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Exploring translocality: negotiating space through the language practices of migrant communities

by

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ABSTRACT

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EXPLORING TRANSLOCALITY: NEGOTIATING SPACE THROUGH THE LANGUAGE PRACTICES OF MIGRANT COMMUNITIES

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This thesis aims to explore the spaces created by migrant communities as they make their place in a new homeland. Theoretically conceived of as translocality, these place-making practices are constructed through vibrant relationships between countries, mainly across national borders. I set out to understand the impact of the global on the local in these negotiations between and within migrant groups and the receiving population through the lens of language practices. Previous studies of translocality have focussed on larger, global cities and this research aims to shed some light on the phenomenon in the super-diverse urban environment of a smaller city.

A migrant's first encounter with a dominant institution in the host country is often in the health domain. My case study is located in a hospital maternity department where large numbers of migrants require language support and is considered to offer a rich site of translocal interactions. I use a qualitative ethnographic methodology and interpretation through induction from contextualised subjective data and a theme-oriented discourse data analysis. This approach is suitable for a study, which requires an understanding of how individuals and groups perceive and construct their worlds, difference, agency and power relations.

My findings reveal the control of languages by local governance framed by dominant monolingualism. The reality of *in situ* multilingualism of the interpreters and patients accessing healthcare in the city is challenging this monolingual dominance. I suggest the vertical top-down to grass roots relationship of the control of languages is becoming increasingly non-hierarchical as the hospital responds to this linguistic reality. The light shed on the negotiation of translocality may inform effective professional practice in the health domain. This knowledge can be of use to other public sectors, language policy makers and planners that engage with members of migrant communities.

DEDICATION

To the bravery and courage of all transnational migrants - your descendants succeed because you dared

And,

To Paul, Louis, Camilla and Rémy as an affirmation that anything is possible.

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DECLARATION OF AUTHORSHIP

I, Linda Cadier declare that the thesis entitled, '**Exploring translocality: negotiating space through the language practices of migrant communities'** and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research.

I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given; with the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission, or [delete as appropriate] parts of this work have been published as: [please list references]

Signed: .....

Date: .....

ACKNOWLEDGEMENTS

I am indebted to my supervisors, Professor Clare Mar-Molinero and Vicky Wright from the University of Southampton for sharing their knowledge and time. Their ever-present support and encouragement enabled me to develop my ideas for this thesis and see it through to completion.

A special thanks goes to Kim Sutton from Southampton University Hospitals Trust for sharing her commitment to the improvement of the interpreting services, welcoming my involvement and supporting me through the numerous practical challenges and delays to completion.

I thank all my informants, anonymous in the text, who gave me their time and the benefit of their wisdom. My respect for the professionalism and dedication of the midwives and interpreters interviewed during the course of this research knows no bounds.

This research was, in part, conceived to make a positive contribution to the services of Southampton General Hospital in thanks for the care and attention they have shown for members of my family over the years.

Last but not least, I count my blessings and give thanks to my family who believed in me throughout this fascinating journey and never let me down.

LINDA CADIER

DEFINITIONS AND ABBREVIATIONS

A2C	Access to Communications
ACPS	Accessible Communications Position Statement
DA	Discourse analysis
EU	European Union
GP	General Practitioner
Language practices	Language practices include the everyday lived practices of a cultural or ethnic group or sub-group.
LE	Linguistic ethnography
LEP	Limited English language proficiency
MREC	Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee
NHS	National Health Service
NRES	National Research Ethics Service
PAH	Princess Anne Hospital
PCT	Primary Care Trust
R&D	Research and Development
SCC	Southampton City Council
SGH	Southampton General Hospital
SISP	SUHT Interpreting Services Policy
SSHP	Southampton's Social Housing Partnership
SUHT	Southampton University Hospitals NHS Trust. Since 1 October 2011 known as University Hospital Southampton NHS Foundation Trust
SVS	SUHT Voluntary Services
SVIS	SUHT Volunteer Interpreter Service
SVI	SUHT volunteer interpreter

TODA	Theme-oriented discourse analysis
UK	United Kingdom
USA	United States of America
>	web-embedded hyperlink

Chapter 1: Introduction and rationale

> "Translocality draws attention to multiplying forms of mobility without losing sight of the importance of localities in people's lives." (Oakes & Schein, 2006, p. 1)

My family arrived in the UK at the turn of the 20th century as economic migrants from Minori in southern Italy. They set up home in the poorest central area of Southampton behind the docks. The family maintained active relationships with family and kin back in Italy, London and the USA. They visited family members in New York to perfect family ice-cream recipes and to collect ice-cream making equipment. They then sold ice cream, first from the house, then a barrow, then from a shop painted in the colours of the Italian flag with marble flooring from their homeland. Impromptu Italian piano accordion recitals entertained the clients creating their version of a 'Little Italy.' Family members from Italy were helped to come to Southampton to work first in the ice cream parlour, in a family greengrocer's business and then in the city. My great-grandfather went back to Italy to marry a girl from his village and brought her back to Southampton, where they had six children. The family spoke Italian at home and my great-grandmother worked in the family business and never learnt to speak English well. As the family prospered, they bought property and had business interests back in Italy. The children all spoke Italian and went back for long periods of Italian schooling and holidays. Italian olive oil and lemons from the home village was the family remedy for all health problems. Premature babies were wrapped in olive oil soaked cotton wool and a sore throat meant an olive oil soaked scarf and gargling with Minori lemon juice. Children, when ill, returned to Italy to convalesce with trusted family members and my great-grandmother returned to live out her old age in Italy.

This thesis will explore aspects of this kind of place-making by transnational migrant communities, conceived of by scholars as translocality. These place-making practices are sustained, as in my family, by vibrant reciprocal links with the homeland, business and family networks, mainly across national borders.

1.1. Thesis themes

The themes of this thesis are translocality and its negotiation through the language practices of migrant communities. I discuss these themes with particular reference to the health domain. The theoretical conceptions of these themes are discussed in Chapter 2.

The context of the first theme is a proliferation of transnational migration to urban environments due to increased social mobilities. This is characterised by overall increases in migration by smaller numbers of migrants from larger numbers of countries, regions and clans. As physical and virtual connections facilitated by new technologies enable global communications in real time, scholars suggest we are entering a new paradigm of super-diversity. A feature of super-diversity is the breaking down of the boundaries of language and ethnicities. Increasing heterogeneity suggests that categories of difference between and within migrant communities and the receiving population are more complex and hybrid.

Migrants are able to maintain active and vibrant reciprocal relationships between their homelands and host countries, mainly across national borders. These relationships actively contribute to the place-making practices of migrants in their new urban environments, effectively linking cross-border localities. I will discuss the work of scholars working in this field who conceptualise these place-making practices as translocality.

Secondly, making ones place in a new homeland involves the migrant in the negotiation of translocality. This negotiation takes place in encounters within their own community, between other migrant communities and with the receiving population. The negotiation of difference underpins these encounters as groups decide their allegiances and accepted practices.

Thirdly, the migrant arriving in the UK may speak little or no English. Language becomes an important and empowering resource in the negotiation of translocality and is viewed as crosscutting to all these interactions. In this context, language practices are from the outset defined as including the everyday lived practices of a cultural or ethnic group or sub-group. These

everyday practices may be viewed as criteria for constructing difference and create real or imagined power imbalances between and within communities.

Finally, these encounters create spaces, public, institutional or private, that may be more or less open to the researcher. Through personal, professional and academic contacts, I identify the health domain as a field relevant to the study of such spaces, as Spolsky suggests it includes:

> "…doctors (locked into professional terminology), nurses (who serve a brokering role in monolingual situations – 'What did the doctor say?" the patients ask) and patients, including in the modern multilingual city a good chunk of undigested new immigrants, all occasionally connected by interpreters…" (Spolsky, 2012, pp. 4-5)

The health domain is identified as a powerful space of negotiation of translocality for the migrant as it may be their first encounter with one of the host country's institutions. As in the case of expectant mothers who may have only recently arrived in the country. As homemakers, they may in encounters to date, rely on partners and family for negotiating English language contacts. Antenatal care necessitates their active participation in their own health care. It is of interest to the health service to understand the features of translocality that may be framing the migrant's interactions with their services. Such translocal features may include transnational migrant women returning to, or accessing, their homeland services for health care and medications.

1.2. Aims of the study

I aspire to reveal through the exploration of my themes, the impact of global processes on local practices. In Chapter 2, I suggest these global processes are driven by powerful ideologies that affect the everyday lived experience of citizens. Top-down at the macro level, a default monolingualism may empower national and local governance to favour the monolingual at the expense of multilingual citizens. Bottom up the *in situ* multilingualism of an increasingly super-diverse population may challenge this hegemony.

At a theoretical-methodological level, outlined in Chapter 3, the study aims to demonstrate how a theme-oriented discourse analysis approach to the examination of data can generate an effective account of translocal negotiation. Data will be gathered using a linguistic ethnographic case study design based on recordings of interviews, observations and document analysis.

The context of my case study described in Chapter 4 is a provincial city in the UK and I aim to make the case for this non-global city as an important site of linguistic and cultural diversity. I am looking for evidence of the rich linguistic landscapes previously described by scholars in cities such as London, New York, Tokyo and Jerusalem. These city landscapes include signs and markings of other languages and cultures that mark out their territories in religious, social and media sites.

At an applied level, the site for the case study is the institutional domain of a local hospital maternity service. Through my findings presented in Chapters 5 and 6, I aim to inform health care professionals working with transnational migrants to increase their knowledge about the features of translocality that may affect their practices. I am also interested to understand the role of interpreters as mediators of translocality. I suggest that this information is applicable to professional practice in other public sector organisations with multilingual clients and workforces. I am interested to identify processes of research activism that may result during the research. I suggest this activism may reveal itself in an increased sensitivity to languages. I aim to disseminate my findings to other public sector domains such as local governance, legal, voluntary and community sectors.

1.3. Rationale for case study

The identified themes and aims together with my background knowledge and experience in the health sector field helped me to define my study and research questions. My selected qualitative approach suggested data collection from an emic perspective that would allow hypotheses to emerge from naturally occurring data. For this reason, a case study design was the preferred option.

Chapters 5 and 6 will present the analysis and interpretation from the data gathered. This is of particular interest in the health sector where many professional staff in a small provincial city are white-British and may be lacking in intercultural knowledge and competences. Ideologies that inform discourses of power and the construction of difference can regulate the control and management of language in professional practice. Language policy controls the extent of the institutional use of the English language, when to bring in interpreters, when to allow access to family and friends and when to allow them to act as interpreters are all key decisions. Translocal health practices that may contradict routine UK health practices need to be negotiated. For example, midwives would not routinely advise kohl to be drawn around the babies' eyes or mixtures given to newborn babies that they are not familiar with. Understanding how difference is nuanced and negotiated through talk in these scenarios can assist the development of professional practice, and the interpreter and patient experience.

Particular language choices can lead to miscommunications, misunderstandings, lack of trust, missed appointments, wrong diagnoses, and incorrect use of medication or repeated testing. Complicity or contestation on the part of any of the actors in these interactions with gatekeepers, midwives, interpreters or staff can offer valuable information on the relationship between the local and the global to inform language policy and planning. It is hoped that the results from investigations in this health domain can be extended to other public sector domains. I understand that this knowledge is transferable to other public sectors working with multilingual clients and workforce.

1.4. Research questions

My research questions derive from the aims and rationale presented above. The main driver of the research is an attempt to evaluate translocality in the context of its impact of the global on the local. I wish to answer:

(i) How do translocal 'place-making' negotiations link the micro to the macro and demonstrate the impact of the global on the local? (More

specifically, what are the features of translocal spatiality that link the global with the local that can demonstrate the impact of the micro to the macro?)

(ii) How does this negotiation of translocality contribute to research on the non-global city as a site of linguistic and cultural diversity? (More specifically, considering translocality in the context of the relationship between language, power and difference, how do language practices discursively contest or disadvantage transnational migrants in the city?)

(iii) How is translocality negotiated in the non-global city of Southampton? (More specifically, how is translocality constructed, accomplished and maintained top-down and grass roots-up in the city, using my case study of maternity service interactions and information from community contacts in the City of Southampton as an example?).

1.5. Overview of chapter plan

This introductory chapter describes the focal themes of my research and presents the aims, rationale and research questions. There are six following chapters. Chapter 2 sets out the theoretical context for the research and a literature review of the related area of study. Scholars' work on the proliferation and intensity of transnational movements and translocal practices are presented as features of globalisation. This is discussed in relation to the proposed new paradigm of super-diversity and smaller new urban environments. This chapter explores the conceptualisation of language as a social construct that is shaped and shaped by dimensions of language ideologies such as power, agency and difference.

Chapter 3 provides the theoretical approaches of my methodology, analysis and interpretation that take into account the historical and social structural forces underpinning everyday encounters. It focuses on a discussion of the assumptions of linguistic ethnography and case study as a suitable methodological approach for this qualitative study. The chapter also presents the inter-relatedness of emic theme-oriented discourse analysis and its analytical tools as a coherent basis for the interpretation of the data in

Chapters 5 and 6. Sections of Chapter 3 describe the data collection sites, procedures and ethical considerations with a worked example of the analysis and interpretation of an excerpt of data collected.

Chapter 4 sets the historical, demographic and linguistic landscapes that provide the context of the case study in the City of Southampton. Southampton is described as a port city, historically a gateway and home to transnational migrants characterised by an increasingly super-diverse urban environment.

Chapter 5 and 6 critically analyses the data collected using the tools described in Chapter 3. Answers to my research questions are explored through the two macro themes identified from data analysis. These themes are the negotiation of space in translocal health interactions and the control and budgeting for languages.

Chapter 7 draws the main conclusions of the research to address the over-arching question of the impact of the global on the local. The limitations of the study are discussed and the concerns about establishing reliability and validity. I make the claims for the important contributions of the research in the theoretical field of super-diversity and translocality. In particular, I raise the research activism benefits of sensitisation to languages during the on-going research process. I conclude by suggesting possible areas for further research.

Chapter 2: Theoretical approaches

2.1. Introduction

This research is situated in the context of globalisation, a highly contested term, but generally agreed by scholars such as Bloch (2002), Hansing (2008) and Stern and Deardoff (2009) to include economic, commodity transactions and migration. These movements take place mainly across national borders. Scholars from Hannerz (1996b) to Smith and Eade (2008), suggest transnational migrants keep up active reciprocal links between their hosts and homelands and describe these practices as transnationalism. My personal family story (see 1.0.) describes these types of Anglo-Italian relationships and networks in the early 20th century. However, In the 21st century an increase in the intensity of economic and social mobilities (Urry, 2007) has led Vertovec (2010) to suggest a new paradigm of super-diversity. Super-diversity is facilitated by more accessible telecommunications and travel and connections that compress space and time.

In the first section of this chapter (2.2), I will discuss the concepts related to transnationalism derived from the fields of social anthropology, urban geography and migration. I am interested to explore whether Vertovec's proposed super-diversity is indeed a new paradigm or another term for transnationalism. Super-diversity proposes a challenge to the traditional connections between ethnicity, language and territory. It is characterised by an unlinking of identity markers as smaller numbers of people from a greater number of linguistic and cultural backgrounds move across national borders and settle outside their countries of origin. Super-diversity suggests that the increased intensity of physical and virtual interactions facilitates social mobilities. Individuals can negotiate and construct multiple identities and spaces through family, work-related and virtual social networks. I will argue that linguistic super-diversity, identified in the studies of Blommaert and Rampton (2011), provides supporting evidence for this new paradigm.

Transnational migration is traditionally a feature associated with the larger global cities of the world. In section 2.3 I will explore features of global cities associated with transnational migration from the work of scholars such as Mac Giolla Chríost (2007). These include spatial differentiation, bounded and

overlapping community contact zones and an increase in linguistic and cultural markers. These markers can produce locales in cities such as Little Italys or Chinatowns. This is important for my research where I will be looking for these features in the smaller provincial city of my case study. If revealed, it is hoped that my findings may contribute to smaller cities being identified as important sites of linguistic and cultural diversity. Scholars such as Chríost conceive of these cities as non-global cities and I will examine the usefulness of this categorisation in the context of super-diversity.

In section 2.4 I will present the theoretical conceptualisation underpinning my main theme of translocality. A feature of all these transnational movements is migrants making their homes or places in a new environment. Sassen (2007b) describes this place-making as becoming embedded and situated in certain cities. Hannerz (1996b) and Smith and Eade (2008) conceive of it as translocality produced and enacted as transnational migrants bring their music, food, social, religious and trading practices to the city. Blommaert elaborates that migrants have all kinds of social, cultural, epistemic, and affective attributes that produce particular places, defined as spaces, 'onto which senses of belonging, property rights and authority can be projected.' (Blommaert, 2005, p. 222) These places are characterised by mobility and fluidity (Soja, 1989) where new communities interact with each other, more established migrant groups and the receiving population.

I continue to explore the negotiation of translocality between migrant communities and their receiving populations through the lens of language practices. I present a review of the work of scholars on these kinds of situated language practices. These include linguistic heteroglossia (Leppänen, 2011) metrolingualism (Otsuji & Pennycook, 2010) and transidiomatic variation (Jacquemet, 2005).

In section 2.6 I identify a dimension of translocality as the negotiation of difference derived from notions of the Other or the Stranger. I explore the linguistic construction of difference by migrant and receiving populations to decide who is in and who is out of a particular group. I refer to scholars such as Blommaert (2010) who suggest that these negotiations are becoming more complex due to the hybridisation of bounded, standardised languages and

ethnicities in the paradigm of super-diversity. In this paradigm increasing diversity is a feature not only of the incoming migrant communities but also of an increasingly heterogeneous receiving population. In the context of this hybridisation, I argue that individuals and groups continue to value the language(s) they speak as an important marker of their own difference and the product of their own rich social and cultural heritages (Anzaldúa, 2007).

Moyer suggests that we need to understand, 'the ways language and locally realised multilingual practices are connected to wider, social, political and economic processes.' (Moyer, 2012, p. 34) This is my overarching research question and in section 2.7 I look to provide the theoretical underpinning for the link between these global processes (the macro) and the local spaces (the micro) created by migrant communities. I suggest the conceptualisation of Gidden's (1999) Structuration theory helps us to understand how transnational migrants may be seen to act as agents in systems of interaction with the dominant social structures.

In the context of language practices I understand global, dominant social structures to exert top-down influence through language policy and planning. On the other hand, I understand local migrant communities and their champions to represent the grass roots that contest or comply with these policies. I am interested to explore whether these are fixed positions and the conditions that influence the other to change. Gal (2006) illustrates the monolingual and multilingual ideologies that underpin these interactions. I explore the ideologies that can be said to inform current European supranational and national UK language policy. I use examples from the studies of scholars such as Mar-Molinero (2010) to illustrate other linguistic contestations

Power relations are important in the negotiation of the global and the local. Language is a powerful resource in these negotiations. I use Bourdieu's (1991) theoretical concepts of *habitus* and market that situate language as a linguistic resource and builder of capital for a group. Access to the dominant language of the city empowers the migrant. In the UK, for example, the migrant needs to have the ability to speak English to navigate institutional bureaucracy, access services, education, work and settle their family into the locale. In my case

study, equitable access to maternity health services depends on one's ability to speak English. Woloshin et al. (1995) describe the miscommunication in the health domain that can result in missed appointments, incorrect prescription taking and misdiagnosis. Interpreters are important mediators in these relations but the decision as to when to use them, when to use family or friends rests with the health practitioner. In this sense the patient is disempowered and dependent on the institutional top-down language policy. The exploration of policy control of language policy and planning will be a key line of enquiry for my research.

2.2. Transnationalism and super-diversity: features of globalisation

2.2.1. Globalisation contested

This research is set in the context of globalisation. A highly contested term that can be defined as an, 'increase in international transactions in markets for goods, services and some forms of production, plus the growth and expanded scope of institutions that straddle national borders.' (Stern & Deardoff, 2009, p. 21). Hyperglobalists, such as Friedman (2005) use the metaphor of the world as 'flat' to describe the way that a single global free trade market is operating without obstacles across and within borders. The debate continues as to who exactly are the agents and beneficiaries. Heller (2003) suggests globalisation might only be of benefit to the West, in particular the USA and first world orders that are seeking global governance and commodification of products, goods, language and identity. In this scenario, the scholar, Bauman (2001) suggests that the global (macro) is able to direct events and the local (micro) is isolated and powerless. All but the wealthy may be excluded from global life and influence. However, previously marginalised countries, such as China, continue to close the gap between themselves and the advanced industrial countries aided by increased access to technologies and markets. The gap continues to widen between them and the Latin American low-growth economies that only benefit a small group of high-income earners. Stiglitz (2006) identifies these phenomena together with the decline in per capita income in Africa and the increase in poverty in the post-communist Eastern

block countries. Given these disparities, globalisation could be another name for elitist homogenisation as the privileged few move between the major international airports and high-income shopping districts of the world. As far as culture is concerned, Appadurai argues that these terms are not synonymous and he suggests that:

> "….the globalisation of culture is not the same as its homogenisation, but globalisation involves the use of a variety of instruments of homogenisation (armaments, advertising techniques, language hegemonies, clothing styles and the like), which are absorbed into local political and cultural economies, only to be repatriated as heterogeneous dialogues of national sovereignty, free enterprise, fundamentalism, etc." (Appadurai, 1990, p. 307).

As Welsch (1999) concurs and argues, 'champions of globalisation would have a hard time ignoring the resurgence of particularisms worldwide.' I am interested to explore in my research the relationship and hierarchy of the global to the local. I am asking questions as to whether this relationship is one of homogeneity to the particular (heterogeneity). Also, at which level heterogeneity features, in national sovereignties (as Appadurai suggests) or at the grass roots (as Welsch suggests).

2.2.2. Transnational migration

Historically migrants and refugees have always moved across borders. My own migrant family from Southern Italy came with large numbers of other able-bodied villagers to the City of Southampton at the beginning of the 20th century (see 1.0). From this personal experience and literature review, I understand and agree with the traditionalists who argue that transnational migration is not new. Portes et al (1999) identify economic migration from the times of the Venetians and Genoese merchants through to the Portuguese, Dutch, English and Spanish colonisers of the Americas and Africa. Pre-19th century, immigrant colonisers often from the trading elite, for example of the Americas, tended to move to that one country and settle but retained active links with their homes and countries. In the 19th and 20th centuries, a circular pattern of cross-class labour migration of more economically diverse

populations, particularly to and from the USA, can be identified with periods of short tenure characterised by frequent returns to the homeland. For example, Poles worked in the mines of the Ruhr, Germany; Algerians in mainland French industries and Mexicans fruit-picking in the southern states of America in seasonal cycles.

In the 1990s, 24 million refugees were displaced as a result of war or catastrophe, particularly in Africa (Castells, 2000) and by 2008 an estimated 214 million people, 3.1% of the world's population were living outside their country of birth. These figures translate to a population of migrants that would constitute the fifth most populous country of the world, 49% of whom are women (United Nations, 2008). A feature of this transnational migration identified by Bloch (2002) is a pattern of a highly skilled north-north migration compared to that of the poorer, refugee and asylum-seeking south-south. In 2009, those migrants sent £414 million in financial remittances back to their homelands, of which £316 billion of that was sent to the developing countries of the world. Whichever view is taken on the agency, outcomes and risks of globalisation, the reality is a marked increase in the movement of the world's populations across borders. Some sociologists and urban geographers regard these increases in social mobilities as challenging the structure of the nation states, the family and religion. Sassen (2007b) suggests they lead to a 'cracking' of the nation state.

2.2.3. Cross-border activities: transnationalism

The sociologist and ethnologist, Steven Vertovec concluded that:

> "The simultaneity of current long-distance, cross-border activities, especially economic transactions – which provide the recently emergent, distinctive and, in some contexts, now normative social structures and activities which should merit the term transnationalism." (Vertovec, 2009, p. 3)

Glick-Schiller (1999) and Kearney (1995) argue that the dense, reciprocal and complex migrant social networks created in the sending and receiving nations are transnational social formations. These are facilitated by better and cheaper

transport, faster communication links, and growth in new technologies. A new generation of transnational institutions, corporations, entrepreneurs and travellers from across the social spectrum are able to maintain active reciprocal links between their homelands and their adopted host countries in real time.

> "The transformation of time under the information technology paradigm, as shaped by social practices, is one of the foundations of the new society we have entered, inextricably linked to the emergence of the space of flows." (Castells, 2000, p. 496)

Business networks, cyber communities, ethnic diasporas, worldwide criminal and policing activities are maintained through these links. We saw recently the financial and political support for the uprisings in Tunisia, Egypt and so-called 'Arab Spring' through these networks. Hannerz describes people in transnational networks of short-term relationships or fleeting encounters as a result of:

> "Tourism, charter flight 'hajj' and other modern day pilgrimages, invisible colleges in science, exchange students, au pair girls, foreign pen pals, transcontinental families, international bureaucracies, summer beach parties of backpacking Interrail passholders from all over, and among voluntary associations everything from Amnesty International to the European association of Social Anthropologies". (Hannerz, 1996b, pp. 46-47)

Ma suggests that:

> "There are various forms of transborder spatial practices. The most obvious and widely discussed is the global-to-local spatial flows such as transnational McDonaldization, a process in which a stable set of spatial practices (symbolism, management, routine and spatial design) travels across borders and reproduces spaces transnationally. Another form is a local/global spatial flow, which is exhibited in migration and cultural tourism." (Ma, 2002, p. 132)

2.2.4. Transnational networks reciprocally linked across borders

Transnational migration increased following the enlargement of the European Union in 2004, to include Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. This has given researchers from a wide number of disciplines, economists, sociologists, anthropologists, migration and diaspora studies, more opportunities to examine the family networks sustained across national borders. Of interest is the manner in which families create separate living arrangements in two or more countries whilst retaining links with their homeland (Burrell, 2009).

Studies by scholars such as Bryceson and Vuorela (2002) have identified that transnational families located in two or more nation states spend significant times apart and construct multiple identities to maintain close family and community ties. Lobel (2003) identified that multi-sited families, with family members separated by large geographical distances, are common features of the transnational migratory experience. Currie (2008) and White (2011) in their work on migration in the enlarged European Union provide evidence that, in addition to temporary migrants, significant numbers of extended family units migrate together, simultaneously or consecutively and engage in transnational practices.

Levitt (2001) identifies the rich transnational connections between families from Miraflores, a town in the Dominican Republic who migrate to Jamaica Plain, an area of Boston, that transform both locales through transnational activities. These activities include sending financial remittances to build homes and schools, support families, pay for family members to migrate for marriage or work and influence political campaigns. Such migrants may hold dual nationality and be enfranchised in both locations and thus be able to make a considerable impact on their homeland politics or hold office in both locales.

As Bourdieu suggests, maintaining such social links is a natural human endeavour, as we are pre-programmed to reproduce patterns of thinking and behaving specific to our societies in which we were socialised:

> "Because the subjective necessity and self-evidence of the common sense world are validated by the objective consensus on the sense of the world, what is essential goes without saying because it comes without saying." (Bourdieu, 1977, p. 167)

Yet transnational individual and group identity is becoming more complex and nuanced, moving away from any conflation of the binary points of a horizontal axis of homeland and host country. Crowley argues in his work on the construction of European Union citizenship identity that there are 'thicker' dimensions to this identity-formation informed by the experiences of inter and intra-community experiences:

> "In this context the historical relationship between state and citizenship is challenged and the nation states are no longer capable of being the exclusive form-giver of citizenship. In the emerging multilateral political entities, where the possibility of exclusive ethno-culture basing on ethnic homogeneity is no longer possible, new projects of citizenship have become inevitable. They should be less and less nationally delimited and citizens should be linked to each other both by a concrete fellow-feeling based on social intercourse and shared practices." (Crowley, 1999, p. 478)

2.2.5. Super-diversity, a new name for transnationalism?

Increased social mobilities and the complexities of relationships and networks are challenging all the Herderian (Barnard, 2003) notions of connections between language, ethnicity and soil. Vertovec (2010) identifies the emergence of a new paradigm of transnationalism conceived as super-diversity. He argues that it is a feature of a post-multicultural world that transcends ethnic minorities and is characterised by an unlinking of identity markers as smaller numbers of people from a greater number of diverse backgrounds move across national borders and settle outside their countries of origin. Whilst

super-diversity could be said to be transnationalism by another name, scholars are identifying step-changes in proliferations, intensity and simultaneity of transnational phenomenon. Could it be that a certain degree of homogenisation as a result of globalisation (see 2.2.1) at the global level is allowing heterogeneous individuals and groups to assume and access more particularisms? Previous migrants may have had more limited repertoires related to bounded language, ethnicity, religious and social practices. Taking into account essential referencing, I suggest a white British middle-class individual can convert to Islam, adopt the dress and religious practice without leaving their hometown. Creese and Blackledge note, especially in urban societies, the reconfigurations resulting from the complexity of:

> "….other factors which come into play (that) include, *inter alia,* differential immigration statuses, gender, age, economic mobility, social class/caste, locality, and sexuality." (Creese & Blackledge, 2010, p. 552)

The growth in the use of social networking sites offers individuals and groups the opportunity to share information outside of closer kinship and familial circles. Bakshy et al. (2012) from their study of 253 million Facebook interactions over a two-month period in 2010, found that Facebook users were more likely to share information with distant contacts. They argue that people share and consume information from people with different perspectives rather than those who share the same opinions, tending to widen and increase their contact circles rather than narrow them.

I understand this conception of super-diversity to parallel Holliday's (1999) paradigm of small cultures. Holliday suggests these have developed in a world that is increasingly less coherent with loose boundaries. Sub cultures are distinguished from, and largely subservient to, monolithic essentialist national cultures. Small cultures do:

> "…not therefore relate simply to something smaller in size than the large ethnic, national or international culture, but presents a different paradigm through which to look at social groupings [that are]…..non-essentialist in

> that it does not relate to the essences of ethnic, national or international culture." (Holliday, 1999, p. 240)

Holliday cites Baumann's ethnographic work in the West London suburb of Southall, where adult Somalians asked to describe their 'culture' said they:

> "….saw themselves as a member of several *communities*, each with its own *culture.* The same person could speak each as a member of the Muslim *community* in one context, in another take sides against other Muslims as a member of the Pakistani *community,* and in a third, count himself part of the Punjabi *community* that excluded other Muslims but included Hindus, Sikhs, or even Christians." (His italics) (Holliday, 1999, p. 240)

I note the work of scholars that understand these identity markers within the paradigm of super-diversity to change and evolve throughout one's life. As Blommaert argues:

> "…Super-diversity compels us to abandon the presumption of stability of communities, and replace them with a more fluid view of networks, knowledge communities and communities of practice – all of them dynamic, in the sense that most of them are peculiar to particular stages of life, (as e.g. the family or regional forms of memberships) and those that persist through life change in shape and value during one's lifetime." (Blommaert & Backhaus, 2010, p. 22)

2.2.6. Linguistic super-diversity

Referring to language to identify features of this new phenomenon of super-diversity. Blommaert and Rampton discuss the linguistic super-diverse features of a small piece of text found in the main street of an inner city area of Antwerp, Belgium:

> "….handwritten in 'Chinese' (though this will need to be qualified). In English translation, the text reads "apartment for rent, first class finish-ing, water and electricity included, 350 Yuan per month", followed by a mobile

> phone number…… But when we pay closer attention, we discover a very complex object, and here are some of the issues: (1) The text is written in two forms of 'Chinese': a mixture of the simplified script which is the norm in the People's Republic of China (PRC) and the traditional script widespread in Hong Kong, Taiwan and earlier generations of the Chinese diaspora. (2) The text articulates two different styles or voices, that of the producer and that of the addressee(s), and the mixed script suggest that their styles are not identical. In all likelihood, the producer is someone used to writing traditional script, while the addressee is probably from the PRC. (3) The latter point is corroborated by the use of 'Yuan' rather than 'Euro' as the currency, and (4) the mixed character of the text suggests a process of transition. More specifically, it suggests that the producer (probably an 'older' diaspora Chinese person) is learning the script of the PRC, the unfinished learning process leading to the mixing of the scripts. Thus (5) this text points towards two very large scale phenomena: (a) a gradual change in the Chinese diaspora, in which the balance of demographic, political and material predominance gradually shifts away from the traditional diaspora groups towards new émigrés from the PRC; (b) the fact that such a transition is articulated in 'small' and peripheral places in the Chinese diaspora, such as the inner city of Antwerp, not only in larger and more conspicuous 'Chinatowns' such as London." (Blommaert & Rampton, 2011, pp. 1-3)

These scholars demonstrate how the intensity of physical and virtual mobility facilitates movement and multiple interactions. Individuals are able to negotiate multiple identities and spaces in family, work, social networking, education, residential, cultural and religious roles. Transnational migrants, characterised by their own heterogeneity, encounter strangers from other heterogeneous migrant communities and the receiving population. Oren describes 'the opportunity not only to observe and experience the cultural other but also to partake in a process of continuous encounter, exchange and transformation.' (Oren, 2003, p. 54)

2.3. The importance of the global and non-global city as a site of linguistic diversity

> "The city is a discourse and this discourse is truly a language: the city speaks to its inhabitants, we speak our city, the city where we are, simply by living in it, by wandering through it and looking at it.....it is in relation to personal histories that urban texts are interpreted and reinterpreted" (Barthes, 1997, p. 168)

Traditionally, large capital cities, like New York, Tokyo and London uniquely met the global city criteria of hosting economic, political, cultural and transport hubs. They were characterised by the diverse nature of their large populations who originated from many different linguistic and ethnic backgrounds (Sassen, 1991). However, although Tokyo and New York are still in the top ten world cities by size of population (London is No. 18), cities like Guangzhou, Seoul, Shanghai, Mexico City, Delhi, São Paulo, Mumbai and Manila now all have populations of over 17 million. There is a lack of linearity on the axis of criteria of global to non-global cities that scholars of urban studies such as McCann (2004) identify. Larger and smaller cities now both feature global trading capabilities and attract more diverse populations. Due to these changes, McCann argues that the classification of global or non-global cities may no longer be useful and suggests that:

> "....a language already exists to assist in the retheorisation of the globalisation–urbanisation nexus. Proposing the concept of the 'multiplex city', Amin and Graham (1997, pp. 417–421) see the city as produced by complex and often contradictory interactions of diverse political economic and cultural networks (from the intrafirm connections of global producer services firms to the sociospatial practices of the cleaners who maintain their offices (Allen and Pryke, 1994))....Merrfield, for his part, emphasises the notion of co-presence as part of his dialectical understanding of space and place. He argues that **within** the very moment of place ... there lies a copresence of heterogeneous and conflictual processes, many of which are operative over a broader scale than the realm of place itself (Merrifield, 1993, p. 522; original emphasis). The understanding connecting these

> various terms is that the social processes constituting cities are 'bundled' into intense complexes of interaction, are simultaneously 'distanciated' over wider geographical fields and can only be understood in reference to these interscalar connections." (McCann, 2004, p. 2329)

Kokot agrees and argues that port cities, whatever their size, are internationally competitive and that:

> "….in order to improve their position in the global network, municipal governments have been creating infrastructures and policies encouraging investment and the establishment of new business enterprises, the professionalisation of labour and high-end recreation and consumption, to reorient the cities to the real and imagined interests of globally mobile investors." (Kokot, 2008, p. 13)

Following employment and refugee resettlement programmes across the country, Rienzo and Vargas-Silva (2011) argue that the foreign-born population of the UK has now spread significantly beyond London into smaller cities and even rural areas. Legrain's (2010) study reveals that UK regions, such as the East of England, employ large numbers of transnational migrants in food manufacturing, catering and health care sectors. I look in my case study to contribute to this field, with particular reference to a small port city and a study in the health domain.

2.3.1. Communities spatially differentiated in the city

Facilitated by improved transport connections, transnational migrants locate in cities, often in locations close to their original entry point. Drawing on Bloch's (2002) research into migrant, refugee and asylum-seeker settlement in London, places of extreme wealth are often located close to areas of deprivation, for example the London Borough of Kensington and Chelsea in the City of London with the richest per capita income in England also has one of the largest council estates in the city, World's End. This estate is home to many transnational migrants and a site of extreme social deprivation. The state-of-the-art architecture and financial powerhouses of the City of London

share a border with the Whitechapel district of London. The latter, traditionally, a working-class area, now hosting a 52% Bangladeshi community and many other groups of varied ethnic origin living in crowded conditions, operating from small shops and large areas of street markets. Both districts attract migrants; the unskilled to Whitechapel, where they may already know others from their homeland communities, where there is available housing, accessible cheap food and possibilities of work. To the City of London, come the highly skilled transnational migrants, moving between global city headquarters, able to afford luxury city apartments and access all of the city resources and travel connections.

Members of transnational groups seek each other out and create shared spaces. From my own experience from living in London, significant numbers of the French community choose to send their children to the Lycée Charles de Gaulle in South Kensington, visit the cinema at the French Institute or buy French food in the local shops located there. In Whitechapel in East London, the Bangladeshi community send their children to the local Sylheti language supplementary Saturday schools and attend the East London Mosque or London Muslim centre. Food from homelands is available in the street markets. However, a feature of super-diversity, as described by Vertovec's (2010) study in London, is that whilst particular communities may exist in one London borough, there is more and more heterogeneity.

Vertovec describes the foreign-born population in London as:

> "….widespread and unevenly distributed….. The borough of Brent has the highest percentage of its 2001 population born outside the EU, with 38.2% (100,543 people), followed by Newham with 35.6% (86,858 people), Westminster with 32.4% (58,770 people) and Ealing with 31% (93,169 people) (see www.statistics.gov.uk). Within each such area, the diversity of origins is staggering, as depicted …. with reference to Newham." (1990)

Super-diversity challenges a simple description of the location of speakers of different languages linked to one particular area, as in London where:

> "There are predictable groupings of South Asian languages in places of renowned Asian settlement like Harrow, with the top three non-English languages being Gujurati (18.8%), Hindi/Urdu (2.4%) and Punjabi (1.6%). Other places show fascinating conjunctions, such as in Haringey where Turkish (9.9%) is commonly spoken alongside Akan (3.5%) and Somali (2.7%); in Lambeth where Yoruba (6.4%) speakers mingle with speakers of Portuguese (4.1%) and Spanish (2.1%); in Merton where English Creole (29.8%) is common next to Cantonese (2.2%) and French (1.9%); and in Hackney where Turkish (10.6%), Yoruba (6.8%) Sylheti (5.4%) can be heard….." (Vertovec, 2006, p. 8)

All of these individuals and communities affect and are affected by differentiated rhythms of the city and the rhythms of the dominant host community that govern economic, trading, religious and educational flows may be challenged by those of new transnational migrants. In the UK, incoming migrants set up their own businesses, like the corner shop, offering 24-hour access that opened up Sunday shopping which then spread throughout the whole country. Religious practices that include different holy days, such as the Jewish Sabbath on Saturdays and the Muslim main day of worship on Fridays; supplementary community language schools that open after school and on Saturdays all affect the rhythms of the daily life of all the population. These rhythms need to be negotiated by all of the population and in the case of the public sector the challenge is to offer services to all of the population equally and fairly, taking into account the wide diversity of these rhythms.

2.3.2. Contact zones in the city

> "City spaces are not simply given: they are produced through many movements and interactions coming together in ways that often disrupt existing rhythms and relationships across cities." (Massey, 2005, p. 66)

The migrant may be isolated in an urban environment by a lack of the language and knowledge of the dominant culture (see 2.6 and 2.7). A migrant has to access local services in negotiation with members of their own community, other communities and the receiving population. Pratt suggests the sites of these encounters create 'contested contact zones' (Pratt, 1991, p.

34), where two or more cultures meet and intermingle and negotiate their linguistic and cultural interactions. Bhabha (1994) referred to these spaces as 'third space' or Kramsch (2002) as 'third culture' or a 'third place.' These third spaces being characterised by hybridity that juggles with cultural references from homeland cultures.

As new minority groups of migrants arrive, districts may change their character and challenge the existing dominant group. From my own experience of living in London, Vauxhall in South London was a predominantly Afro-Caribbean area. It now attracts large numbers of migrants from Brazil, Madeira and mainland Portugal. Shops, signs, restaurants, churches, names for clothing and available music and TV channels in Portuguese join the rich Afro-Caribbean referenced landscape. Local schools have a high intake from the Portuguese-speaking communities mixing in with the large numbers of Afro-Caribbean-origin children.

2.3.3. Linguistic landscapes in the city

Appadurai (1996) used global 'scapes to describe various dimensions of the city including financial, ethnic, technical, media and ideological 'scapes characterised by differences, contrast and comparisons. Studies of linguistic landscapes in the urban environment show them to be dynamically constructed and co-constructed in the city. In addition to the number of languages spoken (see 2.6), they include semiotic acts of writing one's language on a sign, physically or virtually to mark one's territory (Shohamy, Ben-Rafael, & Barni, 2010). The city's landscape can include the 'visibility and salience of languages on public and commercial signs in a given territory or region' (R. Landry & Bourhis, 1997, p. 23). Gorter (2006) suggests that an analysis of the linguistic landscape can reveal the ideological underpinnings of the host society (see 2.7.1) and answer important questions about policy, regionalisation and localisation.

Erecting one's sign(s) may contest the official language(s) or define geographical influence in the city. Backhaus (2007), in his study of urban multilingualism in Brussels, identified more Flemish on billboards, shops and signs in the northern parts of the city where the majority of the Flemish-

speaking population lived and worked. The French language dominated the majority French-speaking area in the south.

Place naming is immediately recognisable as a feature of a linguistic landscape, officially or unofficially. Naming can reflect a political or cultural change to reinforce national identity, in the case of Bombay to Mumbai, Peking to Beijing and Madras to Chennai. Street names, shop, house, church, signage and restaurant names make an immediate link between people and the place to express ownership and identity and change over time with the influence of different communities (Backhaus, 2007). In the Chinatown (Chinese gates), Little Italy (fire hydrants painted in the colours of the Italian flag) and Latin Quarters of New York and London, street furniture, bilingual signs and statuary and the language spoken by staff in the shops all colourfully add to this linguistic landscape.

Resistance to authority is often expressed by the refusal to use the official name of a place and instead substitute it with a popular local one, sometimes in the language of resistance. For example, in Londonderry, during the troubles in the 1980s, Irish street signs, that had been banned in the 1940s, started to reappear as a demonstration of Irish nationalism as language is used to recover memory and meaning (Mac Giolla Chríost, 2007) (see 2.5 and 2.6). Physical maps and street names may not give the full picture as locales can be transformed symbolically and encoded with cultural meanings.

Lazdina and Marten (2009; Marten, 2010) and Marten (2010) in their work in the Baltic States, post-USSR government, have illustrated how the use of languages in public space, for example, English, is linked to prestige. Whereas, the use of regional variations, like Latgalian (regional language of Latvia) is on the increase in populations looking to assert their new identities as separate from the national Latvian government.

2.4. Translocal space

2.4.1. Translocal place-making

Scholars such as Guss and Kutlay (2004) and Blommaert and Rampton (2011) argue that deterritorialisation is a feature of super-diversity. Giddens suggests we are in a runaway world where processes of detraditionalisation unlink identity markers, language and cultural practices to one country, religious or ethnic group (Giddens, 1999; 2007b). Ties are then recreated and re-situated in a new locale as re-territorialisation. Sassen (2007a, p. para. 6) describes these global movements and dispersals that 'hit the ground' resulting in a 'terrestrial moment,' where language, culture, music, food, social, religious and trading practices become embedded and situated in certain cities. These practices may be refreshed by physical or virtual interaction with a homeland and other communities. Virtual interactions create, as Anderson (2006) suggests, imagined communities. These communities gather around common interests in publications, websites, blogs and social networking sites. Individuals and groups may also enact practices referenced to those known at the time of departure from the homeland, and thus frozen in time. Sanghera (2011) describes how her migrant parents in the UK required their daughters to return to the Punjab to marry. When she refused, she was ostracised from her family. However, when she herself returned to the Punjab, she was told that, as far as the community there was concerned those strict practices were out dated. They told her that they thought that their family in England would have moved on, as they had.

Hannerz (1996b) drew on the work of ethnographers, to conceptualise the situated local practices of transnational migrants, described above, as translocality. My understanding is that many scholars use different terms to describe a similar phenomenon. For example, grounded globalisation or grounded transnationalism that articulates a global ethnography of place is proposed by Burawoy (2000) and Wapner (Burawoy, 2000; 1995). In the field of urban and transnational studies, Smith (2001) uses the terms transnational urbanism or glocalisation.

My review of the research suggests that these terms broadly embrace the same theoretical concepts that are all located within the debates on transnationalism. I am therefore exercising a degree of arbitrariness in choosing to use the term translocality for my main working term. This term resonates with me as the trans- of dynamic, reciprocal border crossing and the local of situated practices. I propose it has clear heuristic value as an abstraction to interrogate my data.

Hannerz (1996a) suggests translocality develops in three phases in a locale. In phase one, the transnational community may eat together and make music together and have an internal matrix of personal relationships. In phase two, there is a higher degree of division of cultural labour. A critical mass of people is attained making it more profitable to commoditise their sub cultural-distinctive items for consumption. They may lobby for their food to be stocked in a local supermarket or fast-food restaurants and their music may be performed in their locality or on a local radio station. In phase three, there is a wider cultural market place with restaurants open to all communities. Others are able them to discover a different ethnic cuisine, ethnic musicians may be signed to a label and reach a far wider audience, City-wide festivals are open to the public with fashion, interior and exterior house decoration choices, shops, magazines and media available to all.

Wojtowicz (2002) argues that networks of similarly-minded individuals can act as translocal agents in cyberspace as local nodes within the geographical and cultural systems. I am aware to of the latest arguments that posit translocality as grounded in a variety of locales both beyond and within national borders. Brickell and Datta produce evidence of rural village to the city translocality in the same country, in Cambodia and Thailand.

2.4.2. Translocal spaces

> "A space exists when one takes into consideration vectors of direction, velocities, and time variables. Thus space is composed of intersections of mobile elements. It is in a sense actuated by the ensemble of movements deployed within it." (De Certeau, 1984, p. 117)

The literature reviewed, in the context of super-diversity (see 2.2.5) conceives of translocal space, in the Foucauldian sense, as fluid, mobile and a contextualised space of flows rather than dead and immobile. It is constructed through inter-relations (Massey, 2005). Giddens argues that:

> "....space is not an empty dimension along which social groupings become structured, but has to be considered in terms of its involvement in the constitution of the systems of interactions." (Giddens, 1984, p. 396).

In this sense space is a social construct, a container for relations of meaning-making, legitimation and power relations through which the narrative of individual, group and institutional narratives flow. Translocal spaces may be invisible to those who are not intimately connected with them and may disappear when the participant actors move away.

Studies of translocal interactions in relation to space, power and difference are a complex undertaking. Deleuze and Guttari's (2004) concept of 'assemblage' elaborates space in its complexity of heterogeneous elements as physical objects, happenings, events, signs and utterances enter into relations with one another. Translocal assemblages have more depth than the notion of nodes or points suggested in networks, due to their historicity and the effort that goes into producing them and in:

> "...their inevitable capacity to exceed the connections between other groups or places in the movement.....they are not simply a spatial category, output, or resultant formation, but signify doing, performance and events." (McFarlane, 2009, p. 561)

These doings construct a:

> "...dynamic account of space, text and interaction (where translocal) readers and writers are part of the fluid, urban semiotic space and produce meaning as they move, write, read and travel." (Pennycook, 2010, p.67)

2.5. Negotiating translocality through language practices

Sociolinguistics is by default an urban discipline, developed as a response to dissatisfaction with the methods of research used to examine dialect. Critics argued that language does not inhabit an external reality divorced from its social context (Vertovec, 2006). Scholars, such as Coupland and Jaworksi (1997), Rampton et al. (2004) and Blommaert (2010) argue that language is not a passive thing but deeply situated and implicated historically, politically, culturally and socially at every level.

The history of linguistic relativity is informed by the work of early anthropologists such as Boas who is often credited with the founding of anthropology in the United States. He suggested that one could only understand the culture of a society through the language of that culture. Culture, then, began when speech was present; and from then on, the enrichment of either meant the further development of the other. (Joseph & Taylor, 1990). Sapir and Whorf (1983) proposed a systematic relationship between the grammatical categories of the language a person speaks and how that person both understands the world and behaves in it. Thus, a particular language's nature influences the habitual thought of its speakers and different language patterns yielding different patterns of thought. This idea challenges the possibility of perfectly representing the world with language, because it implies that the mechanism of any language conditions the thoughts of its speaker community. This hypothesis is often used to defend the continuing existence of a plethora of languages in the world as each language represents its very own individual view of the world.

Various terms are in current use to describe language practices with terms such as multilingualism and polylingualism predicated on a number of monolingual discrete languages spoken. Heller (2003) reflects the duality in the French/English-speaking language practices in Canada in the categorisation of 'parallel monolingualism.' Fishman (1967) and Baker (2007) refer to 'bilingualism with diglossia', where two dialects of one language are used in the same speech community. Swain (1983) uses 'bilingualism through monolingualism.' Wei, in his paper on the language practices of Chinese youth

growing up in London describes Garcia's (2009) notion of 'translanguaging' as the:

> "….multiple discursive practices in which bilinguals engage in order to make sense of their bilingual worlds. Her use of the term covers multilingual practices which have traditionally been described as code-switching, code-mixing, crossing, creolization, etc." (Wei, 2010, p. 1490)

On the premise that the social reality in our cities is changing, scholars such as Blommaert and Rampton are suggesting that the paradigm shift to super-diversity is challenging the fixed classification of the discrete standard languages of French, German, and English etc. They suggest that rather than the polarised boundaries of standard languages, we should be thinking of registers, styles, discourses, genres and practices (Blommaert & Rampton, 2011). Practice, in this sense is underpinned rather than by the notion of a repeated action for improvement but:

> "…more to do with activities we engage in, habits, customs, things we do in a very general sense. This idea is captured by the addition of the term 'practices' to other words, hence language practices, cultural practices, discursive practices and so forth". (Pennycook, 2010, p. 21)

Language practices can be understood as linking the global and the local (see 2.7) in that:

> "….language practices both and are shaped by social reality in the locale and through 'worldliness', as a counterpoint to globalisation" (Pennycook, 2010, p.79).

