), p.15

[104] A Cox and L Gutierrez, Interpreting in the Emergency Department: How context matters for practice, (2015), p.2

[105] Schlemmer and Mash, cited above at note 50, p.1087

[106] Poisson, cited above at note 88, p.6

Birmeta et al. in the only study conducted in Ethiopia on the barriers to access healthcare service has identified income, marital status, ethnicity, health insurance and individual attitude towards health service as a barrier to access the healthcare service.[107]However, a review of the literatures, demonstrates this thesis is the first in examining the implication of the language barrier on the patient's right to access and utilized the healthcare service in Ethiopia in general and in DDA in particular. Even though, there were around 562 studies (to my knowledge) up to 2010,[108] conducted in various countries[109]on the correlation between the language barrier and quality healthcare services, there is no single study intended to address the language barrier in healthcare setting from the international human rights laws perspective.

Therefore, this thesis is unique in that it intended to address the problem of the language barrier from international, regional and national instruments perspectives. This thesis is also important because it affects more than 163,920 Afaan Oromo speaking peoples, who are limited or non Amharic proficient residents of DDA, and many more in Addis Ababa and many user of federal healthcare setting from regional states. It will be useful in identifying the critical issues and forward recommendations to healthcare providers, healthcare institutions and policy makers at the DDA and federal level; so that the challenges faced by the patients with limited Amharic proficiency will be resolved.

1.11. Significance of the Study

The study will address the language barriers faced by AOSPs and/or having limited Amharic proficiency in DDA and forward a recommendation for the policy makers so that they use it as an input when they try to put in place LAS in healthcare setting, which will enables effective communication between the patients and healthcare providers, leads to increased positive patients outcomes, enables the patients to access and utilize the healthcare service in full pledge manners and equally with their counterpart Amharic proficient patients. It also enables the government in combating the diseases. It will also serve as the springboard to other researchers.

[107] K Birmeta et al, "Analyzing Barriers to Accessing Health Care Services in Holeta Town, Ethiopia" Primary Health Care, Vol. 5 Issue 2(2015), p.6
[108] Schwei et al. cited above at note 2, p.2
[109] Yeo, cited above at note 86, p.61

The finding of this study will improve quality of healthcare by limiting or avoiding medical errors resulted from the language barrier. The MoH and DDHB will find out as to how the absence of the LAS affect the quality of healthcare and thereby help them to assign bilingual healthcare providers as much as possible rather than assigning them to the area where many customers are proficient in Amharic, and to assign professional interpreters. Hence, this thesis will contribute for the protection of the right to health of AOSPs who live in the federal cities, where working language is solely Amharic and thereby help to bridge the gap between the laws and policies, and its practical implementation.

1.12. Limitation of the Study

There are several limitations to this study. First, only patients in DCH who already start treatment were approached. Secondly, the researcher has only addressed the perception and experience of the respondents' regarding language barrier encountered by AOSPs; it did not address the perception and experience of other language speaking patients. Third limitation is that, this thesis did not deal with the detail health outcome disparity between AOSPs and Amharic proficient patients. Nor it intended to generalize the health outcome disparity to the wider population of the city administration.

1.13. Operational Definition[110]

Ad Hoc interpreters: are family members, friends or untrained healthcare setting staff and others who act as interpreters for the patients.

Adverse events: an event which results in unintended harm to the patient and is related to the care provided to the patient rather than to the patient's underlying medical condition.

Bilingual provider: a healthcare provider who is able to provide fluent, effective service in both the working and patients' language.

Interpretation: refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language.

[110] All operational definitions are adapted from the report prepared by Bowen, on the The Impact of Language Barriers on Patient Safety and Quality of Care (2015), p.6-7. except definition of patient education, which is taken from online source https://www.encyclopedia.com/medicine/encyclopedias-almanacs-transcripts-and-maps/patient-education last visited on September 19,2018

Language access: an umbrella term that describes strategies to enable patients to communicate effectively with healthcare providers and for providers to communicate effectively with them.

Language concordant encounters: healthcare interactions where both provider and patients are fluent in the same language.

Limited language proficiency: limited ability to speak, read, writes, or understands the language at a level that permits the person to interact effectively with other.

Medical error: an act of commission or omission that substantively increases the risk for a medical adverse event. An error may result from the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

Medical events: are medication errors, missed or delayed diagnoses, failure to monitor patient, diagnostic procedures performed on the wrong patient and the other similar scenario.

Patient safety: the pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices that to lead to optimal patient health outcomes.

Patient Education: involves helping patients become better informed about their condition, medical procedures, and choices they have regarding treatment.

Translation: the written conversion of one language into another.

1.14. Overview of Chapters

This thesis comprises five chapters. Chapter one has set out the rationale of the study, identified the problem, present the research questions, delineated the methods of the study, reviewed the available literatures and discussed the limitation of the study. Chapter two discusses international, regional and national legal frameworks on the right to health, and national health policies. Chapter three will discuss the obligations of the government in relation to the right to health, elements of the right to health, the correlation between the right to health and other human rights, types of LAS, cost of providing LAS and it also discuss the experiences of other countries on the LAS in their healthcare setting. Chapter four will examine whether Ethiopia realize the right to health of limited Amharic proficient patients - monolingual AOSPs in DDA healthcare setting by critically inspect various legal instruments and policies on the right to health, and substantiate with the data collect from the study site and other relevant organs. Chapter five will present the conclusion and recommendations of the study.

Chapter Two

The Ethiopian Legal and Policy Framework on the Right to Health

"Enjoyment of the human right to health is vital to all aspects of a person's life and well-being and is crucial to the realization of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind."[111]

Introduction

Ethiopia has ratified numerous international and African regional legal instruments that deal with the right to health, and which are guaranteed in the FDRE Constitution. There are also various national policies regarding the health issues.[112] A clear understanding of the nature of the right to health will help to ensure the right to health of all, *inter alia*, by put in place the LAS in the healthcare setting to solve the language disparity between the patients and healthcare providers. Thus, under this chapter it is important to discuss the concept of the right to health, and international, regional and national instruments on the right to health and domestic health policies, to have a clear image of the right to health of the citizens and the corresponding obligations of the government.

2.1. The Right to Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease.[113]The right to health is a short-form for the right to the highest attainable standard of physical and mental health.[114]It is one of the central social rights, which refers to access and universal coverage of health services, in quality and quantity for the whole population.[115]It is a fundamental part of our human rights and of our understanding of a life dignity.[116]It is not the

[111] African Commission on Human and Peoples' Rights, Communication 241/2001, Purohit and Moore v The Gambia, 33rd Ordinary sess (15th to 29th May 2003), para 80.

[112] Federal Democratic Republic of Ethiopia National Human Rights Action Plan 2013-2015 (June 2013), p.84

[113]Preamble of the Constitution of the World Health Organization, adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 and entered into force on 7 April 1948 para.1

[114] Health and Human Rights, Resource Guide, FXB Center for Health and Human Rights and Open Society Foundations (5th Ed, November 2013) p.6; ICESCR art.12 (1)

[115] F Mitano et al., "Right to health: (in) congruence between the legal framework and the health system" Rev.Latino-Am. Enfermagem , Vol.24 (2016), p.2

[116] The Office of the United Nations High Commissioner for Human Rights, World Health Organization Fact Sheet No.31, The Right to Health , p.1

right to be healthy,[117] rather as the United Nations Committee on Economic, Social and Cultural Rights (hereafter Committee on ESCR) delineate "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."[118]As it has been mention above, this right is recognized under international, regional and national instruments and domestic policies, the detail of it, will be delineate hereunder.

2.2. Legal Frameworks on the Right to Health

2.2.1. International Legal framework

Core international instruments have already recognized the right to health, from their respective purposes. These instruments are the UDHR,[119] the ICESCR,[120] the CRC,[121] CEDAW,[122] the CERD,[123] the CRPWD[124] and other international human rights treaties including the CRMW.[125]Further, the WHO Constitution[126]and the Charter of the UN[127]has recognized the right to health without distinction as to language. The primary treaty that meant to protect the right to health is ICESCR. As ICSECR places emphasis on equal access to health care and minimum guarantees of healthcare in the event of sickness,[128]and the right to access and utilize the

[117] Health and Human Rights ,Resource Guide, cited above at note 114

[118]The UN Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No.14: Right to the Highest Attainable Standard of Health (Article 12 of the Covenant) U.N.Doc, E/C.12/2000/4 (August 11, 2000), para. 9

[119] Art.25 of United Nation Universal Declaration of Human Rights 1948

[120]Art.12 of International Covenant on Economic, Social and Cultural Rights, adopted and open for signature, ratification, and access by General Assembly resolution 2200 A (XXI) of 16 December 1966, entered into force on 23 March 1976.

[121] Art.24 of Convention on the Rights of the Child adopted and opened for signature, ratification, and access by General Assembly resolution 44/25 of 20 November 1989.

[122] Art.12 of Convention on the Elimination of All Form of Discrimination against Women, adopted and open for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979, enter into force on 3 September 1981

[123] Art.5(e) (iv) of International Convention on the Elimination of All Forms of Racial Discrimination, adopted and open for signature, ratification and accession by General Assembly Resolution 2106 (XX)of 21 December 1965 enter into force on 4 January 1969

[124] Art.25 of Convention on the Rights of Persons with Disabilities, adopted on 13 December 2006 and opened for signature on 30 March 2017, enter into 3 May 2008.

[125] Article 28,43(e) and 45(c) of International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted on 18 December 1990, enter into force 1 July 2003

[126] Preamble of the Constitution of the World Health Organization, cited above at note 113

[127]Art.55 of United Nations Charter

[128] ICESCR, cited above at note 120, article 12(2)(d)

healthcare service shall not be hampered due to the language disparity between the patients and healthcare providers. Accordingly, LLPPs are entitled to enjoy their right to health without discrimination of any kind,[129]as proficient patients do.

The Committee on ESCR in its General Comment 14, while clarifying the content of the right to health, has noted that the right to health interconnects with other human rights such as the rights to life, non-discrimination, equality, liberty, food, housing, work, education, and access to information and other rights.[130]The same committee has also asserted that the right to health contains both freedom and entitlements. The freedoms include the right to be free from interference. The entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[131] Even though, none of international instruments and monitoring organs specifically addresses the patients' right to LAS, they had dealt with the right of everyone to the enjoyment of the highest attainable standard of health without discrimination, which prerequisite the equal treatment and the smooth communication between the healthcare providers and the patients.

2.2.2. African Regional Legal framework

The ACHPR enshrines that everyone has the right to enjoy the best attainable state of physical and mental health[132]and the right to free from discrimination on the ground of language in the enjoyment of the rights and freedoms guaranteed in the Charter,[133]including the right to health. The African Charter on the rights and welfare of the child also recognized the right to health[134]and the principle of non-discrimination.[135]The African Charter further created the African Commission on Human and Peoples' Rights, to promote human and peoples' rights and to ensure their protection in Africa.[136] For instance, the African Commission in the Purohit case held that the Enjoyment of the right to health is a vital to all aspects of a person's life and well-

[129] ICESRC, cited above at note 120, art.2(2); UDHR, cited above at note 119

[130] ESCR Committee General Comment No.14, cited above at note 118, para.3

[131] Id, para.8

[132] African Charter on Human and Peoples Rights, adopted in Nairobi June 27, 1981,entered into force October 21,1986

[133] Id, art.2

[134] Article 14 of the African Charter on the rights and welfare of the child; OAU Doc.CAB/LEG/24.9/49(1990), entered into force Nov.29,1999

[135]Id, art.3

[136] Id, art.30

being and is crucial to the realization of all the other fundamental human rights and freedoms.[137]The Commission further asserted that the right to health includes the right to health facilities and access to goods and services be guaranteed to all without discrimination of any kind.[138]In its decision on Free Legal Assistance Group and Others v. Zaire,[139] and Sudan Human Rights Organization and Center on Housing Rights and Evictions v Sudan,[140]the Commission held that the failure of the government to provide medicine constitute a violation of the right to health recognized under African Charter. Further, pursuant to article 60 and 61 of the ACHPR, the Commission can make a necessary reference to international human right instruments to which member states of ACHPR are members.

2.2.3. Domestic Laws and Policies

Pursuant to article 9(4) of the FDRE Constitution, all the above discussed international and African regional instruments are part and parcel of the law of Ethiopia. Further, the Constitution pursuant to article 41(4) imposed an obligation on the government to allocate ever increasing resources to provide the public health and sub-article 3 of the same article stipulated that every Ethiopian national has the right to equal access to publicly funded social services. Furthermore, article 39(2) of the same Constitution state that, "every nation, nationality and people in Ethiopia has the right to speak, to write and to develop its own language." Hence, all patients have the right to speak their own language for two reasons; first to communicate with the healthcare providers thereby enjoy their right to health by communicating with their healthcare providers. Secondly, in order to develop their own language by utilizing in all government sectors. However, in the Ethiopian context, Amharic is the only working language of the federal government. Consequently, all federal government institutions in general and healthcare setting in particular are delivering their service via Amharic while in reality, in the DDA context many of the service seekers are limited Amharic proficient- Afaan Oromo speakers.[141]

[137] African Commission on Human and Peoples' Rights, Communication 241/2001, Purohit and Moore/ The Gambia para.80
[138] Ibid
[139] African Commission on Human and Peoples' Rights, Communications 25/89, 47/90, 56/91 and 100/93, Free Legal Assistance Group and Others v. Zaire para.47
[140] African Commission on Human and Peoples' Rights, Communication 279/03-296/05: Sudan Human Rights Organization and Center on Housing Rights and Evictions v Sudan, para.211

[141] Zekaria, cited above at note 13

There is no LAS trend in Ethiopia so far except in court proceedings. Even though, there are policies which has been designed to address health issues in Ethiopia under various regimes,[142]all these policies did not comprehensively address the issues of the language barrier except the health sector transformation plan (herein after HSTP), which accidently dealt with the language barrier when it addresses the accessibility issue, by asserting that the healthcare services shall directly and permanently be accessible with no undue language barriers.[143]

In1993, the Ethiopia government launched the country's first health policy to reorganize the health services delivery system with the objective of expanding the primary healthcare system.[144] In, 2015 the Ethiopia government has developed the HSTP. It is the first phase of a 20-year plan titled, 'envisioning Ethiopia's path to universal health care through strengthening of primary health care'.[145]This plan, in line with Ethiopia's second growth and transformation plan, has set ambitious goals to improve equity, coverage and utilization of health services and improve quality of healthcare.[146] Ethiopian national healthcare quality strategy builds on the plan laid out in HSTP, to further align key stakeholders across prioritized interventions that will drive large-scale improvement in quality of care delivery over the next five years from 2016 to 2020.[147]

[142] The Preamble of the Health Policy of the Transitional Government of Ethiopia (1993) paras.2 and 3
[143] K Admasu, Health Sector Transformation Plan (2015/16-2019/20) (2015), p.3.
[144] R Wamai, "Reviewing Ethiopia's Heath System Development" JMAJ, Vol. 52 No.4 (2009), p.279
[145] Admasu, cited above at note 143, p.69
[146] Id, p.10
[147] Federal Democratic Republic of Ethiopia Ministry of Health; Ethiopian National Healthcare Quality Strategy, (2016-2020), p.IV

Chapter Three

The Obligations of the Government in Relation to the Right to Access Healthcare Services and the Experiences of other Countries

"While the full realization of the relevant rights may be achieved progressively, steps towards that goal must be taken within a reasonably short time after the Covenant's entry into force for the state concerned."[148]

Introduction

Once states become party to a given treaties, it shall guarantee the rights enshrined in the treaties they have ratified and shall undertake to adopt legislative or other measures to give effect to the rights guaranteed, and to comply with the duties pursuant to such treaties expectation. Hence, States parties have the obligation to respect, protect and fulfill human rights in general and of the right to health in particular.[149] These three-level 'typology' of obligations each contain elements of the obligation of conduct and obligation of result.[150] Hence, this chapter tries to delineate Ethiopia's obligations regarding to the right to health in general and the right to health of the patients with limited Amharic proficiency and/or with no Amharic proficiency at all. In doing so, it tries to touch upon the obligations to respect, protect and fulfill from the language accessibility aspect. It will also deal with the obligations of conduct and of result, the immediate obligations and progressive realization. It further, discusses the elements of the right to health and the correlation between the right to health and other human rights. Furthermore, it will touch upon the types of LAS, cost of providing LAS and the experiences of other countries on LAS in their healthcare setting. Finally, this chapter will be wind up by discussing the cost of interpretation and the health outcome gained with the help of interpretation.

