EQUAL ACCESS TO HEALTH INFORMATION: EVALUATING THE USE OF A MULTILINGUAL WEBSITE IN FACE-TO-FACE CONSULTATIONS. / IGUALDAD DE ACCESO A LA INFORMACIÓN SANITARIA: EVALUACIÓN DEL USO DE UN SITIO WEB MULTILINGÜE EN LAS CONSULTAS PRESENCIALES.

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Abstract: In a 21st century superdiverse world, public service providers increasingly resort to technologies facilitating face-to-face consultations. In this paper, we evaluate the use and efficiency of a multilingual website in 11 video-recorded consultations of HIV/STI counselling. We address three central research questions: (i) How is the multilingual website embedded (or not) in the consultations? (ii) For what particular communicative purposes? (iii) How are the interactional routines shaped by the use of the multilingual website? The results show that the website is most efficient in consultations characterized by high levels of institution-specific arrangements of talk enabling varying tasks, e.g. announcing the taking of a HIV test, asking the patient's consent for taking a HIV test, exploring sexual risk behaviours and infections, empowering the patient in the search for reliable information on sexual health related topics.

Keywords: Language support; Multilingual website; Sexual and reproductive health consultations.

Resumen: En un contexto de superdiversidad, los proveedores de servicios públicos recurren cada vez más a tecnologías para facilitar los encuentros multilingües. En este artículo evaluamos el uso y la eficiencia de un sitio web mediante el análisis de 11 consultas sobre VIH/ETS. Abordamos tres preguntas de investigación: (i) ¿Cómo se incluye (o no) el sitio web multilingüe en las consultas? (ii) ¿Con qué fines comunicativos? (iii) ¿Qué efectos tiene el sitio web en las rutinas de interacción? Los resultados muestran que el sitio web es más eficiente en consultas con organizaciones conversacionales específicas y propias de la institución. Así, el sitio facilita comunicar la realización de una prueba VIH, solicitar el consentimiento del paciente para realizarla, explorar conductas sexuales de riesgo, y capacitar al paciente en la búsqueda de información fiable sobre temas relacionados con la salud sexual.

Palabras clave: Apoyo lingüístico; Sitio web multilingüe; Consultas de salud sexual y reproductiva.

1. Introduction

In a 21st century globalized and superdiverse world (Vertovec, 2007; Arnaut et al., 2016), public service providers face multiple challenges: the demand for Public Service Interpreting and Translation (PSIT) is stronger than ever. PSITs for lesser resourced languages are often scarce, government budgets for PSIT are tight, public policies ensuring quality standards and procedures for language support are lacking, PSITs face high workloads and service encounters need to be handled swiftly (Valero-Garcés, 2014; Tipton and Furmanek, 2016).

Still, public service providers have been able to rise to these challenges by tackling technology and expanding their expertise. Social workers, legal counsellors and health care service providers increasingly resort to technologies facilitating non-face-to-face encounters (e.g. Instant Messaging systems, tools for remote interpreting services, see e.g. Braun, 2015), as well as digital resources supporting face-to-face encounters (e.g. machine translation systems, terminological resources, multilingual question-answering systems or audio-recorded pre-translated messages, see e.g. Cox and Gutiérrez Lázaro, 2016; Kerremans et al., 2018).

Bringing in technological tools in face-to-face interactions means bringing in another *voice*, a *third party*, which in turn requires flexibility and a tolerance of ambiguity (Swinglehurst et al., 2014). Research on the communicative effects of technological tools in face-to-face interactions also warns of an increase in the duration of the service encounter and a loss of eye contact between participants (De Wilde, Van Praet and Van Vaerenbergh, 2019; Van Praet, De Wilde and Karanfil, forthcoming). Conversely, research also underscores positive effects on participants' mutual comprehension and well-being measured in terms of perceived service outcome satisfaction (De Wilde, Van Praet and Van Vaerenbergh, 2019).