This theoretical concept of practice, introduced in the political philosophy of Foucault (1977) and Bourdieu (1991), provides the bridge across structure and agency. As Pennycook argues, language practices negotiate meaning as they are not only concerned with the ways of speaking, but also the relationships between agent and field, semiotics, power asymmetries and linguistic ideologies:

> "….that take shape through exchange across different types of capital, social, cultural and symbolic'. It is the field that individuals learn the 'rules of the game' in valuing different types of capital and learning how to exchange one for the other. And it is so doing that the highly subjective values associated with different forms of capital, become objective criteria for differentiation." (Pennycook, 2010, p. 21)

Smith (2001) suggests that the representations of the postmodern city are the myriad ways in which every day practices of ordinary people mediate the impact of global capitalism on urban culture and often in the process modify the very structural conditions of everyday local urban life.

2.5.1. Linguistic heteroglossia and hybridity

Linguistic heteroglossia is a term for a language practice introduced by Bakhtin (1981) to refer to a dialogic linguistic interaction that produces a number of varieties in one linguistic code. Linguistic heteroglossia include elements of multilingualism. They make use of resources from more than one language or intralingually use of more than one variety or style from one language.

> "Furthermore, multilingual heteroglossia consists of two types of language use: it can take the form of (i) a mixed style characteristic of a particular group which makes use of resources from more than one language…., (see Auer, 1999), and (ii) code switching, i.e. the use of more than one language to contextualize meanings within a discourse entity". (Leppänen, 2011, p. 240)

Leppänen provides an example from fan fiction *Konsolien sota* (in the original Finnish text with italics to show the English elements of the text) (The war of the consoles) to illustrate:

> "Kuninkaamme lausuukin siksi taikasanat ja tästä seuraa erittäin huonolla *motion capturella* toteutettu selvästi Midwayn tekemä välianimaatio, jossa giganttinen dino muuttuu pikkuriikkiseksi

PlayStation- ohjaimeksi."

translated as:

"Our king therefore utters the magic words, and what follows is an intermission, an animation produced by an extremely bad *motion capture,* clearly by Midway, in which a gigantic dino is transformed into a tiny PlayStation console." (Leppänen, 2011, p. 240)

2.5.2. Metrolingualism, transidiomatic practices

On the premise that speakers or writers use the linguistic resources available to them from any language rather than separate and distinct languages, scholars use a number of descriptive terms. I understand these terms to be broadly comparable features, such as Leppänen's (2011) 'intralingualism,' Garcia's 'translanguaging' (2009) and Otsuji and Pennycook's 'metrolingualism' that:

"….describe(s) the ways in which people of different and mixed backgrounds use, play with and negotiate identities through language; it does not assume connections between language, culture, ethnicity, nationality or geography, but rather seeks to explore how such relationships are produced, resisted, defied or rearranged…. Its focus is not on language systems but on languages as emergent from contexts of interaction" (Otsuji & Pennycook, 2010, p. 246)

Similarly, Jacquemet describes transidiomatic practices in his findings from his case study of Albanian migrants' as practices that:

" ….describe the communicative practices of transnational groups that interact using different languages and communicative codes simultaneously present in a range of communicative channels, both local and distant…….This triangulation of linguistic activities, indexicality, and semiotic codes needs to be complexified to account for how groups of people, no longer territorially defined, think about themselves,

> communicate using an array of both face-to-face and long-distance medias, and in so doing produce and reproduce social hierarchies and power asymmetries." (Jacquemet, 2005, p. 264)

In daily practice this can result in the linguistic profile of individuals that Jacquemet describes in his case study in Albania, such as:

> "….Emeralda, the only sister who still lives in Tirana. She works as a translator for an international organization and speaks English at work all day. After work she interacts with her friends in Albanian and Italian. Every night she watches South American soap operas (dubbed into Italian), listens to Italian pop music, and surfs the English-saturated Internet". (Jacquemet, 2005, p. 286)

Language is changed and shaped through these practices resulting in forms such as 'Spanglish.' This is illustrated in a text by Stavans:

> "¿Como empezó everything? How did I stumble upon it? Walking the streets of El Barrio in New York City, at least initially. Wandering around, as the Mexican expression puts it, con la oreja al vuelo, with ears wide open. Later on, of course, my appreciation for Spanglish evolved dramatically as I travelled around los Unaited Esteits." (Stavans, 2003)

In France, the street language of *Verlan* is prevalent in the poorer northern suburbs of Paris. It is a composite language of Arabic and French based on the reversal of words. Some *Verlan* words have gained mainstream currency; a notable example is the word *beur* derived from the French word *arabe*, to describe a French-born individual of North African descent. However, the language evolved rapidly and this term has since been re-verlanised into *rebeu*. As quickly as words become mainstreamed, other words develop, to keep the group identity intact and exclude others.

Doran (2004) argues that street languages challenge the dominant hegemony and are used, in her example, in music to situate a particular group's experience. Afro-American hip-hop as a musical genre, tells everyday city

stories over a beat that carves out a young Black-American identity. This identity is situated in an African experience rooted in the linguistic, oral and cultural origins of South American Brazil through to Puerto Rico and Jamaica (Alim, 2006; Pennycook, 2007). These language practices can also empower as Mar-Molinero (2008) argues that US Latino popular music is able to access a global stage using Spanish topics and code-switching.

Language practices, including forms such as graffiti can also provide a vehicle for contestation that:

> "…challenge(s) assumptions about who has access to public literacy; who controls the space; who can sanction public images and lettering; who gets to decide what a city looks like". (Pennycook, 2010, p. 58)

Jessop (2002) suggests that the drivers of these language practices are 'survival strategies' to cope in unstable situations. The newly arrived, isolated migrant or member of an ethnic minority understands their Otherness and, as Giddens (1991) suggests, needs to re-balance and re-establish their ontological security. The use of hybrid languages, code switching, language variation in music and other cultural genres can therefore be understood as a coping mechanism, used in an attempt to emulate the possible near-perfect correspondence or *doxa* (using Bourdieu's (1991) terminology) between the objective established order and the subjective agency that is experienced by an indigenous member of an established community.

These theoretical concepts are of particular interest to this study as they can shed light on the situated language practice of transnational migrants in the negotiation of translocality.

2.6. Markers of difference

> *"Que l'importance soit dans ton regard, non dans la chose regardée !*" (Everything is in **how you** look, not in the thing you are looking at) (my emphasis), (Gide, 1897, p. 10)

2.6.1. The stranger or the Other

The sociologist, George Simmel, identified the Stranger in 1908 as:

> "….close to us, insofar as we feel between him and ourselves common features of a national, social, occupational, or generally human, nature. He is far from us, insofar as these common features extend beyond him or us, and connect us only because they connect a great many people." (Wolff, 1950, p. 404)

That Stranger or the Other may be identified as an insider or outsider by identified differences. This may be by ethnicity, language, skin colour, religious or cultural background. Thompson and Pennycook (2008) describe the discursive tensions between the stranger and the insider as driven by forces of homogenisation (standardisation, dominance and uniformity) and polarisation (cultural clash based on the identification of the Other). However, in a paradigm of super-diversity and a more heterogeneous receiving population, polarities and binary opposites are more difficult to define. Some time ago, Derrida (1982) suggested that ethnicity and ethnie are no longer purely static attributes of humanity as migrants move across borders and are susceptible to many influences in their own homelands. Adopted countries and cultures are more fluid and the boundaries between them are permeable (see 2.2 and 2.3). Second and third generation migrants have choices to reject or embrace and nuance cultural markers, including language, customs, dress codes and religious practice.

Yet, markers of difference still attract pejorative or positive generic categorisations. For example, the discursive difference between calling someone by country, 'Polish' or a 'Pole' or 'Paki,' the latter two terms generally

understood as a pejorative. By sub-continent, 'the Indians', or 'the Americans.' By religion as 'the Sikhs' or 'the Muslims.' These terms can be culturally loaded. Identity markers change according to the group you choose to reference or who reference you as an insider or an outsider. The exact shade of darkness of your skin may be nuanced to a particular caste in India but in the UK only signifies that you belong to a general category classified as 'Asian'.

Discursive terminology to describe the Stranger is also historically and culturally situated, as Gal and Irvine (1995) describe how the term 'Hispanic' only appeared for the first time in the United States Census in 2000 as a generic term to cover the Spanish/Hispanic/Latino categories of the population.

Dawney (1982), in her paper on the racialisation of Central and Eastern Europeans migrants in Hertfordshire discusses how tensions can arise when an imagined homogeneous community perceives itself to be infiltrated by individuals from other cultures and linguistic backgrounds. Terms such as 'migrant' are discursively conflated with terms such as 'the alien', 'black', 'poor' and 'unskilled'. The popular press, informed by the dominant ideologies (see 2.7.1) use influential discursive constructions. Certain migrant groups may consistently be portrayed, as taking our jobs, who once here will never return to their homelands, constitute a flood to engulf our society, make heavy demands on the welfare state or engage in criminality. As in:

> "[A] **million more** Poles plan to seek jobs in Britain next year, according to the findings of a new survey. If they all come to this country, **the influx will dwarf** the numbers who have already arrived in the three years since the UK opened its borders to immigrants from Eastern Europe." (My emphasis), (McGuire & Canales, April/June 2010, p. 130)

Sheptycki illustrates the discursive threat of 'the Stranger as a terrorist,' relating to issues in transnational policing, in an extract from a news report that describes:

> "…..a moral panic where the immigrant is the folk devil who threatens our social tranquillity, a pathetic image (resulting in the) …..consequent polarisation between 'us' and 'them'…… with a new picture of criminality, one which juxtaposes the criminal and the immigrant……with a continuum of threats which binds terrorism, drugs, organised crime, smugglers, illegal immigrants and asylum seekers……" (Sheptycki, 2000, p. 93)

Using racist campaigns to target neighbourhood spaces, labelled as enclaves or ghettos are examples of this kind of discursive negativity (Leapman, 2007). The assumptions made by these terms construct and reinforce homogeneity in the receiving population (see 2.2 and 2.3). The reality is that members of the receiving population may be second or third generation members of migrant families or hybrid sub-groups of nationalities or ethnicities, such as clans and tribes. Said suggests that the tendency is to homogenise and stereotype to try to make sense of the world:

> "….partly not only out of ignorance but also fear. Where there should be a human presence there's a vacuum and where there should be exchange and dialogue and communication (between people from different cultures), there's a debased non-exchange." (Said, 2001, pp. 223-245)

This ignorance can be bridged, as when Daniel Barenboim and Edward Said conceived of the West-Eastern Divan (Orchestra) in 1998, to bring together young musicians from Israel and other Middle Eastern countries, not only to play music together but also to share knowledge. Barenboim later described how:

> "What seemed extraordinary to me was how much ignorance there was about "the other"….One of the Syrian kids told me that he's never met an Israeli before and, for him, an Israeli is someone who represents a negative example of what can happen to his country and what can happen in the Arab world….they were trying to play the same note….with the same stroke of the bow….having achieved that one note, they already can't look at each other the same way, because they have shared a common experience." (Barenboim & Said, 2004, p. 9)

These external and internal constructions are dynamic and ever changing as Kramsch, citing Kristeva, describes how an individual's *own* subject position is continually constructed and re-constructed:

> "According to [Kristeva], the subject emerges at the intersection of a world without words (but not without signification) and the world of words. The first she calls the realm of the semiotic, the second….the realm of the symbolic. The subject is born as it positions itself not within the symbolic, but at the border between the semiotic and the symbolic. This positioning process that she calls thetic (from the Greek thesis or positioning) is on-going; the subject always hovering on the thetic border is never finished, it is always in construction. Because of the unstable nature of the symbolic at the border with the semiotic, the subject is not only constantly made and remade, that is, a work in progress, but it constantly interrogates and problematizes itself, because in the symbolic order, the Other is in the Self. We are in Kristeva's famous phrase…..**'strangers to ourselves.'** " (my emphasis), (Kramsch, 2009, pp. 96-97)

2.6.2. Language as a marker of difference

Two incompatible positions, the primordial and the social constructivist have underpinned classifications of ethnicity. The primordial view fixes one's ethnicity, derived from a fixed cultural heritage at the time of birth and one then carries it through to the death. It reflects the views of the 19th century German philosophers such as Herder and Fichte (Barnard, 2003) that provided the context for the formation of the nation state where German people were defined by 'their language, blood and soil'. Such a perfect homology among nation, state and language never really existed in Europe, or anywhere else. Gal (2006) describes how more recent primordialists acknowledge that ethnic attachments are only 'perceived to be' inherited at birth. Geertz (2001) agrees and further suggests that groups are able to change their sense of ethnicity and over time to create *in situ* and imagined new discursive spaces. Spaces that are fluid and mobile and can accommodate multiple identities.

> "Modern people of all sorts of conditions have had as a condition of survival to be members, simultaneously, of several overlapping imagined communities." (Hall, 1993, p. 359)

Schmidt suggests that:

> "….although an intrinsic link between language and identity is usually presupposed in the sociolinguistic discussion of language loss, a thorough analysis of academic discourse on the relationship suggests that language constitutes only one of many cultural markers for identity." (Schmidt, 2008, p. 3)

Expressing how the language one speaks embraces ones difference and empowers (see 2.7.4), Gloria Anzaldúa so eloquently wrote:

> "Until I am free to write bilingually and to switch codes without having always to translate, while I still have to speak English or Spanish when I would rather speak Spanglish, and as long as I have to accommodate the English speakers rather than having them accommodate me, my tongue will be illegitimate. I will no longer be made to feel ashamed of existing. I will have my voice: Indian, Spanish, white. I will have my serpent's tongue - my woman's voice, my sexual voice, my poet's voice. I will overcome the tradition of silence." (Anzaldúa, 2007, p. 59)

Jeannie Bell, referring to her Aboriginal parents' experience of being rounded up by the Australian government and put on reserves, said:

> "…people were forced to speak English and forget their traditional languages and culture…..I felt I had been really cheated of something – that our identity and presence in Australia had been minimised and marginalised. Our languages are fragmented……it's an essential part of our being….like a religious thing, a spiritual thing. Language is part of that." (Bell, 2001, pp. 45-52)

2.7. The link between the global (macro) and the local (micro)

The increasing complexity of urban societies has led scholars such as Giddens to attempt to describe the processes of change in their value, social and cultural knowledge systems. One lens is that of global (macro) entities acting upon other local (micro) individuals, classes or institutions. The role we, as actors, play in these processes has been intensely debated by philosophers. At the extremes, structuralism posited that human beings have no agency in these relationships and volunteerism suggested that individuals are completely free to create their lived environment.

Drawing on the work of Goffman (1961) on the regionalisation of encounters, Giddens (1984) developed his Structuration theory to attempt to explain the relationship that individual agency (local individual forces) has with the structure (global external forces). Structuration treats the individual as a knowledgeable object interacting with the social order to create or change their social reality. In this context global and the local forces are inseparable and interdependent. Through this lens, the transnational migrant has their own normative values and yet is constrained by the modalities, sets of rules and resources, of the social structures of their own kinship groups and those of the host. I understand these social structures to include institutional structures.

What are created are systems of interaction, such as speech (a system of interaction) where a speaker is only understood if the listener understands the language (structure or rules). This is particularly pertinent in the health domain, which may be the first site of encounter with a host institution for the transnational migrant. There is a requirement to know the system of rules and shared assumptions to facilitate the health interaction and enable access resources. A caveat here is that society's structural relationships and rules are all concepts that suggest dualism, linearity and fixed borders. Translocal practices can be organic and lack of fixity of boundaries that may challenge a hierarchy along a vertical axis (see 2.4).

Health interactions assume shared common background knowledge of the health system that health practitioners, and patients born into that system, use

to interact, confident that others will understand their indirect allusions. 'The rules' are constructed by the dominant institution or culture (global) informed by its hegemonic ideologies (see 2.7.1), a feature of global or macro processes.

In this Structuration theory (Giddens, 1984), the micro and macro, local and global are inextricably linked. The *de facto* reality may be that a migrant may not be able to access health services (global) because of lack of knowledge of the language (local). However, if appointments are missed, the health service has global responsibilities and has to respond by providing linguistic mediation. The grass-roots (local) individual or group can influence and change service provision (global).

Elements of Structuration theory have been used by government policy-makers in the UK to inform their understanding of the impact of these global-local systems of interaction, They are used to inform the equal and fair construction, provision and maintenance of goods and services, particularly for the growing numbers of transnational migrants in the city. I understand that Structuration has been criticised for assigning too much importance to the individual agent on the structure. That it does not address what needs to occur, and how and when structural change actually takes place (Held & Thompson, 1989). I suggest that Structuration theory provides a useful framework to link the global and the local and evaluate its impact. I will use this theoretical underpinning to inform my understanding of the control and budgeting for languages.

2.7.1. Language ideologies

Ideologies refer to the way we think about the world. Expressed by a state, institution, group or individual, they reflect an aspiration to the way that things ideally should be. They are mainly invisible as an unchallenged public opinion. With reference to language in particular, multilingual and monolingual ideologies:

> "….label cultural ideas, presumptions and presuppositions with which different social groups name, frame and evaluate linguistic practice." (Gal, 2006, p. 13)

Bakhtin suggests that:

> "We are taking language not as a system of abstract grammatical categories, but rather language conceived as ideologicaly saturated, language as a world view….in vital connection with the processes of sociopolitical and cultural centralization." (Bakhtin, 1981, p. 271)

2.7.2. Supranational and national language policies informed by ideologies

Fairclough (2006) argues that the hegemonic processes that underpin globalisation rely on an implicit assumption that a world of nation-states with monolingual ideologies is a natural way to organise society. Historically, nation-states and regional-ethnic minorities have argued for the standardisation and categorisation of languages, such as German, French, English, and Polish (see 2.6.2).

The supranational European Union (EU) acknowledges the importance of language and the rich resource of the language and cultural diversity of its members. It advocates its members to adopt educational pluralingual policies, where individuals are encouraged to speak their own mother tongues plus two other languages. In 1992, the European Charter for Regional and Minority Languages, (2006) encouraged the use of territorial and non-territorial languages. The European Charter of Fundamental Rights (Council of the

European Union, 2007) which is not currently legally binding on the member states, declares that it respects linguistic diversity (Article 22) and prohibits discrimination on the grounds of language (Article 21). It states that respect for linguistic diversity is a fundamental value of the European Union, in the same way as respect for the person, openness towards other cultures and tolerance and acceptance of other people. The Action Plan for Language Learning and Linguistic Diversity of 2004-6 states that:

> "…every European citizen should have meaningful communicative competence in at least two other languages in addition to his or her mother tongue……taken as a whole, the range on offer should include the 'smaller' European languages as well as all the 'larger' ones, regional, minority and migrant languages as well as those with national status, and the languages of our major trading partners throughout the world." (European Parliament, 2000)

The European Constitution agreed in the Treaty of Lisbon to commit its member states to pluralism in all sectors and concerning non-discrimination states:

> "Any discrimination based on any ground such as sex, race, colour…… **language**, religion or belief…. shall be prohibited." (My emphasis), (European Commission Education and Training, 2003, p. 4)

Yet, despite a series of EU-funded initiatives, research and debate, no common European language policy has been achieved and language policies, the majority of which are monolingual, remain the responsibility of each member nation state. The response of national governments in Europe, as has been widely documented, is increasing consolidation of their own standard languages (Council of the European Union, 2007, pp. Article II-81). National governments in Europe are consolidating their national languages and the ability to be proficient in them as a key test of citizenship. The Netherlands introduced citizenship trajectories in the 1990s and this scheme has toughened over the subsequent years with more stringent language and cultural knowledge tests being imposed. It now extends to family formation

partners, that is, a family member joining an existing citizen, having to first pass a language test. Belgium and France have followed suit (Extra, Spotti, & Piet Van Avermaert, 2009; Hogan-Brun, Mar-Molinero, & Stevenson, 2009) England has a new citizenship test based on testing for knowledge of cultural and social practices based on 'Life in the UK.' (UK Border Agency, 2011)

2.7.3. The contestation of ideologies: top-down and from the grass roots

Gal and Woolard (2001) contrast the anonymity of these top-down, orthodox language policy-making processes with the rich, heterodox authenticity of grassroots non-standard language practices (see 2.6). Gal (2006) suggests that hegemonic monolingual ideologies promote standard languages which shape and hide many of the everyday practices of speakers, especially those of ethnic minorities and migrants.

Whilst these divisions still exist, I suggest that in the paradigm of super-diversity and increased heterogeneity, we may have to re-evaluate a clear top-down to grassroots dichotomy, as Spolsky warns:

> "In essence the classical model [of Language Planning] was a 'top-down' only process, tending to ignore any demographic practice. To make this over-simplification work, many scholars tried to identify competing forces, which they labelled 'bottom up', perhaps not realising that one is dealing with a complex and chaotic non-hierarchical system. Each domain within a sociolinguistic ecology has its own variety of language policy, and each influences and is influenced by all the other domains." (Spolsky, 2012, p. 3)

Enforced monolingualism, legitimised by the state, denial of the right to speak one's language, border-controls and language-related citizenship criteria used to dominate, persuade and integrate are contested. In the USA, millions of Hispanics have migrated to the urban areas where a total of 9 million (over a quarter of all the Hispanics in the USA) reside in Los Angeles, Chicago, Miami and New York. Hispanics are now the largest ethnic minority in the entire USA, at 12.5%. Street signs, adverts and slogans used in political rallies in these cities are now often bilingual in Spanish and English, the American anthem is

now available in a Spanish version and the urban phenomenon of the use of a code-mixed English-Spanish language, 'Spanglish' (see 2.5.2 and 2.6.2) is emerging (Mac Giolla Chríost, 2007).

From the grassroots level, the USA Spanish-speaking population is contesting English monolingualism and these language practices are shaping language policy. Spanish-speaking migrants from Latin America and Mexico make a valuable contribution to the global and local economy, but national and state policy has treated them as alien and threatening. The policy in the USA has been to strengthen its borders to keep as many illegal immigrants as possible out and make slow progress to change laws to allow them to become full US citizens. Conversely, as numbers and their influence have grown, American politicians have become increasingly dependent on the Hispanic vote and are finding it advantageous to engage with their communities. During the USA Presidential elections of 2008, Sergio Bendixen took a key role in supporting the Obama/Clinton campaign by his knowledge and ability to capture the Hispanic vote in:

> "…..websites, podcasts, TV and radio broadcasts, billboards, and particularly musical jingles and videos (commonly available on YouTube), translating key campaign messages into Spanish. A cameo moment encapsulating this desire to climb onto the Latino bandwagon was Senator Ted Kennedy attempting to sing in Spanish in support of Obama whilst campaigning in Laredo." (Real Clear Politics, 2010)

Far from remaining monolingual, marketers and advertisers have come to understand the persuasive impact of code switching in marketing messages when selling to American/Spanish bilingual customers. Luna and Peracchio's study (2005) demonstrated that minority language slogans switching to majority language ones resulted in greater persuasion, attributed to the salience of the code-switched word in the slogan, a powerful message that can mean profit. Taking into account the spending power of Hispanics who at the time of the study made up 13% of the population of the USA.

2.7.4. Language as a powerful resource of control

Language is an available resource (see 2.5.1) in the negotiation of translocality to facilitate interactions between actors, be they objects, institutions, organisations, groups or individuals. Access to the dominant language increases the group or individual's resources and, as argued by Bourdieu (1984), increases their symbolic power. Bourdieu drew on the economic trading metaphors of the marketplace that use the metaphor of the building of capital to identify the empowerment of a group or individual based on their linguistic capital. Meinhof and Triandafyllidou (2006), in their work on diaspora, extend this concept to include transnational practices that can be understood as transcultural capital. In the context of increased social mobility and linguistic super-diversity, scholars suggest it may now be more appropriate to preference the term of linguistic resources, rather than linguistic capital, as the latter nuances language(s) as a countable noun (Blommaert & Rampton, 2011; Pennycook, 2010).

Li et al., working with Dutch-speaking, Chinese nationals learning Chinese in Eindhoven in the Netherlands, note that:

> "…rather than assuming that young people's identities would necessarily be 'dual' or 'fragmented', we consider that people articulate a whole repertoire of inhabited and ascribed identities and that they do so by means of a complex display and deployment of cultural **resources**. The learning of Chinese language and literacy in the complementary schools generates a particular enregistered set of **resources**, allowing the organisation of different micro-identities." (My emphasis) (Li, Juffermans, Kroon, & Blommaert, 2011, p. 37)

Pennycook understands that individuals in the community learn to use language as a resource to negotiate the hegemonic rules. He argues that it is:

> "…in the field that individuals learn the 'rules of the game' in valuing different types of capital and learning how to exchange one for the other. And it is so doing that the highly subjective values associated with different

forms of capital, become objective criteria for differentiation." (Pennycook, 2010, p. 21)

2.8. Summary

This chapter sets the theoretical context for this research in the context of globalisation and one of its recognised features, transnational migration. Transnational migration, historically, refers to the movement of peoples across the borders of nation states and I have explored transnationalism that allows active, reciprocal links to be maintained by individuals, families and groups, between homelands and hosts across borders. I understand these movements to be enabled by the compression of the time-space continuum, cheaper travel and communications. I argue that a new paradigm shift to super-diversity has occurred, differentiated from transnationalism due to increased social mobility within and across borders. Migrants are now able to sustain complex and simultaneous networks, both physical and virtual, that transcend ethnicity and allow a proliferation and mixing of identity markers. Transnational migrants' social, cultural, religious and economic practices, informed by the dynamic reciprocity of their known locales, emerge as translocality. I explored translocal spatiality, which produces translocal places and spaces onto which senses of being and control can be projected. I argue that language practices are cross cutting to all these translocal interactions in these dynamic and fluid spaces of flows.

Transnationalism has traditionally been a feature of the world's major global cities but now extends to smaller, provincial cities and rural environments. Consequently, I have made the case for the importance of the non-global city as an important site of linguistic diversity. I discussed key features such as spatial differentiation (by architecture, religious buildings, markets, housing, transport links), rhythms (of education, business hours, religious practices), and the inevitable contact zones of migrant communities to the production of rich linguistic landscapes in these new urban environments.

I have explored the ways in which meaning is shaped and negotiated through language practices, such as linguistic heteroglossia and metrolingualism, code-

switching and mixing and language variation which are challenging traditional language standardisations. I note that the discourse of the Stranger/the Other is ever-present but that the heterogeneity and multiple identity markers of the receiving population and migrants is challenging standard classifications of language, ethnicities and other social and cultural groupings.

Giddens' theory of Structuration provides the theoretical framework for linking the global (macro) with the local (micro) through the situation of individuals' and groups' everyday practices in their life narratives and their local, national and supranational contexts. I have problematised language ideologies that preference monolingual top-down policy implementation and may be contested or shaped by the multilingualism of the grass roots. I suggest that the linearity of top-down to grass roots may now be challenged by hybridity and super-diversity. In this context I identify language(s) as an important resource of control through governance (globally) and access and empowerment of speakers (locally).

Chapter 3: Research methodology

3.1. Introduction

The increasing number of transnational migrants positions this research, as Robson (1997) argues, as a current, contemporary and topical issue in the domain of real world research. This kind of research calls for clear justification of the methods identified, their appropriateness and their theoretical underpinning if the results are to yield meaningful contributions to the relevant research field and participating research sites. Studies of translocal interactions in relation to space, power and difference are a complex undertaking. Deleuze and Guttari's (2004) concept of 'assemblage' (see 2.4.2) describes this complexity of heterogeneous elements that enter into relations with one another, not only as physical objects, happenings, events but also as signs and utterances. I will ask questions suggested by scholars such as how much people are constructing their social identity through language practices to fit the social situation, presuppositions and perceived expectations (J. Gumperz, 1982). Should the 'how of talk' come before the 'why?' and at what point should the *'what'* be discussed? Does 'language in a working interaction' provide more valid data than 'talk about work?' (Sarangi & Slembrouck, 1996). What constitutes context? (Silverman, 1997), and how much of it should be brought in? (Ronald Scollon & Scollon, 2003). Just what kinds of data one should collect? How much and under what circumstances?

The nature of transnational studies in the context of sociolinguistics is multidisciplinary and the process of researching the negotiation of space through language practices seems to raise a number of questions about the relationship between claims and evidence within an interpretive qualitative paradigm. How far, for instance, can the researcher come up with a sufficiently comprehensive interpretation of negotiation strategies through use of the analytical approaches? Taking into account theme-oriented discourse analysis is suggested in the work of Sarangi and Roberts (2005) as particularly appropriate for the study of medical interactions, do I need to discuss other insights that might emerge outside of this framework?

Analysis and interpretation of the data can therefore be best served if the research methods are holistic, allowing for the use of hybrid forms of analysis to examine these negotiations through language practices. These observations suggest to me that this research study requires a qualitative and interpretative ethnographic methodology that leads to interpretation through induction from contextualised subjective data. This is particularly suitable for this type of study which requires an understanding of how individuals from a particular group perceive the world, difference, agency, power relations and construction or co-construction of meaning and their own and others' identity. Qualitative enquiry has the distinct advantage that it allows the data to speak for itself. The analyst and reader of the research document can, from what the interlocutors say, as Cicourel (1992) suggests, determine what is going on here; and as Smith (2002) suggests allow what will be brought under ethnographic scrutiny to unfold as the research is pursued.

> "Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them … It is understood, however, that each practice makes the world visible in a different way". (Denzin & Lincoln, 2000, p. 3)

In this chapter I set out to describe and justify the qualitative research methodology of linguistic ethnography and protocols adopted. These include use of case study methodology, field notes and ethnographic detail in order to get a fuller account of the research sites in the city and the activities recorded and observed there. I present the rationale for the choice of informants followed by a discussion of the analytical and interpretive approaches used in this research. The chapter also includes a sample demonstration and

discussion of how the analyses in Chapters 5 and 6 will be conducted and an exploration of the ethical issues.

3.2. Research aims and questions

As discussed in Chapter 1, this research aims to make a contribution to our understanding of translocality, situated in the field of urban transnationalism, with particular reference to the negotiation of space through the language practices of migrant communities. I aspire to make a contribution to our understanding of the impact of the global on the local; in this case with data collected in a provincial city in the UK, and to make the case for the non-global city as an important site of linguistic and cultural diversity. At a theoretical-methodological level, the study aims to demonstrate how a theme-oriented discourse analysis approach to the examination of data, gathered through the use of a linguistic ethnographic case study design, based on recordings of interviews, observations and document analysis, can generate an effective account of translocal negotiation, using the language support services in a hospital maternity service as a case study. At an applied level, it aims to inform health care professionals working with transnational migrants and increase their knowledge about the features of translocality that may affect their practices.

3.3. Research methods

3.3.1. Linguistic ethnography

> "The Institutional Ethnographer takes up a point of view in a marginal location; she looks carefully and relatively unobtrusively, like any field worker, but she looks from the margins inward-toward centers *(sic)* of power and administration-searching to explicate the contingencies of ruling that shape local contexts." (DeVault, 1999, p. 48)

The decision to use linguistic ethnography (LE) as a research method to explore translocality through the language practices of migrant communities,

partly in the institutional context of the hospital, was influenced by the argument that LE:

> "……generally hold(s) that language and social life are mutually shaping, and that close analysis of situated language use can provide both fundamental and distinctive insights into the mechanisms and dynamics of social and cultural production in everyday activity." (Rampton, et al., 2004, p. 2)

LE is interested in language as constitutive as well as constructive in the whole of communication in context, rather than viewing it as composed of isolated messages, and is helpful in gathering data involving intercultural encounters. LE draws on anthropological traditions to the study of language such as Hymes' (1972) ethnography of communication and Gumperz' (1982b) interactional sociolinguistics. It is informed by developments in linguistic anthropology, which challenge the generalisations that can be made about society and culture as a whole, without particular analysis of language use in interaction. Its roots are in Goffman's work (1959), on the regionalisation of encounters, that suggests that in everyday encounters we unconsciously give off signals that reveal aspects of our identities, whether it be about our class, educational, social, cultural or linguistic background in the way in which we interact. Hymes, informed by Goffman's (1962) work, in his ethnography of speaking and expanded in his work on the ethnography of communication (Hymes, 1974), proposed that ethnography make its starting point language use, and anthropology to examine linguistics to understand cultural context. He said that:

> "…it is not linguistics, but ethnography, not language but communication, which must provide the frame of reference within which the place of language in culture and society is to be assessed." (Hymes, 1974, p. 4)

Hymes suggested that linguistic anthropological theory and the development of knowledge be based on the analysis of the diversity of speech, repertoires and ways of speaking based on these proposals. Using these concepts, Gumperz (1982) went on to develop interactional sociolinguistics that uses

discourse analysis to study how meaning is created by language used in interactions and identified the contextualisation cues which describes how:

> " a sign services to construct the contextual ground for situated interpretation and thereby affects how constituent messages are understood." (J. Gumperz, 1999, p. 461)

Hammersley (2007) argued that qualitative ethnographic methods were particularly suitable in natural contexts for making observations and field notes from informal conversations. Predetermined assumptions are minimal, unstructured and not predetermined, referring to a small number of cases where interpretation of how human beings construct meanings and functions and their views were required. I agree, and view my chosen qualitative methodology of data collection and analysis of themes as appropriate to investigate how translocal meanings and spaces are interpreted, produced and constructed.

This case study would not be suitable for a quantitative reductive method that emphasises the measurable and observable rather than meaning and reifies phenomena by measurement. It would not be helpful to generalise from a purposive or randomised sample to a population through the use of survey, record analysis or closed question interviews. For example, there is no record of languages spoken on patient records at Southampton University Hospitals Trust (SUHT), which would lend itself to any form of quantitative analysis. (Although to note that a quantitative review of the SUHT Volunteer Interpreting Service (SVIS) (Southampton University Hospitals Trust, 2009b), demonstrated the increase number of languages required for its interpreting service. These figures informed my decision to choose the hospital, and in particular the maternity service, as a possible site for rich translocal interactions).

3.3.2. Use of linguistic ethnography in language, cultural and medical encounters

LE methodology has often been used to analyse intercultural encounters and in particular in the medical setting. Gumperz et al. (1979) in their Crosstalk studies aimed to:

> "...show how individuals participating in such exchanges use talk to achieve their communicative goals in real life situations by concentrating on the meaning making processes and the taken-for-granted background assumptions that underlie the negotiation of shared interpretations." (J. Gumperz, 1999, p. 454)

Cicourel (1992), in his examples from medical encounters in the interpenetration of communicative context, stressed the importance of ethnographic work to obtain the breadth of data needed to analyse the context of medical interactions.

I am drawing on the number of reputable studies that have utilised an ethnographic approach. Namely, Drennan & Swartz (2002) who examined the impact of language barriers on patient-provider interactions in a psychiatric hospital using chart reviews, semi-structured interviews with staff, interpreters, ward observations and multi-disciplinary team meetings. Erzinger (1991) looked at communication between Spanish-speaking patients and doctors in twenty-six medical encounters, which were tape-recorded and analysed. Gerrish (2000) undertook participant observation of six district nursing teams, four with high South African caseloads and two with high white caseloads to look at miscommunication and the process and decision-making around the engaging interpreters.

Roberts et al. (2005) transcribed key consultations across a wide range of English language abilities in inner-city areas to identify how patients with limited English and culturally different communication styles consult with general practitioners. They randomly selected routine and emergency surgeries and video-recorded interactions, which were then analysed by two

discourse analysts for language/cultural differences. Leila Dawney (2008), in her work on the racialisation of Eastern European immigrants in Hertfordshire, used data from interviews and focus groups to explore the construction of identity of immigrant groups by their host and own communities. Blackledge, Blommaert, Jørgensen and Lainio (Blackledge, Blommaert, Jørgensen, & Lainio, 2012; 2011) use LE methodology in the investigation of discourses of inheritance and identity in four multilingual European settings. This research gathered textual and audio-recorded data to enable a close LE analysis and synthesis relating to young people's performance and narration of identities. They propose that the situated events and practices observed in the transnational settings reveal elements of how speakers may access certain linguistic features to position themselves and others in particular ways.

3.3.3. Case study methodology

My choice of research design, in this instance, the case study method, was also guided by a number of other considerations. The case study approach was selected over and above all other research techniques (notwithstanding its shortfalls) because, as Robson suggests:

> "…it is typically a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence…"

And that the case study method:

> "…is particularly suited to studies of organisations and institutions, of workplaces and firms, management and organisational issues, organisational cultures, processes of change and adaptations." (Robson, 1997, pp. 146-147)

The LE approach undertaken for this case study supports the evaluative purpose of the research, which is exploratory, in trying to answer that question of what is going on here? No methodology is prescribed in a research site such as the hospital. There is very little guidance to what one should be looking for and I needed to work through discussion and observation of the participants.

The methodology adapted and continually evolved as I familiarised myself with the maternity service procedures in place. It was a research environment, which although I had had some familiarity with in other locations, it was in essence strange. I needed methodology, which would engage me in the process of making the familiar strange and the strange familiar, whilst remaining aware of the framing of experience by convention. As a researcher, I needed to be sufficiently flexible to come to the study with general ideas but allow for inclusion of other data sources, which might be 'strange' to me, to allow discovery of more features of the case.

I conclude that for purposes of data collection for this study, a qualitative, LE case study research design is clearly indicated.

3.3.4. Selecting data, contacting and information about the informants

I accessed a small number of cases, selected through a purposive and rare sampling technique, which allowed me to focus on the object of my research. The principle of this well-recognised sampling technique (Mason, 1996), in the researcher's judgement, is guided by the research questions to choose participants and research sites which specifically suit the study's aim and requirements. There is no attempt made to provide quantitative data, particularly as so little was available (see 3.3.1) that could be statistically analysed. Instead I tried to make the sampling relevant to the theoretical investigation in this qualitative research.

Secondly, the rare sampling technique looked to a site where the low frequencies in the population are overrepresented in the sample and could therefore provide another rich, easily accessible source of translocal interactions (see 1.3 for the rationale for the case study). I looked to the local hospital as a city institution where the maternity services have the highest call-out for language support services (see 5.4.5) and where members of the local migrant communities work as hospital staff and interpreters. I made an educated guess that it might be the first point of contact with an institution in the city for some recently arrived or non-working migrant families requiring antenatal care. Thirdly, I collected the city and hospital's language policy and planning documents for detailed analysis. Altogether, I worked with 21 SUHT

staff/midwives, 22 SUHT Volunteer interpreters (SVIs), and 20 users of SUHT services and 45 Southampton public sector and community contacts.

My first point of contact at SUHT was my hospital supervisor, the Voluntary Services Manager. Her role offered advice on accessing interpreters and their mediated interactions with patients. She provided an introduction to key gatekeepers from the maternity and hospital healthcare services, education and research and design department to enable me to prepare the rationale and content of the first ethics submission (see 3.5 and 7.3). These contacts included the Head of the Wider Healthcare Teams Education unit who shared previous successful ethics application forms to provide me with guidelines of the requirements. The Voluntary Services Manager's line manager, the Head of Chaplaincy shared his experiences of working with migrant groups at a major London hospital and those since arriving in Southampton. He indicated his support and need for the research. To proceed with a case study in the maternity services, I needed health practitioners' support and the Head of Midwifery provided that commitment and her views on the need for qualitative research in this area. She, in turn, introduced me to the Maternity Information Liaison Officers, one of whom worked as a Polish-English language interpreter, and the Head of the Sure Start midwifery teams who made suggestions and checked through the proposals for access to the midwives and patients. I liaised throughout with the SUHT Maternity and main Research and Design teams who initially approved the MREC Ethics proposal and after that approval, the latter submitted the proposal to their final checklist and sign off procedures.

During the ethics submission procedure, the Head of Voluntary Services and the Head of Midwifery provided me with a number of community contacts, contacts who they worked with in their own interactions with the community. The Head of Midwifery was particularly interested in reaching maternity patients from migrant groups to ensure that they were aware of the services available and the appropriate means of access. She introduced me to the Head of EU Welcome who in turn invited me to attend his sessions at the Polish Club (see 3.3.51). Whilst attending these sessions, I was able to organise preliminary interviews with attendees and address one session on my proposed research and gain feedback, which was essential in refining the

content of my research protocols. During this exploratory period I was training the interpreters and working as a volunteer that allowed reflection on the migration space in this health domain.

This research process was characterised by the co-operation of all concerned who introduced possible contacts and facilitated me to meet with them at a number of data sites (see 3.3.5). Following full ethics approval, these first SUHT gatekeeper contacts facilitated access to other SUHT and health service-linked personnel including the interpreter service Voluntary Service administrators, the Head of Patient Advice and Liaison Services, the Head of Access to Communications, a local GP surgery, the Workers Educational Association and the Southampton Voluntary Services. My attendance at a Sure Start midwives meeting opened up the invitation to individual interviews, attendance at the Parentcraft sessions, the opportunity to observe interpreted health interactions and an introduction to the Head and Deputy Head of the Sure Start Centre in Clovelly Road (see 3.3.5.4). SUHT developed plans for a Polish-only maternity patient group I was invited to attend the exploratory meetings to set this up and act as the liaison and trainer for the selected interpreters. It was fortuitous that a decision was taken to run this group at the Sure Start Centre in Clovelly Road with interpreters that I had already interviewed.

The Diversity Officer from the local police force attended the EU Welcome session that I presented and offered his time and for an interview. During this session he provided me with contacts from the religious communities, such as the local mosque and Southampton Council of Faiths. In contact with the latter, I learnt of the Southampton Peace Walk (see 4.3.3) and during that participation I made valuable contacts for interviews in all the major faith groups in the city. Representatives from the Vedic, Sikh, Muslim and Baha'i faiths that I met also provided chaplaincy services at SUHT thus providing first hand knowledge and valuable insights into local healthcare practices. The Head of the local GP surgery invited me to present my on-going research and get feedback at their away day at which a co-presenter was the police officer with responsibility for honour violence in the city.

My university supervisors also had a number of university and community contacts garnered during their work to support community language programmes and a citywide language strategy. These contacts included the former Head of Southampton's Oral History Unit, a local Councillor (and ex-midwife), members of the Southampton City Council New Communities team, the Head of the Community Languages programme, the Community Café project, a university-community project to support teachers of community languages and postgraduate students who worked as interpreters and came from migrant communities. I was invited to lecture on a university Modern Language module, 'Reading the City,' through which I met a guest speaker who agreed to be interviewed in his capacity as the former Head of Racial Equality for Southampton and co-author of a 'Black History of Southampton' (John & Muirhead, 2010).

In accordance with my ethics permissions (see 3.5), my hospital supervisor sent out the invitation to SVIs to participate in the study. These interpreters were SUHT staff and external volunteers who agreed to take part voluntarily. I had to hope that these respondents would reflect the spread of languages offered at SUHT. The SUHT Voluntary Services Manager told me that she tried to recruit interpreters in numbers to match the profile of what she understood to be languages with the highest demand (see 6.6.2). In reality, the SVIs I interviewed did reflect this spread as they were predominantly Polish-English language speakers with single informants with less called-for languages or those who could offer a number of languages, especially from the Indian sub-continent (see 3.3.5.2). The workforce of SUHT and interpreters is predominantly female (see 6.6.2.3) reflecting the volunteer interpreter recruitment criteria of female gender preference to provide for the high call out in maternity services. My interpreter informants reflect this predominance of female over male profile. In addition, all these interpreters were recruited from a pool of people who had applied for a volunteer role at the hospital. This suggests, and was confirmed in my interviews, a profile of those who want to help in their community, who may have only just arrived in the country and wanted to establish themselves. Acting as a volunteer interpreter may be viewed as a stepping stone to finding work at the hospital, improving English language skills, understanding the system and the training offered was indeed a stepping stone to working as a paid interpreter.

I was concerned that the profile of those who responded may be weighted to the better educated of the interpreters who were interested in this kind of research and had the time to meet with me. The majority of the SVIs I interviewed were degree-level educated as the previous SUHT quantitative study of interpreters noted (Southampton University Hospitals Trust, 2009b). However, I did offer time and location of interviews to suit my informants and used locations not only at the hospital, the university, local cafes and home visits to access as wide a group as possible.

3.3.5. Brief overview of the data sites

3.3.5.1. City of Southampton

Sites in the city were identified for exploration as possible sites of linguistic and cultural diversity (see 4.3), either as providing homes for large numbers of recently-arrived migrants, places of worship, social meeting places, local schools, shops and restaurants. I consider myself an insider to many of these communities as my background is from an Italian migrant family (see 1.0) that settled in Southampton, particularly in the central city areas (postal codes SO14-0 and SO15-5, see Figure 3.1 below). These areas are home to established and new transnational migrant communities, as represented in this thematic map of ethnicity by postcode from survey data collated by Southampton City Council in 2009 (see 4.3 and 5.4.1). I spent time in the area during the course of my interviews, trying to look with fresh eyes at familiar surroundings (see 4.3.3).

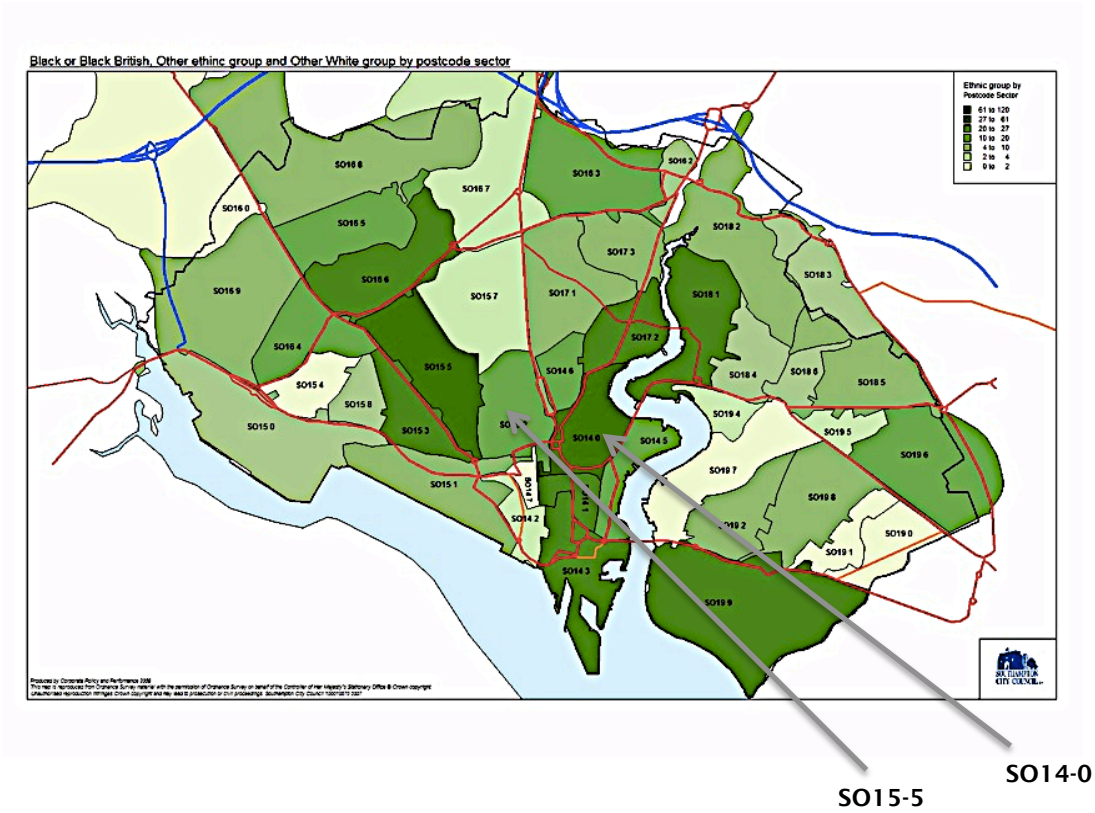

Figure 3.1. City of Southampton thematic map shaded to represent Black or Black British, Other ethnic and Other white group by postcode (Southampton City Council, 2009)

I interviewed in depth a member of the Sikh Gurdwara Nanaksar, a member of the Council for the Central Mosque, a member of the Council for the Vedic Temple, the organiser of the Baha'i faith meetings and the administrator of the Southampton Council of Faiths. Also, the organiser of the charity EU Welcome, the Head of Southampton Voluntary Services, the Manager and a worker from the New Communities Team and the former Racial Equality Officer from Southampton City Council and the Equality and Diversity Officer from Hampshire Police.

I attended EU Welcome meetings and advice sessions held in the Polish Club in Portswood and in particular held one of their sessions to discuss linguistic diversity, which eight members of the Polish community and a local police officer attended.

I had in-depth conversations with the Head of the Southampton Oral History Unit, three in-depth conversations with one other oral historian who collected oral histories of local residents in the 1970-80s and currently works on a

Department of Modern Languages project about the Basque children who were located in the city in 1937. I visited the oral history archives, now lodged in the Central Library, to listen to histories of migrants from Afro-Caribbean, Indian subcontinent, Chinese and Italian origins. I attended a meeting of the Community Café project organised by the Subject Centre for Languages for community language teachers - Gujurati, Bengali, Mandarin Chinese, Afghan Farsi, Hindi, Malay, Malayalam, Persian, Punjabi, Polish and Urdu - at Mount Pleasant Junior School, SO14 (see Figure 3.1). I arranged an in-depth discussion with the Head of the Community Languages programme that is based there.

I interviewed in depth three female members of the Polish community who had arrived in Southampton during the last five years, one of whom invited me into her home for this conversation. I interviewed in depth a Southampton City Councillor for the central city area, a former midwife who works for the Primary Care Trust (PCT).