3.1. The three-level 'typology' of obligations that Radiate from the Right to Health

The right to health, like all other human rights, imposes three types of obligations on States parties[151] and these three-level obligations are now widely accepted as an interpretative tool to be

[148] The UN Committee on Economic, Social and Cultural Rights, General Comment No.3: The nature of states parties' obligations (Art.2, para.1) 5Th session, E/1991/23 (December 14, 1990), para. 2

[149] Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, 22-26 January 1997, Guideline 6

[150] Id, Guideline 7

[151] ESCR Committee, General Comment No.14 cited above at note 118, para.33

utilized in discerning the duties incumbent upon States.[152] All three State's obligations have its own peculiar expectations. Thus, the obligation to respect requires State to refrain from interfering directly or indirectly with the right to health.[153]Consequently, the obligation to respect requires State to refrain from denying or limiting access to healthcare services.[154]The obligation to protect requires State to prevent third parties from interfering with the right to health.[155]As a result, State should adopt legislation or other measures to ensure that private actors conform to human rights standards when providing healthcare. For instance, State shall ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of healthcare.[156]The obligation to fulfill involves the adoption of appropriate legislative, administrative, budgetary, judicial, and other measures to realize the right to health.[157]Accordingly, State must adopt a national health policy or plan covering the public and private sector that ensure equal access to the provision of healthcare for all.[158]It also requires State to ensure that doctor and other staff are adequately trained.[159]

3.2. Obligations of Conduct and of Result

Each of three types of State's obligations discussed above contains elements of both the obligations of conduct and of result. The obligation of conduct requires action reasonably calculated to realize the enjoyment of a particular right.[160]In case of the right to health, it could entail the adoption and implementation of a plan of action to reduce mortality.[161] The obligations of result require State to achieve specific targets to satisfy a detailed substantive standard.[162]Regarding the right to health, it requires the reduction of mortality rate.[163]

[152] V Dankwa et al. "Commentary on the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights" Human Rights Quarterly,Vol.20, No.3 (1998), p.20
[153] Fact sheet 31, cited above at note 116, p.25
[154] Ibid
[155] Id, p.26
[156]Ibid
[157] Id, p.27
[158] Ibid
[159] Ibid
[160] Maastricht Guidelines, cited above at note 149, Guideline 7
[161] Ibid
[162] Ibid
[163] Ibid

3.3. Minimum core obligations under the right to health

The concept of the minimum core seeks to establish a minimum legal content for the notoriously indeterminate claims of economic and social rights.[164] The legal basis of minimum core obligation (herein after MCO) supplements a 'generic obligation' set out in the ICESCR which place an obligation on the State parties to undertake to take steps, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the covenant by all appropriate means, including the adoption of legislative measures.[165] It also imposes various obligations which are of immediate effect towards the realization of the rights including the right to health.[166]

The Committee on CESR has equated the MCO with a non-derogable obligation.[167] Hence, despite the wealth of a given country, MCOs are incumbent on all states to secure minimum essential levels of each right found in the ICESCR, under all circumstances including periods characterized by resource scarcity.[168] In both general comment No.3[169] and general comment 14,[170] the Committees confirms that States parties have a MCOs to ensure the satisfaction of, at least, minimum essential levels of each of the rights stipulated in the ICESCR. The Committees are of the view[171] that the MCO shall include the obligation to ensure the right to access to healthcare on a non-discriminatory basis. It should be clear that a State party cannot, under any circumstances, justify its non-compliance with the MCO, which are expected to be observed by all States irrespective of its wealth. In this regard, the Maastricht Guidelines on violations of ESCR stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of essential primary healthcare'.[172]

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[164] K Young, "The Minimum core of Economic and Social Rights: A Concept in Search of Content," The Yale Journal of International Law, Vol.33. No. 113 (2008), p.113

[165] K Shields, The Minimum core obligations of Economic, Social and Cultural Rights: The Rights to Health and Education, Research Paper; The Nordic Trust Fund, The World Bank (2017), p.3

[166] ESCR Committee, General Comment No.3 cited above at note 148, para.1

[167] Young, Cited above at note 164, p.115

[168] Maastricht Guidelines, cited above at note 149, Guideline 9 & 10

[169] ESCR Committee, General Comment No.3 cited above at note 148, para.10

[170] ESCR Committee, General Comment No.14 cited above at note 118, para.43

[171] Ibid

[172] Maastricht Guidelines, cited above at note 149, Guideline 9

3.4. Progressive Realization regarding the Right to Health

The ICESCR stipulated that, States have the obligation to progressively achieve the full realization of the rights under the Covenant by all appropriate means including the adoption of legislative measures.[173] This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions.[174] Thus, some components of the rights protected under the Covenant, including the right to health, are deemed subject to progressive realization.[175] That means, "States parties have a specific and continuing obligation to move as expeditiously and effectively as possible" towards full realization of the right to health.[176] Consequently, State has an immediate obligation to take steps towards the realization of the right to health, referred to as a progressive realization.[177] The ICESCR also requires each State party to realize the Covenant rights by taking steps "to the maximum of its available resources," to realize the right to health and to take steps in that direction without delay.[178]Available resources refer to those existing within a State as well as those available from the international community through international cooperation and assistance. We have to bear in mind that, the international cooperation and assistance is not a substitute for domestic obligations, but it comes into play in particular if State is unable to give effect to ESCRs on its own, and requires assistance from other States to do so.[179] Thus, if a State fails to meet the MCO and attributes the failure to a lack of available resources, the State party must demonstrate that it made every effort to use all available resources in an effort to satisfy the MCO.[180]

3.5. Elements of the right to health

The right to health is not the right to be healthy but it must be understood as the right to enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the right to health.[181] Accordingly, the right to health in all its forms and at all levels contains the following interrelated and essential elements. [182] These elements are: availability,

[173] ICESRC, cited above at note 120, art.2(1)
[174] Fact sheet 31, cited above at note 116, p.23
[175] Ibid
[176] Health and Human Rights ,Resource Guide, cited above at note 114, p.8
[177] Ibid
[178] Fact sheet 31, cited above at note 116, p.5
[179] Id, p.23
[180] ESCR Committee, General Comment No.3 cited above at note 148, para.11
[181] ESCR Committee, General Comment No.14 cited above at note 118, para.9
[182]Id, para.12

accessibility, acceptability and good quality. The principles of availability, accessibility, acceptability and quality are not only guiding concepts that help to clarify the nature of the responsibility that governments owe under the right to health[183]and they also highlight actions to be taken to achieve the goal of universal health coverage (herein after UHC).[184]The United Nations general assembly underscored that one of the goal of UHC is to make healthcare accessible to all without discrimination.[185]

3.6. The correlation between the Right to Health and Other Human Rights

It is an established principle that all human rights are universal, indivisible, interdependent and interrelated.[186] Further, the importance given to the underlying determinants of health that is, the factors and conditions which protect and promote the right to health beyond health facilities, goods and services, shows that the right to health is dependent on, and contributes to, the realization of many other human rights.[187]In this regard, the CESCR General Comment 14 stipulated that, the right to health is closely related to and dependent upon the realization of other human rights which shall embrace the rights to life, non-discrimination, equality, food, housing, work, education, access to information, and other rights.[188] The above affirmations implicated that violating the right to health may often impair the enjoyment of other human rights.[189]

To substantiate in a detail manner the correlation between the right to health and other human rights, it is important to at least deal with, the right to non-discrimination. To this end, the Committee on ESCR has interpreted the right to health as it imposes a number of core obligations; inter alia, the obligations to ensure the right to access to healthcare without discrimination.[190] The Committee on ESCR has defines discrimination as -any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly

[183] Making fair choices on the path to universal health coverage: final report of the WHO Consultative Group on Equity and Universal Health Coverage, Geneva: World Health Organization; 2014. http://www.who.int/iris/handle/10665/112671 last visited on July 2, 2018

[184] Ibid

[185] United Nations General Assembly. Global Health and foreign policy, United Nations document A/67/L.36 (6 December 2012) para.10.

[186] Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna on 25 June 1993 (A/CONF.157/23), para.5

[187] Fact Sheet 31, cited above at note 116, p.6

[188] ESCR Committee, General Comment No.14,cited above at note 118, para.3

[189] Fact Sheet 31, cited above at note 116, p.6

[190] ESCR Committee, General Comment No.14 cited above at note 118, para.43(a)

based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights.[191] Therefore, discrimination can be direct or indirect; especially indirect discrimination refers to laws, policies or practices which appears neutral at face value, but have a disproportionate impact upon certain groups.[192] To this end, the committee has asserted that the denial of access to healthcare to particular groups as a result of de jure or de facto discrimination is amount to a violation of the obligation to respect by State.[193]

Since non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to health,[194]it is impossible to imagine the realization of the right to health without ensuring the right to non-discrimination.

3.7. Types of Interpretation Services or LAS

When a language barrier is identified between patients and healthcare providers, provision of various interpretation services are frequently proposed solution. To this end, various approaches of interpretations are adapted by different countries. It is vital to discuss the features of the major types of LAS herein under.

3.7.1. Proximate-consecutive interpretation or Face to face

Face-to-face interpretation is when the interpreter meets the healthcare provider and the patient at the health facility or at the patient's home in person.[195]

3.7.2. Remote simultaneous medical interpretation (RSMI)

RSMI allow the interpreter to interpret at the same time as the patient is speaking via headsets as performed at the United Nations.[196] The interpreters can be stationed at a remote location,

[191] The UN Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No.20: Non-Discrimination in Economic, Social and Cultural Rights (art.2 (2) of ICESCR), UN Doc. No. E/C.12/GC/20 (2009), para.7

[192] Id, para.10

[193] ESCR Committee, General Comment No.14 cited above at note 118, para.50

[194] Fact Sheet 31, cited above at note 116, p.7

[195] New South Wales Health Care Interpreter Services: Professional Development Committee; Interpreting in healthcare, Guidelines for Interpreters (2014), p.6;Youdelman and Perkins, cited above at note 47, p.27

[196] Karliner et al, cited above at note 87, p.181

possibly allowing for distant access to interpretation.[197]Both patients and healthcare providers wear headsets during a given encounter, and their conversation is transmitted to a nearby receiver and then digitally over a fiber-optic line to a central switching station in the interpreter room and the provider and patient only hear their own languages.[198]The interpreters, also wearing headsets, listen to what is said by one party and then transmit an interpretation to the other.[199]

3.7.3. Telephone interpreting (TI)

TI in healthcare are not usually pre-booked but requested as the need arises and it is usually happens when a patient is in the doctor's room and a face-to-face interpreter has not been booked.[200]

3.7.4. Video Medical Interpretation (VMI)

VMI enables to utilize video conferencing technology to allow interpretation to take place in real-time from a remote location, while at the same time maintaining the three-way nonverbal communication among the patient, interpreter, and clinician.[201] It also allows access to interpreters in languages that would otherwise be unavailable in person.[202]

3.7.5. Ad Hoc Interpreters

Ad hoc interpretation is an interpretation conduct by untrained interpreters, but who claimed to be proficient in the language they intended to interpret. Ad hoc interpreters could include medical or nonmedical bilingual staff pulled away from other duties to interpret, patients' friends and patients' family, strangers from the waiting room and other untrained interpreters.[203]

3.8. Experiences of Other Countries on Language Assistance services in Healthcare Setting

An overwhelming studies have demonstrated negative ramifications of the non-existence of professional interpreters and the use of ad hoc interpreters, that result in misunderstandings,

[197] Ibid
[198] Youdelman and Perkins, cited above at note 47, p.26
[199] Ibid
[200] New South WalesHealth Care Interpreter Services, cited above at note 195, p.23
[201] Karliner et al, cited above at note 87, p.181
[202] Ibid
[203] Flores, cited above at note 40, p.257

misdiagnoses, and medical errors,[204]and in legal actions against hospital and physicians for medical malpractice.[205]In another fashion, the use of professional interpreters[206] is one of the robust proposed solutions to solve the language barrier in healthcare setting. Consequently, many countries have put in place the LAS in their healthcare setting.

The USA executive order 13166 requires agencies and programs to take steps to ensure that federally conducted activities are accessible to all persons who, as a result of national origin, are limited English proficiency.[207]In this regard, the Supreme Court has rules that discrimination based upon language is tantamount to discrimination based on national origin.[208]Consequently, hospitals in the USA started to provide the LAS for their patients.[209]To this end, the office of minority health's created the LAS standards[210] to provide a consistent and comprehensive guidance to promote linguistic competence in healthcare, inter alia, standard 4 requires the healthcare organizations to provide LAS, including bilingual staff and interpreter services, at no cost to each LLPPs at all points of contact, timely during all hours of operation.

In 1973, Kaiser Hospital in Oakland, California, provided translation services in Amharic and Tigrigna.[211]The cross cultural health care program in Seattle has translated a medical glossary to the Amharic, Somali and Tigrigna languages[212]and there is also telephone line interpretation in Minnesota for Somali language speaking patients.[213]In 2008, New York City has put in place the language access executive order 120, that require city agencies to provide LAS for the six languages most commonly spoken by New York City residents including patients.[214]Rhode Island has also the law that mandates that LAS must not only be provided to patients directly but

[204] Flores, cited above at note 64

[205] Decola, cited above at note 6, p.171

[206] Baker, cited above at note 83

[207] Strategic Language Access Plan for Persons with Limited English Proficiency, Department of Health & Human Services Centers for Medicare & Medicaid Services Baltimore, Maryland 21244-1850(2014), p.1

[208]Daniel Levinson, Guidance and Standards on Language Access Services: Medicare Providers, Department of Health & Human Services; Office of Inspector General (2010), p.3

[209] Youdelman and Perkins, cited above at note 47, p.25

[210] Levinson, cited above at note 208, p.6

[211] Perkins, cited above at note 95, p.38

[212] Youdelman and Perkins, cited above at note 47, p.34

[213] Id, p.11

[214] Melanie et al, cited above at note 89, p.7

also be advertised through written posting in the three most prevalent languages, served by the facility.[215]All in all in 2008, fifty states in USA put in place LAS in healthcare setting.[216]

In 1973, Australia has taken a population-based approach to translation and interpreting services (herein after TIS).[217]TIS agency is highly computerized and enables access to more than 1500 interpreters, who can be reached through a national call center located in Melbourne using a standard, toll-free number.[218] On a daily basis, interpreters speaking over 120 languages and dialects are available to accept TIS assignments.[219] Note that the TIS agency gives a priority for the Healthcare callers.[220]

In Quebec there are a number of regional interpreter banks that solely intended for users who speak languages other than English or French.[221] In particular, the bank could offer remote interpretation services via video conference or telephone for patients with a limited French proficiency, which would be especially useful for the healthcare facilities located in remote regions or for patients living in regions where a small percentage of the population is Allophone, Anglophone, or speaks an aboriginal language.[222]British Columbia, Alberta and Winnipeg each offers telephone interpretation services.[223] Winnipeg uniquely offers services in private clinics.[224]

Although South Africa is a heteroglossic society with 44 living languages,[225]of which 11 have official languages status,[226]most healthcare workers can only speak one or two.[227]As a result, there has been a longstanding call to employ trained interpreters to address language barriers in

[215] Poisson, cited above at note 88, p.4-5
[216] Melanie et al, cited above at note 89, p.2
[217] Y Partida, "Addressing Language Barriers: Building Response Capacity for a Changing Nation" Journal of General Internal Medicine, (Suppl 2) (2007), p.347
[218] Id, p.348
[219] Ibid
[220] Ibid
[221]Ouimet et al, cited above at note 102, p.21
[222] Ibid
[223] A Sultana et al, Language Interpretation Services in Health Care Settings in the Great Toronto Area, Wellesley Institute advancing urban health (2018), p.2
[224] Ibid
[225] E Benjamin, "Language barriers in health: lessons from the experiences of trained interpreters working in public sector hospitals in the Western Cape" South African Health Review, Vol.2016, Issue 1 (2016), p.74
[226] Ibid
[227] Schlemmer and Mash, cited above at note 50, p.1084

healthcare in South African.[228] For instance, a significant number of patients at Hottentots Holland hospital can only speak Xhosa, and although most of the staffs are fluent in Afrikaans or English, only a handful of personnel can speak Xhosa.[229] Consequently, the LAS have been put in place in the Western Cape Town hospital.[230]

The rationale for these countries to put in place the LAS in their healthcare setting is to ensure equal healthcare services for their multilingual societies and to address the language barrier challenges faced by their new immigrants. In this regard, some states to enforce LAS in their healthcare setting, take into consideration the numbers of the service seekers. Accordingly, in California every facility is required by law to provide LAS 24 hours a day for language groups that comprise at least 5% of the population it serves.[231] While in the case of DDA residents, Afaan Oromo speakers constitute 47.9% (163,920 people) of the total population, there are no LAS. Consequently, non-existence of LAS directly discriminated AOSPs in their country and birthplace.