The data discussed in the present article follow from this strand of research. In particular, we elaborate on prior research conducted in 2013-14. At that time, the Ghent University Research Unit *Multiples* collaborated with the then Flemish expertise centre 'Kruispunt Migratie-Integratie' or Junction Migration-Integration (now the Flemish Agency for Integration and Civic Integration) to develop a decision tree ('matrix') enabling care providers to make informed decisions to communicate with non-native speakers of Dutch. Over the years, the decision tree was further refined by the Flemish Agency for Integration and Civic Integration and implemented by several public service institutions in Flanders who adapted it to their specific communication needs (e.g. Kind & Gezin *Gesprekswijzer*[1], see also Van Praet De Wilde and Rillof, 2014; De Wilde, Van Praet and Rillof, 2016; De Wilde, Van Hoof, et al., 2018). Public service providers can now consult the decision model on the Agency's website[2] and decide which bridging functions can efficiently be used when communicating with non-native speakers of Dutch, taking into account criteria such as the goals of the interaction and the participants' multilingual repertoire.

In this paper, we build on the knowledge gathered from this project and zoom in on the effects of using technology in face-to-face communication about sexual health with non-native speakers of Dutch. We analyse a subcorpus of a research project evaluating the multilingual multimodal website zanzu.be. This website was launched in Belgium in 2015 by Sensoa vzw, the Flemish expertise centre for sexual health and aims at facilitating communication with foreign-language migrants on sexuality and topics related to sexual health. For the evaluation of the website zanzu.be we used a mixed-methods approach and collected three different data sets: (1) an online survey of 247 professionals, (2) data from interviews with 24 migrants residing in Flanders and (3) 11 video-recorded interactions of HIV/STI[3] (prevention)

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[1] The online learning module is open access, but users have to register first through following the tab "gesprekswijzer" on https://www.kindengezinacademie.be/course/index.php?categoryid=7

[2] https://www.integratie-inburgering.be/communicatiewaaier

[3] Sexually transmitted infection.

counselling and birth control where the website is used in support of the multilingual communication (for a report on the first and second data sets, see De Wilde, Van Praet, et al., 2018). For the purpose of this paper, we will discuss only the third data set and address three central research questions: (1) How is the multilingual website embedded (or not) in these interactions? (2) For what particular communicative purposes is the website used? (3) How are the interactional routines shaped by the use of the multilingual website?

Before embarking on the results in section 3, we will elaborate on the research method, data collection and research context in section 2.

2. Method, data collection and research context

The dataset consists of 11 video-recorded authentic consultations between service providers (SPs) and vulnerable migrants[4], either in a one-on-one conversation or a two-on-one conversation, in cases where the patient was accompanied or when two SPs conducted the consultation together. The duration of conversations varies between 12 and 26 minutes[5]. 8 interviews were conducted by a specialist nurse, 2 by a doctor and 1 by a doctor and nurse team. In 2 of the 11 consultations, an intern/volunteer was also present.

All the interactions took place between October and December 2017 in the Antwerp section of the NGO *Dokters van de Wereld* ("Doctors of the world")[6]. We limited data collection to one single fieldwork site for 2 reasons. First, access to the field and data collection turned out to be more complex than we had anticipated because we came up against organisational obstacles (i.e. staff's busy time schedules, difficulties in planning in advance the types of services or the topics and the patient/client language background) and reservations regarding the type of data (i.e. video recording). A second reason for limiting data collection to one single ethnographic setting was methodological: in view of the contrasting scope (i.e. comparing consultations *with* and *without* the use of the website), we aimed at collecting consultations that are comparable in terms of conversation methods, relationships between participants and institutional purposes. By collecting data in a single organisation we increased the likelihood of this comparability.