3.3.5.2. Southampton University Hospitals Trust

To familiarise myself with the Southampton University Hospitals Trust (SUHT) sites, I registered as a volunteer. My volunteer work included conducting patient survey questionnaires about hospital experiences in the SUHT sites of Southampton General (SGH) and Princess Anne Hospitals (PAH); the latter provides SUHT's maternity service. Qualified by my previous work experience in the field of languages for business and employability and my postgraduate status in the Department of Modern Languages, I also became the trainer of the SVIs, Level 1 course for the University of Southampton in 2009 (see 6.6.2).

To ensure the appropriateness of this study for submission for ethics approval, I interviewed key SUHT personnel including the Voluntary Services Manager, site supervisor for this research, her line manager, Head of Chaplaincy, Head of Midwifery, Maternity Patient Information Manager and her Polish-speaking assistant, the Head of the Sure Start Central team and the Head of Education and Learning. The Head of Wider Healthcare Teams Education assisted me with preparation of my ethics submission. The Voluntary Services Manager provided me with SUHT documents relating to language policy and planning.

SUHT were interested to support this study as part of their mission statement to improve the patient experience of all of those in their catchment area, but in particular because of their growing awareness of language issues in health interactions at their sites which may be prejudicing fair and equal access to health services for members of the migrant communities (SUHT, Head of Voluntary Services, personal communications, 2009-11). They expressed an interest in a complementary qualitative study to the internal quantitative one (Southampton University Hospitals Trust, 2009b). This would contribute to an Evaluation Quality Impact Assessment of their Trust Volunteer interpreting service.

I interviewed in depth, 14 SVIs offering the following languages: 8 Polish, 7 female and 1 male; 2 Spanish/Portuguese, both female; 1 male Bengali/Urdu/Hindi interpreter; 1 female Gujurati/Marathi/Hindi; 1 male French; 1 male Russian/Estonian and 1 female Swahili interpreter. I attended and observed meetings with 22 SVIs. I interviewed in depth and observed working practices in the office of the two female Voluntary Services administrators and the female Voluntary Services Manager. I had meetings with the Head of Chaplaincy, the Head of Patients Advice and Liaison Services and a General Practitioner who is SUHT's School of Medicine Assistant Diversity Co-ordinator and senior teacher.

I understand this workforce including middle management to represent policy advisers and the grass roots of the organisation that enact language policy and practice.

3.3.5.3. Princess Anne Hospital, SUHT

The maternity service offered at PAH which is part of SUHT is the focus of this study (see rationale for case study 1.0 and 5.4.5). SUHT maternity services are based at PAH but also include the birthing centre in the New Forest, providing maternity care for about 5000 patients a year. The Head of Midwifery, the Senior Midwifery Manager and the Midwifery Operational Manager at PAH in Coxford Road, opposite the main SGH site, oversee the service and midwifery teams.

I spent time at PAH and interviewed in depth the Midwifery Operational Manager, the Polish-English language-speaking assistant in Maternity Information services team and two Sure Start midwives whilst they were working at PAH. I also observed interpreted medical interactions undertaken by the PAH Polish-English language-speaking assistant.

3.3.5.4. Central Sure Start Centre, Clovelly Road, Southampton

There are fifteen Sure Start Centres in the City of Southampton. These are located in areas identified as disadvantaged in the city where maternal and child health needs attention. The Sure Start programme is funded by the UK government in England to 'give children the best possible start in life through improvement of childcare, early education, health and family support with an emphasis on outreach and community development.' (UK Parliament, 2009-10). SUHT's community midwives work from the Sure Start Centres.

During the consultation phase for my research, I was introduced to the Head of the Central Sure Start Team who suggested that her team of community midwives would be very useful informants. The Central Sure Start Centre, Clovelly Road is in the central Southampton city area of Nicholstown, postal code SO14 (see Figure 3.2 and 4.3), servicing one of the largest numbers of members of the migrant communities in the city.

Figure 3.2. Suburbs of the City of Southampton within the city boundary Nicholstown

The Sure Start Centre, at the time of this research, had a Manager and Deputy Manager supported by a co-ordinator and one or two administrators, five community workers, two to four family or health advisers, a librarian, three community play link workers, five health visitors, six SUHT community midwives, six family support workers and approximately thirty full or part-time play workers. Many of these support workers have been employed because they speak the language and come from the same cultural background as the centre users. In addition to the health advice provided by midwives and health visitors, including antenatal classes, bumps and babies groups, breast feeding support groups and baby clinics, this Sure Start Centre offers a nursery, toy and book library, parent and toddler, first-time parent and breakfast groups for dads, information for parents who want to find training and job opportunities.

Interpreting services are ordered as required by the Sure Start community midwives either for a home visit or at the Sure Start centre. They use a local private provider (Access to Communications (A2C), and sometimes SVIs (see 6.6.2), when at the main PAH site for births and more complicated maternal medical interventions. Ethics approval limitations (see 7.3) to this study meant that I was not able to sit in on antenatal medical interactions mediated by interpreters from A2C.

The rationale for the focus on this site is that the midwives, interpreters and service users engage in rich translocal interactions, with language practices cross-cutting to them all. In addition to taking opportunities to observe in the surrounding area and at the Sure Start Centre during the course of research, I met and was introduced to a number of representatives from the voluntary, public sector and migrant communities who lived in or worked with these communities who agreed to be interviewed for this study.

The Central Sure Start Centre in Clovelly Road is a secure building and I could attend meetings, arrange interviews and observations only by appointment. I was given access to the team meetings of the community midwives based there, arranged interviews with the Central Sure Start Centre Manager and Deputy Manager and midwives and was able to sit in the reception area and also attend a number of Parentcraft sessions held there.

I interviewed in depth the Head and Deputy Manager of the Sure Start Centre in Clovelly Road and three Sure Start community midwives. I sat in on these midwives' team meetings, usually comprising of 4-5 midwives on a Tuesday afternoon and a series of two-hour Parentcraft sessions offered at the Sure Start Centre for mums-to-be with their partners or family members. At the six sessions I attended there were one or two female interpreters present and in all the sessions I sat in on these interpreters were for Polish language speakers. 8-10 expectant mothers attended sessions, most of who were with their partners, and received information about what to expect at the birth and available postnatal support. I also attended and presented my research study to the away day for ten doctors, nurses and administrators of the Nicholstown General Practitioner surgery where a member of the Hampshire Police led a session on honour and domestic violence.

3.3.6. Summary of Activity at Research Sites

See Appendix 1 for the summary of my activity at each research site

3.3.7. Data Collection procedures

Appendix 2 includes the table of the overview of the phases undertaken in the various data collection procedures. This includes the early scoping phase for the study and the application for ethics approval. This covers the period October 2008 to May 2011, the approximate time taken to cover each activity, the reason, and lastly, comments on that phase.

The data used in this study comes from a corpus of in-depth interviews and observations providing 25 hours of recorded material, detailed field notes and language policy and planning documents that were collected between 2010 and 2011. The phases of data collection undertaken (see Appendix 2) gives an outline of the activity and procedures followed, facilitated by my period of familiarisation with the hospital, staff and interpreters during my work as a volunteer and teaching on the interpreting course. I was able to obtain a wealth of ethnographic material from my observations before, during and after these interviews at SGH, PAH, the Central Sure Start Centre and in city locations. I was involved in many informal discussions with midwives, interpreters, voluntary services staff and city contacts prior to meetings or at networking events, finding out permissible histories and personal details which have helped me to contextualise the findings of this linguistic ethnographic study and try to make sense of how meaning is constructed by individuals and what goes in translocal interactions.

The interviews were transcribed and checked for accuracy and anonymisation of all personal details and all data was loaded in to the Atlas Ti software programme. Reading through all my material and conducting a broad themed analysis, I proceeded to themed-oriented discourse analysis (TODA), (see 3.4.2). I used all the material collected for inclusivity and triangulated selected comments with reference to the informant's comments, observations, notes taken and policy documents.

3.3.8. Position of researcher as a participant observer

I understand my qualitative data collection methods of interviews and observations to constitute fieldwork in the sense that DeWalt and DeWalt (2002) suggest in that it involves participating and observing people and communities. This research activity positions the researcher as a participant observer differentiated from a simple participant by the need to record observations in field notes and include an interpretation of the behaviours observed. This activity is 'the process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the researcher setting.' (Schensul, Schensul, & LeCompte, 1999, p. 91)

The oxymoron of participant observation is that, as Bernard (1994) argues, it requires a certain amount of deception and the management of informants' impressions as the researcher seeks to become part of what is observed but maintain objectivity. De Walt and DeWalt (2002) argue that pure observation is not possible as the researcher brings their own prejudices and positions to the situation (see 3.4.2). For example, female researchers may have access to different information than males as Kawulich suggests that,

> "Participant observation is conducted by a biased human who serves as the instrument for data collection; the researcher must understand how his/her gender, sexuality, ethnicity, class, and theoretical approach may affect observation, analysis, and interpretation." (Kawulich, 2005)

The researcher endeavours to learn about the everyday practices of their informants by observing carefully and actively listening whilst maintaining an open and nonjudgemental stance.

Reflecting on my own position as a participant observer in this research, my initial engagement with SUHT was as a volunteer. I signed up as a volunteer in an attempt to give something back to an institution where so many of my relatives, and in particular both my parents, received such excellent care. I consider these intentions to reflect a positive stance in relation to the hospital, one that has the potential to compromise my impartiality. To become a

hospital volunteer, I had an interview with the Voluntary Services Manager, completed and application form and underwent a Criminal Record Bureau check by the police. I was given an all-ward pass and assigned to self-organise and conduct patient surveys throughout the SUHT and PAH sites. It was during this time that I became more familiar with the hospital site and could make general observations about everyday health care practices. This was helpful later as I could use these volunteer experiences to reflect on context as ethics permission was denied to actively engage in observations in public areas of the hospital (see 3.5 and 7.3).

Due to my position as a mature researcher with relevant working experience in project management in the field of languages for business and employability, my credibility and professionalism was established quickly with the Voluntary Services Manager. She invited me to contribute to the drafting of SUHT's first interpreting policy and a review of the Trust Volunteer interpreter service. I was informed that the Modern Languages department at the University of Southampton conducted the interpreter training. This coincided with a time when I had returned to academic study at the University of Southampton and was considering preparing a doctoral thesis. An opportunity also presented itself to stand in for the university interpreter trainer whilst she was on sabbatical. This created a fortunate synergy in my academic, research and practical.

My main gatekeeper at SUHT, the Voluntary Services Manager identified me as a volunteer with the experience and professional background to assist her in the area of interpreter training. This led to a positive facilitation by her of my introduction to other hospital and community gatekeepers plus her endorsement of my cover of the university post to provide the Level 1 interpreter training.

I was not allowed by the ethics committee (see 3.5), to interview interpreters that I had trained but acting as a trainer did allow me to engage as a participant in the everyday practice of the SUHT management and observer of interpreting practices as many of my students commenced and fed back about their interpreting experiences during the training. This experience facilitated my subsequent access to other interpreters that I had not trained, as I had met

many of them at social gatherings organised by the SUHT Voluntary Services Office.

I see myself as occupying a number of positions in this participation and observation of everyday healthcare practices at SUHT. As a 'volunteer' I am positioned with the interpreters, as a 'trainer' I am positioned me with the SUHT gatekeepers and the institution, as a member of a Southampton migrant family (albeit second generation) and as a mother of children myself positions me with the transnational migrant patients. As a 'mature' researcher with working experience in the public sector I had more awareness of the ways and means to approach other gatekeepers, for example in the Southampton City Council, the Police and the voluntary sector. All of these 'positions' of myself in relation to others and their relation to me carry prejudices and biases, which are part of the participant observation oxymoron discussed above. I suggest that these positions and the way in which my informants perceived me, can work both negatively and positively. For example as a mature researcher, my professionalism and credibility may be more quickly established with informants to enhance access and the sharing of information. Conversely, my age and experience may be viewed more readily as aligned with the institution. This may inhibit sharing by those informants who may wish to protect their professional position and worry that their comments or practices may hold more sway if relayed by me in a prejudicial way. I continually tried to reflect on this and maintain an analytically critical but non-judgemental stance. I reflect on the limitations of my own position as a participant observer during the data collection process in section 7.3.

3.4. Approaches to analysis and interpretation of data

In this section, I present approaches to data analysis and interpretation as concepts in research. I will summarise the theoretical approach of TODA, problematize its use and its appropriateness for use in this study. I then refer to 3.3.7, to illustrate how certain extracts of data were selected for closer analysis. I discuss data analysis and interpretation as co-dependant tools of research and close this section with a discussion of the framework used to make sense of the findings. I refer to a worked example of how the analyses presented in Chapters 5 and 6 were carried out, followed by a brief reference

to the discussion of the elements and factors and deliberations that informed the interpretation of the selected excerpt.

The theoretical approaches that inform this research offer the opportunity to explore the translocal spatiality of migrant communities through their language practices. Translocal spaces may be invisible to those who are not intimately connected with them and may disappear when the participant actors move away. However, by using the TODA as an analytical tool on the data collected for this research, I intend to arrive at as accurate an account as possible of the meanings and constructs of translocal space.

TODA is used to examine discourse at the meso and macro levels, looking at how the story is told, in what context and what identities are constructed through situated verbal, written and multimodal language use. Within the constraints of the conditions imposed on data collection in these health interactions (see 7.3), I hope to arrive at as rich an explanation as possible in the relevant context.

The excerpts I present in Chapters 5 and 6 were selected for their content, to illustrate the range of both direct and indirect discourse strategies (see 3.4.2) which members of migrant communities, health practitioners, policy and planners use to say what they say. These excerpts are drawn from the meetings attended, interviews, policy documents and general observations to identify various variables of this kind of language use (see 3.3.7). A process of triangulation is then undertaken across these data sources to produce as accurate an interpretation of meaning as possible. This process of triangulation is examined in more detail below (see 3.4.1).

I am looking for the diversity and complexity of situated language practices used in translocal interaction strategies in the selected excerpts. The excerpts selected confirm the dynamic nature of this field of discourse and the constantly changing identity positions taken by individuals and policy makers in these interactions. Analysis of how members of migrant communities move between an empowered and in control, situation with a fellow migrant or mediating communication to their relative disempowerment as a member of a minority came to light in the data (see 2.6, 2.7.4 and 5.4.7).

3.4.1. Analysis and interpretation of data: an overview

Theoretical approaches, data analysis and interpretation, as tools of research are co-dependant and make a joint contribution to the final conclusions drawn. and Jackson (DeWalt & DeWalt, 2002; Kawulich, 2005; 2011) take Deleuze and Guttari's (2004) concept of the plugging-in of theory to data as a constant, continuous process of making and unmaking to identify emerging and recurrent themes from the data corpus that is under investigation. Mazzei (2011) argues that data needs to be engaged with repeatedly at the deepest of levels, to understand that the context of comparable excerpts may be so different as to reflect quite different dynamics and circumstances, giving each data chunk a profile of its own. Flawed by subjectivity, less scientific interpretation tries to make sense of the data to arrive at an understanding that can, in this instance, stand up to academic scrutiny.

The process of analysis inevitably overlaps with the interpretive process, with porous boundaries between the two. Mazzei in her work, cited above, suggests we need to understand this and work within the limitations of what is inevitably incomplete data to attempt to understand what gets made. Are the trends identified a reality, a constructed representation or a subjective view of the researcher? Understanding the exact boundaries of the encounter *in situ* is important, so as not to contaminate the data from another source which may or may not be contextually relevant. I am aware that all these considerations needed to be taken into account during the analysis phase.

Engaging with my research sites and informants as a discourse analyst and sociolinguist, my aim is to make the strange, familiar and the familiar, strange (see 3.3.3). In so doing, the triangulating of data to arrive at meaningful interpretation is of vital importance. Mazzei and Jackson (as above) suggest that getting feedback on the data and analysis we are undertaking is one way to achieve this. In this research study, the feedback from informants to the study, obtained through day-to-day constant on-going interactions, allowed me to re-check interpretations questions. Using policy documents, record of observations and interview data achieved a multi-modal approach to data collection, facilitating triangulation across sites. Sites which one midwife

suggested were not only geographically but also ideologically distant from each other (see 6.7). In my research, triangulation of the data was achieved through the re-visiting of sites, discussions held in *ad* hoc post-interviews, telephone conversations and regular meetings with my hospital supervisor and member checking of the transcribed interview data with some of the people that took part in the research.

My aim was to reach the local, as Marcus suggested that:

> "…For ethnographers interested in contemporary local changes in culture and society, single-sited research can no longer be easily located in a world system perspective. The perspective has become 'fragmented' indeed 'local' at its core." (Marcus, 1995, p. 98)

Atkinson (1999) in his work on medical discourse raised a methodological concern over analysis and interpretation of data, suggesting that discourse analysts should deal with multiple data sites which would then include the multiple contexts to interactional encounters. To address this concern, I used my insider knowledge (see 3.3.5.1) and familiarisation with the sites (see 3.3.5) to tap a rich vein of ethnographic detail. This is used at the interpretation and explanation stage to go some way to make up the deficit of not being able to record live talk at work. I am looking to balance and challenge my assumptions in my findings. See Appendix 3 for a sample analysis.

Unfortunately, as I was not allowed to video record the observed interactions and interviews (see 7.3), no paralinguistic features of pitch, volume or intonation were gathered. I can note that to do so for group interactions would have involved two or three cameras and could be challenging to set up. I note that to make such recordings would, in all probability, need a purpose-built room. I was, however, able to note seating arrangements, times of meetings, length, size of room, equipment in the room, layout and material objects present and discuss these where I deem them to be relevant to semiotic analysis, as proposed by Scollon and Scollon (2003).

3.4.2. Theme-oriented discourse analysis (TODA)

TODA is an analytic method widely used in health care, health professions, sociological and psychological studies that offers a theoretically flexible approach to analysing qualitative data (see 3.3.2). I have set my research interest in the theoretical context of transnationalism and socially constructed translocality (see 2.2 and 2.4). I look to my themes (see 1.1) from these conceptualisations rather than the development of theory from concepts grounded in the data, from which I would develop a framework of core categories.

Discourse analysis (DA) is particularly relevant for this study of language practices as it can be applied to the study and analysis of the use of language with multiple discourses. 'It looks to understand how people use language to create and enact identities and activities' (Glaser & Strauss, 1967). DA involves looking at how the story is told and what identities are constructed through the use of language, with the researcher actively positioned in the discourse(s).

TODA combines the two strands of qualitative analytic methodology, the one rooted in the theoretical position of DA suggested by scholars such as Wetherell and Potter (Starks & Trinidad, 2007, p. 1373). The other in the more independent of theoretical approaches which is often, as suggested by Aronson (1994), framed as a pragmatic or realist approach.

This approach, developed from DA, has its roots in linguistics, philosophy and discursive cognitive psychology developed by Schiffrin (1994). TODA acknowledges the active role that the researcher plays in identifying themes across a data set (the data extracted for analysis) rather than within one item such as an interview or document. It is a method which has been used effectively by Sarangi and Roberts (2005) to look at how language constructs professional practice and how meaning is negotiated, particularly in medical interactions.

3.4.2.1. Discourse Analysis (DA)

There are three main types of orientation to discourse, firstly formal linguistic analysis of samples of written or oral language and texts, which then conducts a microanalysis of linguistic, grammatical and semantic uses and meanings of text. Secondly, empirical DA of samples of written or oral language, talk and texts plus data on the 'uses' of texts in social settings such as conversation and genre analysis (Cameron, 1990). These samples are then submitted to micro and macro analysis of the ways in which language/talk and/or texts are organised, such as in turn taking and framing and how that constructs social practices. Thirdly, critical discourse analysis (CDA), a method suggested by Foucauld (2002) and Fairclough (2003) adds another source of data from the institutions and individuals. This approach understands these participants (actors) to produce and be produced by the language they speak. A multi-dimensional macro analysis can then be undertaken to understand how discourses (in many forms such as ideologies of power and language) construct identity and what individuals regard as possible to think and say. For example, Foucault (1977) in his study of madness was able to identify three different historically and place-dependant discourses that have constructed what madness is: madness as possession by spirits, madness as social deviancy and madness as mental illness. Discourse can then be seen as positioning subjects in terms of their social practices.

The development of DA as a research practice is informed by many other approaches. Wetherell and Potter (1988), discursive psychologists, introduced the concept of interpretative repertoires which explore the beliefs and values that people draw on when using language. Pragmatics has also informed discourse analytic practice in terms of understanding not only how elements of language (words, grammar) convey meaning, but also understanding the influence of context, location, setting and the actors involved (Grice, 1989).

> "….Discourse is a level or component of language use, related to but distinct from grammar. It can be oral or written and can be approached in textual or sociocultural or sociointeractional terms. It can be brief, like a greeting and thus smaller than a single sentence, or lengthy, like a novel or narration of personal experience…" (Scherzer, 1987, p. 296)

A large number of discourse data sources are available from transcripts from interviews, samples of conversations, focus groups, published literature, media and web-based materials. However, Blommaert (2005) in his discussion of CDA as the study of language in action, where attention needs to be paid to both language and the action, proposes to widen these objects of enquiry to all non-linguistic elements that include:

> "…. All kinds of semiotic 'flagging' performed by means of objects, attributes, or activities can and should be included for they usually constitute the 'action' part of language-in-action. What counts is the way in which such semiotic instruments are actually deployed and how they start to become meaningful against the wider background." (Blommaert, 2005, p. 3)

3.4.2.2. Discourse analysis shortcomings

Many social psychological researchers now use the DA approach, in particular to study the use of language. However, there is still a debate, mainly between the purist conversation analysts and those who think that DA should be combined with critical social theory as to how far information from outside a particular text can be used by analysts to analyse that text. Critical social theorists challenge the objectivity of DA researchers and the validity of their results. Many of these arguments are encapsulated in the quantitative vs. qualitative debate, where quantitative analysts suggest that qualitative analysis is not systematic and lacks robust theoretical underpinning. DA scholars, such as van Dijk (Blommaert, 2005, p. 3; 1990) and editors of journals, in particular, are addressing this and emphasise the need for explicit and systematic analysis based on serious methods and theories.

It is important to understand what qualitative DA is not, and Antaki et al. (2003) suggest that, as is the case with the analysis of quantitative data, it is not enough just to present the data without putting it through some sort of analysis that does something with it. DA means doing analysis. Transcription is not a substitute but a preparation of the data for analysis, and summarising

themes loses the discursive fine detail and can change the object of analysis before analysis even starts. Analysis is not undertaken if the data collection questions (for example, at interview) are used as the themes, or where the themes are ill-defined and the data or the theory does not match the analytic claims (Braun & Clarke, 2006). The analyst who starts from, or adopts a particular positive or negative position in relation to the data compromises and can miss discursive complexity. Similarly, it is not DA to use quotation after quotation or insert isolated quotations with no further explanation as this misses the opportunity to analyse these utterance in their situated context.

Data cannot be left to speak for itself, particularly when describing how speakers share discursive resources such as repertoires (Blommaert & Backhaus, 2010), or language ideologies (Fairclough, 1989) that are based on different sets of theoretical concepts. DA risks circularity and different writers engaging in more detailed analysis of the same texts may come to very different conclusions about it. Tautologically, quotes used to provide justification for a particular ideology, can be used to imply that the speakers used this language because they shared that ideology. DA, to avoid this circularity, needs to add an extra dimension, which demonstrates the commonalities of the detail of the text or talk and/or, for example, substantiates the existence of ideologies through historical evidence. There is also a danger of under-analysis by identifying mental constructs as giving direct access to people's inner thoughts and feelings and DA has argued against talk being seen as representative of an inner psychological state that gives rise to certain ideas and opinions.

With my own academic roots in psychology I do not want to reject mental schemata completely and concur with researchers who incorporate cognitive factors into their models of DA (van Dijk, 1998). An informant is situated, for example, in the discursive context and part of an interview where they understand the rules of that encounter and manage their delivery of their views in a particular order that is reasoned and presented in a certain way. If health interactions could be captured, micro-DA would continue to analyse these situated conversational moves together with reflections on previous research undertaken to enable a full interpretation. Care needs to be taken that findings from qualitative DA, as in analysis of quantitative findings from

surveys, are substantiated before being extrapolated to all members of a certain category. Finally, understanding and recognising the features of conversational and rhetorical utterances is important for the DA but is not a substitute for the analysis itself. The feature needs to be identified, for example the rhetorical device of a three-part list, but then interpretation is needed to show what that device 'does at a particular point in the talk, how it is used, what it is used to do and how it is handled sequentially and rhetorically….good analysis moves convincingly back and forth between the general and the specific'. (Antaki, et al., 2003, p. 17)

3.4.2.3. Theme-oriented methodology

I am looking to analytic themes that capture something important in relation to the research question (Braun & Clarke, 2006) for this case study to shed light on the impact on and how translocality is negotiated. TODA was used effectively by Sarangi and Roberts (2005) to shed light on how meaning is negotiated in multilingual medical encounters between healthcare professionals and families in genetic counselling and primary care consultations. This social constructionist approach is not interested in the individual psychologies or motivations of the individuals concerned but uses the selected analytic themes to explore the underlying latent ideas, assumptions, ideologies that co-construct and construct meanings.

3.4.2.4. Theme-oriented discourse analysis tools

There are a number of DA tools available to engage with data to extract themes, and Gee (2011) argues that they are not necessarily hierarchical. During the course of this research and the constraints imposed on data collection (see 7.3), I had to revise my intention to perform a micro-linguistic analysis on health interactions that would have shed light on talk at work rather than talk about work. Sarangi and Roberts (1999) argue, and I concur, that capturing talk at work reveals deeper insights into actual practices. They suggest that a key principle of context, which surrounds talk, cannot be assumed, but is constructed and co-constructed by the talk itself. They argue for the importance of analysis of the talk at work before gathering data on the

wider context issues from talk about work and raising the why questions. This is necessary, for as Bennett (2004), a scholar from the field of intercultural communication, argues that participants may behave in live interactions very differently than the way they speak about how they would behave in a given situation. Hak (1999) suggests that the researcher focus uniquely on the centrality of talk, that does not necessarily need context, that can be micro-analysed to account for the complexity and nuances of professional practices in the urban workplace.

However, I adapted my interpretive tools according to my methodological limitations. As I am interested in cross-discipline approaches, informed by my undergraduate and postgraduate fields of study in psychology and sociology crossing now to sociolinguistics, I found Gee's theoretical tools helpful as they are situated in the theoretical social constructionist view of language underpinning my research.

These include the situated meaning tool, the social languages tool, the inter textuality tool, the figured worlds tool and the big 'D' discourse tool (see Appendix 4) Gee (2011, pp. 150-184).

As I started to engage and interrogate my data (see 3.4.3.1), and established the macro areas of enquiry, I explored the theme of frame analysis derived from Goffman's work (1974). I understand this to be a useful tool to reveal hegemonic structures of meaning that can work alongside Gee's theoretical DA tools outlined above. I use Gitlin's definition of frames (cited by Koenig, 2006, p. 62 as closest to the Goffmanian idea) as, 'principles of selection, emphasis and presentation composed of little tacit theories about what exists, what happens, and what matters.' Of relevance to this study on translocality is that Koenig explores the problems of uncovering tacit frames, particularly with reference to cross-national research where 'identical words might not always measure the same concept. (Koenig, 2006, p. 63)

As suggested by Koenig's review of frame analysis literature I use as a guide, the three by three taxonomy structure of generic and content frames (see Appendix 5). I find this framework helpful to interrogate my data for potential

conflicts, life narratives and economic factors through the lens of ethno-nationalist, language and power relations.

Koenig gives an example of how group conflict can be explored using this matrix that is relevant to my aim to explore the construction or reproduction of the collective identities of translocal migrants. Citing the work of Billig (1995), Reisigl and Wodak (2001), van de Mieroop (2005) and Baumann (1996) through (i) the use of deictics and the use of the first person plural pronouns to identify who is in and who is out of the we; (ii) particularising and generalising synedoches that employ the use of the collective singular to identify an action of a person, group or institution through an attribute such as religion, gender, nationality or language and (iii) assumed or historical constructions that call on collective memory.

As mine is a qualitative approach, I will not engage in algorithmic computations to ascertain and aggregate the map of the word clusters but will look through the query table and co-occurrence table in Atlas Ti (see 3.4.3.1) focussing on keywords or codes from my text e.g. Pole, Sikh, Punjabi, Indian to aid my analysis. As Koenig identifies there is a problem with 'cross-national rhetoric which can reinforce 'state-centred conventions of data-gathering that make nation states the predominant units of comparative research,' (Koenig, 2006, p. 72), but care will be taken in analysis and interpretation to avoid and problematize these tacit assumptions.

3.4.2.5. Phases of theme oriented discourse analysis

For the phases of TODA outlined by Braun and Clarke (2006) see Appendix 6.

3.4.2.6. Theme-oriented discourse analysis reliability

Labuschagne (2003) argues that for many scientists used to doing quantitative studies the whole concept of qualitative research is unclear, almost foreign, or airy fairy and not 'real' research. However, a case can be made for the rigour of analysis in qualitative research and the validity of generalising from the particular, (see 7.4). Theory and method need to be applied rigorously with accurate transcription, attention to all data items for coding in a thorough and

comprehensive coding process with all relevant extracts collated. Themes need to be checked against each other and back to the original data set and have internal coherence, consistency and be distinct from each other. Furthermore, data is analysed (see 3.4.5) rather than described in a timely manner. A report of findings is produced, as suggested by Braun and Clarke (2006), where method and analysis are consistent with the epistemological approach and the researcher is actively positioned in the research process.

3.4.3. Analysis of data

The process of selecting data for analysis involved reading through the documents sourced and provided by informants, observation notes, listening to interview tapes, looking at photographs and then re-reading and re-playing, as soon as possible after the gathering of that data (as described in Appendix 2). Phases 4-5 in that table suggest, re-visiting the data several times, in an uncritical manner to try and get the gist and sense of the narrative so as to become very familiar with it. Phase 6 involves returning to informants, where necessary, to re-check for accuracy. Proceeding to a stage to engage with the texts in a more critical manner, in phase 7 I identify emerging themes and trends, which Hammersley and Atkinson describe as:

> "… us(e)ing the data to think with. One looks to see whether any interesting patterns can be identified; whether anything stands out as surprising or puzzling; how the data relate to what one might have expected on the basis of common-sense knowledge, official accounts, or previous theory; and whether there are any apparent inconsistencies or contradictions among the views of different groups or individuals, or between people's expressed belief or attitudes and what they do." (Martyn Hammersley & Atkinson, 1995, p. 210)

In an attempt to relate what is happening across different sites and at different times, analytical concepts either emerged spontaneously from those used by the informants themselves or were flagged up by the use of unusual terms or references to be used as headings for analysis. I returned to the data many

times to re-examine listings under which the initial codings of these recurring themes occurred.

3.4.3.1. Atlas Ti qualitative software programme

At the second stage of data analysis, the recorded interviews were transcribed and all the data were entered as primary documents into the software programme, Atlas Ti. This qualitative software programme acts as a computerised interactive pencil and paper configuration, with source documents uploaded, including Word and rich text documents, PDFs, audio files and photographs, displayed on the left hand side of the screen and highlighted, marked codes, notes, memos and segments appearing on the right hand of the screen. Drag and drop coding facilitates the coding process which allows for an unlimited number of individual or overlapping codes. Once coded, coding families can be highlighted, enabling interrogation of the data across all documents or selected families. Reports on selected coded quotations can be viewed on screen or printed. The query tool can be used to interrogate the data to look for patterns, overlaps and sequences and the co-occurrence table allows a display of co-occurring codes combining operators such as within, encloses, overlaps, overlapped by and 'and'.

Once uploaded, I worked through the documents, coding and grouping and discussed my emerging themes and topics with other researchers and supervisors (see Appendix 2, phase 8). I used my field notes collected through my ethnographic observations to support this worked primary data, asking questions of the emerging patterns such as - so what? Spivak (D. Landry & MacLean, 1996), describes this as, putting the data to work, looking for moments of interruption. I understand a similar concept to be that of Derrida's (1982) moments of difference, to deconstruct the events rather than perform acts of pedestrian coding which might yield no new knowledge.

My further analysis of the text, looked at language practice features used to express meaning, and I interpreted these, informed by my understanding of its context. I used a range of questions, based on the TODA analytical approach and tools, including frame analysis, outlined above in 3.4.2.4, to guide me through the analysis as I sought to understand and explain the conduct and

construction of meanings used by the informants and the issues they discussed. I looked to critically explore texts for specific meanings where informants may have shared taken-for-granted knowledge. I tried to challenge my assumptions of meaning.

I asked questions such as:

- What exactly was said?
- When was it said? How was it presented?
- What shared meanings were implied by specific situated word use or normative situated systemic practices (in particular in the health service)?
- What devices were used linguistically to achieve meaning and engage the listener?
- In what ways did the informants presume or infer particular identities, roles and relationships?
- How was meaning constructed or co-constructed?
- Was there any evidence of miscommunication?
- How was the listener affected by the utterance?
- How did the observed listener interpret the utterance?
- Could there be any other explanation of the interaction?
- Did the informant's talk enact a particular social language appropriate to a particular role, relationship or status or social identity? Did this change at all during the course of the interaction?
- Was more than one language used, how and in what context?
- How were other texts or styles of language referred or alluded to?
- How did the speaker or listener manipulate language, using technologies or objects to articulate an ideology?

- Was the text organised in such a way to reflect a certain discourse type?
- Whose voice was being authorised or expressed in the communication?
- What or who were the perceived beneficiaries of this communication?
- Who or what agency was exercising power in this discourse and over whom? Was this overt or covert?
- Was there any evidence of contestation of the discourse?

Throughout the analysis, interpretation and explanation stages I referred to my observations in the institutions and of practices. I looked for linguistic paralinguistic landscape features of physical space, physical placements, and the social and cultural dimensions of the discursive encounters. I was interested to see how they were shaped by and shaped the nature of the discursive practice. In my interviews, I asked questions about the use of space contiguous to the interactions and the roles and status of participants. Within the restraints of my ethical permissions for the study I explored other dimensions of age, gender, ethnic origin, language, religion and educational background and group dynamics.

3.4.3.2. Language and power analysis

I reflected on any evidence of participants' understanding and informed by Widdowson's (1998) proposals that sentences, phrases and words can be used to exercise control, questioned whether equality of access was compromised or facilitated by texts or in interactions. In the context of Bourdieu's (1991) wider discourse on hegemonic language and symbolic power (see 2.5 and 2.7.4); scholars such as Fairclough (1989) discuss how power can be expressed at the sentence level by nominalisation, omissions of information about agency or withholding certain facts and the use of the passive tense. Speakers can abrogate or ascribe responsibility by talking in a manner, such that someone else, who may or may not be present, is constructed as the agent who is the producer of actions and therefore the power and authority.

Persuasive rhetoric, nuance, double meanings, undertones and insinuations of lack of trust or trust can also convey the agencies of power. Widdowson (1998)

suggested that a speaker can feign innocence through linguistic devices, slang or use of buzzwords, latest advertising slogans and/or acronyms that seem to shift agency away or towards them, or define the insider-outsider positions, which are often culture-referent-specific in an ideologically complex text. Single words, used familiarly in certain circles, can convey register, formal, professional or informal, and intention to include or exclude the listener. The first, second and third person use can convey different messages around the objectivity of the information or its authority.

Fairclough (1989) also suggests looking for topicalisation or foregrounding to ascertain political alignments of speech that can make sense of the text. Using open-ended questions and mirroring prompts to encourage speakers to choose or change the topic can illuminate that speaker's perspective and perceptions. Finally, tones of doubt or surety expressed through the tone or use of modals, such as may, might, would, and could, can position the speaker as an authority or subordinate.

Gender issues, where referred to by informants, were considered too as a dimension of the discourses of power, sex, identity and difference. This meso-level of analysis is followed by a macro-review of whole interactions in an attempt to triangulate and improve interpretation based on the combination of a variety of analytical approaches rather than foreground one or another.

I exercised the researcher privileges, discussed by Hak (1999) to dip into the full data corpus for corroborating detail or refer to similar instances. I tried to avoid assuming homogeneity across ethnic or language groups and was also mindful that two contributions, seemingly structured in the same way, are situated differently in contexts that may not submit to comparison. The process of analysis of an extract is exemplified in Appendix 3 and the excerpts used will illustrate the complexity of meaning in situated language practices.

The data analysis process is constantly enriched by the rich ethnographical detail gathered from the immersion of the researcher in the data collection sites. I constantly drew on my own life and family experiences in the city as described in 3.3.5.1 It is hoped that this thick and rich vein of qualitative

inquiry enable me to match across specific utterances to fully appreciate the general interpretative stance taken.

3.4.4. Interpretation of data

I understand interpretation in research as a process of making sense and meaning from the data to enable me to draw credible conclusions. These conclusions represent my personal and theoretical understanding of the phenomenon under study that:

> "….provides sufficient description to allow the reader to understand the basis for an interpretation, and sufficient interpretation to allow the reader to understand the description." (Patton, 1990, pp. 503-504)

Seeking to understand the context, particularly in relation to an institution in the health domain, mainly from the informants' perspectives is critical to the interpretive process. Duranti and Goodwin propose four dimensions of the theoretical framework for the understanding of institutional/workplace contexts as:

> (a) The setting of a social and physical framework in workplace interactions.
> (b) The behavioural environment of the workplace, which includes non-verbal communication and use of social space.
> (c) Language as context, where language calls up contexts and provides context for talk.
> (d) Extra-situational context, which draws on wider social, political and cultural institutions and discourses. (Duranti & Goodwin, 1992, pp. 291-310)

The TODA analytical approach, (see 3.4.2), allows for the consideration of these four dimensions of context to enhance the interpretation of meaning in an institution. Researchers will inevitably find themselves in unfamiliar institutional or workplace settings and trying to understand what is going on

can be challenging. Gumperz (1999) suggests that diversity enters into the interpretive process and how missed contextualisation cues can be critical markers of miscommunication. Interactants from different cultures and researchers may miss what Garfinkel (1967) described as practical reasoning and the shared, taken-for-granted contextual knowledge to fill in gaps of what was unsaid.

It is hoped that this LE study using TODA tools, combined with as much contextual data as the scope of this study allows, should provide sufficient information to provide meaningful and credible interpretations as to what is going on.

3.4.5. From interpretation to explanation

The aim of this study is to explore translocality and its theoretical framework (see Chapter 2) to move from interpretation to explanation. This section will give an overview of the methodology of the analysis and interpretation of data conducted in Chapters 5 and 6. The two analytical approaches combined in TODA (see 3.4.2), themed and discourse analysis, work together as an inductive method of studying data to identify patterns and proto- and sub-themes. When viewed alone these fragments of ideas or experiences, gathered ethnographically, are often meaningless but as a whole, composed of data from a number of sources they can form a comprehensive and coherent picture. To illustrate the method of analysis I offer an illustrative excerpt in Appendix 3. This should reveal a step-by-step illustration of the analytical process that will be used in Chapter 5 and 6. However, the analytical process in these chapters will not be revealed in such detail but will be presented descriptively as a whole sequence. I have marked the comments numerically in this section but that will not be marked in a similar way in Chapters 5 and 6.

I generally follow the stages from Aronson (1994) and Gee's (2011, pp. 150-184) discourse analysis framework and toolkit following three levels of description, interpretation and explanation.

Stage 1	From the informants' transcribed conversations and interviews notes extracts are selected that illustrate the themes.
Stage 2	A brief background to the extract is described and participants identified.
Stage 3	**Description** of themes and sub-themes and identification of phenomena in the extract.
Stage 4	Using TODA and linguistic ethnographic information, analysis and **interpretation** of the extract
Stage 5	Explanation of phenomenon with reference to the theories of super-diversity, translocality, urban language practices, difference and power relations explained.

NB: As interpretation and explanation are usually co-dependant, Stages 4 and 5 are combined in Chapter 5 and 6 but shown separately here.

3.5. Ethical issues

Entering a hospital environment or working with members of communities who may be disadvantaged, socially, financially or linguistically, necessitates close attention to ethical issues. The rationale, methodology, data protection arrangements and dissemination plan for ethics approval for the part of this study to be conducted at SUHT was submitted to the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee (MREC). See Appendix 1 for the full timetable of this process. The application portal was the National Research Ethics Service (NRES) now the Integrated Research Application System (National Patient Safety Agency, 2011). Once approved I needed approval from the University of Southampton Research Governance and final sign off to proceed was by SUHT's own Research & Development (R&D) team.

The research application submitted was in compliance with the Research Governance Framework for Health and Social Care and Good Practice, 2nd Edition, (GCP) (Department of Health, 2005). I provided evidence that I was covered by the University of Southampton's indemnity scheme which may

apply where any cause of harm was not due to clinical negligence. Otherwise the Clinical Negligence Scheme for Trusts applies, as a National Health Service (NHS) Trust is the sponsor. See Appendix 7 for all the MREC and SUHT approved project letters of invitation, information sheets and consent forms for patients, SUHT midwives, SVIs and community contacts.

There was no commitment to pay any informant for their participation or share the data collected with them. SUHT committed to put a synopsis of the report submitted to them on the review of the SVI onto the SUHT website (Southampton University Hospitals Trust, 2011). I had to satisfy the MREC and SUHT's R&D team of my research professionalism to ensure that the informants would not be misrepresented in any way. I guaranteed that full consent would be obtained with procedures in place to enable participants to report any concerns or withdraw from the study at any time.

3.5.1. Working with participants, research activism

My aim was to work in a reciprocal relationship with the hospital and the research informants rather on or for them. Sarangi and Roberts (1999) suggest that more attention needs to be paid to the possible benefits of research for institutions and their sensitisation to languages and communications. In this case, I agreed to use some of the initial data to contribute to a report on a qualitative evaluation of the Trust Volunteering Service. Whilst continuing to use that data for my doctoral thesis, I intended to offer a practical contribution to the institution and its language support services and engage in an on-going dialogue about language issues. See section 7.5 for a discussion of research activism in relation to this study. Following submission of that report in July 2011, I was asked to sit on SUHT's Equality and Diversity Committee to present the preliminary findings and continue to support their work. I continue, as required, to offer one-off training for SVIs.

I understood that my background and experience helped me to maintain professional credibility, authority and a relevant and understandable presence to informants in an, initially at least, unfamiliar research site. I consider this to be a positive force for gaining access to information but conversely, I was aware, in some instances that informants: (i) interpreters and (ii) midwives may

position me as partial and possible reporting to their line managers and might feel their employment could be compromised by their contributions. I took every opportunity to reassure them of my impartiality but cannot discount the effect of my age, sex and experience may have had in categorising their perceptions of me and shape the provision of their information. My self-reflection on this matter is an attempt to recognise partiality-impartiality issues to improve the clarity of my analysis, but on the understanding that there are no clear-cut categories, as Hannan argues:

> "Sociological researchers invariably sweep partiality from the picture by design. If the world being analysed is nearly crisp (has minimal partiality), then this practice makes little difference for substantive conclusions. Sometimes, social worlds crystallize in crisp configurations such as the well-ordered jurisdictions of the system of medieval craft guilds. But such cases are more the exception than the rule. Sociologists usually study worlds in flux, with categories that emerge, transmute, and decay. Category boundaries are anything but crisp under such conditions, and sweeping partiality out of the picture can surely distort analysis." (Hannan, 2010, p. 160)

I regard this as a key ethical issue to working with participants to inform the formulation of a coherent methodology and outcomes.

3.5.2. Confidentiality

All participants were advised that their contributions would be anonymised, assured of complete confidentiality and that they were under no compulsion to take part in the study and could withdraw at any time (see Appendix 7). The researcher understood that patients may refer to personal, sensitive health or maternity issues during an interview and committed to treating this information confidentially and sensitively. I did provide both MREC and SUHT with an outline of my training in psychotherapy and counselling, backed by undergraduate and postgraduate qualifications in psychology. I was required to give an assurance that if the patient became distressed in any way during the interview, physically or mentally, I would call an appropriate member of the

health care team and the interview would be terminated. Fortunately, this was not necessary on any occasion.

3.5.3. Avoiding coercion to participate

To avoid any element of face-to-face coercion of the SVIs or staff to take part in the study, after presentation of the project at group meetings and questions invited, the Voluntary Services Manager or Midwife Manager sent out the invitations to participate. Participants were advised that they could approach the SUHT Voluntary Services Manager at any time, with guaranteed confidentially, if they had any concerns about the study. The dates of the study were given to the interpreters with no deadline given to respond, to ensure again that they were under no obligation to participate during this period.

3.5.4. Working with vulnerable patients

The majority of health care professionals and interpreters who work in the maternity services are female and as the researcher is female, same sex interactions reduced concerns about access to informants and hopefully reduced the risk of added stress or discomfort for patients from different cultural backgrounds. As any maternity patient may be medically, emotionally stressed or in labour, discussions with the Sure Start Manager and Maternity Information Manager suggested that the first appointment with the midwife at 8-10 weeks, the booking, would not be an appropriate time for a researcher to be present. This is a very busy appointment, medical notes need to be generated, and the patient may be nervous and may need to ask the midwife many questions. I regarded it is as inappropriate to attend any appointment where results would be given to the patient, to avoid any distress to a patient if these should be negative in some way. My attendance at further routine appointments was considered more appropriate, e.g. 16 weeks serum screening and dating, 25, 28, 34 or 36 weeks when midwife will be present are often booked in advance. Often at the end of one appointment, an interpreter may be booked for the next, it was agreed that the participating midwife would request the patient's permission to have an observer at the next appointment.

The midwife introduced the subject of the project and on the understanding that some patients may not have high levels of literacy; the interpreters explained, where necessary, verbally and to check understanding. Patients were given a stamped addressed envelope to return the consent form to the midwife or give to the midwife on their next appointment. The midwife made the final decision about who was approached and decisions as to whether a patient was suitable to continue to be part of the study.

3.5.5. Length of interviews

There were assurances that needed to be given to MREC and the hospital that staff would not be taken away from their work for too long and for this reason interviews with midwives were agreed to be only one hour in length. In practice, however, I was often able to spend longer with midwives as part of their 2-hour team meetings or Parentcraft classes.

3.5.6. Data protection

It was hoped that observations and photographs of general access areas in the hospital and tape recordings of medical interactions mediated by interpreters could have been undertaken but, due to concerns about invasion of privacy through surveillance, the MREC did not grant approval for these activities (see 7.3). Commitments were given to store any data collected securely, in accordance with the University of Southampton policy that all doctoral research data must be kept for a minimum of 10 years. All participants were informed that the research was carried out according to the principles of data protection and conformity to the Data Protection Act 1998.

3.6. Summary

The description and explanation for the methodology selected was set out in this chapter. I aimed to explore the critical methodological features that could be used to examine, identify and offer explanations that would answer my research questions. I make the case for the appropriateness of LE as the main principle underlying the methodology of my research and for analysis derived from TODA, which has a reputable track record with scholars for use in the

analysis of medical interactions. The suitability of the case study method was explored, criteria for selecting informants, an overview of the selected data sites, how contact was made and the profile of informants, data collection procedures and approaches to data collection. I also explored the tensions in the positioning of the researcher as a participant observer of the individual and groups in these data collection activities.

I discussed the explanatory framework used in analysing and interpreting the findings with a demonstration of how the analysis and interpretation of data was conducted as a prelude to Chapters 5 and 6. The ethical issues related to this research included my self-reflections on my perceived partiality or impartiality by informants and the acknowledgement of the lack of clear-cut categories in these constructions. I make reference to the procedures required for medical ethics approval, which will be followed by a more detailed discussion in a critical appraisal of the limitations of the methodology in section 7.3.

Chapter 4: The City of Southampton

4.1. Introduction

In this section I set the context for my case study located in the City of Southampton, a provincial city on the south coast of the United Kingdom (UK). I introduce Southampton as a non-global port city which, as Kokot (2008) argues, in common with many other port cities, is able to demonstrate some of the criteria of the great world global cities: as a strategic location, trading hub, transit point and host to transnational migrant communities. Southampton has a long tradition of hosting a population of socially mobile transnational migrants that include the highly skilled, academics, engineers and service sector workers, economic migrants and refugees and asylum seekers, escaping poverty and war-torn situations. I identify a new urban environment of increasing diversity in the city facilitated by increasing social mobilities. I will explore the demography, profile of the new communities and the rich linguistic landscapes they create in order to contextualise my data collection and analysis.

4.2. The City of Southampton: a global gateway

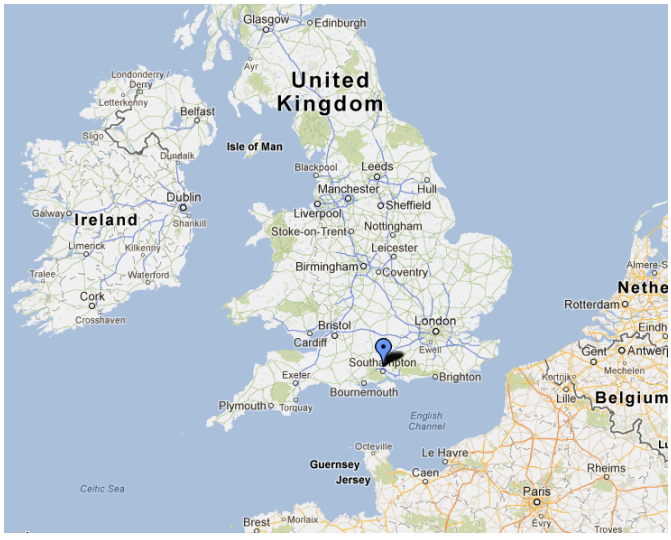

Figure 4.1. City of Southampton location in the UK

© Google Maps 2013

4.2.1. Southampton's rich history

Southampton is situated on the south coast of the UK, some 70 miles from London. Patterson (1970) describes the city's wealth and fortunes that have risen and fallen over the ages. However, the city has continued to provide a base, strategic hub and transport link for trade and migrants from Europe and beyond from Roman times, when passageways to the interior of the country through the Rivers Itchen and Test (with a double tide) opened up trading possibilities. French families settled in the town after the Norman Conquest of 1066, followed by Spanish and Italian traders, Flemish Walloon craftsmen fleeing religious persecution in Belgium, and French-speaking Channel Islanders. The port expanded, serviced by workers who lived in the nearby newer, but poorer, working-class districts and the opening of the London to Southampton railway line. The town prospered as the North Atlantic trade increased and the White Star transatlantic liners moved to Southampton, with the maiden voyage of the Titanic leaving from the port in 1912. From 1913 flying boats were built in Southampton and from 1923 there was a flying boat service to the Channel Islands. In 1932 the Council purchased an airport at Eastleigh, which, by 1934 was the third most important airport in Britain. During the Second World War, 1939-45, Southampton became the major embarkation and supply port for the British Expeditionary Force. Using local labour and Irish and Pakistani workers, the city took a major role in the construction of aerodromes and hardware to support the war effort, including the manufacture of the Spitfire aircraft. Following the war, it acted as a major dispersal point for refugees fleeing the war devastation in mainland Europe. (Kushner & Knox, 1999)

4.2.2. The town becomes a city

Lambert (2009) describes how after the destruction of the city in the Second World War (1939-1945), a major rebuilding programme established the oil refinery at Fawley, attracting international shipping trade, the expansion of the docks, the renewal of the city centre and the proliferation of light industries including the first hovercraft manufacturer. The town revived during the 1950s and 60s and in 1964 Southampton officially became a city. The University of

Southampton, founded in 1862, received its Royal Charter status in 1952 with 1000 students, rising to over 4,000 in 1968.