3.9 Cost of Providing Interpretation vis-à-vis Positive Health Outcome

While there is a concern for the cost of hiring interpreters, the study in the USA showed that the annual cost of interpreters per patient was compensated by significant improvements in patients' services use, compliance and health outcomes.[232] Though, providing professional interpreters necessitate cost from the government, the evidence suggests that optimal communication, patient's satisfaction, and outcomes and the fewest interpretation errors occur when LLPPs have access to LAS.[233] For a fortiori reasons the cost of employing professional interpreters will be offset by improved quality of care and utilization of resources.[234]

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[228] Benjamin, cited above at note 225, p.73

[229] Schlemmer and Mash, cited above at note 50, p.1084

[230] The Constitution of the Republic of South Africa, No.108 of 1996 Section 30; Republic of South Africa Policy on Language Services for the National Department of Health, Pretoria: National Department of Health; 2011; and Western Cape Department of Health Language Policy, Cape Town: Provincial Government of the Western Cape: Department of Health; 2008

[231] Ouimet et al, cited above at note 102, p.25

[232] Zezula et al, cited above at note 3, p.224

[233] Flores, cited above at note 40, p.255

[234] Schlemmer and Mash, cited above at note 50, p.1087

Chapter Four

The Realization of the Right to Health of Limited Amharic Proficient Patients: The Case of Afaan Oromo Speaking Patients in Dire Dawa

"What the scalpel is to the surgeon, words are to the clinicians….the conversation between doctor and patient is the heart of the practice of medicine."[235]

Introduction

The right to health is a prerequisite for the right to life and an effective communication is a precondition for proper medical treatment. Since about 75%-80% treatments are based on the patient history and only 20%-25% treatment are conducted through physical examination and investigation,[236] clear communication is critical for the provision of safe, appropriate, and high-quality healthcare.[237] In the multi-lingual societies, more patients may prefer speaking their respective first language with their healthcare provider. Even, people who are generally comfortable speaking working language in their day-to-day life need to use their primary language in some circumstances, such as in an emergency or when discussing highly technical information.[238] In the case of DCH, majority of the providers (93.6%) speak Amharic and only a handful of providers (6.4%) speak Afaan Oromo as their first language, and although most of the patients can only speak Afaan Oromo. This problem is reinforced by non-existence of LAS for non-Amharic speaker- monolingual AOSPs. Since LAS is an effective way of addressing language barriers in clinical setting,[239]in the absence of adequate LAS, navigating the healthcare system with language barriers can be difficult, frustrating, and potentially detrimental to the quality of care[240] of non-Amharic speaking patients in general and of AOSPs in particular.

Whether the number of the accused persons are significant or not in a particular area, the FDRE Constitution grants the right to interpretation services at state expense where the court

[235] E Kale and B Kumar, Challenges in Healthcare in Multi-Ethnic Societies:"Communication as a Barrier to Achieving Health Equity."In Jay Maddock (eds.)Public Health-Social and Behavioral Health, (2012), p.298

[236] Interview with Doctor Daniel G/Egzaber G/Michael, Medical Services General Directorate Director General of FDRE Ministry of Health, on 10 October 2018; Doctor Alem W/Aregay Dubale, Medical General Practitioner in Dil Chora Hospiral, on 28 September 2018 and Doctor Dagmawi Eyob Mehrete, Medical Services Director in Dil Chora Hospiral, on 26 September 2018

[237] A Sultana et al, cited above at note 223, p.1

[238] Ibid

[239] Ibid

[240] Ibid

proceeding are conducted in a language accused persons do not understand.[241] The implicit assumption is that without interpretation, there would be a miscarriage of justice. The situation in the federal healthcare setting is such that medical interviews are generally conducted through Amharic which is second language for many patients and which many patients cannot speak at all. In other word, in the Ethiopian federal healthcare setting there is a monolingual healthcare service in a multilingual society. In the same fashion, a clear assumption that can be drawn here is that in the absence of LAS in the federal healthcare setting, particularly in DDA healthcare setting, there would be inappropriate treatment for significant patients-AOSPs due to the language barrier. This assumption is supported by various findings where the language barrier is taken as a primary challenge for non-speaker of the working language of a given country.[242]

The Ethiopian government has the obligation to fulfill the right to health of its citizens without language discrimination. Specifically, the obligation to fulfill requires Ethiopia to adopt appropriate legislative, administrative, budgetary and other measures[243] to fully realize the right to health of AOSPs. Accordingly, Ethiopia must adopt a national LAS policy to correct the gap created by the language barrier. The failure of Ethiopia to provide healthcare to those in need without language discrimination is tantamount to a violation of the right to health.[244] This chapter will, therefore, discuss legal, policy and administrative measures taken regarding health in general and LAS in particular. It will also deal with the consequences of the language barrier based on the data collected from the study area, the experience of all respondents, and on other countries experience. This chapter will wind up by discussing the remedies for the victim of the violation of the right to health due to language barrier.

[241] The Constitution of the Federal Democratic Republic of Ethiopia: A Proclamation to Pronounce the Coming in to Effect of the Constitution of the Federal Democratic Republic of Ethiopia, 1995, art.20 (7), Proc.No.1/1995, Fed. Neg. Gaz., year 1, No.1

[242] E Kale, and B Kumar, cited above at note 235, p.256

[243] Fact sheet 31, cited above at note 116, p.27

[244] ESCR Committee, General Comment No.14 Cited above at note 118, para.12 (b) cum paras.18 and 19

4.1. Legal, Policy and Administrative Measures: Healthcare and LAS in Healthcare Setting

4.1.1. Legal Measures

4.1.1.1. FDRE Constitution

The FDRE Constitution stipulated human rights as one of its five fundamental principles and declares that human rights and freedoms, emanating from the nature of mankind, are inviolable and inalienable[245]and that the human rights of citizens and peoples are respected.[246]Specifically, the Constitution stipulated that every Ethiopian national has the right to equal access to publicly funded social services.[247] It also imposed an obligation on the government to allocate ever increasing resources, so that all Ethiopians have access to public health.[248] To boost up the standards of the human rights of its people, Ethiopia has ratified core international treaties that recognized human rights including the right to health. To this end, the Constitution lay down that any international treaties ratified by Ethiopia are part and parcel of the law of Ethiopia.[249]The Constitution also guarantees that the fundamental rights and freedoms specified in the Constitution are to be interpreted in a manner conforming to the principles of the UDHR, international Covenants on Human Rights and international instruments adopted by Ethiopia.[250] That means when the need to interpret the Constitution is arisen, the international human rights treaties and UDHR will serve as inspirational standards to construe an ambiguous provisions of chapter three of the Constitution.

For instance, the ESCR Committee through its General Comment 14 asserted that for the full realization of the right to health, the healthcare settings must be accessible for everyone in law and in fact, without discrimination of any kind.[251] Furthermore, it interprets the right to health as it contains quality health facilities, goods and services which must be culturally acceptable[252] which for a fortiori reason include linguistic accessibility. Thus, as Ethiopia is party to ICESCR the above assertion of ESCR Committee is applicable to the Ethiopia's healthcare setting. In this

[245] FDRE Constitution, cited above at note 241, art.10(1)
[246] Id, art.10(2)
[247] Id, art.41(3)
[248] Id, arts.41 (4)
[249] Id, art.9(4)
[250] Id, art.13(2)
[251] ESCR Committee, General Comment No.14 Cited above at note 118, para.12(b)
[252] Id, para.12(d)

regard, a medical services general directorate director general of FDRE ministry of health underscored a medical treatment is ineffective without smooth communication between the providers and patients.[253]As substantiated by various findings and experiences of all respondents, an effective communication is an integral part of healthcare services. However, in the Ethiopia federal healthcare setting, Amharic is the only working language while there are multi-lingual societies with their respective first language and majority of DDA residents are limited Amharic proficient- AOSPs. Ipso facto of the above objective reality, the MoH were expected to pass LAS policy, so that the rights to health of all citizens will be implemented in an equal manner as guaranteed by international agreements, which is part of the FDRE Constitution. However, the reasons for not passing the LAS policy so far in the federal healthcare setting are, as one informant from MoH told the researcher,[254] attributed to a presumption that many people could speak Amharic and that the MoH gave priority to UHC, not to language accessibility as the language accessibility is an aspect of quality healthcare that came after the UHC are achieved.

It is a blatant failure on the part of MoH to conclude that the majority of the federal healthcares setting customers are proficient in Amharic; ipso facto they are the residents of the federal cities. The failures of the MoH could be expressed from two dimensions. Firstly, they did not take into account the healthcare need of the rural population who speak a different language other than Amharic. Though, many DDA urban kebele residents are not proficient in Amharic let alone the rural kebele residents. Secondly, MoH underestimated the number of non-Amharic speaking patients when they concluded that many customers of the federal healthcare setting could speak Amharic. This assertion is not based on scientific evidence or study.

Ethiopia had taken serious measures for the realization of the right to health of its people when it ratified the ICESCR which recognized the right to health; however, there was no constitutional commitment to fully implement the right to health of all citizens without language discrimination. Therefore, for proper implementation of the right to health, the government is expected to enact the enabling act regarding the LAS.

[253] Interview with Doctor Daniel G/Egzaber G/Michael, Medical Services General Directorate Director General of FDRE Ministry of Health, on 10 October 2018

[254] Interview with Doctor Ashenafi Beza Wasse, Director General Office Of the FDRE Ministry of Health, on 15 October 2018

4.1.2. Policies Measures

As mentioned in chapter two, section 2.2.3 of the thesis, the Ethiopian government has passed various high level intent health policies. Their applicability from the language aspect is discussed hereunder.

4.1.2.1. The National Health Policy of the Transitional Government of Ethiopia

The national health policy of the transitional government of Ethiopia (herein after NHPTGE) was initiated in 1993. This health policy was deemed to be the result of a critical examination of nature, magnitude and root causes of the prevailing health problem of the country.[255]This policy put appropriate emphasis on the needs of the less-privileged rural population which constitute the over-whelming majority of the population.[256]One of the general directions of this policy is the development of an equitable and acceptable standard of the health services system that will reach all segments of the population within the limits of resources and the assurance of accessibility of healthcare for all segments of the population.[257] The policy at hand put a stressed on the importance of having new rules and regulation to help in the implementation of the current policy and it also emphasized standardizing the human resources.[258] Since language is an observable obstacle for implementation of NHPTGE and for the realization of the right to health, the MoH shall develop a comprehensive LAS policy[259]to ensure the right to health of a multi-lingual society in equal footing.

For instance, for effective antiretroviral therapy (herein after ART) treatment of the HIV-positive patients, maintaining the patients' education is mandatory and to implement patients' education, it is a prerequisite to have an effective communication between the healthcare providers and the patients. Regarding this, Doctor Alem W/Aregay from DCH told the researcher that,[260] she has been facing a communication barrier when she used to treat AOSPs. She gave prominence to the importance of the patient's education to treat all patients, especially to treat HIV-positive patients. When patient's education is smoothly delivered, patients could understand the benefits and risks of non-adherence to medicines and able to take medicines every day and exactly as

[255] The preamble of National Health Policy of the Transitional Government of Ethiopia,1993
[256] Ibid
[257] Id, p.1
[258]Id, p.7
[259] Ethiopian National Healthcare Quality Strategy, cited above at note 147, p.70
[260] Doctor Alem W/Aregay Dubale, Medical General Practitioner in Dil Chora Hospiral, on 28 September 2018

prescribed. So in order to solve the communication barrier, she recommended a provision of professional interpreter.

Indeed, treating patients in the language they fully understand would result in two positive outcomes. First, teaching patients about the importance of adherence to the drugs and the side effect of non-adherence will help to gain the intended outcome of drugs. Otherwise poor adherence to taking medicines would increase the risk of drug resistance and treatment failure.[261] Secondly, the patients will take care of the transmission of the disease.

4.1.2.2. National Health Care Quality Strategy

National health care quality strategy (herein after NHCQS) builds on the plan laid out in the health sector transformation plan to further align key stakeholders across prioritized interventions that will drive large-scale improvement in the quality of care delivery over the next five years from 2016 to 2020. The ultimate aim of this strategy is improving the outcomes of clinical care, patient safety, and patients-centeredness, while increasing access, equity and dignity of care for all segments of the Ethiopian population by 2020.[262] This strategy while evaluating the challenges and opportunities of the healthcare system, considered the lack of trust due to inconsistency in provider-patient service interaction as a threat to the quality of healthcare system.[263]It also specifically indicated that language is one factor in defining who would access healthcare services.[264] To this end, all physicians interviewed, save one physician who is proficient in Afaan Oromo, two psychiatrists, head of DDHB, and Chief Executive Officer of DCH and Medical Services Director of DCH told the researcher that:[265] "*Due to the language barrier the quality of the healthcare services delivered by DCH has been affected."*

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[261] HIV Treatment: The Basic Understanding HIV/AIDS, AIDSinfo, https://aidsinfo.nih.gov/undertanding-hiv-aids/fact-sheets/21/51/hiv-treatment-the-basics last visited on October 26, 2018

[262] The preamble of Ethiopian National Healthcare Quality Strategy; cited above at note 147, p. IV

[263] Id,p.67

[264] Id,p.72

[265] Interview with Doctor Victoria Diribsa Gelmesa, Medical General Practitioner in Dil Chora Hospiral, on 3 October 2018; Doctor Bethelem Getahun Abebe, Medical General Practitioner in Dil Chora Hospiral, on 4 October 2018; Doctor Dereje Ayalew Asmare, Medical General Practitioner in Dil Chora Hospiral, on 4 October 2018; Doctor X (he has requested for anonymity), Medical General Practitioner in Dil Chora Hospiral, on 5October 2018;Doctor Alem W/Aregay Dubale, Medical General Practitioner in Dil Chora Hospiral, on 28 September 2018; Psychiatrist Abel Mamo Kafani and Psychiatrist Henok Nega Kifle Professional Psychiatrists Medical General Practitioner in Dil Chora Hospiral, on 26 September 2018; Doctor Faud Kadir Hassan, Head of Dire Dawa Health

From the above analysis, it is palatable to draw the conclusion that all these health policies cannot be implemented unless the language barrier is coped with.

4.1.3. Administrative Measures

4.1.3.1. Health Sector Transformation Plan

The Ethiopian government has developed the health sector transformation plan (herein after HSTP) that meant to run from 2015/16-2019/20. HSTP is the first phase of a 20-year plan titled, 'envisioning Ethiopia's path to universal healthcare through strengthening of primary healthcare'.[266] HSTP has mention the health service delivery, and quality improvement and assurance as the health sector strategic pillars.[267]For instance, the first pillar suggests that the healthcare services shall directly and permanently be accessible with no undue barriers of language, culture, geography or any other factor.[268]

4.1.3.2. Growth and Transformation Plans

Growth and transformation plan I (herein after GTP I) was aimed to achieve 100% primary health services coverage,[269]through the health extension program.[270] GTP I aimed to improve access to, and quality of health services.[271] Based on the result of GTP I evaluation, health coverage has reached 94% which nearly conforms to millennium developments goals (herein after MDGs) target.[272] As an extension of GTP I, the growth and transformation plan II (herein after GTP II) is expected to run from 2015/16 to 2019/20. Under GTP II, health services coverage is expected to reach 100% by the end of 2019/20.[273]The main objective of the GTP II

Bureau, on 1October 2018;Muhedin Redi Beshir, Chief Executive Officer, Dil Chora Hospital, on 8 October, 2018; Doctor Dagmawi Eyob Mehrete, Medical Services Director in Dil Chora Hospiral, on 26 September 2018.Among eight physicians interviewed, Doctor Tesfaye Motara Bulto, Medical General Practitioner in Dil Chora Hospital, is the only physician proficient in Afaan Oromo,25 September 2018

[266] Admasu, cited above at note 143, p.69

[267] Id, p.75

[268] Id, p.76

[269] Ethiopia Growth and Transformation Plan I, Ministry of Finance and Economic Development (2010/11-2014/15),Addis Ababa, Ethiopia,(2010), p.18

[270] Id, p.55

[271] Id, p.56

[272] Ethiopia Growth and Transformation Plan II, National Planning Commission (2015/16-2019/20), Addis Ababa, Ethiopia, Vol.1 (2016), p.73

[273] Id, p.97

regarding the health sector is to improve the health outcomes of citizens through provision of equitable, accessible and quality health services.[274]

The MoH has given priority to coverage, not to the language accessibility. According to one respondent from the MoH, the language accessibility is an aspect of quality that came after the UHC are achieved.[275] Though, pursuant to the priority set by the MoH the language access was considered as a secondary issue that could come after the UHC is achieved, because the health coverage has already reached 94% during GTP I and the period for implementation of HSTP and GTP II is the same (i.e. 2015/16-2019/20), now the language accessibility must be considered as primary issue and the government is expected to pass the LAS policy to fully implement GTP II and HSTP.