The NGO caters to a multilingual and multi-ethnic clientele. It operates a typically mixed economy of language support (Tipton and Furmanek, 2016) combining paid (multilingual) staff and unpaid volunteers, paid professional interpreters and unpaid lay interpreters, either physically present or via remote interpreting. Next to that, the NGO also uses information leaflets in various languages, Google Translate, and picture and photo material to facilitate communication. The NGO does not use a formal language policy to determine which kinds of language support are best suited for a specific kind of interaction or set of conditions (e.g. patient or SP characteristics, topic sensitivity, etc.). Determining the language of the interaction and assessing whether the patient has sufficient knowledge of Dutch, or whether the service provider should switch to another language, is usually done

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[4] "Vulnerable migrants" are defined by Sensoa vzw as "first generation migrants who are more vulnerable to sexual health risks, due to particular social, economic or cultural reasons" (Decat et al., 2011, our translation). The category groups persons with a varying profile with regard to status and origin and includes newcomers, refugees, asylum seekers and people without a legal residence.
[5] Only actually completed consultation time is taken into consideration here: long interruptions caused by a telephone call to a partner institution for a referral appointment, or long interruptions for carrying out additional examinations in another room (e.g. urine sampling, blood collection), were filtered out.
[6] The NGO 'Dokters van de Wereld' is the Belgian section of Médecins du Monde. The organization was a pioneer in humanitarian aid by broadening its focus and including developed countries. The NGO provides medical care where this is not (yet) provided by the government. See also: https://doktersvandewereld.be/over-ons#Onzewerkterreinen

intuitively and after a very brief initial language negotiation, where the SP asks a short question in Dutch. If the patient communicates that his or her knowledge of Dutch is not sufficient, through silence, gesturing or by answering the question in another language, then the SP explores other options, usually working with a contact language. In the 11 consultations analysed here, conversations took place either in Dutch, or in a contact language (French or English in this corpus). In one case, an Arabic-speaking patient asks permission to call an acquaintance for language support via telephone. This consultation is conducted through remote telephone interpreting with a non-professional Dutch Arab interpreter and the multilingual website. In none of the consultations analysed for this article does the conversation break down or is it abruptly interrupted because of the patient's insufficient command of either Dutch or a contact language. However, this does not allow us to determine participants' mutual comprehension with absolute certainty, because the researchers involved did not assess patient comprehension directly (e.g. by asking the patient to recount the information conveyed during the consultation in his or her native language) nor did we ask the SPs if they experienced difficulties understanding specific parts of the patients' contribution. Instead, patient comprehension was assessed only by the researchers involved who drew conclusions on the basis of analyses of interactive discourse management, in particular with regard to (verbal and non verbal) turn-taking and communicative feedback (or the lack thereof).

Initial ethnographic activities (observations and ethnographic interviews with the NGO's SPs and volunteering staff) aimed at collecting basic information on the general working procedures, targeted audiences, types and frequency of health care services offered, types and basic principles of HIV/STI counselling, conversation structure. After preliminary ethnographic activities, the staff recorded consultations in the absence of the researchers who had previously set up practical arrangements for recordings combining three viewpoints: (1) one camera pointed at the SP, (2) one camera pointed at the client and (3) one screen capture recording of the SP's computer in order to monitor the movements on the multilingual website.

Broadly speaking, the subjects of the recorded consultations fall into three categories or a combination of these: (1) family planning, (2) general sex education and (3) HIV/STI prevention and infection. The latter category was most frequently discussed in the data-set and concerns discussions on clinical symptoms in case of suspected STIs, identifying risk behaviour for STI and HIV infection, taking HIV rapid test and communicating the results, and performing pre-test counselling (HIV and STIs) to discuss risky behaviour.

In order to answer the research questions, we examined which website pages were consulted and for how long, which particular website components or functions were activated (e.g. written text, images, read-aloud function, dictionary, search function), and how these searches were performed (e.g. web browser, predetermined website pages, website in-built search function). Next we juxtaposed these data with the communicative purpose(s), phases of the consultations, sequential organization, as well as with the patients' (verbal and non-verbal) reactions to the website content and the SP's verbal and non-verbal input. We repeatedly watched the video-recordings, with frequent pausing and note taking in separate text processing files. Due to budget constraints, multimodal transcriptions were done only for 6 of the 11 interactions, selected because they were either very 'typical' or extremely 'deviant' cases (cf. Patton, 1990).