After a peak in the 1960s as the foremost passenger port in Britain, the boom years of the city's docks were over. Following long-running industrial disputes in the docks and containerisation, many of the old workforce, old docks and supply chain industries became redundant. In the 1960s the number of passengers travelling through the port declined as air travel became more common. In the 1980s and 1990s some of the old docks were converted into areas of shops and offices and marinas; again the city reshaped itself to offer its cultural heritage as a tourist and desirable residential location. The city benefits from its proximity to the coast and London, maritime historical connections, and to areas of natural beauty enabling it to expand its airport, university and light industries. Latterly, Southampton has re-emerged as a global gateway with the second largest container port in the UK, handling most of the UK trade to the Far East and a new luxury cruise terminal linked by rail to Southampton Airport that offers UK and European transport links to approximately 1.76 million passengers. Southampton is now the twenty-sixth largest city in the UK, with a population of 236,700 and actively maintains international links and is twinned with Le Havre, France; Rems-Murr-Kreis, Germany; and Kalisz, Poland. It is the sister city of Hampton, Virginia, United States and Qingdao, China and the sister port to Busan in South Korea. Links and exchanges take place with all of these cities, for business and education purposes. Chinese nationals from Qingdao recently visited and worked in the city on short-term contracts in the health and care sector. (Southampton Partnership, 2007)

The University of Southampton, fully established in 1952, plays an integral part in the economy and life of the City and its student population contributes to the linguistic and cultural diversity of the city. In 2008-9, the University of Southampton registered 2764 international non-EU students from 105 countries other than England, and Southampton Solent University registered 1824 students from 114 countries other than England. (University of Southampton, personal communication, 8 June 2010)

4.2.3. Transnational migration to the city

Kushner and Knox (1999) argue that Southampton, historically, was an arrival and departure point for transnational migrants rather than a destination *per se*. These people were sometimes spending money and sometimes needing accommodation and sustenance while they waited for on-going transport, often on their way to London or to the New World. Some did stay and the poorest gravitated towards the central downtown areas, closest to the port, that are today still some of the poorest parts of the city, where newly arriving immigrants and the lowest paid live side by side (see Figures 3.1 and 3.2).

A local writer, Maie Hodgson, describes her 1920s childhood home in 'The Ditches', one of those central, poor, downtown parts of Southampton along Canal Street, East Street and Main Street (see Figure 3.1) as home to Jewish (mainly refugees from the Transvaal) and Italian neighbours that created a '….fair-ground atmosphere which exuded a real cosmopolitan atmosphere…' (Hodgson, 1992, p. 16). My own family of Italian immigrants arrived about this time too (see 1.0) Hodgson mentions them as, '….the Donnarumma family who owned a spotlessly clean tea-room and ice-cream parlour… (with) seven children… (and) a trio playing their accordions.' Hodgson tells how her own mother said that Mrs Donnarumma, my great-grandmother, 'spoke little English (but) they communicated easily by lots of hand movements and facial expression.' (Hodgson, 1992, pp. 17-18) Tanner (2011) describes our family and many of the children of my mother's fourteen siblings, myself one of thirty-one first cousins who live in Southampton and its surrounds to this day.

Kushner and Knox argue that there is evidence of contestation between these migrant communities that may in part be due to the time when they arrived, and partly due to the circumstances that caused them to migrate. Class and wealth divided the Jewish community in Southampton in the 19th and 20th centuries, some holding on to their cultural views and others adapting more quickly to those of the English. The Jewish Association of Southampton refers to two social groups:

> "…one reserved and 'English' and the other from the vibrant culture of 'Yiddishkeit' …. (that were) quite simply unable to communicate with each other." (Kushner & Knox, 1999, p. 41)

Migrant communities did not always welcome new arrivals just because they were from the same ethnic group or religion. The more established Jewish communities, such as the Hebrew Association were often ambivalent about generosity to new Jewish refugee groups or young, unaccompanied women in case their actions might "lead to an increased presence of poorer Jews in the town." (Kushner & Knox, 1999, p. 41) On the other hand, the local Jewish community did assist the 1000 refugees stranded after the First World War from southern and eastern Europe, many of whom were housed at Atlantic House in Eastleigh. They formed a small population just outside the town's boundaries, settled around a railway works and interchange and campaigned for their onward passages, mainly to the United States of America, to be expedited and their conditions improved. In 1937, local Southampton residents including Rotarians, university students, union workers and scouts set up a reception campsite in the same location for the 3,840 Basque children, 'Los Niños,' who were evacuated from unsafe locations due to the Spanish Civil War. Pozo-Gutierrez and Broomfield (2012) describe these 'Basque babies,' as they became known, who were only expected to stay a few months, yet two years later, 250 of them still remained in this tented city. Kushner and Knox (1999) refer to language as being one of the greatest challenges to building trust between the authorities and the children as local helpers were unable to speak Spanish and the Basques unable to speak English.

4.3. Southampton: the new urban environment of a non-global city

4.3.1. Demography of Southampton

Sample surveys of the 1950s population in the city show an increase in Afro-Caribbean and Asian workers, with 6.2% of the population born in the colonies and dominions. However, Patterson (1970) argues that in the late 1960s they

were not a major, noticeable feature of the city's population. Paterson notes the surviving medieval remains of the old walled town and the 18th and 19th century Regency and Victorian domestic buildings, but makes no reference to any other religious or other edifice that had features relating to another mainland European or overseas culture.

Small communities of mainland Europeans, mainly Polish, many of whom were escaping persecution or resettling after the Second World War, joined the existing small groups of Jewish, Italian and other transnational migrants. Bloch (2002) describes how Southampton employers, together with many of their UK counterparts, travelled to Jamaica and the St. Vincent islands in the West Indies in the 1960s to recruit workers for factories, the health service, as bus conductors and cleaners. About this time, a larger group of economic migrants from the Asian sub-continent, mainly from Pakistan, India and those resettling from Kenya and Uganda joined them. A fresh wave of Polish people who had experienced living under communism, and had little in common with their post-war compatriots, arrived after the fall of communism in 1989, followed by a new wave of Polish migrants following Poland's accession to the European Union (EU) in 2004.

In 2004, Southampton City Council (SCC) Ethnicity Research and Information Unit reported that: 'non-white people account for 7.6% of Southampton's population, and primarily live in the central wards of Bargate (City Centre), Bevois, Portswood and Swaythling (see Figure 3.2). The largest single ethnic group, other than White British, is the Indian population (2.7% of the total). In some ethnic groups, such as the Chinese, a large number of the resident populations are students.' (Uni Network Policy Briefing, 2009, p. 6)

The demography of Southampton underwent a step-change between 1991 and 2001 and increased overall by 6.2% compared to the average 2.5% of England and Wales in the same period (National Statistics, 2003). By 2005 it was the third most densely populated city in England after London and Portsmouth respectively (National Statistics Online, 2007). Contributing to this growth in population were the incoming nationals, in this case mainly the Polish, who were free to travel and work in the UK following the accession of their countries to the EU in 2004.These countries included the Czech Republic,

Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia. The Mediterranean islands of Malta and Cyprus and of Romania and Bulgaria, acceded on 1 January 2007.

In 2006, Southampton's Social Housing Partnership (SSHP), concerned about the changes in migration trends requested that:

> "…due to changes in migration trends including the prominence of asylum-seeking communities and economic migrants, the SSHP wanted an updated picture of current housing needs." (Southampton's Social Housing Partnership, 2006, p. 11)

The SSHP report, 2006, identified more widespread locations of black, minority ethnic groups in the city of self-identified by country of birth, Polish, Filipino, Zimbabwean, Kurdish, Lithuanian, Pakistani, Indian, Filipinos, Afghani, Bengali and Somalian communities. From these groups the Bengali and Pakistani community tended to be highly concentrated in the central city Newtown area with 48% of Somalis living in Derby Road, both of which lay within Bevois ward. (all wards in SO14 postal code area, see Figure 3.1 and 3.3.5.1) 38% of Filipinos were living in Shirley and 22% of Polish people consulted for the report lived in Portswood. 32% said that their preferred spoken language was English, followed by Polish (7%), Kurdish (7%), and Somali (7%) with 45% of the sample stating a preference to read and write in English, followed by Arabic (6%), Polish (5%) and Kurdish (4%).

SCC (2009) recorded the city's increasing demographic diversity when they mapped the self-identified ethnicity of black, black British or other ethnic or white group (excluding white British) to postcodes in the city. The highest concentrations are now linked to the postcodes, SO14s (Northam/Newtown/Bargate/Bevois Valley), SO15-5 (Shirley) followed by the area around the university, Portswood and Thornhill (SO17-2, SO18-1 and SO19-9 respectively), (Southampton City Council, 2009), (see Figures 3.1 and 3.2).

In its report SCC estimates that:

"....based on the Mid Year Population Estimate 2009.... Southampton is becoming a more diverse city with the non-white population now standing at 13.1% of the population. The largest non-white population in Southampton is the Asian or British Asian which makes up 6.4% of the population followed by the Other White population which make up 4.3% of the population. (Southampton City Council, 2012a)

4.3.2. Southampton new communities

A member of the SCC New Communities team told me that they were formed as far back as November 2002 to respond to tensions between the resident receiving communities (many from black, minority and ethnic communities) and newly arrived European and refugee communities or 'new' communities. (SCC New Communities Team, personal communication, 14 May 2009).

In 2008, based on estimated figures from worker registrations and the nationality of children registered in schools provided by SCC Communities, Care and Health Directorate, SCC reported that 6% of the city's population, approximately 12,000 are Polish. The 4-6000 in the new refugee communities is from Somalia, Afghanistan, Iraq/Kurdish, Iran and Zimbabwe.

SCC told me that the new, refugee and asylum-seeking communities face issues relating to children's education, housing, employment and training, racial discrimination, attacks on their community, stress-related to the conditions of war in their homelands, and possible forcible return to their homeland and language barriers. The new communities come from an increasing number of backgrounds, often differentiated by clan or tribe from one national country (SCC communication, personal communication, 14 May 2009).

SCC estimated in 2009 that 2,000 members of the Somali community have been in Southampton since 2000 and comprise up to 40% of families with large numbers of single parents families. Their main religion is Muslim Sunni, and their main ethnic group is the S*amaal* which has four main clans, each clan having a common male ancestor for ten or twenty generations. The minority

group are the Bantu from the south of Somalia. Their languages are Arabic (official), English and Italian, French and Somalian.

The Afghan community arrived from about 2000 and are made up of 90% single or unaccompanied young men, approximately 84% are Muslim Sunni and 16% Muslim Shi'a. Their main ethnic groups are Pashtuns, Rajiks, Hazaras, Uzbeks, Chahar, Aimaks and Turkmen who mainly speak the Dari and Pashto languages.

The Kurdish community are the largest ethnic group in the world without a nation state, spread across a range of middle and central eastern countries such as Iraq, Iran, Syria, Turkey, Armenia, Georgia and Khazakstan. They come from a very traditional society based around the tribe with individual *Sheikhs* and *Aghas* providing tribal and religious leadership respectively. The majority of the 500-700 who have arrived in Southampton since 2000 are single young men speaking Kurdish and a number of eastern, central and Middle-Eastern languages, depending on their origin.

The Iranian community splits into three communities, those that have been in the city since the 1970s, mainly professional from wealthier backgrounds that may have intermarried with local members of the population. A second group of mainly single young men arrived since 2000 and a third group of university students with their families. The majority are Muslim Shi'a, with about 8% Muslim Sunni and the rest Zoroastrian, Jewish, Christian or Baha'i. They have a number of ethnicities, Persian, Azerbaijani, Gilaki and Mazanarani, Kurd, Arab, Lur, Baloch and Turkmen. Their languages are a majority of Persian and Persian dialects, Turkic and Turkic dialects, Kurdish, Luri, Balochi, Arabic and Turkish.

Polish migrants in the city split into three main communities; those who came post-Second World War as refugees and settled here, a group arriving after the fall of the Berlin Wall in 1989, who had lived their lives under communism, and a third group of economic migrants arriving after accession to the EU in 2004. Overall, the Polish community are mainly Roman Catholics with a minority practising Eastern Orthodox, Protestant or other religions. The majority speak

Polish and many of the second-wave arrivals also understand Russian, as it was formerly a statutory language taught in schools, under the communist regime.

4.3.3. The rich linguistic landscape of the city

The City of Southampton Strategy (Southampton Partnership, 2007) refers to over fourteen faiths and forty languages spoken in the city including Punjabi, Hindi, Gujurati, Bengali, Urdu, Chinese, Farsi, Dari, Arabic, Polish, Russian, Portuguese and Somalian. By 2010, SCC report that the fastest growing community languages are Arabic, Dari, Farsi, Polish, Portuguese, Russian and Somalian with over 110 languages spoken by Southampton school children (Southampton City Council, 2010b).

From information provided by SCC (personal communication, 14 October 2010) these transnational migrant groups share their rich cultural heritage in city-wide community group festivals throughout the year, including a Chinese market and dragon dance throughout the main streets for the Chinese New Year celebrations, designed to raise awareness of the Chinese culture and the city's twin city of Qingdao. Members of the Sikh faith celebrate their *Vaisakhi* (Sikh New Year), welcoming members of all Southampton's communities who are asked respectfully that all children are to be accompanied by an appropriate adult whilst attending the festival, heads must be covered at all times and no tobacco or alcohol consumed as a sign of respect for the Sikh Holy Book, (The Guru Granth Sahib Ji). A Thai and a Mela Asian festival take place each year, the latter attracting about 8000 members of the general public to Hoglands Park in the city. The Sikh, Judaism, Christian, Baha'i, Muslim, Hindu and Buddhist faith groups are members of the Southampton Council of Faiths and invite local residents, to a separate adult and young persons' Peace Walk each year to learn about their religions. There are many other societies, clubs and associations that come under the umbrella of and are supported by the Southampton Voluntary Service organisation. (Southampton community contacts, personal communications, 2009-11).

These community groups provide physical and virtual spaces for Southampton communities, for example: the bilingual, Polish-English website, *SOS Polonia* (www.sospolonia.net) that provides news, support and advice for the local

Polish community. Another, *Sotland* (www.sotland.pl) is Polish language only and advertises services including Polish newspapers, *Polskikurier*, *Express Polish*, *The Polish Observer* and the services of Polish-speaking accountants, IT consultants, dentists - *PolskI Dentysta W Southampton*, clinics, clubs, hairdressers, fitness instructors and car repairers. Bilingual Polish-English leaflets to advertise money transfer services are available in local supermarkets; specialist food and telecommunication shops offer services, publications and noticeboards featuring all of the community languages. Many communities can meet, discuss, socialise and/or access services, some exclusively in their own language and others with information in English and open to the public at large. (Southampton community contacts, personal communications, 2009-11)

The Polish community have a Saturday school for their children and a nursery group that runs in a local church; the Asian communities provide language and religious education at their religious establishments and there are a number of women's associations; for example, the Somalian women's association that meet regularly. The districts of Shirley, Portswood and St Marys have a number of Polish food shops, with signage and service, sometimes exclusively, in Polish. (Southampton community contacts, personal communications, 2009-11).

Unity 101, based in Nicholstown, SO14 (see Figure 3.2), advertises itself online and in local shops and publications as 'The South's only Asian and Ethnic Radio Station', catering for a number of language groups including Afghani, Bengali, Chinese, Gujurati, Polish, Punjabi and Urdu. (Southampton community contacts, personal communications, 2009-11)

Some community organisations keep a lower profile, as the only identifying mark of the Vedic Society, a Hindu worship location, is the flag flying from its rooftop. The Central Mosque, in Nicholstown (see Figure 3.2), is in an unchanged former English school building. However, the Gurdwara Nanakasar and Medina mosque have silver and green domes respectively, with Arabic script featuring on the exterior of the mosque, making them identifiable as Sikh and Muslim places of worship. In the case of the Gurdwara Nanaksar Sikh temple, Bevois Valley, Southampton, it was originally purchased as an existing

church and church hall but has undergone major refurbishments including the placing of the golden domes on the roof. (Southampton community contacts, personal communications, 2009-11).

4.4. A city migration space in the health domain

The population of Southampton live in the catchment area of Southampton University Hospitals Trust (SUHT) and have access to this and other public sector services provided by the Southampton City Council, voluntary education, health and social care and police sectors. This is confirmed by SUHT on their website as they state that they 'provide(s) services to some 1.3 million people living in Southampton and south Hampshire, plus specialist services such as neurosciences, cardiac services and children's intensive care to more than 3 million people in central southern England and the Channel Islands.' (University Hospital Southampton, 2013) (see 5.2).

The contemporary issue (see 3.1.) of the City's changing demography (see 4.3) is noted as a rationale for the need to draft SUHT's first interpreting policy in 2009,

> "1.1. The populace of Southampton is once again changing, with EU enlargement and an increase in refugee communities particularly from Somalia, Afghanistan, Iraq, Iran, Zimbabwe and other African countries. Southampton City Council now reports that over 70 languages are spoken by Southampton school children. Estimates are that these communities are likely to make up 3% of Southampton's local population, (this will be on a similar scale to the more established Asian communities in the City) and the hospital needs to take this change in profile in its catchment area into consideration." (Southampton University Hospitals Trust, 2009a)

This confirmed conclusions drawn from my work at SUHT as a volunteer and trainer of interpreters (see (3.3.8) that many members of transnational migrant communities work in and access SUHT health services. As a case study (see 3.3.3) and possible site of first interaction with a City institution (see 3.5.1), I concluded that this health domain could offer me a rich sample of translocal interactions in an accessible location. The proposed collaborative research also

offered the opportunity to the hospital to benefit from an evaluation of their language support services, which as their interpreting policy outlines, their Trust Board has identified as a strategic priority to the delivery of an effective patient service.

4.5. Summary (Southampton City Council, 2010b)

In this chapter, I have set a brief context of the City of Southampton for my case study. I presented this port city as a global gateway that has had a rich history of transnational migration. In common with other port cities it has features of many of the great global cities, as described by Mac Giolla Chríost (2007) such as the physical spatial differentiation of areas containing migrant communities and the internal differentiation of those areas. Differentiated economic, religious and cultural rhythms associated with different communities and particularly due to increasing transnational mobilities a population that is linguistically and culturally diverse (see 2.3). I have discussed these demographic changes and the profile of the new communities and their rich linguistic landscapes to set the context for my case study research sites. I make the case for the rationale of a case study in the health domain as a city migration space where an increasingly heterogeneous population access services and provide a rich site for translocal interactions.

Chapter 5: Presentation, analysis and interpretation of data: negotiating translocal spaces through the language practices of migrant communities

5.1. Introduction

In this chapter, I present the first part of the analysis of the data in an attempt to respond to my focal research questions (see 1.4). I am exploring how translocality (see 2.4 and 2.5) is accomplished in the health domain of my case study (see 3.3.5); how are transnational migrants discursively constructed in these negotiations, considering dimensions of power and difference (see 2.6); and finally how translocal health negotiations might be interpreted as linking the global and the local (see 2.7)

These findings are from a corpus of data collected from the public sector, health domains (see 3.3.5) and community contacts (see 4.3) in the City of Southampton through the use of the case study and ethnographic methods presented in Chapter 3. I will introduce my analysis and one of my two identified macro-themes that of negotiating translocal spaces through the language practices of migrant communities and move on in the following chapter to my second macro-theme of the control and budgeting for languages.

This chapter offers a discussion through the lens of the of the language practices of migrant communities and attempts to offer an explanation of the findings from interpretations of interviews with informants, observations, analysis of language policy documents and desk research informed by super-diversity, translocality and identification of the Other theories. I will conclude this part with a summary of these research findings.

I focus in this chapter on presenting and analysing selected representative excerpts that reflect the emerging and recurrent themes identified from the

transcribed data and of the meetings recorded, notes taken from meetings, observations and policy documents. These excerpts will illustrate how members of migrant communities in the city use various language practices in their interactions, focussing on the health sector, to negotiate translocality.

The data is analysed from the interviewer and observer-participant (as in the Parentcraft antenatal classes and mediated medical interactions) perspective, using mainly sociolinguistic ethnographic and theme-discourse analysis, which is the theoretical context for my methodology. I hope to shed light on the, what is going on here? as discussed in section 3.4.3, in translocal spaces (see 2.4). The described experiences from the individual interviews, together with a wide range of my own socio-cultural presuppositions, policy documents and ethnographic data will serve as an important explanatory and discussion framework for evidence of translocality emerging from my data.

5.2. Overview of the interviews, meetings and observations

The interviews recorded and the meetings observed and analysed in this chapter derive from situations where the majority of informant statuses are institutionally defined (see 3.3.4). For the profile of my informants see 3.3.8.

Southampton University Hospitals Trust (SUHT) senior management, midwives, interpreters -SVIs, Sure Start Midwives and Sure Start Centre staff, Princess Anne Hospital (PAH), SUHT maternity patients, Southampton City Council (SCC) employees, other public or private sector support agencies, such as A2C and EU Welcome and the Hampshire Police.

The exceptions are those informants from the community, some who shared information as representatives of their organisations and others who shared information as members of the public. The interviews were characterised by the sharing of information about mediated and non-mediated health interactions, mainly in the maternity services, language support and local and cross-border activities involving members of migrant communities in the city.

Ethical restrictions (see 7.3) meant that permission was not obtained for the recording of live health interactions, but a limited number of observations

were undertaken in routine mediated antenatal appointments at SUHT and in the Sure Start Centre, Clovelly Road. Permission for observations in the public spaces of SUHT was not granted. However, a rich source of ethnographic context was obtained through daily visits to attend meetings, through my work as a hospital volunteer and trainer of interpreters at SUHT, the Sure Start Centre and at locations throughout the city. My data collection was facilitated by the invitation from SUHT to explore their language issues and I found that in the course of the interviews and observations that form the corpus of this study, informants shared their views freely, giving examples of their own translocal experiences of negotiations with health practitioners or members of migrant communities. They made suggestions for future improvement and seemed committed to finding solutions to improve communication and negotiations. I discuss this in more detail as a positive benefit of research activism in section 7.5.2.

5.3. Introduction to the analysis

As discussed in the introduction to this chapter, my aim here is to conduct a close analysis of my informants' contributions supported by my observations and text analysis. I treat these contributions as primary data to examine how translocal health interactions are negotiated through the language practices of members of migrant communities.

5.3.1. Presentation of the data

It was necessary to be selective and systematic in the selection of data for close analysis and the presentation of the results of that analysis (as discussed in 3.4). I discuss briefly the category under study, for example 'returning home for health treatment,' as translocal health interactions, and outline its critical features. Where appropriate, I give a short descriptive account of the informant and the interview from which the excerpt is drawn. I follow this with a particular excerpt, chosen for its typicality, which I refer to in discussing my observations. In the discussion, I note some general patterns I observed in my encounters, with a particular focus on my informants and documents analysed using certain discourse strategies to present their ideas. The origin of each data excerpt is referenced to a document either in the bibliography or in the

appendices. Where those data excerpts are direct quotations from transcripts of interviews they are labelled with a date and as a personal communication. To protect anonymity, in the majority of cases, the quote is ascribed to a department or organisation rather than by job title.

As suggested by Glaser and Strauss, I use available theory to view the data at hand, and in addition to this emic perspective, I follow the inductive method of developing theory, 'to bring out underlying uniformities and diversities, and to use more abstract concepts to account for differences in the data' (Glaser & Strauss, 1967, p. 114). This method allows the researcher to make theoretical sense out of the vast amount of data. I also decide which evidence (in excerpts) to use to illustrate the points I want to ensure, as Smith (2002) argued, the theoretical conceptions are grounded in the evidence. I reinforce the credibility of my statements by substantiating the assertions I make by examples and quotations from the data so that the interpretation is grounded in illustrated documentation.

As Patton (1990) proposes, I am inviting the reader to enter into the situation and access the thoughts of the informants presented in this analysis through provision of sufficient description, direct quotations and excerpts, which all clarify the points made, so that others who are interested in similar issues can relate to them in the text. In this way theory should materialise and be seen to be apparent from the data presented.

5.3.2. Naming categories

A conscious effort was made to problematize the standardised naming of group members of migrant communities or the languages (see 2.2.6 and 2.5), to reflect on heterogeneity and in an attempt avoid language standardisation, essentialism and stereotypes that, as Blommaert (2010) argues, are common pitfalls in some migrant and language research.

Acknowledging researcher and informant partiality (see 3.5.1), I attempt, rather than to interpret an informant's behaviour, personality and so on in terms of common-sense attributes, commonly applied to whole groups, to pay heed to the differences between them. I am interested in accessing the

multiple variables present that may be influencing production. I am trying to look with a fresh eye so as not to overgeneralise from past studies and patterns and to challenge any prejudicial or stereotypical perspective. In this section I will therefore try to offer a critical appraisal of how members of migrant communities are negotiating translocal spaces and interactions in the health sector through *in situ* language practices. This approach to analysis allows me, as a sociolinguist to qualify my data and suggest correlations between linguistic and social structures.

5.3.3. Contextualisation over time

My process of analysis is recording tendencies and for that reason all the data gathered was treated as one set (see 3.3.7). Many of the interviews with informants were very lengthy and my observations were made over long periods of time; therefore relevant sections, which I deem to constitute situational context, are presented here.

5.3.4. Macro-themes

Two macro-themes, using theme-oriented discourse analysis (TODA) (see 3.4.2) emerged from the data. I categorised these as negotiation of space in translocal health interactions and secondly, the control and budgeting for languages, which will be discussed in Chapter 6.

I chose to focus on aspects of negotiating translocality to examine the impact of the global on the local or local-to-local. Language and cultural practices are cross-cutting and situated in all elements of translocality and I will move on to use these practices to evaluate the importance of the non-global city as a site of linguistic and cultural diversity (see 2.3). The selection of this category was therefore not arbitrary.

The focus of the analysis in this chapter is therefore is to identify translocal health care practices and then interpret how they are negotiated between the member of the migrant community and the health care practitioners. I draw on the theoretical conceptualisations detailed in Chapter 2 as a framework for my analysis.

It can be argued that the selected extracts are notably complex and can contain references that could be used to establish more than one discourse strategy, but the selections I have made are specific to the point I wish to make. I acknowledge that overlaps between various interactional mechanisms may occur, but cannot be avoided altogether. I note that certain extracts could be used to illustrate features of both macro-themes and I have made every effort to cross-reference these in the report of my findings.

5.3.5. Anonymisation

Ethical considerations require that all informants, members and participants' names be anonymised; therefore no informant is referred to directly by name. Job titles are used where appropriate, e.g. Sure Start Midwife or SVI and in certain cases, particularly senior management, where a job title could be used to identify them, it is omitted to protect their identity. All informants gave a signed consent to use their utterances. In addition, informants are referred to as F (female) and M (male) with numbering if necessary.

5.4. Negotiating translocality through language practices

With increasing transnational social mobilities and the movements of refugee and asylum seeker population into the UK, the demography of the City of Southampton has become more diverse (see 4.3). To explore these changes, in the context of translocality (see 2.4-7), I will use the theoretical conceptualisation of scholars such Hannerz (1996b), Smith and Eade (2008) and Vertovec (2009), I will examine my data in relation to translocal spaces, ties and connections and super-diversity (Blommaert & Rampton, 2011; Creese & Blackledge, 2010; Vertovec, 2010) (see 2.2).

I understand that linguistic mediation, in this case, interpretation, to be a key component of negotiating translocal spaces (see 2.5). I am also interested to explore features in my data of the discursive strategies employed by the in situ heterogeneous receiving population and between different migrant groups to construct Otherness (see 2.6).

5.4.1. Proliferation of transnational migrants in the city

In section 2.2 I discussed the conceptualisations of scholars in the field of transnationalism and super-diversity characterised by an increase in transnational migration to large and small urban environments (see 2.3). In section 4.3, I described the facts and figures of the changing demography of the City of Southampton due to an increase in transnational migration from a large number of language backgrounds. These changes and their impact of the linguistic landscape of the city were confirmed and commented on by members of the city's communities in my case study. For the purposes of this section and throughout when illustrating the increasing linguistic diversity, I use the term 'language' here as a standard, countable noun (see 5.3.2).

One informant said:

> "…plenty of economic migrants from the EU settled in the central part of the city, from 1998 they added to the number of refugees, which increased the black community and the number of languages in the city. One could hear the increase in the number of languages spoken in the High Street." (SCC New Communities team, personal communication, 14 October 2010)

An informant from a mosque, in Nicholstown, SO14 (see Figure 3.1 and Figure 3.2 and 4.3) in central Southampton, described a situation in the latter part of the 20th century when the main languages heard at the mosque were Urdu, Hindi and Bengali. He described how languages have proliferated amongst the worshippers at the mosque with the arrival of refugees from other parts of the Islamic community to include, Pashto, Farsi, Somali and Kurdish. The smaller community of three to four thousand Muslims has risen to fifteen to twenty thousand over the last ten years. The communities of Shia and Sunni Muslims worship at one of the more liberal or traditional mosques in the city. He described this linguistic diversity as 'challenging' for personal and social communications. Problems arose over cultural issues, which he described as punishments acceptable for children or treatment of wives. He told me that migrants often did not know how to access health services. He told me that they saw their role at the mosque to broker the acceptance of, what he called,

and ‘English values’ in these cultural matters. They used *ad hoc* interpreters to mediate interactions and where possible used English as a working language. Religious practice was conducted for all Muslims in classical Arabic and the working non-religious language of their community is English. (Central Mosque, personal communication, 18 June 2010)

My informant from the Hampshire Police described working with diverse communities in the central Southampton areas, which he referred to as ‘Pakistani’, ‘Indian’ including the ‘Polish’ and ‘the newcomers’ of ‘Afghani’ and ‘Kurdish’ refugees. His post was created to give information to these groups as to how to access the police services in the city, to give guidance on what the law of this land is, services that can be accessed, how to make a complaint and how stop and search works. (Hampshire Police, personal communication, 8 October 2009)

The Central Sure Start team in Clovelly Road, Nicholstown (see Figure 3.2) confirmed the changing nature of their client population:

> “…they (Sure Start) drew some stats out on the children, school age children there. So, this is under-fives in our patch, this is our patch. In the school age children there are 16,000, and over half of them didn’t speak English in their own homes…..54%... …..So, we’re the fastest growing population in Central. So, this is… we’re becoming… you say we’re not a global city but we kind of are, really… The other thing we’ve got then, we’ve got this… quite a wealth of stuff with different languages. We’ve got a list somewhere, which is probably a bit out of date but, um, you know, there’s probably about 16 or 18 languages on it…(looking at the list of ethnicities)…So, then under this white other, this is predominantly Polish but there’s also Russian, Latvian, Lithuanian, and I think they all speak different…although Polish and Russian are the two main languages.” (my added words for sense) (Sure Start team, personal communication, 30 September 2010)

A Sure Start Midwife described the increasing diversity and language variation in her interactions with patients, she told me:

"…I still haven't quite gotten my head around how many different languages walk through this door as a mother tongue. I really haven't. You know, every time I think I know how many languages there are, there'll be another one that I think, oh crumbs, I haven't thought of that language…Have we ever had a day where we've not needed an interpreter at least once for our antenatal clinic? I don't think, pretty much since I started, I have had one day's clinic where I've not needed at least one interpreter for one reason or another……Mandarin, Cantonese, Panjabi….Dari…Farsi, um… A few Polish…Hindi, Polish, Russian…um, I'm just thinking. Just, that's literally off the top of my head. Let me have a look at my list and let's see. Yeah, well, we've got all the Indian, um……Yeah, there are all sorts of variations in that……Variations, haven't we? We really have. …..Some of them are quite similar, but you still have……I'm just thinking, yeah. Honestly, it just goes… and that was literally off the top of my head. Polish, we said Polish, didn't we?" (Sure Start Midwife 3, personal communication, 28 September 2010)

The manager of the Southampton City Council's (SCC) Community Languages described the changes in their programme of community language teaching since 1991 as in the past:

'….. but it was a bit ad hoc, you see, and there are not many classes, there are only a few classes in the communities which are very strong (for) six or seven...Yeah, but now you have got 17 languages (with language classes), you see… you basically had the Urdu classes, Punjabi classes, Chinese classes, uh, the Greek class was here. Yeah, there has been a Greek orthodox class in town. Mainly these. You didn't have any other languages, but now you have got all sorts of languages like you've got Hungarian language, Russian class, we have got... Mind you, those communities were not here in those days… the Polish class has been there all the time." (my emphasis and added words for sense), (SCC Community Languages, personal communication, 17 May 2011)

A member of SCC New Communities team described a situation of the city's changing profile of transnational migrants and the arrival of smaller numbers of migrants from a larger number of countries. He told me they were dispersed

throughout the city. From my notes of an interview with him, he said that following EU Accession (see 4.3) in 1998 a 'critical mass' was reached in 2008. At that time, 'the height of Polish migration to the city,' from their windows in the Council, they could see two to three buses arriving each week from Poland. He told me that diminished to them seeing one to two a month. He linked this to the decrease in National Insurance registrations for work by Eastern Europeans in general. He said that whilst Polish-origin transnational migration may be decreasing, there is an increasing diversity noted in school registrations and consequently an increasing number of languages spoken by Southampton school children (see 4.3.2).

He quoted evidence from his organisation, SCC, that more organisations in the city were reporting linguistic and cultural diversity. There was an increased need for language support services, for example in General Practitioner practices. He told me that SCC regards migration as an issue for the whole city now. He gave the example of how it used to be that the Bargate and Bevois Valley areas in central Southampton had high numbers of migrants, but now they are dispersing to outer city estates such as Millbrook, Redbridge and Aldermoor (see Figure 3.2). Southampton was a refugee dispersal centre under the National Asylum Seekers contract and a few did settle here but he told me that by the end of 2004 there was a shift to receiving smaller numbers from a greater number of different African communities. He suggested that members of these communities were often hidden in the city, such as those from Eritrea and Sudan. The refugees did not continue in their refugee-status and anecdotally many 'disappeared' off the public sector radar. Southampton Voluntary Services often made contact but found that they had isolated links with families rather than with the larger community. He said 'SCC knew they were there' but SCC couldn't locate them. This was often because they rented private instead of council accommodation and they did not feature as highly as the Polish in the press and the media. (SCC New Communities team, personal communication, 14 October 2010)

5.4.2. Super-diverse translocal ties and communications

Informants interviewed from and working with migrant communities identified reciprocal transnational ties and communications (see also 5.4.6 and 5.4.7).

Described by scholars as translocality, see 2.2.3 and 2.4). Migration now routinely, no longer involves travelling and communications between a homeland and host country but may involve multiple displacements with reciprocal family, kinship and business networks involving many locations and mobilities within just one country, (see 2.4.1 and 5.4.2)

One informant told me that 'people are always on their mobile phones and receive messages from all over the world.' Their subjects are business and social transactions between them and their homeland communities. (Central Mosque, personal communication, 18 June 2010)

An informant who was a member of the Hindu religious community and sat on the council of the Vedic temple told me that her father is the priest there and he will seek advice from cousins in India on religious and astrological advice matters to inform conducting of religious observance at the temple in Southampton. (Vedic Temple, personal communication, 18 June 2010)

Hampshire Police described migrant communities with access to their own language satellite television channels, for example Aljazeera (Arabic(s)) or TV Polonia (Polish) or E_Sat (Estonian), Polish daily newspapers and access to blogs that allow communities to keep in touch with events 'back home' or that affect their communities. He told me that a few months before, an American drone barrage destroyed many villages and businesses on the northern frontier of Pakistan and was reported on a Pakistani satellite channel. In his work in the community this policeman saw how angry and tense the first generation Pakistani migrants were about this event. There was anti-American feelings expressed and they told him that they were phoning 'home' (in Pakistan) to make sure all their family was safe. They were actively sending assistance and planned to return just as soon as it was safe to do so.

He gave examples of when the Polish journalist who was beheaded in Afghanistan or the month-long bombings that took place in Gaza, events that hardly made the English news but enflamed and erupted in tension between and within perceived opposing communities on the city's streets. (Hampshire Police, personal communication, 8 October 2009).

During the Peace Walk I participated in, organised by the Southampton Council of Faiths (see 4.3.3), the organisers told me that the mosque we visited did not want to let members of the Jewish community into the mosque because of 'all the trouble in Gaza.' (Southampton Council of Faiths, personal communication, 28 June 2010).

A French national described how he gave his proxy vote in the French local and national elections to his mother (SVI, M, personal communication, 11 May 2010) and a Polish national described to me she voted in her country's elections and went into a local Southampton Polish club to watch for the results. (SVI, F, personal communication 4 May 2010).

An informant described to me how she and her family have reciprocal networks across the globe that influence the day-to-day decision making of individual members. This affects language, culture and religious practices and decisions from health care and education to the purchase of cars for younger family members, informed by experiences in countries of birth, in this case, such as Kenya or Uganda, which are in turn informed by countries of ethnic origin, such as India or Pakistan:

> "Asian communities keep their connections right across the globe now because, I mean, when I look at myself, I have family in Kenya, I have family in Canada, in America, in Hong Kong, in Japan, in India, in Pakistan, wherever. Yes, I come from Kenya myself. My husband is from Uganda, so we have all this family all over the world. So not only do we link on Skype every week with everybody, but when there are major decisions to be made in the family we link with them too, because you know if you have close-knit families, and I guess things will change, I don't know if this, that will change, but they'll change somewhat, then I will make sure that if there's a big decision to be made that everybody is part of that because you are a close-knit family." (PCT, personal communication, 7 July 2010)

A Polish transnational migrant patient, now with a young baby uses the Polish language with her baby. She studies and works using the English language and is learning Spanish for possible future business connections. She

explained to me that the father of the baby is from the Indian sub-continent, so she is now learning Hindi. She described speaking to her partner in Hindi whilst the baby, during our interview, is in a rocker chair watching a video of a Hindi-language Bollywood movie. However, she too expressed her own surprise when one of her 'identity markers' surfaced unexpectedly on a recent visit to Poland:

> "….when I went on first trip to my country after when I came I went to Krakow because... and I said that I would buy the Polish music in some like big market with the music and I went there and on the middle was the Indian music……and I bought this music. Not Polish, Indian music……And I come back with the Indian music, not Polish." (Maternity patient, personal communication, 4 May 2010)

One interpreter interviewed illustrated the rich linguistic resources she had acquired through family networks, education and work. She said:

> "It's just I had friends and neighbours who spoke different languages, and it's just... it came naturally. I didn't make a, um, an effort to learn it officially. It was just I was brought up with those languages and I studied Marathi and Hindi at school up to GCSE level. It was compulsory and, um... because Gujurati is my mother tongue, of course I know that……I studied at a convent in India actually and all the studies were taught in English….And then we had either French or Spanish as a second language and Hindi being the national language, it was compulsory. Everybody had to learn Hindi and then I chose Marathi because where I lived in Mumbai, Marathi is Maharashtra and that's the language of that state." (SVI, personal communication, 30 September 2010)

I understand these excerpts to illustrate super-diversity of translocal ties and communications as individuals and groups maintain networks and relationships within their own communities and across the globe.

5.4.3. Negotiating super-diversity and technology

Blommaert and Rampton discuss super-diversity in terms of transnational demographic and social changes nuanced by 'new technologies of communication and knowledge as well as new demographies.' They are changing the 'lived experiences and sociocultural modes of life' for large number of people across the world, in ways and degrees that we have yet to understand.' (Blommaert & Rampton, 2011, p. 3) (see 2.2.5 and 2.2.6)

Access to satellite television, whilst not only connecting communities from the homeland and host countries, can also virtually link communities with common religious, social or political connections, as a member of a local gurdwara told me:

> "I was watching the Sikh channel last night, and they were talking about, um, Sikhs in France. There's about five to seven thousand Sikhs in France, mainly living in the province of Paris or not too far, and they've, of course, passed a law in France saying that you know, you're not supposed to wear turbans or any religious symbols in public office or in schools. And that is creating an awful lot of problems because a Sikh defines himself by a turban and the five Ks." (Gurdwara, personal communication, 15 June 2010)

5.4.4. The receiving population of professionals negotiating super-diversity

From the analysis of my data, I understand the negotiation of super-diversity to be experienced not only by the transnational migrant population, but also by the receiving population. This is particularly true for professionals in workplaces where there is a proliferation of interactions with members of migrant communities. They themselves may be first generation, second and third generation migrants. Traditional practices in these communities may be abandoned or partially embraced. Professionals working in these communities need to adapt their working practices to these super-diverse heterogeneous realities. In the health domain (see 5.4.6) or other public services, this involves

the understanding, sensitisation and negotiation of translocal practices. (See 5.4.6)

Hampshire Police have appointed a dedicated officer to deal with these problems and report about one honour violence crime per week. They told me that victims are about nine out of ten female, with some homosexual and businessmen targeted. Transnational networks resolve complicated issues surrounding family finances, education and health and including forced marriage. The defence of the 'honour' or 'face' of individuals and families in migrant communities is very important. One individual's actions are seen to reflect on the whole family and need to be redressed. These issues affect many different communities, Polish, Turkish, Somali, Kurdistan, Afghani, south Asian, gypsy and Roma where the head of a family who may live in a different country to many other family members.

Individuals from these families, who believe they are victims of honour violence, appeal to the local police. My informant described how they routinely send a victim(s) to a new city with a new identity but the families use every method at their disposal to find them. Reporting them as a thief or having committed a crime, missing persons, or saying they are diabetic or have learning difficulties, using family in call centres or those with access to mobile phone records or pressurising officers with migrant community backgrounds to reveal information.

Families often bring someone in from outside of the country to commit an act of honour violence. The public sector professionals (healthcare in particular) working with these families, need to recognise signs of harassment or appeals for help and know when to intervene and risk breaking confidentiality. The doctors I interviewed for this study expressed concerns about how to negotiate these interactions. (Hampshire Police, personal communication, 11 May 2010), (Nicholstown General Practitioner (GP) surgery, personal communication, 11 May 2010), (Sure Start midwives, 25 May 2010)

5.4.5. Challenging standard language classifications

Blommaert (2010) and Pennycook (2010) argue that the normative classification of monolingual standard languages are challenged in super-diverse environments (see 2.2.6 and 2.5.2). An informant from SCC, described how miscommunication could occur through the receiving population's assumptions about a migrant's language. He said he:

> "….went to a secondary school on Monday actually and there were some difficulties with a pupil, a South African pupil. A boy there had some sort of issues of, you know, that the boy was uncooperative, etc. etc. etc. His parents are both professionals and you know, he was quite aggressive as a result. And after having a discussion with the boy on Monday, I discovered that the school weren't aware of that, interestingly enough. That, um, the boy, he's 14, and he'd lived in South Africa from the age of eight. So he'd only learnt… he'd only been speaking English for six years….. Right, um, and the school were unaware of that, because his English was actually very good. I mean it looked as if he had been speaking English all his life. But he could understand the language. But there must have been certain aspects of understanding about the language that must have been a barrier in terms of education." (SCC, personal communication, 2 March 2011)

5.4.6. Individual positioning in the paradigm of super-diversity

The patients and interpreters interviewed for my study were all members of migrant communities. Using the TODA tools (see 3.4), I analysed the notes and transcriptions from my interviews and observations for evidence of identity positioning. Many of these informants had arrived in the UK and Southampton within the last two years. I found them to take many positions linked to identity markers linked to the national territory of their homeland, England, Southampton, language(s) and religious practices, other members of their communities, class and education.

These informants appeared to constantly exercising choices about how they positioned themselves to others and me. For example, I was able to observe

two Polish-English language interpreters interacting during a discussion about the Polish maternity group and see the changes in their projections. I understand this dynamic and selective position taking across physical and virtual identity markers to illustrate super-diversity (see 2.2.5, 2.5 and 2.6.2).

My worked example in Appendix 3, illustrates the methodology to arrive at these interpretations.

(i) SVI, female, an English citizen originally born in Gujurat. She offers interpreting across Gujurati, Marathi, Hindi, Punjabi and English these languages, see worked example in Appendix 3. This lady is a member of staff at SUHT. My worked example reveals her taking a number of positions in languages she speaks, groups she identifies with, class-related, education-related, family-related positions across a number of locales in England and India. (SVI, personal communication, 30 September 2010)

(ii) A PAH member of staff, female, Polish-English interpreter, married to an Englishman with two children and has lived in the city for 10 years. She was an English teacher in Poland and now works at SUHT in the maternity service as an information officer for Polish-language patients, liaising with them and translating literature into Polish. She is also paid for her interpreting interactions.

She positions herself with as a successful transnational migrant who can 'see many sides,' and 'adapt her behaviour' and considers herself 'integrated.' She is keen to distance herself from Polish female migrants who she sees as coming to the UK and not making an effort to adapt. She thinks they are always criticising the English system, especially the health system. She constructs her difference, emphasising how well educated she is. She is the interpreter who explains to a colleague that she plays 'spot the Pole' games (see 5.4.9). She is distancing herself from newly arrived migrants who she sees as less integrated, more attached to the homeland ways than herself. She has made her decisions to so-call 'integrate' and she is proud of that.

She maintains a pride in her homeland culture and when she tells me that she is well educated, she stresses that the levels of education in Poland are very

high. She is very embarrassed when I meet her with a Polish Roma female patient and it transpires that this lady is illiterate. She is keen to point out that this is not 'the norm' in Poland.

She takes pride in cooking Polish food at home and celebrating Polish customs while she is in this country. She told me that Christmas Eve is very important in Poland. And even though she had her baby on Christmas Eve, she had no cards, no balloons and no cakes in hospital but went home to celebrate 'the Polish way'. Her parents and siblings live in Poland. She is bringing her children up bilingually, Polish-English.

She explains that many Polish maternity patients criticise the English health care system. They think the Polish system is better because, if pregnant, they are always treated by a consultant not a midwife (see 5.4.8). She thinks this is an antiquated view and that the English system has many benefits that are based on a more advanced knowledge of healthcare.

Sometimes she rejects Polish-linked identity constructions and at other times embraces them. I understood her as a 'transnational migrant', "Polish national,' 'a UK resident', 'English,' 'Polish-language speaker,' 'English language speaker,' 'educated,' 'a wife', 'a mother', 'a daughter', 'a SUHT employee', 'a student,' 'an interpreter' and 'a teacher'. (PAH, personal communications, 2009-11)

(iii) SVI, male, Bangladeshi national, offers interpreting across Bengali, Urdu, Hindi and English. He offers volunteer interpreting services at SUHT and is a paid interpreter for Portsmouth Hospitals NHS Trust. He lives with his sister, her husband and their children in the city and attends the University as an undergraduate.

During the course of our meetings he takes many positions, some related and some not to his territory of origin. He refers to himself as a 'Bangladeshi national' through a concise history of the struggle of his country for independence. He is a 'Bengali-language speaker' who takes pride in his language through work for International Mother Language Day. He mentions many times his Muslim faith and how important it is that he volunteers as part

of his religious practice. He helps to teach his nephew and niece the Bengali language. He positions himself as a member of the educated Bengali-speaking elite in Southampton that is mainly associated with the university. He does this by explaining to me at length that he does not mix with Sylheti speakers. He describes them as Bangladeshi nationals but ill-educated. He describes his family celebrating their religious festivals in a different physical location than Sylheti-speakers. He seems keen to point out that he does not know where they (the Sylheti speakers) come together as group. He is also keen to tell me that whilst he understands Sylheti, it is a less sophisticated language than Bengali.

Family connections, both with his parents back in Bangladesh and with his family that he lives with in Southampton are very important to him. He describes himself as grateful to his parents for giving him such educational opportunities and he will repay them by looking after them in their old age.

I understand him shifting his positions between 'a loving son,' a Bengali-language speaker,' 'not a Sylheti speaker,' 'a volunteer,' 'an interpreter,' 'a student,' 'an organiser of activities, 'a brother,' 'an uncle,' 'a devout Muslim,' ''and English language speaker,' a member of an elite,' ' a transnational migrant.' These positions relate to territories in Bangladesh, Southampton and Portsmouth. They also relate to physical and virtual communities of academics and a religious group. (SVI, personal communication, 18 February 2011)

(iv) Maternity patient, female, Polish national (See 5.4.2) who now has a three-month old baby and constructs positions during our interviews as a 'new mother,' 'in a relationship,' 'a student,' 'an interpreter,' 'a Polish-language speaker,' 'a Hindi-language speaker,' 'an English-language speaker,' 'a traveller,' 'a daughter' and 'a sister,' (Maternity patient, personal communication, 4 May 2010)

I understood these informants to be enjoying the luxury of being selective about her positioning. It makes me question as to whether this ability to select is class-related? Are they the features of a cosmopolitan elites or features of skilled transnational migrants?