4.1.3.3. National Human Rights Action Plan

The concept of national human rights action plan (herein after NHRAP) was first developed as part of the second world conference on human rights held in Vienna in 1993, which culminated in the adoption of the Vienna declaration and programm of action (herein after VDPA).[276] This document was later endorsed by the united nations general assembly and recommended in part 11, paragraph 71 that each state "shall consider the desirability of drawing up a NHRAP identifying steps whereby that State would improve the promotion and protection of rights."[277]Hence, it is believed that the preparation of a NHRAP will prove to be a very good opportunity for the nation to implement its international commitments in this regard.[278]The preparation of the document assumed the political commitment to draw policies and programs, and effective budgetary allocation to advance the promotion and respect for human rights, particularly to provide health services.[279]

One of the recommendations of the universal periodic review accepted by Ethiopia was the necessity to prepare a NHRAP.[280]The NHRAP could play an internationally recognized role to

[274] Id,p.190

[275] Interview with Doctor Ashenafi Beza Wasse, Director General Office Of the FDRE Ministry of Health, on 15 October 2018

[276] Ethiopia National Human Rights Action Plan (2013-2015), Addis Ababa, Ethiopia (2013), p.1

[277] Id, p.2

[278] Ibid

[279] Ibid

[280] Id, p.2

respect, protect, and fulfill human rights at a national level in a structured and comprehensive manner.[281] Accordingly, the Ethiopian government prepared the NHRAP in 2011 to enforce the realization of the human rights in a comprehensive and structured manner.[282] Among the minimum conditions stipulated in relation to the right to health to be included in the policies and programmes is the principle of non-discrimination in the provision of health care[283]and it is proven, during the national consultative workshop regarding the proper implementation of human rights including the right to health,[284] that one of the main challenges in the healthcare setting is the problem of accessibility and quality.[285] Hence, the government shall pass LAS policy as part of the NHRAP, to ensure equality among its people and thereby avoid discrimination.

4.2. Elements of the right to health

The right to health in all its forms and at all levels contains the following interrelated and essential elements,[286] the precise application of which will depend on the conditions prevailing in a particular State party. These elements are: availability, accessibility, acceptability and quality.

4.2.1. Availability

Effective public healthcare facilities, goods and services must be available in sufficient quantity within a State,[287] which includes adequate number of medical and other trained professionals to provide healthcare services.[288]The mere existence of the physical infrastructures is worthless if there are no enough skilled healthcare providers including professional interpreters. Consequently, until the bilingual healthcare providers are assigned in the manner that complies with the providers to patients' ratio, particularly for AOSPs there has to be professional interpreters so that the healthcare procedures are conducted without communication barrier.

[281] Id, p.1
[282] Ibid
[283] Id, p.86
[284] Id, p.5
[285] Id, p.89
[286] ESCR Committee, General Comment No.14 cited above at note 118, para.12
[287] Id, para.12(a)
[288] Ibid

One respondent from MoH has described the ramifications of the language barrier and non-existence of professional interpreters in the federal healthcare setting.[289] According to him, communicating with patients in the language they could understand is mandatory to deliver successful treatments. However, if the healthcare providers could not smoothly communicate with patients, it is impossible to collect patient's specific data and to deliver patients educations, which are the core aspects of the treatments. For him, unless the language barrier is solved, the treatments may end with misdiagnosis. This assertion led him to conclude that, if there is no effective communication there would not be effective medical treatment.

4.2.2. Accessibility

State party to ICESCR shall make accessible health facilities, goods and services to everyone within their jurisdiction, without discrimination.[290] Accessibility has four dimensions in itself.[291]These are: non-discrimination, physical accessibility, and affordability and information accessibility.

4.2.2.1. Non-Discrimination

Since ensuring non-discrimination is an immediate obligation of State party,[292]the ICESCR obliges Ethiopia to implement the rights enunciated in the covenant without discrimination of any kind,[293] including language. In order for Ethiopia to ensure the rights recognized by ICESCR without discrimination of any kind, discrimination must be eliminated both formally and substantively.[294] In this respect, patients told the researcher that,[295]physicians turn to treat those who are fluent in the working language, until they get ad hoc interpreters, which led them to consider themselves as inferior to those patients who are proficient in Amharic. In another

[289] Interview with Doctor Daniel G/Egzaber G/Michael, Medical Services General Directorate Director General of FDRE Ministry of Health, on 10 October 2018.
[290] ESCR Committee, General Comment No.14 cited above at note 118, para.12(b)
[291] Ibid
[292] The UN Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No.20: Non-discrimination in economic, social and cultural rights (Art. 2, para.2 of the Covenant) U.N.Doc, E/C.12/GC/20 (2July, 2009), para.7
[293] ICESCR, cited above at note 120, art.2(2)
[294] ESCR Committee, General Comment No.20 cited above at note 292, para.8
[295] Interviewed with Fatuma Musa Kadir, patient from Dil Chora Hospital, on 25 September, 2018; Nuria Mohmed Ame, patient from Dil Chora Hospital, on 27 September, 2018 and Kalifa Abdula Yusuf, patient from Dil Chora Hospital, on 28 September, 2018

scenario, patients told the researcher that[296] physicians did not tell them the causes of their illness, what to do and not, rather they simple put the prescription papers on their bed and left them without any explanations.

Hence, discrimination in practice should be eliminated so that AOSPs could enjoy the right to health. Accordingly, they must get treatment via the language they could understand.

4.2.2.2. Physical accessibility

As every citizen of the country is equal, the health facilities, goods and services must be within safe physical reach for all sections of the population, especially for marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, an older person, persons with disabilities and persons with HIV/AIDS.[297] Accessibility also includes adequate access to building for persons with disabilities.[298]

The paragraph 12(b) sub-paragraph 3 of General comment 14 stipulated that accessibility implies that medical services and underlying determinants of health are within safe physical reach, including in rural areas. It further indicated that accessibility shall include adequate access to buildings for persons with disabilities. A closer look at the wording of this paragraph shows that there are two important things. One is the fact that physical accessibility implies the availability of the healthcare institutions in sufficient number both in rural and urban areas. The second thing is that, the committee gives emphasis to the accessibility of physical infrastructure for a person with disability. Regarding the second issue, DCH is in a better position in terms of physical access for persons with disability. Though, there are no sign language interpreters for a deaf patient.

4.2.2.3. Affordability

There is lack of access to basic healthcare facilities in Ethiopian rural areas.[299] Consequently, the majority of the rural residents' healthcare needs have been covered by the nearby towns or cities'

[296] Interview with Shamro Yasin Ali, patient from Dil Chora Hospital, on 30 September, 2018 and Momina Ali Ahmed, patient from Dil Chora Hospital, on 26 September, 2018

[297] ESCR Committee, General Comment No.14 cited above at note 118, para.12(b)

[298] Ibid

[299] Ethiopia Health Insurance/Healthcare System-Globalsurance, https://www.globalsurance.com/health-insurance/ethiopia/ last visited on November 9, 2018.

hospitals. For instance, DCH serves a population of approximately 5 million coming from Dire Dawa, and neighboring Oromia and Somali regions.[300] Thus, as the healthcare setting must be affordable for all,[301] payment for healthcare services has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all.[302]For example, the average annual gross income of all 28 interviewed AOSP household from DCH is only 4926 birr (four thousand nine hundreds twenty six birr).This could imply that, they have no economic capacity to afford for private hospitals. As a result, the government should make public hospitals (economically) accessible for disadvantaged sections of the people including poor AOSPs coming from both urban and rural areas.

4.2.2.4. Information accessibility

The right to healthcare information accessibility includes the right to seek, receive and impart information and ideas concerning health issues which are important aspects of healthcare services. [303] Despite the importance of the information in healthcare setting, patients are embarrassed since they do not have access to information. For instance, two patients have told the researcher that,[304] even though, they requested physicians to let them know the kind of the disease for which they were to admitted to the hospital, a physician did not explain the causes of the disease due to the language barrier. In the same manner, a pharmacist told the researcher that,[305]he is working in the emergency department's pharmacy- a place where urgent services with smooth communication are mandatory. Besides, many customers are monolingual AOSPs, which restricted him from telling the patients how and when to take the drugs as he speaks only Amharic and there is no interpreter in the pharmacy.

[300] U.S. Government Inaugurates New Outpatient Department at Dil Chora Hosptial, cited at above note 18
[301] ESCR Committee, General Comment No.14 cited above at note 118, para.12 (b)
[302] Ibid
[303] Ibid
[304]Interview with Hindisar Abdukarim Ibro, patient from Dil Chora Hospital, on 30 September, 2018 and Abrahim Abdi Kamil, patient from Dil Chora Hospital, on 26 September, 2018
[305]Interview with Tameru Mulatu Zeke, Pharmacist in Dil Chora Hospital, on 2 October 2018
There are two pharmacies in Dil Chora Hospital; one is; general pharmacy that gives services for all patients including those coming from private clinics and hospitals, and the second is serving patients from the emergency department.

4.2.3. Acceptability

All health facilities, goods and services must be in line with medical ethics and culturally appropriate and shall also respect confidentiality of the patients.[306] One of the medical ethics is not to discriminate the patients based on the language disparity rather respect the dignity of patients, and shall have sympathetic, friendly and helpful attitudes.[307] In this regard, a patient has told the researcher that,[308]the physician has disregarded his concern by waving his hand to show that he cannot understand Afaan Oromo and gave him the prescription paper without explaining his disease.

4.2.4. Quality of Services

Healthcare facilities, goods, and services must be scientifically and medically appropriate and of good quality.[309] This requires, *inter alia*, skilled medical and other personnel, scientifically approved and appropriates hospital equipment and other services.[310]It is important to analyze quality dimensions of healthcare services of DCH from the language access aspect hereunder.

4.3. Quality of the Healthcare and Language Barrier

In the Ethiopia context, taking the definition given by IOM and Ethiopian national priorities into consideration, NHCQS define quality of healthcare as "a comprehensive care that is measurably safe, effective, patient-centered, and uniformly delivered in a timely, and appropriately utilizes resources and services efficiently.[311]As laid out by HSTP and US IOM, and the elements derived from the definition given by NHCQS, there are six generally accepted dimensions of quality. These are effectiveness, efficiency, equity, patient-centered, safety, and timely.

4.3.1. Effectiveness

Effectiveness implies that the healthcare institution shall provide services that are based on scientific knowledge to all who seek services.[312] The healthcare institution shall deliver healthcare that is adherent to an evidence base and results in improving health outcomes for

[306] ESCR Committee, General Comment No.14 cited above at note 118, para.12 (c)
[307] Art. 2 and 4 of Medical Ethics For Doctors In Ethiopia, Ethiopian Medical Association April, 2010
[308]Interview with Jamal Ame Usman, patient from Dil Chora Hospital, on 28 September, 2018
[309] ESCR Committee, General Comment No.14 cited above at note 118, para.12 (d)
[310]Ibid
[311] Ethiopian National Healthcare Quality Strategy, cited above at note 147
[312] Id, p.12

individuals and communities, based on their need.[313] Though the government shows strong commitment in terms of formulating healthcare quality strategies and plans, it is short of details in describing and ensuring every aspect of the right to health of the patients including the language access.

The researcher has conducted three focus group discussions each of which has five respondents. During discussion sessions all group's members/patients told the researcher that;[314] there is a clear discrepancy between their healthcare needs and the delivered services in the study area due to a communication problem. They unanimously asserted that the healthcare providers had neglected their pains and problems due to the language barrier.

The chief executive officer of DCH has described the scenario around the language barrier and an attempt put in place to solve it.[315] Since the majority of the Hospital customers are AOSPs, many physicians brought a grievance regarding the language barrier and they are very dissatisfied with the services they provide for those patient. To mitigate the challenges of the language barrier, the hospital tried to assign Hospital's runners to help the healthcare providers in mitigating the language barrier and now four of them are upgrade to ad hoc interpreters. He further told the researcher that the Hospital requested the Dire Dawa administration public service and human resource development bureau to assign additional ad hoc interpreters, but did not get an affirmative answer.

In this regard, key respondent from the Dire Dawa administration public service and human resource development bureau told the researcher that,[316] they have already upgraded four hospital runners to ad hoc interpreters as the majority of the hospital customers are AOSPs. He recommended two means to solve the language barrier in the hospital. First, he recommended the importance of having enabling act on LAS, which empowers them to assign professional interpreters. Secondly, he asserted that the MoH shall deploy bilingual healthcare providers as much as possible. In this regard, he has shared his experience where MoH assigned a public

[313] Admasu, cited above at note 143, p.78

[314] Interview with respondents from all three focus group discussions: For details information as to interviewees (patients) see bibliography page xxi

[315] Interviewd with Ato Muhedin Redi Beshir, Chief Executive Officer of Dil Chora Hospital, on 8 October, 2018.

[316] Interviewd with Ato Seyfedin Abdurehman Salih, the Dire Dawa Administration public service and human resource development bureau Deputy Head, on 10 October, 2018.

health officer who cannot speak a single Afaan oromo word, and with limited Amharic proficiency and proficient in Tigrigna for Jaldesa rural kebele healthcare center of DDA

In spite of the fact that many healthcare providers cannot speak Afaan Oromo, some patients have recognized the existence of the Afaan Oromo speaking healthcare providers in DCH. Furthermore, there is an attempt to mitigate the problem by assigning the runners to interpretation work.

4.3.2. Efficiency

Efficient element of quality healthcare suggests the proper utilization of resources, which means the health care institution, ought to avoid waste of resources.[317]The services delivery must be in a manner which maximizes resource use and skills are appropriate to medical need.[318]Despite this quality strategy plan, there is a shortage of the mechanism to implement this strategy into practical use of drugs supplies, healthcare providers' energy and other hospital scarce resources, because in a setting where there is shortage of skilled interpreters, it would challenge the providers to treat patients by asking their medical history, to give patients education and to prescribe the exact drugs.

When asked whether there is the ramification of the language barrier on both the patients and the hospital, the chief executive officer of DCH has shared one scenario where the language barrier caused unfounded grievance by the patient against the physician. In that scenario[319] the patient could not understand Amharic and the physician could not speak the language of that patient. As part of the medical treatment, the physician decided to examine the patient's sexual organ. When he started to touch the patient's sexual organ for treatment, she restricted him to touch her. Consequently, the patient brought a grievance to the hospital chief executive office that the physician has tried to sexually abuse her. However, when the case was investigated, the fact was that there was misunderstanding on the part of the patient caused by communication gap between her and the physician.

[317] Ethiopian National Healthcare Quality Strategy, cited above at note 147, p.13
[318] Admasu, cited above at note 143, p.78
[319] Interviewd with Ato Muhedin Redi Beshir, Chief Executive Officer of Dil Chora Hospital, on 8 October, 2018

Therefore, had the physician properly told the patient that examining her sexual organ was mandatory and part of the medical treatment in the language she would have been able to understand or had the patient understood the explanation made by the physician via Amharic, such problem would not have been materialized. The objective reality is that such problem would cause waste of a physician's and hospital's time.

4.3.3. Equity

HSTP suggests that the health system should seek to make improvements in equity, which means delivering healthcare which does not vary in quality because of personal characteristics such as gender, ethnicity, geographical location, or socioeconomic status.[320]Thus, equity is the absence of avoidable differences among groups with the objective of reducing disparities among them.[321]Equity in healthcare has the following important three elements.[322] These are; equal access, equal utilization of equal need and equal quality of care for all.