For readers who are less familiar with conversation analysis, we will first explain two basic analytical notions that will be used in the results section (cf. Section 3). A first central notion is that of turn-taking, which traces back to work initiated by Sacks, Schegloff and Jefferson (1974) claiming that talk-in-interaction is ordered and organized and that speakers coordinate the talk according to a set of orienting rules with regard to who can speak at what particular moment. While the principle of taking turns in speech is claimed to be general, institutional interactions have distinctive features compared to ordinary talk. Heritage and

Maynard (2006) for instance describe medical consultations as interactive processes of turn-taking in which doctor and patient alternately take the floor, but where there are particular rights and obligations for turn-taking mechanisms. Likewise, in classroom interaction it will be mostly the teacher who has rights for speaker selection, much more than other participants, such as pupils.

A second basic notion is that of adjacency pairs, which consist of two turns or basic pairing linked by a particular relation of relevance and where the first pair part (e.g. question, invitation) conditions the production and interpretation of the second pair part (e.g. answer, acceptance).

3. Results

In general, the consultations followed a relatively uniform conversation structure. This specifically holds for the HIV/STI counselling. A typical session starts with a guarantee of discretion, and then follows mainly two broad formats, described previously for similar, though monolingual, healthcare settings as a combination of the *interview format* (IW) and the information or *advice delivery format* (ID) (Peräkylä and Silverman, 1991; Peräkylä, 1995). In the IW format the counsellor and the patient are aligned as questioner and answerer, i.e. the counsellor asks a question, the patient answers and so on. The chain of questions / answers (Q/A) is the basic structure. The Q/A chains fulfil information gathering phases with different purposes: factual information, enhancing or expanding information on such varied issues as intimate sexual relations, needle-sharing, administration and content of health education. In the ID format, on the other hand, the counsellor has the role of the speaker and the patient confines him- or herself to recipiency, i.e. the counsellor gives information, advice, guidance, and explanation whereas the patient confines him- or herself to the role of listener. This latter conversational format is characterized by a much more asymmetric division of labour: the counsellor talks most of the time whereas the role of the patient is limited to the expression of continuers and typical response-tokens such as *aham, hmm, yes*.

In what follows we will describe how the language barrier and the use of a multilingual website interact with or alter these typical institutional talk-in-interaction patterns. If we focus on the role the website plays during the conversations, we identify three main categories, which we will address in the next three sections.

3.1 Sequential embedding of website components

We labelled the first category *sequential embedding*. This category refers to situations where the website pages temporarily take over the role of the SP, notably in his or her role of information provider, i.e. when the information on the website is displayed by the SP, and the patient reads the information, or listens to it via the read-aloud function. Next, when the patient has taken in this information, the SP takes over the consultation again. This particular use of the website was mainly observed with patients with Arabic and Farsi mother tongue (or second language) and where communication via a contact language such as Dutch, English or French was difficult. In two cases the patient indicated that they were unable to read, at which point the SP activated the read-aloud function. In a number of other conversations the read-aloud function was spontaneously activated by the SP. In one other conversation the information was not assimilated by the patient through the read-aloud function, but only by textual input in the foreign language (Farsi). Screen capture observations showed that the sequentially embedded use of website pages was established for factual information on infections ("what is HIV and

AIDS"), ways of contracting ("how is HIV contracted", "how to protect against HIV/STIs"), "what is the HIV test", (v) "what are STIs", "treatment of STIs".

Interactional analysis highlights the communicative success of this procedure: both verbal and/or non-verbal patient reaction suggests that the patient has understood the contents of the website. Sometimes, the SP explicitly checks the patient's understanding ("did you understand?") or the SP continues with the explanation after the patient indicates that s/he has understood the page content, as happens in interaction (1):

(1) Conversation participants P = patient // SP: specialist nurse - image via screen recording with integrated audio + video. Contact language: English. Simplified multimodal transcription.