5.4.7. Multilingualism and SUHT

There is no requirement or routine recording of languages spoken on the patient record. General Practitioner's (first point of call doctors in the UK health system) may note that a patient needs an interpreter, although which language needed may not be recorded accurately. (SUHT, personal communication, 4 March 2009) SUHT records the increase in the number of languages, (see 5.3.2), required for interpretation at SUHT. Accurate figures are not available and the figures quoted below are based on random return of evaluation forms from the healthcare practitioners that use the SVIS (see 6.6.2) and actual costs paid for outsourced interpreting services.

A2C, the Southampton-based public sector provider of language support services has grown from offering support in six to seven languages in 2002 to thirty languages offered face-to-face, and many more available by telephone interpreting. A2C told me that the challenge is finding new interpreters and servicing the 'changing population and the changing number of languages.' They also said, that they need to provide a service to new members of the community who have no knowledge of the system. (A2C, personal communication, 7 November 2009) (see 2.5)

Some public sector service websites offer local health-related information in a number of languages. EU Welcome (2012) offers contact information in twelve languages and the website of Southampton's New Communities (2010b) is translated into eleven languages, other than English. See section 6.6 for more discussion issues relating to translation of websites.

The SUHT Interpreting Policy (SISP) (Southampton University Hospitals Trust, 2009a) was developed as a direct response to the increasing diversity of the patient and health practitioner populations. SUHT Voluntary Services, who manage the service, told me about the demand for language support services:

> "...it's growing at such a rate, and part of that is because of the diversity of Southampton and the populace is changing, and it's keeping ahead of this, like we know Somalians are coming in. And, even now, um, I'm starting to interview some that want to be medics, um, so we know that that 3%

> populace is changing in Southampton, and it's keeping ahead of it….." (SUHT Voluntary Services, personal communication, 27 October 2009)

The purpose of the SISP is summarised in its introduction:

> "The populace of Southampton is once again changing, with EU enlargement and an increase in refugee communities particularly from Somalia, Afghanistan, Iraq, Iran, Zimbabwe and other African countries. Southampton City Council reports that over 70 languages are spoken by Southampton school children. Estimates are that these communities are likely to make up 3% of Southampton's local population, (this will be on a similar scale to the more established Asian communities in the City) and the hospital needs to take this change in profile in its catchment area into consideration." (Southampton University Hospitals Trust, 2009a, p. 3)

The growing number of languages required is evidenced in the 28 languages required in call outs to the SVIS in the first half of 2010, with the most requested languages being Polish, Russian, Farsi and Mandarin.

The changing nature of requirements for languages is illustrated in that in the first six months of 2010, the most requested language was still Polish, but was now followed by Punjabi, Farsi and Portuguese.

Call-outs for the SVIS increased from 254 in 2005, 506 in 2008 and to 873 in 2010. SUHT's Princess Anne Hospital (PAH) had the highest number of call-outs during this period with16.3% of 397 call outs in the first six months of 2010. (Southampton University Hospitals Trust, 2011)

Increasing language support is also evidenced by the increase in expenditure for language support services as a whole. SUHT recorded a 181.9% increase in the cost of using external agencies to provide language support services from 2006/7 to 2007/8. In the first 10 months of 2008 SUHT paid £43,613.85 to agencies interpreting for patients. To put this in context, the Southampton PCT's increase was 20% and the national average was 8.7% over the same period.

5.4.8. Negotiating multilingualism in the health domain

The reality of the *in situ* multilingualism is demonstrated by the SVIs and patients interviewed for this study (see 5.4.6 and 5.4.7). This assessment is based on treating languages as countable nouns (5.3.2). It was evident from my informants' contributions and my observations that SVIs and patients did not consider language(s) in these bounded categories. Language(s) was negotiated and mediated within the healthcare interaction. SVIs routinely worked across languages and managed these interactions.

I observed Polish-English language SVIs called to interpret for Czech and Slovakian-speakers. Estonian and Latvian SVIs called to interpret for Russian-speakers. An SVI from mainland Spain told me that she is always comfortable about taking Portuguese-English interpreting assignments. She identified this diverse population of Portuguese speakers as from mainland Portugal, Brazil, Madeira and the 'Isles of Jersey' (*sic).* She said:

> "….I think it's also a bit of practice, if their voice is clear, sometimes I can understand quite well when they speak a bit faster, I say okay fine, and I say please can you repeat what you have said? And they ah, yes, they tell me again, a little slower and yes, and it's quite good, I'm quite positive… the Spanish and Portuguese languages are quite similar…But that's always something that I mention to the patient and to the clinician, I just tell them that Portuguese is not my main language, it's Spanish and ….I tell them in words they can understand". (SVI, personal communication, 28 September 2010)

Classifying the language that a member of a migrant community speaks is necessary to ensure the correct and accurate interpretation is provided. A variable is the knowledge of classifying the language of the patient by the healthcare practitioner who books the interpreting service. One of the SUHT Voluntary Services team told me that she had been asked by a member of staff for an 'African' interpreter. She had tried leaving a list of 'languages by country' in the office for reference, but found that it is not always used or easy to identify exactly which language a patient speaks. She described how she

had tried to make a linguistic identification for a generically described 'Bangladeshi' patient. She found six official languages in Bangladesh and similar cases for South Africa with nine official languages plus English and Afrikaans. In this instance she called the Bengali interpreter and relied on them 'to manage the situation'.

SUHT Voluntary Services understood that a member of the Polish Roma community may not speak standard Polish and a Mandarin Chinese speaker may/cannot understand Cantonese. The SUHT Voluntary Services team identified a lack of knowledge about languages in their own team and the health practitioners who booked interpreting services. This was complicated by patients who may not be able to self-identify their own language, due to lack of a sample of their own written language to point to, illiteracy or a medical condition which compromises communication. (SUHT Voluntary Services, personal communication, 13 September 2010)

Hampshire Police and SCC reception (Gateway) staff, describe being encouraged to use language cards for people to point out the language that they use (Hampshire Police and SCC, personal communications, 8 October 2009 and 14 October 2010 respectively). The doctor's surgery has touch-screens that a patient can use to identify their language and access instructions in it. (Nicholstown GP surgery, personal communication, 11 May 2010) This (and the language card option above) does rely on a patient being literate.

I understand the examples above and the formation of the SVIS (see 6.6.2) as attempts to negotiate and manage multilingualism at SUHT.

5.4.9. Negotiating translocal health spaces

I am interested in this section to identify and explore the features and actors in translocal health spaces (see 2.4).

I reflect on my own experience as I arranged to meet one of my community contacts in a local mosque (18 June 2010). I arrived in the morning and there was nobody about; I called but no one answered. I wanted to use the toilet and

saw a ladies cloakroom ahead. I went in but after use realised that there was no toilet paper, only jugs of water for washing. I knew that this was customary in Islamic cultures and that there were customs about which hand to use. However, by now both my hands were wet and I could find no towel to use to dry them. I heard my contact call out, I was flustered at the thought that I might have to shake his hand with wet hands but as I met him I was relieved to remember that another custom, certainly male to female, is not to shake hands. I understood that in the City of Southampton I had entered a translocal space.

5.4.9.1. Driver of healthcare translocality

I referred in sections 2.5.2 and 2.7.3 to Giddens (1999) arguments that the driver of these local to local practices by members of migrant communities is the need of an individual to maintain their ontological security in an unfamiliar environment.

I cite my own experience of consulting health services when I lived in France, especially when my young children were involved. Despite having a good command of the language, I was anxious to hear diagnoses and treatment plans, see instructions on how to take or administer medicines in my own language. I telephoned my doctor in the UK to check out instructions. When a family friend visited, who is a consultant in the UK, I double-checked with him about prescriptions and dosages, not only for understanding the language but also the constitutive properties of medications. On one occasion he did recommend that I stop applying a French medication to my young daughter, which was stronger than a similar UK prescription. I found myself expressing a wish to return home to check everything as I found these overseas health interactions very stressful.

In the UK, migrants who can speak English competently may still prefer to use their mother tongue in a health interaction. Fountain and Hicks (2010) report on two studies among Kurdish, Turkish and Turkish Cypriots and one among Somalians where parents felt stressed about raising their children in a country whose language they do not understand. They related this especially in terms of accessing support for their families from health and social services.

5.4.9.2. Cross-border and *in situ* translocal spaces

Brickell and Datta (2011) provide evidence from their translocal geography case studies that the notion of translocal space can be expanded to include not only that constructed across borders, but also between cities and city to rural areas in one country (see 2.4.1). My data analysis reveals this too. I start with an example of translocal space within the city.

An informant born in London to parents born in the Gujurat is married to a man with a similar background. She told me that in her own family there is plenty of travel to and from Gujurat to deal with property owned there. She said that many British-born Gujuratis have decided to buy property in India to use as winter second homes. She and her husband thought that they would prefer to buy a second home in Europe. They went on a property-buying trip to Spain but did not feel at home there. They 'felt foreign' there, in ways in which she did not feel in Southampton. She told me that here she felt that they had their 'Indian things.' She chose to illustrate this by the fact that she can listen to the community radio station, Unity 101 who broadcast in her own language so that she 'feels at home' here. (Vedic Temple, personal communication, 18 June 2010)

An informant working within the health domain said:

> "I have many families who actually have either family or friends who are doctors or whatever outside this country which means they are prescribing things to them or **they go all the way there** (to India), have their treatment, **come back** with medication that they are using that is given there and then the GPs are giving them the other medication. If they have to go to hospital they get something different and what is happening is this mish-mash of all that. And there are some real concerns about sharing of drugs, getting drugs from abroad but also at the same time taking drugs from here." (My emphasis and added words for sense), (PCT, F, personal communication, 7 July 2010)

And,

> "It was also during my **pregnancy I was like two or three times in my country** (Poland) to check it was other thing and first time I find out the sex of the baby." (My added words for sense), (PAH maternity patient, personal communication, 4 May 2010)

Midwives, SVIs and patients told me they knew about or had visited one of the Polish health clinics with Polish language-speaking staff for paediatric, dermatological and dental care:

> "I know a couple whose baby had a rash. It was their first baby and they preferred **to travel from Southampton to London** to consult a dermatologist because they had heard that the doctors don't do anything in the UK…others paid out money, that they could ill-afford to consult **a Polish-speaking doctor (NHS qualified) in Southampton** who offers check-ups during pregnancy, including extra medication for pain relief, which is not available through regular NHS doctors". (My emphasis), (Sure Start Centre, personal communication, 31 March 2011)

I interpret these comments as evidence for translocal healthcare spaces within the city and other cities rather than linking practices across national borders. Midwives are sometimes and sometimes not aware of these practices. They expressed concern at the consequences of cross-country prescribing or healthcare practices that they were not familiar with. Midwives offered a real sense of these translocal healthcare practices creating spaces from which they were shut out of and uncertain about:

> "….they rely on each other quite a lot….I think they are isolated…..**they mix with each other a lot**….they know each….you know it's the culture and the language, they're quite happy together, aren't they?" (Sure Start Midwife 1, personal communication, 15 June 2010)

> "…I've found them, you know... sometimes with the Asian communities I think **we're, kind of, allowed in so far** and, you know, they'll, um... you'll be **involved in the family so far** but there's definitely, sort of, parts of their

life and their business kept apart…" (Sure Start midwife 3, personal communication, 28 September 2010)

One midwife described her uncertainty about translocal health practices, and in this case was prepared to accept it. She said:

"…Some of the Asian families have...they will start giving their daughter-in-law… at round about 37 weeks….it's a very buttery drink with lots of condensed milk or cream and… some herbal things maybe. And this, they believe, ensures they won't be overdue their date. So it's not to actually induce labour but it's to... well they don't want them to go over their date, they don't want to be late. Once they've got to 37 weeks they're impatient, they just want to have their baby, so that's what they give them. And there is one family in particular that I looked after and she gave it to all her family members, and I think the majority of them, I can't remember off the top of my head, never did go over their due date. They were all first-time mums and as a general rule first-time mums do go over their due date, and they never did. So I don't know." (Sure Start Midwife, personal communication, 15 June 2010)

However, sometimes it is more important for midwives to understand and not to be shut out from these spaces. In the hospital, women sometimes refuse to use breast milk from the breast milk bank. Midwives need to know about these practices and if necessary, negotiate alternatives. I was told:

"And so if we have children at the same time and your breast milk is given to my child, whether you put them to your breast or not, the fact that your breast milk is given to that child, if they grow up together, around the same age and they marry, then it's incestuous. And Islam does not agree with that practice. You can have nursing mothers, you know, I can say to you, will you breast feed my child as a friend, as a sister, whatever? But then I would know definitely who those children were and we would link up together as family, you see?" (PCT, personal communication, 7 July 2010)

5.4.9.3. Negotiation of imagined homeland spaces

The context in the community is described by an informant who told me that those migrants who moved here 40 or 50 years ago are 'just kind of stuck in an archaic caste system (see 2.4.1):

> "...in Sikhs there's various different castes. So if you're a Jatt there's landowners, carpenters, shopkeepers, you know, even the Gurdwaras, the Sikh temples here in Central, are kind of divided into caste systems, which I'm sort of totally against, but there you go, you know, it's there and it's very hard to change. But, um, you know, it seems to be the Bhatra Sikh community here in Central that is specifically still in the mind-set of, say, I don't know, 40 or 50 years ago, how women were kind of controlled. And I think when I hear things from back in India, they have moved on but they are still as the same, just kind of stuck..." (Sure Start Centre, personal communication, 30 September 2010)

A Polish national, interviewed when she was a PAH maternity patient and then an SVI told me that the Polish maternity health system is changing mainly because of economic constraints. She gave me articles downloaded from the Internet, translated from Polish, which discussed introducing more antenatal care for patients by midwives rather than by doctors or consultants. Also the opening of antenatal clinics in the community rather than in hospitals (Polish Ministry of Health, 2010).

This is evidence that healthcare practices change in a homeland. Members of migrant communities, particularly those who do not travel back regularly, may construct their homeland healthcare practices as those at the time of their departure. These are maintained as imagined practices of an imagined community in the homeland (see 2.4.1).

The *in situ* reality of the UK health service is often obscured by these imaginings as one Polish PAH maternity patient told me that there has been criticism of Polish medical facilities. They say they have outdated equipment and Polish prescription practices pharmacies are not as informed as those of

the UK. (PAH maternity patient, personal communication, 15 June 2009)

Many of my informants described antenatal and birthing practices in Poland that did not reflect the changes mentioned above. According to one informant, antenatal care in Poland is more medicalised than in the UK. Once a woman knows she is pregnant, she is seen for every antenatal appointment by a consultant. If she is seen by a midwife in a community clinic in the UK, and is not routinely offered a scan and tests sent to a laboratory for analysis, a Polish woman feels neglected. More often than not, she is told by her Polish doctor to look after herself during the pregnancy. She may be signed off work for the whole pregnancy. Consequently, many women in Poland decide not to work or leave work early during pregnancy. Polish doctors suggest that to avoid germs and stress during pregnancy, women may feel that by staying at home they are safer. At routine antenatal appointments she is examined internally by the doctors and given a scan every month with urine tests sent off to the laboratory and the results given back to her by the doctor. Private healthcare (in Poland) is not as expensive as it is here (in the UK) and many Polish women take this option for their pregnancies as they feel it is better for the baby. (PAH maternity patient, personal communication, 15 June 2009)

To contextualise to the UK a midwife, not a doctor, sees maternity patients routinely for antenatal care. In the case of many transnational migrants they are seen in a Sure Start Clinic (3.3.5.4) in their community. Hospital antenatal appointments are reserved for those patients with complications or those not able to attend during clinic daytime hours. Regular scans are not conducted in routine antenatal appointments and urine tests are carried out by the midwife and tested with a paper. (PAH, personal communication, 4 March 2009)

An SVI was interpreting for a woman in labour who had had her first baby by caesarean section (C-section). The midwife said she would let her push for a limited period of time because there was a danger of the previous scar splitting open, if the baby wasn't born she would use forceps. The woman was in panic and asked to be given another C-section there and then because she was so frightened of the use of forceps. This SVI told me that Polish doctors do not recommend the use of forceps hence, **all** (her emphasis) Polish women are 'very, very frightened' of the use of forceps. Women are **routinely** given C-sections in Poland rather than use them. (SVI, personal communication, 10

March 2011)

A patient told me that diagnosing babies with a milk allergy is very common in Poland. Special non-allergen milk is prescribed and this is free in Poland. This milk is not routinely prescribed in the UK and is also very expensive. She wanted her English doctor to prescribe it and he refused, based on the UK criteria of allergies. She went to a Polish doctor in Southampton who prescribed it for their baby. (PAH, personal communication, 15 June 2009)

5.4.9.4. Negotiation of translocal healthcare

The Sure Start midwives based at Clovelly Road (see 3.3.5.4) have a caseload of about 24 women. One midwife told me that they are allowed to see their ladies (her term) for 30 minutes instead of the usual 15 minutes at PAH. This allowed for more time for interpretation and to attend to the more complex needs of patients from a more socially deprived community. She said they book their ladies:

> "….as early as we can, somewhere between eight and ten weeks if possible, sometimes a bit earlier, but, you know, sometimes we're a bit late. And then we personally caseload them through their entire pregnancy, um, and run, you know, our diaries so we have days where we're community-based when we're doing ante-natal clinics and post-natal checks and stuff here… ante-natal clinics here at Sure Start, and then post-natal checks out in the community. And then we have on-calls that we do, where, you know, we're basically covering labours, the whole team, and the phones quite often on weekends as well. So, um, so then, you know, it's kind of like a pot luck who the women get when they come in in labour, but they may get a midwife known to them or they may get another member of the team, but we do endeavour to make sure that all of the team is at least known to them by name before they actually go into labour so that nobody is a scary, unknown face… The good thing with us is that we're in a privileged position to, sort of, have our women from booking all the way for, sort of, like, a seven-month period roughly. Um, so actually you build a lovely relationship with them that's strong, it's on trust, and you, sort of, start to, sort of, think, did you really understand that? Are you just being polite? And so you can

challenge them, but that comes with the fact that you're seeing them regularly and they're getting to know you." (Sure Start Midwife 1, personal communication, 15 June 2010)

I interpret this as a service put in place to negotiate translocal health practices. It identifies the need for a longer interaction and the building of trust through continuous contact and meet specific needs. I do reveal below that this service provision may not transfer continuously through to the main PAH hospital site (see 6.7).

Midwives describe how they need knowledge of migrant cultures to negotiate translocal health practices and avoid miscommunication and misunderstandings. A midwife told me that:

"We have quite a lot of Somalian women and they often are on the Orchard Lane Estate… they're quite, they're quite, um… we call it African time….." (Sure Start Midwife 3, personal communication, 28 September 2010)

A midwife told me:

"Because, yes, I think the charcoal under the eyes, that's something I just picked up. The fact that the Polish women, you know, like a lot of intervention, that's just picked up as we go along. No, we don't have any formal training." (Sure Start Midwife 1, personal communication, 15 June 2010)

Or when it could, in the most extreme cases, result in a mother being reported to Social Services, as one ex-midwife told me:

"Yes, there are instances where there are women who will be discharged, and the baby is back in intensive care, or whatever, and only the husband would raise it, the mother would not raise it. And there were issues around, well, let's call Social Services; she doesn't care about her baby, whatever. But nobody bothered to find out that this woman (practising Muslim), for 40 days, is going to stay indoors and look after herself. It doesn't mean she

> doesn't care for her baby but she also has to look after herself. If the baby's being well cared for somewhere, and the husband is coming in to see that everything's fine, why do you need the mother? You know, the philosophies are different and that doesn't mean that you don't care about your baby. You look after yourself, put yourself in a good health, because we do believe that childbirth on your body is one of the most dramatic experiences and women need that rest." (My added words for sense), (ex-midwife, F, personal communication, 7 July 2010)

Interpreters needed to be aware of the possibility of miscommunication too, as one SVI told me that:

> "She had been called to attend a scan that was taking place in the early months of a Polish woman's pregnancy. The radiologist said that the baby was **no bigger than a 5p piece** and at that the Polish woman was very alarmed and obviously in panic. She (the SVI) had interpreted it word for word and the woman thought there was something wrong with her baby. Despite A. asking the radiologist to explain that this was a normal size for that time in the pregnancy, it was very difficult to calm the woman down. She thought the baby was deformed in some way." (My emphasis), (SVI, F, personal communication, 10 March 2011)

Physical space at the PAH or the Sure Start Centre is very limited and the antenatal consulting rooms are very small. There is a desk and chair for the midwife and her papers, a hospital examination bed and one to three chairs for patient and family members or interpreter. I observed antenatal mediated interactions where, by default, space is more limited due to the interpreter needing to be in the room. Midwives and interpreters, I observed, were very professional in ensuring that chairs were arranged to maintain eye contact between the health practitioner and the patient. However, the patient was often confused about whom to look at, particularly in an Indian family interaction where the mother-in-law or elder sister was present. I could see the hierarchy of routine communications was challenged. The young patient looked to her mother-in-law or elder sister to answer for her. The midwife present confirmed this could be a regular occurrence, as she said:

> "…The Indian, Pakistani families, like I say, you're, kind of... they get to know you quite well and you get to know the families quite well, and sometimes you've got quite a bit of hierarchy going on. You could have, sort of, hierarchy going on with the original mum and dad. Often the mum's house who it is quite ruling the roost with the daughters or daughter-in-laws, often. So you've got quite a lot of, sort of, unspoken messages going around, um, that can be quite complicated. Sometimes absolutely straightforward and there's none of that, but it tends to be... that'll be more with their direct daughters than it will perhaps be with the daughter-in-laws. A whole load of complications." (Sure Start Midwife 3, personal communication, 28 September 2010)

In a mediated antenatal interaction, I observed, the patient seemed confused as to which language to speak, sometimes attempting to speak English words. She was trying to help the situation, but it resulted in further confusion. (Sure Start maternity patient, personal communication, 15 June 2010)

An antenatal interaction, I observed, focussed on the giving of a telephone number to ring when the patient went into labour. This took some time to communicate, even with the assistance of the interpreter, mainly because the patient said that her husband/partner did not speak English and it would be difficult for him to make that call. (PAH, maternity patient, personal communication, 13 October 2010)

I identify these excerpts as describing features of translocal space, which require negotiation.

The uncertainty at the boundaries of translocal space

Midwives meet their patients, often not knowing the level of their English language competence. The midwives linguistically construct the starting point for this interaction as uncertain, alluding to the barriers that need to be crossed. Descriptive words used in my interviews with them express their own and patients' uncertainty, as in the excerpt below:

> "They often sit and look at you **blankly** or answer not what you've said to them. Some **random thing**, something they **can manage** in English. They might come out with some **random** answer that doesn't in any way, you know, answer what you've asked them. So they've **obviously not grasped** what you've said at all, and they **look terrified** half the time. **Not very nice**." (My emphasis), (Sure Start Midwife 2, personal communication, 28 September 2010)

Sure Start staff were unhappy in a situation where a patient did not understand and said:

> "…It breaks my heart when I sort of see women downstairs and the other day, there was a prime example where an Afghan mum… and the health visitor had done the check, the eight-month check on the baby and she'd weighed the little boy and so forth. So, the mum had her back to the health visitor. I was in the room and the health visitor was trying to talk to the mum, but mum didn't have any idea that she was actually talking to her at all….But it was really bizarre that she just did not understand anything that the health visitor was saying about the little boy…And at the time there was an Afghan, we've got an Afghan worker now and she was in the admin office downstairs. So I actually said to the health visitor I've got somebody here who can help. And it took about an hour for them to sort of… because she had lots of questions. The minute she knew that there was somebody there who could help her, there was just so much that came out and I think D. was there for about an hour.' (Sure Start Centre, personal communication, 30 September 2010)

5.4.9.5. When to use an interpreter?

Health care practitioners faced with this increasingly multilingual population may not have had training in the communication skills necessary to mediate these encounters. Diamond et al. (2009) in their study at a hospital in the United States where 170 languages are readily available on site or by phone showed that health practitioners were getting by using family members, sign language or their own limited language skills.

The uncertain reality of leaving one's own family and known spaces is described by a maternity patient who told me that her husband,

> "…left me at the door of the hospital when I was due to give birth…at the time of the birth of my first child I spoke no English, I had no interpreter and I was very frightened. The staff were **very very** (her emphasis) good and used sign language and always tried to communicate with me to tell her what was going on.' (PAH maternity patient, personal communication, 27 September 2010)

Staff from the Sure Start Centre told me:

> "But we could have conversation (English) groups and stuff like that, you know, if we really wanted to push it? But then the other side of it was that, you know, it takes several years to learn a language, obviously. … for most people it takes a long time to learn a language and they haven't got the time while their children are young, so they need to be able to access all the services. And whether people agree with the immigration policy or not is irrelevant because we're in this business to ensure people access services." (My added word in brackets for sense) (Sure Start Centre, personal communication, 30 September 2010)

Findings from the Diamond et al. study, cited above, indicate that interpreters are called to instances of particularly complicated decision making. Also those doctors in their study were struggling to adapt to the care of limited English language proficiency (LEP) patients.

Health care practitioners are routinely called upon to make judgements about the level of a patient's English language skills and that can compromise the effectiveness of the medical interaction and the patient experience. A midwife told me that it was often a difficult call as to when to use an interpreter as a patient would attend and appeared to understand a lot of English and a decision was made not to call an interpreter for the next visit, but at that next

visit it all went wrong, and communication was not very good without an interpreter. (Sure Start Midwife, personal communication, 25 May 2010)

5.4.9.6. Use of family and friends

A Sure Start Midwife not only has to make the decision when to use an interpreter, but also when to advise family and friends that they cannot interpret, a midwife explained to me that she sometimes felt:

> "….a bit awkward sometimes about saying to, and I do have to do that, I have had to do that when I've had a husband say, well, I'll interpret. And I've actually sat there and said, my policies within my Trust direct me that I cannot expect you to… and I always make it, I cannot expect you to interpret for me. Some of what I'm going to ask is medical, and I want to make sure that it's going across, you know, exactly as I say and I don't expect you to try and interpret complex medical, you know, things for me." (Sure Start Midwife 2, personal communication, 28 September 2010)

The Silkap report (2004) and the Joseph Rowntree Foundation report (2004) indicate that there is a significant use of informal interpreters (such as family and friends) to mediate interactions with public services, although views vary as to the actual extent of this usage. The Joseph Rowntree report has made the case for a useful role to be played by informal interpreters within clear parameters, although specialist help should be employed in medical or legal matters. The report stated that patients often preferred family members to interpret for them because they mistrusted outsiders having access to their personal information.

The consensus of these reports is a strong case for formal interpreting being the minimum acceptable standard. There is an element of risk in introducing a third party into the patient-practitioner relationship but it is generally agreed to be best practice. Particularly, following the Victoria Climbié Enquiry (Department of Health, 2003b), into a case where a family member was interpreting for a child that was being abused by them. The reports and

enquiry cited acknowledge that the ability to speak a language does not qualify a person to interpret it.

The Fountain & Hicks study reported that:

> "….in a study of over 130 Bangladeshi people, almost half were fearful of contacting services owing to lack of trust, including of interpreters…..some people were unsure about whether or not the interpreters they had been provided with when they used services were professional or not. This was particularly the case in relation to interpreters in hospitals and from community organisations." (Fountain & Hicks, 2010, p. 35)

Communication through untrained interpreters can result in conflict of interest which may breach confidentiality as a Sure Start Midwife said:

> "….women have not wanted an interpreter because it's someone who is within the community so it doesn't feel confidential for them anymore." (Sure Start midwife 3, personal communication, 28 September 2010)

This may not allow not allow the patient to ask questions on their own. A midwife questioned whether:

> "…they actually feel that they've been able to make a decision on whether they'd like an interpreter or not? It's a decision that's actually made by somebody else in their family….have they really understood that, look, somebody is going to talk you through your journey of pregnancy, and have they really understood when they've said no? Because their relatives aren't trained interpreters… And also, do you always want your sister-in-laws or… you know, you've got me going now, but do you always want your relatives? Because the majority of them walk through our doors, not necessarily with their husbands but, like, with their sister-in-law, and so do you really want them knowing your personal medical details? Yes, who is deciding? And the other question is that often… quite a lot of the interpreters are actually employed through the community. So, what happens is it's like… it's somebody related to them that turns up, so then they don't want to know.

> And that seems to be across the board, that oh, you know, we don't want an interpreter, it's only going to be somebody from within the community. I mean I've been asked downstairs if I could do interpreting for somebody, and they sort of look at me and say, you don't live here, do you?" (Sure Start Centre, personal communication, 30 September 2010)

The SUHT 2009 quantitative review of the interpreting service (Southampton University Hospitals Trust, 2009b), reported that 95.6% of LEP patients coming into contact with twenty five of the SVIs, (consulted for the study), said that they had had no interpreter present in their past medical interactions forcing them to rely on family and friends. The Sure Start midwifery team were not surprised that one of the SVI highest call out per language figures was Punjabi. They had high caseloads of Urdu and Farsi language speakers but they more commonly relied on friends and family to interpret.

5.4.9.7. Using Bilinguals employees as interpreters

Meyer et al. (2010) discuss the language challenges in European hospitals that lead to bilingual professionals being employed to work with their dual skills of language and professional skills. Using informal or untrained interpreters, as argued by Woloshin et al. (1995), can lead to interpretive errors, mistranslation, omissions, abridged or distorted responses and inadequate information about diagnosis or treatment. Duchêne (2009), from his work in call centres, argues that bilingual employees are exploited in these scenarios. In addition, the use of bilingual employees as interpreters can create confusion between their roles.

CILT argue for the formalisation of the role of bilingual employees to distinguish it from their professional position in health care in that:

> "….if bilingual staff members are asked to serve as interpreters, the organisation should provide clear protocols regarding how they fulfil this role in addition to their normal duties. Staff will need training in how to negotiate the interpreting role away from a family member. During the interpreting encounter they should clearly explain their role in order that

their usual duties are not confused and should temporarily step away from their usual duties as a nurse, clinician, manager, healthcare assistant or other position. They need to alert the parties when they take off or switch their roles." (CILT the National Centre for Languages, 2005, p. 22)

A trainee SUHT Volunteer Interpreter (SVI) said that she was fed up of being asked to interpret when she was on duty. She was asked to interpret for Polish language patients by other healthcare practitioner who did not want to pay or go through the formal booking process. (Trainee SVI, personal communication, 11 November 2009) For detail on the SUHT Volunteer Interpreter service (SVISS) see 6.6.2.3.

PAH told me that they had tried to take on new staff (and cleaners) to reflect the changing demographics and languages required including Bulgarian, Polish and Sudanese. (PAH, personal communication, 4 March 2009)

A lack of a language policy and the loss of a budget for interpreting (see 6.3) meant that the Sure Start Centre took on bilingual employees. They told me that they had:

"...looked at kind of what is a multilingual or bilingual employee worth? And what we've kind of done, **covertly**, is we'd employ people with lots of languages for nothing, really, um, or we'd employ people with lots of languages who have a deficit in other skills, because they've got the strength in the languages." (My emphasis), (Sure Start Centre, personal communication, 30 September 2010)

However, one informant told me that there might be barriers to accrediting bilingual employees as he said:

"...I mean one thing I did try and push, it was never ever going to work, was trying to, because a lot of organisations they do have a multi-racial workforce, a multi ethnic workforce and I mean I tried to argue for accreditation of people using other language skills to be able then to deploy within the institution. But you know, I mean I think there was a resistance

to that because I think there was a feeling that it was, well, to be blunt and frank there was a perception **that white workers wouldn't really like it, you know."** (My emphasis), (SCC, personal communication, 2 March 2011)

In some sections of the public sector this situation may have changed as Access to Communications told me that Southampton Neighbourhood Wardens were cutting back their requirement for language support services as many of those wardens are now bilingual (A2C, personal communication, 7 November 2009).

5.4.9.8. Accrediting interpreters

Professional bodies for interpreting and translation (Amicus/NUPIT, 2004) underline the risk to both public sector service providers and their clients of employing unqualified interpreters and of asking family members, fellow patients, co-defendants and children to act as interpreters. Professional bodies are keen to see the establishment of regulatory mechanisms creating a transparent and consistent system and discouraging the use of unqualified, unregulated interpreters.

The Chartered Institute of Linguists (CIoL) recommends a degree level interpreting qualification such as the internationally recognised Diploma in Public Service Interpreting (DPSI) or the Metropolitan Police interpreting exam. CIoL recommends, ideally, 1000 hours of experience and a criminal record security check. For an interpreter to work in a legal setting, where provision of interpretation is statutory, a DPSI level qualification is usually required whilst many private interpreting and translation agencies set their own tests or require/provide Level 1/NVQ Level 3 National Qualification framework (NQF) training. (Southampton University Hospitals Trust, 2011)

5.4.9.9. The role of interpreters

Interpreting services can be provided face-to-face or by telephone. The most common form of face-to-face interpretation is consecutive interpreting where the interpreter waits while you speak and then relays the message, sometimes

with the help of notes. However, this all takes time and significantly increases the interpreter-mediated patient consultation time.

The interpreter is a mediator and the most common position proposed by Angelelli (2005) is as an invisible mediator who interprets everything that is being said by the parties in the conversation rather than engage in any advocacy. However, the interpreter has a powerful role in being the only participant who needs to have access to the relevant vocabulary and briefing. They should have the skills (see 5.4.9.8) to follow all that is said in a multilingual discussion. They may pick up on cultural difference and also need to control the flow of information to achieve the desired outcomes.

The distinction between an interpreter and advocate is not clear-cut. In the UK the advocacy role involves more than interpreting. Parsons and Day suggest that health advocates have been defined as those who:

> "….mediate between patients and professionals to make sure that clients are offered an informed choice of health care. If there are clinical or cultural problems they will negotiate, although ultimately they see themselves as advocates for their people." (Parsons & Day, 1992, p. 184)

Kaplan et al. (1989) presented some evidence to suggest that patients who use an advocate are more in control (i.e. they ask more questions, make more attempts to direct conversation flow and physician behaviour) report fewer days off from work, health problems, and functional limitations because of illness, whilst rating their health more favourably during follow-up. This would suggest that, in so far as advocates are able to put patients in control, they might be able to improve patient well-being and health status.

Training of interpreters and the healthcare practitioners that use them is important. It enables the interpreters to understand their code of conduct to remain impartial, professional, respect confidentiality, discuss sensitive topics and gain the trust of all parties in the interaction. Particularly pertinent for life, death and serious illness health interactions that can be so stressful, is that interpreters need to know where they go for pastoral support. Health

practitioners do not always come with ready-made skills on how to use an interpreter, needing to understand to maintain eye contact with the patient, speak slowly and break their sentences up into manageable chunks.

I did observe in a Parentcraft antenatal class (see 3.3.5.4) that an interpreter behaved inappropriately in the session, playing with her mobile phone and joking with the patient she was interpreting for. She distracted the midwife presenting the talk and other participants in the group. This is unprofessional behaviour that training and review would address. (Parentcraft sessions, personal communication, 8 June 2010)

The Amicus survey (2004) found that most respondents had received no training to equip them to deal with the stress levels and unique aspects of their job. It reveals that those in the interpreting and translating professions expressed concern about inadequate opportunities for continuous professional development.

5.4.10. Negotiating difference

I am interested in this section to explore the discursive constructions of difference and Otherness within and by migrant communities and the receiving population(s). I understand these constructions of Otherness to enact the physical and virtual borders between translocal spaces. Borders which once defined, may be contested or accepted (see 2.6)

5.4.10.1. Generic terms for naming Others in the city

My data reveals the discursive construction of certain groups in the city. 'The Polish' or 'Pole(s)' is used as generic terms to describe all Eastern European, as one informant said:

> "…There were a number of different shades of black people and Polish was a catchall for all Eastern Europeans." (SCC New Communities team, personal communication, 14 October 2010)

Informants referred to the increased number of 'Poles' in the city. A SUHT maternity nurse described how her manager, when asked to book an interpreter for a patient, responded negatively, framing migrants as a large group with a three times deictic use of the word 'all' as a linguistic repetition to emphasise a perceived threat as he said:

> "…..that **all these Polish** people coming over, needing interpreters, it was **all too much** and **too much** money was being spent on it." (SUHT, personal communication, 10 December 2009)

A Polish national told me how he was considering, like a friend of his, changing his name to a recognisably English one to enhance his job prospects. He said that if an employer saw a Polish name on an application form he was less likely to call that person in for interview. (EU Welcome Polish Club, personal communication, 8 October 2009)

The construction of migrant identity by any individual or group can identify a characteristic and then name that group as a signifier of ethnicity, language, social or religious practices, for example 'Pakis,' 'Poles,' 'Indians' and 'Eastern Europeans.' Policy documents and healthcare practitioners quoted above, name groups of Others or migrants. These namings serve to construct a homogeneity, which may or may not exist in reality. On closer questioning, my informants revealed the hybridity within these namings. Groups named 'Somalians,' 'Gujuratis' or Bangladeshis are in reality hybridised by clan structures, countries of origin, time of migration, class, location, languages and gender (see 4.3.2).

An informant, self-identified as a member of the receiving population and a first generation member of the Punjabi community, illustrated with an example of her construction of the differentiated clan/caste-based 'Somalian' community, as she said:

> "….but certainly within the sort of the Somali group here in Central, there's five different groups apparently. To me if I see a Somali mum just with her dress, I just think of her as Somali but there's, like, five different tribes.

> We've had a Somali worker who sort of tells us about all the different tensions that go within their own, and they've got a caste system within that group. We need to do a bit more work on that, actually, but, you know, just need to find out because it's really interesting. But there are problems there, and actually in schools as well. The Somalian, sort of boys, are saying to other boys, actually, you're from the lower caste and I'm from the higher caste, that sort of thing does go on'. (Sure Start Centre, personal communication, 30 September 2010)

Naming Other groups is challenged by the conditions of super-diversity (see 2.2.5). An elder from one of the city's mosques spoke of the common threads that used to be shared by many that the group identified as 'Muslims' in the city who originated from the Indian sub-continent. He told me that there are now Muslims arriving in the city who come from a greater number of countries from across North Africa and the Middle East who speak a number of languages and who have very different views on matters such as discipline of children, female circumcision and how they treat their wives (see 5.4.2). In the mosque he is aware that events even in one country, such as those in Afghanistan, can be very divisive and so-called Afghani community members, such as those from Swat in South East Afghanistan want to know which side each are on and will reject or embrace accordingly. (Central Mosque, personal communication, 18 June 2010)

There was other evidence of Otherness discursively constructed in both imagined (see 2.4.1 and 5.4.9.3) and actual practices within migrant communities. One of my informants described the newest arrivals of 'Gujuratis' as opposed to those she named UK Gujuratis, who migrated here some time ago. The latter group she described 'as backward,' because, they had left their homeland culture some thirty to forty years ago and 'held on tighter (to the cultural, linguistic and religious norms that existed at the time of their departure) and don't want to lose it'. She put herself in this group for some features of life including religion and keeping up her language. She explained how visitors or new migrants from India often didn't know the old prayers that the community were using here. Western influences are changing the culture so fast in India, most of which the older migrants to the UK were

unaware. In some villages it has stayed the same, but she gave an example of vegetarianism, saying that she and all of her family are vegetarian but that many of her Indian family and kin back in India, including her own nephew, eat meat. She told me that Hindus do not condemn each other, but she finds herself reminding them to read their scriptures and the importance attached to not eating meat." (Vedic temple, personal communication, 18 June 2010)

5.4.10.2. Visible and invisible markers of difference

Deciding who is in and who is out is a process of identifying difference or Otherness. There is an assumption in this process of the homogeneity of their and Others' groups. During this research process, I continually came across heterogeneity, in my own background and that of my informants. My analysis suggests that this heterogeneity did not stop the highly visible and invisible processes of Othering.

The community contacts of first, second and third generation migrants from the Indian sub-continent and African communities some who chose to wear traditional dress, keep up religious and culinary practices and yet often move away from high density migrant areas. It seemed as though identity markers are visible to some and not others. Sometimes, as in the excerpt below traditional dress is put on to make oneself visible to a member from the same community. As a Punjabi-speaking informant at the Sure Start Centre in Clovelly Road described:

> ".....there's constant challenges because they're coming through and if white British, our receptionist, Natalie, is there she needs support constantly for languages.....Because she recognises, she's experienced now to see that she's actually not... that they're actually not understanding what she's trying to say... (she told me that she personally will wear her traditional dress of a *salwar kameez* tunic and trousers to make her more recognisable to Punjabi-speaking clients and then).... sometimes the parents will see me and they'll start talking in their mother tongue, just by seeing me." (Sure Start Centre, personal communication, 30 September 2010)

I was interested to hear a sense of Britishness used to define the insider/outsider. A first generation Afro-Caribbean informant told me when discussing the challenges of the current super-diversity in the city's populations he said:

> "….Everything changed after 9/11 because people came from the Middle East and other parts of the world that were not colonial and previously ruled by the Queen, and people were more suspicious of them." (SCC, personal communication, 2 March 2011)

This statement relating to Britishness in those of Commonwealth origins discursively creates a group commonality with shared values and resources (see 2.5 and 2.7). It glosses over the historically discursive prejudices constructed by the receiving population against Afro-Caribbean and Indian arrivals in the 1950's and 60's.

Incoming transnational migrant communities may be deemed to share more or less knowledge of the rules, values and resources of the receiving population or other migrant groups (see 2.7). In this excerpt, the Polish, in contrast to the Gujurati or Urdu community, are seen as being given preferential treatment because they share a white skin colour with the majority of the receiving population. She said:

> "….what upsets me most right now is, and I, my view is, this is racism at its best, that is my personal view, is now the Polish community comes in. It's white, European, migrant. Everybody's rushing around to put in resource to interpret for them… I don't see anybody running around and saying, but let's do this for the Urdu community or for the Gujurati community who really contribute to our lives in this country. No, nobody does that. What we do? We run around the Polish and I believe that this is racism at its finest…." (PCT, personal communication, 7 July 2010)

This process of Othering between communities is also illustrated by the SVI who told me of a preference she (from the Gujurat) noted for provision of interpreters for Polish over Indian patients:

"And sometimes it's just easier to use the husband or someone so they don't bother. I find that especially with Indian ladies. Not many people bother about their translation because they use the husband to do it for them……Sometimes I think that nurses, they just don't bother to find interpreters. Because on my ward, for example, they have me or if they have Polish people, they used to find someone, but I didn't meet many interpreters from Indian people and we have quite a lot of them." (SVI, personal communication, 30 September 2010)

5.4.10.3. Re-affirming and acknowledging difference

Once accepted in a group, second or third generation migrants may have the confidence to make visible identity markers that their parents tried to hide. They have the confidence to become the Other. My informant from the Sikh community, born in this country to parents of Indian origin from East Africa said that:

"….With the growth in attendance (at the gurdwara), and it's just being aware of who we are in the sense that we're a bit more... I think it boils down to a bit more confident, because when you move into a new place, you really want to fit in and you don't want to rock the boat, because the last thing you want to do is rock the boat. But once you're established both economically and financially, you can then take on certain things that you find are unfair, because you know how the system works, and you know that you've been through the system, so you know you've been educated in the system, knowing the regulations and laws. You know what you can and cannot do. (Gurdwara, personal communication, 15 June 2010)

5.4.10.4. Negotiating with Others in the health domain

Pergert et al., in their study on protecting professional composure, discuss the strategies used by those who care for those from other cultures and report a nurse describing the awareness of the patient as one who doesn't share the same codes and the insecurity of the dealing with the unfamiliar saying:

> "We were very scared that it was something we couldn't handle. And then there will be cultural misunderstandings, one doesn't share codes and...things happen that one hasn't experienced before. One has felt insecure and or uncomfortable when there have been situations that one doesn't recognize. Where there has been a . . . culture, and where things have happened that one has not been able to prepare for, because one has never encountered them before... and that one then as nursing staff doesn't know how to handle the situation." (John & Muirhead, 2010)

A SUHT staff member illustrated her figured world of something out of her control with exotic elements of difference that she chose to label 'Somalian.'

> "It's a bit like Topsy, it's **growing** at such a rate, and part of that is because of the diversity of Southampton and the populace is **changing**, and it's keeping ahead of this, like we know Somalians are coming in…." (My emphasis), (SUHT Voluntary Services, personal communication, 27 October 2009)

The SUHT Chaplain who told me that SUHT staff were not good at recording the race and ethnicity of patients on their admission notes. Training sessions emphasise the urgent need for this baseline information to assist in the planning for the budgeting for languages. He suggested that staff find this a sensitive question to ask of strangers, which in turn suggests awareness of difference and concerns about negotiating it. (SUHT Chaplaincy, personal communication, 9 March 2009)

Women may not tell their midwife that they have been to Poland or have seen a Polish-speaking doctor because they find it 'awkward' to explain, as they feel they may be accused of 'interfering with' the English system or may be exposed 'to ridicule.' (Maternity patient, personal communication, 31 March 2011)

5.4.10.5. Protecting ones space

A maternity patient told me that at her place of work in Southampton, the factory floor staff are mainly Polish-language speaking. Her manager insisted they all speak English and she claimed that the managers did not like 'the Poles.' She understood 'Pole,' 'not to be a nice word.' (Maternity patient, personal communication, 15 October 2009)

I understand the protecting of monolingual spaces (see 6.6.1) to be a defence against Otherness. As an example, the governing body of SUHT has been very resistant to the putting up welcome signs in other languages in the main entrance to the hospital (SUHT, personal communication, 9 March 2009). I understand this decision reinforces the hospital's dominant monolingual space.

5.4.10.6. Exploring Otherness in the workplace

The midwives interviewed for this study told me that they had chosen to work with diverse patient groups in deprived areas of the city. They are, however, constantly reminded of difference. They are prepared to take on complex and challenging cases such as those of honour violence and genital mutilation, which are outside of their own cultural sphere of professional practices. A midwife described visiting a lady with the latter condition; she said that midwives are like swans, calm on the exterior but paddling furiously to keep balanced under the water line. It was she who told me that she had:

> "….trouble interfering with their cultural practices because I think that's what they (migrants) do, and that's all they've known, and that's what they're happy with…" (My added words for sense), (Sure Start Midwife, personal communication, 15 June 2010)

I understand 'that's what they do' and 'what they're happy with' to construct this sense of difference whilst reinforcing the superiority of the receiving population practice.

A midwife refers to her migrant patients as 'just very different.' She refers to herself as an explorer into new *terra incognito.* She lives in a white, middle class prosperous outlying small market town and commutes for work into Central Southampton. She constructs her journey into work, as is more than just a physical journey. She is moving between cultural experiences that challenge her assumptions (some pejorative) of Otherness. She told me:

> "….and out of my whole joy of this job, the community here has been an absolute education and **just been overwhelming**. You know, **you get used to**, sort of, like, what houses you go into and you, sort of, like, God, **I hope my friend, if she was a fly on the wall, she'd be thinking, oh my God! But I'd go into anything**. And most of the time **it's very rare that it's dirty**, but **just very different**. And often with the Afghani people, often the **most lushest of rugs**, with a, **sort of, soft cushions** on the floor. And you, sort of, think, actually, **it's really uncluttered in here**, it's probably a good idea. But **they also double up**... **there'll just sleep on that as well**. But often quite **velvety fabric**, quite a **dark, heavy fabric**. But, you know, there'll bring out, like, a lovely... like, **their best selection of nuts, all displayed nicely, out comes the green tea, and just really, really lovely**….." (my emphasis), (Sure Start Midwife 3, personal communication, 28 September 2010)

Another midwife told that, "….every time I set foot outside of this building, I'm, it's a magical mystery tour for me…." (Sure Start Midwife 2, personal communication 28 September 2010).

5.4.10.7. Challenging the status quo in professional services

An informant who had worked in the public sector in the city for many years discussed with me the lack of public sector professionals from the migrant communities. He said:

> "….it does beg that whole big, big question of despite all we've done, how far issues of institutional racism and discrimination play their part in just preserving the status quo in terms of professional services, you know… (he

gave the examples of)… our local education authority as dedicated as they all are, um, they are almost exclusively white, right… The counselling service is almost exclusively white and therefore, and bearing in mind there's a disproportionate high number of black and ethnic minorities. And particularly in black and ethnic communities in our mental health services, all the counsellors are white." (SCC, personal communication, 2 March 2011)

This informant went on to tell me how they successfully employed black counsellors for a year but were not able to continue to fund it and described how:

"…the professional kind of systematic, systematic kind of, um, you know, institution that actually just replicates its own, you know, and um, it's very hard. I mean it may be to do with the old traditions, I don't know. But most of the, I mean particularly and we're talking about the health services here. Most of the professional services, um, are almost exclusively, um, white still….. And I think and I don't think the institutions appreciate the fact that the knowledge and appreciation of cultural and language differences is as much a professional requirement as knowing the technical elements of the job, you know."

Hampshire Police told me that they had intentionally selected their officer who deals with honour violence issues, from those who did not come from black, minority and ethnic communities to lessen the chances of pressure being able to be exerted on that individual. (Hampshire Police, personal communication, 11 May 2010)

The Sure Start midwives interviewed for this study were self-reported British white ethnicity. A Sure Start midwife interviewed for this study (with a student midwife present) told me:

"…I can honestly say, thinking about my community out here, I can honestly say I've never some across a midwife or a student midwife in my ten years of experience that would have come from pretty much most of my cultural backgrounds here. I've never seen a student midwife in a burka, have

you?...No, but there is one from here, the Sure Start Centre here, who's starting to do training this September…She's from this community, this Indian ethnicity, who's going to be training and says she'll be able to come out here, and….But that's the only case I've ever heard of…." (Sure Start Midwife 2, 28 September 2012, personal communication)

5.4.10.8. Providing equal access to maternity services

Midwives, in common with all public sector professionals, have to provide an accessible service for their patients. I was asked during the course of this study to attend a meeting with the Sure Start Manager at SUHT and two Sure Start midwives, one from Clovelly Road, Nicholstown and one from the Shirley districts of Southampton on 19 November 2010 (see Figure 3.2). The brief was to discuss the set-up of a Parentcraft group (antenatal classes), which would comprise only of Polish ladies who needed an interpreter. Their aim was to engage more maternity ladies who could benefit from their services and who they suggested they were not reaching in the community. They were proposing an invitation to attend a group, sent out in the Polish language, to provide a meeting point for them and other Polish-speaking ladies. This could then give those ladies a support network, which could continue after the birth of their babies.