4.3.3.1. Equal Access

Equal access to health services implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on healthcare needs and ease of access in each geographical area and the removal of other barriers to access including language.[323] However, the realities in the study area are far from the goal of HSTP because the working language is only Amharic while the customers of the hospital are multi-lingual and the majority is being limited Amharic proficient-AOSPs. This discrepancy is highly rampant by the huge ratio gap between Afaan Oromo speaking physician and the AOSPs. For instance amongst 47 physicians in the Hospital, only 3 physicians are proficient in Afaan Oromo while 70-75% hospital's customers are AOSPs. In this regard, the head of human resource directorate director of DCH told the researcher that,[324] due to the language barrier many physicians were requesting for the deployment of interpreters. For instance, she mentioned a recent grievance from one physician (ophthalmologist) that he would not be responsible would error happen due to

[320] Admasu, cited above at note 143, p.78
[321] Id, p.87
[322] Id,p.112
[323] Ibid
[324] Interview with W/ro Azeb Tessfaye Ateker, Head of Human Resource Directorate Director, Dil Chora Hospital, on19 October, 2018

miscommunication. In this regard, two patients told the researcher that,[325] they have been admitted to the hospital's ward, one for diabetic treatment and stayed for eight days while the other patient was admitted for broken leg treatment and stayed for one month and five days. They have been ordered by the physicians to find ad hoc interpreters. There were a days when the physicians left a ward after they found ad hoc interpreters because it took a while to find volunteer interpreters.

Several literatures on the language barrier categorically indicate ad hoc interpreters have a tendency to omitt 23 to 52% of the questions asked by physicians and 80 words in the 143 questions and answers by patients and physicians were mistranslated, misunderstood, or not translated.[326]These literatures further demonstrated the fact that use of untrained interpreters can result in a breach of patient confidentiality.[327]Furthermore, these literatures hit upon the fact that the patients' children who interpreted were embarrassed by, and tended to ignore questions about menstruation and other sensitive issues such as sexual practices.[328]

4.3.3.2. Equal Utilization of Equal Need

Equal utilization of equal need refers to a planned intervention to redress differences in the rates of utilization of essential services by different segments of the population.[329] For proper utilization of healthcare services, the health institution shall be physically accessible to patients with disability and it shall equally be accessible to patients coming from rural areas and with limited working language of the study area. To this end, the researcher has observed one patient cried while her husband was running here and there.[330]Then the researcher with the intention to help asked her why she cried. She told the researcher that the healthcare providers are unwilling to render the services she need.

Though, she attributed the challenges to the healthcare provider's unwillingness and negligence, the researcher found out that the problem was directly associated with communication barrier.

[325] Interview with Fatuma Musa Kadir, patient from Dil Chora Hospital, on 25 September, 2018 and Nuria Mohmed Ame, patient from Dil Chora Hospital, on 27 September, 2018

[326] Flores, cited above at note 40, p.269

[327] Perkins, cited above at note 95, p.39

[328] Flores, cited above at note 40, p.269

[329] Admasu, cited above at note 143, p.112

[330]Interview with Alfiya Abdulkarim Hassen,patient from Dil Chora Hospital, 26 September, 2018 and Nasru Jawar Ahmed, patient's husband from Dil Chora Hospital, on 26 September, 2018.

That is service provider in one service point did not told them where they were supposed to go. This problem was aggravated by the patient and her husband inability to read written post or direction written in Amharic and English posted at each service point. It is equally important to note that there are many patients, especially from rural areas who are illiterate even in their own first language let alone Amharic.

4.3.3.3. Equal Quality of Care for All

Equal quality of care requires that every Ethiopian has an equal opportunity of accessing health services based on need rather than social factors.[331]It also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community so that everyone can expect the same standard of professional care.[332] As stated by the head of DDHB,[333] the language barrier has curtailed him to render quality healthcare services. To this end, he said that during the time he served as the physician he faced a communication challenge and was hindered to treat the majority of the hospital's customers – AOSPs.

4.3.4. Patient-centered

When we say patient-centered services, it is to say that the delivering healthcare shall take into account the preferences and aspirations of individual service users.[334]Accordingly, the healthcare institution shall provide care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions.[335]

All literatures recommended that the healthcare services should be rendered in the language of the patients, or through professional interpreter. For instance, all 28 interviewed patients[336] through personal interview and all 15 patients interviewed[337] during a focus group discussion testify that there is a discrepancy between their healthcare needs and the delivered services in the study area due to a communication problem.

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[331] Admasu, cited above at note 143, p.112

[332] Ibid

[333] Interview with Doctor Faud Kadir Hassan, Head of Dire Dawa Health Bureau, on 1 October, 2018.

[334] Admasu, cited above at note 143, p.78

[335] Ethiopian National Healthcare Quality Strategy, cited above at note 147, p.12

[336] Interview with twenty eight patients via personal interview: For details information as to interviewees see bibliography page xix

[337] Interview with respondents from all three focus group discussions: For details information as to interviewees see bibliography page xxi

4.3.5. Safety

The WHO defines patients safety as the prevention of errors and adverse effects to patients associated with healthcare.[338]Accordingly, safe healthcare services refer to the circumstances whereby the delivering healthcare is expected to minimize risks to service users.[339] One patient's husband[340] has described the consequence of language barrier, which resulted in a serious risk to his wife body. His wife has been admitted twice for the reason they did not know since the physicians had not informed them the cause of disease. After the first admission the patient was discharged with drugs prescription, then after a while his wife's skin was detached from most of her body part. The husband brought this within a plastic bag to show it to the physician. The physician then told them that the patient had taken overdose drugs.

Since avoiding injuries to patients is one aspect of the quality healthcare services, the pharmacists should clearly tell the patients to adherent to the recommended prescription, regarding how many tablets, when and between what interval the patients shall take the drugs. They should also tell what to eat or drink or not so, to avoid unnecessary drugs reaction. To this end, bilingual pharmacists or professional interpreters are mandatory.

4.3.6. Timely

In order to make the healthcare services delivery sophisticated, the right care shall be given at the right time, to reduce or avoid delays.[341]As cited by Perkins, Mark Hagland found that language difference caused treatment of non-proficient patients to take 25 to 50% longer than treatment of proficient patients.[342]Rendering healthcare services on time would reduce waits and harmful delays for both those who receive and those who give care.[343]Psychiatrist from DCH[344] has mentioned the scenario where due to the language barrier the treatment has been delayed. That is in the course of treating patients, due to language barrier he was obliged to give priority to other patients so as to utilize the scarce time, despite the fact that AOSP was in the front of queues.

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[338] Patient Safety www.euro.who.int/en/health-topics/health-systems/patient-safety, last visited on 6 November, 2018.

[339] Admasu, cited above at note 143, p. 78

[340] Interview with Kalifa Abdula Yusuf, patient's husband from Dil Chora Hospital, on 28 September, 2018

[341] Admasu, cited above at note 143, p.78

[342] Perkins, cited above at note 95

[343] Ethiopian National Healthcare Quality Strategy, cited above at note 147, p.12

[344] Interview with Abel Mamo Kafani, Professional Psychiatrists General Practitioner in Dil Chora Hospiral, on 26 September 2018

Then after he has treated all patients, he got one volunteer from amongst the hospital's staff to help as an interpreter. One of the concerns raised by the patient to the psychiatrist was why he did not treat her first.

4.4. Consequence of the Language Barrier and Quality Healthcare

For every aspect of life, communication is a primary instrument to interact with others. Hence, smooth communication between the healthcare providers and the patients is of paramount important for effective utilization of the healthcare services. So it is inevitable that lack of effective communication would result in poor health outcome including disability[345] and other medical errors.[346]More specifically, Kale and Kumar, summarizing the works of Jacobs et al., have demonstrated that LLPPs are more likely than their proficient counterparts to experience adverse events resulting in harm.[347] In this regard, various adverse events will be analyzed hereunder in nexus with data collected from DCH. To this end, the following table has summarized the experiences and perspectives of the healthcare providers regarding the quality healthcare dimensions from communication aspect while they used to serve AOSPs.

[345] Lopez, cited above at note 1, p.7; see also Wang, cited above at note 21
[346] Flores et al., cited above at note 64, p.9
[347] Kale and Kumar, cited above at note 235, p.302

Multivariate data from Healthcare providers in DCH (6 physicians, 2 psychiatrists, 4 public health officers, 4 nurses and 3 pharmacists) regarding the following dimensions of quality healthcare from communication aspect while they serve AOSPs						
Did language barrier caused		**Healthcare Providers**	**Yes/ No**	**No.of Providers**	**%**	**Reasons**
1	**Misunderstandings**	**Physicians**	Yes	5	83.3	They could not understand Afaan Oromo and there is no interpreter
			No	1	16.7	Fluent in Afaan Oromo
		Psychiatrists	Yes	2	100	One is not fully fluent in Afaan Oromo and the other could not understand Afaan Oromo at all
			No	0	0	
		Public Health Officers	Yes	3	75	They could not understand Afaan Oromo and there is no interpreter
			No	1	25	There is one ad hoc interpreter
		Nurses	Yes	4	100	Two of them could understand certain words and the rest cannot understand Afaan Oromo at all
			No	0	0	
		Pharmacists	Yes	2	66.6	They could not understand Afaan Oromo and there is no interpreter
			No	1	33.3	There is one ad hoc interpreter
		Average	Yes	16 of 19	**85%**	
			No	3 of 19	**15%**	
2	**Problem in gathering Patient's history**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Public Health Officers	Yes	3	75	
			No	1	25	
		Average	Yes	10 of 12	**86%**	
			No	2 of 12	**14%**	
3	**Problems with giving preventive health information and in getting informed consent**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Average	Yes	5 of 6	**83.3%**	
			No	1 of 6	**16.7%**	
4	**Difficulties with involving patients in their treatment and decision making**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Public Health Officers	Yes	3	75	
			No	1	25	
		Nurses	Yes	4	100	
			No	0	0	
		Pharmacists	Yes	2	66.6	
			No	1	33.3	
		Average	Yes	16 of 19	**85%**	
			No	3 of 19	**15%**	
5	**Increased risk of misdiagnosis**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Average	Yes	7 of 8	**91.7%**	
			No	1 of 8	**8.3%**	

6	**Inappropriate treatment or lack of treatment**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Public Health Officers	Yes	3	75	
			No	1	25	
		Nurses	Yes	4	100	
			No	0	0	
		Pharmacists	Yes	2	66.6	
			No	1	33.3	
		Average	Yes	16 of 19	**85%**	
			No	3 of 19	**15%**	
7	**Increased use of unnecessary diagnostic resources**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Average	Yes	7 of 8	**91.7%**	
			No	1 of 8	**8.3%**	
8	**Non Compliance**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Public Health Officers	Yes	3	75	
			No	1	25	
		Nurses	Yes	4	100	
			No	0	0	
		Pharmacists	Yes	2	66.6	
			No	1	33.3	
		Average	Yes	16 of 19	**85%**	
			No	3 of 19	**15%**	
9	**Frustration and less satisfaction**	**Physicians**	Yes	5	83.3	
			No	1	16.7	
		Psychiatrists	Yes	2	100	
			No	0	0	
		Public Health Officers	Yes	3	75	
			No	1	25	
		Nurses	Yes	4	100	
			No	0	0	
		Pharmacists	Yes	2	66.6	
			No	1	33.3	
		Average	Yes	16 of 19	**85%**	
			No	3 of 19	**15%**	

Source: Data collected from healthcare providers

Note that: The reasons the healthcare providers gave regarding variables two up to nine were similar to the reason given for variable one (misunderstanding). Consequently, the reasons given under variables one is equally applicable to the variable two up to variable nine.

4.4.1. Misunderstandings

Carrasquillo et al., found that non-working language speaking patients reported more problems with care including a discussion of causes of a medical condition, understanding discharge instructions, and explanation of reasons for diagnostic testing and their result.[348] In this regard, 85% of the healthcare providers from DCH were asserted that there is misunderstanding resulted from the language barrier when they treated AOSPs. Particularly one nurse[349] described the intensity of the communication problem by referring to one congestive heart failure outpatient, who was treated by a physician at time. She was in a serious health risk because she had given up taking the medicine which was supposed to be taken life long, assuming that she was cured. Had education on diabetics been given in the language she could understood, she would not given up the medicine and face such serious health problem. Whereas 15% of the healthcare providers were underscored that there was no communication problem between them and AOSPs, because of two reasons. The first is due to the existence of some ad hoc interpreters and the second reason is because of the fact that some of them are proficient in Afaan Oromo.

4.4.2. Problem in gathering Patient's history

A true patient medical history provides a foundation for patient diagnosis and treatment.[350] Patient history is also one of the key drivers of precision medicine.[351] In this regard, studies have indicated that over 80% of diagnoses in general medical clinics are based on the medical history, a further 5-10% on examination and the remainder on investigation.[352]Though taking patient history is primary tool to treat patients, 86% of the healthcare providers from DCH were challenged to gather patient's history due to the language barrier when they treat AOSPs. Whereas 14% of the healthcare provider has underscored that there was no communication challenge in gathering patient's history.

[348] Carrasquillo et al, cited above at note 92, p.85

[349] Interview with Getachew Bogale Gudata, Nurse in Dil Chora Hospiral, on 25 September 2018.

[350] Knowing starts with the patient history, www. questprimaryinsights.com/patienthistory/last visited on December 24,2018

[351] Ibid

[352] History and Physical Examination, 22https://patient.info/doctor/history-and-physical-examination last visited on December 24, 2018

4.4.3. Problems with giving preventive health information and in getting informed consent

Ngo-Metzger et al., have found that limited working language proficient patients with language-discordant providers were less likely to receive health education compared to those with language-concordant providers.[353] 83.3% of the physicians were underscored that giving patient education and securing informed consent of patients were impossible in the existence of language barrier. One physician asserted that,[354] in the existence of the language barrier giving diabetic care education is impossible and that some of the amputation cases would not have been happened had the diabetic care education been properly given to the patients. 16.7% of the healthcare provider was underscored that there was no communication challenge.

4.4.4. Difficulties with involving patients in their treatment and decision making

Flores has found that the patients' understanding of diagnosis and treatment significantly got worse when there is the language barrier and interpreters were needed but not used.[355] From the study area, 85% of the healthcare providers were asserted that there was difficulty to enable the AOSPs to participate in their treatment due to language barrier. Particularly, one physician[356] discussed the challenges of enabling the patient to participate in the treatment procedures. Since giving patient education is one of the treatment aspects and making the diabetic patients part of treatment is mandatory, as they are supposed to inject themselves insulin injection in their home, in the existence of the language barrier, it is very difficult to tell them how they could take the injection, which would result in risk, because if patients take injection on the same part of their body repeatedly, infection would be inevitable. Whereas 15% of the healthcare providers were underscored that they did not encounter difficulty in communicating with AOSPs.

[353] Ngo-Metzger et al, cited above at note 97, p.327

[354] Interview with Doctor Alem W/Aregay Dubale, Medical General Practitioner in Dil Chora Hospiral, on 28 September 2018

[355] Flores, cited above at note 40, p.259

[356] Interview with Doctor Victoria Diribsa Gelmesa, Medical General Practitioner in Dil Chora Hospiral, on 3 October 2018

4.4.5. Increased risk of misdiagnosis

Diamond and Jacobs, has found out that having limited working language proficiency is a risk factor of health disparities, that result in an increased risk of medical errors and misdiagnoses.[357] From DCH, 91.7% of the healthcare providers were stressed that there were high risks of misdiagnosis due to language barrier when they treated AOSPs. Regarding this, one physician from DCH and one respondent from MoH have shared the same perspective.[358] In their opinion, the problems of misdiagnosis are not solely related to a communication problem rather language barrier is a leading factor for poor diagnosis since managing patient cases is difficult unless detailed patient's history is gathered through the language they could understand. Whereas 8.3% of the healthcare providers were underscored that they did not faced communication barrier.

4.4.6. Inappropriate treatment or lack of treatment

Divi et al., revealed that the inability to communicate with a provider decreases the likelihood that patients will receive appropriate follow-up.[359] Regarding lack of treatment, 85% of the healthcare providers from DCH were asserted that there were possibilities of rendering inappropriate treatment as a result of language barrier when they treated AOSPs. To this end, the then physician, now the head of DDHB told the researcher,[360] a scenario where due to language barrier, the mother of the child patient gave hydrogen peroxide through mouth, instead of the physician's instructions to drop it in the child ear with strong pressure in order to remove over accumulated wax from the child ear. Whereas 15% of the healthcare providers were underscored that they did not faced language barrier.