Turn		Transcription spoken word	Notes non-verbal communication
[Before: P read the info on the page "HIV test"].			
16	P	Yes, I understand	P directs gaze away from the screen and looks at SP, nods with head and therefore verbally indicates that read info was understood.
17	SP	Yes? (yes) OK. So uhm that's what we do eh we do tests for HIV for do for this disease (ah) okay? Now you have read this (yes) eh uhm you know a little bit about HIV?	Computer screen is turned again to SP. SP uses a lot of hand gestures, looking at P while she talks to him. When expressing the words "a little bit" she uses supportive hand gestures (2 fingers pressed together).
18	P	No problem	
19	SP	Yes? You think the test is okay?	SP leans slightly forward, big eyes, asking intonation.
20	P	Yes	
21	SP	Okay. Do you think you are at risk? Is there a chance you may have HIV?	Hand gestures, hand stretched out when first "you" is spoken.
22	P	Uhm …	

Table 1. Results of the sequential embedding of website components

The above interaction makes clear that the SP uses the explanation in the patient's native language to first check whether he agrees with the HIV test (turn 19) and immediately move on to the next phase of the interview, namely the discussion on possible risk behaviour that starts with the SP's words "Do you think you may be at risk?" in turn 21. In conversation analytical terms, both adjacency pairs of question/answer are possible only because pre-sequence information is transmitted through the website content. Put sharply, the website is essential for the management of the ongoing conversation: without the information previously inserted in this institutional talk, the SP would not have been able to ask agreement for the test (adjacency pair in turns 19/20) nor would she have been able to discuss sexual risk behaviour and infections with the patient (adjacency pair in turns 21/22).

The sequential embedding of the website in the conversation does not alter the pre-established system of turn allocation expected in this institutional setting: the SP is the one initiating the action of introducing a specific page so that the patient can read it in his native language. In a way, the website input only *replaces* information the SP would have given verbally in an information-providing conversation phase without language barrier and website-

facilitation. What is striking is that the SP states rather explicitly how this information fits into the subsequent agenda-setting moves when she mentions the purpose: "I'm going to take an HIV test, I'll show you something about it first". Only then is the laptop screen turned towards the patient, who reads or listens to the page content. The SP also often states out loud which part of the conversation and purpose they pursue through a certain action on the website. For example: "I'm going to explain to you what HIV is, here, you can read it in Farsi [points to the website on screen, and turns laptop to patient]".

Not only *before*, but also *after* the patient received specific information via a page, does the SP provide feedback and are links between conversation phases made explicit. In one particular consultation, the SP refers back after having activated the speak-aloud function of a webpage on HIV: "Ok, do you get the picture? So, you asked about cutting with a knife, a Gilette. I also have information about that". In this specific case, the service provider refers back to an earlier answer the patient gave to her question if she thinks she might be HIV infected. The woman had then formulated a rather unclear answer highlighting isolated words such as "friend", "Gilette knife", "blood". Here, after the woman received information about HIV infection in Arabic through the read-aloud function, the SP refers back to a previous sequence and uses the generic information on the website to formulate a *personalized answer* to the patient.

3.2 Simultaneous integration of website components

Next to sequential embedding of the website during the consultation, we also witnessed *simultaneous integration* of website components. In these cases, website components are used to support the SP's verbal communication, rather than substitute. For example: after previously ruling out an STI through a urine and blood test, the SP uses images on the website page of a man's internal genitals. The SP, who suspects a urological problem, uses these images to support a conversation in which she wants to make it clear that the patient will be referred to a specialist for additional tests. Contact language between the two participants is French.

(2) Conversation participants P = male patient // D: doctor - video-recording for D, only audio-recording for P. Contact language: French. Simplified multimodal transcription. Translation into English is signalled in **bold**.