Providing one or two Polish-English interpreters for these meetings would offer an economy of scale and encourage group-wide discussions. I noted their comment that if interpreters were needed for routine Parentcraft sessions, this could result in two to three interpreters of different languages being present in the room at the same time, which was managed by the midwives but as they said was, 'not ideal' as there was a 'constant murmur' of other voices in the room. (Parentcraft session observations, 8 and 15 June 2010)

Interestingly, there were midwives (Sure Start Centre team meeting, personal communication, 25 May 2010) who voiced concern at the plans to 'hive off' one group of their patients and preferred to work with a mixed group plus their interpreters as needed.

A lengthy discussion followed which concluded with the decision to set up a pilot group, translate an invitation letter, agreed date of distribution and location and dates for the meetings. I was asked to brief two interpreters (already attending SUHT interpreter training) for the interactions and given permission to observe.

However, despite two attempts to distribute the invitations and the two midwives, two interpreters and myself arriving on two separate occasions to meet with this group, not one lady turned up for the sessions. We used the time allocated to the meeting to problematize this outcome. The first time it was decided that the translation was not accurate enough and the letter had not been distributed with enough lead-in time to arrange attendance. This was rectified for the second occasion but still not one lady arrived. This time the midwives and interpreters tried to call the telephone contact numbers they had for the invitees, but one by one there was no reply or a husband or partner who answered said 'she was picking up the children', 'the lady was in Poland,' or 'she was too busy.' I noted that the midwives who were attempting to organise these classes were 'white, monolingual English speakers,' and the Polish language interpreters were more sceptical about the success, predicting many of the responses received over the telephone prior to the event.

Singling out one named group can have the reverse effect, as Hampshire Police told me about the disbanding of an Asian-only woman's refuge from domestic violence in the city and the current situation where all the women, whatever their background, were all put in the same one. Their view was that they had lost the opportunity to deal with specific language and cultural issues and Asian women were now less likely to come forward. (Hampshire Police, personal communication, 8 October 2009)

I understand both of these outcomes to represent a serious miscommunication and misunderstanding in a health interaction (see 3.3.2) evidenced by a failure of understanding of an-Other community.

5.4.10.9. Relationships between migrant communities

From my data, members self-identified as from one community describe dimensions of the difference between themselves and members of their own or Other national or language communities. One criterion was he time they have been in the country. A Polish national maternity patient and a SVI, who had been in the UK for some time described to me she played 'spot the Pole' games (see 5.4.7) which were more accurate in direct correlation with how long the person had been in the country. This distancing may be explained by whether the migrant is deciding to stay in their adopted country. These two ladies made it clear to me that they wanted to stay in Southampton, one was married to an English man and the other to a Polish husband who she had met here, both had children being educated in local schools. In this conversation I was aware that there was a 'distancing' from other members of the Polish community who they described as 'too Polish', 'women who were obsessed by physical appearance, the cleanliness of their homes and status symbols. They described the efforts that they themselves were making to be part of the English-speaking community, through social and work interests and not frequenting Polish clubs or monolingual Polish-language speaking places. (SUHT maternity patient and SVI, personal communication, 31 March 2011)

A self-described member of the middle-class, Bangladeshi community described his own lack of understanding of the Other communities of Bangladeshis in the City. He said:

> "I think that is the Bangladeshis, middle-class Bangladeshis, in the north. That, we are part of that. That is, well, they have got Bangladesh national events, Independence Day or Freedom Day, those kind of things they do, yeah. They are doing the chanting, they hire the church hall and do this, and then eat. But those are not the majority of the Bangladeshis. I am talking about the majority of Bangladeshis live around here….. in some of the communities they are still very, very keen on keeping the language, but Bangladeshi community, they want the speaking and listening part. But reading, writing, not as much….. not in Southampton, but in Portsmouth, yes. In Portsmouth, the Bengali classes are doing very well….It's very strange. I have been trying to find out the explanation why these two communities are so different. In Portsmouth they have got strong Bangladeshi communities, they organise a lot of Bangladeshi events like

> Independence Day, Language Movement Day, Bangla New Year, Bengali poets and all these things. But in Southampton it's really limited to some universities, people who work in the university, **the other community**, and some of them don't take part in those things. It's very strange. I don't know why the two, the dynamics of the two communities, it is so different [laughs]. (my emphasis), (SCC Community Languages, personal communication, 17 May 2011)

An Estonian national interviewed demonstrated how clearly differentiated the Eastern European community was, he said:

> ".....for, say, Estonian or Russian groups here it's very difficult to get in contact with other people, you know, **even in…** with the Polish people.....We live in a... between ourselves, you know, and there is no connection with other groups, even in, ah... Latvians, you know, Latvian... Estonia, Latvia, Lithuania, no bounds, no points, no……" (my emphasis), (SVI, personal communication, 28 September 2010)

The Head of EU Welcome told me that he had been advising two Latvian migrants on finding accommodation either through an agency, which could be expensive, or by walking through the Portswood or Shirley areas of the city and looking for advertisements that said '*pokóy'* ('room' in Polish) and make contact. The Latvians said that would not work because the Poles did not like 'Russians.' I questioned the use of 'Poles,' and 'Russians' and he confirmed that the Latvians used these namings in English. (EU Welcome, personal communication, 14 July 2009)

Members of the receiving public sector workforce may attempt to bring together communities they regard as sharing commonalities such as language or culture in the City Hampshire Police described how they had been working to bring the Filipino and Chinese communities in the city together as they were constantly disagreeing and never doing anything together. They encouraged a debate about how the religions of these two communities differ but how their cultures are very similar and they now are able to sit on each other's

community committees. (Hampshire Police, personal communication, 8 October 2009)

Communities may not always be able to be reconciled or portrayed accurately. A Polish national SVI told me her husband told her not to go to the 'Asian' area of Clovelly Road or Derby Road area in Nicholstown, as he worked near there and he had heard gun shots and it was 'too dangerous.' (SVI, personal communication, 31 March 2011)

5.5. Overview of research findings

The overall findings of this macro-theme illustrate how translocality is constructed, maintained and accomplished through the language practices of migrant communities.

5.5.1. Proliferation of transnational migration in the city

The context of translocality is a proliferation in transnational migration to the City of Southampton (see 5.4.1). Migration is considered to be an issue for the whole city, which is host to refugee and asylum seekers and economic migrants from the expanded European Union. Although concentrated in the central areas of Nicholstown, Portswood, Bevois Valley and Shirley (see Figure 3.2) these migrants are now spreading out in smaller numbers through all districts of the city. Members of migrant communities reflected on the increase in their own social mobility and the increasing linguistic diversity within their own communities. For example the religious community of Muslims in Southampton, previously mainly from the Indian sub-continent, are now joined by small numbers of new migrants who speak a greater number of languages. Midwives and public sector informants describe the increasing number of new languages they encounter. This is supported by a recent study in a central city location, reporting that fifty-four per cent of the school-age children in that area do not speak English at home. Public sector services, such as the Hampshire Police, now provide dedicated resources to working with transnational migrants to facilitate their access to public services and, at the time of this study, the SCC provided funding for supplementary community language classes (after school or Saturdays) in seventeen languages.

5.5.2. Transnational reciprocal links

The interpretation of my data reveals the engagement of all migrant communities in active and vibrant, physical and virtual, reciprocal links across borders (5.4.2). Migrants make full use of new technologies such as Skype, the Internet, blogs, e-mail and satellite television channels to engage in real time communications (see 5.4.3). In addition, they travel to and from countries of origin and other locales to maintain those links. These locales extend to virtual mutual support networks maintained in real time. The reciprocity of these links is illustrated by the Sikh community in England supporting other Sikhs in France with money to pay fines for contravening the new laws about the secularisation of clothing. This transnational support allows the French Sikhs the individual or group choice as to whether to abide by these laws. Through real time information from satellite television channels tensions erupt on the city's streets between opposing communities due to incidents in home countries, such as Afghanistan and Palestine (see 5.4.2).

I understand this change in the demography of the city and the increased use of new technologies to be changing the lived experience of transnational migrants. These dynamic transnational links contribute to super-diversity through the linking of many locales across urban and rural environment throughout the world and within the UK. My informants described, large global networks of family, kin and business relationships, that have moved from country to country, that engage in decision-making on health, education and financial matters and the complicated issues surrounding honour violence and forced marriage (see 5.4.2).

5.5.3. The receiving population negotiating super-diversity

I suggest that the receiving population are intimately involved in negotiating super-diversity (see 5.4.4). Not only because of their increasing heterogeneity but also, as in this study, because of the need to adapt working practices to the needs of a super-diverse population. This was illustrated with the engagement of police and health domain workers with victims of honour violence.

5.5.4. Challenging standard categorisations of languages

I describe a feature of super-diversity as the challenge to the normative assumptions of which standard languages spoken (see 5.4.5). In countries such as South Africa, where a multilingual language policy is in place, one can no longer assume that all their nationals will speak the English language to the same level.

5.5.5. Interpreter super-diverse positioning

I discuss the positions constructed by my interpreter informants who are from the community of transnational migrants (see 5.4.6). I find them adopting a number of positions linked to their homelands, the UK, Southampton, other migrant communities within the city and virtual communities. I question whether the ability to adopt these identity markers is a cosmopolitan luxury of the skilled economic migrant and will return to this in my conclusions.

5.5.6. *In situ* multilingualism at SUHT

Multilingualism is now a feature of the patient population at SUHT. In section 5.4.7 I discuss the increase in the countable languages needed to provide language support at the hospital, and will discuss the language policy and management response put in place to deal with it in 6.6.2.2. The main strand of that response has been the approval of SUHT's interpreting policy (Pergert, Ekblad, Enskär, & Björk, 2008, p. 651). With the creation of this policy SUHT is sensitising to the languages of its migrant communities. It is starting to make budgetary provisions to manage multilingualism in the institution.

5.5.7. Managing multilingualism at SUHT

In section 5.4.7 I explore the management by interpreters of multilingualism at SUHT. I observed multilingual interpreters managing mediation in healthcare interactions across a number of languages. SVIs at SUHT provided examples of working across Gujurati/Hindi/Marathi/ English, Polish/ Czech/ Slovakian/English, Bengali/ Sylheti/Urdu/ Hindi/English and Spanish/

Portuguese/English. A feature of this management is that interpreters admit that they may not have fluency in all these languages. A pattern is identified of multiple languages and multiple competences, which matches theoretical features of linguistic super-diversity (see 2.2.6). SUHT management often call interpreters to interpret so-called 'related' languages.

SUHT staff understood the challenges of identifying the actual language(s) spoken by their patients (see 5.4.5). Examples of measures such as languages spoken in different countries lists, language cards and touch screens are given as a means of facilitating management of this.

5.5.8. Physical and imagined translocal health spaces in health domain

In 5.4.9 I identify and explore the features and actors in translocal health spaces. I suggest the driver to accomplishing translocal health space is the need to maintain ontological security. I relate this to my own experience accessing health services overseas and that of my informants. I find cross-border and an *in situ* reality of translocal spaces. I note across geographical locations within the country, in my example, patients attending clinics with Polish-speaking doctors with Polish health practices.

My data suggested the bounded nature of translocal health spaces. Midwives described how they could feel shut out of certain communities and their practices. Conversely, patients unable to speak the English language are excluded from the shared resources of the dominant community. The receiving healthcare professionals need to understand these bounded spaces and the options available to them to mediate interactions to prevent misunderstandings (see 5.4.4).

Translocal negotiations are nuanced by the construction of imagined translocal spaces that may be informed by customs, religious and health practices in use at the time a migrant left their homeland. Migrants may construct their current practices on these imagined practices when the reality is that practices in the homeland may have changed. Interpreters provided me with evidence of this from the maternity services in Poland that are adopting more features of the English system.

5.5.9. Negotiating translocality

Dedicated maternity services, Sure Start Centres, (see 3.3.5.4) have been set up in an attempt to improve the quality and equality of access to health services for members of migrant communities. They allow for longer appointment times to provide linguistic mediation and services appropriate to these communities. Midwives explained how they made an effort to understand the impact of translocality of health care in terms of time-keeping, birthing, antenatal and postnatal care practices.

Linguistic mediation provided by interpreters did have a physical impact on these interactions. Any consideration of equality of access to health services has to take this into consideration if limited English language proficiency (LEP) migrants are to be treated equitable. The space within the Sure Start consulting rooms was very limited and in some instances I was unable to observe interactions, as, with the midwife, a family member, the patient and interpreter, there was no space left in the room. In the mediated interactions that I observed the midwives and interpreters seemed very comfortable with maintaining eye contact between the midwife and the patient, although this was challenged in the instance when older relatives were present. I noted that simple transactions, such as organising for the patient to have a telephone number to ring when they go into labour, were complicated by language issues such as a LEP partner/or husband who would not be able to make that call.

My informants identified the challenges of the successful linguistic mediation of health interactions. They spoke of a starting point that may be one of complete or limited incomprehension necessitating important decisions by the midwife as to if and when to bring in interpretation services. I understand that midwives intend to do everything they can in these situations to ensure shared meaning in these health interactions. However, these good intentions may be compromised by a lack of training in communication skills, ability to correctly assess the level of English language skills of the patient, whether and when to use friends and family as interpreters and correct use of interpreters during the health interaction.

Health practitioners and interpreters are aware that confidentiality may be compromised by using an interpreter known to the patient as trust issues and lack of confidentiality was revealed as major concerns in these mediated interactions. I noted too that the routine use of family and friends in certain communities, for example in Urdu or Farsi speaking communities, might mask their actual language needs.

I explored the issues surrounding the use of bilingual employees as interpreters. This may be because their language skills are being exploited in the workplace. On the understanding that speaking a language does not qualify one to interpret it professionally, the need for of quality protocols and standards, accreditation for employing bilingual staff need to be put in place. Employers need to understand the role of the interpreter as an invisible communicator of only what is said or an advocate. My findings suggest, by default, that advocacy is an integral part of the negotiation of translocality.

5.5.10 Markers of difference

Finally, (see 5.4.10) I explored the discursive constructions of migrants as strangers or The Other. I understand these constructions to recognise and nuance difference(s). I reflect on the challenges to the naming of these differences to identify homogenous groups, such as 'Poles' or 'Somalians.' I find this is due to the increasing heterogeneity of migrant groups and the receiving population in the city.

I find visible and invisible identity markers of difference that make the insider or outsider difficult to identify. I suggest it really is from where you are looking that constructs difference. Members of migrant communities born in this country may feel more confident to embrace their difference than those that are trying very hard to make a new life and assimilate.

I understand from my data that negotiation with the Other is the negotiation of uncertainties and, sometimes there is not enough information to ensure success. This is the case in the failure of the midwives to bring a Polish-speaking group of maternity patients together because of a lack of

understanding about that community. Communities need to share the rules of engagement and if they don't effective communication is compromised.

I suggest that having identified the Other, a group may want to try to keep them out of dominant institutional spaces. I saw this at SUHT where a monolingual environment is preserved. Conversely, the midwives in this study chose to work in a super-diverse multilingual environment. They were keenly aware of the translocal spaces of difference that they entered into on a daily basis.

It was suggested that members of migrant communities could be employed more to work as professional practitioners with their own communities. One can only hope that professionally skilled midwives from migrant communities will emerge over time. It may be that larger cities, such as London, already embrace this diversity in the workforce and that this is a feature that will ultimately spread to the smaller provincial cities such as Southampton.

A key finding from this research was the differences constructed within and between migrant communities. Language, education, class, time in the country and ethnicity constructed these differences.

Chapter 6: Presentation, analysis and interpretation of data: control and budgeting for languages

6.1. Introduction

I continue in this chapter to present the analysis and interpretation of my data in the second macro-theme of my exploration of translocality. This concerns the control and budgeting for languages of migrant communities in the city. I offer a discussion of a number of themes that emerge from the data, including the framing of absence or presence, textual and rhetorical devices and an explanation for practices situated in language ideologies and other big 'D' discourses. The overview of these research findings will be included in the conclusions of this chapter.

I consider the analytic theme of frames to be appropriate to the healthcare setting, as in the work of Sarangi and Roberts (2005) in their work on misunderstandings in primary health care consultations (see 3.3.2). I will explore the frames of the presence or absence of policy, rhetorical work and discursive strategies to tacitly control and position the languages and speakers of languages other than English. As Schön and Rein see:

> "….policy positions as resting on underlying structures of belief, perception, and appreciation, which we call 'frames.' ….. Moreover, the frames that shape policy positions and underlie controversy are usually tacit, which means that they are exempt from conscious attention and reasoning." (Schön & Rein, 1994, p. 23)

I am interested to understand how these tacit constructions may accomplish and maintain dimensions of translocality as Sarangi and Roberts suggest that:

> "…framing works as a filtering process or membrane through which general values and principles of conduct are reworked to apply to the particular encounter in hand. These frames trigger inferences by constructing possible scenarios." (Sarangi & Roberts, 2005, p. 634)

Analysing framing as an instrument of global control should produce interesting results about language practices and migrant communities that can relate to the wider focal themes of translocal group identities, power relations and equality of access in the health sector. This information may also be useful to other sectors that engage with migrant communities.

I use headings and sub-headings to organise the linguistic resources, metaphors and practices used in the construction and co-construction of discourse, as recommended by Schegloff (1999). I use the TODA tools and methodological questioning to interrogate what is going on here (see 3.4.2). I have extended the frame of presence to include its binary of absence in relation to policy or naming of languages or speakers of languages other than English as suggested by Heath (1977).

I include examples of my analysis of rhetorical and textual devices. These devices are used to persuade and influence in order to create shared assumptions and social worlds. They may employ many grammatical devices, such as the use of personal pronouns, deictics (pointing words), adverbs, metaphors and arguments as suggested by Reisigli & Wodak (2001) and van Dijk (1985).

I note that many other analytic themes could have been used to interrogate this data (see 7.3 for the limitations of my research) and that my data may be able to fit into other categories of linguistic analysis. However, I suggest that my choices are broad enough to provide a comprehensive interpretation.

6.2. The theme of control

I intend to explore my data relating to my macro-theme of the control and budgeting of languages. I will explore the relationship of grassroots

contestation to top-down control and budgeting for languages. I am testing the theoretical concepts of Spolsky (2012) and evidence from Gunnarsson (2009) that suggests that the model of top-down to grass-roots hierarchy is out-dated in the negotiation of super-diverse organisational and workplace discourses.

The described experiences from the individual interviews, together with a wide range of my own socio-cultural presuppositions, policy documents and ethnographic data will serve as an important explanatory and discussion framework for exploration of translocality emerging from my data.

In this chapter, I describe the means and tools used by public sector agencies, in particular in the health domain, to negotiate and frame language interactions with members of transnational migrant communities (see 2.7). Bourdieu (1977) suggests that the kind of language in which an idea is framed determines what happens to it on the ideas market. He suggests that there are many factors that contribute to these means of manipulation and negotiation. Scholars such as Fairclough (1989) suggest that global factors in policy-making, handed down from supranational to national to local agents, the author/speaker's own social identity and historical and situational context and roles, are some of the contributing factors to these negotiations.

Monolingual ideologies (see 2.7.1) inform a discourse that there is a need to control languages, in effect keep out multilingualism and, in consequence, those who speak other languages need to be controlled. I understand this process also links to the discursive construction of 'them' or Others by the dominant hegemony (see 5.4.10). An informant from Southampton Voluntary Services (SVS) used dramatic persuasive rhetoric (in bold in the excerpt below) to construct this Otherness. Battle lines seem to be drawn up as she said:

> "Demand is increasing **exponentially** as SVS **swamped** with newcomers and refugees'. She felt they were now in a **defensive** position and had lost the big vision. There is **disengagement because of the demand** …." (my emphasis), (SVS, personal communication, 27 October 2009)

I suggest that the construct of the need to control may be viewed as a response to a situation that is 'out of control.' This is illustrated too by my SUHT informant when she describes the pace of demographic change and uses the migrant category of 'Somalians' as a rhetorically dramatic example of exotic diversity:

> "…It's a bit like Topsy, it's growing at such a rate, and part of that is because of the diversity of Southampton and the populace is changing, and it's keeping ahead of this, like we know Somalians are coming in…." (SUHT, personal communication, 27 October 2009)

It is interesting to note that the driver of control exists without the hospital having accurate baseline figures of languages spoken and language competences (see 5.4.10.4) (SUHT Chaplaincy, personal communication, 9 March 2009).

6.3. Frame of absence or presence

Heath argues that, '[a] critical analysis should take into account absences as well as presences in the data.' (1977, p. 92) He argues in his work on language and politics in the United States that absence may be viewed as an act of language policy in itself. A lack of a formal language policy generates a scenario where there is no mechanism for the formulation of a budget and funds to cover effective and accountable operationalization, standards and budgeting for languages.

6.3.1. Absence of language policy in the public sector in Southampton

I note that, despite the increasing linguistic diversity in the city (see 4.3), Southampton City Council (SCC) and other public sector bodies in the city such as Hampshire Police Force, Southampton Voluntary Services and Sure Start Centres have no formal language policy or strategy. In this absence, default monolingualism can prevail.

SCC choose to issue a '**Position** Statement' on Accessible Communications (ACPS), rather than a '**policy**' (my emphasis), (The Stronger Communities and Equalities Team and Communications Division, 2010). This document is an internal SCC document given to me in hard copy on the day of my meeting with the SCC informant. SCC permissions allow me to quote but not reproduce this document in an appendix.

On page 7 of the ACPS document, it says:

> "…training, briefing and guidance for employees on this *policy* and guidance and related practice…." (my italics)

This wording suggests some confusion on the part of the authors of this document as to whether it is a 'policy' or 'guidance' and possibly that they view the terms as interchangeable? Use of the deictic, 'position,' allows the Council to frame the statement as something that can be changed at any time, suggesting 'a view' or an 'opinion' rather than a 'policy.' Whereas, a policy suggests a 'rule' or 'a contract' which is enforceable and sets a benchmark that comes with delineated review timelines and for which full accountability must be detailed.

To support my interpretation, in my interview with the Sure Start Centre, a 'policy' is explicitly understood as setting a standard. They said:

> "….we've got this draft language policy which has been shelved, really, and that is a… that's kind of… The intention was **to set a kind of standard** for our services….." (my emphasis), (Sure Start Centre, Clovelly Road, transcription of personal communication, 30 September 2010)

The ACPS makes no explicit mention of languages or speakers of languages other than English. Those who fall into this 'languages category' are grouped generically with those who have 'specific communication needs.' I suggest this tacitly backgrounds their presence.

The SCC New Communities Team (personal communication, 14 May 2009), informed me that in 2008, explicit mention of services available for speakers of languages other than English existed on its public-facing website. This situation has now changed. There is, at the current time of access, an absence of information translated into languages other than English on the SCC main website (Southampton City Council, 2010a). Furthermore, there is an absence on the site of the word(s) 'language(s)' or mention of services available for speakers of other languages.

In 2010 (SCC, personal communication, 14 October 2010) and at the time of writing in June 2012, the ACSP is only available through the SCC intranet (substantiated by web search on the main SCC site). It is only SCC employees that can access the SCC intranet. I interpret this as a frame of absence. I suggest that this withdrawal of a public position and mention of languages, whilst acknowledging prevailing financial constraints, implicitly and explicitly reflects the controversial sensitivities around language issues (discussed below) and the assumption of default monolingualism.

6.3.2. Language policy in SUHT

In the city's health domain, Southampton University Hospitals Trust (SUHT) includes the Southampton General (SGH) and Princess Anne Hospitals (PAH). The latter provides maternity services and is responsible for the management of Sure Start midwives based in the city's Sure Start Centres (see 3.3.2-4). In 2009, SUHT produced, for internal publication, the SUHT Interpreting Services Policy (SISP), (Southampton University Hospitals Trust, 2009a). An enthusiastic language champion from middle management promoted the development of this policy (see 6.7.1). This policy put in place a framework for the provision of an interpreter's service. At the time of its creation, A2C who provide interpreting and translation services to the public and voluntary sector across Hampshire, told me that they were sceptical of how far a policy could be enforced. (A2C, personal communication,
7 November 2009)

I suggest that the existence of this document, as a policy alone, sets a positive frame of presence and the recognition of transnational migrant groups and

their languages. They are framed as belonging to a group with LEP and this framing explicitly and implicitly empowers. It also acts as an explicit acknowledgement of the need to set standards and protocols for communications with them. There are no literary devices or lengthy excuses for lack of action (see 6.4), and the target group is clearly defined.

The title page of the SISP's (Southampton University Hospitals Trust, 2009a) confirms it as being 'material suitable for publishing on the 'SUHTranet (available to SUHT Staff Only),' the 'Extranet (NHS Community)' and the 'Internet (Public). I interpret a frame of presence for languages to be constructed in the uploading of the SISP to the main SUHT website. (Southampton University Hospitals Trust, 2009a) Its presence challenges the absence shown in parallel public sectors discussed in 6.3.1. The visible presence of languages in this context challenges the clear vertical line of hierarchical control of languages in the public sector in the City to be discussed more fully in section 6.7 below.

6.4. Textual devices

With reference to the methods of discourse analysis (DA) proposed by Fairclough (2003), Widdowson (1998) and other scholars for web page analysis, I revisit the SCC and SUHT websites. I am interested to explore another method of analysis as a means of triangulating, (see 7.4), my findings about the framing of LEP groups.

6.4.1. Framing of speakers of other languages on SCC Gateway website

The SCC Gateway is described as a one-stop-shop that offers appointments for face-to-face services and website information on council services for the community. The SCC Gateway website page (Southampton City Council, 2012b) is accessible from the main SCC home page via >(web-embedded hyperlink) Customer Services then >Gateway. The section to be analysed is available by scrolling down the page and selecting option number 2 in the Gateway Services Information section entitled, 'Services for customers with specific needs.'

Unlike those who are hard of hearing, have difficulty standing, or need an accessible toilet, there is no explicit mention in this sub-section of speakers of other languages. SCC takes ownership of its actions expressed by the use of the first person plural 'we,' in lines 1, 5 and 6 or possessive 'our' in line 1; and acknowledgement of the reader, who needs British Sign Language or has difficulty standing. 'Arrangements for interpretation/translation' contains no such SCC grammatical ownership or acknowledgement. It is a metaphorically blunt statement. I interpret the number of clicks (>) needed to get to this information and the concrete positioning of the text on 'interpretation/ translation' at the bottom of the section as framing a textual device to reflect low importance and low priority for languages other than English and those that speak them.

The employment of these rhetorical devices, by the SCC, symbolically creates a bounded semiotic frame on its main website from which the transnational migrant is excluded. Access is predicated on knowledge of the English language (see 2.7.4).

6.4.2. Framing of speakers of other languages on SCC New Communities website

The SCC virtual space that can be accessed in other languages exists in a separately bounded website for SCC 'New Communities' (Southampton City Council, 2010b). This bounded framing constructs languages (other than English) as a category of distinction, rather than a shared resource. In addition, on this site national flags identify the language translations. The link of language to a national image is discussed by Billig (1995) as a form banal nationalism. I understand this pairing to categorise language speakers by their nationality rather than language actually spoken and without acknowledging increasing linguistic super-diversity (see 2.2.6 and 5.4.5).

Accessing the New Communities site relies on web navigation skills and knowledge of the URL or mediation by an intermediary. These actions have to be accomplished in English, from the SCC home page. It took me - computer literate and a native English speaker - some time to navigate through the

appropriate links to the new communities site. Finally, I found my way from the SCC website home page (Southampton City Council, 2012c):

- to **living** > (no indication in the category description that new communities are included)
- to >**community living**
- to >**Information for migrants, refugees and asylum seekers**

to the Southampton new communities site.

Once there, the website gives links to documents in other translated into Afghani, Chinese, Farsi, French, Kurdish, Lithuanian, Polish, Russian, Slovak, Somali and Urdu and offers information on accessing advice and emergency services, education, housing, employment, citizenship, health, money and the law which all of these communities of language speakers would find useful.

6.4.3. Framing of speakers of other languages on SUHT website

All of the web pages of the SUHT website (Southampton University Hospitals Trust, 2012), including those of the maternity services of PAH, are in English. At the bottom of each page there is a link through to >Translation. This > links through to a page on translation.

On this page the sentence:

> "If your first language is not English, interpreters are available. Please ask a member of staff…'

…is translated into SUHT's five most called-for languages of Polish, Punjabi, Farsi, Portuguese and Russian (see 5.4.7). By these translations, SUHT frames these five main communities of LEPs as significant members of their catchment population.

There was a debate about whether maternity information should be provided on the PAH website in Polish, (see 6.6.4.4) (their most called-for language), but

this was vetoed by SUHT on the grounds that it might discriminate against speakers of other languages. (PAH, personal communication, 4 March 2009)

However, I cannot discount that these decisions may be due to the economic realities of managing such a large health sector websites, as discussed by Carreon & Todd (2011). LEP speakers accessing the SUHT website will need web navigation skills and sufficient English language to recognise the written form of the word 'translation.' Once at this page, the five main languages are available, leaving other language speakers reliant on their English language skills.

6.5. Rhetorical and literary devices

6.5.1. What is really being said?

The ACSP (see 6.3.) contains elaborate rhetorical and literary devices to suggest the inclusion of all groups of the city's population:

> "The **particular** focus is on assisting customers with **specific** communication needs, including customers with a physical impairment such as hearing, sight or speech impairment, as well as those with learning disabilities or difficulties or mental health disabilities. It **also** covers customers whose first language is not English and those with poor literacy skills. But it **equally** tries to assist people who **simply** prefer information and communication from the council to be **plain** and **simple** to understand and in accessible formats – that may **particularly** apply to some older people and young people – **but also** many others." (my emphasis), (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 2)

The deictics of the use of adverbs such as 'particular,' 'specific,' 'equally,' 'simply,' 'plain,' 'simple' and 'particularly' frames the SCC's intention to present a balanced, caring organisation that are taking the time to draw a transparent, explicit and exact picture, whereas the implicit message may be

to covertly manipulate the focus away from the contentious issue of language(s).

> "We are **committed** to taking **positive** action to meet the communication needs of customers whose first language is not English. We will do this by **promptly** responding to customer requests for our information in other languages and we will **actively** let customers know they can ask for this….." (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 4)

The authors of the document immediately align themselves in the first word with all SCC employees in the use of the1st person plural, 'We.' This enacts agreed inclusion rather than a dictate and sets a frame to construct a positive attitude to meeting the communication needs of customers whose first language is not English. This is elaborated by the use of verbs such as 'committed,' adjectival qualifications of 'positive action' and adverbial qualifications such as 'promptly responding,' 'actively let customers know.' This frame sets up a positive transactional process later described as 'meeting' needs, 'responding to' requests and 'actively letting customers know they can ask for this.'

The Council's ACPS deals specifically with 'the communication needs of customers whose first language is not English' (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 4). This document is prefaced by an explanation of the 'purpose of this guidance,' 'the contents' and seven sub-headings addressing 'why is 'Accessible Communications' important?'

The literary device of this lengthy preamble implicitly authenticates the SCC 'position' adopted and the reader may question what it is about the sensitivities of this position that needs so much justification and lengthy rationale. My interpretation is that the authors are discursively recognising the sensitivities and negative constructions that the receiving population might make through their acknowledgment of Other language speakers (see 2.6 and 5.4.10). Rhetorically and literally, they are exercising extreme caution,

illustrated in the physical length of the rationale, to distance them from the statutory provision of blanket language support.

> "This guidance aims to make clear how the council will provide information and communicate in ways that can be easily understood by ALL customers." (SCC capitalisation) (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 1)

This extract uses the graphological emphasis on 'ALL' (by its capitalisation) before 'customers' as a persuasive 'shouted' literary rhetorical device. This foregrounds the inclusiveness of the term 'accessible communications', rather than individual groups. Once again language is not foregrounded but backgrounded in a generic category. Speakers of other languages are constructed here not as warranting a special policy, foregrounded as a special case or not singled out.

The use of the word 'customers' after 'ALL' constructs the author and its employees in a transactional relationship as an equitable provider of services.

There follows a lengthy description of who falls within the criteria of 'ALL.' The length of this description alone suggests the importance and sensitivity that SCC attaches to the point it is making. Attention here is given to describing, in detail, the profile of customers as a linguistic device to reassure of its inclusiveness. It also serves the purpose of taking the focus away from 'customers whose first language is not English' and the need for translation or interpretation services. Those who speak languages other than English, to whatever level, are positioned in the middle of the text, maybe to lose their significance and then bracketed with 'those who have poor literacy skills, to construct an identity for non-English speakers of lack of education? Inferring and implicitly attempting to reassure the reader of a balanced rationale the text employs the adverbial use of 'equally' coupled with 'tries.' Following on, the document states:

> "….in law we must take reasonable steps to ensure we provide **equal** access to our services and information. But there is no legal reason for all materials

to be translated. The Race Relations Act 1975 **simply says** that all parts of the community should have access to services and although that might involve translation it does not always have to. The Human Rights Act 1998 **only requires** translations if someone is arrested or charged with a criminal offence. We believe our position on translated material is reasonable, especially if we focus on ensuring we communicate well with minority ethnic communities in lots of different ways." (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 4)

The use of the words 'simply says' and 'only requires' uses persuasive rhetorical devices of evoking a higher authority of the Law that offloads local responsibility for the proposed limitations to these services. By interpreting to 'the letter' the voice of national law there is an implicit suggestion that SCC authors and employees are exonerated from any accusations of prejudice or discrimination.

6.5.2. Framing inclusion

The SISP (Southampton University Hospitals Trust, 2009a) uses the genre of institutional (local government) language with identifiable features, as described by Sarangi (1998), that reinforce the authority and authenticity of the institution and the purpose of the document.

The formal layout of the title page and elaborates on validity dates, 'Final Validating Committee,' 'Accountable Officer/Executive,' sites where it can be published (discussed below), 'Audit Trail' and 'Signature of Chairman of Validation.' (Southampton University Hospitals Trust, 2009a, p. 1)

The SISP, page 2 includes the names and dates of committees/ groups consulted including the 'Patient Experience Group,' the 'Volunteer Group,' and the 'PAH Interpreter Users Group;' the names of Staff/Patient groups consulted, including the 'Volunteer Interpreters Service Group' and the 'Patient Experience Strategy Group.' The detail of these deliberations and layout in tabular formal format is a textual device to reinforce authority and formal authenticity inviting the reader to the assumption that the procedures outlined

will be enacted, monitored and formally reviewed. The use of language and layout throughout is formal, with little/no adjectival or adverbial use. Compared with the textual devices discussed above, I interpret this sharper use of formal language to indicate less of a sense of need to modify and justify the proposed actions and evidence of a less complex relationship between the implicit and explicit intentions. The SISP does evoke the authorities of 'Southampton City Council,' 'a quantitative survey of the interpreting service,' 'the Trust's response to the Kennedy Report of March 2002,' the implementation of the Action Plan and the Response to the Victoria Climbié Enquiry of March 2003' and the 'New Equality Bill' (Southampton University Hospitals Trust, 2009a, p. 4) but they appear without qualifying or modifying adverbs, with the author evoking their voices to suggest concordance between global authority and local objectives.

6.6. Big 'D' Discourse(s)

In this section I will outline the major discourses that I understand as underpinning the control and budgeting for languages. I am interested to understand the vertical hierarchies or contestations that underpin and interact in this control through discourses of language, economics, patient experience and power.

6.6.1. Default monolingualism in the public sector in the city

The control of languages through the presence or absence of language policy is informed by ideology and beliefs about language and language practices (see 6.3). Li and Juffermans (2011) argue that language policy is a body of ideas, laws and regulations intended to achieve a planned change (or to stop it happening) in the language use of one or more communities. The explicit and implicit linguistic ideological discourse of the ACPS (see 6.3 and 6.4) elaborates a default English monolingualism by the construction and attempt to co-construct positive links between community cohesion and monolingualism.

This discourse is explicitly constructed in the evocation of the national authority of the Commission on Integration and Cohesion that 'suggest(s)

translation of all information may not assist cohesion and integration' (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 4). Further on that page, their default position is that the 'translation of information is no substitute for learning English.' This suggests the examples of language testing regimes, discussed by scholars writing in Hogan-Brun, Mar-Molinero and Stevenson (2009) that are dominantly monolingual.

In the ACPS, the SCC implicitly declares and the readers of SCC staff are invited to share, through a persuasive frame made in two consecutive sentences, the monolingual discourse. As requests for translated material are qualified by the strong deictic of '**we,**' in the excerpt below, (evoking the authority of the SCC) professing a commitment to provide English courses:

> "Southampton Online provides customer information on how to request translated material and/or an interpreter. This information is online in a range of community languages. In addition, **we** are committed to supporting, encouraging and enabling people whose first language is not English to access 'English as a second language' courses locally." (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 5)

The SCC Community Languages Manager confirms this when he said:

> "I am very fortunate that the, the current leadership still, I think feels that there is a need for this kind of service, which I was surprised, because initially the last committee leader …. said why should they learn these languages, and when we **explained to them that they are not doing it at the expense of the English language,** they are doing it in addition to, I think then they were convinced that there is a need, and especially when they see about 150 GCSEs from Southampton schools and all are mostly A Grade, then they appreciated the need for the service, and that's why they still kept it." (SCC Community Languages, personal communication, 17 May 2011)

This default monolingualism is explicitly linked to the discourse of power (see 2.7.4 and 6.6.4) as the Sure Start Centre in Clovelly Road confirmed:

> "….but our position was that everybody should learn English because that was the route to power." (Sure Start Centre, Clovelly Road, personal communication, 30 September 2010)

An informant from SCC described to me his view of the monolingual nature the workplace in the city, he said:

> "…..if two people came in doing let's say a job that was a very general job. One spoke Punjabi very well and the other only spoke English and the English one would think, well, why is that person getting extra money because they speak Punjabi when we're doing the same job. But there'll be an expectation that Punjabi could be used in appreciation that it was a skill. **The thing is we've got people who speak many other languages and because we are such a mono language culture in this country we don't accredit, you know**, because if somebody speaks another language, I mean I only speak one language, but if someone speaks another language, that is a skill." (My emphasis), (SCC, personal communication, 2 March 2011)

This taken-for-granted monolingualism is illustrated by the fact that midwives working at Sure Start Central, with one of the most diverse client/patient populations in the city, send out the first invitation to attend an antenatal appointment in English. During the discussion at a weekly Sure Start midwifery meeting at which I was present, one midwife said that what they find is that they (the migrant who speaks a language other than English) must know somebody because every time they turn up. She said 'it always puzzles us but I think they must know somebody.' (Sure Start midwives, personal communication, 25 May 2010). Solutions were suggested such as putting information on the booking form that could be translated into the language of the patient, although they did say that this might be difficult and costly to organise. This comment evidences contestation between the major discourses of language, economics (see 6.6.2) and power (see 6.6.3) interacting with that of the patient experience and *in situ* multilingualism (see 5.4.7-9).

6.6.2. Economic

6.6.2.1. SCC budgeting for languages

An informant told me, face-to-face, that the SCC permits their staff to arrange up to three interpreter-mediated interactions with a customer (unless it is 'exceptional' – a term which was not defined). The use of telephone interpreting is encouraged with the rationale that it is cost-effective and more accessible Gateway staff (SCC, personal communication, 14 October 2010). I interpret this as an economic frame, which is imposed top-down to restrict expenditure. On the other hand, it may also be viewed as accomplishing the power of the dominant monolingual reality (see earlier in this section on default monolingualism). I noted that this directive (the three-times rule) is absent from the written form of the ACPS (The Stronger Communities and Equalities Team and Communications Division, 2010). This is a rule that is therefore communicated verbally rather than written down. The source of authority of enforcement lies with the Stronger Communities and Equalities Team or Communications Division. I have no evidence that it is conveyed and understood by SCC staff. Although I suggest that this may be hard to implement systematically. I suggest that this indicates SCC sensitivity to possible controversy and accusations of discrimination (see 6.5) in this ruling, if elucidated in print.

In the ACPS the criteria for staff to arrange interpreter-mediated interactions is discursively constructed by the rhetorical work of the deictic of the word, 'reasonable' (see use in excerpt below). The usage of this word creates an opaque economic frame. SCC staff are reassured by the writer of the document that customers are also aware that they can make a 'reasonable' request. I suggest the disempowerment of migrants is revealed in the blocking tautological process of customers needing to know what they are entitled to and staff uncertain about what the criteria for 'reasonable' interpreting provision are. (Quotes see below with my emphases):

> "…those engagements every effort will be made to respond to all **reasonable** requests for information in accessible formats within 15

working days……customers are informed of their right to make a **reasonable** request for alternative formats on all published information and additionally in the 'Let's Be Clear' information sheets available in community venues, online (Southampton Online) and in council reception points. This information is translated and in accessible formats…" (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 3)

And,

> "….For all events/meetings participants should be invited to inform the organising service of any specific requirements and all **reasonable** requests should be met……The council will not routinely, pro-actively provide BSL (British Sign Language) and language interpreters for public events (where no specific requests have been received). However, where there is a **reasonable** expectation of attendance of people with specific requirements, for example due to the subject/issues/purpose of the meeting, the targeted audience or locality in which it is held, it may be deemed appropriate to have interpreters in place. This decision is at the discretion of the relevant senior officers in discussion with the **Stronger Communities and Equalities Team or Communications Division**." (The Stronger Communities and Equalities Team and Communications Division, 2010, p. 7)

6.6.2.2. SUHT budgeting for languages

As discussed in section 6.3, the absence of the word 'languages' in public documents can be viewed as a policy decision that results in a lack of funding for the management and service support of the languages of migrant communities. In contrast to European statute (see 6.6.4.1) and NHS Action Plans (see 6.6.4.2) that includes non-discrimination by language as a right and freedom of all citizens, I note that the parameter 'language' is not explicitly mentioned as a grounds of discrimination on the SUHT website, Equality and Diversity pages. They describe that:

"The Trust has a zero tolerance approach to any form of discrimination and is committed to ensuring fairness for all and eliminating discrimination on the grounds of:

age
sex
race and ethnicity
disability
religion or belief
sexual orientation
gender re-assignment
pregnancy and maternity
marriage and civil partnership"
(University Hospitals Trust, 2012b)

This may be explained as an economic discourse, reflecting default monolingualism (see 6.6.1), which then sets service provision for languages other than English as too expensive. The absence of the mention of languages as a parameter of discrimination in this list exists despite legal requirements to recognise it (see 6.6.4). This discourse is shaped by the same ideological underpinnings as those that construct migrants as Others and as disempowered citizens through their lack of resources in the dominant language (see 5.4.10 and 6.6.4). In this situation the institution finds itself holding conflicting positions, as it also needs to improve all of its patients' experiences and quality of services. SUHT's three-year strategic objectives in its Annual Plan 2010-11 illustrate this conflict between economic (final point) and patient experience and service provision (first two points) in the emphasised text below:

"To be the hospital of first choice for patients within our catchment areas for the services that we choose to provide.

To be in the UK top quartile for quality indicators for the services that we choose to provide.
To be one of the top ten clinical research NHS organisations in the UK.
To be recognised as one of the UK's top ten NHS organisations for education and training, for externally commissioned services.

To be rated as an excellent employer by 90% of our staff.
To be one of the five best regarded public organisations in the region.
To achieve sustainable financial performance year on year to enable delivery of the Trust's vision".
(My emphasis), (University Hospitals Trust, 2012a)

Line managers have to navigate these discursive constructions. As illustrated by a SVI, who was a member of the SUHT workforce. She said her line managers released her for interpreting duties because, '…they are aware of how expensive it is to get an outside interpreter.' On the other hand, there was tension because if she is called to the maternity services to a woman in labour, she could be away from her desk for many hours. (SVI, F, personal communication, 30 September 2010).

The economic realities are ever-present in the context of £30 per hour plus travel expenses for A2C, telephone interpreting and other private providers (Southampton University Hospitals Trust, 2011).

6.6.2.3. SUHT Volunteer Interpreter Service

In 2004 UK NHS hospitals were advised to evaluate the contribution that could be made from their bilingual staff to interpreting and translation services (Silkap, 2004). In response, SUHT set up the volunteer interpreter service. SUHT recognises the establishment of this service as a cost-effective measure and an opportunity to improve the patient experience by the provision of an accessible on site interpreter service. (SUHT Voluntary Services, personal communication, 27 October 2009)

Bilingual hospital volunteers, either staff or externals, are required to attend an interpreter-training programme, organised by the University of Southampton, to obtain a Level 1 (Higher Education) qualification as an introduction to medical interpreting. The course provides a programme of weekly seminars and guest speakers that cover the code of conduct, linguistic and cultural awareness, confidentiality, data protection, medical terminology, role play and preparation for oral and written presentations. It has, to date, run 10 cycles with approximately 20 enrolling each time. On average 10-15

volunteers complete each course and commit to a six-month period of work for the Trust. Individual Learning Accounts are used to part fund this course for staff whilst external volunteers are paid local travel expenses but give their time to attend and work as interpreters for free.

Staff negotiate their working schedules with their managers or external volunteers journey in to give their time to interpret. The SUHT Voluntary Services Office, who manages the service, tries to ensure that the supply and languages provided by SVIs matches the demand. In 2011, at any one time, there were up to 50 qualified (by University course), active SVIs covering approximately 34 languages. At the time of the interpreter evaluation in 2009, 76% of the volunteer interpreters were female, viewed as appropriate by SUHT, in view of the high call out for maternity services and the preference there for female interpreters. (I discuss how this may affect the validity of this study in section 7.4). The SVIS option is particularly important in the case of the maternity services, to avoid the high costs of external agencies, where interpreters may need to be present during labour and birth for long periods.

The use of this service does rely on SUHT health care staff knowing when and how to book the service and to allocate the correct interpreter for the language of the patient (see 5.4.8). A manager of PAH maternity services expressed her concern that maternity staff often could not name correctly the language of their patients and frequently forgot to book an interpreter even for a planned appointment where they know that the patient cannot speak English. This means that they have to take a last-minute expensive option rather than book a hospital interpreter. (PAH, personal communication, 4 March 2009)

I puzzled over interpreting this observation, which seems counter-intuitive. I conclude that it may reflect an economic decision as payment of interpreters is taken out of a department's budget. It also suggests a lack of sensitisation to languages or intentional omission by front line health care practitioners. All of these scenarios construct and disempower the speaker of other languages than English through marks of difference (see 5.4.10).

6.6.3. Improving the Patient Experience

A member of the SUHT Voluntary Services Department described her personal sense of achievement about the development of the SVIS and identified 'making the patient experience' a criteria of its success. Linked to the construct of control (see 6.2.) as bringing matters under control, she said:

> "When I took over the service, it worried me that it's the one thing that was just open to so much going wrong, and it was not just about watching my own neck, it's actually **about making the patient experience better,** and I feel that we have dragged it, kicking and screaming through to a better service; we are giving a better service…." (my emphasis), (SUHT Voluntary Services, personal communication, 27 October 2010),

She said that every effort is made to provide a female interpreter for a maternity patient for those female patients who would not customarily see a male doctor or nurse.

How far this motivation to improve all of their patient's experience by SUHT is contested by the following. The final validating committee of the SISP is the 'Patient Experience Strategy Group.' When I asked if I could attend a meeting of this group to inform my qualitative review of SUHT's Volunteer Interpreting Service, I was told that it would not be worth it as 'they know nothing about languages." (SUHT Voluntary Services, personal communication, 27 October 2010). On presenting my review findings to SUHT's Equality and Diversity Committee in 2011, I learnt that there is no direct chain of accountability for the interpreting policy up to SUHT Board level.

Individual SUHT managers, the SUHT Volunteer Services and SVIs revealed a commitment to championing and improving migrant patient's experience through the provision of the SVIS. However, top-down ruptures in lines of accountability undermine their actions (see 6.7 for further discussion of hierarchies). A number of discourses, economic, language and power are once again seen in complex interactions.

The objectives or success factors of the SISP explicitly illustrate the two discourses of the economic and patient experience. This is in terms of understanding diagnoses and treatment and communication needs:

> "To ensure patients who have Limited English Proficiency (LEP), including speech and hearing disabilities, have access to the communication tools required to allow complete understanding of their diagnosis, and proposed treatment and to ensure that each patients' communication needs are met……..To achieve this in the most effective as well as economical way for the Trust." (Southampton University Hospitals Trust, 2009a, p. 3)

A member of the PCT, an ex-midwife, said:

> "What we need to do is give them the right service and if you have a supporting interpreting and translating service it makes your job easier; it reduces the risk of mistakes, reduces the risk of wrong diagnosis, all these kind of things. And instead of people coming time and time again because either they haven't understood you, or you haven't been very clear, then it saves us money because in that one interaction you could actually make sure that people don't keep coming back and forth, back and forth because they haven't understood something." (PCT, personal communication, 7 July 2010)

The complexity of the discourse of improving patient experience is complicated again by the SUHT direction not to use family or friends as interpreters and trust issues around using interpreters that patients may know. (see 5.4.9), (Southampton University Hospitals Trust, 2009a, p. 4).