4.4.7. Increased use of unnecessary diagnostic resources

Yeo, and Ferguson and Candib have demostrated that the language barriers are associated with more lab tests and more emergency room visits.[361] From DCH, 91.7% of the healthcare providers were underscored that there were possibilities of using unnecessary diagnostic resources due to language barrier when they used to treat AOSPs. For instance, Doctor Victoria from DCH has

[357] Diamond and Jacobs, cited above at note 77, p.189

[358] Interview with Doctor Bethelem Getahun Abebe, Medical General Practitioner in Dil Chora Hospiral, on 4 October 2018; and Doctor Daniel G/Egzaber G/Michael, Medical Services General Directorate Director General of FDRE Ministry of Health, on 10 October 2018, respectively

[359] Divi et al, cited above at note 93, p.60

[360] Interview with Doctor Faud Kadir Hassan, Head of Dire Dawa Health Bureau, on 1October 2018

[361] Yeo, cited above at note 86, p.62; Ferguson and Candib, cited above at note 90, p.354

shared her experience that,[362] when there is language barrier, it is impossible to collect patient's history. As a result she was obliged to use differential, which means ordering many laboratory tests, to discover the possible causes of the disease. Whereas 8.3% of the healthcare providers were underscored that they did not faced language barrier.

4.4.8. Non Compliance

Manson has found out that LLPPs are less likely to be adherent with medications.[363] To the contrary, patients are better able to follow directions that are communicated in their language and as a result of which, their health outcomes were demonstrated to be improved.[364] From the study area, 85% of the healthcare providers were underscored that due to language barrier there were a possibilities by which AOSPs were not adhered to the medications. With the same assertion of Manson, two physicians[365]affirmed that a communication barrier is a leading factor for non-adherence of patients to physicians' advice, patient education and drugs prescriptions. Whereas 15% of the healthcare providers were indicated that there were no communication barriers.

4.4.9. Frustration and less satisfaction

Several studies have proven that language barriers have adverse effects on patients' and healthcare providers' satisfaction.[366] In this regard, Steinberg et al., demonstrated that non-proficient patients' family were frustrated with their healthcare encounter as they characterized their healthcare encounter as a battle to bring an interpreter and to make appointments.[367] Particularly from the study area circumstance, Anteneh Eshetu et al., found that the satisfaction level of HIV/AIDS patients in DCH was influenced by service providers' communication.[368] From the study area, 85% of the healthcare providers have indicated that they are very

[362] Interview with Doctor Victoria Diribsa Gelmesa, Medical General Practitioner in Dil Chora Hospiral, on 3 October 2018

[363] Manson, cited above at note 59, p.1119

[364] Poisson, cited above at note 88, p.8

[365]Interview with Doctor Bethelem Getahun Abebe, Medical General Practitioner in Dil Chora Hospiral, on 4 October 2018 and Victoria Diribsa Gelmesa, Medical General Practitioner in Dil Chora Hospiral, on 3 October 2018

[366] Zezula et al, cited above at note 3; Schwei et al, cited above at note 2 p.1; Karliner et al, cited above at note 87, p.180 and Flores, cited above at note 40, p.274

[367] Steinberg et al, cited above at note 94, p.5

[368] A Eshetu et al, "Quality of Clinical Care for People Living With HIV/AIDS in Dil Chora Referral Hospital, Dire Dawa, East Ethiopia"The Pharma Innovation-Journal ,Vol.2 No.9 (2013), p.10

dissatisfied with the services they rendered to AOSPs due to language disparity. Whereas 15% of the healthcare providers were satisfied with the services they rendered to AOSPs.

By and large, due to communication barrier the majority of the healthcare providers have rated the healthcare services they rendered to non-Amharic proficient patients-AOSPs as very poor.[369] Similarly all interviewed patients[370] described their satisfaction rate as very poor, because their treatment proceeded with an observable communication barrier and sometimes they have been set aside until volunteer interpreters were found. This problem led them to conclude that they were under served when they compare the services and the priority their counter Amharic proficient patients got.

4.5. Legal Cases

4.5.1. Hassen Mohamed's Case

Though there is no claim brought on the ground of the language barrier, there was a charge against study area hospital's staff that used to abuse the language challenges in the hospital for his individual advantage. In this regard, it is important to analyze Hassen Mohamed's case, not only from the court decision but also from the disciplinary measures taken against him by DCH before he was charged and punished with a crime of fraudulent misrepresentation, as a result of which he was fired from the hospital.[371]

Shermarke Aden brought tort claim against CCECC Mieso-Dawanle Railway project for the injury he has incurred, when he used to serve as Crusher. Since the employer is deemed to be liable, irrespective of fault, for employment injuries incurred, Shermarke was supposed to have the medical certificate as written evidence, which demonstrates his degree of disability. To this

[369] Interview with Sister Hiwot Tesfaye Aketa, Nurse in Dil Chora Hospital, on 29 September 2018; Sister Berhane Mokonen Abera, Nurse in Dil Chora Hospiral, on 1 October 2018; Lesanu Belete Wegayo, Nurse in Dil Chora Hospiral, on 2 October 2018; see interviews conducted with six Doctors and two psychiatrists, cited above at note 256. Note that among six physicians interviewed, Doctor Tesfaye Motara Bulto, Medical General Practitioner is the only physician proficient in Afaan Oromo. Amongst four public health officers interviewed only Kalkidan Desalegn Besazen, public health officer serve in central triage of Dil Chora Hospital and amongst three pharmacists interviewed only Kassahun Tefasse Sidamo, the clinical pharmacist in Dil Chora Hospital are satisfied somewhat in communicating with AOSPs because of the fact that there are ad hoc interpreters in their respective departments.

[370] Interview with twenty eight patients via personal interview and Interview with respondents from all three focus group discussions. For details information as to interviewees see bibliography page xix and xxi respectively

[371] Hassen Mohamed V Federal Anti-Corruption Prosecutor (Criminal File No.11099, Federal High Court, September 04, 2010 E.C) (Unpublished, Federal High Court Registrar, Dire Dawa Bench)

end, as he cannot smoothly communicate with the healthcare provider, Shermarke has approached Hassen Mohamed to get help on how he could get a medical certificate.

Hassen Mohamed, who has served DCH as a runner, was known by his act of taking advantage of the patients' confusion and patients' language challenges. He pretended to be a person who can deal with patients' issues. In the case at hand, Hassen was punished for fraudulent misrepresentation for his act of preparing the medical certificate which showed that Shermarke has sustained 75% permanent disability on his left hand, in the name of medical board doctors by simulating their signatures. For this fraud, he had taken 2000 birr (two thousand birr) from Shermarke. However, there were grievances from AOSPs and Somali language speaking patients, that whenever he (Hassen) come across patients who faced a language barrier and did not know what to do and where to go, he would promise that he would facilitate their treatment and take a bribe in return.[372] This happens because there are no professional interpreters and no posted information written in the language majority of the patients understand.

Had there been no language barrier and all services points written post were written in the language of at least the majority of the patients, this and other problems would have not been materialized or at least, it would have been mitigated. Even though, there are four ad hoc interpreters in DCH, absence of professional interpreters, reinforced by the absence of sufficient information posted at each service point in a language the majority of patients understands has violated patients' rights to access healthcare services.

4.5.2. Willie Ramirez's Case

Bernard Lopez found that, substandard clinical dialogue between linguistically discordant patients and providers can lead to numerous negative outcomes for LLPPs.[373] In this regard, as an indicator of the negative ramification of the language barrier; he mentioned the tragically famous case of Willie Ramirez.[374] Upon arrival to the emergency department, Willie's family told the physicians that Willie was "intoxicado". The physician misinterpreted "intoxicado" to mean "intoxicated". With the lack of understanding of medical history, Willie was misdiagnosed: the physician erroneously believed Willie had suffered from drug overdose, so he treated him

[372] Interviewd with Ato Muhedin Redi Beshir, Chief Executive Officer of Dil Chora Hospital, on 8 October, 2018
[373] Lopez, cited above at note 1, p.8
[374] Id, p.7

accordingly. Note that among Cubans, "intoxicado" is kind of all-encompassing word that means there's something wrong with someone because of something he/she ate or drank. Willie was suffering from an intracerebral hemorrhage (cerebral bleed), continued to bleed for two days. This case, however, would have called for a neurosurgeon. The misinterpretation of one word and the subsequent course of action resulted in paralysis of both the arms and legs of the patient, and in a $71 million malpractice settlement.[375]

4.6. Best Practice from St. Paulos Hospital and from healthcare professionals

The St. Paulos Hospital has conducted study regarding the language backgrounds of its patients, by which they have proved that the majority of the patients are AOSPs. Due to the fact that, a clear communication is a prerequisite for safe, appropriate, patient-oriented services delivery system and a means to assure high quality healthcare, St. Paulos Hospital in collaboration with Addis Ababa University, Afaan Oromo department started to teach their healthcare providers Afaan Oromo by arranging various training schedules. It further, used Amharic, Afaan Oromo and English languages side by side in writing the written post of each department. The researcher is of the opinion that DCH and other federal healthcare settings should learn from this practice of St. Paulos Hospital.

One physician and one public health officer crafted their own individual mechanism to solve the language barrier they have suffered from. Doctor Fuad Kadir the head of DDHB was used to serve as medical general practitioner in Sabian primary Hospital before the current position.[376]

Since he cannot speak Afaan Oromo, he was challenged by the language barrier in the majority of treatments cases. In order to mitigate this problem, he used to apply two mechanisms. One was purposely establishing strong relation with Afaan Oromo proficient accountant of the hospital so that she could interpret for him when he used to treats AOSPs. His second means was giving written notes regarding the advice and education he has for patients in Amharic, assuming that the patients would at least have someone at home or neighbor who could explain his intention from such written notes. He used the second means when the accountant was unavailable.

[375] Ibid
[376] Interview with Doctor Faud Kadir Hassan, Head of Dire Dawa Health Bureau, on 1 October 2018

A public health officer, Getahun Gorfu,[377] shared his experience that despite his interest not to be assigned in the area where almost all patients are AOSPs and he could not understand a single Afaan Oromo word, the MoH had assigned him to leg-oda rural kebele healthcare center of DDA. During his time at leg-oda he used to pay an incentive for healthcare center cleaner from his pocket so that she could help as ad hoc interpreter between him and his patients.

4.7. Remedies for the violation of the Right to Health due to the Language Barrier

'There is no right in the African Charter that cannot be made effective'[378]

The detail debates of whether socio-economic rights are justiciable are out of the scope of this thesis. Pursuant to FDRE Constitution, ACHPR, a range of communications entertained by African Commission and various international treaties that have been ratified by Ethiopia, the researcher is of the position that ESCRs are justiciable including the right to health. Thus, AOSPs can bring her/his claim, based on the legal maxima of **"Ubi jus ibi remedium"**, regarding the violation of their right to health due to the language barrier based on the right to access healthcare services, or the right to non-discrimination or the right to life and other rights violation, as all rights are indivisible, interrelated and interdependent.

Regarding the forum, there are national, regional and international forums. Accordingly, AOSPs can bring complaint to the court of law, and to national human rights institutions like Ethiopian Human Rights Commission and Ombudsman. The latter two institutions are important domestic mechanisms in promoting and protecting human rights.[379] Two institutions can order that the act having caused the grievance be discontinued and that the injustice committed be redressed or that any other appropriate measures be taken[380]and they can also make recommendations for the enactment of new laws and formulation of policies,[381] which include the passing of LAS policy

[377] Interview with Getahun Gurfa, public health officer, Sabian Primary Hospital, on 29 September 2018

[378] The Social & Economic Rights Action Centre & the Centre for Economic & Social Rights v Nigeria, Communication 55/96, 15th Annual Activity Report. Para.68
Note that **"Ubi jus ibi remedium"** is a legal maxima which means "if there is a violation of rights there must be a remedy."

[379] Fact sheet 31, Cited above at note 116, p.34

[380] Art.26 of Ethiopian Human Rights Commission Establishment Proclamation No.210/2000 and Art.26 of Institution of the Ombudsman Establishment Proclamation No.211/2000

[381] Id, art.6 (5) of Procl.No.210/2000 and art.6 (6) of Procl.No.211/2000

in the federal healthcare setting. Moreover, as everyone has the right to bring a justiciable matter,[382] the court can entertain a case bring to it based on the language discrimination.

At regional level, the African Commission plays an important role in protecting the right to health.[383] The commission avers that violation of any provision of the charter automatically means a violation of article1of the charter.[384] According to this article, the Member States of the Organization of African Unity, parties to the charter shall recognize the rights, duties and freedoms enshrined in the charter and shall undertake to adopt legislative or other measures to give effect to them. Hence, upon exhaustion of the existing local remedies or if the court fail to entertain their case due to argument of ouster clauses in the FDRE Constitution, the victim can bring their case before African Commission.[385]

International complaint mechanism is also there for a victim of violation of the ESCRs. Provided that Ethiopia will accesses to the optional protocol to ICESCRs, a victim can bring her/his complain to the committee on ESCRs, as the optional protocol was adopted to ensure that, victims of ESCRs have access to remedies at the international level.[386]

By and large, for the purpose of the violation of one element of the right to health - accessibility, the possible remedies[387]can be the restitution by enabling the victim to enjoy their human rights. The other remedy could be satisfaction-which is an order for a cessation of violations while compensation and guarantees of non-repetition are other sorts of remedies.

[382]FDRE Constitution, cited above at note 241, art.37(1)

[383]Fact sheet 31, Cited above at note 116, p.35

[384]Dawada k.Jawara v.The Gambia, Communication 147/95, 149/96, Ann.Act.Rep. (2000), Para.46

[385]African Charter on Human and Peoples Rights, cited above at note 132, art.56(5)

[386] Lilion Chenwi, "Correcting the historical asymmetry between rights: The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights" African Human Rights Law Journal, Vol.9 (2009), p.23

[387] Antoine Buyse, "Lost and Regained?: Restitution as a Remedy for Human Rights Violations in the Context of International Law" Heidelberg Journal of International Law , Vol.68 (2008), p.2-3; The United Nations Commission on Human Rights; The Basic Principles and Guideline on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law (2005)

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

Existing studies on the language barrier have robustly demonstrated that language disparity between healthcare providers and patients is a major factor of health inequality in healthcare. This study has revealed that language barrier has significantly affected quality of care in the healthcare system in general and in Dil Chora Hospital in particular. It also has found that the language barrier has adverse effects on accessing the proper service, patient satisfaction, health outcomes and healthcare provider satisfaction. Since collection of accurate and comprehensive patients' history are the basis for proper diagnosis and prognosis and because about 75%-80% treatments are based on the patient history and only 20%-25% treatment are conducted through physical examination and investigation, the absence of effective communication cause the provision of healthcare ends or proceeds only with errors, poor quality, and risks to patient safety. When there is a language barrier between the healthcare providers and the patients, for the patients, explaining a medical problem becomes an impossible task and it is reinforced by high illiteracy level amongst rural AOPSs, which challenges them to communicate effectively with the providers. It also limits the healthcare providers' ability to provide optimum care.

Since the majority of DDA residents are Afaan Oromo speakers, and the working language is only Amharic and the majority of the healthcare providers cannot speak Afaan Oromo, the challenges due to language difference are apparent. Several studies have indicated that patients preferred speaking their respective first language with their healthcare provider. Even, people who are generally comfortable speaking official languages in their day-to-day life need to use their primary language in some circumstances, such as in an emergency or when discussing highly technical information.

Ethiopia has already ratified core African regional and international instruments that have recognized the right to health and thereby makes it an integral part of its law and it has also passed various health policies, of short and long terms. However, despite the existence of these encouraging efforts, Ethiopia has not adopted appropriate legislative, administrative, budgetary and other measures to fully realize the right to health of all patients in equal footing and to correct the gap created by the language barrier. Accordingly, there is no LAS policy.

Since language accessibility is one element of the right to health, serving the majority of the patients in the language they cannot understand amounts to the violation of the obligation to fulfill on the part of Ethiopian government. Since all human rights are universal, indivisible, interdependent, and interrelated, the violation of the right to health is resulted in violation of the other rights like the right to life and the right to non-discrimination. Since LAS is an effective way of addressing language barriers in a clinical setting, in the absence of it, navigating the healthcare system is difficult, frustrating, and potentially detrimental to the quality of care of the patients who cannot speak Amharic. For instance, when the experiences of other countries on the LAS in the healthcare setting are examined, particularly USA, one can found the language access for Amharic, Somali and Tigrigna speaking patients. Whereas in the case of DDA, AOSPs are treated in the language they could not understand in their own country in general and in their birthplace in particular.