Turn		Transcription spoken word	Notes non-verbal communication
9	D	ici, vous voyez l'image du testicule, le pénis, le vésicule et puis en derrière le prostate. Donc vous avez des douleurs quand tu fais pipi. Et ça [= D refers to pain] vient juste avant le pipi vient, ou déjà quand tu as l'intention que tu dois uriner? C'est déjà depuis ce moment que vous avez les douleurs ou juste quand le pipi sort? **here you see the image of the testicle, the penis, the blister and then behind the prostate. So you have pains when you pee. And that [= D refers to pain] comes just before the urine comes, or already when you intend to urinate? It's already from that moment that you feel pain or only when the urine comes out?**	D points to the image on the screen when she pronounces testicle, she then rotates the desktop screen so that both interlocutors, who are opposite to each other, can follow. D points again to the screen with finger and moves it regularly up and down.

10	P	Juste quand le pipi sort. **Only when the urine comes out.**	P directs gaze away from the screen and looks at D, and then immediately looks at the screen again.
11	P	Donc, je pense que vous avez l'urétra, donc le tube ici, il y a quelque chose dedans. Donc je pense que je dois vous envoyer à un spécialiste urologue pour voir s'il y a quelque chose dedans. **So, I think you have urethra, so the tube here, there is something in it. So I think I have to send you to a urologist specialist to see if there is anything in it.**	D points finger at image on screen and moves up and down, showing.

Table 2. Results of the simultaneous integration of website components

Besides images (as in excerpt (2)), the website's written input is also used to support the verbal message transfer. This is particularly the case when the SP uses a contact language and therefore experiences lexical retrieval difficulties of specialized terminology. In this case, the website's textual written input in the language of service provision serves as a cue to facilitate word retrieval and terminologically precise verbal production. For example, in a conversation between the SP (specialized nurse) and a female patient with contact language French, the nurse discusses various forms of contraception and uses the French version of the website as a support. Both participants look alternately at each other and at the laptop screen which stands between them on the table. The SP uses the text on the screen several times to support her message: for instance, after a hesitation, they both look at the web page and find the correct term in French; the SP corrects herself and reformulates a previously pronounced but non-existent French word for a specific contraceptive method. This simultaneous use of website components never alters the institutional structure of the talk: the SP never abandons her footing as questioner or information deliverer whereas the patient maintains the role of answerer or more passive recipient. There are short hesitations in their speech, but never awkward silences[7] nor is the ideal model of "no gaps no overlaps" (Sacks, Schegloff and Jefferson, 1974) overtly transgressed.

Where the sequential integration of page content is mainly about the relay of relatively defined and large parts of information (e.g. going through a page on "What is HIV?" or "How do you contract HIV?" can easily take up to 55 seconds), the support offered by the website in this case is aimed at a very timely integration of various semiotic modes (image, text in another language) mapped onto the verbal interaction between participants.

3.3 Website components as the object of conversation

Besides *sequential* and *simultaneous* use of the website (cf. 3.1 and 3.2), the website is typically referred to during consultations in still another form; i.e. as the *object* of conversation, rather than as a tool for facilitating the communication between the participants. This happens in both technology-facilitated (*with* website use) and technology-free consultations (*without* website use). In three of the four consultations where this type of use occurred, it was near the end of the conversation and always referring back to preceding talk. This latter case is particularly interesting in terms of goal-orientedness inserted at the end of a technology-free consultation and aims to personalize content which is available on the website and tailor it to a question or concern expressed by the patient during the conversation, but which could not be dealt with

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[7] In conversation analysis, silences of 4 seconds or more are evaluated as unnatural and/or awkward (Koudenburg, Postmes and Gordijn, 2011).

during the consultation. The SP then refers to the website content for additional information without actually using it during the consultation, and thereby seems to empower the patient's independent search for information and knowledge. Referring patients to externally available documentation is not different from other types of medical consultation nor is it specific to language discordant interaction. Our point is that the SP refers to information that is available in the patient's native (or contact) language and which she deems reliable.