Midwives in practice are the ones who have to resolve these discursive tensions, often in emergency situations. They have operational responsibility as to when to bring in an interpreter, negotiating the balance between need to provide information and choices clearly, the trust and confidentiality issues of whether to use family and friends as interpreters and budgets, as illustrated by:

> "…you know, I can think of a family I've had recently, a very happy family. They work, you know... you just know that they're comfortable with each other, trust each other to, sort of, cover any misunderstand... anything she doesn't understand. And then I can think of another family where I think, hmm, how much has she got there?" (Sure Start Midwife 3, personal communication, 28 September 2010)

and,

> "I actually feel a bit awkward sometimes about saying to, and I do have to do that, I have had to do that when I've had a husband say, well, I'll interpret. And I've actually sat there and said, my policies within my Trust direct me that I cannot expect you to… and I always make it, I cannot expect you to interpret for me. Some of what I'm going to ask is medical, and I want to make sure that it's going across, you know, exactly as I say and I don't expect you to try and interpret complex medical, you know, things for me. (Sure Start Midwife 2, personal communication, 28 September 2010)

The discursive tensions are evident as midwives reflect and agonise over these decisions:

> "Had I thought about it… we have talked a lot about what happened on Saturday, and I talked with a more senior midwife about what happened on Saturday with this poor woman… had I thought about it, I think the whole of Saturday's shift might have gone better had we just bitten the bullet and got interpretation services in really, whether it be the volunteer services or paid-for services, I don't know, but, you know. But I didn't… we're used to using her husband, aren't we, and it was just one of those unfortunate scenarios under pressure. It wasn't necessarily the best idea, really." (Sure Start Midwife 2, personal communication, 28 September 2010)

Midwives were concerned about the cost to the service of missed appointments. If a patient did not turn up for an appointment with an interpreter booked, about £160 was wasted. In a discussion with a group of

four midwives for this research they were very critical of no-show patients. They later reflected that many of these patients were completely unaware of the costs and that it might be an idea to discuss this at their first appointment so that they were aware of the costs of missed appointments. One midwife told me how one of her patients was genuinely upset when she was told about the cost of her missed appointment. (Sure Start midwives, personal communication, 25 May 2010).

Midwives in the field would budget for languages in a different way that acknowledged *in situ* multilingualism (see 5.4.7). One midwife said:

> "What would be an absolute treat, for all the leaflets that we have would be... if we had leaflets in multiple languages. To photocopy stuff is another job and another chore, but leaflets, if they came in more… you know, in several key languages. I mean, our breastfeeding, like, this disc is fantastic because you can say to women, actually, it's done in several languages and it's great, you know, it's fantastic and they can have a look at it. But, you know, we do have quite a number of leaflets..." (Sure Start Midwife, personal communication 3, 28 September 2010)

Migrant patients have their own discursive constructions of the patient experience framed by opting for translocal healthcare (see 5.4.6-9).

6.6.4. Power

6.6.4.1. European and UK Law

Equality of access is a founding principle of the UK NHS, regardless of age, gender, sexual orientation, race, religion or belief. These principles are now enshrined in European and UK law including:

(i) Article 14 of the European Convention on Human Rights (Council of Europe, 1998) that states that 'the enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or

social origin, association with a national minority, property, birth or other status.'

(ii) The Race Relations Acts (UK Parliament, 1976, 2000) set out actions for a range of public services to improve the way in which they deal with people who are at risk of receiving a poorer service due to their ethnic background. Its 2000 amendment places a duty on public bodies to eliminate direct and indirect discrimination and introduced a positive duty for all public authorities to promote race equality.

(iii) Building on the Best: Choice Responsiveness and Equity in the NHS (Department of Health, 2003a) identifies that the NHS needs to 'work at ensuring choices and services to genuinely reach everyone, including the most disadvantaged and marginalised groups.'

6.6.4.2. Provision of appropriate NHS health services

It is now a legal, as well as a moral, duty of the NHS to identify and address issues associated with the delivery of health care to a diverse population. This was reaffirmed in 2004 by the NHS Chief Executive's Race Equality Action Plan (Department for Health, 2004) and the Victoria Climbié Enquiry, (Department of Health, 2003b) (see 5.4.9).

Themes such as English language proficiency, religion and the influence of culture on health beliefs and health-related lifestyles are vital considerations to healthcare planning for the provision of appropriate health services. However, at the time of writing, only two National Service Frameworks (NSF) integrate language into their standards, that for Older People and Diabetes (Department for Health, 2001; Department of Health, 2001). These standards aim for 'person-centred care', with 'procedures to identify and meet needs relating to … communication, and for interpreting and translation services to be available … and information to be provided in appropriate formats.'

6.6.4.3. Importance of language in health care interactions

Communication is an integral part of all medical interactions and failure to communicate can result in access to health inequalities for those with LEP. The lack of a reasonable proficiency in English is an obstacle to both individuals and communities achieving their full health potential and it is recognised that LEP patients' access is currently the most significant barrier to equitable healthcare (Aspinall, 2007; Schellekens, 2001). Communication is one of the criteria by which patients judge consultations to an improved patient experience (Short, 1993). It supports the building of a relationship of trust between the doctor and patient and allows the practitioners and the patient to understand each other and tailor medical care to each individual patient (see 5.4.6-9 and 6.6.3). When it breaks down it can lead to misunderstandings, conflicting messages, patient dissatisfaction and is the most common root of complaints and potential legal action (Huntington & Nettie, 2003; Sarangi & Roberts, 2005).

Knowledge of the dominant language in the host community is a resource that empowers the transnational migrant to access health services (see 2.7.4). This discourse of language and power was discussed by Reid and Phillips (2004), who from work in the UK healthcare system, described how the inability to speak English is a major contributor to miscommunications that reduces the accessibility to appropriate care. It appears to accentuate other obstacles, such as a lack of knowledge of the type of services available and how to access them. The investigation into the maternal deaths at Northwick Park Hospital between 2002 and 2005 noted the importance of language proficiency as:

> "….There was very little communication by the staff with the woman. It was, and is, usual practice to ask women if they may be pregnant, but in the case of woman A. this did not happen. This may have been because woman A. was from Somalia and English was not her first language. As we described in our first investigation into maternity services at the trust, staff had limited access to interpreters at Northwick Park Hospital. We were told that, even now, if English is not the first language of a patient admitted to the A&E department, staff tend to assess them according to their physical signs and

rely on whoever is accompanying the patient to act as an interpreter for them." (Healthcare Commission, 2006, p. 27)

Roberts et al. filmed primary care interactions in inner London, UK and reported that:

"Twenty per cent of all these consultations contained misunderstandings caused by language/cultural differences." (Roberts, et al., 2005, p. 473)

The Joint Strategic Needs Assessment for Health and Well-Being in Southampton said that it needed to:

"….to improve our understanding of the needs of different Minority and Ethnic communities within our population, including Gypsies and Travellers, asylum seekers and refugees and new economic migrants, especially around maternity services and children's health….(and to)….improve primary care data collection relating to the ethnicity and other equality strands and **language ability**…" (My added word and emphasis), (Southampton City Primary Care Trust, 2008, p. 17)

6.6.4.4. Hierarchies of empowerment in health care interactions

An informant confirmed the power of knowledge of the English language saying:

"….living in the UK and English is the language that you need to get the most out of the life, you know, really." (Sure Start Centre, personal communication, 30 September 2010)

An informant from Bangladesh described how a lack of language could disempower the patient, as he had visited a relative in a local hospital recently and said:

"….I think she had a stroke…..so I went to see her in the hospital and when I went there, she saw me, she was so relieved, and she said, I don't want to stay here for a minute. I said why? Because first of all, she cannot communicate with anybody, and, then at one point the nurse said, to me, does she know where she is? I said yes, she is, I think mentally her cognitive sense is completely fine, because when I spoke to her, we had a conversation, she was fine… no non-coherent behaviour. I mean, she was perfect, she is strong. So, but the reason they think she is mentally ill, or she has become some kind of cognitive disability or something, because she couldn't explain to them what she wanted. She was going to the toilet and she asked, they asked her, what do you want? I think she answered something, which they thought oh, she is not right. So they assumed that she has lost her sense, her mental ability. So these things can happen very easily to somebody who doesn't have languages and can't understand….." (SCC, personal communication, 17 May 2011)

The PCT told me of the serious consequences of healthcare practitioners' assumptions about a patient's language ability:

"….I had a Bengali woman, young woman, in fact from near here, just a few years back and that's not even long ago. Had a stillbirth and the comment was made by a doctor, um, that they don't speak English, they do not need to be referred to the genetic service. Normally if you have a stillbirth you get referred. Yes. So, my concern becomes, why is this access not being allowed because somebody's making that assumption and I'm kind of concerned about these types of attitudes from professionals….." (PCT, personal communication, 7 July 2010)

An informant working for the local PCT suggested to me a hierarchy of empowerment dependant on racial origins, European to African to Indian:

"….Why are we not running after the Somali community and doing, investing the same amount of energy for the Somali community. We have a large Afghani population now, growing, has grown, having babies one, two, three, four. Large numbers of babies. Why aren't we running around and saying

let's get things in Dari or in Pashto or whatever language they speak. Why now, why are we just focusing on the large Polish community, why? I don't have the answers but I feel from where I sit and looking at the inequalities over the last 20-25 years now, I believe that this is racism. Conscious or unconscious is another question."

Literacy and equality of access to health care

The literacy skills of migrants may also compromise equality of access as an informant from Nicholstown (see Figure 3.2) told me that:

"…a lot of the women wouldn't really understand their own language either because they haven't read… they haven't been educated in their own language either, so when we were talking about translating something onto paper, no, it's a waste of money. It's a waste of money because they haven't actually got literacy skills in their own language." (Sure Start Centre, personal communication, 30 September 2010)

Gender and equality of access to health care

Equality of access may also be compromised from within the migrant community, where male members construct the positive relation between language and power, and may want to keep their women powerless, as one informant illustrated:

"So, we focussed a lot on language classes and, you know, and making sure that children get access to English and that sort of thing, and the parents….But there's barriers, where they're actually stopped from learning English because then they're being empowered, aren't they, the women?" (Sure Start, personal communication, 30 September 2010)

This may also be because the woman is more home-based and is busy child rearing, as was evidenced from my observations of interactions at the EU Welcome advice centre sessions. I noted that a majority of the women who came for advice, who did not speak English and needed an interpreter were

those who had stayed in the home, not working and/or raising children, supported by a husband. (EU Welcome, personal communication, 23 September 2009).

Language and equality of online access to health care

SUHT publishes a website which is in English (Southampton University Hospitals Trust, 2012).This site has an English language keyword to act as a navigation tool to a page where their five most-called for languages are shown (see 6.4.). These languages translate the sentence 'If your first language is not English, interpreters are available'. Please ask a member of staff.'

The criterion for selection of the five most needed languages at the hospital is taken from analysis of the response sheets from health care practitioners who use the SUHT Volunteer Interpreter Service (SVIS). I noted that there is no requirement by health practitioners to return these sheets. Hence, the information gained may be non-representative and unreliable, as healthcare practitioners may return information on some mediated encounters more than others. The information returned may be more common when a mediated encounter is self-evaluated as successful or a failure (or vice versa).

In recognising the five highest interpreter call-out languages, I understand SUHT is going some way to acknowledging *in situ* multilingualism in their patient population and looking to reach out directly to their identified main groups of language speakers (see 5.4.7. and 6.4). However, there is only one sentence of translation and the choice of languages in translation may be unreliable.

A decision not to publish information on the SUHT/PAH site in Polish was contentious (see 6.4.3). Staff explained to me that this was because of the need to avoid accusations of showing a preference and therefore an act of discrimination over other languages. This solution is more cost-effective (see 6.6.2) than SUHT paying and checking the translations of online material in every language for which they have SVIS call-outs (Southampton University Hospitals Trust, 2009b), (see 5.4.8). Conversely, acting SUHT staff explained to me the need for this information to be supplied online in Polish. They

identified the Polish as their largest LEP group and shared their views that 'it would make their job easier' and that 'they would reach more of the people that they needed to.' (SUHT, personal communication, June 2009)

6.7. Lack of coherence in the control of languages

6.7.1. Language policy

The population studied and the corpus of data collected for this study and its interpretation is characterised by heterogeneity and complexity. I reveal similar complexities in the interaction of discourses in 6.6 above. The lines of control and budgeting for languages by local governance, the city's public sector institutions, including the health domain and the grass roots of migrant populations are not coherent.

To illustrate, the public sector ultimately failed to work together in the city for the control and budgeting for languages. In the 1980's, health, County Court, probation, benefits, public services, the voluntary sector and the then, five to six well-established migrant communities (of Punjabi, Gujurati, Indian, Bengali, Cantonese speakers) participated in a consultation about language needs in the city. As a result, A2C was set up to provide language support in the six main languages of the migrant communities. These communities lived mainly in the SO14 city areas of Newtown St. Mary's and Bevois Town (see Figure 3.1 and Figure 3.2 and 4.3). Hampshire Police took part in the initial consultation but they were unable to contribute financially to the set-up of A2C because it was not a national initiative. (Hampshire Police, personal communication, 8 October 2009). From 2002 there was an option appraisal and the PCT took over the management and sole funding of the service and needed to generate income, so would provide a free quality service for the PCT and sell on a contract basis to SUHT, SCC, Hampshire Police, General Practitioners and health visitors. (Access to Communications, personal communication, 7 November 2009)

The situation became more complex as the SCC New Communities Team (SCC, personal communication, 14 October 2010) saw the Hampshire Police and PCT (responsible for funding frontline health services, GPs, community services

etc.) working together, but expressed concern that SUHT was not part of that. SCC had identified problems of new migrants going straight to the Accident and Emergency departments (SUHT responsibility) because they had not received the correct information about the need to register and see a General Practitioner (PCT responsibility).

6.7.1. Individual language champions

Gunnarsson (2009) and Spencer (2011) argue that the dimensions of complexity increase as city managers and officials face inconsistencies of approach and attitude across the administration in communicating on migrant-related issues. An enthusiastic individual or team can champion language planning, while other parts of the local administration are doing nothing or taking a more negative view. Sometimes momentum is lost when attempts are made to mainstream integration across the authority. For example, Hampshire Police told me that members of the police force were routinely offered cultural and faith diversity training. However, because of a new manager who had taken over with his own ideas and budgetary concerns, all that type of training had been cancelled and they felt they were 'going backwards' (Hampshire Police, personal communication, 8 October 2009)

Discussing the change one individual's attention can make to an interpreting service, a SUHT staff member told me:

> "I've been looking after the interpreter service for about eight years here. I, sort of, inherited it because it didn't, sort of, sit anywhere……. it used to be that people were just taken from anywhere in the Trust. Um, they could have been mopping the floor, they could have been operating, they could have been anything in between. If they spoke a language, they were plucked out of the workplace, they were asked to interpret for patients and they just went on a list, and that's how I found them… I think, is just, it's been absolutely magnificent to get some structure, some… when I took over the service, it worried me that it's the one thing that was just open to so much going wrong, and it was not just about watching my own neck, it's actually about making the patient experience better, and I feel that we have dragged it, kicking and screaming through to a better service; we are giving a better

service. (SUHT Voluntary Services, personal communication, 13 October 2010)

6.7.2. SUHT management of languages

This complexity challenges the coherence of the control and budgeting for languages. This is illustrated by inconsistencies between the SCC, EU Welcome and SUHT websites (see 6.4). An organisation such as SUHT, which is information-rich, is trying to keep pace with information that may be changing daily. For example, keeping track of the availability of SVIs:

> "There was a list that was out in the Trust. It wasn't up-to-date at all; people had left, but that… it's just the same now as far as that's concerned. Daily that list changes, but this well out of… um, there was a list all round, everybody had a list, so trying to gauge it, trying to maintain it, trying to put boundaries down and protect it and all, it was just impossible." (SUHT, personal communication, 27 October 2009)

From my review of the SUHT interpreting services (Southampton University Hospitals Trust, 2011), I concluded that information on how to use and book the SVIs was sometimes patchy. I highlighted above the lack of reliability in selecting the five most called for languages at SUHT (see 6.6.4); the use of family and friends and the lack of overall provision of interpretation at SUHT (see 5.4.9). In addition, I noted disparities in the extent of provision of interpretation for specific languages. An SVI told me:

> "We know now because a while ago there was an information rollout (on the interpreting policy) but sometimes they (the ward staff) don't have an idea of how to do it really. And sometimes it's just easier to use the husband or someone so they don't bother. I find that especially with Indian ladies. Not many people bother about their translation because they use the husband to do it for them……Sometimes I think that nurses, they just don't bother to find interpreters. Because on my ward, for example, they have me or if they have Polish people, they used to find someone, but I didn't meet many

interpreters from Indian people and we have quite a lot of them." (SVI, personal communication, 30 September 2010)

6.7.3. Dis-location across SUHT sites

Individual SUHT sites such as Southampton General, Mount Pleasant Hospital, Princess Anne Hospital to Sure Start Centre can be dis-located, acting as 'distinct satellite(s),' that cannot access coherent information flows, as one informant said:

"I can't remember what it was I was looking at, and I've picked up the fact that there is a volunteer service at the hospital for interpreters. Because we don't often, you know, most of what we do happens out here on Clovelly Road. We kind of almost see ourselves slightly as this distinct satellite to the hospital…" (Sure Start Midwife 1, personal communication, 15 June 2010)

6.8. Overview of research findings

In the findings reported in this chapter, I present the analysis and interpretation of data in the macro-theme of the control and budgeting of languages.

6.6.1. Driver of control is difference

I understand a driver of this theme of control to be underpinned by the marking of the difference of members of transnational migrant communities by the dominant group in the receiving population. This marking of difference shapes and is shaped by the fear of the unfamiliar and the public discourses of being overwhelmed by it (see 6.2). It leads to a need to control informed by the dominant group's ideologies. I illustrated this discursive construction in contributions from my informants, self-identified as the receiving population, as a fear of being 'swamped' by an influx of migrants. The language(s) of migrant communities is cross cutting to all these markers of difference. This is

certainly the case in a small provincial city such as Southampton, with a majority white British, mainly monolingual, population (see 4.3.1).

The term language(s) refers in this section, unless directly mentioning the English language, to languages other than English and embraces the people who speak it (them).

I was interested to explore the relative positioning of public sector institutions in the city to languages through frames, textual, rhetorical and literary devices and discourses. I understand that these devices and discursive constructions reveal the ideological, economic, patient experience and relative empowerment of the speakers of these languages.

In this chapter, I explored the themes underpinning the construction or removal of barriers to transnational migrant communities accessing public services as full citizens in the city. Baseline data on demographic profiles routinely leads to the drafting of policy with an allocated budget and plan for service delivery in the public sector. However, my data reveals a lack of robust baseline data on the number of languages spoken and to what levels in the city that could inform public sector language policy. The rhetoric is that this information is hard to access because these communities of language speakers are hard to reach. Fountain and Hicks suggest that:

> "…..socially excluded communities are often described as being 'hidden' or 'hard to reach' by researchers and by health and social services. However, a basis of the ISCRI approach is that it is not the communities themselves that are hidden or hard-to-reach, but rather that those who usually conduct research have little success in accessing them and/or obtaining the desired information, and that there are barriers hindering their access to health and social services." (Fountain & Hicks, 2010, p. 16)

6.8.2. Absence as a frame of default monolingualism

Inconsistencies were noted in frames of absence and presence of languages across the public sector in the city. An analysis of public sector documents (see

6.3) revealed an absence of language policy and the mention of languages by the local city council's (SCC), documents (see 6.3). In its place, the council's tentative 'position' rather than a language 'policy' is understood to both reflect and shape the sensitivities of the receiving population to languages other than English (see 5.4.10). Words in a council documents and websites were revealed, on semiotic analysis, as elaborated and positioned carefully to de-prioritise languages (compared, say, to special needs). This framing reinforces a dominance of the English language and its speakers in default monolingualism. Whilst the physical sites of SUHT may be dominantly monolingual (see 5.4.10), SUHT frames a presence for languages other than English by publishing an interpreting services policy and making it available on its public-facing website (discussed further in 6.6.2).

6.8.3. Language as a category of distinction

An analysis of frames of textual devices reveals languages bound and segregated on local council websites. Languages are accessed only through the medium of English, enabling language(s) to become a category of distinction rather than a rich and valued resource for the whole city.

In contrast, SUHT in the health domain takes a small step to frame an acknowledgement of the increasing multilingualism of its patients. Although still accessible through the medium of the English language, it translates one sentence of language support advice into five languages on its website (see 6.4).

I reveal the elaborate rhetorical and literary devices used in a council documents to provide a rationale for default monolingualism (see 6.5). Referring to itself as an organisation that cares and takes responsibility for <u>all</u> of its citizens, linguistic analysis of the SCC documents reveals the opposite. Deictic and lengthy appeals to higher authorities are used to justify its position to its staff that need to work face to face with those who speak other language. Languages are subsumed in a large generic category of those customers with special needs. Over-amplification of exactly who is in the target audience of those with special needs, only serves to background languages even more. A driver reveals itself as the sensitivity to possible accusations of

prejudice and discrimination against languages. So that what is actually being said is in fact a detailed public defence of monolingualism.

SUHT frames no such elaborations in its interpreting policy. Using formal language to reinforce its global authority, SUHT's document frames a global-local concordance that frames the inclusion of a multilingual patient population

6.8.4. Global-local discursive tensions

Gunnarsson says:

> "In the global economy, organizations have to strike a balance between local and global concerns as well as between economic concerns and social-societal values in order to be competitive and trustworthy. The challenge for large organizations is to find a balance in policy and practice between these various considerations." (Gunnarsson, 2009, p. 137)

My data reveals the complex interaction of the discourses constructed to achieve the balance between local and global concerns realised in policy and practice (see 6.6.). Local governance is revealed as globally discursively constructing default monolingualism (see 6.6.1) as a rationale for the local economic restraint of budgeting for languages (see 6.6.2). This construction is inconsistent with global anti-discrimination principles in European and UK law (see 6.6.4) and elaborate rationales are needed to defend this position. In this public sector institution, globally language(s) are backgrounded with the local effect of preventing the transnational migrant having full access to local services. Lack of literacy and gender issues also contribute to this position (see 6.6.4). Local governance is concerned with housing and community services and it seems, from the findings of this case study that in the health services the global-local concerns are addressed differently. Whether it is because life and death issues in the provision of health services is more visible to the wider community, rather than community services could be the reason but will not be explored further here.

A dominant institutional monolingualism prevails at SUHT (see 6.6.1) but global to local balancing of policy and practices is driven by the need to provide equitable access for an increasingly multilingual population (see 6.6.3). Global, national economic budgetary constraints evoke monolingual ideologies but the local reality of the multilingualism of patients requires changes in practice (see 6.6.2). It is worth noting at this point that there is no statutory requirement, as in the legal services, for the NHS in the UK to provide language support to its patient population. Yet, scholars such as Woloshin et al. (1995) describe the financial costs of not providing language support can lead to missed appointments, misdiagnoses, incorrect taking of prescriptions and possible repeated testing. Funding the SVIS (see 6.6.2.3.) may be viewed as an attempt to balance these tensions.

6.8.5. Non-hierarchical reality of the control and budgeting for languages

The complexity of these discursive tensions challenges vertical lines of control. I discuss in section 6.7 the lack of coherence in the control of languages across the public sector in the city (see 6.7). Public sector organisations have not come together to create coherent language policy or planning. National priorities for certain organisation, for example, the police, appear to take priority over local ones. The council are able to operate with no language policy whilst SUHT has created one. I describe how individual language champions have taken up the causes for languages resulting in changes of global institutional policy, as at SUHT. Dislocation of institutional practices occurs across SUHT sites, as shown by the Sure Start Centre in this case study that prioritises languages and provides more equitable services that cannot be provided at the main site.

Chapter 7: Conclusions

7.1. Introduction

In this final chapter, I refer to the main findings from the interpretation and explanation of my data and link those findings to my research questions (see 1.4). Sections 5.5 and 6.8 of these chapters summarise these findings. They cover my macro themes of how translocality is negotiated in a health domain and the control of budgeting for languages of the City of Southampton.

I draw conclusions that locate small provincial cities, such as Southampton, as important sites of linguistic and cultural diversity for the research community. Using Southampton as an example, I problematize the continuing usefulness of the categorisation of a non-global city, which may now share so many features common to the world's larger global cities.

I use my findings to approach my overarching research question to evaluate how translocal place-making negotiations can demonstrate the complex and, I suggest, increasingly non-hierarchical impact of the global on the local.

I discuss the limitations of the methodology of this study and the steps I took to establish the validity and reliability of my findings.

I offer the theoretical contribution of this research, in particular, to the field of super-diversity and translocality. I suggest that a major contribution of this type of study is the process of research activism. I cite the sensitisation to languages in this health domain that occurred during the research process as evidence of this.

I conclude this chapter with a discussion of how these findings can inform the generation of future research studies in translocality in other institutional domains. I suggest that these findings shed light on the professional practice of healthcare practitioners. This knowledge may be useful not only for workforce development in this sector but also in other sector workplaces that work with members of transnational migrant communities.

7.2. Summary of findings

7.2.1. Transnational connections proliferating across and within national borders

The findings of this research reveal the context of multiple, reciprocal, cross-border transnational ties and connections of migrant individuals and groups in the City of Southampton. These connections are facilitated by new technologies (see 5.4.1-3)

Large global networks of family, kin and business relationships emerge connected across and within a number of countries. Members of these networks engage in decision-making processes on health, education and financial matters. Individuals move between these relationships and networks and, notwithstanding certain scenarios of obligations to conform, my observations suggest the tendency of highly mobile individuals and groups to adopt multiple positions relating to language, religion, social, political and cultural practices (see 5.4.6). The performance of that mobility emerges in the physical, imagined and virtual fields (see 5.4.9.3-4). I understand from this that transnational individual and group identity is becoming more complex and nuanced, moving away from any conflation of the binary points of a horizontal axis of homeland and host country.

7.2.2.Translocality negotiated in the health domain

This section looks to respond to my third research question of, how is translocality negotiated in the non-global city of Southampton? (See 1.4) My findings reveal transnational connections emerge locally as the situated place-making practices of transnational migrants in evidence from the health domain in the city (see 5.4.9).

7.2.2.1. Default institutional monolingualism */in situ* multilingualism

The health domain of the maternity services at SUHT proved to be a rich site of translocal interactions and spaces. I revealed the *in situ* grass-roots multilingualism of transnational migrant patients and interpreters (see 5.4.7-

8). The extent of the institutional default of monolingualism top-down forms part of my discussion of the control of languages (see 7.2.3).

The increasing super-diversity of the city's population is revealed in my study (see 5.4-5). Different ethnicity groupings, first, second and third generation migrants, white British, white European, black, mixed-race individuals with members of clan or tribe-based groups from all five continents made up the population of my informants. The linguistic diversity of these individuals was also noted, thus compromising the informants normative assumptions about a particular individual related to a particular group.

7.2.2.2. Maternity service is the first encounter with host institution

My informants findings confirm those of Roberts (2007) that the health domain is often the first encounter with a host institution by newly arrived migrants.

Maternity patients confirmed that they had little time to gain sufficient English language proficiency or understand health service systems to interact effectively with it. In consequence, transnational migrants revealed a framing of their negotiation of access to these institutions with reference to health practices in their homelands.

7.2.2.3. Translocal health practices construct bounded translocal spaces

Expectant mothers described how they returned to their homelands for long periods of their pregnancies and after the birth or visited other cities within the UK for the reassurance of their own language-speaking health practitioners and familiar medications (see 5.4.9.2).

However in instances where return travel was not undertaken and from current material on change of practices, I note that known homeland health practices may be informed by knowledge current at the time of departure rather than up to date information. There was also evidence of access to virtual communities to consult health information and services. I understand imagined communities of translocal health practices to be constructed and accomplished in these interactions (5.4.9.3).

My data illustrates that a driver of these translocal negotiations, as suggested by Giddens (1991) (see 2.5.2), is the need to maintain a sense of ontological security between the familiar health practices of a migrant's homeland and the unfamiliar in the host country. My findings agree that the translocal spaces in the health service is characterised by a lack of trust (see 5.4.9.1). The migrant maintains trust in the practices of their homeland in contrast to treating the health service of the UK with suspicion. Trusted and bounded translocal spaces are created.

Translocal health practices are characterised by miscommunication and distrust on both sides of the practitioner–patient relationship. Patients reported going to their homelands for medications not routinely prescribed in the UK. They often did not inform their midwives, for reasons given such as a lack of confidence, lack of language skills or ignorance. Midwives found this kind of translocal practice unacceptable and difficult to understand (see 5.4.9.4).

I conclude that borders of unfamiliarity and strangeness characterise the institutional spaces that are the sites of translocal encounters. Midwives, patients, family members, interpreters and centre staff struggle to negotiate difference. I observed goodwill on all sides but midwives referred to the strangeness of physical characteristics of their patient's homes and practices and in turn, patients to the unfamiliarity and anonymity of clinic and hospital spaces.

7.2.2.4. Knowing the rules to manage health encounters and negotiate translocality

Participants in these encounters revealed varying assessments of the success of the negotiation of translocality (5.4.9.4). Migrants seemed to understand that it was about knowing the rules and having the resources to manage the interactions. Language is recognised as a key and powerful resource in these negotiations by all participants in these interactions (see 5.4.9). Although patients told me that sometimes, even if they understood the rules and expectations of the health system they still felt outside of the system.

I understand that the healthcare staff, practitioners and midwives working with these maternity patients are a part of a receiving workforce population who are key actors in the negotiation of translocality. They hold the knowledge that underpins the shared assumptions in UK health encounters. Knowledge of how to share these with transnational migrants and the understanding of translocal practices is important for effective professional practice. I found evidence of successful and less successful awareness and adaptation of working practices (see 5.4.4). To negotiate translocality successfully, midwives revealed the important decisions that needed to be made about language practices, as to the level of English and knowledge of health practices that are need to inform when to use an interpreter. (See 5.4.9.5-6).

Part of that understanding concerns the knowledge of linguistic super-diversity which challenges bounded language classifications. This is particularly important if they are to assign the correct interpreter to the patient. It is also important to appreciate the increasing heterogeneity of the transnational migrant population to avoid normative assumptions and stereotyping based on national groupings (see 5.4.5).

7.2.2.5. Translocality is a moving target

A major theme emerging from my findings is the heterogeneity of markers of difference between and within all communities in the city and health domain (see 5.4.10). They naming of these groups permeated the data gathered in this study (see 5.4.10.1). Interpreters differentiated between French speakers from mainland France and those from the African continent. Spanish speakers spoke of those from mainland Spain differentiated from those from the Spanish speaking countries of South America.

Standard languages were not the only normative groupings to be differentiated. Ethnicity, country of origin, profession, institutional role, age, gender, education, class, time in the country were all elaborated as markers of difference (5.4.10.2-9). There was a marked absence of simple binaries of constructing difference between the receiving population and homogenous communities of transnational migrants. Markers of difference were noted within and between all national groupings.

Markers of difference create fragmentation and highly differentiated bounded translocal spaces. Discussed in detail in 5.4.10.2-9 they include, Bengali-speaking nationals from Bangladesh isolating themselves in the city from the perceived lower status Sylheti speakers. The interpreter from the Gujurat distinguishing herself from the receiving population in terms of attitudes to care for the elderly, and from fellow Indian sub-continent Punjabi speakers in terms of their lower education. The Polish-language interpreter distances herself from the illiteracy of the Polish Roma patient and a Polish-speaking interpreter left the interpreters service (and my study) on the grounds that she did not share the same values as the Polish-speaking patient she was asked to interpret for. On questioning, it emerged that the interpreter was an older Polish migrant who came to the UK after the war and the patient was a newly arrived Polish economic migrant. This interpreter told me that she had arrived in the UK and had to make her own way, whereas she felt this patient was trying to take advantage of free services available in the UK. She was angry with this and distanced herself from this value system.

First, second and third generation cultural groups, many of whom had lived in the UK for many years, regarded themselves as the receiving population to the newer arrivals. An informant distinguishes between those migrants who came before 2001, marked by the attack on the World Trade Centre, and those who came after that date. He told me that those that arrived before 2001 came mainly from the Commonwealth and shared what he described as British value systems and love of the Queen. He regarded post-2001 migrants, unsubstantiated by me, as coming to the city from war-torn areas in the Middle East in Iraq and Afghanistan, as a result of the war on terror following the World Trade Centre attacks.

Dissatisfaction is expressed by a midwife, born in the Punjab who identified the Polish group of migrants as sharing the same white skin colour as the white British and therefore receiving preferential health service treatment over those from the Indian sub-continent. The contestation within named groups in the Polish community in the UK is summarised by White (2011). Scholars such as Li et al. (2011) and Pieterse and Rehbein (2009) argue that ethnicity is a moving target. My findings suggest widening this conception to include

translocality as a moving target as it embraces such highly differentiated markers of difference.

7.2.2.6. Lack of authentic translocal spaces in the health domain

As a site of translocal interactions, I looked for evidence of translocal space created within SUHT's maternity services. My findings reveal institutionally anonymous monolingual public spaces and consulting rooms maintained at the main hospital maternity site. (See 5.4.10.5)

For a space to be authentic it would need to demonstrate some of translocal features 'onto which senses of belonging, property rights and authority can be projected.' (Blommaert, 2005, p. 222) (see 2.1). Although there were some other language features at the Central Sure Start Centre located in the SO14 high-density migrant city area (see Figure 3.1 and 3.3.5.2-4). I question whether these latter are indeed authentic spaces with features of the translocal assemblages described by McFarlane, (2009) (see 2.4.2). I am not convinced as I did not see the urban semiotic spaces where readers and writers, as argued by Pennycook (2010) produce meaning jointly to create urban semiotic spaces.

I saw an attempt to create that space by the institution but suggest it remains largely tokenistic. (In the sense conceived in the tokenist theory of Kantner (1977). This was based on her work, which suggested that men in the workplace employed token women. This ticked the box of equality in the workplace rather than authentic equality). I understand this tokenism to be reflected in a Sure Start staff member's (herself a first generation migrant who has lived in the country since her youth) comment that when she remembers she wears her traditional Indian dress as it helps her to communicate with certain visitors to the centre. Whilst appreciating the good willed intention of this gesture, I understand it is a contrived attempt to create and impose authenticity, rather than a joint construction from the interactants.

7.2.2.7. Interpretation as a mediator of translocality

As proposed by Angelelli (2005) interpreting is one of the means employed to accomplish the negotiation of translocality (see 5.4.9.9). Midwives in the Sure Start Centres have more resources than main SUHT hospital midwives for interpreters. They are allowed longer appointment times to accommodate the extra time needed for interpretation (see 5.4.9.4).

In accord with the findings of Alexander et al. (2004) all my informants identified some challenges in the linguistic mediation of translocal health interactions either as health practitioners, interpreters or patients (see 5.4.9.4-6). The record of the language spoken by the patient may or may not be recorded by the GP at the time of referral and first appointment invitation letters are not translated into other languages resulting in missed first appointments and engendered mistrust on the part of all parties. Midwives reported difficulties with decisions as to which language to provide for interpretation. They commented on their lack of training to assess the appropriate level of English spoken by the patient and when to call in interpreters or use friends and family. Midwives had little or no training on transcultural matters.

Patients reported concerns about confidentiality if interpreters from their own community were used. Certain communities, mentioned as Urdu and Farsi speakers, routinely preferred to use their friends and family to interpret, thus masking their real language needs.

I noted no instances of health practitioners learning other languages and they mainly spoke English only. However, a rich multilingualism was revealed in the patient and interpreter informants. The interpreters and patients interviewed for this study spoke of learning other languages more formally, for example, through evening classes primarily English but also Hindi, French, Polish or Spanish. Interpreters also offered interpreting services in a number of languages to which they had skills, for example, self-identified Spanish speakers offering Portuguese; Gujurati speaker offering Hindi and Marathi; Bengali offering Urdu and Hindi; Polish offering Russian and Estonian offering

Russian.

7.2.2.8. Conclusion

These findings suggest the contested and complex nature of the negotiation of translocality and the contribution of this research is to provide evidence for this from the health domain. Translocal health interactions are not a situated practice crossing from just one country to another, one language to another, and one ethnic background to another. They are a social construct maintained by reference to many locales and their accomplishment, as in this study, includes dialogue with members of the receiving population.

In this context, a main finding emerging from this research is that a migrant will access a changing repertoire of translocal markers informed by their language, age, sex and time in the country and ethnicity.

Translocality is a complex social construct, which through the lens of language practices can offer us a window onto *de facto* social realities. As evidenced above, translocal practices can construct and maintain social hierarchies from the homeland and as local practices can influence social processes. These local practices shape and are continually being shaped by language and cultural practices that are part of the lived experiences of all the transnational migrant individuals and groups in the city.

7.2.3. The new urban environment

This section looks to respond to my second research question of, how does this negotiation of translocality contribute to research on the non-global city as a site of linguistic and cultural diversity?' (see 1.4).

In Chapter 4, I explored the context of the changes in demography and linguistic landscape in the City of Southampton. These findings reveal that this port city fails to meet all of the global city criteria listed by Sassen (1991) but certain criteria of the city's global trading capabilities, super-diversity, differentiated translocal spaces are fulfilled. In my view, this evidence supports the argument for the lack of linearity between global and non-global cities as

posited by McCann (2004) (see 2.3). I suggest that this renders the categorisation of the non-global city as unhelpful to the current research community. McCann's re-theorisation of the globalisation-urbanisation nexus suggests the existence of a new urban environment. I suggest this is a more useful categorisation to include the translocal networks that connect over wider geographical fields revealed in this study in a smaller city.

Studies, such as those of Dawney (2008) in the a region of the UK and Brickell and Datta (2011) in Thailand and Cambodia suggest that these inter-scalar connections can also extend to more rural areas and include rural to city networks within one country. This challenges the traditional global urban-local urban to rural divide. We may need new terminology to describe the indexicality of these new environments and is a suggestion for future research (see 7.6).

This new urban environment is an important site of linguistic and cultural diversity. It therefore provides a rich vein for studies of language, power, mobility, difference and their negotiation. It provides a microcosm, as this study reveals, of accessible institutional and workplace sites.

My findings reveal that the languages of transnational migrants in the city prejudice equitable access to public services see 6.3-7). As Spencer (2011) suggests migration is a shared responsibility for all of the city. City governance is responsible for collecting data to inform coherent policy-making to ensure that protocols are in place to avoid discrimination. This sets a positive tone to ensure access to health, education and social service for all. My research suggests that the new urban environment will take its place, alongside larger global cities, as an important site of study of the factors affecting the provision of inclusive public services.

7.2.4. Impact of the global on the local

My overarching research question is, how do translocal 'place-making' negotiations link the micro to the macro and demonstrate the impact of the global on the local? (see 1.4)

7.2.4.1. Linking the global and the local

In the context of globalisation (see 2.2.1), I understand that when a transnational migrant crosses a national border or boundary they cross into a demarcated territory, which may have different global governance to that of their homeland. I understand this global governance, nationally, regionally or institutionally to be effected by agencies top-down. In effect, the migrant enters in at the grass roots (local) into a relationship or space with another set of rules and agencies (global), (see 2.7).

Global agencies, informed by their ideologies, set the rules and the hierarchical values of resources needed to engage with them in their territory. For example, in the setting of monolingual testing regimes. I discussed in section 2.7.2 how these regimes may act in opposition to pluralingual supra-national EU policy (see 2.7.2). Global default monolingualism in the UK sets the English language as a high-value resource for full citizenship (see 2.7.1). The English language, for the transnational migrant, is therefore a resource of empowerment in the negotiation of place-making translocal practices (see 2.5). Yet, many newly arriving transnational migrants have little or no English language proficiency. Their local language practice(s) is in a language(s) other than English (see 7.2.2). Through the exploration of the interface of the global control of language, default monolingualism, and any local *in situ* multilingualism, the impact of the global on the local can be explored.

In this case study, in the health domain, the maternity services are often the first port of call for the female multilingual transnational migrant (see 7.2.2). I am using the exploration of the control and budgeting of languages at the hospital and city council as an indicator of global-local impact. I understand the driver of this control is language as a marker of difference (see 6.6.1) suggesting language as a category of demarcation rather than a shared resource (see 6.6.2).

7.2.4.2. Top-down control of default monolingualism

I suggest that the impact of default monolingualism has a significant impact on the control and budgeting of local languages (other than English) in the city

(see 6.8.2). This impact is revealed in an absence of language policy, which allows default monolingualism to prevail. The majority of online and face-to-face services are offered in the English language with controlled and limited access to interpretation and translation.

7.2.4.3. Grass roots challenge of *in situ* multilingualism

However at the hospital, the reality of the *in situ* multilingualism and translocal health practices (see 5.5.8) of the migrant patient population has contested this top-down control. Changes have been made in a published language policy and the SUHT Volunteer interpreter service created. I understand this to evidence a local, grass-roots multilingual contestation of global top-down monolingualism.

The themed-discourse analysis undertaken of data gathered in my study (see 6.6.2-4) confirms that this is, as Gunnarrsson argues, is an attempt,

> "to strike a balance between these global and local concerns in the context of economic concerns and societal-societal values to be competitive and trustworthy." (Gunnarsson, 2009, p. 137) (see 6.7.)

Midwives and gatekeepers at SUHT confirmed these local concerns to offer an equitable service to all its patients, including members of migrant communities in the context of budgetary constraints and service targets. Decisions as to when to use and train interpreters, use translators and establish trust are weighed against the costs of missed appointments, misdiagnoses, incorrect taking of prescriptions and possible repeated testing. (See 6.8.4).

7.2.4.4. The realities of the impact of the global on the local in the health domain

However, the actual impact of these changes is not a total resolution of language issues at the hospital. Interpretation is not provided for the majority of health interactions that need it (see 5.4.9.6). Resources for the volunteer

service are limited (see 6.6.2.2), the hospital maintains a physical monolingual institutional space (see 5.4.10.5) and there is little evidence of authentic translocal space at the hospital (see 7.2.2).

7.2.4.5. Challenges to vertical control of languages top-down to bottom-up

Scholars such as those writing in Gal and Woolard (2001), Gal (2006) and Hogan-Brun, Mar-Molinero and Stevenson (2009) or and argue that the contestations described above evidence top-down, anonymous, global monolingualism versus bottom-up, authentic multilingualism (see 2.7.3). Policy makers and managers work to create policies, regulations, mission statements and directives to be imposed and implemented from above. Top-down *de facto*, institutional monolingualism remains hegemonic (see 2.7). This agrees with findings of scholars such as Moyer (2010) and Codo and Garrido (2010) from their case studies of language choice and the management of multilingualism in institutions in Catalonia. But at a horizontal level of everyday contact and interactions choices are made, decisions are acted upon and beliefs and prejudices are brought to bear, regardless of these. Spolsky (2012) argues that the top-down model ignores the complex and chaotic-hierarchical system as every domain (including the sociolinguistic ecology of the home) has a variant of a language policy that shapes and is shaped by all those in other domains.

My findings suggest a lack of coherence of control and increasing linguistic super-diversity is challenging the vertical axis of the top-down through to bottom-up model. For example at the hospital, the sensitisation to languages (see 7.5.4), creation of language policies and services, inconsistency between policy implementation and management at different hospital sites and individual language champions compromises coherent top-down control of languages (see 6.7 and 6.8.5).

On one hand, the lack of homogeneity and increase in linguistic super-diversity challenges control and brings languages into the everyday workplace. On the other hand, this is a proliferation that may not be well organised, as in examples of linguistic landscape changes by communities of same language speakers, as mentioned in section 2.7.3. If pockets of smaller numbers of

migrants come from larger numbers of countries, they may not be able to find each other and organise themselves as easily as large numbers who come together.

Another dimension of this local incoherence may be in the tensions I noted between and within communities in the receiving and migrant populations (5.4.10). This may hinder organised bottom-up linguistic contestations. I noted a comment from a community contact who, spoke about a change since the 1980s and 1990s. He suggested that community groups were more organised then:

> "So there was an access point in terms of like people, you know, joining in and therefore, beginning to share, you know, what were, you know, some of the gaps and the barriers that there may have been between those who arrived and those who were here…there were specific, um, issues of culture and language, at that time I think there was a perception that we were able to break that down, you know. We were able to I mean the whole business of, for instance, um, sort of other languages and interpreting and translation services was big in the 80s and 90s. I mean that was a major, major thing, you know. Everybody had an interpreting and translation service, you know." (SCC, personal communication, 2 March 2011)

The global has a significant impact on the local but my findings suggest a movement towards an increasingly non-hierarchical relationship between the two. I concur with scholars such as Welsch (1999) who argue that the homogenising forces underpinning globalisation continue to challenged by the particularisms of heterogeneity.

7.3. Limitations of the study

The methodology used for this research has a number of limitations. Firstly, as the original protocol requested, due to limited ethics approval data I was not able to record or video authentic medical interactions, take photographs or carry out explicit observations of spaces within the institution; I was therefore limited to undertaking interviews, their transcription, meeting and field notes

of observations.

In their case study of misunderstandings in primary care interactions Roberts et al. (2005) took video footage of patient-doctor interactions. They discuss the importance of being able to analyse live institutional talk-at-work rather than descriptive talk-about-work. I understand that my study was severely limited by the restriction on capturing live health interactions. In talk-about-work, members of informant groups, staff, interpreters and migrant communities may have a vested interest in protecting their positions and could be fearful of making statements about their own or their community's practices that could be misinterpreted and prejudice their employment status.

I endeavoured to counter these limitations by building trust through active re-engagements with the informants, the guarantee of anonymity and observations of practice. I used the interview setting as Hamersley and Atkinson suggest as:

> "A resource rather than a problem… there may be positive advantages to subjecting people to verbal stimuli different to those prevalent in the settings in which they normally operate….. (so that) they are still capable of illuminating that behaviour……(and) there is no reason to dismiss them as no value at all." [My additions for sense] (Martyn Hammersley & Atkinson, 1995, p. 118)

The small sample of informants for this study was limited to mainly women as a result of its focus on the maternity services. This may be viewed by some as a limitation to this study, compounded by the preference for female interpreters to be used for this service. However, qualitative research by its very nature does not rely on the size of the sample alone upon which to generalise research findings. My suggestions for future research below do include the extension to other male and mixed gender samples.

Taking into consideration the gender issue, the views expressed may not represent the views of all staff, interpreters and users of services in the health domain. However, I make the case for the reliability and validity of these

findings by the triangulation of interview data with research findings from other sources, observations, issues and trends.

Ethics limitations meant that the researcher was reliant on participants to volunteer to take part in the study. This limited access to a representative sample and another Sure Start Centre in the Western part of the city was approached as a possible site for enquiry. However, they did not reply to an invitation to participate.

As I was reliant on volunteer informants, I had authorisation to select interpreters who matched the profile of languages provided at SUHT for interpretation. I was aware of the languages in the highest demand at SUHT and in particular for the maternity department at PAH and the Sure Start Centres (see 5.4.5). I was aware that the SUHT Voluntary Services Manager and the Head of Midwifery took steps to ensure that the SVIs taken on reflected the profile of languages required. On consideration of the interviews I was able to undertake, I suggest that I achieved a representative sample of interpreters that matched the range and profile of languages offered. In particular, the largest numbers of interpreter informants were Polish-English language interpreters that matched the SUHT record of the highest demand for this language in interpretation.

There was no financial provision for translation of all my consent forms into the language(s) of my patient informants, hence they were produced only in English and explained through an interpreter. This did counter the ethics concerns about the checking of translations and also that selected patients may have literacy problems and be unable to understand what was required and enable their full consent to be given. However, I do identify and discuss in suggestions for future research below, that using researchers speaking the language(s) of the participants could be another line of research. On the other hand, speaking the language of the informant could also position the researcher inappropriately in relation to the informant. Potential tensions might be detected in same language speakers in terms of background, education, class or gender that would not surface in different-language speaker interactions.

Finally, I was limited by lack of interview facilities. I was unable to proceed with some interviews because there was lack of space in the hospital. It was difficult to find a private and quiet space for the interview. One interview had to be abandoned because other members of staff needed the room urgently. If I had been located on a daily basis at the hospital or in the Sure Start Centre or if my hospital supervisor had been able to free up her office more regularly or if she had been a member of the maternity service team this may have facilitated more access to an interview room.

The suggestion of shadowing particular interpreters and their interactions was unsuccessful. SVIs were often booked at short notice, which did not allow enough time for me, although located locally, to get there. Midwives were very willing for me to sit in on mediated interviews at the Central Sure Start Centre. However, it was not known at the beginning of the study that these midwives did not routinely use SVIs. They used A2C paid interpreters. (This was being addressed during the course of the study (see 7.5.2)).

These limitations were addressed by using data from other informants who had used the maternity services from the community and interpreter contacts. An informant gave me feedback from research with more than forty women from self-identified black minority ethnic groups. This reported on their views on the quality of the public services and the services of interpreters in Southampton.

I reflected on my own situation as a researcher in this study, identifying a number of factors that could position me in relation to and by my informants. I am British-white, female, mother of three children, a mature PhD student with a background working in the field of languages for business and employability. I am a second-generation migrant from an Italian family, with a French married name and a native English speaker. Any one of these factors, if not a complex mixture of them, may have hindered or benefited access to my informants and affected their impressions of me.

Having an extended family in Southampton built my insider credentials with local community contacts and provided me with a deep contextual knowledge of the city. On the other hand, this may suggest some subjective insider bias.

As my family experiences in the city were concentrated into my early childhood, adolescent and young adult years and had no connection with the health domain, I do not identify this as a limitation.

I identify being female and a mother as assisting my relationship development with maternity patients. My professional experience assisted me with access to and building the trust of the gatekeepers at SUHT. However my interpreter informants may have identified me as aligned to the institution, SUHT, on who had authorised my access. Some SVIs knew me as a trainer of interpreters (see 3.3.5.2) and that may have led to the impression that any criticism they expressed could be passed on to the authorities and possibly put their employment as an interpreter in jeopardy. I hope that the ethics permissions for this study (see 3.5), that prohibited the interview of volunteers who I had trained and my repeated reassurances of the anonymity of my informant's contributions and the building of trust in relationships limited these concerns.