For instance, the FDRE Constitution grants the right to interpretation services at state expense where the court proceeding are conducted in a language accused persons do not understand. The implicit assumption is that without interpretation, there would be a miscarriage of justice. The situation in the federal healthcare setting is such that medical interviews are generally conducted through Amharic which is second language for many patients and which many patients cannot speak at all. In other word, in the Ethiopian federal healthcare setting there is a monolingual healthcare service in a multilingual society. In the same fashion, a clear assumption that can be drawn here is that, in the absence of LAS in the federal healthcare setting, which is multilingual setting, there would be mistreatment of patients as a result of the language barrier. This assumption is supported by various findings where the language barrier is taken as a primary challenge for non-speaker of the official language of a given country.

Patient's rights, patient's safety, quality of care and government obligation to fulfill, each in itself is sufficient to justify a need to put in place the LAS in DCH as it is one of the perquisite to deliver optimum healthcare services for all in an equal manner.

5.2. Recommendations

In light of the finding of the study, the researcher has set out the following recommendations regarding what shall be done by the concerned governmental organs to ensure the right to health of AOSPs in the federal healthcare setting in general and in DCH in particular.

1) **What shall be done by Federal Government**

- The government shall realize the right to health fully for all in an equal manner. Specifically, as the obligation to fulfill requires Ethiopia to adopt appropriate legislative, administrative, budgetary and other measures to fully realize the right to health of AOSPs, and the justification for court interpretation is equally analogized to the healthcare setting interpretation, the government should pass LAS policy forthwith by redefining the language barrier as the national concern.

2) **What shall be done by Minister of Health**

- Previously the MoH used to take into consideration the language proficiency when they assigned the healthcare providers for Afar, Oromia, Somali and Tigray regional states; however, due to the fact that other regional states asked for language proficiency to be considered, MoH to treat all regional states equally by omission has given up to assign professionals by their language proficiency. Thus, until institutional bilingualism/trilingualism is ensured, patient-bilingual healthcare provider ratio is met and sufficient professional interpreters are produced, the MoH shall maintain the language proficiency criterion.
- The MoH in collaboration with the higher education institutions has to work on how to prepare the curriculum on the LAS to generate prospective healthcare professional interpreters.

3) **What shall be done by Dil Chora Hospital**

- The DCH in collaboration with DDHB and Dire Dawa public services and human resource development bureau will be expected to assign professional interpreters.
- Because of the fact that based on the finding of the study they conducted, the majority of its clients are AOSPs; St. Paulos hospital has arranged the condition to teach its healthcare providers Afaan Oromo in collaboration with Addis Ababa University, Afaan

Oromo department. In the same manner, DCH shall work in collaboration with Dire Dawa University, Afaan Oromo Department to teach its staff.

- The effort of rearranging (four) hospital's runners to ad hoc interpreters by DCH is appreciated. The DCH in collaboration with the DDHB and DD public services and human resource development bureau, shall hire (by short term contract) sufficient and competent ad hoc interpreters with nursing or pharmacy or other health profession background in each service points until institutional bilingualism/trilingualism is ensured, patient-bilingual healthcare provider ratio is met and sufficient professional interpreters are produced and assigned.
- The DCH should arrange training for ad hoc interpreters so that they could respect the confidentiality of patients and able to interpret main medical terms. Moreover, they shall acquaint with standard knowledge, their respective responsibility, and the possible ramifications of inappropriate interpretation of medical terms and the liability thereof.
- The DCH shall give training for providers as to how to use efficiently the ad hoc interpreters at their hand.
- The existences of ad hoc interpreters must be informed by written post and advertise through local FM radio and Dire TV, so that the patients could utilize it. When professional interpreters produced and start working, the same advertisement shall be done.
- Professional interpreters or ad hoc interpreters shall be provided with similar uniform (clothes) with healthcare providers; so that the patients will not afraid to tell all his/her concern to interpreters by fearing that an interpreter will not observe confidentiality and tell their disease to others.
- Patients' family, attendant, passerby and other shall not be used as interpreters. As there are issues which cannot be discuss between the patient and family members, and between patient and the stranger. Family members, friends, or other attendants must be utilized as interpreters only in the emergency situations or at the express request of patients.
- All physicians, psychiatrists, and other healthcare professional as much as possible shall accompanied by Afaan Oromo proficient nurses.
- To avoid overestimated proficiency, DCH shall assess the language proficiency of staff considered capable of intervening in a second language-Afaan Oromo.

- To solve the communication problem between deaf patients and healthcare providers in general and Afaan Oromo speaking deaf patients and providers in particular, there has to be sign language interpreters.
- The DCH and other healthcare institutions shall make a survey for quality control like patients feedback regarding the effectiveness of and challenges of communication.

4) What shall be done by Dire Dawa Health Bureau

- In addition to activities it shall work in collaboration with MoH, DCH and DD public services and human resource development bureau, DDHB shall prepare clinical material written in Afaan Oromo to help deliver of patients' education.

5) What shall be done by Other Organs

- All federal hospitals shall undertake the study regarding the patients' language preference. The language preference can be identified at central triage within a short time where patients are first arriving to start their treatment. Then hospitals should use the language spoken by majority of their customers in all service points. They shall also use the language spoken by their patients in writing posted information regarding the direction and the specific task of each service point.
- The medical schools shall provide adequate instruction on the importance of linguistic issues in healthcare setting so that the prospective medical professionals try to learn other language as their second language.
- Though not visible for now, in the future there should be communication and information technology, like machine translation devices that can help the physicians to understand the words of non-speaker of working language (like a system used by AU conference).
- Since the study at hand, did not address the perception and experience of other language speaking patients and did not deal with the detail health outcome disparity between Amharic proficient patients and other language speaking patients, further studies must also be done to clearly indicate the details adverse medical events and errors that materialized due to language barrier.

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11.Interviews

A) **Personal Interview with 28 patients**

(1) Interview with Nuria Mohmed Musa, patient from Dil Chora Hospital, coming from Deder, East Hararghe, Oromia Region, September 24, 2018

(2) Interview with Kadir Abdela, patient from Dil Chora Hospital, coming from Wahil Lega-Oda Gunufata rural Kebele of Dire Dawa, September 24, 2018

(3)Interviewed with Fatuma Musa Kadir, patient from Dil Chora Hospital, coming from Erer Gota rural Kebele of Dire Dawa, September 25, 2018

(4)Abrahim Abdi Kamil, patient from Dil Chora Hospital, coming from Burka Nagaya, Melka Belo, East Hararghe, Oromia Region, September 26, 2018

(5)Interview with Shamro Yasin Ali, patient from Dil Chora Hospital, coming from Madhisa Jalala, Goro Gutu, East Hararghe, Oromia Region, September 30, 2018

(6)Interview with Jamal Sule, patient from Dil Chora Hospital, coming from Kombolcha, East Hararghe, Oromia Region, September 25, 2018

(7) Interview with Nasru Jawar Ahmed, patient from Dil Chora Hospital, coming from Harkonca, Goro Gutu East Hararghe, Oromia Region, September 26, 2018

(8) Interview with Dehabo Ibro, patient from Dil Chora Hospital, coming from Mililo, Galamso, West Hararghe, Oromia Region, September 25, 2018

(9) Interview with Mustefa Ali Dima, patient from Dil Chora Hospital, coming from Hasliso rural Kebele of Dire Dawa, September 25, 2018

(10) Interview with Ahmed Ibroshe, patient from Dil Chora Hospital, coming from Boko, Fadis, East Hararghe, Oromia Region, September 26, 2018

(11) Interview with Abdela Mohmed, patient from Dil Chora Hospital, coming from Langey, East Hararghe, Oromia Region, September 26, 2018

(12) Interview with Ahmedin Adem Ahmed, patient from Dil Chora Hospital, coming from Deder, East Hararghe, Oromia Region, September 30, 2018

(13); Interview with Nuria Mohmed Ame, patient from Dil Chora Hospital, coming from Hasliso rural Kebele of Dire Dawa, September 27, 2018

(14) Interview with Amina Umer, patient from Dil Chora Hospital, coming from Melka Belo, West Hararghe, Oromia Region, September 27, 2018

(15) Interview with Usman Umer, patient from Dil Chora Hospital, coming from Bedano, East Hararghe, Oromia Region, September 27, 2018

(16) Interview with Fatima Ame, patient from Dil Chora Hospital, coming from Kufa Calee, East Hararghe, Oromia Region, September 28, 2018

(17) Interview with Eftu amhed jama, patient from Dil Chora Hospital, coming from Leg-hare, Bilal 08 Kebele, Dire Dawa, September 28, 2018

(18) Interview with Sharif Mohmed Habib, patient from Dil Chora Hospital, coming from Afa Tisa, 09 Kebele, Dire Dawa, September, 2018

(19) Interview with Momina Ali Ahmed, patient from Dil Chora Hospital, coming from Facatu, Choroko, Fadis, East Hararghe, Oromia Region, September 26, 2018

(20) Interview with Hindisar Abdulkerim Ibro, patient from Dil Chora Hospital, coming from Leg-hare 08 Kebele, Dire Dawa, September 30, 2018

(21) Interview with Ayantu Mohmed Hassen, patient from Dil Chora Hospital, coming from Heyale Gumgum, rural Kebele of Dire Dawa, September 29, 2018

(22) Interview with Kuftu Kabeto warako, patient from Dil Chora Hospital, coming from Gande Kore, 04 Kebele, Dire Dawa, September 29, 2018

(23) Interview with Amin Ali Yusuf, patient from Dil Chora Hospital, coming from Café, Melka Belo, West Hararghe, Oromia Region, September 29, 2018

(24) Interview with Jamal Ame Usman, patient from Dil Chora Hospital, coming from Kombolcha, East Hararghe, Oromia Region, September 28, 2018

(25) Interview with Ibrahim Hamid Ahmed, patient from Dil Chora Hospital, coming from Sodu, Karsa, East Hararghe, Oromia Region, September 30, 2018

(26) Interview with Jabir Mohmed usman, patient from Dil Chora Hospital, coming from Ulul Mojo, rural Kebele of Dire Dawa, October1, 2018

(27) Interview with Sadiya Hassan Ibro, patient from Dil Chora Hospital, coming from Heyale Gumgum, rural Kebele of Dire Dawa, October1, 2018

(28) Interview with Nasir Jabir Ahmed, patient from Dil Chora Hospital, coming from Bake Halo, rural Kebele of Dire Dawa, October2, 2018

Interview with three focus group discussion members (patients)

Interviewed with respondents from focus group discussion One

Interview with Sumeya Yusuf Mohamed, patient from Dil Chora Hospital, coming from Sabian 02 Kebele, Dire Dawa, September 28, 2018

Fatuma Ahmed Sadik, patient from Dil Chora Hospital, coming from Ganda Kore 03Kebele, Dire Dawa, September 28, 2018

Kalifa Abdula Yusuf, patient from Dil Chora Hospital, coming from Badano, East Hararghe, Oromia Region, September 28, 2018

Maftuha Rafik Sani, patient from Dil Chora Hospital, coming from Badano, East Hararghe, Oromia Region, September 28, 2018

Hassan Mume Mustefa, patient from Dil Chora Hospital, coming Gurawa, East Hararghe, Oromia Region, September 28, 2018

Interviewed with respondents from focus group discussion Two

Interview with Usuman Abrahim Ali, patient from Dil Chora Hospital, coming from Kafira, 06 Kebele, Dire Dawa, September 29, 2018;

Abdela Aliyi Ibrahim, patient from Dil Chora Hospital, coming from Karsa, East Hararghe, Oromia Region, September 29, 2018

Shamshadin Aliyi Mumed, patient from Dil Chora Hospital, coming from Ganda Gerada 09Kebele, Dire Dawa, September 29, 2018

Ahmed Mohamed Ahmed, patient from Dil Chora Hospital, coming from Sabian 02Kebele, Dire Dawa, September 29, 2018; and

Bakri Abdula Abrahim, patient from Dil Chora Hospital, coming from Hulul Mojo rural Kebele of Dire Dawa, September 29, 2018

Interviewed with respondents from focus group discussion Three

Interview with Aisha Isa Usman, patient from Dil Chora Hospital, coming from Bako Halo rural Kebele of Dire Dawa, September 30, 2018

Hajara Abdi Giree, patient from Dil Chora Hospital, coming from Bako Halo rural Kebele of Dire Dawa, September 30, 2018

Nuria Umare Yuya, patient from Dil Chora Hospital, coming from Hayale GumGum rural Kebele of Dire Dawa, September 30, 2018

Tayiba Musa Sali, patient from Dil Chora Hospital, coming from Hayale Gumgum rural Kebele of Dire Dawa, September 30, 2018

Kamaro Abdela Yubee, patient from Dil Chora Hospital, coming from Kafira 06 Kebele of Dire Dawa September 30, 2018

B) **Interview with Dil Chora Hospital's Healthcare Providers**

Interview with Doctor Victoria Diribsa Gelmesa, Medical General Practitioner in Dil Chora Hospiral, October 3, 2018

Interview with Doctor Bethelem Getahun Abebe, Medical General Practitioner in Dil Chora Hospiral, October 4, 2018

Interview with Doctor Alem W/Aregay Dubale, Medical General Practitioner in Dil Chora Hospiral, September 28, 2018

Interview with Doctor Dereje Ayalew Asmare, Medical General Practitioner in Dil Chora Hospiral, October 4, 2018

Interview with Doctor X (he has requested for anonymity), Medical General Practitioner in Dil Chora Hospiral, October 5, 2018

Interview with Doctor Tesfaye Motara Bulto, Medical General Practitioner in Dil Chora Hospital, September 25, 2018

Interview with Abel Mamo Kafani, Professional Psychiatrist Medical General Practitioner in Dil Chora Hospiral, September 26, 2018

Interview with Henok Nega Kifle Professional Psychiatrist Medical General Practitioner in Dil Chora Hospiral, September 26, 2018

Interview with Hiwot Tesfaye Aketa, Nurse in Dil Chora Hospital, September 29, 2018

Interview with Berhane Mokonen Abera, Nurse in Dil Chora Hospiral, October 1, 2018

Interview with Lesanu Belete Wegayo, Nurse in Dil Chora Hospiral, October 2, 2018

Interview with Kalkidan Desalegn Besazen, public health officer serve in central triage of Dil Chora Hospital, September 25, 2018

Interview with Kassahun Tefasse Sidamo, the clinical pharmacist in Dil Chora Hospital, September 28, 2018

Interview with Menaye Kassahun Zerfu, Nutritionist in Dil Chora Hospital, September 28, 2018

Interview with Tameru Mulatu Zeke, Pharmacist in Dil Chora Hospital, October 2, 2018

Interview with Getachew Bogale Gudata, Nurse in Dil Chora Hospiral, September 25, 2018

Interview with Biyalfew Zewde Getahun, public health officer, Dil Chora Hospital, September 28, 2018

Interview with Getahun Gorfu Biratu, public health officer, Sabian Primary Hospital, September 29, 2018

Interview with Heymanot Nuguse Tegaye, ad hoc interpreter, Dil Chora Hospital, September 26, 2018

Interview with Yodit Abenet, ad hoc interpreter, Dil Chora Hospital, September 26, 2018

C)**Interview with Official from MoH, DDHB, Dil Chora Hospital and DDA public service and human resource development bureau.**

Interview with Doctor Ashenafi Beza Wasse, Director General Office, FDRE Ministry of Health, October 15, 2018

Interview with Doctor Daniel G/Egzaber G/Michael, Medical Services General Directorate Director General, FDRE Ministry of Health, October 13, 2018

Interview with Wakgari Dheresa Amente (PHD), Technical Advisor, Policy Translation Senior Advisor, FDRE Ministry of Health, October 13, 2018

Interview with Kahsu Bekuretsion G/Mariam, Technical Advisor, Policy Translation Senior Advisor, FDRE Ministry of Health, October 14, 2018

Interview with Biruk Abate Halolo, Policy, Planning, Monitoring and Evaluation Directorate Director, FDRE Ministry of Health, October 11, 2018

Interview with Mebrhatom Belay Reda, Policy Analysis and Planning Case Team Technical Advisor, October 11, 2018

Interview with Suleman Shugute Gaso, Legal Affairs Directorate Director, FDRE Ministry of Health, October 17, 2018

Interview with Habtamu Demisse Dabala, Head of Human Resource Directorate Director, FDRE Ministry of Health, October 17, 2018

Interview with Megersa Taddese Nagao, Human Resources Senior Officer V, FDRE Ministry of Health, October 18, 2018

Interview with Girma Bogale Werkneh, Human Resources Officer, FDRE Ministry of Health, October 18, 2018

Interview with Doctor Faud Kadir Hassan, Head of Dire Dawa Health Bureau, October 1, 2018

Interview with Mohmed Habib Saed, Head of Human Resource Directorate Director, Dire Dawa Health Bureau, September 28, 2018

Interview with Muhedin Redi Beshir, Chief Executive Officer, Dil Chora Hospital, Ethiopia, October 4, 2018

Interview with Doctor Dagmawi Eyob Mehrete, Medical Services Director in Dil Chora Hospiral, September 26, 2018

Interview with W/ro Azeb Tessfaye Ateker, Head of Human Resource Directorate Director, Dil Chora Hospital, October 6, 2018

Interviewd with Ato Seyfedin Abdurehman Salih, the Dire Dawa Administration public service and human resource development bureau Deputy Head, October 5, 2018

Appendixes

Interview questions (guide) prepared to study the challenges of the Language Barrier to Access and Utilized the Healthcare.