In the following excerpt, after a negative HIV test, a male patient is referred to another specialized centre for testing other STIs, including hepatitis B. When delivering the referral documents, the service provider hands over first a business card of the website, along with additional information, and mentions hepatitis B in her explanation:

> (3) [SP - Specialist nurse] What we thought, I have good news for you. (...) You don't have HIV. So, what I wanted to give you was this paper with the website you can go on [SP hands business card of the website to the patient], to find out more about the diseases you can get from sexual contact. And as we discussed, I prepared a document for you [SP refers to referral document for the Institute of Tropical Medicine] I wrote down for hepatitis B. You can go to the website, look up hepatitis B, and see if you need testing.

In the previous section we discussed several ways in which the website is efficiently used during interactions, performing a role either subsequently or simultaneously to the SP's verbal speech transfer. In terms of context-specific goal orientedness, we observed that the website enables varying tasks: (i) announcing an HIV test, (ii) asking the patient's consent for taking a HIV test, (iii) exploring sexual risk behaviours and infections, (iv) answering specific questions related to ways of getting HIV, (v) empowering the patient in the search for reliable information on topics related to sexual health.

Findings are not, however, one-sidedly positive. The analyses reveal that the website is efficient in consultations characterized by high levels of institution-specific arrangements of talk. Put in other words: the website is used most efficiently in interactions where the topics, sequencing, types of expected contributions and order of speakership is well organized and predictable. HIV-testing pre-consultations, for instance, typically involve factual information about the infection, ways of contracting and of preventing HIV, and, therefore, involve predictable question-answer sequences on the patient's risk behaviour (e.g. questions on recent sexual activity, past blood transfusions, previous HIV tests, other STIs, etc.). However, when the structured and thus highly predictable character of the consultation decreases or disappears altogether, locating relevant website content across different pages proves time-consuming and delays the immediate interactional goal. Screen capture recordings testify to this: the SP is searching for the relevant information through chaotic, fast navigation movements back and forth to different navigation levels, or the same pages are being opened and closed several times successively. The SP's verbal and non-verbal behaviour also reflects these difficulties. In excerpt (4), which is very similar to excerpt (3) with the SP informing the patient on negative HIV-testing results and referring to a specialist centre for further STI testing, an unexpected question on the symptoms of gonorrhoea and chlamydia confuses the SP who was already working towards closing the conversation asking the patient whether she has any further questions:

(4) Conversation participants P = patient // SP: specialist nurse. Image via screen recording with integrated audio + video. Video-recording for SP, only audio-recording for P. Contact language English. Simplified multimodal transcription, inserted Dutch words are signalled in **bold**.

Turn	Participant	Transcription spoken word	Notes non-verbal communication and website movements

11.	SP	**Voilà**. I'll already give you uhm this. Do you have any more questions for me?	SP hands over referral document for the Institute of Tropical Medicine. Has given business card of the website previously. SP supporting hand gesture when saying "any more".
12.	P	Uhm not really	
13.	SP	Not really, okay.	SP supporting head nodding expressing negation.
14.	P	Uhm what is gonorrhoea actually?	P lays referral document on desk between participants, text turned towards SP. P points with finger to point on the referral document.
15.	SP	Gonorrhoea it's uhm **wacht eh** I will show you on the site (uhu) uhm then I can **hup**	I turns to the computer screen to look for something on the website. Hands laying on typing board but no movement recorded on website screen.
16.	P	And now syphilis also	P point to document. No screen movement. Hands still laying on typing board.
17.	SP	Syphilis also?	SP now withdraws hands from typing board, and points to referral document. No computer activity.
18.	P	It's not ((unclear)) to woman eh?	
19.	SP	Yeah but uhm syphilis less because syphilis it's more a sickness uhm that exists when two men have sex (ah) **ja**	
20.	R	**Oke** ((laughs)) that's for the gay men	P and SP both laugh.
21.	SP	Yeah (**oke**) it's more with gay men (**oke**) or uhm also anal sexual (aha) contact you can it. Chlamydia?	Hand P pointing to referral.
22.	P	Chla chlamydia?	
23.	SP	Yeah uhm **wacht eh** I will **ah nee** I will search it in English ((mumbles))	SP turns upper body again towards computer screen. Hands moving to typing board.
24.	P	So if I want to do test of uhm those tests I should go to this uhm hospital	