7.4.Establishing validity and reliability

As discussed by Antaki et al. (2003) quantitative positivist analysts criticise qualitative ethnographic methodology for only providing subjective, anecdotal and temporal evidence of synchronic events or moments in time. I agree that elements of subjectivity and the danger of making generalisations from the particular are always present. However, I locate my methodology (see 3.4) in the social constructivism theorised by scholars such as Giddens (1979) and the modernism of scholars such as Bourdieu (1977), Foucault (2002, 2006), Blommaert and Huang (2009) and Scollon and Scollon (2007). They argue that the embodiment of a person's social and language practices are located in the context of rules, place, nexus or *habitus* and that when analysed in greater depth can provide the historicity of a moment in time that allows for more objective interpretations to be made.

I employed a number of strategies suggested by scholars to further enhance the validity of this data, as Mazzei and Jackson (2011) suggest to 'make the data work.' I engaged in the rich-thick description of data as suggested by Bourdieu (1991), which ensured that the context and spaces in which interactions and professional practice were taking place was fully explored and

embedded within an ethnographic framework. I looked to combine this contextual knowledge with linguistic and nexus analysis to throw light on a fuller interpretation. I approached the data from the emic perspective, which is an inductive approach suggested by Geertz (1973) and Mason (1996). This allows the data to speak for itself often through the use of quotations from taped data, documents or field notes. Citing different types of data, I coded it under certain themes (see 3.4.2) relating to the context of the enquiry to enhance the validation of interpretations.

Headland (1990) suggested employing triangulation to cast the research net wide and look at as many sources as possible that could be affecting the data. In this instance, use of an audiotape, ethnographic data collected via a number of channels including observations in the city, informal contacts with participants, contextual notes at the time of recording and policy and planning documents. Triangulation also involves constant reflection on ones position as a researcher that may affect the reliability and validity of the findings (see 7.3 for limitations of the study). The researcher and reader is then fully or more aware of the lens(es) though which the data is being collected and viewed.

Finally, I engaged in the prolonged engagement with the data collection processes, as suggested by Hammersley and Atkinson (1995). The immersion in the context of the data sites enabled a gathering of a rich-thick description. In this case developing a four-year relationship with the key personnel, interpreters and maternity services at the hospital. I worked first as a volunteer, as a lecturer and then a researcher, which has enabled access for crosschecking of information with informants. I became more and more familiar with the environment of the hospital and the Central Sure Start Centre over the period of the research, which allowed a keener sense of the emerging themes from the data, allowing me to revise some of my original ideas.

7.5. Contribution of research

I set out as one of the aims of my research to make a contribution to inform the theory, methodology and scope for the application of my findings (see 1.2). I evaluate here the suggested main contributions of my research with

particular reference to the important insights gained into the process of research activism.

7.5.1.Theoretical level

The development of Vertovec's (2010) new post-multiculturalist concept of super-diversity is informed by the previous work of scholars on transnationalism and translocality (see 2.2). Super-diversity posits a new condition of the proliferation and intensity of political, economic and social transnational mobilities, characterised by an equally prolific unlinking of identity markers.

Scholars are currently debating the usefulness of the term super-diversity, as to whether it is in fact a new concept or whether it is transnationalism under another name (see 2.2.5). Previous studies may have used categories of difference based on standardised and bounded groupings of language, culture, religion and ethnicity groupings in the study of transnationalism. My findings suggest the need for this new concept of super-diversity to embrace the increasing heterogeneity of transnational migrant communities. As a consequence of these mobilities, research attention may need to turn to a highly mobile and super-diverse receiving population.

I suggest that my findings contribute to the theoretical field of translocality (see 2.4) as conceived by scholars such as Kearney (1995), Hannerz (1996b), Bryceson and Vuorela (2002) and Vertovec (2009). My findings suggest an extension of the field of study of translocal connections both across and within national borders. These locales were identified in findings from the case studies of Brickell and Datta (2011) in Thailand and Cambodia and my contribution is to add evidence from a small city in the UK.

The negotiation of translocality in the new urban environment of a smaller provincial city is a feature previously identified with larger global cities. This research makes a contribution to challenge the linearity of the categorisation of global to non-global cities, as argued by McCann (2004) (see 7.2.3). In doing so, it sites this new urban environment as an important site of linguistic and cultural diversity.

My over-arching research question of the impact on the local (see 7.2.4) attempts to shed light on the relationship between the individual local agency (individual forces) and global structures (external forces) mentioned in Giddens' (1984) structuration theory (see 2.7). I propose that my findings position translocal groups and individuals as knowledgeable objects in this relationship in an institution setting in the health domain. They are seen to negotiate with the prevailing global institutional order to create a meaningful lived experience. Local language practice is a powerful and empowering resource in these negotiations (see 7.2.2).

I suggest that the relationship of the global to the local in the top-down control to bottom-up contestation in language ideologies, proposed by scholars writing in Hogan-Brun, Mar-Molinero and Stevenson (2009) is challenged by an increasing lack of coherence (see 7.2.4.5). My findings suggest a movement towards the non-hierarchical as suggested by Spolsky (2012).

7.5.2. Methodological level

This research was hampered by ethical restrictions particular to the health sector (see 7.3). The insights gained into the workings of MREC in this case study suggest that the academic community needs to engage with these governance bodies to make the case for qualitative research. MRECs are familiar with quantitative research and need to be reassured of similar protocols governing qualitative research. Until then, these findings can inform future researchers in the health domain of the need to engage appropriate stakeholders and the timescales needed and scope of protocols required for such applications.

Studies included in the work of scholars such as Bradbury and Reason (2001) and Lewin (Lewin, 1946) argue that community action research encourages relationships between researchers and diverse organisations. It creates an environment for collective reflection on difference and identity markers and a learning community for transformative change. Fountain & Hicks (2010) argue that these kind of community based approaches are more successful at reaching the hidden or hard-to-reach individuals and groups. Critics in the

same works suggest that this kind of research is not rigorous or scientific. However, the insights gained in this research suggest a re-evaluation of the possibilities for co-operative community action and academic research methods in this field.

7.5.3. Applied level

My research extends the work of Sarangi and Roberts (2005) on misunderstandings between doctors and patients in primary health care (see 6.1) to another setting of maternity that includes midwives, patients and interpreters in the maternity setting. It is hoped that these findings of the negotiation of translocality in an institutional health domain will be useful to inform the development of professional practice and mediated health interactions. Light shed on translocality may also be useful for all public service sectors that engage with migrant communities.

The light shed on the impact of the global on the local (see 7.2.4) suggests that the reality of *in situ* monolingualism will need the presence of policy and management throughout all of our cities and institutions. City and institutional governance are responsible for coherent policy-making to ensure that protocols are in place to avoid discrimination. It is hoped that this research makes a contribution to this debate and may inform policy makers and planners from all sectors engaging with the languages of migrant communities.

7.5.4. Research activism: the applied contribution of language sensitisation in the health domain

I am a mature PhD student from a transnational migrant family (see 1.0) with a career in languages for business and employability. I acknowledge my choice of research question to be ideologically motivated from my family roots and previous engagement with migrant issues in the health service in London. My intention was to choose a field of research that I regarded as personally and socially important and to be active in this field.

I started working as a volunteer at SUHT before my research started, part-

intentionally, in order to gain an understanding as to how I could engage with research in a smaller, provincial health location than London. SUHT Voluntary Services had their own economic and service delivery-led agenda to engage with language issues. They were looking for qualitative feedback to complement their previous quantitative survey of the interpreting service to meet equality improvement targets. (Southampton University Hospitals Trust, 2009b)

SUHT's executive body had had the language issues of their migrant population brought to their attention by SUHT Voluntary Services. I can only assume that these were marked as low priority as the majority of their patients are white-British English language speaking and they had more pressing health practitioner-led objectives.

The realities stemming from this context is that, whilst I was invited in to undertake this research, no funding was allocated to it. It was difficult to engage all the gatekeepers and access was limited due to ethical permissions. There were a small number of gatekeepers who supported the research but time was limited, and yet feedback was required immediately to inform the development of the interpreting service.

Holmes et al. (2011) describe this process. Notwithstanding methodological restrictions, an organisation interested in workplace communications invites the researcher in and identifies mutual concerns and interests. The organisation in return for their investment of time and staff goodwill is looking for timely concrete benefits rather than recommendations received after a lengthy wait for academic publication. Sarangi and Candlin (2011) suggest this kind of applied contribution to a workplace domain creates 'hot feedback' from the researcher to the organisation that encourages reflexivity on the part of the researcher at every point in the research process.

This process of research activism and 'hot feedback' was noted during the research process for this case study. Before the submission of the final report on the interpreting services, I was invited to regular monthly meetings with my hospital supervisor, the Voluntary Services Manager, to report back on progress.

During this process, I noted my verbal reports and suggestions for actions were engendering sensitisation to language issues. This was reflected in immediate capacity-building actions being taken, before formal submission of my report. This long list included policy and protocol changes that most importantly included the production and publication of the SUHT Interpreting Policy and an updated interpreters' code of conduct.

Guidelines for the use of interpreters started to be sent to bookers of service and put in the patient file. Duty Managers were advised not to keep out of date lists of volunteer interpreters. All SUHT staff were advised not to use any employees of Medirest (the in-house cleaning company) for interpreting services, unless they have attended the interpreter-training programme. Volunteers waiting to join the interpreter-training course were asked to do patient surveys in the language they might share with the patient. A list of the use of languages by country was put into the SUHT Volunteers' Office to inform interpreter language choice. SVIs started to be used for communication training for Year 3 medical students and interpreting interactions simulations in its simulated patient programme.

The setting up of a Polish-speaking maternity support group, facilitated by myself and mediated by one/two dedicated Trust Volunteer interpreters, was explored. An increasing number of maternity service documents were translated into Polish.

I suggest this study has shed light on the important contribution that can be made through a process of research activism. This finding may be cited as a benefit to encourage institutions to engage with research without losing sight of the need for rigorous and robust longer-term research methodologies.

7.6. Suggestions for future research

This research serves as a pointer to studies that will continue to enhance our knowledge of translocality in the changing nature of our urban environments and the local language practices that are constructed to negotiate it. My analysis has raised questions about the extent of translocal place-making

activities, real and imagined, both across and within national borders. Sites of enquiry in these new kinds of urban environments can be extended to include other provincial and rural areas and the translocal activities that occur within national borders. This research could inform the re-theorisation of the linearity of the global-non-global city categorisations and the discursive complexity of the translocality within them.

I suggest that the most useful future lines of enquiry are through co-operative academic, institution and community based research projects. These could involve participant observers who speak the language(s) of the communities and answer some of the questions raised in this study about the depth and manipulation of constructions of Otherness. Limitation to a mainly female sample of informants suggests an extension to mixed gender samples and to examine to what extent gendered behaviour is shaped or constrained by translocal negotiations.

Important topics for future research would be to further address questions on the inter-relationship between language and power. It would be of interest to open up research pathways into large organisations and institutions. Once there, to analyse the discourse from talk-in-work between policy and practice and employment practices.

I understand the findings of this research to be relevant to other sectors where the workforce engage with migrant communities. Other volunteer-based language support models in the health domain and other sectors could be explored as to their contribution to research activism, innovation, efficiency and improved patient accessibility and experience. Questions raised by these findings suggest the need to understand the impact on public sector services of reciprocal links that migrants have with their home communities. I hope that in turn this knowledge will assist us in appreciating linguistic and cultural diversity as a resource rather than a barrier to institutional practices.

APPENDICES

Appendix 1

The summary of activity at each research site

SITE	No. of meetings	No. of interviews recorded	No. of hrs captured (on tape/notes)	No. of participants (inc. repeats)	Type of data
City of Southampton	22	8	48	72	Recorded, transcription and ethnographic data
SUHT					
SUHT staff	12	1	6	12	Recorded, transcription and ethnographic data
SUHT Interpreters	22	8	20	14	Recorded, transcription and ethnographic data
SUHT Interpreting Course	12	-	-	20 per session	Ethnographic data
Service users	20	4	8	20	Recorded, transcription and ethnographic data
Monthly supervision sessions	15	-	15		Notes and ethnographic data
PAH					
PAH staff	5	-	6	8	Notes and ethnographic data
Medical interactions	6	-	-	18	Ethnographic data
Sure Start Centre Clovelly Road					
Parentcraft sessions	8	-	12	80	Ethnographic data
Midwives/staff	7	4	10	19	Recorded, transcription and ethnographic data

Appendix 2

Outline of the phases undertaken in the various data collection procedures

Phase	Activity	Time	Rationale	Comment
1	Registered as SUHT Volunteer and started PDA surveys at Southampton General and PAH	**October 2008- June 2009** **36 weeks**	To familiarise with hospital site	Welcomed by gatekeepers as study identified as much area needing more understanding
	Meetings with Voluntary Services Mgr, Head of Nursing and Head of Midwifery and Head of Education and Learning		Gain approval for study from hospital gatekeepers Agree hospital mentor/supervisor (Vol Svcs Mgr). Decided to focus on maternity as high call out for languages. To understand requirements for MREC submissions	Difficulties in networking at SUHT to ensure all stakeholders consulted and approved. Would have benefited from health care professional as supervisor and location at hospital to work from
	Meetings with City Council and city contacts, observations in city		Understanding city context	Polish community feeling 'over studied' and Council wanting to dispel myths about numbers of migrants.
	Pilot interviews with members of migrant communities and external interpreters		Testing out interview procedures in 3 interviews and sites for location, taping logistics, questions and ethnographic procedures	To inform research going forward and protocol for ethics submission
	Preparing ethics submission to University and MREC		To gain access to maternity service sites	Complicated procedure to gain MREC approval (see 7.)
	Drafting of themed-interview discussion topics for different		To include in ethics submission: Themes informed by research	Kept interview structure very open to encourage breadth and depth of

	informants Drafting of letters of invitation, research participant information and consent forms		aims and questions and insights from pilot interviews held with 2 members of the migrant Polish community and a city contact. Letters and document text required for ethics submission	comment
2	MREC resubmission SUHT R&D submission Teaching SUHT interpreters course Level 1 Language Policy and Planning document collection Interviews and meetings with senior hospital personnel and city contacts	**October – December 2009** **12 weeks**	MREC approval for study protocol, then required SUHT R&D approval for access to site To familiarise with Trust Volunteer procedures and participants Collecting documents for later analysis Background context of institution and services for migrants	SUHT R&D approval delayed due to delay in hospital gaining senior staff signatures. Excellent opportunity to gain ethnographic information about hospital and interpreting service as working very closely with Voluntary SVCS Office
3	Interviews with city contacts and senior maternity service personnel Addressed Central Sure Start team, invited midwives for interviews, Interviews and observations with midwives and interpreters	**May - July 2010** **October 2010 – May 2011** **44 weeks**	Study commenced, gathering interview notes and ethnographic observations, before, during and after meetings for field notes and later transcription of taped material 27 interviews taped, approximately 54 hours	SUHT R&D approval not given until March 2010, study could then commence Problems identified with accessing observations at Sure Start as they use A2C interpreters. Difficulties with arranging this hospital and no quiet place to go at SUHT for patient interviews. Decided to mainly use interview data from

	Transcription of 25 hours of recorded interviews Observation at Parentcraft classes			service users from migrant communities met during the course of the study in city and through interpreters Had to use those midwives and interpreters who volunteered to take part in the study
4	Picking out of themes from data for draft and final report to SUHT on review of language support services Preliminary presentation of findings to SUHT Equality & Diversity Committee (EDS)	**June - July 2011** **8 weeks**	SUHT agreed for me to undertake study and use data for doctoral thesis if I undertook preparation for this report for them. Benefit to institution	Report well received by SUHT and EDS to take findings to senior management level Addressed question of what do the researched get out of research – this was a benefit
5	Checking transcription for accuracy	**July 2011** **4 weeks**		
6	Checking with informants	**September 2011** **2 weeks**	To ensure accuracy of data, deletion of any confidential info	
7	In depth second and third and further reading of notes and interview transcriptions	**September - October 2011** **8 weeks**	To interrogate data in more detail for initial analysis and interpretation	Note emerging patterns and need of triangulation (see 4.3.6 below)
8	Presentation of initial findings to supervisory team	**November 2011**	To check and confirm interpretation	

Appendix 3

Sample analysis of excerpts from a transcription of an interview with an informant

Stage 1: Selection of representative extract from data: these extracts are from an interview with one of the SVIs to demonstrate positioning and identify her construction as a member of a migrant community in relation/contestation to her own, host culture and dominant institutional practices.

Stage 2: Background to meeting: the extract is drawn from a one-hour interview with myself, a female, mature postgraduate student and a female, mature SVI, who is also a member of staff at the hospital working in the risk and governance department. We have not met before. This interpreter is registered to interpret for a number of Asian sub-continental languages. She came to the UK in her 20s and is married, with children and older relatives living at home. This interpreter is not a native speaker of English but has a good level of English, which although spoken with a strong accent did not interfere with understanding or the social language of the question and response format of the interview. This interpreter responded to the invitation to participate and the interview took place at the hospital in a private room. I explained the details on the participant consent form concerning anonymity and right to withdraw at any time and that was signed by the informant.

Stage 3: Initial description and analysis
(IV = Interviewer, IF = Informant)

(1) IV: "What is your background that led you to be a bilingual interpreter at the hospital?

IF: "So every time I used to go on the wards and they had a patient who was an Indian patient, they would just ask me to help out and, um, I just used to do it at that time, just... so I realise there's a need for this, until, um, I came... um, I met K. once and she... this, um, course for interpreting, um, just happened to happen when I just came across it through K."

This portion illustrates the interpreter constructing herself in this discourse generically (*as Indian)* who was *(just)* asked to help out with interpreting and (*just happened)* to come across K, to speak about the course for interpreting, suggesting a situated meaning of a lack of empowerment, in the assumption that she has to describe herself generically to listeners who do not make any finer distinctions and an implicit criticism of a lack of valuing of her language skills.

(2) IV: "….so what is your language background?

IF: "Um, my mother tongue is Gujurati but because I was born and brought up in Mumbai, I speak lots of different languages. I speak Marathi, Hindi and Punjabi as well. It's just I had friends and neighbours who spoke different languages, and it's just... it came naturally. I didn't make a, um, an effort to learn it officially. It was just I was brought up with those languages and I studied Marathi and Hindi at school up to GCSE level. It was compulsory and, um... because Gujurati is my mother tongue, of course I know that….. I did all my schooling in a school where... I studied at a convent in India actually and all the studies were taught in English…… then we had either French or Spanish as a second language and Hindi being the national language, it was compulsory. Everybody had to learn Hindi and then I chose Marathi because where I lived in Mumbai, Marathi is Maharashtra and that's the language of that state. In India, whichever state you go, they have their own language and because Mumbai is in Maharashtra most of the people where I, um, lived in spoke Marathi, so...Yes. So you didn't make a conscious effort of learning these languages. It was just because as I born in that environment and naturally I was good at picking up languages. I write Gujurati, Hindi and Marathi, but not Punjabi and, um... yes, those three. And Marathi, yes, those three."

This interpreter constructs a discourse of a number of identity positions in relation to her language practices as a (*mother tongue)* speaker of Gujurati linked to her birth being brought up as a natural, effortless figured normative world of a multilingual *(who didn't make a conscious effort of learning these languages);* suggesting her position in a close community of a kinship network

of other multilinguals *(friends and neighbours)*, setting up later opposition to the way she experiences her current environment, (see (3) below).
Other identities constructed are as a city citizen *(Mumbai)* and a school student (subtly re-qualified as a *convent in India actually),* by the common adverb for emphasis, *actually,* in the dialogue as a mark of prestige to impress the listener) and learner of languages *(Marathi, Hindi, English, French, Spanish).* She forcefully uses the first person pronoun 'I' until she introduces a topic change to talk about *'we had either French or Spanish'* and *'everybody had* to learn Hindi,' shifting responsibility to another source of authority. Making a distinction between her other languages and the obligation to speak her national language *(Hindi being the national language, it was compulsory)* implying a criticism that would not have been her choice as she contrasts immediately with her own choice to speak the state (regional) language *(Marathi in Maharastra)*. She is framing herself positively from a close kinship network, well educated, as *convent-educated I* and intelligent, *naturally good at picking up languages.* She knows that the interview is about language practices at the hospital and she wants to position and ratify herself as someone who is well qualified to give her opinion.

(3) IV: "Are you aware when you're interpreting that there are cultural matters that you have to negotiate, that you have to let the health practitioner know about?"

IF: "If your elderly relative is... needs help with feeding and all, um, we just do it. You know, somebody would just do it for them and help them, but I went to a ward where there was a tussle. He was not used to the... the patient wasn't used to eating by himself and the nurses wanted to make him independent, so that... because he had a disability, so they provided him with equipment but they wanted him to be independent, so there was tussle between... there was, you know, like for them, for the nurses to make them understand and for him to make them understand from where the nurses are coming, so it was making both of them understand where they were coming from and come to a compromise, but then not to be so harsh with him..... then I made him understand why they are making him eat by himself so you you're independent and all that, but he put an excellent... you know, because he was always fed at home and they... and the nurses had left him hungry a few times. So then I

made them understand as well, so then they came to a compromise that he would try... start off, you know, eating by himself and then they would help the patient... and so then there was an understanding from there, because they thought, why is he being stubborn, why is he not helping... he's not that ill enough to... there were patients who were better than him, like he should be doing it himself."

This is a complex description of a translocal health interaction negotiation. The interpreter's figured world is where elderly relatives are given any help they need automatically *(we just do it)* implying a criticism of this host institution where the nurses expect elderly patients to feed themselves otherwise there are dire consequences *(or had left him hungry a few times)*. The accusation that *'he was always fed at home',* does not include the explanation (given to me) that 'he was always helped to eat at home,' making the criticism of the nurses behaviour explicit. The implicit implication is a construction of a positive, caring 'family' that this elderly person comes from that does not distinguish between 'who helps who,' with an assumption that extended family members take on any role in the family that is required. There is an assumption of the language and cultural barrier (as it is not explicit), which brings the narrative to a person-to-person story, which is trying to elicit the sympathy of the listener (me) and describe that need for negotiation. The repetition is an attempt to illustrate the to-ing and fro-ing to effect a communication (*to make them understand and for him to make them understand from where the nurses are coming, so it was making both of them understand where they were coming from and come to a compromise)* and its complicated contested nature *(tussle)* and need for resolution. The interpreter does not position this patient as from a particular ethnic or linguistic background, she shows a positive gentle face for him by describing him as *elderly,* possibly a *relative,* someone who is *helped, with a disability, excellent* contrasted with the patient construction by the nurses as someone who they are *harsh* with and who they want to make *independent, stubborn, not helping, not ill enough,* comparing with patients who were *better than him.* The 'good' patient in this discourse does not cause trouble and is independent. This interaction suggests the disempowerment (DA) of this patient from access to a fair and quality health service.

(4) IV "Yes. Do you get the... I mean, you talked about being in the hospital for quite a long time, has it changed, I mean, from your language perspective? Was it more in the past or has it stayed about steady the amount of interpreting you're asked to do?"

IF "I would say it would steady. I wouldn't say it has made any difference, according... because what happens is especially with Gujuratis, they're all learned, they always... most of the new generation, they all speak English, so they don't need it. It's only when... and most of the times, they have... most of the time they're coming in to live with their in-laws, with their children, because that's our culture... and so, um, the need for interpreting, sometimes because they have them at home to make them understand, you know, most of the time what I find is [overtalking], they're using religion and think they're religious, but it is very important that the patient's views are heard and their views are taken, then they will call them [unclear]. But I find that it's the same, or even it's very even they have got no other support they can call, or people who... especially Punjabis who are young ones, have just married and come from India and... or mums-to-be actually. They don't speak English at all. So most... for Gujuratis the migration is not like... I don't know, again that's a cultural thing, like most... girls, that's from my experience, I also don't mean to pity them, Gujurati girls, who... they will come from India, probably know English more... if they marrying the other children here, then they are quite lonely themselves, they are quite professionals, and they don't need interpreting at all because they're very, very... they're like all doctors and engineers and all the... of course, professional people, they get married and come here so they are very [unclear] with the English language and they don't need interpreting. But from my experience of interpreting, I've found that people who are getting married and bringing brides from India, from the north of India, probably need more help with it, because, um, their, um, background or their [unclear] status is not that higher up like, you know, and because they're in-laws don't themselves speak English as well, so that's when I get called in, you know, and these young girls who come in from... that is particularly the Hindi or Punjabi, those... that's what my experience says."

In this extract the construction of Gujurati identity is as *learned*, and this quality is linked to the ability to speak English, is a term of empowerment and

prestige reinforcing her own position in this self-determined category. Gujurati girls are described, hesitatingly (false modesty), venturing an opinion as, even if they come over to get married here, *professionals….doctors….or engineers,* who *don't need interpreting.* The need for interpreting therefore co-constructs and is 'filled in' for the listener as a migrant identity that is not so well-educated, poorer, more deprived, especially those 'from the north of India'. The discourse of the ability to speak English empowers the transnational migrant identity, to move more easily between countries. As, she describes, Punjabi identity contrasted in this extract as *young, just married* (implicit assumption that these newlyweds have just come into the country) and *mums to be, who don't speak English at all.* She assumes her more powerful position, although does so in an unfinished, disfluent, sentence implying a false modesty, and detensifier, of contrasting what she calls a *cultural thing* for *Gujuratis, the migration is not like….* (an economic need, they don't have to marry in to get here or get pregnant to get here). She gives authority to her pronouncements by the rhetorical device *'that's what my experience says.'* Again (see (3) above), the implicit assumption is a figured world of an extended family where in-laws come to live *most of the time* with their younger family members in almost an aside but emphasised in the unfinished sentence….. *because that's our culture….* There is an implicit criticism of the culture that she now lives in that maybe does not value the extended family in the same way. She again does not mention language explicitly but refers to *'them'* (implicitly, the non-English speakers) as having interpreters at home. It was hard to reconstitute from the audio tape but she mentions '*religion'* (and my notes say that she mentioned that 'they' interpreted here as 'other to her self-group identity' think it is all about difference in religious practices) but she is making the point here that that is one dimension but in essence, <u>all</u> *the patient's views* need to be heard.

Stage 4 and 5: Discussion of how the Demonstration of two approaches of TODA and linguistic ethnography were used in analysing and interpreting data.

Themed analysis

The interviewer (me) is directing the themes of this interview to elicit patterns of experiences from a series of open-ended questions which, by careful 'nodded agreements,' 'body language mirroring' and quiet assents encourages the informant to expand their narrative. The extracts are, in this case direct quotes in response to the questions, which I have included, chosen for their relation to the themes identified from the theoretical context in Chapter 2 to explore translocality. In this case, the interpreter speaks of themes that can be categorised as super-diversity, multilingualism, language and identity, language and power and equality of access. I have used sub-themes derived from patterns such as 'conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs,' (Taylor & Bogdan, 1989, p.13, cited in Aronson 1994) to drill down into these themes.

Discourse Analysis

I am drawing on features of discourse analysis, which focus on social production and context to observe the constructed social identities of individuals and groups in their reported interactions. I am selecting from the mainly theoretical tools of deixis, fill in, making strange, subject, frame, context, significance, activities, relationships, connections, identity building, situated meanings, social language, intertextuality, figured worlds, and the big 'D' of discourse (Southampton University Hospitals Trust, 2011).

In this interview extract, the interpreter sets herself discursively in a 'power position' as a credible source of information, through use of the personal pronouns, false modesty and other rhetorical devices. She positions herself as a multilingual, able to assume many identity positions linguistically and culturally across borders, characterised positively by supportive kinship networks and a good education that implicitly criticise her perception of the host culture. Her conversational shift to the first person plural of 'we' and 'everybody' when discussing the imposition of a national language illustrates

awareness of conflicting language ideologies. She further positions herself as a negotiator of unequal power relationships through her interpreting work that interestingly does not explicitly mention linguistic mediation but calls mainly on cultural advocacy. She constructs and encourages me as the listener to co-construct an identity for groups of language speakers for whom she interprets, and health professionals by implicit assumption opening a window on her figured worlds. That discourse is informed by her view of 'her culture,' characterised as caring and family-oriented with that of the host which can be 'harsh' and 'uncaring.' She nuances the marginalisation of Other migrants from the Indian sub-continent, who are not Gujurati-speakers (her mother tongue), into poor, uneducated and deprived categories.

TODA is a composite theoretical approach to the analysis of data and draws on variables such as imagined and relevant knowledge of the social world, beliefs, attitudes and assumptions that speakers use to scaffold their communications. The two strands of theme oriented and discourse analysis are considered to be sufficiently complementary to provide a credible analysis of this data.

Ethnography

In my notebook, I noted that this interpreter seemed very nervous on arrival. She was very anxious about the confidentiality clause in the consent form and before we started the recording she asked for assurances that her comments would be anonymised. I took this to be a natural concern for one who has an employment position to protect at the hospital but also that had some serious and possibly critical perceptions to share with me. I met her some weeks later at a training session for Level II interpreters and she asked me if I had written up her interview and the report and when would she be able to see it, also that she was very interested to read it. This would explain why, during the interview, she was hesitant in the formulation of her remarks, the way she implicitly assumed certain criticisms, linguistically circumvented certain critical remarks and allowed me to 'fill in' the detail of her remarks.

Overall, the extract above could be used to show the multilingual identity positions of a member of a migrant community in the city and elements of power relations in the translocal health interactions. The extract could also be

used to illustrate the heterogeneity of a super-diverse ‘Indian’ community and their perceptions of each other.

I could also comment on important factors that could be affecting this interaction, in terms of the perception of me, as the researcher, as a system-insider, and the trust issues that were raised.

Appendix 4

Gee's discourse analysis tools

(Gee, 2011)

(i) THE SITUATED MEANING TOOL = Specific meanings that listeners/readers attribute to words/phrases given the context and how the context is constructed. Shared experiences and background knowledge are seen as a prerequisite.

(ii) THE SOCIAL LANGUAGES TOOL = How words and grammatical structures can signal and enact a given social language, that is to say styles or varieties of a language that are associated with a particular social identity. The communication may blend two or more social languages or switch between two or more. Conversely, a social language can be composed by words and phrases from more than one language.

(iii) THE INTERTEXTUALITY TOOL = How lexical and grammatical items can be used to quote, refer to or allude to other "texts" or other styles of language.

(iv) THE FIGURED WORLDS TOOL = What figured worlds (namely the unconscious and taken-for-granted pictures of a simplified world that capture what is considered to be typical or normal) the words and phrases of the communication assume and in turn invite listeners/readers to assume.

(v) THE BIG "D" DISCOURSE TOOL = How the speaker/listener manipulates language and ways of acting, interacting, thinking, believing, valuing, feeling, dressing and using various objects, tools and technologies to enact particular social identities and engage in social activities.

Appendix 5

Frame analysis generic and content frames

Koenig (2011, pp. 150-184)

	CONTENT FRAMES			
GENERIC FRAMES		Ethno-nationalist presupposes primordial groups based on religion, culture, language, kinship	Liberal-individualist freedom and equality in the eyes of the state	Harmony with nature in different realms of culture and intrinsic worth of nature
	Conflict between individuals, groups or institutions			
	Human Interest life stories and emotivity			
	Economic consequences			

Appendix 6

Phases of theme-oriented discourse analysis

Braun and Clarke (2006, p. 63)

Phases of theme-oriented discourse analysis		
	Phase	**Description of process**
1.	Familiarising yourself with the data	Transcribing data, where applicable and understanding the interpretive nature of this (2006, p. 87), reading and re-reading the data 'actively', noting down initial ideas.
2.	Generating initial codes	Using analytic themes above to code into interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code and broader units of analysis (themes) in Atlas Ti software (see 3.4.3.1). Note context of coding.
3.	Searching for themes/frames	Collating codes into potential themes/frames, gathering all data relevant to each potential theme to ascertain significance of certain theme. Nb. create visual mind mapping.
4.	Reviewing themes/frames	Checking if the themes work in relation to the coded extracts and the entire data set, generating a 'thematic map' of the analysis nb internal homogeneity and external heterogeneity. (i) check coherent pattern for each theme or revise theme structure. (ii) Consider individual items in relation to the whole data set.
5.	Defining and naming the themes	On-going analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme. NB. Identify what is of most interest about each theme, not just a description. Describe each theme in a couple of sentences.

		What does this theme mean? What are the assumptions underpinning it? What are the implications of this theme? What conditions are likely to have given risen to it? Why do people talk about this in a particular way (as opposed to other ways)? What is the overall story that the different themes reveal about the topic?
6.	Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix 7

7.1. Letter of invitation to patients approved by MREC and SUHT R&D

UNIVERSITY OF Southampton

Southampton NHS
University Hospitals NHS Trust

Voluntary Services
C Level, Centre Block
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD
Direct Dial: 023 8079 6062 / 4688
Fax: 023 8079 4377

13 September 2010

The Language and Cultural Practices of Migrant Communities at Southampton University Hospitals Trust

Dear [Name],

Re: Invitation to participate in study

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement, (please see the enclosed information sheet for more information about the study). The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

REC ref: 09/H0502/108 263 version: 4
R&D number: RHM MED0859 Date: 18/08/09

POSITIVE ABOUT DISABLED PEOPLE

Migrants for the purposes of this research project are defined as those members of the community who may have arrived in this country where English is not their first language.

I am approaching you because you have requested use of the language services at the Hospital. Participation in the study involves you agreeing for the researcher to attend one of your routine antenatal appointments with me and an interpreter present; and after that an interview to collect information about you and your perceptions, attitudes and experiences of this service at the Hospital. Information given to us in interviews will be presented anonymously so that you cannot be identified from what you said. The interview will take approximately one hour. Interviews can be conducted at a time and place that is convenient to you.

We are inviting you to engage with the research which will assist the Southampton University Hospitals Trust in strengthening and developing its patients' experiences and contribute to a research project on this subject.

If you are interested in taking part, please complete and sign the enclosed reply slip and return in the stamped, addressed envelope supplied to the researcher or give to me at our next meeting.
If you have agreed, you will be advised at your next appointment when the researcher, Linda Cadier, will be present with your interpreter at an appointment and an interview time arranged with you. An interpreter will be available for this meeting.

Yours sincerely,

Linda Cadier, Researcher

7.2. Participant information for patients approved by MREC and SUHT R&D

Southampton NHS
University Hospitals NHS Trust

UNIVERSITY OF Southampton

Voluntary Services
C Level, Centre Block
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD

Direct Dial: 023 8079 6062 / 4688
Fax: 023 8079 4377

13 September 2010

The Language and Cultural Practices of Migrant Communities

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Migrants for the purposes of this research project are defined as those members of the community from outside of the UK, who do not speak English.

What is the purpose of the research?

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement. The overall aim of the project is to support Southampton University Hospitals Trust's

service development vision to improve the patient experience for all members of the community. The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

Why have I been chosen?

You have been chosen because you are using the services of an interpreter.

How will I take part?

We are looking for patients to participate in an interview and agree to be observed, using an interpreter, during a routine antenatal appointment.

All contributions you make or record of the interpreting interaction will be confidential and your personal details anonymised.

The researcher will arrange an interview with you, of about one hour, with an interpreter present. The interview will be tape-recorded. Your comments will be invited on a number of themes relating to you, your language and experience of the language support services whilst at the hospital.

The researcher would also invite your consent to be present at one of your routine antenatal appointments with the midwife and the interpreter present. You or the midwife may ask the researcher to leave at any time during that appointment.

Do I have to take part?

It is up to you to decide. We will describe the study and go through this information sheet with you. We will then give to you 7 days to consider whether you would like to take part. The study takes place from April 2010 to March 2011. If you agree, please sign the consent form to indicate you have agreed to take part and return to your midwife at your next appointment or in the stamped, addressed envelope provided. You can withdraw from the study at any time and only information you have given up to that point will be used as part of the study.

Please be assured that agreeing to take part in this research will in no way affect your medical care.

What will happen with the results of this research?

The findings from the research will be written up in a report for the Hospital. The researcher will use the information gathered to inform the writing of an academic thesis. This information may also be used in articles prepared for academic and professional journals or presentations. Any references to interviews in reports, the thesis, articles and presentations will have personal, organisational and place names anonymised to ensure confidentiality.

If you have any question about this study, please contact:

Linda Cadier, Researcher, Department of Modern Foreign Languages, University of Southampton, Southampton SO17 1BJ

Tel: 023 8059 3298 Email: l.cadier@soton.ac.uk or

Kim Sutton, Head of Volunteering and Workforce Development, Southampton General Hospital, Tremona Road, Southampton SO16 6YD

Tel: 023 80796062

They will do their best to answer your questions.

If you remain unhappy and wish to complain formally about any aspect of this project, you can do so through the NHS Complaints Procedure (or Private Institution). Details can be obtained from the Hospital.

Or you may contact Dr Martina Prude, Head of Research Governance, University of Southampton on 023 8059 5058 or in writing to:

Building 37, Level 4, Room 4055, University of Southampton, Highfield Campus, Southampton SO17 1BJ.

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee.

7.3. Letter of invitation to SUHT midwives approved by MREC and SUHT R&D

UNIVERSITY OF Southampton

Southampton NHS
University Hospitals NHS Trust

Voluntary Services
C Level, Centre Block
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD

Direct Dial: 023 8079 6062 / 4688
Fax: 023 8079 6969

13 September 2010

The Language and Cultural Practices of Migrant Communities

Dear Colleague,

Re: Invitation to participate in study

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement, (please see the enclosed information sheet for more information about the study). The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

Migrants for the purposes of this research project are defined as those members of the community who may have arrived in this country where English is not their first language.

I would like to invite community midwives who work with members of the migrant communities to take part in an interview with the researcher who would like to collect information about your perceptions, attitudes and experiences of carrying out these responsibilities in the community and at the Princess Anne Hospital. Information given in the interviews will be presented anonymously so that you cannot be identified from what you said. The interview will take approximately one hour to complete. The interview can be conducted at a time and place that is convenient to you.

The study would also like to identify maternity patients from the migrant communities that request an interpreter, for their permission for the researcher to attend a routine antenatal appointment (not the first booking) and a subsequent interview. It is not appropriate for any patient who you consider to be vulnerable or 'at risk' to be considered for this study. You will be provided with the letter of invitation, project information sheet and consent form in the language of the patient. If you could identify, at the first appointment, suitable participants, the interpreter will explain the contents of the letters to the patients face-to-face and leave the forms with them to be returned by s.a.e. to the researcher or to you at the next appointment. The interpreter will check the understanding of those patients who may not have literacy skills. Once consent has been received, the researcher will attend a routine appointment with you and the interpreter. Please note that the researcher is interested in the interpreting interaction and not the medical interaction.

This research will assist SUHT in strengthening and developing its patients' experiences and contribute to the academic research on the subject.

If you agree, please return the signed, completed consent form in the envelope enclosed to me, the researcher, Linda Cadier, I will contact you to arrange a convenient time to meet with you.

Yours sincerely,

L. Cadier
Researcher

7.4. Participant information for interpreters and SUHT midwives approved by MREC and SUHT

UNIVERSITY OF Southampton

Southampton NHS
University Hospitals NHS Trust

Voluntary Services
C Level, Centre Block
Southampton General Hospital
Tremona Road
Southampton, SO16 6YD

Direct Dial: 023 8079 6062 / 4688
Fax: 023 8079 6969

13 September 2010

The Language and Cultural Practices of Migrant Communities

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Migrants for the purposes of this research project are defined as those members of the community, from outside of the UK, where English is not their first language.

What is the purpose of the research?

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement. The overall

aim of the project is to support Southampton University Hospitals Trust's service development vision to improve the patient experience for all members of the community. The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

Why have I been chosen?

You have been chosen because you are a bilingual staff interpreter or a midwife working with members of the migrant communities at Southampton University Hospitals NHS Trust. We are looking for such members of staff to participate to help us understand the current service provision for these communities.

How will I take part?

The researcher will arrange for an interview of about one hour with you in a location to suit you. The interview will be tape-recorded. Your comments will be invited on a number of themes regarding provision of language and cultural support services for the migrant communities. We would also like to identify patients who agree to be interviewed and for the researcher to attend one of their routine maternity clinic appointments with the interpreter. We will ask midwives to assist identifying suitable patients, who are not at risk or vulnerable in any way. Interpreters and midwives will also be asked to consent for the researcher to be present during a routine maternity outpatient appointment. To note the researcher is interested in familiarisation with the interpreting and <u>not</u> the medical interaction

Do I have to take part?

It is up to you to decide. This sheet describes the study and you have time to consider whether you would like to take part. The study runs from April 2010 to March 2011. If you agree to participate, please sign the enclosed consent form to indicate that you have agreed to take part. You may decide to withdraw from the study at any time and only information you have given up to that point may be used in the study.

What will happen with the results of this research?

The findings from the research will be written up in a report for SUHT. The researcher will use the information gathered to inform the writing of a doctoral thesis. This information may also be used in articles prepared for academic and professional journals or presentations. Any references to interviews in reports, the thesis, articles and presentations will have personal, organisational and place names anonymised to ensure confidentiality.

What will happen if you disclose any bad practice or danger to others?

The hospital supervisor for this research is Kim Sutton, Head of Voluntary Services who is committed to improving the language support services at the SUHT. With your permission this information will be passed on for investigation. Please be assured that your information will be treated in confidence and will not affect your job, nor will you be discriminated against for passing it on in any way. However, confidentiality cannot be guaranteed if malpractice is revealed.

If you have a question about any aspect of this study, please ask your Maternity Services Line Manager or Kim Sutton, SUHT Voluntary Services Manager, the hospital supervisor for this project who will do her best to answer your question, telephone 023 8079 6062 or to Linda Cadier, Researcher for this project on 07xxxx or e-mail her to l.cadier@soton.ac.uk.

If you remain unhappy and wish to complain formally about any aspect of this project, you can do so through the NHS Complaints Procedure (or Private Institution). Details can be obtained from the Hospital.

Or you may contact Dr Martina Prude, Head of Research Governance, University of Southampton on 023 8059 5058 or in writing to: Building 37, Level 4, Room 4055, University of Southampton, Highfield Campus, Southampton SO17 1BJ.

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee.

7.5. E-mail cover note and letter of invitation to interpreters approved by MREC and SUHT R&D

Language and cultural practices of migrant communities

Dear Colleague,
Please find attached an invitation to take part in a study of the language and cultural practices of members of migrant communities, who do not have English as a first language, which will take place at the hospital over the next six months.

Participation in this study is entirely voluntary and you can withdraw from it at any time. A letter of invitation and project information sheet are attached. If you are clear about the nature of the study and the way in which you would be asked to be involved, please complete and return the attached consent form to me and I will then contact you directly to arrange a convenient time to meet.

If you have any queries, please do not hesitate to contact me directly.

Best wishes

Linda Cadier, Researcher

UNIVERSITY OF Southampton

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4 May 2010

The Language and Cultural Practices of Migrant Communities

Re: Invitation to participate in study

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT).

The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement, (please see the enclosed information sheet for more information about the study). The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

Migrants for the purposes of this research project are defined as those members of the community who may have recently arrived in this country and where English is not their first language.

REC ref: 09/H0502/108 278 version: 3
R&D number: RHM MED0859 Date: 1/11/09

We would like to invite you to share your perceptions, attitudes and experiences of the language and cultural practices of the communities with which you are involved. Information given to us in interviews will be presented anonymously so that you cannot be identified from what you said. The interview will take approximately one hour of your time. Interviews can be conducted at a time and place that is convenient to you.

This information will be used by Southampton University Hospitals Trust in strengthening and developing its patients' experiences and as part of the researcher's academic study.

Please let me know at the contact details below if this would be convenient.

Yours sincerely,

Linda Cadier, Researcher

7.6. Letter of invitation to community contacts approved by MREC and SUHT R&D

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13 September 2010

The Language and Cultural Practices of Migrant Communities

Dear Colleague,

Re: Invitation to participate in study

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement, (please see the enclosed information sheet for more information about the study). The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

REC ref: 09/H0502/108 281 version: 3
R&D number: RHM MED0859 Date: 1/11/09

POSITIVE ABOUT DISABLED PEOPLE

Migrants for the purposes of this research project are defined as those members of the community who may have arrived in this country and who do not have English as a first language.

As the researcher, I would like to invite you to take part in an interview with me to enable me to collect information about your perceptions, attitudes and experiences of carrying out these responsibilities in the hospital. Information given in the interviews will be presented anonymously so that you cannot be identified from what you said. The interview will take approximately one hour to complete. The interview can be conducted at a time and place that is convenient to you.

The study would also like to identify maternity patients from the migrant communities that request an interpreter and for the researcher to be present at on of their routine antenatal appointments (not the first booking). These patients will also be invited for interview with an interpreter present. Suitable patients will be identified by the community midwife at their first antenatal appointment and will be given a letter of invitation, project information sheet and consent form in their own language. If you are present, you will be asked to explain the contents of the letter, information sheet and consent form to the patient face-to-face and check that they have understood them. At a subsequent booking of a routine antenatal appointment for this patient, if you and the patient are in agreement, the researcher will attend.

This research will assist SUHT in strengthening and developing its patients' experiences for those with limited English proficiency and contribute to the academic research on the subject.

If you agree, please return the signed, completed consent form to me and I will contact you to arrange a convenient time to meet with you.

Yours sincerely

Linda Cadier, Researcher

7.7. Participant information for community contacts approved by MREC and SUHT R&D

UNIVERSITY OF Southampton

Southampton NHS
University Hospitals NHS Trust

13 September 2010

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The Language and Cultural Practices of Migrant Communities at Southampton University Hospitals Trust

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Migrants for the purposes of this research project are defined as those members of the community, from outside of the UK, where English is not their first language

What is the purpose of the research?

A research project conducted by the University of Southampton will explore the languages and cultural practices of migrant communities within Southampton University Hospitals Trust (SUHT). The purpose of the research is to provide a better understanding of the need for language and cultural support services at the Hospital and to provide recommendations for improvement. The overall aim of the project is to support Southampton University Hospitals Trust's service development vision to improve the patient experience for all members of the community. The data collected will also be used to inform a doctoral study to evaluate the impact of the global on the local and the way in which migrant communities make their place in their new homelands.

Why have I been chosen?

You have been chosen because you are in contact with those who may need to use the language support services at the hospital. We are looking for such people to participate in an interview to help us understand their needs and how this service is used at the hospital.

How will I take part?

The researcher will arrange an interview with you of about one hour. The interview will be tape-recorded. Your comments will be invited on a number of themes regarding your experience of language and cultural support services for the migrant communities that you are involved with or support.

Do I have to take part?

It is up to you to decide. The study lasts from April 2010 to March 2011. This is the description of the study and you can decide whether you would like to take part. If you are in agreement, please sign the enclosed consent form to indicate that you have agreed to take part. You may decide to withdraw from the study at any time and only information that you have given up that point may be used as part of the study.

What will happen with the results of this research?

The findings from the research will be written up in a report for the Hospital. The researcher will use the information gathered to inform the writing of an academic thesis. This information may also be used in articles prepared for academic and professional journals or presentations. Any references to interviews in reports, the thesis, articles and presentations will have personal, organisational and place names anonymised to ensure confidentiality.

If you have any question about this study, please contact:

Linda Cadier, Researcher, Department of Modern Foreign Languages, University of Southampton, Southampton SO17 1BJ

Tel: 023 8059 3298 Email: l.cadier@soton.ac.uk or

Kim Sutton, Head of Volunteering and Workforce Development, Southampton General Hospital, Tremona Road, Southampton SO16 6YD

Tel: 023 8079 6062

They will do their best to answer your questions. If you remain unhappy and wish to complain formally about any aspect of this project, you can do so through the NHS Complaints Procedure (or Private Institution). Details can be obtained from the Hospital. Or you may contact Dr Martina Prude, Head of Research Governance, University of Southampton on 023 8059 5058 or in writing to:

Building 37, Level 4, Room 4055, University of Southampton, Highfield Campus, Southampton SO17 1BJ.

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee.

7.8. Participant Informed Consent Form approved by MREC and SUHT R&D

Participant Informed Consent Form

Researcher: Linda Cadier

The Language and Cultural Practices of Migrant Communities

Please initial each box

1. I confirm that I have read and understand the information sheet dated 1/11/09 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without legal right being affected. ☐
3. I understand that I will participate in research about the language support services for migrants at the Hospital and that if I am interviewed the interview will be audio-recorded. ☐
4. I have informed the researcher if I am participating in any other research study. ☐
5. I understand that in any reference to my interview made in reports, research thesis, articles, and presentations and so on, personal organisational and place names will be changed (anonymised) so that I, and any other individuals mentioned cannot be identified. I also understand that fully anonymised verbatim quotations from my interview may be used in the ☐

report and subsequent publications.

6. I also understand that what I say will not be shared with other colleagues or patients. *[Please note that as required under the Data Protection Act (1998) your details will not be passed on to anyone else and data collected will be held securely].* ☐
7. I understand that I may be contacted again, if contact details are given, during the project for clarification of points raised in the interview. ☐
8. I agree to the possibility of the transcription of any interview being archived as an audio file and stored on a secure computer on the understanding that it will be totally anonymous such that nothing in it, such as organisation, place or individual names can be identified. ☐

I have read and understood the above information and agree to participate in this research project on 'The Language and Cultural Practices of Migrant Communities' that is being conducted by a researcher from the University of Southampton at the Southampton University Hospitals Trust.

Name.....

Signature.....

Date.....

If you have any question about this study, please contact:

Linda Cadier, Department of Modern Foreign Languages, University of Southampton, Southampton SO17 1BJ
Tel: 023 8059 3298 Email: l.cadier@soton.ac.uk or
Kim Sutton, Head of Volunteering and Workforce Development, Southampton General Hospital, Tremona Road, Southampton SO16 6YD
Tel: 023 8047 5312

If you have any concerns about this study or need advice, you can contact the Patient Advice and Liaison Service (PALS) by asking the ward staff or by calling 023 8079 8498 or by calling into the Information Point just inside the main entrance of the General Hospital. PALS is available 9am to 4.30 pm Monday to Friday. Out of hours there is an answer phone. If you have a problem that cannot wait until PALS are available contact the duty manager for the hospital via a member of staff or through the hospital switchboard 023 8077 7222.

Thank you.

Signed .....

Linda Cadier
Researcher

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