This interview has the aim of assessing the existence of the language barrier and its negative ramification on the right to access and utilized the public hospital, Dil Chora hospital. The data you provide me will solely be used to evaluate the impact of language barrier on accessing and utilizing healthcare services in Dil Chora hospital and thereby the study will serve as a basis for police framework to put in place the language assistance services. Therefore, I kindly request you to provide genuine data.

Thank you in Advance for your cooperation!

September, 2018

Appendix 1-Interview Guide One: In-depth Interview Guide with Patients

1. **Patient's Personal Information**

1.1. Place of birth

1.2. Place of current residence

1.3. Patient's Sex

1.4. Patient's age

1.5. Patient's marital status

1.6. Are you with any disability (i.e. physical be it deaf, difficulty of hearing or speaking)?

2. **Patient's education level**
3. **Patient's Income**

3.1. What is your gross annual income?

4. **Language**

4.1. Is there communication problem as a result of language barrier when you sought services or treatment from Dil Chora hospital?

4.2. By which language Dil Chora Hospital entertain you when sought healthcare services?

4.3. Did you encounter any problems due the existence of the language disparity between you and healthcare services providers?

4.4. Did you have an experience when the language barrier caused you discharge from hospital without sufficient explanation of the possible cause of your medical problem?
4.5. Did you have an experience when the language barrier challenged you to understand the discharge instructions?
4.6. Did you have an experience when the language barrier caused the disregard of your concerns or questions by healthcare services providers?
4.7. What will be the solution to solve the language barrier challenges, so as to increase the patient's services satisfaction?

Appendix 2-Interview Guide Two: In-depth Interview with Healthcare Providers (Physician and Psychiatrists)

Respondent's Personal Information:

Name of respondent_____

Profession of respondent (specialization) _____

How many year you have served_____

Sex_____

1. Has language been a barrier between physician/psychiatrists and patients, when the physician/psychiatrists speak Amharic as their first language and the patients speak Afaan Oromo as their first language?
2. How the existence of the language barrier affect the quality of the healthcare services, if healthcare providers are speaking Amharic and the patients are speaking Afaan Oromo?
3. How do you rate the effectiveness of the communication while language disparity is exist between the physician/psychiatrists and the patients

   ☐ Excellent ☐ Very good ☐Good ☐ Poor ☐ Very poor

4. Did you encounter when AOSPs were misunderstood the treatment procedures due to the language barrier?
5. Did you have an experience when the language barrier caused difficulty in getting the patient's history?
6. Did you have an experience when the patients failed to understand and to adhere to prescribed treatment due to language barrier?

7. Did you have an experience when the language barrier caused inappropriate treatment or lack of treatment?
8. Do you think that the language barrier could result in an increased use of unnecessary diagnostic resources like ordering additional laboratory examination?
9. Did the language barrier cause patients longer length of stay in hospital, especially in the emergency department?
10. Did you have an experience when the language barrier caused unnecessary costs on the patients and healthcare centers?
11. Did you have an experience when the language barrier caused difficulties with involving patients in their treatment and decision making?
12. Did you have an experience when the language barrier caused misdiagnosis?
13. Does the language barrier cause problem with giving preventive health information, and in getting informed consent?
14. Does the language barrier result in breach of patient's confidentiality when physicians called up on the ad hoc interpreters?
15. Did you had any questions to ask the patients or patient's family but did not due to language barrier?
16. Did you satisfied by overall medical care you have provided to the patients in the presence of language disparity, if you are more proficient in speaking Amharic and the patients are speaking Afaan Oromo?
17. What will be the durable solution to solve the language barrier challenges, to ensure the patient's right to access and utilize the healthcare setting?
18. Do you think that the healthcare providers need to receive training in how to use interpreter effectively?
19. Do you think that the interpreters need to receive training in how to interpreter medical terms?
20. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality?

Appendix 3-Interview Guide Three: In-depth Interview with Healthcare Providers (Public Health Officers)

Respondent's Personal Information:

Name of respondent_____

Profession of respondent (specialization)_____

How many year you have served_____

Sex_____

1. Has language been a barrier between healthcare services providers and the patients, when the healthcare services providers speak Amharic as their first language and patients speak Afaan Oromo as their first language?
2. How the existence of the language barrier affect the quality of the healthcare services, if providers are proficient in Amharic and the patients are speaking Afaan Oromo?
3. How do you rate the effectiveness of communication while language disparity is exist between healthcare providers and patients

   ☐ Excellent ☐ Very good ☐Good ☐ Poor ☐ Very poor

4. Did you have an experience when the language barrier caused difficulty in identification of the patients' medical problem so that you could refer to the proper specialized physician?
5. Did you encounter when AOSPs were misunderstood or confused regarding specific department from which they could get treatment due to the language barrier?
6. Did you have an experience when the language barrier caused difficulty in getting the patient's history?
7. Did you have an experience when the language barrier caused difficulties with involving patients in their treatment?
8. Did you have an experience when the language barrier caused inappropriate treatment or lack of treatment?
9. Do you think that the language barrier could result in unnecessary use of diagnostic resources?

10. Did you have an experience when the patients failed to understand and to adhere to prescribed treatment due to language barrier? Did you have any questions to ask the patients or patient's family but did not due to language barrier?
11. Do you think that the language barrier result in healthcare providers' poor satisfaction?
12. What will be the durable solution to solve the language barrier challenges, to ensure the patient's right to access and utilize the healthcare setting?

Appendix 4-Interview Guide Four: In-depth Interview with Healthcare Providers (Nurses)

Respondent's Personal Information:

Name of respondent_____

Profession of respondent (specialization)_____

How many year you have served_____

Sex_____

1. Has language been a barrier between the healthcare services providers and patients, when nurse speak Amharic as their first language and patients speak Afaan Oromo as their first language?
2. How the existence of the language barrier affect the quality of the healthcare services, if nurses are more proficient in Amharic and the patients are speaking Afaan Oromo?
3. How do you rate the effectiveness of the communication while the language disparity is exist between you and patients

   ☐ Excellent ☐ Very good ☐Good ☐ Poor ☐ Very poor

4. Did you have an experience when the language barrier caused longer length of stay in emergency department?
5. Did you have an experience when the language barrier caused poorer patient understanding of prescribed treatment?
6. Did you have an experience when the language barrier caused inappropriate treatment or lack of treatment?
7. Did you have an experience when the language barrier caused difficulties with involving patients in their treatment?
8. Did you have an experience when the language barrier caused follow-up problems including lack of information about the danger signs of worsening illness?

9. Did you have an experience when the language barrier caused discharge of patient from hospital without sufficient explanation of the possible cause of the problem?
10. Did you have an experience when the language barrier caused discharge of patient from hospital without understanding the discharge instructions?
11. Did you have an experience when the language barrier caused disregard of patient's concerns or questions?
12. Did you have an experience when the patients failed to adhered to prescribed treatment due to language barrier?
13. Did you have any questions to ask the patients or patient's family but did not due to language barrier?
14. Do you think that the language barrier result in healthcare services providers' poor satisfaction?
15. What will be the durable solution to solve the language barrier challenges, to ensure the patient's right to access and utilize the healthcare setting?
16. Do you think that the healthcare providers need to receive training in how to use interpreter effectively?
17. Do you think that the interpreters need to receive training in how to interpreter medical terms?
18. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality?

Appendix 5-Interview Guide Five: In-depth Interview with Healthcare Providers (Pharmacists)

Respondent's Personal Information:

Name of respondent_____

Profession of respondent (specialization)_____

How many year you have served_____

Sex_____

1. Has language been a barrier between a pharmacists and patients, when pharmacist speak Amharic as their first language and patients speak Afaan Oromo as their first language?

2. How do you rate the effectiveness of the communication while language disparity is exist between you and patients

   ☐ Excellent ☐ Very good ☐Good ☐ Poor ☐ Very poor

3. How the existence of the language barrier affect the quality of the healthcare services (proper prescription), if pharmacists proficient in Amharic and the patients are speaking Afaan Oromo?
4. Did you have an experience when the patients failed to understand how to take the prescribed drugs due to the language barrier?
5. Did you have an experience when the language barrier caused difficulties with involving patients in their treatment including insufficient instruction about potential side effects of the drugs?
6. Did you have an experience when the language barrier caused failure on the part of patients to appropriately adhere to prescription or to overall treatment?
7. How do you rate your satisfaction of the overall service you had provided to the patients in the presence of language disparity, if you are more proficient in speaking Amharic and the patients are speaking Afaan Oromo?
8. What will be the durable solution to solve the language barrier challenges, to ensure the patient's right to access and utilize the healthcare setting?
9. Do you think that the healthcare providers need to receive training in how and when to use interpreter effectively?
10. Do you think that the interpreters need to receive training in how to interpreter medical terms?
11. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality?

Appendix 6-Interview Guide Six: In-depth Interview Guide with Official from MoH

Respondent's Personal Information:

Name of respondent_____

Name of respondent Institution_____

Profession of respondent (specialization)_____

Position of respondent in the Institution_____

Sex_____

Age_____

1. How do the language disparities between patients and healthcare services providers could affect the quality of healthcare services?
2. Does the existence of the language disparity between patient and healthcare services providers, affect the patient's right to access and utilized the health care services, if providers are speaking Amharic and the patients are speaking Afaan Oromo?
3. How the poor communication due to language disparity between the healthcare services providers and patients could result in the risk of malpractice claims against healthcare services providers and hospital, if medical error is committed as a result of the language barrier?
4. Do you think that the language barrier between the healthcare services providers and patients could be one factor for poor health outcome in Ethiopia (in federal healthcare setting)?
5. What are the objective criteria to assignment healthcare services provider to certain local areas or regions or both cities administration?
6. Does the ministry take into account the language as a criterion during assignment of the healthcare services provider to a given regions or both cities administration?
7. Is the inaction on the side of the government by not introducing formal language assistance service in the healthcare setting is amount to breach of the health right of those groups of the people seeking healthcare services in a federal cities, who could not speak Amharic at all or with limited Amharic proficiency?
8. What will be the durable solution to solve the language barrier challenges, so as to increase the healthcare services provider's and patient's services satisfaction as well as to ensure the patient's right to access and utilize the healthcare setting?

9. Do you think that the healthcare services providers need to receive training in how and when to use interpreter effectively?
10. Do you think that the interpreters need to receive training in how to interpreter medical terms?
11. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality?

Appendix 7-Interview Guide Seven: In-depth Interview Guide with Official from Dil Chora Hospital

Respondent's Personal Information:

Name of respondent_____

Name of respondent Institution_____

Profession of respondent (specialization)_____

Position of respondent in the Institution_____

Sex_____

Age_____

1. Is language barrier a problem because of the fact that official language is Amharic whereas significant residents (patients) AOPSs in DDCA?
2. How does the language disparity between patients and healthcare services providers could affect the quality of healthcare services?
3. Does the existence of the language disparity between patient and healthcare services providers, affect the patient's right to access and utilized the health care services, if providers are speaking Amharic and the patients are speaking Afaan Oromo?
4. How the poor communication due to language disparity between the healthcare services providers and patients could result in the risk of malpractice claims against healthcare services providers and hospital, if medical error is committed as a result of the language barrier?
5. Do you think that the language barrier between the healthcare services providers and patients could be one factor for poor health outcome in Ethiopia (in federal healthcare setting)?

6. Is the inaction on the side of the government by not introducing formal language assistance service in the healthcare setting is amount to breach of the health right of those groups of the people seeking healthcare services in a federal cities, who could not speak Amharic at all or with limited Amharic proficiency?
7. What will be the durable solution to solve the language barrier challenges, so as to increase the healthcare services provider's and patient's services satisfaction as well as to ensure the patient's right to access and utilize the healthcare setting?
8. Do you think that the healthcare services providers need to receive training in how and when to use interpreter effectively? why?
9. Do you think that the interpreters need to receive training in how to interpreter medical terms? why?
10. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality? why?

Appendix 8-Interview Guide Eight: In-depth Interview Guide with Official from DDHB

Respondent's Personal Information:

Name of respondent_____

Name of respondent Institution_____

Profession of respondent (specialization)_____

Position of respondent in the Institution_____

Sex_____

Age_____

1. Is language barrier a problem because of the fact that official language is Amharic whereas significant residents (patients) AOPSs in DDCA?
2. How does the language disparity between patients and healthcare services providers could affect the quality of healthcare services?
3. Did the existence of the language disparity between patient and healthcare services providers, affect the patient's right to access and utilized the health care services, if providers are speaking Amharic and the patients are speaking Afaan Oromo?
4. How the poor communication due to language disparity between the healthcare services providers and patients could result in the risk of malpractice claims against healthcare

services providers and hospital, if medical error is committed as a result of the language barrier?

5. Do you think that the language barrier between the healthcare services providers and patients could be one factor for poor health outcome in Ethiopia (in federal healthcare setting)?
6. Is the inaction on the side of the government by not introducing formal language assistance service in the healthcare setting is amount to breach of the health right of those groups of the people seeking healthcare services in a federal cities, who could not speak Amharic at all or with limited Amharic proficiency?
7. What will be the durable solution to solve the language barrier challenges, so as to increase the healthcare services provider's and patient's services satisfaction as well as to ensure the patient's right to access and utilize the healthcare setting?
8. Do you think that the healthcare services providers need to receive training in how and when to use interpreter effectively? why ?
9. Do you think that the interpreters need to receive training in how to interpreter medical terms? why?
10. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality? why?

Appendix 9-Interview Guide Nine: In-depth Interview Guide with DDA public service and human resource development bureau

Respondent's Personal Information:

Name of respondent_____

Name of respondent Institution_____

Profession of respondent (specialization)_____

Position of respondent in the Institution_____

Sex_____

Age_____

1. Is language barrier a problem because of the fact that official language is Amharic whereas significant residents (patients) AOPSs in DDCA?

2. How does the language disparity between patients and healthcare services providers could affect the quality of healthcare services?
3. Did the existence of the language disparity between patient and healthcare services providers, affect the patient's right to access and utilized the health care services, if providers are speaking Amharic and the patients are speaking Afaan Oromo?
4. How the poor communication due to language disparity between the healthcare services providers and patients could result in the risk of malpractice claims against healthcare services providers and hospital, if medical error is committed as a result of the language barrier?
5. Do you think that the language barrier between the healthcare services providers and patients could be one factor for poor health outcome in Ethiopia (in federal healthcare setting)?
6. Is the inaction on the side of the government by not introducing formal language assistance service in the healthcare setting is amount to breach of the health right of those groups of the people seeking healthcare services in a federal cities, who could not speak Amharic at all or with limited Amharic proficiency?
7. What will be the durable solution to solve the language barrier challenges, so as to increase the healthcare services provider's and patient's services satisfaction as well as to ensure the patient's right to access and utilize the healthcare setting?
8. Do you think that the healthcare services providers need to receive training in how and when to use interpreter effectively? why ?
9. Do you think that the interpreters need to receive training in how to interpreter medical terms? why?
10. Do you think that the interpreters need to receive training in how to take care of patient's confidentiality? why?