Table 3. Results of using the website components as the object of conversation

The SP experiences much more difficulty here in combining her verbal content and gestures with digital activity and movements on the screen. In fact, she does not execute any movement on screen, because the repeated questions from the patient interrupt her actions and make her lose track of the initial purpose of looking for information and showing the patient where to look on the website. The pauses, the repetitive continuers and the non-deliberate code-switches (turns 15 and 23) from English to the SPs mother tongue show that the patient's non-compliance with consultation phasing and her unexpected questions lead to a situation where the SP's (digital) skills decrease.

4. Discussion and conclusions

By making content available in 14 languages, the website zanzu.be promotes access to reliable information on sexual and reproductive health. Apart from being an important building block in assuring basic human rights (e.g. reproductive rights as established by the *World Health Organization* or the International Guidelines on HIV/AIDS by the *United Nations Human Rights*), reliable and broadly accessible information is also essential in terms of public health:

the prevalence of infectious diseases, such as HIV, or the number of unplanned / unwanted pregnancies and sexual violence has shown to be higher among first-generation migrants than among the general population (e.g. Alvarez del Arco et al., 2013; Keygnaert, Vettenburg and Temmerman, 2012).

The results of this paper call attention to the fact that use of the multilingual website in face-to-face interaction is neither straightforward nor automatic. The micro-analytical analyses demonstrate that the more structured and predictable the interaction is, the more efficient the use of the website will be. Technology changes the skill sets required of professionals aiming to effectively communicate but, most importantly, it requires time to reflect and anticipate on their conversational routines and departures from the routinized talk-in-interaction. Is the consultation divisible into clear phases? Which contents are typically communicated in specific consultation phases? How much input do I expect from the patient, and in which particular parts of the conversation? What does my patient (possibly) already know? Which key concepts and topic-specific terminology are likely to be used? Are they available in the patient's language through the website? Can I integrate them as written or audial input to support my speech? How strictly do I, as a professional, respect predefined consultation phases and overall structural organization? These questions are relevant for any type of service provision, but become pressing when deciding whether technology can or cannot bridge language discordance to reach institutional goals.

This brings us to another concern, situated not at the level of the individual SP but at the organisational and institutional level. Against the backdrop of rapidly growing multi-ethnic and multilingual realities, public service organisations and governments in Flanders (Geldof, Connerty and Phillimore, 2016; Noppe et al., 2018) are faced with the limits of traditional ways of language bridging and a pressing need for additional measures to ensure mutual understanding. Technological resources addressing these challenges are slowly gaining territory. The initiatives, some of which have been mentioned in the introduction, show that there is an increasing recognition of the needs faced by public SPs. Yet, what is often missing is an awareness of the fact that digital innovation is always a struggle and that novelties come with a host of fears and insecurities. To facilitate the implementation of digital language support tools in an age of superdiversity (Vertovec 2007), "institutions need to adopt a bottom-up, empowering culture and a trial-and-error mind-set, embracing failure as part of the process and understanding that capabilities are built up through experience over time" (De Wilde, Van Praet and Van Vaerenbergh, 2019: 35). What is more, in the process of change, SPs need to be given the opportunity to take a step back for reflection (see also Iedema and Carrol, 2013). To exploit the full potential of technological mediation in language discordant health care encounters, it is highly recommended that public institutions invest in additional training sessions or facilitate peer learning network meetings to encourage reflection.

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